



UAEU

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NATIONAL INSTITUTE FOR HEALTH SPECIALTIES

NIHS Entrustable Professional Activities (EPAs) for Specialty Education in Family Medicine

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Family Medicine

EPA 1: Documenting and communicating clinical encounters, including telemedicine, to support continuity of care

Key Features: This EPA focuses on the ability to clearly, accurately, and professionally communicate and document clinical encounters across in-person, virtual, and telemedicine settings to ensure continuity, safety, quality, and coordination of care.

- The resident presents concise, structured, and clinically relevant oral and written case summaries that communicate pertinent findings, clinical reasoning, differential diagnoses, risk assessment, and management plans to healthcare team members, patients, families, caregivers, and consultants when appropriate.
- Documentation must be accurate, timely, organized, and completed using appropriate formats such as admission notes, consultation notes, progress notes, discharge summaries, referral letters, procedural documentation, virtual care notes, and telemedicine encounter records.
- The resident documents clinical findings, patient concerns, psychosocial and contextual factors, shared decision-making, safety-netting advice, follow-up arrangements, and transitions of care in a manner that supports continuity and medico-legal standards.
- The EPA includes communication and documentation during telemedicine and virtual care encounters, including verification of patient identity and location, assessment of suitability for virtual care, documentation of limitations of remote assessment, use of secure communication platforms, and escalation to in-person assessment when clinically indicated.
- The resident communicates clearly and compassionately using verbal, written, and electronic formats, adapting communication to patient health literacy, language, developmental stage, sensory or cognitive needs, and virtual care limitations.
- It includes effective use of electronic health records, digital communication tools, secure messaging systems, and virtual care platforms to ensure information is accessible, up to date, and supports safe handover and interdisciplinary collaboration.
- The resident maintains patient confidentiality, privacy, professionalism, and compliance with legal, ethical, and institutional standards governing documentation, electronic communication, and telemedicine practice.
- The resident ensures effective transitions of care through structured handover, referral communication, discharge planning, and coordination between providers, settings, and healthcare systems.
- This EPA excludes independent medico-legal reporting requiring specialized expertise and administrative or legal documentation outside routine clinical practice scope.

Assessment Plan:

Direct or indirect observation with documentation and case review by supervisor. Assessment may include multisource feedback from patients, family members, nursing staff, consultants, and administrative or virtual-care support staff.

Assessment form collects information on:

- Encounter type: in-person clinic visit; hospital encounter; telephone consultation; video consultation/telemedicine; electronic communication/follow-up; handover or transition of care, other
- Case mix: acute presentation; chronic presentation; preventive care; mental health; palliative care; perioperative care; other (write in)
- Presented to: healthcare team; consultant; patient; family member/caregiver; multidisciplinary team; community provider; other (write in)
- Patient age: pediatric; adolescent; adult; geriatric
- Complexity: straightforward encounter; complex medical condition; psychosocial complexity; language or communication barriers; multiple transitions of care; telemedicine with assessment limitations

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement:

- At least 2 acute presentations
- At least 2 chronic or longitudinal care presentations
- At least 2 telemedicine or virtual care encounters
- At least 2 transitions-of-care or handover scenarios
- Minimum 3 different observers

When is unsupervised practice expected to be achieved: PGY 1

Relevant task components:

ACGME

1. SBP2: Performs safe and effective transitions of care and handoffs across clinical settings
2. SBP3: Uses healthcare systems and communication processes to support continuity, coordination, and efficiency of care
3. PROF1: Performs professional responsibilities in a timely, accurate, and accountable manner
4. ICS1: Organizes and initiates patient-centered communication, clarifies expectations, and confirms understanding
5. ICS2: Communicates effectively with healthcare teams and consultants across settings and transitions
6. ICS3: Accurately and efficiently documents clinical information in written, electronic, and telemedicine records
7. ICS3: Demonstrates organized diagnostic and therapeutic reasoning in clinical documentation
8. ICS3: Uses medical records and digital systems to communicate updated and concise clinical information

9. ICS3: Demonstrates effective communication and professionalism in telemedicine and electronic communication environments
10. MK2: Integrates clinical reasoning, contextual information, and risk assessment into communication and documentation
11. SBP2: Coordinates care and communication between providers, services, and healthcare systems
12. PBLI1: Incorporates feedback to improve clinical communication, documentation quality, and virtual care practices

CanMEDS

1. ME 2.4 Establishes patient-centered management plans and communicates them effectively
2. ME 4.2 Implements care plans with continuity, reassessment, follow-up, and coordination across settings
3. Com 1.3 Respects confidentiality, privacy, autonomy, and professional standards in verbal, written, electronic, and virtual communication
4. Com 1.6 Adapts communication to patient needs, health literacy, language, culture, and telemedicine limitations
5. Com 3.1 Shares information clearly, accurately, compassionately, and in a timely manner while ensuring understanding
6. Com 4.1 Facilitates collaborative discussions regarding care plans and transitions in a respectful and culturally safe manner
7. Com 5.1 Maintains timely, clear, accurate, and appropriate written, electronic, and telemedicine records
8. Col 1.4 Collaborates effectively with healthcare professionals and community providers to support integrated patient-centered care
9. Col 3.1 Determines when transitions of care are required and facilitates safe transfer of care
10. Col 3.2 Communicates responsibilities clearly during handover and care transitions to optimize patient safety
11. L 2.3 Uses healthcare resources and digital systems responsibly to support continuity and accessibility of care
12. P 1.1 Demonstrates professionalism, accountability, integrity, and respect in all communication and documentation practices
13. P 3.1 Adheres to ethical, legal, and institutional standards governing clinical documentation, privacy, and telemedicine practice

Family Medicine

EPA 2: Providing newborn and well-child preventive care

Key Features: This EPA focuses on the ability to provide comprehensive, patient-centered routine care for healthy newborns, infants, children, and adolescents in hospital and community settings.

- It includes immediate newborn assessment and support of transition to extrauterine life, thermoregulation, feeding support, routine prophylaxis, newborn examination, and identification of abnormal findings requiring further evaluation or referral.
- It includes routine newborn follow-up after discharge, including assessment of feeding, hydration, weight, jaundice, elimination, maternal–infant bonding, and parental concerns.
- It includes preventive and developmentally appropriate well-childcare, including age-appropriate history and examination, growth monitoring, developmental surveillance, immunization review or administration, and anticipatory guidance.
- Preventive care includes counselling on nutrition, sleep, injury prevention, dental health, physical activity, healthy lifestyle habits, and psychosocial well-being, adapted to developmental stage and family context.
- The residents should recognize mild deviations in growth or development, common minor concerns, and psychosocial issues, initiate appropriate management, and arrange follow-up or referral when indicated.
- Psychosocial assessment includes evaluation of family dynamics, parental concerns, social determinants of health, and barriers to care, with facilitation of access to community resources where appropriate.
- The resident demonstrates initial neonatal resuscitation skills and recognizes situations requiring escalation or specialist involvement.
- This EPA excludes independent management of critically ill neonates or children, advanced neonatal resuscitation, NICU care, emergency pediatric care, complex chronic pediatric disease, and specialized developmental or behavioral management beyond screening and initial counselling.

Assessment Plan:

Direct or indirect observation with case review and including review of documentation by supervisor.

Assessment form collects information on:

- Setting: hospital L&D; postpartum ward; family medicine clinic; pediatric outpatient clinic; school health clinic; simulation
- Patient age: newborn; infant; toddler; preschool; school-age
- Case mix (select all that apply): routine newborn care; feeding challenges; early discharge follow-up; immunization visits; developmental surveillance; common minor concerns; mild developmental or behavioral concerns; socially vulnerable family; other (write in)

- Complexity: straightforward preventive care; parental anxiety requiring counselling; mild social or familial complexity; early identification of abnormal findings; mild developmental concerns, other

Basis for formal entrustment decisions:

Collect a minimum of 14 observations of achievement:

- At least 2 immediate postpartum newborn assessments
- At least 2 inpatient newborn examinations
- At least 3 outpatient newborn/infant follow-up visits
- At least 4 well-child visits across different age groups
- At least 3 preschool or school age health screenings
- At least 2 cases involving mild developmental, psychosocial, or feeding concerns
- Minimum 3 different supervisors (including pediatrician/neonatologist and family physician)

When is unsupervised practice expected to be achieved: PGY 1

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs physical examination, selects appropriate investigations, and interprets results for diagnosis, prevention, and health promotion
2. ME 2.3 Establishes goals of care collaboratively with patients and families
3. ME 2.4 Develops and implements patient-centered preventive and follow-up care plans
4. ME 2.5 Makes clinical decisions informed by evidence and patient context
5. ME 3.2 Obtains and documents informed consent when appropriate
6. ME 4.1 Works collaboratively with patients, families, and healthcare professionals to provide comprehensive care
7. ME 4.2 Ensures continuity of care, follow-up, and reassessment
8. Com 1.1 Establishes positive therapeutic relationships with patients and families
9. Com 1.4 Listens respectfully to patients and families and addresses concerns
10. Com 3.1 Shares information and explanations that are clear, accurate, and timely
11. Com 5.1 Maintains timely, clear, accurate, and appropriate written or electronic records
12. Col 2.2 Engages others in shared decision-making
13. Col 3.1 Determines when transition or referral is required and facilitates the process
14. HA 1.2 Works with families and support networks to encourage healthy behaviors
15. HA 1.3 Incorporates disease prevention, health promotion, and developmental surveillance into care
16. S 3.5 Integrates evidence into clinical decision-making
17. P 1.1 Demonstrates professionalism, compassion, integrity, and ethical behavior

ACGME

1. PC1: Recognizes deterioration or instability and initiates stabilization and escalation when required
2. PC3: Provides preventive care, immunizations, anticipatory guidance, and counselling

3. PC4: Provides longitudinal preventive follow-up, reassessment, and referral when appropriate
4. PC5: Performs procedures within scope (e.g., initial neonatal resuscitation steps) and recognizes limitations
5. MK2: Applies clinical reasoning and interprets growth, developmental, and screening information
6. ICS1: Communicates effectively with patients and families using developmentally appropriate approaches
7. ICS2: Communicates effectively with healthcare teams and consultants
8. ICS3: Ensures accurate documentation and reliable follow-up of plans and results
9. SBP2: Coordinates care and facilitates access to community and specialty services when needed
10. PROF1: Demonstrates professional, ethical, respectful, and patient-centered care

Family Medicine

EPA 3: Assessing and managing children and adolescents with common acute and chronic conditions

Key Features: This EPA focuses on the ability to provide patient-centered assessment, diagnosis, and management of children presenting in primary care with common acute and chronic conditions.

- This includes focused pediatric history and age-appropriate examination, interpretation of basic vital signs and investigations, identification of red flags, and development of evidence-based management plans.
- Provide safe prescribing, parental education and counselling, monitoring of response to treatment, and appropriate follow-up.
- Recognize when specialist input is required and arrange timely referral and coordination with relevant health professionals.
- Assessment of rare or urgent pediatric conditions can be provided in simulation conditions.
- This excludes management of seriously ill or unstable children, complex chronic conditions requiring subspecialist oversight, and pediatric emergencies beyond mild acute illness.

Assessment Plan:

Direct or indirect observation with chart/case review by supervisor.

Assessment form collects information on:

- Settings: family medicine clinic; pediatric outpatient clinic; urgent care/after-hours clinic; simulation.
- Patient age: infant; toddler; preschool; school-age; adolescent
- Case mix (select all that apply): febrile/viral URTI; acute otitis media/sore throat; gastroenteritis or constipation; wheeze/asthma review or mild exacerbation; eczema/urticaria/allergic rhinitis; suspected UTI; common rash/exanthem; minor MSK injury or limping; headache or recurrent abdominal pain; behavioral/sleep; developmental concerns; chronic condition follow-up; other (write in)
- Complexity: straightforward single-condition visit; multi-condition visit (e.g., asthma + eczema); mild psychosocial complexity; parent(s) with concerns or questions requiring counselling.

