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Abdominal Pain

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

Advanced Cardiac Life Support

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Keep up to date with advanced cardiac life support (ACLS) recommendations (i.e., maintain your knowledge base).	<i>Professionalism</i>	<i>Treatment</i>
2 Promptly defibrillate a patient with ventricular fibrillation (V fib), or pulseless or symptomatic ventricular tachycardia (V tach).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i>
3 Diagnose serious arrhythmias (V tach, V fib, supraventricular tachycardia, atrial fibrillation, or second- or third-degree heart block), and treat according to ACLS protocols.	<i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i>
4 Suspect and promptly treat reversible causes of arrhythmias (e.g., hyperkalemia, digoxin toxicity, cocaine intoxication) before confirmation of the diagnosis.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Treatment</i>
5 Ensure adequate ventilation (i.e., with a bag valve mask), and secure the airway in a timely manner.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i>
6 In patients requiring resuscitation, assess their circumstances (e.g., asystole, long code times, poor pre-code prognosis, living wills) to help you decide when to stop. (Avoid inappropriate resuscitation.)	<i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i>
7 In patients with serious medical problems or end-stage disease, discuss code status and end-of-life decisions (e.g., resuscitation, feeding tubes, levels of treatment), and readdress these issues periodically.	<i>Patient Centered</i>	<i>Treatment</i> <i>Follow-up</i>
8 Attend to family members (e.g., with counselling, presence in the code room) during and after resuscitating a patient.	<i>Professionalism</i> <i>Communication</i>	<i>Treatment</i>
9 In a pediatric resuscitation, use appropriate resources (e.g., Braeslow tape, the patient’s weight) to determine the correct drug doses and tube sizes.	<i>Clinical Reasoning</i>	<i>Treatment</i>
Note: Shock is not dealt with in this topic.		

Allergy

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients, always inquire about any allergy and clearly document it in the chart. Re-evaluate this periodically.	<i>Clinical Reasoning</i>	<i>History Follow-up</i>
2 Clarify the manifestations of a reaction in order to try to diagnose a true allergic reaction (e.g., do not misdiagnose viral rashes as antibiotic allergy, or medication intolerance as true allergy).	<i>Clinical Reasoning</i>	<i>History Diagnosis</i>
3 In a patient reporting allergy (e.g., to food, to medications, environmental), ensure that the patient has the appropriate medication to control symptoms (e.g., antihistamines, bronchodilators, steroids, an EpiPen).	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 Prescribe an EpiPen to every patient who has a history of, or is at risk for, anaphylaxis.	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 Educate appropriate patients with allergy (e.g., to food, medications, insect stings) and their families about the symptoms of anaphylaxis and the self-administration of the EpiPen, and advise them to return for immediate reassessment and treatment if those symptoms develop or if the EpiPen has been used.	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment Follow-up</i>
6 Advise patients with any known drug allergy or previous major allergic reaction to get a MedicAlert bracelet.	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment</i>
7 In a patient presenting with an anaphylactic reaction:		
a) Recognize the symptoms and signs.	<i>Selectivity Clinical Reasoning</i>	<i>Diagnosis</i>
b) Treat immediately and aggressively.	<i>Selectivity Clinical Reasoning</i>	<i>Treatment</i>
c) Prevent a delayed hypersensitivity reaction through observation and adequate treatment (e.g., with steroids).	<i>Clinical Reasoning</i>	<i>Treatment</i>
8 In patients with anaphylaxis of unclear etiology refer to an allergist for clarification of the cause.	<i>Clinical Reasoning</i>	<i>Referral</i>
9 In the particular case of a child with an anaphylactic reaction to food:		
a) Prescribe an EpiPen for the house, car, school, and daycare.	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Advise the family to educate the child, teachers, and caretakers about signs and symptoms of anaphylaxis, and about when and how to use the EpiPen.	<i>Clinical Reasoning</i>	<i>Treatment</i>
10 In a patient with unexplained recurrent respiratory symptoms, include allergy (e.g., sick building syndrome, seasonal allergy) in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Anemia

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

Antibiotics

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

Anxiety

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
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).	<i>Selectivity Clinical Reasoning</i>	<i>Diagnosis Hypothesis generation</i>
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.	<i>Selectivity Clinical Reasoning Clinical Reasoning Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis Diagnosis History History Diagnosis</i>
3 In patients with known anxiety disorders, do not assume all new symptoms are attributable to the anxiety disorder.	<i>Clinical Reasoning</i>	<i>Diagnosis Hypothesis generation</i>
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.	<i>Clinical Reasoning</i>	<i>Treatment</i>
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.	<i>Clinical Reasoning</i>	<i>Diagnosis History</i>

Asthma

Key Feature	Skill	Phase
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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.	<i>Clinical Reasoning Selectivity</i>	<i>History Physical</i>
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.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
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).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
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.	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment</i>
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.	<i>Clinical Reasoning Patient Centered</i>	<i>History Diagnosis</i>
	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment</i>

