



## **UBC FAMILY PRACTICE RESIDENCY PROGRAM**

### **PRECEPTOR WORKBOOK**

(Teacher's Toolbox 2011 Edition)

## **Section I: Tips for Preceptors**

## ***Short Tips/Pearls***

(Source: Internal Communication{Abbotsford}, UBC – “Teaching Skills”, Teacher’s Toolbox 2010)

## **Section II: Resident Benchmarks**

## ***Goals for every 6 months of Residency***

(Source: [www.familymed.ubc.ca/residency](http://www.familymed.ubc.ca/residency) -Resources for Evaluating Residents)

## **Section III: Guide to Certification**

## ***SAMPs, SOOs***

(Source: CCFP Website)

## **Section IV: Priority Topics**

## ***List of Topics/Description***

(Source: CCFP Website)

## **Section V: CanMeds Roles**

## ***Description/Definitions, Concepts vs. Competencies/Curriculum Objectives***

(Source: [www.familymed.ubc.ca/residency](http://www.familymed.ubc.ca/residency))

## **Section I: Tips for Preceptors**

### **1. Topics:**

- How to prepare your Office for Teaching?
- How to prepare you Patients for Teaching?
- The Learning Cycle
- How do we apply the Learning Cycle to Teaching?
- “Random Chart Teaching”
- Teacher’s Toolbox workshop Summary
- Goals for the Second 6 months of the Residency Program

### **2. This is “Work in Process/Progress” – Lead and Site Faculty should add to this list – current topics are a “How to get started” list.**

## **Section II: Resident Benchmarks**

The Benchmarks have been organized into five stages:

**Stage I:** Beginning of First Year Residency

**Stage II:** End of First Six Months

**Stage III:** End of First Year

**Stage IV:** End of Eighteen Months

**Stage V:** End of Two Years Residency

**Note:** Be aware of the required skill levels at the end of each stage. Discuss with the Resident and frequently refer back to the document to check progress.

### **Section III: Guide to the Certification Examination in Family Medicine**

1. Examination Description
2. Short Answer Management Problems (SAMPS)
3. Simulated Office Oral (SOOs)

### **Section IV: Priority Topics and Key Features for Assessment in Family Medicine**

1. A List of the 99 Key Topics
2. A detailed description of the Required Knowledge/Skills for the Assessment of each Key Topic

Most of the Key Topics will be covered in Formal Lectures or during Clinical/Case Discussions.

Residents should be encouraged to review the requirements for each topic before every lecture and also use this information to direct their questions during case discussions.

## **Section V: *CanMeds Roles***

- 1. Description of CanMeds Roles**
- 2. Relationship Four Principles of FM <--> CanMeds-FM Roles**
- 3. Description of Four Principles of Family Medicine**



## **Section I: *Tips for Preceptors***

### **Topics:**

- How to prepare your Office for Teaching?
- How to prepare you Patients for Teaching?
  - The Learning Cycle
- How do we apply the Learning Cycle to Teaching?
  - “Random Chart Teaching”
  - Teacher’s Toolbox workshop Summary
- Goals for the Second 6 months of the Residency Program

## **HOW TO PREPARE YOUR OFFICE FOR TEACHING**

At this stage it is important to inform your office manager/staff that you will have a learner/resident in your office from July. Invite all of them to be active participants in the program. They need to be aware that the residents are young doctors and that they will be seeing patients under your supervision.

Most physicians use a "wave" schedule: They continue to see patients and will see 2-3 or more patients while the learner has more time with one patient. The teacher and learner will then have a brief discussion. This can be in front of the patient with the patient participating in providing more information or to confirm physical findings. Focus on one aspect and identify topics for more detailed discussion later. Keep the "wave" moving.

The learner can initially see 1-2 patients per hour with (identified by the teacher) with waiting time to do some reading on the case for later more detailed discussion. Be specific in your instructions and make clear your expectations. "Take a complete history". "Take a past medical and surgical history only". "Examine the shoulder". "Examine the ENT system". Or, "This is a short case: Find out what is wrong with this patient". As the learners gain more experience they will be able to see more patients per hour and you can expect a more detailed management plan.

It is easier for the learner to use a spare examination room. This will cause the least disruption to the teacher's schedule.

Make sure the office staff is made aware of these arrangements and ask for their input at this stage on how it will work best in your office situation to maximize efficiency and minimize disruption.

## **HOW TO PREPARE YOUR PATIENTS FOR TEACHING**

"Our Patients are our best Teachers".

Our patients will be valuable partners to us as teachers. We need to ask their permission to involve them in teaching. Most of them will be excited to be involved. Invite them to give feedback to the learner. Make sure they are reassured that you are still in charge of their care.

Select patients that are appropriate and receptive to involving a learner. Their problems should be common and straightforward. Select friendly patients who are good communicators.

The following is a sample office sign:

THANK YOU!

This practice serves as a teaching site for Family Practice Residents at the University of British Columbia School of Medicine.

As a patient of this practice, you are helping to educate new doctors in the skills necessary to be competent and caring Family Physicians.

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UBC Family Practice Program Preceptor

Ask your resident to write a short letter of introduction for your patients to be posted in the examination rooms or to be handed to the patient before the visit.

### THE LEARNING CYCLE

The following is a Competency Based Model of Learning.

1. A learner may feel s/he could easily do a procedure = Unconsciously Incompetent.
2. Given the opportunity to try to do the procedure, s/he realises it is not as easy as they thought = Consciously Incompetent.  
--> they now realise the learning need and are now motivated to learn

3. By focusing on every step of a technique/skill, repeating the steps, rehearsing and reading, the learner becomes Consciously Competent.
4. The learner stops thinking about the steps and rely on experience rather than textbook knowledge = Unconsciously Competent - doing things without thinking.

**Key concept: Learners need to DO things.**

### HOW DO WE APPLY THE LEARNING CYCLE TO TEACHING?

"Learners need to DO things"

As experienced clinicians, we are Unconsciously Competent. We make many clinical decisions without thinking, based upon our experience.

But, how do we become good teachers?

The best teachers are Consciously Competent, they can see and teach the steps. By teaching the steps repeatedly to our learners, they will over time transition from Consciously Incompetent to Consciously Competent and with more experience eventually become Unconsciously Competent.



### **Key points:**

1. As experienced clinicians (Unconsciously Competent), we need to take a step back and think through the steps of clinical decision-making (Consciously Competent) to be good teachers.
2. We need to understand where our learners are in this process (Unconsciously Incompetent/Consciously Incompetent) and how they will become Consciously Competent.
3. Our learners need to do things repeatedly to learn/gain experience.
4. Our learners will make mistakes and that is okay. The learning cycle is a **process**.
5. Our learners deserve feedback on their progress.

### **TEACHER'S TOOLBOX WORKSHOP SUMMARY**

The following is a summary of useful tips given at the Teacher's Toolbox workshop at UBC (2010). These were contributions from a wide range of very experienced preceptors.

1. **Benchmark Document**: This document can be found at [www.familymed.ubc.ca/residency](http://www.familymed.ubc.ca/residency) - check under Resources for Evaluating Residents. This document is essential to manage resident and preceptor expectations. It gives clear targets for every 6 months regarding skills level to be achieved. This document is most useful if you discuss it with the resident and keep a copy in your office and frequently referring back to it to

check whether you are on track. All the experienced preceptors at the workshop referred to this document as a most useful guideline for progress. I have used it over the last month and can testify to the same.

2. **Objectives**: This document can be found on the same website as above - check under Residency Program and Curriculum Objectives. This is a very comprehensive document, but it is quite easy to find the information you are looking for. It has very clear headings to guide you through the topics. For example: You may be interested to know which ethical issues need to be discussed with the resident. Use this as an example and check under "Ethics" and you will find a comprehensive list of the issues we are faced with every week as FPs. Note: In one of my previous e-mails I have discussed a topic "Random Chart Teaching" - please review this. This is a great technique to cover a wide range of topics in a relatively short time - very time-effective teaching technique.
3. **Feedback**: Set aside time for feedback every week. Example: Give the resident 15 minutes and yourself 15 minutes. Note: Feedback is not the same as evaluation. This is more a "How are we doing?" discussion.
4. **Observation**: This is an essential part of evaluation. It does not need to be the full history or physical examination, can be more focused on one aspect. A chart review is also a form of observation. Note: On the above website under Resources you will find a PowerPoint presentation on Observation for 1.5 Mainpro credits. This gives very practical ideas and tips on observation.

5. "Free the Reporter": Encourage the Resident to give a diagnosis/differential diagnosis and then ask: Why? - they need to be able to back it up with symptoms/signs.
6. "Don't tell it all": Identify a pearl, a take home message. Teach approach. Give homework: This is the lipid profile of this patient (chart). What should the target LDL be for this specific patient and why?

#### **"RANDOM CHART TEACHING"**

You may find the following teaching technique useful. It is widely used by the Royal New Zealand College of Family Physicians. FPs in NZ meet monthly in small groups and use this tool as a self-directed CME tool.

Preparation: The teacher/preceptor asks his/her MOA to keep out all incoming mail for a specific day and attach it to the individual patient charts. The mail will include blood test results, imaging results, specialist reports, ER visit reports, requests from LTC facilities etc.

Method: You will set aside a fixed time for this learning activity.

1. The learner will pick a chart at random.
2. The teacher will present the case to the learner.

3. The teacher will hand over the result/report to the learner for comments.
4. The teacher will facilitate discussion by asking questions:
  - How do you interpret this report?
  - Was the test appropriate?
  - Will the result change management?
  - Did the result confirm the diagnosis or was there a more appropriate test?
  - Should further tests be done?
  - Should this patient be seen for discussion and how soon? What advice will you give the patient?
  - Why was the specialist's findings that much different from mine?
  - Why did this patient go to the ER?
  - Could I have done something to prevent this ER visit, like being more accessible to my patients? Etc.

You will notice that you can cover a wide range of topics in a short space of time. It will also help the teacher to identify patients for the learner to follow-up. This is an excellent tool to teach clinical decision-making skills.

#### **GOALS FOR THE SECOND 6 MONTHS OF THE RESIDENCY PROGRAM**

(From the "Residents Benchmark Document")

1. Residents still need to discuss each patient case with the preceptor – discussions should be more brief and focused.

2. Ongoing relationship between residents and patients should be patient driven. Patients should still maintain a connection with the family physician, while residents are encouraged to be involved with continuity of care.
3. Increasing share in decision-making regarding patient care – full spectrum of cases/diseases seen by preceptor.
4. Look for gaps in knowledge (refer to the “Priority Topics”) and encourage the resident to read and consult treatment guidelines.
5. Discuss preventative care in patient management in addition to disease management.
6. Review examination techniques and observe interviews with patients.
7. Emphasize psycho-social aspects of patients’ experience of illness.
8. Resident to review all tests ordered by them and arrange for follow-up discussions with patients.
9. Residents need to understand billing procedures and start billing for patients seen by them.
10. Review record keeping. Residents need to sign all entries and it should still be counter-signed by the preceptor.



## **Section II: Benchmarks**

**Stage 1: Beginning of the First Year of Residency**

**Stage 2: End of the First 6 months**

**Stage 3: End of the First Year**

**Stage 4: End of 18 months**

**Stage 5: End of 2 Years**

## **Stage I: Beginning of First Year Residency**

### **Resident Abilities (Bordage I or II):**

- Able to take a history and perform an examination. However, hospital-based style; prolonged, mechanical, unfocussed and takes up to an hour to conclude.
- Large gaps in knowledge base especially in relation to commonly seen family practice problems. Unable to differentiate common symptoms from uncommon ones since those seen in hospital practice are skewed.
- Little deductive ability since symptoms are common and disease is not.
- Scant knowledge of therapeutics including drugs and therapies let alone knowing what therapies are likely to influence outcomes.
- Often does not articulate awareness of psychosocial or contextual issues of patients.
- Conversely, medical school education may have focused on the psycho-social approach to the neglect of other competencies.

### **Responsibilities & Goals Of Resident:**

- Need to familiarize themselves with family practice type of problems.
- Consult with preceptor on each case.
- Constantly review how investigations help to determine the management of current problems. Not all investigations need to be done at once; learning concept of step-wise approach.
- Learn to recognize that problems are undifferentiated and often are not solved at first or even subsequent visits.
- Getting comfortable with uncertainty.