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement.

- At least 2 infant visits
- At least 2 toddler/preschool visits
- At least 2 school-age visits
- At least 2 adolescent visits
- Mix of acute and chronic conditions
- Minimum 3 supervising physicians (must include pediatricians and family physicians)

When is unsupervised practice expected to be achieved: PGY 1

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs a physical exam, selects appropriate investigations, and interprets their results for the purpose of diagnosis and management, disease prevention, and health promotion
2. ME 2.4 Establishes a care management plan, finding common ground with the patient in defining problems and priorities, and recognizing the roles of the patient, other healthcare providers and the family physician in each encounter
3. ME 2.6 Manages complex co-existing clinical and contextual issues, both acute and chronic, often in conditions of uncertainty
4. ME 4.2 Implements a patient-centered care plan with continuity to ensure ongoing care, following up investigations, monitoring treatment, and re-evaluating the need for further consultation
5. ME 5.1 Recognizes potential health care delivery risks and patient safety incidents, working proactively to prevent harm, and remediate identified concerns
6. Com 1.6 Adapts communication to the unique needs and preferences of each patient and to their clinical condition and circumstances ensuring that care is inclusive and culturally safe
7. Com 3.1 Shares information and explanations that are clear, accurate, and timely, while checking for patient and family understanding
8. Com 4.1 Facilitates discussions with patients and their families about the plan of care in a way that is respectful, inclusive, non-judgmental, and culturally safe, including using an interpreter or cultural intermediary when needed
9. Com 5.1 Maintains timely, clear, accurate, and appropriate written or electronic records of clinical encounters
10. Col 3.1 Determines when a transition in care is required and facilitates the process
11. Col 3.2 Effectively negotiates and communicates (both verbally and in writing) individual and/or shared responsibilities, through care transition plans, to optimize patient safety
12. L 2.3 Manages health care resources judiciously, including access to referral sources and the ordering of tests and treatments.
13. S 3.2 Identifies, selects, and navigates pre-appraised resources and clinical practice guidelines that are relevant to family practice settings
14. S 3.5 Integrates evidence into decision making in practice
15. P 3.1 Fulfills and adheres to professional and ethical codes, standards of practice, and laws governing practice

ACGME

1. PC4 (Ongoing Care of Patients with Undifferentiated Signs/Symptoms/Health Concerns—clinical reasoning for common presentations, red flags, follow-up and reassessment);
2. MK2 (Critical Thinking and Decision Making—prioritize differential, interpret basic tests/vitals, avoid reasoning errors);

3. PC5 (Procedural Care—when applicable to routine pediatric office procedures and within-scope interventions);
4. ICS1 (Patient- and Family-Centered Communication—counselling, shared decisions, safety-netting with caregivers);
5. ICS2 (Interprofessional and Team Communication—consultation/referral coordination and shared care);
6. ICS3 (Communication within Health Care Systems—timely documentation, test-result follow-up, clear plans);
7. SBP2 (System Navigation for Patient-Centered Care—accessing pediatric/specialist and community resources appropriately);
8. PROF1 (Professional Behavior and Ethical Principles—safe prescribing, confidentiality, accountability and escalation).

Family Medicine

EPA 4: Recognizing and providing initial care of children and adolescents with acute serious conditions

Key Features: This EPA focuses on the ability to assess and stabilize a seriously ill or unstable child, initiate evidence-based emergency interventions, communicate effectively with caregivers and team members, and escalate care appropriately while demonstrating leadership, professionalism, and safe decision-making.

- Provide urgent, patient-centered assessment and initial management of a seriously ill or unstable child in community or hospital acute care settings, including rapid recognition of life-threatening illness or injury, stabilization using an ABC approach, initiation of protocol-based emergency treatment, and timely escalation or transfer.
- This includes focused history and examination with assessment of airway, breathing, circulation, and neurologic status; early identification of conditions such as severe respiratory distress, shock, sepsis, status epilepticus, severe dehydration, or major trauma; initiation of oxygen, fluids, emergency medications, and pain/distress management; ordering and interpreting urgent investigations; and close monitoring of response.
- Communicate clearly with parents and the team, coordinate multidisciplinary care, and provide structured handovers to pediatric emergency service, intensive care, or specialist services.
- The resident participates in emergency drills, including Code Pink, and demonstrates core stabilization and resuscitation skills in simulation-based training, using structured team communication and handover.
- This EPA excludes independent ongoing management in pediatric ICU beyond initial stabilization, surgical management of complex trauma, advanced critical care without appropriate supervision, and long-term management of chronic complex conditions.

Assessment Plan:

Direct or indirect observation with chart review, case-based discussion by supervisor.

Assessment form collects information on:

- Settings: pediatric ED; hospital pediatric ward; community clinic with emergency capacity; other urgent care facility; simulation
- Patient age: infant; toddler; preschool; school-age; adolescent
- Case mix (select all that apply): moderate to severe respiratory distress (asthma/wheeze, bronchiolitis, croup); suspected sepsis or febrile child with red flags; shock or significant dehydration from gastroenteritis; prolonged seizure or status epilepticus; altered level of consciousness; hypo/hyperglycemia; anaphylaxis; significant trauma (e.g., head injury with concerning features or multi-system injury); meningitis signs; severe abdominal pain suggesting surgical abdomen; toxic ingestion; acute exacerbation of chronic conditions; other (write in)
- Complexity (select all that apply): simple stabilization scenario; multi-system acute illness; need for rapid decision-making under uncertainty; coordination with multidisciplinary team; previously healthy child with severe acute presentation; psychosocial or family complexity.

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement.

- At least one case from each age category
- At least 4 different case mix
- At least one rare scenario (e.g., neonatal resuscitation, cardiac arrest) to be assessed in simulation for CPR or NRP
- At least 3 supervising physicians (must include family physician, pediatrician, and emergency physician)

When is unsupervised practice expected to be achieved: PGY 1

Relevant task components:

CanMEDS

1. ME 1.3 Cares for patients through the spectrum of health promotion and disease prevention; diagnosis and treatment, including managing life-threatening illness; acute and chronic disease management; rehabilitation; supportive care;
2. ME 1.5 Recognizes and responds to the complexity, uncertainty, and ambiguity inherent in medical practice
3. ME 2.2 Elicits history, performs a physical exam, selects appropriate investigations, and interprets their results for the purpose of diagnosis and management, disease prevention, and health promotion
4. ME 2.6 Manages complex co-existing clinical and contextual issues, both acute and chronic, often in conditions of uncertainty
5. ME 3.1 Determines the most appropriate procedures or therapies
6. ME 3.3 Prioritizes a procedure or therapy, accounting for safety, clinical urgency, and available resources
7. ME 3.4 Performs a procedure in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances
8. ME 4.2 Implements a patient-centered care plan with continuity to ensure ongoing care, following up investigations, monitoring treatment, and re-evaluating the need for further consultation
9. Com 3.1 Shares information and explanations that are clear, accurate, and timely, while checking for patient and family understanding
10. Com 4.4 Effectively addresses challenging communication issues such as motivating behaviors change, delivering bad news, and addressing disagreements and emotionally charged situations
11. Com 5.1 Maintains timely, clear, accurate, and appropriate written or electronic records of clinical encounters
12. Col 1.4 Respects diversity of roles and perspectives while ensuring integrated patient-centered care
13. Col 1.5 Demonstrates role flexibility; for example, changing from team member to team leader as necessary based on context, team composition, and patient needs
14. Col 2.2 Engages others in shared decision making and finding common ground with team members

15. Col 3.1 Determines when a transition in care is required and facilitates the process
16. Col 3.2 Effectively negotiates and communicates (both verbally and in writing) individual and/or shared responsibilities, through care transition plans, to optimize patient safety
17. S 3.2 Identifies, selects, and navigates pre-appraised resources and clinical practice guidelines that are relevant to family practice settings
18. S 3.5 Integrates evidence into decision making in practice
19. P 1.1 Exhibits appropriate professional behaviors and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality
20. P 1.3 Recognizes and responds to ethical issues encountered in practice

ACGME

1. PC1 (Care of the Acutely Ill Patient—rapid assessment, stabilization, initiate treatment, recognize deterioration and escalate/transfer);
2. MK2 (Critical Thinking and Decision Making—recognize red flags, prioritize life threats, interpret urgent data and avoid reasoning errors);
3. ICS2 (Interprofessional and Team Communication—crisis team communication, coordination, and consultation);
4. ICS3 (Communication within Health Care Systems—structured handover, accurate documentation, and transfer of critical information);
5. ICS1 (Patient- and Family-Centered Communication—clear, compassionate communication with parents/caregivers during emergencies);
6. SBP2 (System Navigation for Patient-Centered Care—activate emergency pathways, coordinate transfer and follow-up across settings);
7. PROF1 (Professional Behavior and Ethical Principles—accountability, informed consent where possible, and acting within competence);
8. PBLI (learning and improvement through drills/simulation and using feedback to improve acute care performance).

Family Medicine

EPA 5: Conducting periodic health examinations and preventive care for adults and older adults

Key Features: This EPA focuses on conducting comprehensive, patient-centered periodic health exams for adults and older adults using a preventive, longitudinal, and holistic approach that integrates medical, functional, psychosocial, and lifestyle factors.

- It includes obtaining a comprehensive medical, family, medication, reproductive, obstetric, gynecological, functional, and social history, with lifestyle and psychosocial risk assessment, age- and sex-appropriate physical examination, and guideline-informed preventive screening and immunization review.
- The resident performs employment-related, pre-employment, and visa medical examinations, including fitness-to-work and fitness-to-travel assessment and completion of the associated certification and documentation.
- The resident performs appropriate examination and counselling for women and men's health needs, including menstrual health, contraception, fertility intentions, sexual health, cervical and breast screening, menopause, pelvic floor symptoms, osteoporosis risk, family abuse, prostate, testicular exam, erectile dysfunction, andropause and other age-appropriate preventive concerns.
- The resident applies evidence-based prevention and screening recommendations while considering multimorbidity, polypharmacy, frailty, functional status, patient preferences, life expectancy, and risk-benefit balance in decision-making.
- It includes assessment of nutrition, physical activity, cognition, mood, falls risk, mobility, hearing, vision, sleep, substance use, sexual health, safety, and social support, adapted to the patient's age and context.
- The resident provides counselling on risk reduction, healthy lifestyle behaviors, disease prevention, maintenance of independence, medication optimization, and quality of life, using shared decision-making to develop individualized health-maintenance plans.
- It includes arranging follow-up, recall systems, referrals, and coordination with allied health professionals and community resources when indicated.
- The residents should recognize abnormal findings, early functional decline, psychosocial vulnerability, and potentially inappropriate medications, and initiate appropriate management or referral.
- This EPA excludes management of acute unstable illness, complex geriatric syndromes requiring specialist care, advanced chronic disease management beyond preventive and longitudinal primary care scope, and hospital-based procedures or surgical interventions.

Assessment Plan:

Direct or indirect observation with review of consultation documentation and/or chart review by supervisor.