Atrial Fibrillation

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

Bad News

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 When giving bad news, ensure that the setting is appropriate, and ensure patient's confidentiality.	<i>Patient Centered Communication</i>	<i>Treatment</i>
2 Give bad news: - in an empathic, compassionate manner - allowing enough time. - providing translation, as necessary.	<i>Communication</i>	<i>Treatment</i>
3 Obtain patient consent before involving the family.	<i>Patient Centered Professionalism</i>	<i>Treatment</i>
4 After giving bad news, arrange definitive follow-up opportunities to assess impact and understanding.	<i>Patient Centered Communication</i>	<i>Follow-up</i>

Behavioural Problems

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
<p>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:</p> <ul style="list-style-type: none"> - 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). 	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
<p>2 When obtaining a history about behavioural problems in a child:</p> <ul style="list-style-type: none"> - Ask the child about her or his perception of the situation. - Use multiple sources of information (e.g., school, daycare). 	<i>Clinical Reasoning</i>	<i>History</i>
<p>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.).</p>	<i>Clinical Reasoning</i>	<i>Treatment</i>
<p>4 In assessing behavioural problems in adolescents, use a systematic, structured approach to make an appropriate diagnosis:</p> <ul style="list-style-type: none"> - 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". 	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
<p>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).</p>	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>

Breast Lump

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

Cancer

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

Chest Pain

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

Chronic Disease

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

Chronic Obstructive Pulmonary Disease

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

Contraception

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 With all patients, especially adolescents, young men, postpartum women, and perimenopausal women, advise about adequate contraception when opportunities arise.	<i>Patient Centered Communication</i>	<i>Treatment</i>
2 In patients using specific contraceptives, advise of specific factors that may reduce efficacy (e.g., delayed initiation of method, illness, medications, specific lubricants).	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment</i>
3 In aiding decision-making to ensure adequate contraception:		
a) Look for and identify risks (relative and absolute contraindications).	<i>Clinical Reasoning</i>	<i>History</i>
b) Assess (look for) sexually transmitted disease exposure.	<i>Clinical Reasoning Patient Centered</i>	<i>History</i>
c) Identify barriers to specific methods (e.g., cost, cultural concerns).	<i>Patient Centered Communication</i>	<i>History</i>
d) Advise of efficacy and side effects, especially short-term side effects that may result in discontinuation.	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 In patients using hormonal contraceptives, manage side effects appropriately (i.e., recommend an appropriate length of trial, discuss estrogens in medroxyprogesterone acetate [Depo-Provera]).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 In all patients, especially those using barrier methods or when efficacy of hormonal methods is decreased, advise about post-coital contraception.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 In a patient who has had unprotected sex or a failure of the chosen contraceptive method, inform about time limits in post-coital contraception (emergency contraceptive pill, intrauterine device).	<i>Clinical Reasoning</i>	<i>Treatment</i>

Cough

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

Counselling

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with mental health concerns, explore the role of counselling in treating their problems. (Intervention is not just about medication use.)	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>Treatment</i>
2 When making the decision about whether to offer or refer a patient for counselling:		
a) Allow adequate time to assess the patient.	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Identify the patient’s context and understanding of her or his problem/situation.	<i>Patient Centered</i>	<i>Treatment</i>
c) Evaluate your own skills. (Does the problem exceed the limits of your abilities?)	<i>Professionalism</i>	<i>Treatment</i>
d) Recognize when your beliefs may interfere with counselling.	<i>Professionalism</i>	<i>Treatment</i>
3 When counselling a patient, allow adequate time.	<i>Professionalism</i>	<i>Treatment</i>
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.	<i>Professionalism</i> <i>Clinical Reasoning</i>	<i>Treatment</i>

Crisis

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Take the necessary time to assist patients in crisis, as they often present unexpectedly.	<i>Patient Centered Professionalism</i>	<i>Treatment</i>
2 Identify your patient’s personal resources for support (e.g., family, friends) as part of your management of patients facing crisis.	<i>Patient Centered Clinical Reasoning</i>	<i>History Treatment</i>
3 Offer appropriate community resources (e.g., counselor) as part of your ongoing management of patients with a crisis.	<i>Patient Centered Professionalism</i>	<i>Treatment</i>
4 Assess suicidality in patients facing crisis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
5 Use psychoactive medication rationally to assist patients in crisis.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 Inquire about unhealthy coping methods (e.g., drugs, alcohol, eating, gambling, violence, sloth) in your patients facing crisis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
7 Ask your patient if there are others needing help as a consequence of the crisis.	<i>Patient Centered</i>	<i>Hypothesis generation History</i>
8 Negotiate a follow-up plan with patients facing crisis.	<i>Clinical Reasoning Communication</i>	<i>Treatment Follow-up</i>
9 Be careful not to cross boundaries when treating patients in crisis (e.g., lending money, appointments outside regular hours).	<i>Professionalism</i>	<i>Treatment</i>
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.	<i>Professionalism</i>	<i>Treatment</i>
11 When dealing with an unanticipated medical crisis (e.g., seizure, shoulder dystocia),		
a) Assess the environment for needed resources (people, material).	<i>Clinical Reasoning</i>	<i>Treatment</i>
b) Be calm and methodical.	<i>Professionalism</i>	<i>Treatment</i>
c) Ask for the help you need.	<i>Professionalism</i>	<i>Treatment</i>