- Becoming aware of the long-term relationship with patients and the importance of family relationships.
- Acquiring effective communication skills, including both verbal and non-verbal cues given by the patient.
- Learning how to give succinct and accurate precis of the pertinent clinical findings to the preceptor.

### **Response of Preceptor Over First Six Months of Residency:**

- Early, observe complete history and examination until comfortable those resident shows appropriate and consistent skills.
- Observe resident doing several pelvic exams.
- Thereafter, observe at least part of the histories and selected examinations once daily or more often if warranted at this level of training.
- There must be a formal viewing of the resident interacting with a patient once a week and a log or note of this encounter kept.
- Look for the resident becoming at ease in greeting patient and being able to initiate the interview.
- Allow lots of time for interviewing, half to three-quarters of an hour.
- Encourage resident to explain thinking patterns and how differential diagnoses are entertained. Ask "What else did you consider"
- Encourage resident to make a most likely diagnosis in each case and the reasons, i.e., make a commitment. Ask "What do you think is going on".
- Emphasize the merits of the SOAP record keeping, with particular stress on the Assessment so you can see the resident's pattern of thinking.
- Emphasize common and most likely diagnoses.

- Tell them what they did right and how that impacts the patient.
- Correct mistakes.
- Encourage resident to read around cases and use the Internet, then report back to you the results of their enquiries.
- Stress the acquisition of a professional approach, appropriate boundary setting and when and where revealing personal information is helpful therapeutically

Date discussed: \_\_\_\_\_

## **Stage II: End of First Six Months**

### **Resident Abilities. (Bordage II):**

- Histories are crisper and better use is made of the patient record and the resident is more comfortable with focused examinations.
- Growing comfort with the patient population and the recognition of people as people, warts and all and the fact that everyone needs professional long-term health care.
- Better appreciation of range of common problems seen in family practice.
- Less likely to consider esoteric diagnoses at first contact.
- Increased ability to demonstrate empathy and active listening.
- More rational use of investigations.
- More familiarity with pharmaco-therapeutics but still large gaps in knowledge and often irrational choice of drugs for family practice.

### **Responsibilities & Goals of Resident:**

- Increased understanding of range of problems dealt with in family practice.
- Building up a group of patients who have been seen on several occasions and who are happy to see the resident on a long-term basis.
- Early understanding of disease and illness patterns in family practice.
- Better understanding of psychosocial issues in illness presentation.
- Beginning to see opportunities for counseling on preventative strategies.
- Still uncertain of own ability to manage family practice problems but less intimidated than six months previously.

- Still dependent on preceptor to make decisions.

### **Response Of Preceptor - Six Months to One Year into Residency:**

- Still need to discuss each case with resident but inter-actions briefer and more focused.
- Acknowledgment that relationship with resident still often patient -driven and most patients want to maintain their connection to you, their family doctor.
- Allow resident an increasing share in decision-making re patient care.
- Remain vigilant for gaps in knowledge and encourage resident to read and consult guidelines. Do they know how to do this quickly and efficiently? Don't assume all residents are highly computer literate.
- Spend time in discussing preventative care and indicate where resident can take the initiative in broaching the topic.
- Review exam technique and watch resident interview intermittently. Formal weekly sessions are still required.
- Probe for understanding and appreciation of psychosocial aspects of patients' experience of illness/experiences.
- Have a system in place whereby resident reviews all tests ordered by them and handles phone calls by patients they have seen.
- Resident needs to understand billing procedures and be billing for patients seen by them.
- Watch for some residents becoming over-confident and over-estimating ability.
- Review record keeping. It should be exemplary by this stage. To protect yourself legally, residents should sign all entries and

have it counter-signed by you. Alternatively, have the resident write that the case was discussed and with whom.

- Preceptor should have a good appreciation of a resident's ability. Any misgivings should be discussed with the resident's educational advisor or the program director.

Date discussed: \_\_\_\_\_



### **Stage III: End of First Year**

#### **Resident Abilities (Bordage II-III):**

- Very comfortable with the family practice setting.
- Good rapport with patients.
- Able to conduct an interview within half an hour.
- Listens well and able to prioritize patient needs/issues.
- Cues into "Red Flag" signs and symptoms.
- Able to formulate a reasonable management plan.
- Still tends to over-investigate.
- Much better grasp of therapeutics, but still needs lots of mentoring.
- Should have respectful relationships with office staff and recognize them as a resource to the physician and the patients.
- Able to confidently and reliably deal with lab results, consultations with specialists, phone calls and requests for medication refills.
- Growing awareness of community resources.

#### **Responsibilities & Goals of Resident for Next Six Months:**

- More aware of weaknesses in the knowledge base and beginning to organize electives to remedy them.
- Recognition that one person cannot carry all the knowledge needed to be effective. Must have an organized approach to accessing knowledge and information.
- Now feels can accept increasing responsibility for patient care.
- Wants increasing autonomy from preceptor in handling patients.
- Still reliant on preceptor in many cases for help with patient care.

#### **Preceptor Response One Year to Eighteen Months into Residency:**

- Gradual relinquishing of teacher/learner role and increasing collegial relationship as resident matures. Period of consolidation.
- Should now be fully integrated into the practice on-call system.
- Allowing resident increasing autonomy in interview situation and less supervision as merited.
- Allows resident to make some decisions regarding patient care even if preceptor is not in full agreement, so long as patient well-being is not compromised.
- Maintains regular feedback both positive and negative.
- Keeps time available for resident to discuss cases and soliciting help.
- Regular review of cases at end of day especially the problematic cases and where more detailed discussion is needed.

Date discussed: \_\_\_\_\_

## **Stage IV: End of Eighteen Months**

### **Resident Abilities (Bordage III):**

- Should be seeing patients at a comfortable rate every fifteen minutes and no more than 20 minutes for a regular appointment.
- Where it is not possible to deal with all the patients concerns, able to prioritize and arrange to see patient at another appointment without patient feeling short-changed.
- Able to see patients alone and make therapeutic decisions in most cases.
- Still needs to consult preceptor over more difficult problems.
- Good appreciation of limitations.
- More comfortable in challenging preceptor over diagnosis and management.
- Manages challenging interactions with effective communication skills and self-awareness.

### **Responsibilities & Goals of Resident:**

- Eager to be well prepared for the CCFP exam.
- Seeking skills in areas of Family Medicine that are deficient or where there is a particular interest.
- Spending more time to complete research project.
- Increasingly aware of the business aspects of entering practice. Spends more time with practice manager or MOAs to see how they do their job.
- Wants to assume responsibility for decision-making for patients' visits as much as possible.

### **Preceptor's Response Eighteen Months to Two Years of Residency:**

- Comfortable in allowing resident to manage care of patient in office.
- Ensuring resident manages time effectively and copes with pressures of day to day practice.
- Increasingly, contact with some patients limited to ensuring that the patient knows that you are still their doctor and will maintain continuity of care.
- Most of the interaction with the resident is on a collegial basis.
- Comfortable with asking resident's advice on difficult cases.

Date discussed: \_\_\_\_\_

## **Stage V: End of Two Years Residency**

### *Resident Abilities (Bordage IV, but at least II):*

- Resident has demonstrated competency through practicum.
- Able to manage office practice, lab and other paperwork, on-call and in-patient responsibilities.
- Interacts with patients and colleagues at the level of a new locum
- Resident has been asked to do a locum for you.
- Preceptor looking forward and prepared to do the whole thing over again with another resident.
- Sadness at seeing resident leave your practice

Date discussed: \_\_\_\_\_



## **Section III: Guide to Certification**

### **Description**

**Short Answer Management Problems (SAMPs)**

**Simulated Office Orals (SOOs)**

## **EXAMINATION DESCRIPTION**

The responsibility for the design and content of the certification examination has been entrusted to the College's Committee on Examinations. The examination is designed to assess the knowledge and skills of candidates in relation to the four principles of family medicine (see appendix A):

*The family physician is a skilled clinician.*

*Family medicine is a community-based discipline.*

*The family physician is a resource to a defined practice population.*

*Patient/physician relationship*

### **Defining competence for the purposes of certification by the College of Family Physicians of Canada: The evaluation objectives in family medicine.**

The evaluation objectives, including topics and key features which guide the College's Committee on Examinations in the development of the test items for the Certification Examination in Family Medicine, is available on the CFPC website. These materials / documents will serve to ensure that the examination maintains acceptable validity and reliability. To do this the evaluation objectives have been designed to clearly describe the domain of competence to be tested within each topic area. The majority of cases will be based on these evaluation objectives.

### ***THE WRITTEN EXAMINATION (SAMPs)***

The written examination is comprised short answer management problems (SAMPs) designed to test a candidate's recall of factual knowledge and problem solving abilities in the area of definition of health problems, management of health problems, and critical appraisal.

This portion of the examination will be delivered using computer-based technology, will be approximately six hours in length and will involve approximately 40 to 45 clinical scenarios.

SAMPs are intended to measure a candidate's problem solving skills and knowledge in the context of a clinical situation. Basic information regarding the presentation of the patient will be provided and a series of three or four questions will follow for each scenario. When answering questions in this examination please read the question carefully and provide only the information that is requested.

The following are some points to remember when answering SAMPs:

- When relevant, the setting in which you are practicing will be described.
- You can answer most questions in ten words or less.
- When ordering laboratory investigations be SPECIFIC.
- When ordering other investigations, be SPECIFIC. For example, ultrasound is not acceptable, you must specify abdominal ultrasound.

- When listing medications, the use of generic names or trade names will be accepted.
- Give details about procedures ONLY IF DIRECTED TO DO SO.
- When providing values or measures only Systeme Internationale (SI) units will be accepted.
- Avoid abbreviations which are not commonly used and which may not be clear to an examiner.
- Put one answer per box, subsequent answers in the same box will not be considered.

Please refer to the CFPC website for an online demonstration of the SAMP examination

## *THE ORAL EXAMINATION (SOOs)*

The oral examination is comprised of five simulated office orals (SOOs) each 15 minutes in length. They are designed to duplicate, insofar as possible, the actual "setting" in which the family physician conducts a practice. Family physician examiners are trained to role-play patients presenting with specific complaints. The physician playing the role of the patient notes the management of the case by the candidate and he or she will score the candidate according to pre-defined criteria. This examination will assess both the definition and management of health problems. The scoring system has been devised to focus on the candidate's approach to dealing with patients -- including their ability to understand the patient's unique experience and to establish a positive doctor-patient relationship. Getting the "right diagnosis" plays only a minor role in the scoring. There are no hidden agendas.

A video demonstration of a SOO is available for download from the CFPC website [www.cfpc.ca](http://www.cfpc.ca). It is also available on DVD, upon request, for candidates who do not have access to the Internet.