Assessment form collects information on:

- Settings: family medicine center; outpatient clinic; occupational health clinic; women health clinics, geriatric clinic; home visit; long-term care facility

- Patient age: 18–39 years; 40–64 years; ≥65 years
- Case mix: preventive health; risk factor modification; stable chronic condition; multimorbidity review; polypharmacy review; frailty screening; falls risk assessment; cognitive or mood screening; osteoporosis prevention; urinary incontinence; sensory decline; social isolation; advance care planning; women health; premarital; other (write in)
- Complexity: straightforward preventive visit; multiple risk factors; multimorbidity with mild complexity; polypharmacy requiring optimization; mild cognitive or functional concerns; counseling regarding behavior change or adherence
- Counselling (select all that apply): nutrition/weight; physical activity; sleep; smoking/vaping cessation; alcohol/substance use; sexual health/STI prevention; contraception/preconception health; genetic, mental health/stress; cardiovascular risk reduction; cancer screening/shared decision-making; vaccination; bone health/fall prevention; occupational/sun safety; domestic violence/safety screening; advance care planning

Basis on formal entrustment decisions:

Collect a minimum of 14 observations of achievement:

- At least 3 young adults (18–39 years)
- At least 3 middle-aged adults (40–64 years)
- At least 3 older adults (≥65 years)
- At least 2 patients with multimorbidity, polypharmacy, or functional concerns
- 2 premarital/women health
- Minimum 3 supervising physicians (including family physicians and general internists/geriatricians)

When is unsupervised practice expected to be achieved: PGY 1

Relevant task components:

CanMEDS

1. ME 1.3 Provides care across the spectrum of health promotion, disease prevention, diagnosis, and chronic disease management
2. ME 2.2 Elicits history, performs physical examination, selects appropriate investigations, and interprets results for diagnosis, prevention, and health promotion
3. ME 2.4 Develops individualized care plans in collaboration with patients and healthcare professionals
4. ME 2.5 Makes clinical decisions informed by evidence, experience, and patient context
5. ME 2.6 Manages complex co-existing clinical and contextual issues, including multimorbidity and frailty
6. ME 4.2 Ensures continuity of care through follow-up, monitoring, reassessment, and referral when needed
7. Com 1.1 Establishes positive therapeutic relationships characterized by trust, respect, and compassion
8. Com 1.3 Respects confidentiality, privacy, and autonomy

9. Com 1.6 Adapts communication to patient needs, preferences, culture, and functional status
10. Com 2.1 Engages patients to understand symptoms, concerns, expectations, and illness impact
11. Com 3.1 Shares information clearly, accurately, and in a timely manner
12. Com 5.1 Maintains timely, accurate, and appropriate documentation
13. Col 1.1 Establishes collaborative relationships with patients and healthcare professionals
14. Col 1.4 Respects diversity of professional roles and perspectives
15. Col 3.1 Facilitates transitions of care and referrals when indicated
16. HA 1.2 Supports patients and families in adopting healthy behaviors
17. HA 1.3 Incorporates disease prevention, health promotion, and surveillance into care
18. HA 2.4 Identifies needs of underserved populations and facilitates access to culturally appropriate care
19. L 2.2 Provides evidence-based and cost-conscious care
20. S 3.5 Integrates evidence into clinical decision-making
21. P 1.1 Demonstrates professionalism, integrity, respect, and ethical behavior

ACGME

1. PC3: Provides preventive care, screening, immunizations, counselling, and shared prevention planning
2. MK2: Applies evidence and guidelines to preventive care and risk-benefit decision-making across adulthood and aging
3. ICS1: Communicates effectively with patients and families regarding prevention, lifestyle, function, and health maintenance
4. ICS3: Ensures accurate documentation, follow-up of investigations, and recall systems
5. SBP2: Coordinates referrals, allied health services, and community supports to optimize patient-centered care
6. PROF1: Demonstrates ethical preventive care, confidentiality, accountability, and professionalism
7. PBL1: Applies best available evidence and updates preventive practices according to outcomes and evolving guidelines

Family Medicine

EPA 6: Assessing and managing patients with new and undifferentiated presentations

Key Features: This EPA applies across a range of clinical settings and patient populations and focuses on the assessment and clinical reasoning required to evaluate and manage patients presenting with new and/or undifferentiated problems.

- This includes obtaining a relevant and patient-centered history and performing an appropriate physical examination adapted to the patient's setting, needs, and circumstances.
- It also includes generating, justifying, and prioritizing a differential diagnosis based on clinical findings and available investigations, integrating biomedical, psychosocial, and preventive aspects of care.
- The residents must synthesize clinical information, identify the most likely and most serious conditions, recognize red flags requiring urgent action, and initiate appropriate management.
- The residents must demonstrate sound clinical reasoning, avoid common diagnostic errors, and adapt communication and clinical approach to patient age, developmental stage, culture, health literacy, and decision-making capacity.

Assessment Plan:

Direct or indirect observation with review of consultation documentation and/or case review by supervisor.

Assessment form collects information on:

- Specialty: family medicine; emergency medicine; internal medicine; pediatrics; psychiatry; Ob/Gyn; cardiology; general surgery; ophthalmology; ENT; dermatology; urology; other (write in)
- Case mix: chest pain; shortness of breath; abdominal pain; headache; fever in child; depression; anxiety; abnormal uterine bleeding; pelvic pain; musculoskeletal complaints; falls or delirium; hematuria; polyuria; skin lesion; vertigo or dizziness; blurred or abnormal vision; other [write in])
- Setting: primary care clinic; ambulatory care; inpatient; outpatient clinic; home care; ER; simulation
- Patient age: pediatric; adult; geriatric

Basis on formal entrustment decisions:

Collect a minimum of 20 observations of achievement:

- At least 4 acute presentations
- At least 5 chronic/ongoing presentations
- At least 8 different clinical presentations (case mix)
- At least 5 different observers
- At least 2 cases from following specialties: gynecology, cardiology, ophthalmology, ENT, urology, dermatology, MSK, internal medicine.

When is unsupervised practice expected to be achieved: PGY 2

Relevant task components:

ACGME

1. MK 2.1: Incorporates key elements of a patient story into an accurate depiction of their presentation
2. MK 2.2: Develops an analytic, prioritized differential diagnosis for common presentations
3. MK 2.3: Synthesizes complex diagnostic information accurately to reach high probability diagnoses
4. MK 2.4: Continuously re-appraises clinical reasoning to minimize diagnostic errors
5. PC 1.1: Generates differential diagnosis for acute presentations
6. PC 1.2: Prioritizes the differential diagnosis for acute presentations
7. PC 1.3: Recognizes urgent and emergent situations and initiates appropriate action
8. PC 4.1: Develops a differential diagnosis for undifferentiated illness
9. PC 4.2: Selects cost-effective diagnostic testing that will influence management
10. PC 2.2: Identifies variability in presentation and progression of chronic conditions
11. PC 2.3: Considers the impact of comorbidities on disease progression
12. ICS 1.1: Uses respectful language and nonverbal behavior to establish rapport
13. ICS 1.2: Establishes therapeutic relationships using active listening and clear communication
14. ICS 1.2: Identifies and adapts to barriers to communication (e.g., cultural, literacy, disability)
15. ICS 3.1: Accurately and timely records information in the patient record
16. ICS 3.2: Demonstrates organized diagnostic and therapeutic reasoning through documentation
17. P 1.2: Demonstrates professional behavior in routine clinical situations

CanMEDS

1. ME 2.1 Identifies priorities for assessment and management based on urgency, context, and patient perspective
2. ME 2.2 Elicits history, performs physical exam, selects and interprets investigations for diagnosis, management, and prevention
3. ME 2.5 Makes clinical decisions informed by evidence, experience, and patient values
4. ME 2.6 Manages undifferentiated and complex presentations under conditions of uncertainty
5. ME 7.2 Demonstrates clinical courage and comfort with uncertainty
6. Com 1.1 Establishes therapeutic relationships based on trust, respect, and compassion
7. Com 1.3 Respects patient confidentiality, privacy, and autonomy
8. Com 1.6 Adapts communication to patient needs and context
9. Com 2.1 Engages patients to explore symptoms, concerns, expectations, and illness impact
10. Com 5.1 Maintains clear, accurate, and timely documentation
11. L 2.3 Uses healthcare resources judiciously, including investigations and referrals
12. S 3.1 Recognizes knowledge gaps and uncertainty
13. S 3.2 Identifies and uses appropriate clinical resources and guidelines

- 14. S 3.5 Integrates evidence into clinical decision-making
- 15. P 1.1 Demonstrates professionalism, integrity, respect, and confidentiality
- 16. P 1.3 Recognizes and responds to ethical issues in practice

Family Medicine

EPA 7: Formulating and communicating management plans for patients and/or families

Key Features: This EPA focuses on the ability to formulate, communicate, and implement safe, patient-centered, and evidence-informed management plans, with emphasis on effectively communicating assessment findings and care plans to patients and/or families.

- The resident should be able to synthesize assessment findings and propose appropriate management for common presentations, including orders, prescriptions, and referrals, integrating pharmacologic, non-pharmacologic, and system-based components.
- This includes clearly explaining diagnoses, uncertainties, and management options in a way that is understandable, culturally appropriate, and responsive to patient needs, values, and preferences.
- The resident must prioritize management components, integrate input from other healthcare professionals, and engage in shared decision-making with patients, families, caregivers, and team members.
- The resident is expected to apply patient safety and quality principles, including appropriate indications, contraindications, recognition of adverse effects and drug interactions, and error prevention strategies.
- This includes clear documentation and communication of management plans through written or electronic orders, prescriptions, consultations, and referrals, ensuring that plans are accurate, updated, and accessible to the healthcare team.

Assessment Plan:

Direct or indirect observation, with or without case discussions and chart review by supervisor.

Assessment form collects information on:

- Specialty: family practice, emergency medicine; internal medicine; pediatrics; psychiatry; surgery; Ob/Gyn; other (write in)
- Clinical presentation: acute; chronic/longitudinal; other (write in)
- Setting: primary care clinic; ambulatory care; inpatient; ER
- Management (select all that apply): non-pharmacological/motivational counselling; pharmacological, surgical procedure; nonsurgical procedure; referral; written/electronic orders; prescriptions; follow-up; other (write in)
- Patient age: pediatric; adult; geriatric

Basis on formal entrustment decisions:

Collect a minimum of 10 observations of achievement:

- At least 5 different clinical disciplines
- At least 2 motivational counselling
- At least 3 acute presentations

- At least 3 chronic/longitudinal care presentations
- At least 5 different observers

When unsupervised practice is expected to be achieved: PGY 2

Relevant task components:

ACGME

1. PC 1.2: Develops management plans for patients with common acute conditions
2. PC 1.3: Implements management plans, including stabilization of acutely ill patients
3. PC 2.2: Uses clinical guidelines to develop and implement management plans for chronic conditions
4. PC 2.3: Synthesizes patient-centered management plans considering comorbidities
5. PC 4.4: Coordinates collaborative treatment plans for undifferentiated illness
6. PC 5.3: Performs risk and appropriateness assessment for procedures and referrals
7. MK 1.2: Applies knowledge of pathophysiology and treatment of common conditions
8. MK 1.3: Demonstrates knowledge of comprehensive management across the lifespan
9. SBP 2.1: Recognizes common patient safety events
10. SBP 2.2: Identifies system factors contributing to patient safety events
11. SBP 2.3: Participates in analysis of safety events
12. SBP 3.4: Manages components of healthcare systems to ensure effective care and transitions
13. PBLI 1.3: Applies best available evidence integrated with patient preferences
14. P 2.3: Implements strategies to meet patient and system needs
15. ICS 1.2: Organizes communication, sets agenda, clarifies expectations, and verifies understanding
16. ICS 1.3: Establishes therapeutic relationships in more complex encounters
17. ICS 1.4: Uses shared decision-making to align patient/family values with care plans
18. ICS 3.2: Demonstrates organized clinical reasoning in documentation

CanMEDS

1. ME 4.1 Works collaboratively with patients, families, and healthcare professionals to provide comprehensive care
2. ME 4.2 Implements patient-centered care plans with continuity and follow-up
3. ME 5.1 Identifies and mitigates patient safety risks
4. Com 3.1 Communicates information clearly, accurately, and in a timely manner, ensuring understanding
5. Com 4.1 Facilitates respectful, inclusive, and culturally safe discussions with patients and families
6. Com 5.1 Maintains clear, accurate, and timely documentation
7. Com 5.3 Uses electronic health records to support communication and shared decision-making
8. Col 1.4 Respects diversity of roles and perspectives in care delivery

- 9. Col 2.2 Engages others in shared decision-making
- 10. Col 3.1 Facilitates transitions of care when needed
- 11. Col 3.2 Communicates responsibilities clearly to ensure safe transitions
- 12. L 1.2 Promotes a culture of patient safety
- 13. L 2.2 Provides cost-conscious care aligned with patient needs
- 14. L 2.3 Uses healthcare resources judiciously

Family Medicine

EPA 8: Providing antenatal and postpartum care

Key Features: This EPA focuses on comprehensive, patient-centered care across the continuum of pregnancy and the postpartum period, from confirmation of pregnancy through six weeks after delivery.