Croup

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with croup, a) Identify the need for respiratory assistance (e.g., assess ABCs, fatigue, somnolence, paradoxical breathing, in drawing) b) Provide that assistance when indicated.	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i>
2 Before attributing stridor to croup, consider other possible causes (e.g., anaphylaxis, foreign body (airway or esophagus), retropharyngeal abscess, epiglottitis).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
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).	<i>Clinical Reasoning</i>	<i>History</i> <i>Physical</i>
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).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i> <i>Investigation</i>
5 In patients with a diagnosis of croup, use steroids (do not under treat mild-to-moderate cases of croup).	<i>Clinical Reasoning</i>	<i>Treatment</i>
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.	<i>Clinical Reasoning</i> <i>Communication</i>	<i>Treatment</i> <i>Follow-up</i>

Deep Venous Thrombosis

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

Dehydration

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

Dementia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with early, non-specific signs of cognitive impairment: a) Suspect dementia as a diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
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.	<i>Clinical Reasoning</i>	<i>Investigation</i>
3 In patients with dementia, distinguish Alzheimer’s disease from other dementias, as treatment and prognosis differ.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
5 Disclose the diagnosis of dementia compassionately, and respect the patient’s right to autonomy, confidentiality, and safety.	<i>Patient Centered Communication</i>	<i>Diagnosis Treatment</i>
6 In patients with dementia, assess competency. (Do not judge clearly competent patients as incompetent and vice versa.)	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
7 In following patients diagnosed with dementia: a) Assess function and cognitive impairment on an ongoing basis.	<i>Clinical Reasoning</i>	<i>Follow-up Physical</i>
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).	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment</i>
8 Assess the needs of and supports for caregivers of patients with dementia.	<i>Patient Centered</i>	<i>History</i>
9 Report to the appropriate authorities patients with dementia who you suspect should not be driving.	<i>Professionalism Clinical Reasoning</i>	<i>Treatment</i>
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).	<i>Clinical Reasoning Patient Centered</i>	<i>Hypothesis generation History</i>
Note: Specific cognition-enhancing pharmacotherapy (initiation/discontinuation) may be assessed later, as controversy on indications diminishes.		

Depression

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
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).	<i>Clinical Reasoning Selectivity</i>	<i>History</i>
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).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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.	<i>Clinical Reasoning Patient Centered</i>	<i>Hypothesis generation Treatment</i>
4 After a diagnosis of depression is made, look for and diagnose other co-morbid psychiatric conditions (e.g., anxiety, bipolar disorder, personality disorder).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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.	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
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).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
7 In patients presenting with depression, inquire about abuse: - sexual, physical, and emotional abuse (past and current, witnessed or inflicted). - substance abuse.	<i>Clinical Reasoning Patient Centered</i>	<i>History Hypothesis generation</i>
8 In a patient with depression, differentiate major depression from adjustment disorder, dysthymia, and a grief reaction.	<i>Clinical Reasoning Selectivity</i>	<i>Diagnosis</i>
9 Following failure of an appropriate treatment in a patient with depression, consider other diagnoses (e.g., bipolar disorder, schizoaffective disorder, organic disease).	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
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).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>

Diabetes

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

Diarrhea

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

Difficult Patient

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

Disability

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

Dizziness

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

Domestic Violence

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

Dyspepsia

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

Dysuria

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

Earache

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

Note: *See the key features on fever.

Eating Disorders

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
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.	<i>Clinical Reasoning</i>	<i>History</i>
2 When diagnosing an eating disorder, take an appropriate history to differentiate anorexia nervosa from bulimia, as treatment and prognosis differ.	<i>Clinical Reasoning</i>	<i>History</i>
3 In a patient with an eating disorder, rule out co-existing psychiatric conditions (e.g., depression, personality disorder, obsessive-compulsive disorder, anxiety disorder).	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
4 When managing a patient with an eating disorder, use a multidisciplinary approach (e.g., work with a psychiatrist, a psychologist, a dietitian).	<i>Clinical Reasoning Professionalism</i>	<i>Treatment Referral</i>
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
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).	<i>Clinical Reasoning</i>	<i>History Diagnosis</i>
b) Evaluate the level of disease activity (e.g., by noting eating patterns, exercise, laxative use).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Elderly

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In the elderly patient taking multiple medications, avoid polypharmacy by: - monitoring side effects. - periodically reviewing medication (e.g., is the medication still indicated, is the dosage appropriate). - monitoring for interactions.	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
2 In the elderly patient, actively inquire about non-prescription medication use (e.g., herbal medicines, cough drops, over-the-counter drugs, vitamins).	<i>Clinical Reasoning</i>	<i>History</i>
3 In the elderly patient, screen for modifiable risk factors (e.g., visual disturbance, impaired hearing) to promote safety and prolong independence.	<i>Clinical Reasoning</i>	<i>History Hypothesis generation</i>
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.	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment History</i>
5 In older patients with diseases prone to atypical presentation, do not exclude these diseases without a thorough assessment (e.g., pneumonia, appendicitis, depression).	<i>Selectivity Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>

Epistaxis

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

Family Issues

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Routinely ask about family issues to understand their impact on the patient's illness and the impact of the illness on the family.	<i>Patient Centered</i>	<i>History</i>
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).	<i>Patient Centered</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>