## **Section IV:**

**Priority Topics**

**Key Features/Description**

**Curriculum Objectives**

## Priority Topics and Key Features

Abdominal Pain

Advanced Cardiac Life Support

Allergy

Anemia

Antibiotics

Anxiety

Asthma

Atrial Fibrillation

Bad News

Behavioural Problems

Breast Lump

Cancer

Chest Pain

Chronic Disease

Chronic Obstructive Pulmonary Disease

Contraception

Cough

Counselling

Crisis

Croup

Deep Venous Thrombosis

Dehydration

Dementia

Depression

Diabetes

Diarrhea

Difficult Patient

Disability

Dizziness

Domestic Violence

Dyspepsia

Dysuria

Earache

Eating Disorders

Elderly

Epistaxis

Family Issues

Fatigue

Fever

Fractures



Gastro-Intestinal Bleed  
Gender Specific Issues  
Grief  
Headache  
Hepatitis  
Hyperlipidemia  
Hypertension  
Immigrants  
Immunizations  
In Children  
Infections  
Infertility  
Insomnia  
Ischemic Heart Disease  
Joint Disorder  
Lacerations  
Learning (Patients/Self)  
Lifestyle  
Loss of Consciousness  
Loss of Weight  
Low-back Pain  
Meningitis  
Menopause

Mental Competency  
Multiple Medical Problems  
Neck Pain  
Newborn  
Obesity  
Osteoporosis  
Palliative Care  
Parkinsonism  
Periodic Health Assessment/Screening  
Personality Disorder  
Pneumonia  
Poisoning  
Pregnancy  
Prostate  
Rape/Sexual Assault  
Red Eye  
Schizophrenia  
Seizures  
Sex  
Sexually Transmitted Infections  
Skin Disorder  
Smoking Cessation  
Somatization

Stress

Stroke

Substance Abuse

Suicide

Thyroid

Trauma

Travel Medicine

Upper Respiratory Tract Infection

Urinary Tract Infection

Vaginal Bleeding

Vaginitis

Violent/Aggressive Patient

Well-baby Care

## Key Features/Description of Key Topics

### Tips:

- *Discuss with Resident*
- *Rate discussion*
- *Resident and Preceptor to keep record*

## **Abdominal Pain**

### *Key Feature*

- 1 Given a patient with abdominal pain, paying particular attention to its location and chronicity:
  - a) Distinguish between acute and chronic pain.
  - b) Generate a complete differential diagnosis (ddx).
  - c) Investigate in an appropriate and timely fashion.
- 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).
- 3 In a woman with abdominal pain:
  - a) Always rule out pregnancy if she is of reproductive age.
  - b) Suspect gynecologic etiology for abdominal pain.
  - c) Do a pelvic examination, if appropriate.
- 4 In a patient with acute abdominal pain, differentiate between a surgical and a non-surgical abdomen.

- 5 In specific patient groups (e.g., children, pregnant women, the elderly), include group-specific surgical causes of acute abdominal pain in the ddx.
- 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.
  - b) Make the diagnosis.
  - c) Stabilize the patient.
  - d) Promptly refer the patient for definitive treatment.
- 7 In a patient with chronic or recurrent abdominal pain:
  - a) Ensure adequate follow-up to monitor new or changing symptoms or signs.
  - b) Manage symptomatically with medication and lifestyle modification (e.g., for irritable bowel syndrome).
  - c) Always consider cancer in a patient at risk.
- 8 Given a patient with a diagnosis of inflammatory bowel disease (IBD) recognize an extra intestinal manifestation.

## Advanced Cardiac Life Support

### Key Feature

- 1 Keep up to date with advanced cardiac life support (ACLS) recommendations (i.e., maintain your knowledge base).
- 2 Promptly defibrillate a patient with ventricular fibrillation (V fib), or pulseless or symptomatic ventricular tachycardia (V tach).
- 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.
- 4 Suspect and promptly treat reversible causes of arrhythmias (e.g., hyperkalemia, digoxin toxicity, cocaine intoxication) before confirmation of the diagnosis.
- 5 Ensure adequate ventilation (i.e., with a bag valve mask), and secure the airway in a timely manner.
- 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.)
- 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.
- 8 Attend to family members (e.g., with counselling, presence in the code room) during and after resuscitating a patient.
- 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.

## Allergy

### Key Feature

- 1 In all patients, always inquire about any allergy and clearly document it in the chart. Re-evaluate this periodically.
- 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).
- 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).
- 4 Prescribe an EpiPen to every patient who has a history of, or is at risk for, anaphylaxis.
- 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.

6 Advise patients with any known drug allergy or previous major allergic reaction to get a MedicAlert bracelet.
<p>7 In a patient presenting with an anaphylactic reaction:</p> <p>a) Recognize the symptoms and signs.</p> <p>b) Treat immediately and aggressively.</p> <p>c) Prevent a delayed hypersensitivity reaction through observation and adequate treatment (e.g., with steroids).</p>
8 In patients with anaphylaxis of unclear etiology refer to an allergist for clarification of the cause.
<p>In the particular case of a child with an anaphylactic reaction</p> <p>9 to food:</p> <p>a) Prescribe an EpiPen for the house, car, school, and daycare.</p> <p>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.</p>
10 In a patient with unexplained recurrent respiratory symptoms, include allergy (e.g., sick building syndrome, seasonal allergy) in the differential diagnosis.

## Anemia

### *Key Feature*

- 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.
- 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.
- 3 In all patients with anemia, determine the iron status before initiating treatment.
- 4 In a patient with iron deficiency, investigate further to find the cause.
- 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.

- 6 In patients with macrocytic anemia:
  - a) Consider the possibility of vitamin B<sub>12</sub> 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.
- 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).
- 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.
- 9 In anemic patients with menorrhagia, determine the need to look for other causes of the anemia.

## Antibiotics

### *Key Feature*

- 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).
- 2 In patients with a clinical presentation suggestive of a viral infection, avoid prescribing antibiotics.
- 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.
- 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).
- 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).

## Anxiety

### *Key Feature*

- 1 Do not attribute acute symptoms of panic (e.g., shortness of breath, palpitations, hyperventilation) 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).
- 2 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:
    - other co-morbid psychiatric conditions.
    - abuse.
    - substance abuse.
  - c) Assess the risk of suicide.
- 3 In patients with known anxiety disorders, do not assume all new symptoms are attributable to the anxiety disorder.
- 4 Offer appropriate treatment for anxiety:
  - benzodiazepines (eg. deal with fear of them, avoid doses that are too low or too high, consider dependence, other anxiolytics).
  - non-pharmacologic treatment.
- 5 In a patient with symptoms of anxiety, take and interpret an appropriate history to differentiate clearly between agoraphobia, social phobia, generalized anxiety disorder, and panic disorder.

## Asthma

### Key Feature

- 1 In patients of all ages with respiratory symptoms (acute, chronic, recurrent):
  - a) Include asthma in the differential diagnosis.
  - b) Confirm the diagnosis of asthma by appropriate use of:
    - history.
    - physical examination.
    - spirometry.
- 2 In a child with acute respiratory distress, distinguish asthma or bronchiolitis from croup and foreign body aspiration by taking an appropriate history and doing a physical examination.
- 3 In a known asthmatic, presenting either because of an acute exacerbation or for ongoing care, objectively determine the severity of the condition (e.g., with history, including the pattern of medication use), physical examination, spirometry). Do not underestimate severity.

- 4 In a known asthmatic with an acute exacerbation:
  - a) Treat the acute episode (e.g., use beta-agonists **repeatedly and early steroids, and avoid under-treatment**).
  - b) Rule out co-morbid disease (e.g., complications, congestive heart failure, chronic obstructive pulmonary disease).
  - c) Determine the need for hospitalization or discharge (basing the decision on the risk of recurrence or complications, and on the patient's expectations and resources).
- 5 For the ongoing (chronic) treatment of an asthmatic, propose a stepwise management plan including:
  - self-monitoring.
  - self-adjustment of medication.
  - when to consult back.
- 6 For a known asthmatic patient, who has ongoing or recurrent symptoms:
  - a) **Assess severity and compliance with medication regimens.**
  - b) Recommend lifestyle adjustments (e.g., avoiding irritants, triggers) that may result in less recurrence and better control.



## Atrial Fibrillation

### *Key Feature*

In a patient who presents with new onset atrial fibrillation,

**1 look**

for an underlying cause (e.g., ischemic heart disease, acute myocardial infarction, congestive heart failure, cardiomyopathy, pulmonary embolus, hyperthyroidism, alcohol, etc.)

**2 In a patient presenting with atrial fibrillation,**

a) Look for hemodynamic instability,

b) Intervene rapidly and appropriately to stabilize the patient.

**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.

**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.**

**5 In a stable patient with atrial fibrillation, identify the need for rate control.**

**6 In a stable patient with atrial fibrillation, arrange for rhythm correction when appropriate.**

## Bad News

### *Key Feature*

**1 When giving bad news, ensure that the setting is appropriate, and ensure patient's confidentiality.**

**2 Give bad news:**

- in an empathic, compassionate manner
- allowing enough time.
- providing translation, as necessary.

**3 Obtain patient consent before involving the family.**

**4 After giving bad news, arrange definitive follow-up opportunities to assess impact and understanding.**

## Behavioural Problems

### *Key Feature*

- 1 Because behavioural problems in children are often multifactorial, maintain a broad differential diagnosis and assess all factors when concern has been raised about a child's behaviour:
  - Look for medical conditions (e.g., hearing impairment, depression, other psychiatric diagnoses, other medical problems).
  - Look for psychosocial factors (e.g., abuse, substance use, family chaos, peer issues, parental expectations).
  - Recognize when the cause is not attention deficit disorder (ADD) (e.g., learning disorders, autism spectrum disorder, conduct disorder).
- 2 When obtaining a history about behavioural problems in a child:
  - Ask the child about her or his perception of the situation.
  - Use multiple sources of information (e.g., school, daycare).

- 3 When treating behavioural problems in children for whom medication is indicated, 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.).
- 4 In assessing behavioural problems in adolescents, use a systematic, structured approach to make an appropriate diagnosis:
  - Specifically look for substance abuse, peer issues, and other stressors.
  - Look for medical problems (bipolar disorder, schizophrenia).
  - Do not say the problem is "just adolescence".
- 5 In elderly patients known to have dementia, do not attribute behavioural problems to dementia without assessing for other possible factors (e.g., medication side effects or interactions, treatable medical conditions such as sepsis or depression).

## Breast Lump

### *Key Feature*

- 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**
  - b) Advise regarding screening (mammography, breast self-examination) and its limitations.
  - c) Advise concerning the woman's role in preventing or detecting breast disease (breast self-examination, lifestyle changes).
- 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.**
  - b) Ensure adequate support throughout investigation of the breast lump by availability of a contact resource.
  - 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.

- 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.**
- b) Consider and diagnose metastatic disease in the follow-up care of a breast cancer patient by appropriate history and investigation.
- c) Appropriately direct (provide a link to) the patient to community resources able to provide adequate support (psychosocial support).

## Cancer

### *Key Feature*

- 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.
- 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).
- 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.)
- 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.

- 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.
- 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.
- 7 In a patient diagnosed with cancer, be realistic and honest when discussing prognosis. (Say when you don't know.)

## Chest Pain

### Key Feature

- 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.).
- 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).
- 3 In a patient with unexplained chest pain, rule out ischemic heart disease.\*
- Given an appropriate history of chest pain suggestive of  
4 herpes  
zoster infection, hiatal hernia, reflux, esophageal spasm, infections, or peptic ulcer disease:
  - a) Propose the diagnosis.
  - b) Do an appropriate work-up/follow-up to confirm the suspected diagnosis.
- 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.
  - b) Begin appropriate treatment immediately.

\*See also the key features on ischemic heart disease.

## Chronic Disease

### Key Feature

- 1 In a patient with a diagnosed chronic disease who presents with acute symptoms, diagnose:
  - 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.
- 2 Regularly reassess adherence (compliance) to the treatment plan (including medications).
- 3 In patients with chronic disease:
  - a) Actively inquire about pain.
  - b) Treat appropriately by:
    - 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:
  - 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.

## Chronic Obstructive Pulmonary Disease

### *Key Feature*

- 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).
- 2 When the diagnosis of COPD is suspected, seek confirmation with pulmonary function studies (e.g., FEV1).
- 3 In patients with COPD, use pulmonary function tests periodically to document disease progression.
- 4 Encourage smoking cessation in all patients diagnosed with COPD.\*
- 5 Offer appropriate vaccinations to patients diagnosed with COPD (e.g., influenza/pneumococcal vaccination).

6 In an apparently stable patient with COPD, offer appropriate inhaled medication for treatment (e.g., anticholinergics/bronchodilators if condition is reversible, steroid trial).

7 Refer appropriate patients with COPD to other health professionals (e.g., a respiratory technician or pulmonary rehabilitation personnel) to enhance quality of life.

8 When treating patients with acute exacerbations of COPD, rule out co-morbidities (e.g., myocardial infarction, congestive heart failure, systemic infections, anemia).

9 In patients with end-stage COPD, especially those who are currently stable, discuss, document, and periodically re-evaluate wishes about aggressive treatment interventions.

Note: \* See the key features on Smoking Cessation.



## Contraception

### *Key Feature*

- 1 With all patients, especially adolescents, young men, postpartum women, and perimenopausal women, advise about adequate contraception when opportunities arise.
- 2 In patients using specific contraceptives, advise of specific factors that may reduce efficacy (e.g., delayed initiation of method, illness, medications, specific lubricants).
- 3 In aiding decision-making to ensure adequate contraception:
  - 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.