- It includes longitudinal antenatal care and postpartum follow-up, encompassing assessment, monitoring, counselling, preventive care, identification of risk factors, and appropriate referral.
- The resident demonstrates comprehensive care by confirming pregnancy and gestational age; conducting focused history and examination; initiating and interpreting appropriate investigations; monitoring maternal (and fetal, where applicable) well-being; and providing patient-centered counselling and shared decision-making throughout the perinatal period.
- It includes postpartum care following vaginal or cesarean delivery, including assessment of physical recovery, mental health screening, breastfeeding support, contraception counselling, and identification and initial management of common postpartum complications.
- The resident should recognize and initiate management of common complications across the perinatal period, including hypertensive disorders, gestational diabetes, postpartum hemorrhage (initial stabilization), endometritis, mastitis, wound complications, venous thromboembolism, and mood disorders, with appropriate escalation or referral.
- Psychosocial and safety assessment is required throughout, including screening for intimate partner violence, substance use, and social isolation, and addressing cultural and social determinants of health with appropriate linkage to community resources.
- This EPA excludes independent management of high-risk obstetric emergencies, operative deliveries, advanced maternal-fetal medicine care, complex psychiatric management beyond scope, and neonatal care beyond the maternal-infant dyad context. Consultation is required for complex or unstable patients.

Assessment Plan:

Direct or indirect observation with chart/case review and/or review of consultation documentation by supervisor (family medicine or obstetrician).

Assessment form collects information on:

- Setting: family medicine clinic; outpatient clinic; OB ward; L&D; urgent care; simulation.
- Case mix (select all that apply): primigravida; multigravida; trimester 1; trimester 2; trimester 3; vaginal delivery; cesarean delivery; uncomplicated postpartum recovery; breastfeeding difficulties; postpartum mood concerns; mild medical complexity; other (write in)
- Complexity: low-risk pregnancy; mildly complex pregnancy; psychosocial complexity; co-management required

Basis on formal entrustment decisions:

Collect a minimum of 12 observations of achievement:

- At least 2 antenatal booking visits
- At least 4 routine antenatal follow-up visits
- At least 3 postpartum encounters (including at least 1 inpatient and 2 outpatient)
- At least 2 cases involving mild complexity or complications
- At least 2 visits in different trimesters
- At least 3 different observers (including at least 1 obstetrician)

When is unsupervised practice expected to be achieved: PGY 2

Relevant task components:

CanMEDS

1. ME 2.1 Identifies priorities for assessment and management based on patient context and medical urgency
2. ME 2.2 Elicits history, performs physical examination, selects and interprets investigations for diagnosis, management, prevention, and health promotion
3. ME 2.3 Establishes goals of care collaboratively with patients and families
4. ME 2.4 Develops and implements patient-centered care plans across the perinatal period
5. ME 2.6 Manages co-existing clinical and contextual issues under conditions of uncertainty
6. ME 4.1 Works collaboratively with patients, families, and healthcare professionals to provide comprehensive care
7. ME 4.2 Ensures continuity of care through follow-up, monitoring, and reassessment
8. Com 1.4 Listens to patients and addresses concerns
9. Com 2.1 Engages patients to understand symptoms, concerns, and illness impact
10. Com 3.1 Communicates clearly, accurately, and in a timely manner
11. Com 5.1 Maintains clear, accurate, and timely documentation
12. Col 1.4 Respects roles and perspectives in team-based care
13. Col 2.2 Engages others in shared decision-making
14. Col 3.1 Facilitates transitions of care
15. L 2.2 Provides cost-conscious, evidence-based care
16. HA 1.3 Integrates prevention, health promotion, and surveillance
17. P 1.5 Maintains professionalism and confidentiality in all interactions

ACGME

1. PC1: Recognizes and initiates management of acute perinatal complications and escalates appropriately
2. PC3: Provides health promotion, preventive care, counselling, and contraception planning
3. PC4: Provides longitudinal care, reassessment, and management of evolving concerns

4. ICS1: Communicates effectively with patients and families, including sensitive discussions
5. ICS3: Ensures timely documentation and communication of care plans and follow-up
6. SBP2: Coordinates care and navigates healthcare systems, including referrals and community supports
7. PROF1: Demonstrates professional behavior, confidentiality, and ethical practice
8. PBLI1: Applies evidence-based practice and adapts care based on guidelines and new information

Family Medicine

EPA 9: Providing intrapartum care

Key Features: This EPA focuses on the provision of safe, patient-centered care to individuals with low- to moderate-risk pregnancies during spontaneous labor and vaginal delivery. This EPA includes the assessment and management of maternal and fetal well-being in a singleton cephalic term delivery.

- This EPA includes assessing progress in labor.
- The EPA includes managing spontaneous vaginal birth of a singleton gestation (including episiotomy, delivery of infant, management of perineum, management of 3rd stage) under direct/indirect supervision, recognizing and initiating management of common intrapartum complications, with appropriate escalation of care while demonstrating effective communication, collaboration, and professional judgment.
- The EPA includes recognition, initial management, and timely escalation of obstetric emergencies (shoulder dystocia, postpartum hemorrhage, and cord prolapse) through simulation.
- This EPA excludes independent operative vaginal delivery (forceps or vacuum), cesarean section, and management of high-risk or complex obstetric emergencies without specialist consultation. Such cases may be encountered but require involvement of appropriate specialists.

Assessment Plan:

Direct observation of labor and delivery management, chart/case review, CTG interpretation review by supervisor.

Assessment form collects information on:

- Settings: hospital L&D unit; simulation
- Case mix (select all that apply): nullipara; multipara; epidural present; spontaneous labor; induced labor; augmented labor; prolonged labor; mild intrapartum complication; normal vaginal delivery; labor/delivery complication requiring escalation of care; other (write in).
- Management (select all that apply): CTG interpretation; labor stage assessment; assist uncomplicated vaginal delivery of the baby; assist placenta delivery; recognizing a labor/delivery complication with proper escalation; participating/leading an Ob emergency drill; other (write in)

Basis on formal entrustment decisions:

Collect a minimum of 10 observations of achievement.

- At least 10 patients in labor
- At least 5 CTG interpretations
- At least 5 spontaneous vaginal deliveries assisted under direct/indirect observation
- At least 3 different observers

- At least one observation of achievement during a multidisciplinary obstetrical emergency drill (team-based assessment)
- At least one observation of achievement during a simulation-based assessment of an obstetrical emergency (individual clinical management assessment)

When is unsupervised practice expected to be achieved: PGY 2

Relevant task components:

CanMEDS

1. ME 1.3 Cares for patients through the spectrum of health promotion and disease prevention; diagnosis and treatment, including managing life-threatening illness; acute and chronic disease management; rehabilitation; supportive care; intra-partum care; palliation; and end-of-life care
2. ME 2.2 Elicits history, performs a physical exam, selects appropriate investigations, and interprets their results for the purpose of diagnosis and management, disease prevention, and health promotion
3. ME 2.6 Manages complex co-existing clinical and contextual issues, both acute and chronic, often in conditions of uncertainty
4. ME 3.1 Determines the most appropriate procedures or therapies
5. ME 3.2 Obtains and documents informed consent, explaining the risks and benefits of, and the rationale for, a proposed procedure or therapy
6. ME 3.3 Prioritizes a procedure or therapy, accounting for safety, clinical urgency, and available resources
7. ME 3.4 Performs a procedure in a skillful and safe manner, adapting to unanticipated findings or changing clinical circumstances
8. ME 4.1 Works collaboratively with patients, their families, other health care colleagues, and key stakeholders to provide comprehensive care to individual patients, patient populations, and communities
9. Col 1.1 Works effectively with physicians and other colleagues in the health care professions
10. Col 2.2 Communicates effectively with other health care colleagues
11. Col 2.3 Works with other health care colleagues to provide effective, patient-centered care
12. Col 3.1 Determines when a transition in care is required and facilitates the process
13. HA 1.1 Works with patients to address determinants of health that affect them and their access to needed health services
14. S 3.1 Recognizes practice uncertainty and knowledge gaps in clinical and other professional encounters, and generates focused questions that have the potential to bridge the gaps
15. S 3.2 Identifies, selects, and navigates pre-appraised resources and clinical practice guidelines that are relevant to family practice settings

16. S 3.5 Integrates evidence into decision making in practice

ACGME

1. PC 1 (Care of the Acutely Ill Patient—recognize deterioration, initiate stabilization, mobilize resources/escalate).
2. PC 5 (Management of Procedural Care—perform/coordinate indicated procedures within scope; recognize limits and refer appropriately).
3. MK 2 (Critical Thinking and Decision Making—prioritized differential, interpretation of diagnostic information, avoid reasoning errors).
4. ICS 2–3 (team-based communication/handovers; accurate, timely documentation to support continuity and safety).
5. SBP (system navigation/coordination for escalation to obstetrics/anesthesia/OR/transfer pathways when required).
6. P (ethical, respectful care; informed consent; confidentiality; accountability in urgent situations).

Family Medicine

EPA 10: Providing preventive, developmental, and psychosocial care for adolescent patients

Key Features: This EPA focusses on providing comprehensive, patient-centered adolescent care (ages 12–18) across preventive, developmental, psychosocial, ~~and common acute and chronic~~ presentations.

- It includes adolescent-focused history and examination with assessment of growth and pubertal development, mental health, sexual and reproductive health, substance use, and social context; delivery of anticipatory guidance; screening for depression, anxiety, eating disorders, and risk behaviors; immunization review; and management of common acute issues and ongoing monitoring of chronic conditions with appropriate coordination of care.
- It requires building a confidential, respectful therapeutic relationship, engaging family appropriately, addressing sensitive topics, and using simulation to develop skills for challenging conversations such as disclosure and substance-use counselling.
- The residents recognize red flags and arrange timely referrals to other specialists, mental health, or community services when needed.
- This EPA excludes independent management of life-threatening conditions, complex psychiatric care beyond initial assessment and stabilization, and surgical or subspecialist interventions beyond primary care scope.

Assessment Plan:

Direct or indirect observation with chart/case review by supervisor.

Assessment form collects information on:

- Settings: family medicine clinic; school health clinic; outpatient adolescent clinic; pediatric clinic, psychiatry clinic, simulation.
- Case mix (select all that apply): routine adolescent wellness visit with immunization review; puberty/growth concern; acne and other common skin issue; menstrual problem and contraception counselling; STI risk assessment/testing and sexual health counselling; anxiety/depression screening and initial management; eating and body-image concern; substance use screening and brief intervention; sleep problems and fatigue; sports participation exam/minor sports injury; asthma follow-up; ADHD follow-up; diabetes follow-up with shared-care coordination; school difficulties and psychosocial stressors; safeguarding concerns and referral; other (write in).
- Complexity: straightforward preventive visit; mild psychosocial or behavioral concern; confidential discussion with sensitive topics; multi-issue visit requiring prioritization and counselling

Basis on formal entrustment decisions:

Collect a minimum of 6 observations of achievement.