Fatigue

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

Fever

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

Fractures

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with multiple injuries, stabilize the patient (e.g., airway, breathing, and circulation, and life-threatening injuries) before dealing with any fractures.	<i>Clinical Reasoning</i>	<i>Treatment</i>
2 When examining patients with a fracture, assess neurovascular status and examine the joint above and below the injury.	<i>Clinical Reasoning</i>	<i>Physical</i>
3 In patients with suspected fractures that are prone to have normal X-ray findings (e.g., scaphoid fractures in wrist injuries, elbow fracture, growth plate fracture in children, stress fractures), manage according to your clinical suspicion, even if X-ray	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Treatment</i>
4 In assessing elderly patients with an acute change in mobility (i.e., those who can no longer walk) and equivocal X-ray findings (e.g., no obvious fracture), investigate appropriately (e.g., with bone scans, computed tomography) before excluding a fracture.	<i>Clinical Reasoning</i>	<i>Investigation</i>
5 Identify and manage limb injuries that require urgent immobilization and/or reduction in a timely manner.	<i>Selectivity</i>	<i>Treatment</i> <i>Diagnosis</i>
6 In assessing patients with suspected fractures, provide analgesia that is timely (i.e., before X-rays) and adequate (e.g., narcotic) analgesia.	<i>Clinical Reasoning</i>	<i>Treatment</i>
7 In patients presenting with a fracture, look for and diagnose high-risk complications (e.g., an open fracture, unstable cervical spine, compartment syndrome).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
8 Use clinical decision rules (e.g., Ottawa ankle rules, C-spine rules, and knee rules) to guide the use of X-ray examinations.	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Investigation</i>
Note: These key features do not include technical and or psychomotor skills such as casting, reduction of dislocations, etc. See Procedural Skills.		

Gastro-intestinal Bleed

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

Gender Specific Issues

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

Grief

Key Feature	Skill	Phase
1 In patients who have undergone a loss, prepare them for the types of reactions (e.g., emotional, physical) that they may experience.	<i>Patient Centered Communication</i>	<i>Treatment</i>
2 In all grieving patients, especially those with a prolonged or abnormal grief reaction, inquire about depression or suicidal ideation.	<i>Clinical Reasoning Patient Centered</i>	<i>Hypothesis generation History</i>
3 Recognize atypical grief reactions in the very young or the elderly (e.g., behavioral changes).	<i>Clinical Reasoning Patient Centered</i>	<i>Diagnosis</i>
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).	<i>Patient Centered</i>	<i>History</i>

Headache

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

Hepatitis

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

Hyperlipidemia

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

Hypertension

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

Immigrants

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

Immunization

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

In Children

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

Infections

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
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).	<i>Clinical Reasoning</i>	<i>Investigation</i>
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).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 Treat infections empirically when appropriate (e.g., in life threatening sepsis without culture report or confirmed diagnosis, candida vaginitis post-antibiotic use).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
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]).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
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).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
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).	<i>Clinical Reasoning</i>	<i>Treatment</i>

Infertility

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

Insomnia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
<p>1 In patients presenting with sleep complaints, take a careful history to:</p> <ul style="list-style-type: none"> - 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. 	<p><i>Clinical Reasoning</i> <i>Selectivity</i></p>	<p><i>History</i> <i>Diagnosis</i></p>
<p>2 When assessing patients with sleep complaints, obtain a collateral history from the bed partner, if possible.</p>	<p><i>Clinical Reasoning</i></p>	<p><i>History</i></p>
<p>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).</p>	<p><i>Clinical Reasoning</i> <i>Patient Centered</i></p>	<p><i>Treatment</i></p>
<p>4 In appropriate patients with insomnia, use hypnotic medication judiciously (e.g., prescribe it when there is a severe impact on function, but do not prescribe it without a clear indication).</p>	<p><i>Clinical Reasoning</i></p>	<p><i>Treatment</i></p>

Ischemic Heart Disease

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given a specific clinical scenario in the office or emergency setting, diagnose presentations of ischemic heart disease (IHD) that are: <ul style="list-style-type: none"> - classic - atypical (e.g., in women, those with diabetes, the young, those at no risk). 	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
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.	<i>Clinical Reasoning</i>	<i>Treatment</i>
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).	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Investigation</i>
4 In a patient with stable ischemic heart disease manage changes in symptoms with self-initiated adjustment of medication (e.g., nitroglycerin) and appropriate physician contact (e.g., office visits, phone calls, emergency department visits), depending on the nature and severity of symptoms.	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 In the regular follow-up care of patients with established ischemic heart disease, specifically verify the following to detect complications and suboptimal control: <ul style="list-style-type: none"> - symptom control. - medication adherence. - impact on daily activities. - lifestyle modification. - clinical screening (i.e., symptoms and signs of complications). 	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>History</i> <i>Diagnosis</i>
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.	<i>Selectivity</i>	<i>Treatment</i>

Joint Disorder

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

Lacerations

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

Learning (Patients/Self)