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]).

5 In all patients, especially those using barrier methods or when efficacy of hormonal methods is decreased, advise about post-coital contraception.

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).

## Cough

### Key Feature

- 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.)
- 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).
- 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.
- 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.
- 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.)

## Counselling

### Key Feature

- 1 In patients with mental health concerns, explore the role of counselling in treating their problems. (Intervention is not just about medication use.)
- 2 When making the decision about whether to offer or refer a patient for counselling:
  - a) Allow adequate time to assess the patient.
  - b) Identify the patient's context and understanding of her or his problem/situation.
  - c) Evaluate your own skills. (Does the problem exceed the limits of your abilities?)
  - d) Recognize when your beliefs may interfere with counselling.
- 3 When counselling a patient, allow adequate time.
- 4 When counselling a patient, recognize when you are approaching or exceeding boundaries (e.g., transference, counter-transference) or limits (the problem is more complex than you originally thought), as this should prompt you to re-evaluate your role.



## Crisis

### *Key Feature*

- 1 Take the necessary time to assist patients in crisis, as they often present unexpectedly.
- 2 Identify your patient's personal resources for support (e.g., family, friends) as part of your management of patients facing crisis.
- 3 Offer appropriate community resources (e.g., counselor) as part of your ongoing management of patients with a crisis.
- 4 Assess suicidality in patients facing crisis.
- 5 Use psychoactive medication rationally to assist patients in crisis.
- 6 Inquire about unhealthy coping methods (e.g., drugs, alcohol, eating, gambling, violence, sloth) in your patients facing crisis.

7 Ask your patient if there are others needing help as a consequence of the crisis.

8 Negotiate a follow-up plan with patients facing crisis.

9 Be careful not to cross boundaries when treating patients in crisis (e.g., lending money, appointments outside regular hours).

10 Prepare your practice environment for possible crisis or disaster and include colleagues and staff in the planning for both medical and non-medical crises.

11 When dealing with an unanticipated medical crisis (e.g., seizure, shoulder dystocia),  
a) Assess the environment for needed resources (people, material).  
b) Be calm and methodical.  
c) Ask for the help you need.

## Croup

### Key Feature

- 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.
  - 2 Before attributing stridor to croup, consider other possible causes (e.g., anaphylaxis, foreign body (airway or esophagus), retropharyngeal abscess, epiglottitis).
  - 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).
  - 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).
  - 5 In patients with a diagnosis of croup, use steroids (do not under
- Reasoning*
- treat mild-to-moderate cases of croup).
- 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.

## Deep Venous Thrombosis

### Key Feature

- 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.
  - 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.
  - 3 Identify patients likely to benefit from DVT prophylaxis.
- Utilize investigations for DVT allowing for their limitations
- 4 (e.g.,  
Ultrasound and D-dimer).
  - 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).
  - 6 Consider the possibility of an underlying coagulopathy in patients with DVT, especially when unexpected.
  - 7 Use compression stockings in appropriate patients, to prevent and treat post-phlebotic syndrome.

## Dehydration

### *Key Feature*

- 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).
- 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).
- 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).
- 4 When treating severe dehydration, use objective measures (e.g., lab values) to direct ongoing management.
- 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.
- 6 Treat the dehydrated pregnant patient aggressively, as there are additional risks of dehydration in pregnancy.

## Dementia

### Key Feature

- 1 In patients with early, non-specific signs of cognitive impairment:
  - a) Suspect dementia as a diagnosis.
  - b) Use the Mini-Mental State Examination and other measures of impaired cognitive function, as well as a careful history and physical examination, to make an early positive diagnosis.
- 2 In patients with obvious cognitive impairment, select proper laboratory investigations and neuroimaging techniques to complement the history and physical findings and to distinguish between dementia, delirium, and depression.
- 3 In patients with dementia, distinguish Alzheimer's disease from other dementias, as treatment and prognosis differ.
- 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 or infection.
- 5 Disclose the diagnosis of dementia compassionately, and respect the patient's right to autonomy, confidentiality, and safety.

6 In patients with dementia, assess competency. (Do not judge clearly competent patients as incompetent and vice versa.)

7 In following patients diagnosed with dementia:

- a) Assess function and cognitive impairment on an ongoing basis.

- b) Assist with and plan for appropriate interventions (e.g., deal with medication issues, behavioural disturbance management, safety issues, caregiver issues, comprehensive care plans, driving safety, and placement).

8 Assess the needs of and supports for caregivers of patients with dementia.

9 Report to the appropriate authorities patients with dementia who you suspect should not be driving.

10 In patients with dementia, look for possible genetic factors to provide preventive opportunities to other family members, and to aid in appropriate decision-making (e.g., family planning).

## Depression

### Key Feature

- 1 In a patient with a diagnosis of depression:
  - a) Assess the patient for the risk of suicide.
  - 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).
- 2 Screen for depression and diagnose it in high-risk groups (e.g., certain socio-economic groups, those who suffer from substance abuse, postpartum women, people with chronic pain).
- 3 In a patient presenting with multiple somatic complaints for which no organic cause is found after appropriate investigations, consider the diagnosis of depression and explore this possibility with the patient.
- 4 After a diagnosis of depression is made, look for and diagnose other co-morbid psychiatric conditions (e.g., anxiety, bipolar disorder, personality disorder).
- 5 In a patient diagnosed with depression, treat appropriately:
  - drugs, psychotherapy.
  - monitor response to therapy.
  - active modification (e.g., augmentation, dose changes, drug changes).
  - referral as necessary.

- 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).
- 7 In patients presenting with depression, inquire about abuse:
  - sexual, physical, and emotional abuse (past and current, witnessed or inflicted).
  - substance abuse.
- 8 In a patient with depression, differentiate major depression from adjustment disorder, dysthymia, and a grief reaction.
- 9 Following failure of an appropriate treatment in a patient with depression, consider other diagnoses (e.g., bipolar disorder, schizoaffective disorder, organic disease).
- 10 In the very young and elderly presenting with changes in behaviour, consider the diagnosis of depression (as they may not present with classic features).



## Diabetes

### Key Feature

- 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.
- 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).
- 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).
- 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.
- 5 In patients with established diabetes:
  - a) Look for complications (e.g., proteinuria).
  - b) Refer them as necessary to deal with these complications
- In the acutely ill diabetic patient, diagnose the underlying cause of the illness and investigate for diabetic ketoacidosis and hyperglycemia.
- 7 Given a patient with diabetic ketoacidosis, manage the problem appropriately and advise about preventing future episodes.

## Diarrhea

### Key Feature

- 1 In all patients with diarrhea,
  - a) Determine hydration status,
  - b) Treat dehydration appropriately.
- 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).
- 3 In patients with acute diarrhea who have had recent hospitalization or recent antibiotic use, look for clostridium difficile.
- 4 In patients with acute diarrhea, counsel about the timing of return to work/school (re: the likelihood of infectivity).
- 5 Pursue investigation, in a timely manner, of elderly with unexplained diarrhea, as they are more likely to have pathology.
- 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).
- 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).

## Difficult Patient

### *Key Feature*

- 1 When physician-patient interaction is deemed difficult, diagnose personality disorder when it is present in patients.
- 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.
- 3 In a patient with chronic illness, expect difficult interactions from time to time. Be especially compassionate and sensitive at those times.
- 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).
- 5 When confronted with difficult patient interactions, identify your own attitudes and your contribution to the situation.
- 6 When dealing with difficult patients, set clear boundaries.
- 7 Take steps to end the physician-patient relationship when it is in the patient's best interests.
- 8 With a difficult patient, safely establish common ground to determine the patient's needs (eg. threatening or demanding patients).

## Disability

### *Key Feature*

- 1 Determine whether a specific decline in functioning (e.g., social, physical, emotional) is a disability for that specific patient.
- 2 Screen elderly patients for disability risks (e.g., falls, cognitive impairment, immobilization, decreased vision) on an ongoing basis.
- 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.
- 4 In a disabled patient, assess all spheres of function (emotional, physical, and social, the last of which includes finances, employment, and family).
- 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.
- 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).
- 7 Do not limit treatment of disabling conditions to a short-term disability leave (i.e., time off is only part of the plan).

## Dizziness

### Key Feature

- 1 In patients complaining of dizziness, rule out serious cardiovascular, cerebrovascular, and other neurologic disease (e.g., arrhythmia, myocardial infarction [MI], stroke, multiple sclerosis).
- 2 In patients complaining of dizziness, take a careful history to distinguish vertigo, presyncope, and syncope.
- 3 In patients complaining of dizziness, measure postural vital signs.
- 4 Examine patients with dizziness closely for neurologic signs.
- 5 In hypotensive dizzy patients, exclude serious conditions (e.g., MI, abdominal aortic aneurysm, sepsis, gastrointestinal bleeding) as the cause.
- 6 In patients with chronic dizziness, who present with a change in baseline symptoms, reassess to rule out serious causes.
- 7 In a dizzy patient, review medications (including prescription and over-the-counter medications) for possible reversible causes of the dizziness.
- 8 Investigate further those patients complaining of dizziness who have:
  - 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.

## Domestic Violence

### Key Feature

- 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).
- 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.
- 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.
- 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.



## Dyspepsia

### *Key Feature*

- 1 In a patient presenting with dyspepsia, include cardiovascular disease in the differential diagnosis.
- 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.
- 3 In a patient presenting with dyspepsia, ask about and examine the patient for worrisome signs/symptoms (e.g., gastrointestinal bleeding, weight loss, dysphagia).

## Dysuria

### *Key Feature*

- 1 In a patient presenting with dysuria, use history and dipstick urinalysis to determine if the patient has an uncomplicated urinary tract infection.
- 2 When a diagnosis of uncomplicated urinary tract infection is made, treat promptly without waiting for a culture result.
- 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.
- 4 When assessing patients with dysuria, identify those at higher risk of complicated urinary tract infection (e.g., pregnancy, children, diabetes, urolithiasis).
- 5 In patients with recurrent dysuria, look for a specific underlying cause (e.g., post-coital urinary tract infection, atrophic vaginitis, retention).

## Earache

### Key Feature

- 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).
- 2 Include pain referred from other sources in the differential diagnosis of an earache (eg. Tooth abscess, trigeminal Neuralgia, TMJ dysfunction, pharyngitis, etc.).
- 3 Consider serious causes in the differential diagnosis of an earache (eg. tumors, temporal arteritis, mastoiditis).
- 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).
- 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.)
- 6 In patients with earache (especially those with otitis media), recommend appropriate pain control (oral analgesics).
- 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).\*
- 8 Test children with recurrent ear infections for hearing loss.

Note: \*See the key features on fever.

## Eating Disorders

### Key Feature

- 1 Whenever teenagers present for care, include an assessment of their risk of eating disorders (e.g., altered body image, bingeing, and type of activities, as dancers, gymnasts, models, etc., are at higher risk). as this may be the only opportunity to do an assessment.
- 2 When diagnosing an eating disorder, take an appropriate history to differentiate anorexia nervosa from bulimia, as treatment and prognosis differ.
- 3 In a patient with an eating disorder, rule out co-existing psychiatric conditions (e.g., depression, personality disorder, obsessive-compulsive disorder, anxiety disorder).
- 4 When managing a patient with an eating disorder, use a multidisciplinary approach (e.g., work with a psychiatrist, a psychologist, a dietitian).
- 5 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.
- 6 In the follow-up care of a patient with a known eating disorder:
  - a) Periodically look for complications (e.g., tooth decay, amenorrhea, an electrolyte imbalance).
  - b) Evaluate the level of disease activity (e.g., by noting eating patterns, exercise, laxative use).

## Elderly

### *Key Feature*

- 1 In the elderly patient taking multiple medications, avoid polypharmacy by:
  - monitoring side effects.
  - periodically reviewing medication (e.g., is the medication still indicated, is the dosage appropriate).
  - monitoring for interactions.
- 2 In the elderly patient, actively inquire about non-prescription medication use (e.g., herbal medicines, cough drops, over-the-counter drugs, vitamins).
- 3 In the elderly patient, screen for modifiable risk factors (e.g., visual disturbance, impaired hearing) to promote safety and prolong independence.
- 4 In the elderly patient, assess functional status to:
  - anticipate and discuss the eventual need for changes in the living environment.
  - ensure that social support is adequate.
- 5 In older patients with diseases prone to atypical presentation, do not exclude these diseases without a thorough assessment (e.g., pneumonia, appendicitis, depression).