- At least 2 preventive visits

- At least 2 visits addressing psychosocial/mental health concerns
- At least 1 visit addressing sexual/reproductive health
- Minimum 3 supervising physicians (must include family physicians and pediatric/adolescent specialist)

When is unsupervised practice expected to be achieved: PGY 2

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs a physical exam, selects appropriate investigations, and interprets their results for the purpose of diagnosis and management, disease prevention, and health promotion
2. ME 2.4 Establishes a care management plan, finding common ground with the patient in defining problems and priorities, and recognizing the roles of the patient, other healthcare providers and the family physician in each encounter
3. ME 2.6 Manages complex co-existing clinical and contextual issues, both acute and chronic, often in conditions of uncertainty
4. ME 4.2 Implements a patient-centered care plan with continuity to ensure ongoing care, following up investigations, monitoring treatment, and re-evaluating the need for further consultation
5. ME 6.2 Seeks to understand and respect culturally based health beliefs
6. Com 1.1 Establishes positive therapeutic relationships with patients and their families that are characterized by understanding, trust, respect, honesty, and compassion
7. Com 1.3 Respects patient confidentiality, privacy, and autonomy
8. Com 1.6 Adapts communication to the unique needs and preferences of each patient and to their clinical condition and circumstances ensuring that care is inclusive and culturally safe
9. Com 2.1 Engages patients to gather information about their symptoms, ideas, concerns, expectations of health care, and the full impact of their illness experience on their lives
10. Com 2.3 Engages with families during important life events to improve understanding of the patient/family experience and/or to mobilize support
11. Com 3.1 Shares information and explanations that are clear, accurate, and timely, while checking for patient and family understanding
12. Com 4.1 Facilitates discussions with patients and their families about the plan of care in a way that is respectful, inclusive, non-judgmental, and culturally safe, including using an interpreter or cultural intermediary when needed
13. Com 4.4 Effectively addresses challenging communication issues such as motivating behavior change, delivering bad news, and addressing disagreements and emotionally charged situations

14. Com 5.1 Maintains timely, clear, accurate, and appropriate written or electronic records of clinical encounters
15. Col 3.1 Determines when a transition in care is required and facilitates the process
16. HA 1.1 Works with patients to address determinants of health that affect them and their access to needed health services or resources
17. HA 1.2 Works with patients and their families and social or cultural support networks to increase opportunities to adopt healthy behaviors
18. S 3.5 Integrates evidence into decision making in practice
19. P 1.1 Exhibits appropriate professional behaviors and relationships in all aspects of practice, demonstrating honesty, integrity, humility, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality
20. P 1.6 Maintains appropriate professional boundaries

ACGME

1. PC3 (Health Promotion and Wellness—screening, prevention, immunizations, anticipatory guidance);
2. PC4 (Ongoing Care of Patients with Undifferentiated Signs/Symptoms/Health Concerns—manage common presentations over time, reassess, recognize red flags and refer);
3. MK2 (Critical Thinking and Decision Making—integrate biopsychosocial context and screening data to guide plans);
4. ICS1 (Patient- and Family-Centered Communication—confidential, developmentally appropriate counselling, shared decisions, sensitive discussions);
5. ICS2 (Interprofessional and Team Communication—coordinate with mental health and community/school supports);
6. ICS3 (Communication within Health Care Systems—documentation, follow-up of screening/results/referrals, information sharing with appropriate confidentiality);
7. SBP2 (System Navigation for Patient-Centered Care—access community and specialty services, coordinate referrals);
8. PROF1 (Professional Behavior and Ethical Principles—confidentiality, consent/capacity, boundaries, and safe escalation);
9. PBLI (learning and improvement through simulation/feedback for high-stakes adolescent communication scenarios).

Family Medicine

EPA 11: Assessing and managing patients with mental health and substance use conditions

Key Features: This EPA focuses on assessing, diagnosing, communicating with, and managing patients with common mental health and substance use conditions in primary care, using patient-centered, evidence-informed, and culturally safe approaches.

- It includes focused psychiatric and psychosocial history-taking, assessment of symptom severity and functional impact, evaluation of substance use, identification of medical or medication contributors, and appropriate use of validated screening tools.
- The resident conducts structured risk assessments for self-harm, harm to others, safeguarding concerns, acute deterioration, and crisis situations, and develops safety plans or escalation pathways when indicated.
- The resident identifies and provides initial management for common conditions such as depression, anxiety, adjustment disorder, insomnia, grief reactions, somatic symptom presentations, substance use problems, and mild eating or obsessive-compulsive symptoms requiring referral when appropriate.
- It includes patient-centered lifestyle counselling and behavioral modification support using evidence-based strategies such as motivational interviewing, readiness-to-change assessment, individualized goal setting, relapse prevention, and referral to allied health or community supports.
- The resident communicates difficult, unexpected, or emotionally charged information sensitively when relevant to mental health, substance use, diagnosis, prognosis, functional impact, safety risk, or need for referral.
- The resident provides clear education, shared decision-making, brief psychosocial interventions within scope, safe prescribing when appropriate, monitoring of treatment response and adverse effects, and follow-up planning.
- It requires respectful engagement with patients, families, caregivers, and the healthcare team while maintaining confidentiality, autonomy, professional boundaries, and culturally safe care.
- Competence in complex, high-risk, or emotionally challenging scenarios may be demonstrated through direct observation or simulation when case exposure is limited.
- This EPA excludes management of complex psychiatric disorders requiring specialized care, advanced psychotherapy beyond primary care scope, crisis management requiring emergency psychiatric intervention, and highly specialized addiction treatment beyond the resident's scope.

Assessment Plan:

Direct or indirect observation with review of consultation documentation by supervisor. Multisource feedback from patients, families, allied health professionals, mental health professionals, or team members may be collated in the supervisor's report. Simulation may be used for high-risk or complex communication scenarios.

Assessment form collects information on:

- Settings: family medicine clinic; inpatient; outpatient clinic; home visit; long-term care facility; hospice or palliative care setting; simulation
- Patient age: child; adolescent; adult; older adult
- Presentation: initial visit; follow-up
- Case mix (select all that apply): depression; generalized anxiety or panic symptoms; adjustment disorder or grief reaction; insomnia; somatic symptom presentations; substance use problems; alcohol reduction; cannabis/stimulant use risk reduction; smoking/vaping cessation; PTSD symptoms screening and initial management; perinatal/postpartum depression or anxiety; adolescent mood or anxiety concerns; older adult depression with cognitive overlap; medication- or medical illness-related mood symptoms; self-harm ideation risk assessment and safety planning; mild OCD symptoms; eating or body-image concerns requiring referral; behavioral change counselling; emotionally difficult diagnosis or disclosure; personality disorder; psychotic disorder; other (write in)
- Complexity: straightforward mild condition; coexisting medical conditions; ambivalence about treatment; substance use complexity; psychosocial complexity; safety risk requiring escalation; emotionally charged encounter; cultural or language barrier; family or caregiver involvement

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement:

- At least 4 different mental health conditions
- At least 1 case involving substance use or behavioral risk reduction
- At least 2 observations involving follow-up, monitoring of treatment response, or medication adjustment.
- At least 2 cases involving risk assessment, safety planning, or escalation
- At least 1 emotionally challenging communication encounter or simulation
- Minimum 3 supervising physicians or assessors (including family medicine and mental health/psychiatry supervisors where feasible)

When is unsupervised practice expected to be achieved: PGY 2

Relevant task components:

CanMEDS

1. ME 1.3 Provides care across the spectrum of health promotion, prevention, diagnosis, treatment, supportive care, and rehabilitation
2. ME 2.2 Elicits history, performs relevant examination, selects and interprets investigations or screening tools for diagnosis and management
3. ME 2.4 Develops patient-centered management plans in collaboration with patients, families, and healthcare professionals

4. ME 2.5 Makes clinical decisions informed by evidence, experience, and patient preferences
5. ME 2.6 Manages co-existing clinical and contextual issues, including uncertainty, psychosocial complexity, and substance use
6. ME 4.1 Works collaboratively with patients, families, healthcare professionals, and community supports to provide comprehensive care
7. ME 4.2 Ensures continuity through monitoring, follow-up, reassessment, and referral when needed
8. ME 5.1 Recognizes patient safety risks, including self-harm, harm to others, safeguarding concerns, and medication-related risks
9. Com 1.1 Establishes therapeutic relationships characterized by trust, respect, honesty, and compassion
10. Com 1.3 Respects confidentiality, privacy, and autonomy
11. Com 1.6 Adapts communication to patient needs, culture, health literacy, language, and clinical condition
12. Com 4.1 Facilitates respectful, inclusive, non-judgmental, and culturally safe discussions
13. Com 4.4 Addresses challenging communication issues including motivation for behavior change, bad news, disagreement, emotion, stigma, and safety concerns
14. Com 5.1 Maintains timely, clear, accurate, and appropriate documentation of assessment, risk, management, and follow-up
15. Col 2.2 Engages others in shared decision-making and finding common ground
16. Col 3.1 Determines when transition, referral, or escalation of care is required and facilitates the process
17. HA 1.2 Supports patients, families, and social networks to adopt healthier behaviors
18. HA 1.3 Incorporates disease prevention, health promotion, and harm reduction into patient care
19. L 2.3 Uses healthcare resources judiciously, including referral sources, community services, and investigations
20. S 3.5 Integrates evidence into clinical decision-making
21. P 1.1 Demonstrates professionalism, compassion, respect, accountability, and integrity
22. P 1.3 Recognizes and responds to ethical issues encountered in mental health and substance use care

ACGME

1. PC3: Provides health promotion, prevention, risk reduction, and behavioral counselling to support mental health and substance use care
2. PC4: Assesses and manages common behavioral, mental health, and substance use presentations over time, including reassessment and escalation when needed
3. MK2: Applies diagnostic reasoning, validated screening tools, evidence-based treatment, and safe prescribing while considering medical or medication contributors

4. ICS1: Communicates sensitively, uses motivational interviewing and shared decision-making, delivers difficult information, and supports safety planning conversations
5. ICS2: Coordinates with mental health professionals, allied health providers, community supports, and crisis services
6. ICS3: Documents risk assessment, safety plans, management decisions, referrals, and follow-up clearly and reliably
7. SBP2: Connects patients to mental health, addiction, allied health, and community resources and coordinates referrals appropriately
8. PROF1: Demonstrates confidentiality, boundaries, ethical risk management, accountability, and respectful nonjudgmental care
9. PBLI1: Applies evidence-based screening and treatment approaches and improves through feedback, reflection, and simulation for high-risk scenarios

Family Medicine

EPA 12: Assessing, optimizing, and managing patients with common surgical conditions across the perioperative continuum

Key Features: This EPA focuses on assessing, stabilizing, optimizing, and managing patients with common surgical conditions across the perioperative continuum, including initial presentation, preoperative assessment, postoperative follow-up, and coordination of surgical care within the scope of family medicine.