Patients

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

Self Learning

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

Lifestyle

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

Loss of Consciousness

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

Loss of Weight

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

Low-back Pain

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with undefined acute low-back pain (LBP): a) Rule out serious causes (e.g., cauda equina syndrome, pyelonephritis, ruptured abdominal aortic aneurysm, cancer) through appropriate history and physical examination. b) Make a positive diagnosis of musculoskeletal pain (not a diagnosis of exclusion) through an appropriate history and physical examination.	<i>Selectivity</i>	<i>Hypothesis generation Diagnosis</i>
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).	<i>Clinical Reasoning Selectivity</i>	<i>Investigation Treatment</i>
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.	<i>Clinical Reasoning</i>	<i>Treatment</i>
4 Advise the patient with mechanical low back pain to return if new or progressive neurologic symptoms develop.	<i>Clinical Reasoning</i>	<i>Follow-up Treatment</i>
5 In all patients with mechanical low back pain, discuss exercises and posture strategies to prevent recurrences.	<i>Clinical Reasoning Patient Centered</i>	<i>Treatment</i>

Meningitis

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

Menopause

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

Mental Competency

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient with 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.	Clinical Reasoning Communication	History Physical
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.	Clinical Reasoning Selectivity	Hypothesis generation Diagnosis
3 When a patient is making decisions (e.g., surgery/no surgery, resuscitation status) think about the need to assess their mental competency.	Clinical Reasoning Professionalism	Hypothesis generation
4 In a patient with cognitive impairment, identify intact decision-making abilities, as many may be retained.	Clinical Reasoning Selectivity	Hypothesis generation Treatment

Multiple Medical Problems

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

Neck Pain

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

Newborn

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

Obesity

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

Osteoporosis

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

Palliative Care

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In all patients with terminal illnesses (e.g., end-stage congestive heart failure or renal disease), use the principles of palliative care to address symptoms (i.e., do not limit the use of palliative care to cancer patients).	<i>Patient Centered Clinical Reasoning</i>	<i>Treatment</i>
2 In patients requiring palliative care, provide support through self, other related disciplines, or community agencies, depending on patient needs (i.e., use a team approach when necessary).	<i>Patient Centered</i>	<i>Treatment</i>
3 In patients approaching the end of life: a) Identify the individual issues important to the patient, including physical issues (e.g., dyspnea, pain, constipation, nausea), emotional issues, social issues (e.g., guardianship, wills, finances), and spiritual issues.	<i>Patient Centered Clinical Reasoning</i>	<i>History</i>
b) Attempt to address the issues identified as important to the patient.	<i>Patient Centered Clinical Reasoning</i>	<i>Treatment</i>
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).	<i>Clinical Reasoning</i>	<i>Treatment Follow-up</i>
5 In patients diagnosed with a terminal illness, identify and repeatedly clarify wishes about end-of-life issues (e.g., wishes for treatment of infections, intubation, dying at home)	<i>Patient Centered Clinical Reasoning</i>	<i>History Hypothesis generation</i>

Parkinsonism

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with suspected Parkinson's disease, accurately distinguish idiopathic Parkinson's disease from atypical Parkinson's disease (e.g., disease at a young age, drug-related disease), as treatment differs.	<i>Clinical Reasoning</i>	<i>Diagnosis</i>
2 In the care of all patients with Parkinson's disease, involve other health care professionals to enhance the patient's functional status.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i> <i>Referral</i>
3 In an elderly patient with a deterioration in functional status, look for and recognize Parkinson's disease when it is present, as it is a potentially reversible contribution to the deterioration.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
4 In a patient with a tremor, do an appropriate physical examination (e.g., observation, use of techniques to enhance the tremor) to distinguish the resting tremor of parkinsonism from other (e.g., essential) tremors.	<i>Clinical Reasoning</i>	<i>Physical</i>
5 As part of the management of patients with Parkinson's disease, identify anticipated side effects of medications, especially those with which you are unfamiliar.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>
6 As part of the ongoing follow-up care of patients with Parkinson's disease: - Assess functional status. - Monitor them for medication side effects. - Look for other problems (e.g., depression, dementia, falls, constipation), as they are more common	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Follow-up</i>

Periodic Health Assessment/Screening

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

Personality Disorder

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
<p>1 Clearly establish and maintain limits in dealing with patients with identified personality disorders. For example, set limits for:</p> <ul style="list-style-type: none"> - appointment length. - drug prescribing. - accessibility. 	<p><i>Professionalism</i> <i>Communication</i></p>	<p><i>Treatment</i> <i>Follow-up</i></p>
<p>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.)</p>	<p><i>Clinical Reasoning</i></p>	<p><i>Hypothesis generation</i></p>
<p>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).</p>	<p><i>Professionalism</i> <i>Communication</i></p>	<p><i>Treatment</i></p>
<p>4 In a patient with a personality disorder, limit the use of benzodiazepines but use them judiciously when necessary.</p>	<p><i>Clinical Reasoning</i> <i>Selectivity</i></p>	<p><i>Treatment</i></p>
<p>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.</p>	<p><i>Clinical Reasoning</i> <i>Selectivity</i></p>	<p><i>Diagnosis</i> <i>History</i></p>