## Epistaxis

### *Key Feature*

- 1 Through history and/or physical examination, assess the hemodynamic stability of patients with epistaxis.
- 2 While attending to active nose bleeds, recognize and manage excessive anxiety in the patient and accompanying family.
- 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).
- 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.
- 5 In a patient with ongoing or recurrent bleeding in spite of treatment, consider a posterior bleeding site.
- 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)
- 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.)

## Family Issues

### *Key Feature*

- 1 Routinely ask about family issues to understand their impact on the patient's illness and the impact of the illness on the family.
- 2 - 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).

## Fatigue

### *Key Feature*

- 1 In all patients complaining of fatigue, include depression in the differential diagnosis.
- 2 Ask about other constitutional symptoms as part of a systematic approach to rule out underlying medical causes in all patients complaining of fatigue.
- 3 Exclude adverse effects of medication as the cause in all patients complaining of fatigue.
- 4 Avoid early, routine investigations in patients with fatigue unless specific indications for such investigations are present.
- 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.
- 6 In patients whose fatigue has become chronic, manage supportively, while remaining vigilant for new diseases and illnesses.

## Fever

### Key Feature

- 1 In febrile infants 0-3 months old:
  - a) Recognize the risk of occult bacteremia.
  - b) Investigate thoroughly (e.g., blood cultures, urine, lumbar puncture +/- chest X-ray).
- 2 In a febrile patient with a viral infection, do NOT prescribe antibiotics.
- 3 In a febrile patient requiring antibiotic therapy, prescribe the appropriate antibiotic(s) according to likely causative organism(s) and local resistance patterns.
- Investigate patients with fever of unknown origin  
4 appropriately (e.g., with blood cultures, echocardiography, bone scans).
- 5 In febrile patients, consider life-threatening infectious causes (e.g., endocarditis, meningitis).
- 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).
- 7 In the febrile patient, consider causes of hyperthermia other than infection (e.g., heat stroke, drug reaction, malignant neuroleptic syndrome).
- 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.

## Fractures

### Key Feature

- 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.
- When examining patients with a fracture, assess  
2 neurovascular status and examine the joint above and below the injury.
- 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
- 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.
- 5 Identify and manage limb injuries that require urgent immobilization and/or reduction in a timely manner.
- 6 In assessing patients with suspected fractures, provide analgesia that is timely (i.e., before X-rays) and adequate (e.g., narcotic) analgesia.
- 7 In patients presenting with a fracture, look for and diagnose high-risk complications (e.g., an open fracture, unstable cervical spine, compartment syndrome).
- 8 Use clinical decision rules (e.g., Ottawa ankle rules, C-spine rules, and knee rules) to guide the use of X-ray examinations.



## Gastro-intestinal Bleed

### Key Feature

- 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.
- 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.
- 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).
- 4 In a patient with obvious GI bleeding, identify patients who may require timely treatment even though they are not yet in shock.
- 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).
- 6 In a patient with an upper GI bleed,
  - a) Include variceal bleeding in your differential,
  - b) Use history and physical examination to assess the likelihood of a variceal bleed as its management differs.

## Gender Specific Issues

### Key Feature

- 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).
- 2 As part of caring for women with health concerns, assess the possible contribution of domestic violence.
- 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).
- 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).
- 5 Interpret and apply research evidence for your patients in light of gender bias present in clinical studies (e.g., ASA use in women).

## Grief

### *Key Feature*

- 1 In patients who have undergone a loss, prepare them for the types of reactions (e.g., emotional, physical) that they may experience.
- 2 In all grieving patients, especially those with a prolonged or abnormal grief reaction, inquire about depression or suicidal ideation.
- 3 Recognize atypical grief reactions in the very young or the elderly (e.g., behavioral changes).
- 4 In patients with a presentation suggestive of a grief reaction without an obvious trigger, look for triggers that may be unique to the patient (e.g., death of a pet, loss of a job).

## Headache

### *Key Feature*

- 1 Given a patient with a new-onset headache, differentiate benign from serious pathology through history and physical examination.
- 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.
- 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.
- 4 In a patient with a history of suspected subarachnoid bleed and a negative CT scan, do a lumbar puncture.
- 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).

## Hepatitis

### *Key Feature*

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).

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.

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.

4 In patients positive for Hepatitis B and/or C,  
a) Assess their infectiousness,  
  
b) Determine human immunodeficiency virus status.

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.

6 In patients who are chronically infected with Hepatitis C, refer for further assessment and possible treatment.

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.

8 Offer post-exposure prophylaxis to patients who are exposed or possibly exposed to Hepatitis A or B.

9 Periodically look for complications (e.g., cirrhosis, hepatocellular cancer) in patients with chronic viral hepatitis, especially hepatitis C infection.



## Hyperlipidemia

### Key Feature

- 1 Screen appropriate patients for hyperlipidemia.
- 2 In all patients whose cardiovascular risk is being evaluated, include the assessment of lipid status.
- 3 When hyperlipidemia is present, take an appropriate history, and examine and test the patient for modifiable causes (e.g., alcohol abuse, thyroid disease).
- 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).
- 5 In treating hyperlipidemic patients, establish target lipid levels based on overall CV risk.
- 6 In patients receiving medication for hyperlipidemia, periodically assess compliance with and side effects of treatment.

## Immigrants

### Key Feature

- 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.
- 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).
- 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).
- 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).
- 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).
- 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).

Hypertension
<i>Key Feature</i>
1 Screen for hypertension.
2 Use correct technique and equipment to measure blood pressure.
3 Make the diagnosis of hypertension only after multiple BP readings (i.e., at different times and during different visits).
4 In patients with an established diagnosis of hypertension, assess and re-evaluate periodically the overall cardiovascular risk and end-organ complications: <ul style="list-style-type: none"> <li>a) Take an appropriate history.</li> <li>b) Do the appropriate physical examination.</li> <li>c) Arrange appropriate laboratory investigations.</li> </ul>
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): <ul style="list-style-type: none"> <li>a) Suspect secondary hypertension.</li> <li>b) Investigate appropriately.</li> </ul>

6 Suggest individualized lifestyle modifications to patients with hypertension. (e.g., weight loss, exercise, limit alcohol consumption, dietary changes).
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).
8 Given a patient with the signs and symptoms of hypertensive urgency or crisis, make the diagnosis and treat promptly.
9 In all patients diagnosed with hypertension, assess response to treatment, medication compliance, and side effects at follow-up visits.

## Immunization

### Key Feature

- 1 Do not delay immunizations unnecessarily (e.g., vaccinate a child even if he or she has a runny nose).
- 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.
- 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.
- 4 Clearly document immunizations given to your patients.
- 5 In patients presenting with a suspected infectious disease, assess immunization status, as the differential diagnosis and consequent treatment in unvaccinated patients is different.
- 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).

## In Children

### Key Feature

- 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).
- 2 As children, especially adolescents, generally present infrequently for medical care, take advantage of visits to ask about:
  - 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).
- 3 At every opportunity, directly ask questions about risk behaviours (e.g., drug use, sex, smoking, driving) to promote harm reduction.
- 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).
- 5 In assessing and treating children, use age-appropriate language.
- 6 In assessing and treating children, obtain and share information with them directly (i.e., don't just talk to the parents).
- 7 When investigation is appropriate, do not limit it because it may be unpleasant for those involved (the child, parents, or health care providers).

## Infections

### Key Feature

- 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).
- 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).
- 3 Treat infections empirically when appropriate (e.g., in life threatening sepsis without culture report or confirmed diagnosis, candida vaginitis post-antibiotic use).
- 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]).
- 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).
- 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).

## Infertility

### Key Feature

- 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).
- 2 In patients with fertility concerns, provide advice that accurately describes the likelihood of fertility.
- 3 With older couples who have fertility concerns, refer earlier for investigation and treatment, as their likelihood of infertility is higher.
- 4 When choosing to investigate primary or secondary infertility, ensure that both partners are assessed.
- 5 In couples who are likely infertile, discuss adoption when the time is right. (Remember that adoption often takes a long time.)
- 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).

## Insomnia

### *Key Feature*

- 1 In patients presenting with sleep complaints, take a careful history to:
    - distinguish insomnia from other sleep-related complaints that require more specific treatment (e.g., sleep apnea or other sleep disorders, including periodic limb movements, restless legs syndrome, sleepwalking, or sleep talking).
    - assess the contribution of drugs (prescription, over-the-counter, recreational), caffeine, and alcohol.
    - make a specific psychiatric diagnosis if one is present.
  - 2 When assessing patients with sleep complaints, obtain a collateral history from the bed partner, if possible.
  - 3 In all patients with insomnia, provide advice about sleep hygiene (e.g., limiting caffeine, limiting naps, restricting bedroom activities to sleep and sex, using an alarm clock to get up at the same time each day).
  - 4 In appropriate patients with insomnia, use hypnotic medication
- Reasoning*
- judiciously (e.g., prescribe it when there is a severe impact on function, but do not prescribe it without a clear indication).



## Ischemic Heart Disease

### Key Feature

- 1 Given a specific clinical scenario in the office or emergency setting, diagnose presentations of ischemic heart disease (IHD) that are:
  - classic
  - atypical (e.g., in women, those with diabetes, the young, those at no risk).
- 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.
- 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).

- 4 In a patient with stable ischemic heart disease manage changes  
*Reasoning*

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.

- 5 In the regular follow-up care of patients with established ischemic heart disease, specifically verify the following to detect complications and suboptimal control:
  - symptom control.
  - medication adherence.
  - impact on daily activities.
  - lifestyle modification.
  - clinical screening (i.e., symptoms and signs of complications).
- 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.

## Joint Disorder

### *Key Feature*

- 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).
- 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).
- 3 In a patient presenting with a monoarthropathy, rule out infectious causes. (e.g., sexually transmitted diseases).
- 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).
- 5 Clinically diagnose ligamentous injuries. Do NOT do an X-ray examination.

6 In a patient presenting with joint pain, include systemic conditions in the differential diagnosis (e.g., Wegener's granulomatosis, lupus, ulcerative colitis).

- 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).

In assessing patients with a diagnosed rheumatologic condition,  
8 search for disease-related complications (e.g., iritis).

- 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.

10 In patients with rheumatoid arthritis, start treatment with disease-modifying agents within an appropriate time interval.

## Lacerations

### *Key Feature*

- 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).
- 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.
- 3 Given a deep or contaminated laceration, thoroughly clean with copious irrigation and debride when appropriate, before closing.
- 4 Identify wounds at high risk of infection (e.g., puncture wounds, some bites, some contaminated wounds), and do not close them.
- 5 When repairing lacerations in children, ensure appropriate analgesia (e.g., topical anesthesia) and/or sedation (e.g., procedural sedation) to avoid physical restraints.
- 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).
- 7 In treating a patient with a laceration:
  - a) Ask about immunization status for tetanus.
  - b) Immunize the patient appropriately.

## Learning (Patients/Self)

### Patients

#### *Key Feature*

- 1 As part of the ongoing care of children, ask parents about their children's functioning in school to identify learning difficulties.
- 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).
- 3 When caring for a child with a learning disability, regularly assess the impact of the learning disability on the child and the family.
- 4 When caring for a child with a learning disability, ensure the patient and family have access to available community resources to assist them.
- 5 To maximize the patient's understanding and management of their condition,
  - a) Determine their willingness to receive information,
  - b) Match the complexity and amount of information provided with the patient's ability to understand.

### Self Learning

#### *Key Feature*

- 6 Continuously assess your learning needs.
- 7 Effectively address your learning needs.
- 8 Incorporate your new knowledge into your practice.



## Lifestyle

### *Key Feature*

- 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).
- 2 Before making recommendations about lifestyle modification, explore a patient's readiness to change, as it may alter advice.
- 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.
- 4 In the ongoing care of patients, periodically review their behaviours, recognizing that these may change.
- 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.