- It includes patients of all ages presenting with common surgical conditions requiring outpatient management, urgent surgical assessment, perioperative optimization, or postoperative follow-up.
- It includes focused assessment of surgical presentations through history, physical examination, medication review, functional assessment, and identification of red flags or urgent surgical conditions requiring escalation or referral.
- The resident recognizes and initiates management for common surgical conditions such as abdominal pain, soft tissue infections, abscesses, hernias, gallbladder disease, anorectal conditions, minor trauma, wound complications, fractures requiring referral, postoperative complications, and acute musculoskeletal injuries within family medicine scope.
- It includes preoperative evaluation and optimization of comorbidities, medications, allergies, anticoagulation, frailty, nutritional status, smoking, diabetes, anemia, cardiopulmonary risk, and functional capacity, with ordering and interpretation of appropriate investigations.
- The resident provides evidence-based perioperative counselling regarding procedural expectations, medication adjustments, postoperative recovery, wound care, pain management, mobilization, and warning signs which require reassessment.
- It includes coordination of care with surgical, anesthesia, emergency, rehabilitation, home care, and allied health teams to ensure safe transitions, medication reconciliation, and continuity of care before and after surgery.
- The resident monitors postoperative recovery, assesses wound healing, pain control, infection risk, thromboembolic risk, bowel/bladder function, delirium risk in older adults, and chronic disease management adjustments during recovery.
- It requires timely recognition of complications or deterioration requiring escalation to surgical or emergency services, including sepsis, bowel obstruction, acute abdomen, uncontrolled pain, wound dehiscence/infection, postoperative bleeding, venous thromboembolism, or delirium.
- Competence in uncommon or high-risk perioperative or urgent surgical scenarios may be demonstrated through direct clinical observation or simulation when clinical exposure is limited.

- This EPA excludes performing major surgical procedures, providing anesthesia, independent operative management, ICU-level postoperative care, and management of highly specialized surgical complications beyond family medicine scope.

Assessment Plan:

Direct or indirect observation with review of consultation documentation by supervisor. Chart review may be used to assess perioperative planning, postoperative follow-up, medication reconciliation, and continuity of care documentation.

Assessment form collects information on:

- Settings: family medicine clinic; outpatient clinic; urgent care clinic; ED; inpatient ward; preoperative clinic; postoperative follow-up clinic; home visit; simulation
- Patient age: pediatric; adult; geriatric
- Case mix (select all that apply): abdominal pain requiring surgical assessment; soft tissue infection or abscess; cellulitis; hernia assessment; gallbladder disease; anorectal conditions (hemorrhoids, fissure, perianal abscess); minor trauma or laceration; acute musculoskeletal injury; fracture; postoperative wound review; suture or staple removal; perioperative anticoagulation management; diabetes/hypertension optimization before surgery; frailty or functional assessment before surgery; postoperative pain management; postoperative fever or suspected infection; postoperative delirium screening; venous thromboembolism risk assessment; medication reconciliation before or after surgery; bowel obstruction concern; acute surgical abdomen requiring escalation; other (write in)
- Complexity (select all that apply): straightforward outpatient surgical condition; urgent surgical referral required; elective perioperative care; medically complex patient; multimorbidity; polypharmacy; frailty; postoperative complication requiring reassessment or escalation

Basis on formal entrustment decisions:

Collect a minimum of 6 observations of achievement:

- At least 2 cases involving assessment of acute surgical presentations
- At least 2 perioperative/preoperative optimization cases
- At least 2 postoperative follow-up or complication assessments
- At least 2 cases involving medically complex, frail, or elderly patients
- At least 4 different case types
- Minimum 2 different supervising physicians (family physician, surgeon, EM)

When is unsupervised practice expected to be achieved: PGY 2

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs physical examination, selects investigations, and interprets findings for diagnosis, management, prevention, and perioperative care

2. ME 2.4 Establishes patient-centered management plans recognizing patient priorities and the roles of healthcare providers across surgical care transitions
3. ME 2.6 Manages complex co-existing clinical and contextual issues in acute and perioperative settings
4. ME 3.1 Determines the most appropriate procedures, therapies, or referrals
5. ME 4.1 Works collaboratively with patients, families, surgeons, anesthesiologists, emergency teams, and allied health professionals
6. ME 4.2 Implements care plans ensuring continuity, follow-up, monitoring, and reassessment
7. ME 5.1 Recognizes healthcare delivery risks and patient safety concerns and acts to prevent harm
8. Com 1.1 Establishes therapeutic relationships characterized by trust, honesty, compassion, and respect
9. Com 1.6 Adapts communication to patient needs, literacy, and perioperative context
10. Com 3.1 Shares information clearly and accurately while checking patient and caregiver understanding
11. Com 4.1 Facilitates respectful and culturally safe discussions about surgery, risks, recovery, and escalation
12. Col 1.4 Respects diversity of roles and perspectives while ensuring integrated perioperative care
13. Col 2.2 Engages others in shared decision-making and collaborative care planning
14. Col 3.1 Facilitates transitions and continuity of care across perioperative settings
15. L 2.3 Uses healthcare resources judiciously, including referrals and investigations
16. S 3.5 Integrates evidence into perioperative and surgical decision-making
17. P 1.1 Demonstrates professionalism, integrity, compassion, accountability, and respect for diversity
18. P 1.3 Recognizes and responds appropriately to ethical issues in surgical and perioperative care
19. P 3.1 Adheres to professional and ethical standards governing patient safety and perioperative practice

ACGME

1. PC1: Performs rapid assessment, stabilization, and escalation for urgent surgical or postoperative presentations
2. PC4: Provides longitudinal perioperative care including reassessment, postoperative monitoring, and continuity planning
3. MK2: Applies clinical reasoning to surgical assessment, perioperative optimization, postoperative complications, and medication management
4. ICS1: Provides patient- and family-centered counselling regarding surgery, risks, recovery expectations, and warning signs

5. ICS2: Coordinates care effectively with surgical, anesthesia, emergency, rehabilitation, and allied health teams
6. ICS3: Maintains accurate documentation, medication reconciliation, handover communication, and reliable follow-up planning
7. SBP2: Coordinates transitions across outpatient, inpatient, surgical, rehabilitation, and community settings
8. PROF1: Demonstrates accountability, safe perioperative practice, ethical decision-making, and recognition of limits of competence
9. PBLI1: Applies perioperative and surgical evidence-based guidelines and improves performance through feedback and simulation

Family Medicine

EPA 13: Selecting and interpreting diagnostic investigations, including imaging, to guide patient management

Key Features: This EPA focuses on the ability to solve diagnostic problems through clinical reasoning, select appropriate investigations, including imaging, interpret results, and communicate findings effectively.

- Residents must develop investigation plans that refine the differential diagnosis and guide patient management, considering test characteristics (e.g., reliability, sensitivity, specificity), availability, patient acceptability, risks, and clinical relevance.
- This includes the appropriate selection and interpretation of laboratory tests, screening tests, and imaging modalities, integrating findings into clinical decision-making.
- Socially sensitive tests (e.g., HIV, adolescent pregnancy) must be discussed appropriately with patients or caregivers.
- Residents must recognize diagnostic uncertainty, avoid over- or under-investigation, and apply evidence-based decisions while considering cost and system resources.
- Residents must accurately interpret diagnostic and screening tests, distinguishing normal variation from clinically significant abnormalities, recognizing urgent or critical findings, and assessing their clinical impact.
- They must communicate results clearly and promptly to patients, families, caregivers, and the healthcare team, ensuring understanding and appropriate follow-up.
- Residents must demonstrate responsibility for follow-up and continuity of care related to all investigations ordered.

Assessment Plan:

Direct or indirect observation with chart/case review by supervisor.

Assessment form collects information on:

- Specialty: family medicine practice; emergency medicine; internal medicine; pediatrics; psychiatry; general surgery; Ob/Gyn; other (write in)
- Setting: primary care clinic; ambulatory care; inpatient; outpatient; ER
- Test(s) ordered: CBC; basic metabolic panel/electrolytes; liver function tests; thyroid function tests; HbA1c/fasting glucose; lipid profile; urinalysis/urine culture; pregnancy test; HIV/Hepatitis screening; chest X-ray; abdominal ultrasound; ECG; musculoskeletal X-ray; Pap smear/HPV testing; fecal occult blood test; pulmonary function test (PFT) other (write in)
- Patient age: pediatric; adult; geriatric

Basis on formal entrustment decisions:

Collect a minimum of 20 observations of achievement:

- At least 3 different clinical presentations (case mix)
- At least 10 different tests or investigations

- At least 5 different observers
- At least 10 different imaging investigations (CXR, MSK, Abd,)
- At least 3 different ECG interpretations

When is unsupervised practice expected to be achieved: PGY 3

Relevant task components:

ACGME

1. PC 1.3: Recognizes urgent and emergent situations and coordinates appropriate diagnostic strategies
2. PC 4.2: Prioritizes cost-effective diagnostic testing and consultations that will change management
3. MK 1.4: Demonstrates knowledge of behavioral and system factors affecting diagnostic choices
4. MK 2.2: Interprets results of common diagnostic testing, including imaging
5. MK 2.3: Identifies and mitigates clinical reasoning errors
6. MK 2.3: Synthesizes complex diagnostic information to reach high probability diagnoses
7. ICS 1.2: Identifies and adapts to barriers to effective communication (e.g., health literacy, cultural)
8. ICS 3.1: Accurately and timely records information in the patient record
9. ICS 3.2: Demonstrates organized diagnostic reasoning in documentation
10. P 2.2: Performs tasks and responsibilities in a timely and thorough manner
11. SBP 2.3: Coordinates care effectively using interprofessional teams

CanMEDS

1. ME 2.2 Selects appropriate investigations, including imaging, and interprets results for diagnosis, management, prevention, and health promotion
2. ME 2.5 Makes clinical decisions informed by evidence, experience, and patient context
3. ME 4.2 Implements patient-centered care plans with appropriate follow-up and reassessment of investigations
4. Com 3.1 Communicates results clearly, accurately, and in a timely manner, ensuring understanding
5. Com 4.1 Facilitates patient discussions in a respectful, inclusive, and culturally safe manner
6. Com 5.1 Maintains clear, accurate, and timely documentation
7. L 2.2 Provides cost-conscious care integrating evidence and patient needs
8. L 2.3 Uses healthcare resources judiciously, including investigations and referrals
9. S 3.2 Identifies and uses appropriate clinical resources and guidelines
10. S 3.3 Applies point-of-care resources effectively
11. S 3.5 Integrates evidence into clinical decision-making

Family Medicine

EPA 14: Assessing and managing minor, self-limited episodic illness in adults and older adults

Key Features: This EPA focuses on providing patient-centered assessment, diagnosis, and management of adults and older adults presenting with minor, self-limited, or low-complexity episodic problems commonly encountered in primary care.

- It includes focused history-taking, medication review, targeted physical examination, and active screening for red flags or warning signs that may indicate serious illness or need for escalation of care.
- The resident considers age-related physiology, comorbidities, functional status, cognition, frailty, psychosocial context, and polypharmacy when relevant, particularly in older adults.
- The resident provides evidence-based treatment, safe prescribing, self-care advice, and anticipatory guidance, while explaining the expected clinical course and providing clear safety-netting instructions.
- It includes recognition of when symptoms persist, worsen, represent atypical presentations, or may indicate higher-risk disease requiring reassessment, urgent intervention, referral, or escalation of care.
- The resident demonstrates safe prescribing practices, including consideration of medication interactions, renal/hepatic function, and age-related risks.
- It requires timely documentation, appropriate follow-up planning, and coordination of referrals or community support when indicated.
- This EPA excludes management of severe, unstable, or life-threatening conditions, complex chronic disease management, major multisystem acute presentations, mental health emergencies, and hospital-level interventions.

Assessment Plan:

Direct or indirect observation with review of consultation documentation by supervisor.