Pneumonia

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

b) Modify the therapy appropriately (e.g., change antibiotics).	Clinical Reasoning	Treatment Diagnosis
9 Identify patients (e.g., the elderly, nursing home residents, debilitated patients) who would benefit from immunization or other treatments (e.g., flu vaccine, Pneumovax, ribavarine) to reduce the incidence of pneumonia.	Clinical Reasoning Selectivity	Treatment
10 In patients with a diagnosis of pneumonia, ensure appropriate follow-up care (e.g., patient education, repeat chest X-ray examination, instructions to return if the condition worsens).	Clinical Reasoning	Follow-up
11 In patients with a confirmed diagnosis of pneumonia, arrange contact tracing when appropriate (e.g., in those with TB, nursing home residents, those with legionnaires' disease).	Clinical Reasoning	Follow-up Referral

Poisoning

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 As part of well-child care, discuss preventing and treating poisoning with parents (e.g., “child-proofing”, poison control number).	<i>Communication</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
2 In intentional poisonings (overdose) think about multi-toxin ingestion.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
3 When assessing a patient with a potentially toxic ingestion, take a careful history about the timing and nature of the ingestion.	<i>Clinical Reasoning</i>	<i>History</i>
4 When assessing a patient with a potential poisoning, do a focused physical examination to look for the signs of toxidromes.	<i>Clinical Reasoning</i>	<i>Physical</i>
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).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>
6 When managing a toxic ingestion, utilize poison control protocols that are current.	<i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i>
7 When managing a patient with a poisoning, a) Assess ABC's,	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Diagnosis</i>
b) Manage ABC's,	<i>Clinical Reasoning</i>	<i>Treatment</i>
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).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Treatment</i>

Pregnancy

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient who is considering pregnancy: a) Identify risk factors for complications. b) Recommend appropriate changes (e.g., folic acid intake, smoking cessation, medication changes).	<i>Clinical Reasoning</i> <i>Patient Centered</i> <i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>Hypothesis generation</i> <i>Diagnosis</i> <i>Treatment</i>
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.	<i>Communication</i> <i>Patient Centered</i>	<i>Treatment</i>
3 In a patient with suspected or confirmed pregnancy, establish the desirability of the pregnancy.	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>History</i> <i>Treatment</i>
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.	<i>Clinical Reasoning</i> <i>Patient Centered</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i> <i>Diagnosis</i> <i>Treatment</i>
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.	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i> <i>Treatment</i> <i>Referral</i>
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.	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Treatment</i>
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.	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i> <i>Treatment</i>
8 In a patient presenting with dystocia (prolonged dilatation, failure of descent): a) Diagnose the problem. b) Intervene appropriately.	<i>Clinical Reasoning</i> <i>Selectivity</i> <i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Hypothesis generation</i> <i>Diagnosis</i> <i>Treatment</i>

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

Prostate

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

Rape/Sexual Assault

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

Red Eye

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In addressing eye complaints, always assess visual acuity using history, physical examination, or the Snellen chart, as appropriate.	<i>Clinical Reasoning</i>	<i>History Physical</i>
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).	<i>Clinical Reasoning</i>	<i>History</i>
b) Do a focused physical examination (e.g., pupil size, and visual acuity, slit lamp, fluorescein).	<i>Clinical Reasoning</i>	<i>Physical</i>
c) Do appropriate investigations (e.g., erythrocyte sedimentation rate measurement, tonometry).	<i>Clinical Reasoning</i>	<i>Investigation</i>
d) Refer the patient appropriately (if unsure of the diagnosis or if further work-up is needed).	<i>Clinical Reasoning</i>	<i>Referral</i>
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
4 In patients presenting with an ocular foreign body sensation, evert the eyelids to rule out the presence of a conjunctival foreign body.	<i>Clinical Reasoning Psychomotor Skills/Procedure Skills</i>	<i>Hypothesis generation Physical</i>
5 In neonates with conjunctivitis (not just blocked lacrimal glands or “gunky” eyes), look for a systemic cause and treat it appropriately (i.e., with antibiotics).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Treatment</i>
6 In patients with conjunctivitis, distinguish by history and physical examination between allergic and infectious causes (viral or bacterial).	<i>Clinical Reasoning</i>	<i>Diagnosis History</i>
7 In patients who have bacterial conjunctivitis and use contact lenses, provide treatment with antibiotics that cover for <i>Pseudomonas</i> .	<i>Clinical Reasoning</i>	<i>Treatment</i>
8 Use steroid treatment only when indicated (e.g., to treat iritis; avoid with keratitis and conjunctivitis).	<i>Clinical Reasoning</i>	<i>Treatment</i>
9 In patients with iritis, consider and look for underlying systemic causes (e.g., Crohn’s disease, lupus, ankylosing spondylitis).	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Schizophrenia

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In adolescents presenting with problem behaviours, consider schizophrenia in the differential diagnosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>
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: <ul style="list-style-type: none"> - 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. 	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>Follow-up History</i>
3 In all patients presenting with psychotic symptoms, inquire about substance use and abuse.	<i>Clinical Reasoning</i>	<i>History</i>
4 Consider the possibility of substance abuse and look for it in patients with schizophrenia, as this is a population at risk.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>History</i>
5 In patients with schizophrenia, assess and treat substance abuse appropriately.	<i>Clinical Reasoning</i>	<i>Treatment</i>
6 In decompensating patients with schizophrenia, determine: <ul style="list-style-type: none"> - if substance abuse is contributory. - the role of medication compliance and side-effect problems. - if psychosocial supports have changed. 	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>History</i> <i>Hypothesis generation</i>
7 Diagnose and treat serious complications/side effects of antipsychotic medications (e.g., neuroleptic malignant syndrome, tardive dyskinesia).	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Diagnosis</i>
8 Include psychosocial supports (e.g., housing, family support, disability issues, vocational rehabilitation) as part of the treatment plan for patients with schizophrenia.	<i>Patient Centered</i> <i>Clinical Reasoning</i>	<i>Treatment</i>