## Loss of Weight

### *Key Feature*

- 1 Pursue an underlying cause in a patient with unexplained weight loss through history, physical examination (including weight) and appropriate investigations.
- 2 Maintain an ongoing record of patients' weights so as to accurately determine when true weight loss has occurred.
- 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.

## Loss of Consciousness

### *Key Feature*

- 1 In an unconscious patient, assess ABC's and resuscitate as needed.
- 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.
- 3 Examine unconscious patients for localizing and diagnostic signs (e.g., ketone smell, liver flap, focal neurologic signs).
- 4 In patients with a loss of consciousness and a history of head trauma, rule out intracranial bleeding.
- 5 In patients with a loss of consciousness who are anticoagulated, rule out intracranial bleeding.
- 6 Assess and treat unconscious patients urgently for reversible conditions (e.g., shock, hypoxia, hypoglycemia, hyperglycemia, and narcotic overdose).

- 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.
- 8 In patients who have had a loss of consciousness without a clear diagnosis, pursue investigations (e.g., rule out transient arrhythmia, seizure).
- 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).
- 10 In patients with loss of consciousness following head trauma, treat and follow up according to current concussion guidelines.
- 11 Advise authorities about appropriate patients with loss of consciousness (e.g., regarding driving status).

## Low-back Pain

### Key Feature

- 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.
- 2 In a patient with confirmed mechanical low back pain:
  - a) Do not over-investigate in the acute phase.
  - b) Advise the patient:
    - 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).
- 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.
- 4 Advise the patient with mechanical low back pain to return if new or progressive neurologic symptoms develop.
- 5 In all patients with mechanical low back pain, discuss exercises and posture strategies to prevent recurrences.

## Meningitis

### Key Feature

- 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).
- When meningitis is suspected ensure a timely lumbar puncture.
- 3 In the differentiation between viral and bacterial meningitis, adjust the interpretation of the data in light of recent antibiotic use.
- 4 For suspected bacterial meningitis, initiate urgent empiric IV antibiotic therapy (i.e., even before investigations are complete).
- 5 Contact public health to ensure appropriate prophylaxis for family, friends and other contacts of each person with meningitis.

## Menopause

### Key Feature

- 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).
- 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.)
- 3 In a patient with atypical symptoms of menopause (e.g., weight *Selectivity* loss, blood in stools), rule out serious pathology through history and selective use of tests, before diagnosing menopause.
- 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.
- 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
- 6 In menopausal or perimenopausal women:
  - a) Specifically inquire about the use of natural or herbal products.
  - b) Advise about potential effects and dangers (i.e., benefits and problems) of natural or herbal products and interactions.
- 7 In a menopausal or perimenopausal women, provide counselling about preventive health measures (e.g., osteoporosis testing, mammography).
- 8 Establish by history a patient's hormone-replacement therapy risk/benefit status.

## Mental Competency

### Key Feature

- 1 In a patient with subtle symptoms or signs of cognitive decline (e.g., family concerns, medication errors, repetitive questions, decline in personal hygiene),
  - a) Initiate assessment of mental competency, including use of a standardized tool,
  - b) Refer for further assessment when necessary.
- 2 In a patient with a diagnosis that may predict cognitive impairment, (e.g., dementia, recent stroke, severe mental illness) identify those who require more careful assessment of decision-making capability.
- 3 When a patient is making decisions (e.g., surgery/no surgery, resuscitation status) think about the need to assess their mental competency.
- 4 In a patient with cognitive impairment, identify intact decision-making abilities, as many may be retained.

## Multiple Medical Problems

### *Key Feature*

- 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.
- 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).
- 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.
- 4 Given a patient with multiple defined medical conditions, periodically assess for secondary depression, as they are particularly at risk for it.
- 5 Periodically re-address and re-evaluate the management of patients with multiple medical problems in order to:
  - 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).
- 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).

## Neck Pain

### *Key Feature*

- 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.
- In patients with non-traumatic neck pain, distinguish by
- 2 history and physical examination, those attributable to nerve or spinal cord compression from those due to other mechanical causes (e.g., muscular).
- 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).
- 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).
- 5 When reviewing neck X-rays of patients with traumatic neck pain, be sure all vertebrae are visualized adequately.



## Newborn

### Key Feature

- 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.
- 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.
- 3 Resuscitate newborns according to current guidelines.
- 4 Maintain neonatal resuscitation skills if appropriate for your practice.
- 5 When a parent elects to bottle feed, support their decision in a non-judgemental manner.
- 6 In caring for a newborn ensure repeat evaluations for abnormalities that may become apparent over time (e.g., hips, heart, hearing).
- 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.

## Obesity

### Key Feature

- 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.
- 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.
- 3 In patients diagnosed with obesity who have confirmed normal thyroid function, avoid repeated thyroid-stimulating hormone testing.
- 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.
- 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.
- 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.
- 7 As part of preventing childhood obesity, advise parents of healthy activity levels for their children.
- 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).

## Osteoporosis

### *Key Feature*

- 1 Assess osteoporosis risk of all adult patients as part of their periodic health examination.
- 2 Use bone mineral density testing judiciously (e.g., don't test everybody, follow a guideline).
- 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).
- 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).
- 5 In patients with osteoporosis, avoid prescribing medications that may increase the risk of falls.
- 6 Provide advice and counseling about fracture prevention to older men, as they too are at risk for osteoporosis.
- 7 Treat patients with established osteoporosis regardless of their gender (e.g., use bisphosphonates in men).

## Palliative Care

### *Key Feature*

- 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).
- 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).
- 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.
- 4 In patients with pain, manage it (e.g., adjust dosages, change analgesics) proactively through:
  - frequent reassessments.
  - monitoring of drug side effects (e.g., nausea, constipation, cognitive impairment).
- 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)

## Parkinsonism

### *Key Feature*

- 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.
- 2 In the care of all patients with Parkinson's disease, involve other health care professionals to enhance the patient's functional status.
- 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.
- 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.
- 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.
- 6 As part of the ongoing follow-up care of patients with Parkinson's disease:
  - Assess functional status.
  - Monitor them for medication side effects.
  - Look for other problems (e.g., depression, dementia, falls, constipation), as they are more common

## Periodic Health Assessment/Screening

### *Key Feature*

- 1 Do a periodic health assessment in a proactive or opportunistic manner (i.e., address health maintenance even when patients present with unrelated concerns).
  - 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).
- In a patient requesting a test (e.g., PSA testing,
- 3 mammography)  
that may or may not be recommended:
    - a) Inform the patient about limitations of the screening test  
(i.e., sensitivity and specificity).
    - b) Counsel the patient about the implications of proceeding with the test.
  - 4 Keep up to date with new recommendations for the periodic health examination, and critically evaluate their usefulness and application to your practice.



## Personality Disorder

### *Key Feature*

- 1 Clearly establish and maintain limits in dealing with patients with identified personality disorders. For example, set limits for:
  - appointment length.
  - drug prescribing.
  - accessibility.
- 2 In a patient with a personality disorder, look for medical and psychiatric diagnoses when the patient presents for assessment of new or changed symptoms. (Patients with personality disorders develop medical and psychiatric conditions, too.)
- 3 Look for and attempt to limit the impact of your personal feelings (e.g., anger, frustration) when dealing with patients with personality disorders (e.g., stay focused, do not ignore the patient's complaint).
- 4 In a patient with a personality disorder, limit the use of benzodiazepines but use them judiciously when necessary.
- 5 When seeing a patient whom others have previously identified as having a personality disorder, evaluate the person yourself because the diagnosis may be wrong and the label has significant repercussions.

## Poisoning

### *Key Feature*

- 1 As part of well-child care, discuss preventing and treating poisoning with parents (e.g., "child-proofing", poison control number).
- 2 In intentional poisonings (overdose) think about multi-toxin ingestion.
- 3 When assessing a patient with a potentially toxic ingestion, take a careful history about the timing and nature of the ingestion.
- 4 When assessing a patient with a potential poisoning, do a focused physical examination to look for the signs of toxidromes.
- 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).
- 6 When managing a toxic ingestion, utilize poison control protocols that are current.
- 7 When managing a patient with a poisoning,
  - a) Assess ABC's,
  - b) Manage ABC's,
  - 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).

<b>Pneumonia</b>
<i>Key Feature</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.
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).
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).
4 In patients with pre-existing medical problems (e.g., asthma, diabetes, congestive heart failure) and a new diagnosis of pneumonia: <ul style="list-style-type: none"> <li>a) Treat both problems concurrently (e.g., with prednisone <i>Selectivity</i> plus antibiotics).</li> <li>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).</li> </ul>

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.
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).
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).
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.
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).
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").
8 In a patient who is receiving treatment for pneumonia and is not responding: <ul style="list-style-type: none"> <li>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).</li> </ul>

## Pregnancy

### Key Feature

- 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).
- 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.
- 3 In a patient with suspected or confirmed pregnancy, establish the desirability of the pregnancy.
- 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.
- 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.
- 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.
- 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.

- 8 In a patient presenting with dystocia (prolonged dilatation, failure of descent):

- a) Diagnose the problem.
- b) Intervene appropriately.

- 9 In a patient with clinical evidence of complications in labour (e.g., abruption, uterine rupture, shoulder dystocia, non-reassuring fetal monitoring):

- a) Diagnose the complication.
- b) Manage the complication appropriately.

- 10 In the patient presenting with clinical evidence of a postpartum

complication (e.g., delayed or immediate bleeding, infection):

- a) Diagnose the problem (e.g., unrecognized retained placenta, endometritis, cervical laceration).
- b) Manage the problem appropriately.

- 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."

- 12 In a breast-feeding woman, screen for and characterize dysfunctional breast-feeding (e.g., poor latch, poor production, poor letdown).

## Prostate

### *Key Feature*

- 1 Appropriately identify patients requiring prostate cancer screening.
- 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.
- 3 In patients with prostate cancer, actively search out the psychological impact of the diagnosis and treatment modality.
- 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.
- 5 In patients with prostate cancer, actively ask about symptoms of local recurrence or distant spread.
- 6 Given a suspicion of benign prostatic hypertrophy, diagnose it using appropriate history, physical examination, and investigations.
- 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.

## Rape/Sexual Assault

### *Key Feature*

- 1 Provide comprehensive care to all patients who have been sexually assaulted, regardless of their decision to proceed with evidence collection or not.
- 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).
- 3 Limit documentation in sexual assault patients to observations and other necessary medical information (i.e., avoid recording hearsay information).
- 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.
- 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.
- 6 Revisit the need for counselling in patients affected by sexual assault.
- 7 Enquire about undisclosed sexual assault when seeing patients who have symptoms such as depression, anxiety, and somatization.



## Red Eye

### Key Feature

- 1 In addressing eye complaints, always assess visual acuity using history, physical examination, or the Snellen chart, as appropriate.
- 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).
- 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.

- 4 In patients presenting with an ocular foreign body sensation, evert the eyelids to rule out the presence of a conjunctival foreign body.

- 5 In neonates with conjunctivitis (not just blocked lacrimal glands  
*Reasoning*

or “gunky” eyes), look for a systemic cause and treat it appropriately (i.e., with antibiotics).

- 6 In patients with conjunctivitis, distinguish by history and physical examination between allergic and infectious causes (viral or bacterial).

- 7 In patients who have bacterial conjunctivitis and use contact lenses, provide treatment with antibiotics that cover for  
*Pseudomonas*.

- 8 Use steroid treatment only when indicated (e.g., to treat iritis; avoid with keratitis and conjunctivitis).

- 9 In patients with iritis, consider and look for underlying systemic causes (e.g., Crohn’s disease, lupus, ankylosing spondylitis).