Assessment form collects information on:

- Settings: family medicine clinic; walk-in or urgent care clinic; ED; home visit, outpatient, inpatient.
- Patient age: adult (18–64 years); older adult (≥65 years)
- Case mix: upper respiratory infection; sore throat/pharyngitis; acute sinus symptoms; otitis externa/media; hearing impairment red eye/conjunctivitis; uncomplicated urinary symptoms/UTI; vaginitis/vaginal discharge; mild gastroenteritis; constipation; dyspepsia/GERD flare; hemorrhoids/anal fissure; acute low back pain; neck/shoulder strain; ankle sprain/minor soft tissue injury; mild osteoarthritis flare; dermatitis/eczema flare; urticaria/insect bite reaction; mild cellulitis/skin infection; acne flare; uncomplicated headache/migraine; benign positional vertigo; insomnia/sleep disturbance; minor wound care/suture removal; other (write in)

- Complexity: straightforward diagnosis and management; low risk/self-limited problem; mild psychosocial complexity; polypharmacy; mild frailty; recognition of red flags or atypical presentation; need for escalation of care

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement:

- At least 4 older adult encounters (≥ 65 years)
- At least 2 complex encounters or requiring recognition of red flags or need for escalation of care.
- At least 6 different clinical presentations across at least 4 body systems (case mix)
- Minimum 3 supervising physicians

When is unsupervised practice expected to be achieved: PGY 3

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs physical examination, selects appropriate investigations, and interprets results for diagnosis and management
2. ME 2.4 Develops patient-centered management plans in collaboration with patients and healthcare professionals
3. ME 2.5 Makes clinical decisions informed by evidence, experience, and patient preferences
4. ME 2.6 Integrates co-existing clinical and contextual issues, including age-related considerations and polypharmacy
5. ME 4.2 Ensures continuity of care through follow-up, reassessment, and referral when indicated
6. Com 1.1 Establishes positive therapeutic relationships characterized by trust, respect, and compassion
7. Com 1.6 Adapts communication to patient needs, preferences, and context
8. Com 2.1 Engages patients to understand symptoms, concerns, expectations, and illness impact
9. Com 3.1 Communicates information clearly, accurately, and in a timely manner
10. Com 4.1 Facilitates respectful, inclusive, and culturally safe discussions regarding management and follow-up
11. Com 5.1 Maintains timely, accurate, and appropriate documentation
12. Col 3.1 Facilitates transitions of care and referral when needed
13. S 3.2 Identifies and uses relevant evidence-based guidelines and clinical resources
14. P 1.1 Demonstrates professionalism, integrity, compassion, and accountability
15. P 3.1 Adheres to professional standards, ethical principles, and governing laws

ACGME

1. PC4: Evaluates common acute presentations, recognizes red flags or atypical presentations, reassesses, and arranges follow-up appropriately
2. MK2: Prioritizes differential diagnoses, applies evidence-based management, and adjusts decisions according to patient risk factors and age-related considerations
3. ICS1: Communicates expected clinical course, self-care advice, and safety-netting effectively with patients and caregivers
4. ICS3: Ensures timely documentation, clear management plans, and reliable follow-up of investigations and referrals
5. SBP2: Coordinates referral and escalation pathways and connects patients with community supports when indicated
6. PROF1: Demonstrates accountability, safe prescribing, ethical practice, and recognizes limits of competence
7. PBLI1: Applies evidence-based guidelines and refines clinical practice through outcomes and feedback

Family Medicine

EPA 15: Providing management of chronic conditions in adults and older adults

Key Features: This EPA focuses on providing longitudinal, patient-centered care for adults and older adults with one or more chronic conditions to maintain health, prevent complications, optimize function and quality of life, and support self-management over time.

- It includes comprehensive assessment of disease status, medications and adherence, lifestyle factors, functional status, cognition, mood, and psychosocial context, with identification of complications, progression, treatment harms, and barriers to care.
- The resident develops individualized, evidence-informed management plans aligned with patient goals, preferences, comorbidities, frailty, and life circumstances.
- It includes interpretation of relevant investigations, monitoring of clinical and functional outcomes, adjustment of therapies based on response and disease progression, and management of common exacerbations or complications within scope.
- The resident optimizes medications with attention to polypharmacy, renal/hepatic function, drug interactions, age-related pharmacokinetics, adherence, and medication safety.
- It includes education, counselling, and advocacy to support disease prevention, healthy lifestyle behaviors, self-management, adherence, and maintenance of independence and quality of life.
- It requires coordination of care with specialists, allied health professionals, caregivers, and community resources to ensure continuity, appropriate surveillance, timely referral, and integrated care planning.
- The resident recognizes functional decline, psychosocial vulnerability, cognitive impairment, caregiver burden, and social determinants of health, and incorporates these into management planning.
- This EPA excludes management of acute life-threatening presentations, highly specialized interventions beyond primary care scope, complex surgical management, and experimental therapies outside of standard chronic care.

Assessment Plan:

Direct or indirect observation with review of consultation documentation and/or chart review for longitudinal care by supervisor.

Assessment form collects information on:

- Settings: family medicine clinic; outpatient clinic; inpatient, geriatric clinic; home visit; telemedicine; long-term care facility, urgent care; other (write in)
- Patient age: adult (18–64 years); older adult (≥65 years)
- Case mix: diabetes; hypertension; dyslipidemia; ischemic heart disease; heart failure; atrial fibrillation on anticoagulation; COPD; asthma; chronic kidney disease; hypothyroidism; osteoporosis; osteoarthritis; chronic pain; obesity; GERD; mild

cognitive impairment; urinary incontinence; frailty with functional decline; other (write in)

- Complexity (select all that apply): single chronic condition; stable multimorbidity; medically complex patient with multisystem involvement; polypharmacy requiring medication optimization; mild cognitive or functional limitations; coordination with multiple healthcare providers

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement:

- At least 4 cases involving different single chronic disease management
- At least 4 cases involving stable multimorbidity or polypharmacy or medication optimization
- At least 2 older adult patients with functional, cognitive, or medication-related complexity
- Minimum 3 supervising physicians

When is unsupervised practice expected to be achieved: PGY 3

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs physical examination, selects appropriate investigations, and interprets results for diagnosis, management, prevention, and health promotion
2. ME 2.4 Develops individualized care management plans in collaboration with patients and healthcare professionals
3. ME 2.6 Manages complex co-existing clinical and contextual issues, including multimorbidity and frailty
4. ME 4.1 Works collaboratively with patients, families, healthcare professionals, and community resources to provide comprehensive care
5. ME 4.2 Ensures continuity of care through monitoring, reassessment, follow-up, and referral when needed
6. Com 1.1 Establishes positive therapeutic relationships characterized by trust, respect, and compassion
7. Com 1.3 Respects confidentiality, privacy, and autonomy
8. Com 1.6 Adapts communication to patient needs, preferences, culture, cognition, and functional status
9. Com 2.1 Engages patients to understand symptoms, concerns, expectations, and illness impact
10. Com 2.5 Engages with families and caregivers to support understanding and care planning when appropriate
11. Com 3.1 Communicates information clearly, accurately, and in a timely manner

12. Com 4.4 Addresses challenging communication issues such as adherence, behavior change, emotional distress, and goals-of-care discussions
13. Col 1.4 Respects diversity of professional roles and perspectives while ensuring integrated patient-centered care
14. Col 3.1 Facilitates transitions of care and referral when indicated
15. HA 1.2 Supports patients, families, and caregivers in adopting healthy behaviors and maintaining independence
16. HA 1.3 Incorporates disease prevention, health promotion, and surveillance into chronic disease care
17. S 3.5 Integrates evidence into clinical decision-making
18. P 1.1 Demonstrates professionalism, integrity, accountability, and compassion

ACGME

1. PC4: Provides longitudinal care, reassessment, continuity, and management of chronic disease complexity over time
2. MK2: Integrates clinical data over time, interprets investigations, adjusts therapies, and recognizes complications and treatment harms
3. ICS1: Communicates effectively regarding education, counselling, adherence support, and shared goal-setting with patients and caregivers
4. ICS2: Coordinates collaborative care with specialists, allied health professionals, and community resources
5. ICS3: Ensures accurate documentation, monitoring plans, medication reconciliation, and reliable follow-up and surveillance
6. SBP2: Coordinates referrals, community supports, and transitions of care to optimize patient-centered management
7. PROF1: Demonstrates accountability, safe prescribing, ethical care, and recognizes limits of competence
8. PBL1: Applies evidence-based guidelines and refines chronic disease management based on outcomes and feedback

Family Medicine

EPA 16: Providing palliative and end-of-life care, including goals-of-care discussions

Key Features: This EPA focuses on providing comprehensive, patient-centered palliative and end-of-life care for adults and older adults with advanced, progressive, or terminal illness across clinical and home-based settings.

- It includes systematic assessment and management of physical, psychological, social, and spiritual symptoms affecting quality of life, including pain, dyspnea, nausea, constipation, delirium, anxiety, fatigue, anorexia/cachexia, terminal secretions, and caregiver distress.
- The resident provides evidence-based pharmacologic and non-pharmacologic symptom management, including safe initiation, titration, monitoring, and adjustment of medications, with attention to comorbidities, renal/hepatic function, polypharmacy, side effects, and patient goals.
- It includes planning and conducting structured goals-of-care discussions with patients and/or families to clarify illness understanding, prognosis, values, fears, trade-offs, treatment preferences, resuscitation status, comfort-focused care, and end-of-life wishes.
- The resident facilitates shared decision-making that respects patient autonomy, incorporates family and caregiver input appropriately, manages emotion or disagreement, and ensures decisions are ethically sound and aligned with clinical realities.
- It includes planning and performing home or facility-based visits when appropriate, integrating medical, functional, social, environmental, and safety factors into the care plan.
- The resident assesses caregiver needs, home safety, functional decline, medication use, access to resources, and social determinants of health, and adapts care plans to the patient's living environment.
- It requires coordination with palliative care teams, nursing, allied health, hospice, home care, community services, caregivers, and other healthcare professionals to ensure continuity, symptom monitoring, anticipatory planning, and transitions of care.
- The resident documents symptom trajectories, medication plans, goals-of-care decisions, treatment limitations, escalation plans, and follow-up arrangements clearly and communicates these plans to all relevant providers and services.
- Competence in rare, high-risk, or complex palliative scenarios may be demonstrated through direct clinical observation or simulation when case exposure is limited.
- This EPA excludes advanced procedural palliative interventions beyond primary care scope, definitive management of acute clinical crises requiring hospital-level intervention, complex legal or ethical disputes requiring formal ethics consultation, and long-term planning of disease-modifying therapies.

Assessment Plan:

Direct or indirect observation with review of consultation documentation and/or chart review by supervisor. Assessment may include observation of family meetings, home visits, and review of symptom-control plans, medication documentation, and goals-of-care documentation.