Seizures

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

Sex

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 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).	<i>Patient Centered Clinical Reasoning</i>	<i>History</i>
	<i>Patient Centered Communication</i>	<i>Treatment</i>
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).	<i>Selectivity Clinical Reasoning</i>	<i>Hypothesis generation History</i>
3 In patients presenting with sexual dysfunction, identify features that suggest organic and non-organic causes.	<i>Clinical Reasoning</i>	<i>Hypothesis generation History</i>
4 In patients who have sexual dysfunction with an identified probable cause, manage the dysfunction appropriately.	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 In patients with identified sexual dysfunction, inquire about partner relationship issues.	<i>Patient Centered</i>	<i>History</i>

Sexually Transmitted Infections

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

Skin Disorder

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In dealing with a persistent skin problem that is not responding to treatment as expected: a) Reconsider the diagnosis (e.g., “eczema” may really be a fungal infection). b) Investigate or modify treatment (e.g., for acne).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
	<i>Clinical Reasoning</i>	<i>Treatment Investigation</i>
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).	<i>Selectivity Clinical Reasoning</i>	<i>Physical Investigation</i>
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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).	<i>Clinical Reasoning</i>	<i>Physical</i>
5 Diagnose and promptly treat suspected life-threatening dermatologic emergencies (e.g., Stevens-Johnson syndrome, invasive cellulitis, chemical or non-chemical burns).	<i>Selectivity</i>	<i>Diagnosis Hypothesis generation</i>
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.	<i>Clinical Reasoning Selectivity</i>	<i>Physical</i>
	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
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.	<i>Patient Centered</i>	<i>Treatment History</i>

Smoking Cessation

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

Somatization

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In patients with recurrent physical symptoms, diagnose somatization only after an adequate work-up to rule out any medical or psychiatric condition (e.g., depression).	<i>Clinical Reasoning</i>	<i>Diagnosis Hypothesis generation</i>
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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.	<i>Patient Centered</i>	<i>Treatment Follow-up</i>
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).	<i>Clinical Reasoning</i>	<i>Treatment History</i>

Stress

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 In a patient presenting with a symptom that could be attributed to stress (e.g., headache, fatigue, pain) consider and ask about stress as a cause or contributing factor.	<i>Clinical Reasoning Communication</i>	<i>Hypothesis generation History</i>
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).	<i>Patient Centered</i>	<i>History Diagnosis</i>
3 In patients not coping with stress, look for and diagnose, if present, mental illness (e.g., depression, anxiety disorder).	<i>Clinical Reasoning</i>	<i>Hypothesis generation Diagnosis</i>
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.	<i>Patient Centered Clinical Reasoning</i> <i>Patient Centered</i>	<i>History</i> <i>History Treatment</i>
5 In patients experiencing stress, look for inappropriate coping mechanisms (e.g., drugs, alcohol, eating, violence).	<i>Clinical Reasoning Communication</i>	<i>Hypothesis generation History</i>

Stroke

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

Substance Abuse

Key Feature	Skill	Phase
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).	<i>Clinical Reasoning</i>	<i>History</i>
2 In intravenous drug users: a) Screen for blood-borne illnesses (e.g., human immunodeficiency virus infection, hepatitis). b) Offer relevant vaccinations.	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Investigation</i> <i>Treatment</i>
3 In patients with signs and symptoms of withdrawal or acute intoxication, diagnose and manage it appropriately.	<i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i>
4 Discuss substance use or abuse with adolescents and their caregivers when warning signs are present (e.g., school failure, behaviour change).	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>Treatment</i> <i>Diagnosis</i>
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).	<i>Selectivity Patient Centered</i>	<i>Hypothesis generation</i> <i>History</i>
6 Offer support to patients and family members affected by substance abuse. (The abuser may not be your patient.)	<i>Patient Centered</i>	<i>Treatment</i>
7 In patients abusing substances, determine whether or not they are willing to agree with the diagnosis.	<i>Patient Centered</i>	<i>History</i> <i>Diagnosis</i>
8 In substance users or abusers, routinely determine willingness to stop or decrease use.	<i>Patient Centered</i>	<i>History</i> <i>Treatment</i>
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).	<i>Clinical Reasoning</i> <i>Patient Centered</i>	<i>History</i>

Suicide

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
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).	<i>Clinical Reasoning</i>	<i>History</i>
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).	<i>Clinical Reasoning</i> <i>Selectivity</i>	<i>Diagnosis</i> <i>Treatment</i>
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).	<i>Clinical Reasoning</i>	<i>Treatment</i> <i>Follow-up</i>
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.	<i>Clinical Reasoning</i>	<i>Investigation</i>
5 In trauma patients, consider attempted suicide as the precipitating cause.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i>