## Schizophrenia

### Key Feature

- 1 In adolescents presenting with problem behaviours, consider schizophrenia in the differential diagnosis.
- 2 In "apparently" stable patients with schizophrenia (e.g., those who are not floridly psychotic), provide regular or periodic assessment in a structured fashion e.g., positive and negative symptoms, their performance of activities of daily living, and the level of social functioning at each visit:
  - seeking collateral information from family members and other caregivers to develop a more complete assessment of symptoms and functional status;
  - competency to accept or refuse treatment, and document specifically;
  - suicidal and homicidal ideation, as well as the risk for violence;
  - medication compliance and side effects.
- 3 In all patients presenting with psychotic symptoms, inquire about substance use and abuse.
- 4 Consider the possibility of substance abuse and look for it in patients with schizophrenia, as this is a population at risk.
- 5 In patients with schizophrenia, assess and treat substance abuse appropriately.
- 6 In decompensating patients with schizophrenia, determine:
  - if substance abuse is contributory.
  - the role of medication compliance and side-effect problems.
  - if psychosocial supports have changed.
- 7 Diagnose and treat serious complications/side effects of antipsychotic medications (e.g., neuroleptic malignant syndrome, tardive dyskinesia).
- 8 Include psychosocial supports (e.g., housing, family support, disability issues, vocational rehabilitation) as part of the treatment plan for patients with schizophrenia.

## Sex

### Key Feature

- 1 In patients, specifically pregnant women, adolescents, and perimenopausal women:
    - a) Inquire about sexuality (e.g., normal sexuality, safe sex, contraception, sexual orientation, and sexual dysfunction).
    - b) Counsel the patient on sexuality (e.g., normal sexuality, safe sex, contraception, sexual orientation, and sexual dysfunction).
  - 2 Screen high-risk patients (e.g., post-myocardial infarction patients, diabetic patients, patients with chronic disease) for sexual dysfunction, and screen other patients when appropriate (e.g., during the periodic health examination).
- In patients presenting with sexual dysfunction, identify 3 features that suggest organic and non-organic causes.
- 4 In patients who have sexual dysfunction with an identified probable cause, manage the dysfunction appropriately.
  - 5 In patients with identified sexual dysfunction, inquire about partner relationship issues.

## Seizures

### Key Feature

- 1 In a patient having a seizure:
  - a) Ensure proper airway control (e.g., oropharyngeal airway or nasal trumpet, lateral decubitus to prevent aspiration).
  - b) Use drugs (e.g., benzodiazepines, phenytoin) promptly to stop the seizure, even before the etiology is confirmed.
  - c) Rule out reversible metabolic causes in a timely fashion (e.g., hypoglycemia, hypoxia, heat stroke, electrolyte abnormalities).
- 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.
- 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).
- 4 In all patients presenting with a seizure, examine carefully for focal neurologic findings.

- 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).
  - b) Include other causes of seizure in the differential diagnosis. (Not all seizures are caused by epilepsy.)
- 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).
  - b) Monitor for complications of the anticonvulsant medication (e.g., hematologic complications, osteoporosis).
  - c) Modify management of other health issues taking into account the anticonvulsant medication (e.g., in prescribing antibiotics, pregnancy).

## Sexually Transmitted Infections

### Key Feature

- 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).
- 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.
- 3 In high-risk patients who are asymptomatic for STIs, screen and  
advise them about preventive measures.
- 4 In high-risk patients who are symptomatic for STIs, provide treatment before confirmation by laboratory results.
- 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).
- 6 In a patient with a confirmed STI, initiate:  
- treatment of partner(s).  
- contact tracing through a public health or community agency.
- 7 Use appropriate techniques for collecting specimens.
- 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).

## Skin Disorder

### Key Feature

- 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).
- 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).
- 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.
- 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).
- 5 Diagnose and promptly treat suspected life-threatening dermatologic emergencies (e.g., Stevens-Johnson syndrome, invasive cellulitis, chemical or non-chemical burns).
- 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.
- 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.



## Smoking Cessation

### *Key Feature*

- 1 In all patients, regularly evaluate and document smoking status, recognizing that people may stop or start at any time.
- 2 In smokers:
  - a) Discuss the benefits of quitting or reducing smoking.
  - b) Regularly assess interest in quitting or reducing smoking.
- 3 In smokers motivated to quit, advise the use of a multi-strategy approach to smoking cessation.

## Somatization

### *Key Feature*

- 1 In patients with recurrent physical symptoms, diagnose somatization only after an adequate work-up to rule out any medical or psychiatric condition (e.g., depression).
- 2 Do not assume that somatization is the cause of new or ongoing symptoms in patients previously diagnosed as somatizers. Periodically reassess the need to extend/repeat the work-up in these patients.
- 3 Acknowledge the illness experience of patients who somatize, and strive to find common ground with them concerning their diagnosis and management, including investigations. This is usually a long-term project, and should be planned as such.
- 4 In patients who somatize, inquire about the use of and suggest therapies that may provide symptomatic relief, and/or help them cope with their symptoms (e.g., with biofeedback, acupuncture, or naturopathy).

## Stress

### *Key Feature*

- 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.
- 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).
- 3 In patients not coping with stress, look for and diagnose, if present, mental illness (e.g., depression, anxiety disorder).
- 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.
- 5 In patients experiencing stress, look for inappropriate coping mechanisms (e.g., drugs, alcohol, eating, violence).

## Thyroid

### *Key Feature*

- 1 Limit testing for thyroid disease to appropriate patients, namely those with a significant pre-test probability of abnormal results, such as:
  - 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).
- 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:
  - after changing medical doses.
  - when following patients with mild disease before initiating treatment.
  - periodically in stable patients receiving treatment.
- 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).

Note: The investigation of thyroid nodules is not covered here.

## Suicide

### *Key Feature*

- 1 In any patient with mental illness (i.e., not only in depressed patients), actively inquire about suicidal ideation (e.g., ideas, thoughts, a specific plan).
- 2 Given a suicidal patient, assess the degree of risk (e.g., thoughts, specific plans, access to means) in order to determine an appropriate intervention and follow-up plan (e.g., immediate hospitalization, including involuntary admission; outpatient follow-up; referral for counselling).
- 3 Manage low-risk patients as outpatients, but provide specific instructions for follow-up if suicidal ideation progresses/worsens (e.g., return to the emergency department [ED], call a crisis hotline, re-book an appointment).
- 4 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.
- 5 In trauma patients, consider attempted suicide as the precipitating cause.

## Substance Abuse

### *Key Feature*

- 1 In all patients, and especially in high-risk groups (e.g., mental illness, chronic disability), opportunistically screen for substance use and abuse (tobacco, alcohol, illicit drugs).
- 2 In intravenous drug users:
  - a) Screen for blood-borne illnesses (e.g., human immunodeficiency virus infection, hepatitis).
  - b) Offer relevant vaccinations.
- 3 In patients with signs and symptoms of withdrawal or acute intoxication, diagnose and manage it appropriately.
- 4 Discuss substance use or abuse with adolescents and their caregivers when warning signs are present (e.g., school failure, behaviour change).
- 5 Consider and look for substance use or abuse as a possible factor in problems not responding to appropriate intervention (e.g., alcohol abuse in patients with hypertriglyceridemia, inhalational drug abuse in asthmatic patients).

- 6 Offer support to patients and family members affected by substance abuse. (The abuser may not be your patient.)
- 7 In patients abusing substances, determine whether or not they are willing to agree with the diagnosis.
- 8 In substance users or abusers, routinely determine willingness to stop or decrease use.
- 9 In patients who abuse substances, take advantage of opportunities to screen for co-morbidities (e.g., poverty, crime, sexually transmitted infections, mental illness) and long-term complications (e.g., cirrhosis).

## Stroke

### *Key Feature*

- 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).
- 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.
- 3 Assess patients presenting with neurologic deficits in a timely fashion, to determine their eligibility for thrombolysis.
- 4 In a patient diagnosed with stroke, involve other professionals as needed (e.g., a physical therapist, an occupational therapist, social service personnel, a physiatrist, a neurologist) to ensure the best outcome for the patient.
- 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).
- 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.

- 7 Provide realistic prognostic advice about their disabilities to stroke patients and their families.

- 8 In stroke patients with disabilities, evaluate the resources and supports needed to improve function (e.g., a cane, a walker, home care).

- 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.

- 10 In patients at risk of stroke, treat modifiable risk factors (e.g., atrial fibrillation, diabetes, hyperlipidemia, and hypertension).

- 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.

## Trauma

### *Key Feature*

1 Assess and stabilize trauma patients with an organized approach, anticipating complications in a timely fashion, using the primary and secondary surveys.

2 Suspect, identify, and immediately begin treating life-threatening complications (e.g., tension pneumothorax, tamponade).

3 When faced with several trauma patients, triage according to resources and treatment priorities.

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).

5 In a patient with signs and symptoms of shock:  
a) Recognize the shock.  
  
b) Define the severity and type (neurogenic, hypovolemic, septic).  
  
c) Treat the shock.

6 In trauma patients, rule out hypothermia on arrival and subsequently (as it may develop during treatment).

7 Suspect certain medical problems (e.g., seizure, drug intoxication, hypoglycemia, attempted suicide) as the precipitant of the trauma.

8 Do not move potentially unstable patients from treatment areas for investigations (e.g., computed tomography, X-ray examination).

9 Determine when patient transfer is necessary (e.g., central nervous system bleeds, when no specialty support is available).

10 Transfer patients in an appropriate manner (i.e., stabilize them before transfer and choose the method, such as ambulance or flight).

11 Find opportunities to offer advice to prevent or minimize trauma (e.g., do not drive drunk, use seatbelts and helmets).

12 In children with traumatic injury, rule out abuse.  
(Carefully assess the reported mechanism of injury to ensure it corresponds with the actual injury.)



## Travel Medicine

### Key Feature

- 1 Make sure travelers get up to date, timely, itinerary-specific advice from a reliable source (e.g., travel clinic, travel website).
- 2 When seeing patients planning travel, discuss the common, non-infectious perils of travel (e.g., accidents, safer sex, alcohol, safe travel for women).
- 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).
- 4 Provide prevention and treatment advice and prescribe medications for common conditions associated with travel (e.g., traveler's diarrhea, altitude sickness).
- 5 Ensure patients understand how to manage their chronic disease while traveling (e.g., diabetes, asthma, international normalized ratios [INRs]).
- 6 Use patient visits for travel advice as an opportunity to update routine vaccinations.
- Advise patients to check insurance coverage issues especially in
- 7 regard to recent changes in chronic disease and any recent treatment changes.
- Advise patients traveling with medications to have an
- 8 adequate supply, documentation of need for use, and to transport them securely (e.g., carry-on bag).

## Upper Respiratory Tract Infection

### Key Feature

- 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.
- Make the diagnosis of bacterial sinusitis by taking an
- 2 adequate history and performing an appropriate physical examination, and prescribe appropriate antibiotics for the appropriate duration of therapy.
- 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).
- 4 Given a history compatible with otitis media, differentiate it from otitis externa and mastoiditis, according to the characteristic physical findings.
- 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.
- 6 In a presentation of pharyngitis, look for mononucleosis.
- 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).

## Urinary Tract Infection

### *Key Feature*

- 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).
- 2 Appropriately investigate all boys with urinary tract infections, and young girls with recurrences (e.g., ultrasound).
- 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).
- 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).
- 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.
- 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.

## Vaginal Bleeding

### *Key Feature*

- 1 In any woman with vaginal bleeding, rule out pregnancy.
- 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.
- 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).
- 4 In a post-menopausal woman with vaginal bleeding, investigate *Reasoning*  
  
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).



## Vaginitis

### Key Feature

- 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.)
- 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.
- 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.
- 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.)
- 5 In a child with a candidal infection, look for underlying illness (e.g., immunocompromise, diabetes).

## Violent/Aggressive Patient

### Key Feature

- 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.
  - b) Recognize warning signs of violent/aggressive behaviour.
  - 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).
- 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).
- 3 In a violent or aggressive patient, ensure the safety (including appropriate restraints) of the patient and staff before assessing the patient.
- 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.

## Well-baby Care

### *Key Feature*

- 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.
- 2 Modify the routine immunization schedule in those patients who require it (e.g., those who are immunocompromised, those who have allergies).
- 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.
- 4 At each assessment, provide parents with anticipatory advice on pertinent issues (e.g., feeding patterns, development, immunization, parenting tips, antipyretic dosing, safety issues).

5 Ask about family adjustment to the child (e.g., sibling interaction, changing roles of both parents, involvement of extended family).

6 With parents reluctant to vaccinate their children, address the following issues so that they can make an informed decision:

- 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).