Thyroid

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Limit testing for thyroid disease to appropriate patients, namely those with a significant pre-test probability of abnormal results, such as: <ul style="list-style-type: none">- those with classic signs or symptoms of thyroid disease.- those whose symptoms or signs are not classic, but who are at a higher risk for disease (e.g., the elderly, postpartum women, those with a history of atrial fibrillation, those with other endocrine disorders).	<i>Clinical Reasoning Selectivity</i>	<i>Investigation</i>
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: <ul style="list-style-type: none">- after changing medical doses.- when following patients with mild disease before initiating treatment.- periodically in stable patients receiving treatment.	<i>Clinical Reasoning Selectivity</i>	<i>Investigation</i>
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).	<i>Psychomotor Skills/Procedure Skills</i>	<i>Physical</i>

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

Trauma

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

Travel Medicine

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

Upper Respiratory Tract Infection

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Given an appropriate history and/or physical examination: a) Differentiate life-threatening conditions (epiglottitis, retropharyngeal abscess) from benign conditions. b) Manage the condition appropriately.	<i>Selectivity</i> <i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Treatment</i>
2 Make the diagnosis of bacterial sinusitis by taking an adequate history and performing an appropriate physical examination, and prescribe appropriate antibiotics for the appropriate duration of therapy.	<i>Clinical Reasoning</i>	<i>History</i> <i>Treatment</i>
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).	<i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Clinical Reasoning</i> <i>Communication</i>	<i>History</i> <i>Diagnosis</i> <i>Diagnosis</i> <i>Treatment</i>
4 Given a history compatible with otitis media, differentiate it from otitis externa and mastoiditis, according to the characteristic physical findings.	<i>Clinical Reasoning</i>	<i>Diagnosis</i> <i>Physical</i>
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.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Follow-up</i>
6 In a presentation of pharyngitis, look for mononucleosis.	<i>Clinical Reasoning</i>	<i>Hypothesis generation</i> <i>Physical</i>
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).	<i>Selectivity Patient</i> <i>Centered</i> <i>Clinical Reasoning</i> <i>Professionalism</i>	<i>Treatment</i> <i>Treatment</i>

Urinary Tract Infection

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

Vaginal Bleeding

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

Vaginitis

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

Violent/Aggressive Patient

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
<p>1 In certain patient populations (e.g., intoxicated patients, psychiatric patients, patients with a history of violent behaviour):</p> <p>a) Anticipate possible violent or aggressive behaviour.</p> <p>b) Recognize warning signs of violent/aggressive behaviour.</p> <p>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).</p>	<p><i>Clinical Reasoning</i></p> <p><i>Clinical Reasoning</i></p> <p><i>Clinical Reasoning</i></p>	<p><i>Hypothesis generation</i></p> <p><i>Diagnosis</i></p> <p><i>Treatment</i></p>
<p>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).</p>	<p><i>Clinical Reasoning</i></p> <p><i>Selectivity</i></p>	<p><i>Hypothesis generation</i></p>
<p>3 In a violent or aggressive patient, ensure the safety (including appropriate restraints) of the patient and staff before assessing the patient.</p>	<p><i>Clinical Reasoning</i></p> <p><i>Professionalism</i></p>	<p><i>Treatment</i></p>
<p>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.</p>	<p><i>Professionalism</i></p>	<p><i>Treatment</i></p>

Well-baby Care

<i>Key Feature</i>	<i>Skill</i>	<i>Phase</i>
1 Measure and chart growth parameters, including head circumference, at each assessment; examine appropriate systems at appropriate ages, with the use of an evidence-based pediatric flow sheet such as the Rourke Baby Record.	<i>Clinical Reasoning Psychomotor Skills/Procedure Skills</i>	<i>Physical</i>
2 Modify the routine immunization schedule in those patients who require it (e.g., those who are immunocompromised, those who have allergies).	<i>Clinical Reasoning Selectivity</i>	<i>Treatment</i>
3 Anticipate and advise on breast-feeding issues (e.g., weaning, returning to work, sleep patterns) beyond the newborn period to promote breast-feeding for as long as it is desired.	<i>Clinical Reasoning Patient Centered</i>	<i>Hypothesis generation Treatment</i>
4 At each assessment, provide parents with anticipatory advice on pertinent issues (e.g., feeding patterns, development, immunization, parenting tips, antipyretic dosing, safety issues).	<i>Clinical Reasoning</i>	<i>Treatment</i>
5 Ask about family adjustment to the child (e.g., sibling interaction, changing roles of both parents, involvement of extended family).	<i>Patient Centered</i>	<i>History</i>
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).	<i>Patient Centered Clinical Reasoning</i>	<i>Treatment History</i>
7 When recent innovations (e.g., new vaccines) and recommendations (e.g., infant feeding, circumcision) have conflicting, or lack defined, guidelines, discuss this information with parents in an unbiased way to help them arrive at an informed decision.	<i>Professionalism Patient Centered</i>	<i>Treatment</i>
8 Even when children are growing and developing appropriately, evaluate their nutritional intake (e.g., type, quality, and quantity of foods) to prevent future problems (e.g., anemia, tooth decay), especially in at-risk populations (e.g., the socioeconomically disadvantaged, those with voluntarily restricted diets, those with cultural variations)	<i>Clinical Reasoning</i>	<i>History Treatment</i>