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.

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)

# CURRICULUM OBJECTIVES

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<http://postgrad.familymed.ubc.ca/residency/curriculum-objectives/>

Behavioural Medicine

Emergency Medicine

Ethics

Evidence Based Medicine

Family Medicine

Informatics

Internal Medicine

Obstetrics

Paediatrics

Procedural Skills

Psychiatry

Professionalism

Research

Rural Family Medicine for Urban Residents

Rural Family Medicine

Surgery

Women's' Health/Gynaecology

Aboriginal Health

Addictions

Geriatrics

HIV Primary Care

Integrative Medicine

International Health

Musculoskeletal Medicine

Palliative Care

Youth Health



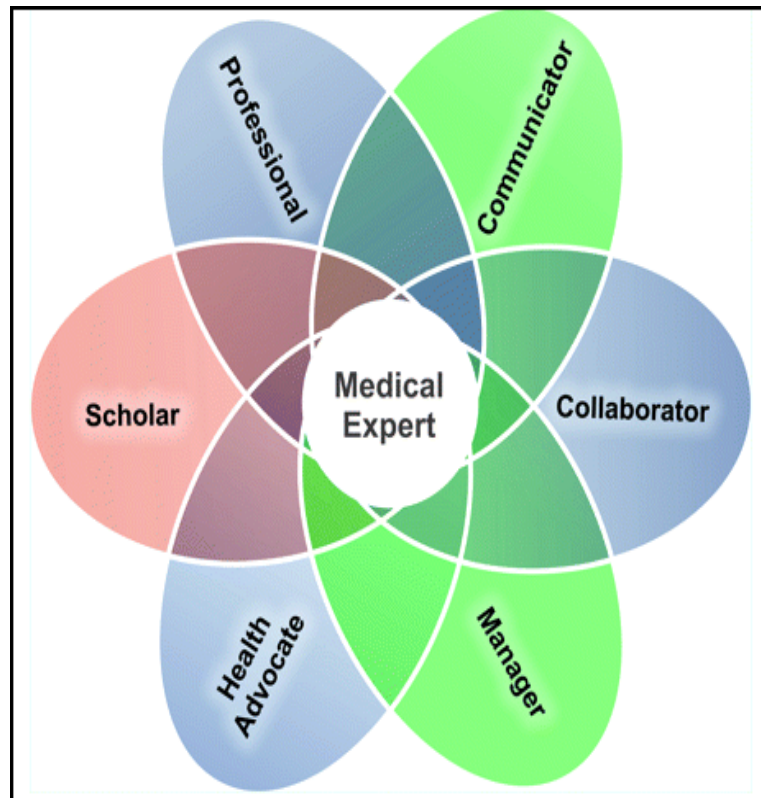
## **Section V**

### **CanMeds-FM Roles**

**Relationship Four Principles of FM → CanMeds-FM Roles**

**The Four Principles of Family Medicine**

## CanMeds-FM Roles



### 1. THE FAMILY MEDICINE EXPERT

#### ***Definition***

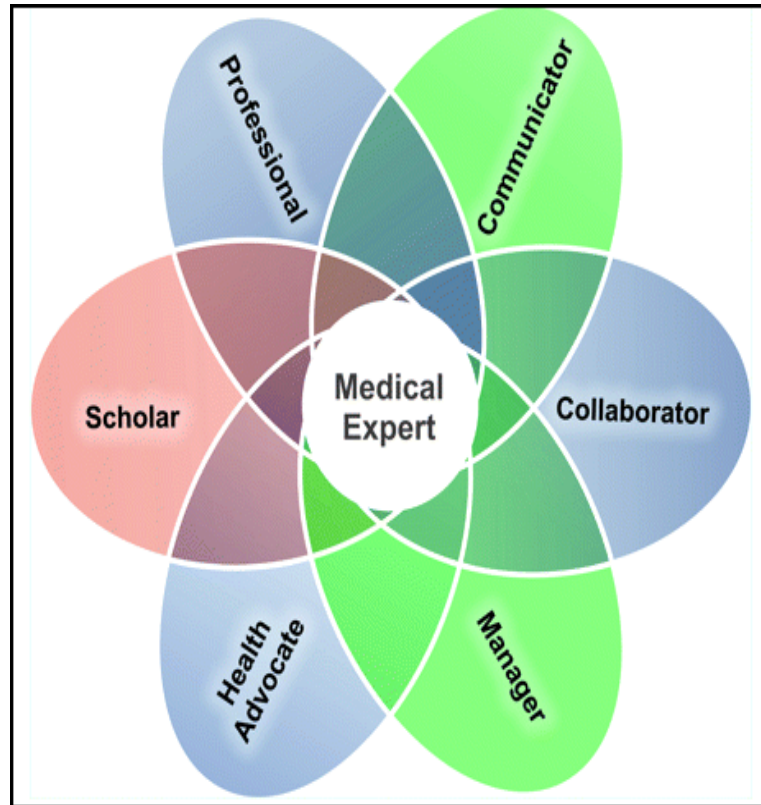
Family physicians are skilled clinicians who provide comprehensive, continuing care to patients and their families within a relationship of trust. Family physicians apply and integrate medical knowledge, clinical skills and professional attitudes in their provision of care. Their expertise includes knowledge of their patients and families in the context of their communities, and their ability to use the patient-centred clinical method effectively. As Family Medicine Experts they integrate all the CanMEDS- Family Medicine (CanMEDS-FM) roles in their daily work.

### 2. COMMUNICATOR

#### ***Definition***

As Communicators, family physicians facilitate the doctor-patient relationship and the dynamic exchanges that occur before, during, and after the medical encounter.

## CanMeds-FM Roles



### 3. COLLABORATOR

#### ***Definition***

As Collaborators, family physicians work with patients, families, healthcare teams, other health professionals, and communities to achieve optimal patient care.

### 4. MANAGER

#### ***Definition***

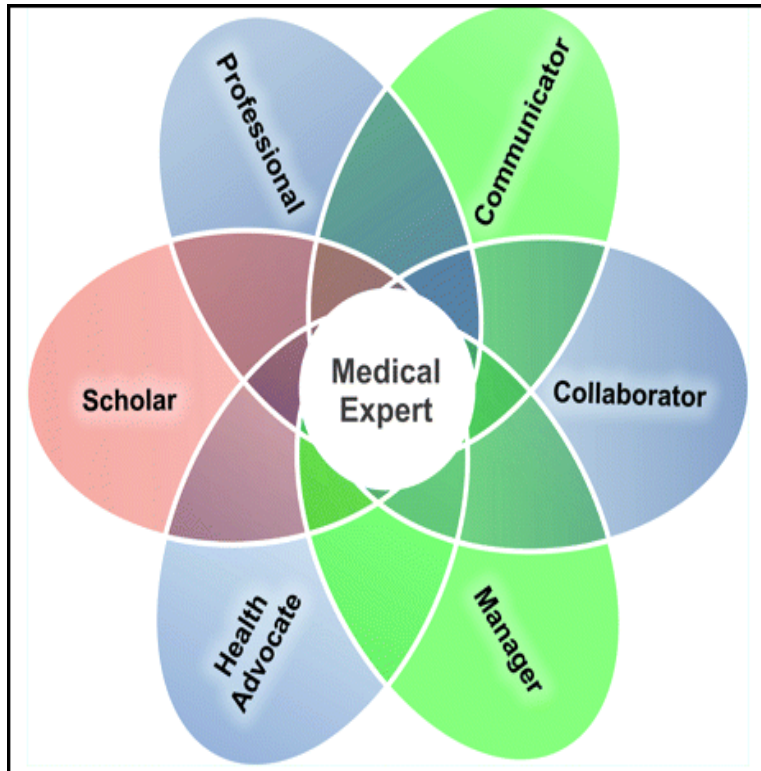
As Managers, family physicians are central to the primary health care team and integral participants in healthcare organizations. They use resources wisely and organize practices which are a resource to their patient population to sustain and improve health, coordinating care within the other members of the health care system.

### 5. HEALTH ADVOCATE

#### ***Definition***

As health advocates, family physicians responsibly use their expertise and influence to advance the health and well-being of individual patients, communities, and populations.

## CanMeds-FM Roles



### 6. SCHOLAR

#### ***Definition***

As Scholars, family physicians demonstrate a lifelong commitment to reflective learning, as well as the creation, dissemination, application and translation of knowledge.

### 7. PROFESSIONAL

#### ***Definition***

As Professionals, family physicians are committed to the health and well-being of individuals and society through ethical practice, profession-led regulation, and high personal standards of behaviour.



## RELATIONSHIP FOUR PRINCIPLES OF FM – CANMEDS-FM ROLES

<b>Four Principles of Family Medicine</b> (foundational concepts)	<b>CanMeds-FM Roles</b> (expected competencies )
The Doctor Patient <u>Relationship</u> is Central to the Role of the Family Physician	<i>2.Communicator</i> <i>3.Collaborator</i> <i>7.Professional</i>
The Family Physician is a <u>Skilled Clinician</u>	<i>1. Family Medicine Expert</i> <i>2. Communicator</i> <i>6.Scholar</i>
Family Medicine is <u>Community</u> -Based	<i>3.Collaborator</i> <i>4.Manager</i> <i>5.Health Advocate</i>
The Family Physician is a <u>Resource</u> to a <u>Defined</u> Practice	<i>3.Collaborator</i> <i>4.Manager</i> <i>5.Health Advocate</i> <i>6.Scholar</i>



## **THE FOUR PRINCIPLES OF FAMILY MEDICINE**

1. **The family physician is a skilled clinician** -- Family physicians demonstrate competence in the patient-centred clinical method; they integrate a sensitive, skilful, and appropriate search for disease. They demonstrate an understanding of patients' experience of illness (particularly their ideas, feelings, and expectations) and of the impact of illness on patients' lives.

Family physicians use their understanding of human development and family and other social systems to develop a comprehensive approach to the management of disease and illness in patients and their families.

Family physicians are also adept at working with patients to reach common ground on the definition of problems, goals of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to "take charge" of their own health care and make decisions in their best interests.

Family physicians have an expert knowledge of the wide range of common problems of patients in the community, and of less common, but life threatening and treatable emergencies in patients in all age groups. Their approach to health care is based on the best scientific evidence available.

2. **Family medicine is a community-based discipline** -- Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs.

Clinical problems presenting to a community-based family physician are not pre-selected and are commonly encountered at an undifferentiated stage. Family physicians are skilled at dealing with ambiguity and uncertainty. They will see patients with chronic diseases, emotional problems, acute disorders (ranging from those that are minor and self-limiting to those that are life-threatening), and complex biopsychosocial problems. Finally, the family physician may provide palliative care to people with terminal diseases.

The family physician may care for patients in the office, the hospital (including the emergency department), other health care facilities, or the home. Family physicians see themselves as part of a community network of health care providers and are skilled at collaborating as team members or team leaders. They use referral to specialists and community resources judiciously.

3. **The family physician is a resource to a defined practice population** -- The family physician views his or her practice as a

“population at risk”, and organizes the practice to ensure that patients’ health is maintained whether or not they are visiting the office. Such organization requires the ability to evaluate new information and its relevance to the practice, knowledge and skills to assess the effectiveness of care provided by the practice, the appropriate use of medical records and/or other information systems, and the ability to plan and implement policies that will enhance patients’ health.

Family physicians have effective strategies for self-directed, lifelong learning.

Family physicians have the responsibility to advocate public policy that promotes their patients’ health.

Family physicians accept their responsibility in the health care system for wise stewardship of scarce resources. They consider the needs of both the individual and the community.

4. **Patient/Physician relationship** -- Family physicians have an understanding and appreciation of the human condition, especially the nature of suffering and patients’ response to sickness. They are aware of their strengths and limitations and recognize when their own personal issues interfere with effective care.

Family physicians respect the primacy of the person. The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients’ well-being, whether or not patients are able to follow through on their commitments. Family physicians are cognizant of the power imbalance between doctors and patients and the potential for abuse of this power.

Family physicians provide continuing care to their patients. They use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time, the relationship takes on special importance to patients, their families, and the physician. As a result, the family physician becomes an advocate for the patient.