Assessment form collects information on:

- Settings: family medicine clinic; hospital ward; home visit; hospice or palliative care unit; long-term care facility; ED; assisted living facility; hospital palliative care ward; simulation; ICU; CCU.
- Case mix (select all that apply): cancer-related pain; dyspnea in advanced disease; nausea/vomiting; constipation or bowel obstruction risk; delirium/agitation; anxiety/depression; fatigue/weakness; anorexia/cachexia; terminal secretions; opioid initiation/titration and side-effect management; end-of-life care planning; last-days-of-life symptom management; caregiver distress or bereavement support referral; advanced cancer transition to comfort-focused care; progressive organ failure; dementia with loss of capacity; frailty/functional decline; code status/DNR discussion; treatment limitation decisions; home-based palliative care; post-discharge palliative follow-up; palliative emergencies requiring escalation; other (write in)
- Complexity: high symptom burden; polypharmacy; psychosocial or caregiver complexity; prognostic uncertainty; variable patient/family goals; patient with cognitive impairment or substitute decisionmaker; family disagreement; cultural or language barriers; home safety or access-to-care concerns

Basis on formal entrustment decisions:

Collect a minimum of 6 observations of achievement:

- At least 2 cases involving symptom control
- At least 2 goals-of-care or family meetings
- At least 2 home, hospice, or long-term care encounters
- At least 2 cases involving psychosocial, caregiver, cultural, religious, or communication complexity
- Minimum 3 supervising physicians (including family physicians and palliative care specialists)

When is unsupervised practice expected to be achieved: PGY 3

Relevant task components:

CanMEDS

1. ME 1.3 Provides care across the spectrum of supportive care, palliation, and end-of-life care
2. ME 2.2 Elicits history, performs physical examination, selects appropriate investigations, and interprets results when relevant to symptom management and goals of care

3. ME 2.3 Establishes goals of care in collaboration with patients and families
4. ME 2.4 Develops care management plans aligned with patient priorities, clinical realities, and family/caregiver context
5. ME 2.6 Manages complex clinical and contextual issues, including uncertainty, advanced illness, frailty, and comorbidities
6. ME 3.1 Determines appropriate therapies for symptom relief and comfort-focused care
7. ME 4.1 Works collaboratively with patients, families, caregivers, healthcare professionals, and community services to provide comprehensive care
8. ME 4.2 Ensures continuity of care through monitoring, follow-up, reassessment, and transition planning
9. ME 5.1 Recognizes and mitigates patient safety risks in home, hospice, and palliative care settings
10. Com 1.1 Establishes therapeutic relationships based on trust, respect, honesty, and compassion
11. Com 1.3 Respects confidentiality, privacy, and autonomy
12. Com 2.1 Engages patients and families to understand symptoms, concerns, expectations, values, and illness experience
13. Com 2.5 Engages families during important life events to improve understanding and mobilize support
14. Com 4.1 Facilitates respectful, inclusive, non-judgmental, and culturally safe care discussions
15. Com 4.4 Addresses challenging communication issues including prognosis, bad news, disagreement, emotion, and end-of-life decisions
16. Com 5.1 Maintains timely, clear, accurate, and appropriate written or electronic documentation
17. Col 2.2 Engages patients, families, caregivers, and team members in shared decision-making
18. Col 3.1 Facilitates transitions of care when required
19. Col 3.2 Communicates shared responsibilities clearly through care transition plans to optimize patient safety
20. L 2.3 Uses healthcare resources judiciously, including community, home, hospice, and specialist services
21. S 3.5 Integrates evidence into palliative and end-of-life care decision-making
22. P 1.1 Demonstrates professionalism, compassion, respect, integrity, and accountability
23. P 1.3 Recognizes and responds to ethical issues in palliative and end-of-life care
24. P 3.1 Adheres to professional and ethical codes, standards of practice, and governing laws

ACGME

1. PC4: Provides longitudinal symptom management, reassessment, coordination, and follow-up for patients with advanced or terminal illness

2. MK2: Applies clinical reasoning and evidence to palliative symptom control, medication titration, prognosis, risk-benefit decisions, and care planning
3. ICS1: Conducts patient- and family-centered goals-of-care discussions, communicates prognosis, manages emotion and conflict, and supports shared decision-making
4. ICS2: Coordinates with palliative care, nursing, hospice, home care, allied health, and community teams
5. ICS3: Documents symptom trajectories, medication plans, goals-of-care decisions, treatment limitations, handover information, and follow-up plans clearly and reliably
6. SBP2: Navigates and coordinates hospice, home care, community supports, specialist referral, and transitions across care settings
7. PROF1: Provides ethical end-of-life care with respect for autonomy, confidentiality, accountability, and professional boundaries
8. PBLI1: Uses evidence, reflection, feedback, and simulation to improve palliative care, home-visit practice, and high-stakes communication

Family Medicine

EPA 17: Coordinating care across providers, settings, and transitions

Key Features: This EPA focuses on coordinating safe, effective, patient-centered care across multiple healthcare providers, clinical settings, and transitions in care.

- It includes integrating information from patients, families, caregivers, consultants, allied health professionals, community services, and healthcare systems to ensure continuity and alignment of care plans.
- The resident identifies the need for transitions of care and coordinates referrals, investigations, follow-up plans, medication reconciliation, and communication between healthcare providers and services.
- It includes managing transitions between settings such as outpatient clinics, emergency departments, hospital wards, rehabilitation facilities, long-term care, hospice, and home care.
- The resident ensures accurate handover of clinical information, including diagnoses, medications, pending investigations, goals of care, safety concerns, and follow-up requirements.
- The residents recognize barriers to care continuity including language, health literacy, cognitive impairment, psychosocial complexity, access limitations, caregiver burden, transportation issues, and fragmentation of services, and works to reduce these barriers.
- It includes collaboration with interprofessional teams and community resources to support chronic disease management, mental health care, rehabilitation, palliative care, preventive care, and post-discharge follow-up.
- The resident engages patients and families in shared decision-making, ensuring that transitions and care plans align with patient goals, values, culture, and functional context.
- The resident prioritizes patient safety during transitions by recognizing high-risk situations such as polypharmacy, frailty, recent hospitalization, unresolved investigations, communication gaps, or high-risk psychosocial circumstances.
- It requires timely documentation, clear communication, reliable follow-up systems, and appropriate escalation when coordination challenges or deterioration are identified.
- This EPA excludes independent management of highly specialized case-management systems or administrative leadership roles beyond resident scope.

Assessment Plan:

Direct or indirect observation with review of consultation documentation, discharge summaries, referral letters, care plans, and handover communication by supervisor. Multisource feedback from healthcare and allied health professionals, nurses, social workers, pharmacists, patients, and caregivers may be included.

Assessment form collects information on:

- Settings: family medicine clinic; outpatient clinic; emergency department; hospital ward; rehabilitation facility; long-term care facility; hospice or palliative care setting; home visit; virtual care; urgent care
- Transitions of care (select all that apply): hospital discharge follow-up; referral to specialist care; transition from pediatric to adult care; emergency department follow-up; home care coordination; rehabilitation or long-term care transition; palliative or hospice care transition; mental health or addiction services referral; community resource coordination; medication reconciliation after transition; follow-up of pending investigations; other (write in)
- Case mix (select all that apply): acute presentation; chronic disease management; multimorbidity; frailty; mental health conditions; substance use disorders; post-hospitalization care; polypharmacy; palliative care; functional decline; psychosocial complexity; caregiver support needs; other (write in)
- Complexity: straightforward referral or follow-up; multiple providers/services involved; polypharmacy or medication safety concerns; psychosocial or socioeconomic barriers; cognitive impairment or caregiver involvement; fragmented care requiring extensive coordination

Basis on formal entrustment decisions:

Collect a minimum of 5 observations of achievement:

- At least 2 hospital-to-community or care-transition cases
- At least 1 case involving multiple providers or allied health coordination
- At least 1 case involving psychosocial, functional, or access barriers
- At least 2 cases involving medication reconciliation or patient safety concerns during transition
- Minimum 2 supervising physicians or assessors, including interdisciplinary input where feasible

When is unsupervised practice expected to be achieved: PGY 3

Relevant task components:

CanMEDS

1. ME 2.4 Establishes care management plans recognizing the roles of patients, families, healthcare professionals, and community resources
2. ME 2.6 Manages complex co-existing clinical and contextual issues, often in conditions of uncertainty
3. ME 4.2 Implements patient-centered care plans ensuring continuity through follow-up, reassessment, monitoring, and coordination of care
4. ME 5.1 Recognizes healthcare delivery risks and patient safety incidents and works proactively to prevent harm
5. Com 1.1 Establishes therapeutic relationships characterized by trust, honesty, compassion, and respect

6. Com 1.6 Adapts communication to patient needs, health literacy, culture, language, and clinical context
7. Com 4.1 Facilitates respectful and culturally safe discussions regarding care plans and transitions
8. Com 5.1 Maintains timely, accurate, and appropriate written and electronic records
9. Col 1.1 Establishes and maintains collaborative relationships with healthcare professionals and community partners
10. Col 2.2 Engages others in shared decision-making and collaborative care planning
11. Col 3.1 Determines when transitions in care are required and facilitates the process
12. HA 1.1 Addresses determinants of health affecting access to services and continuity of care
13. HA 2.4 Identifies needs of underserved patients and reduces barriers to culturally appropriate care
14. L 2.3 Manages healthcare resources judiciously, including referrals, investigations, and community supports
15. S 3.5 Integrates evidence into decision-making and care coordination
16. P 1.1 Demonstrates professionalism, accountability, integrity, respect, and compassion
17. P 3.1 Adheres to professional and ethical standards governing clinical practice and transitions of care

ACGME

1. PC4: Provides longitudinal care, reassessment, follow-up, and coordination across healthcare settings and transitions
2. ICS1: Engages patients and families in shared decision-making and communicates plans clearly and compassionately
3. ICS2: Communicates effectively with interprofessional teams, consultants, allied health providers, and community services
4. ICS3: Performs safe and effective transitions of care, including handover communication, documentation, and follow-up coordination
5. SBP2: Navigates healthcare systems and coordinates referrals, investigations, home care, rehabilitation, mental health, palliative, and community resources
6. MK2: Integrates clinical information from multiple providers and settings to guide safe and effective care planning
7. PROF1: Demonstrates accountability, professionalism, confidentiality, and patient safety during transitions of care
8. PBLI1: Uses feedback, reflection, and system awareness to improve continuity, coordination, and patient outcomes

Family Medicine

EPA 18: Providing culturally safe and equitable care to diverse and vulnerable populations

Key Features: This EPA focuses on providing culturally safe, equitable, trauma-informed, and patient-centered care to diverse and vulnerable populations by integrating social determinants of health, communication needs, functional abilities, cultural context, and barriers to care into assessment and management.

- It includes caring for patients from diverse cultural, linguistic, ethnic, socioeconomic, developmental, cognitive, and marginalized backgrounds, including refugees, migrants, people living in poverty, people with developmental disabilities, and patients facing social vulnerability or inequitable access to care.
- The residents elicit the patient's understanding of illness, beliefs, priorities, lived experience, support, and barriers to care while recognizing the effects of culture, discrimination, trauma, disability, stigma, poverty, and health literacy on health outcomes and healthcare access.
- The resident adapts communication to the patient's developmental, cognitive, sensory, linguistic, and cultural needs using simplified language, visual supports, culturally sensitive approaches, professional interpreters, caregivers, substitute decisionmakers, or cultural mediators when appropriate.
- It includes assessing social determinants of health such as housing instability, food insecurity, transportation barriers, financial limitations, education, employment, caregiver burden, social isolation, and access to medications or healthcare services.
- The resident provides preventive, acute, chronic, developmental, and mental health care with reasonable accommodation and individualized care planning that balances patient autonomy, cultural context, functional abilities, and evidence-based practice.
- The resident identifies barriers to adherence, safety, communication, follow-up, and healthcare access, and collaborates with social work, allied health professionals, community agencies, educational supports, advocacy services, and caregivers to improve continuity and equity of care.
- It includes adapting investigations, treatment plans, and follow-up strategies to patient context, affordability, health literacy, and caregiver capacity while maintaining safe and effective care.
- The resident demonstrates advocacy for vulnerable and underserved patients and works to reduce inequities and improve access to culturally appropriate and inclusive healthcare services.
- Competence may be demonstrated through direct clinical observation or, when exposure to complex scenarios is limited, through simulation as an acceptable alternative.
- This EPA excludes highly specialized social, legal, behavioral, or cultural interventions requiring advanced specialty expertise beyond the scope of family medicine practice.

Assessment Plan:

Direct or indirect observation with review of consultation documentation by supervisor. Multisource feedback from patients, caregivers, interpreters, allied health professionals, social workers, community partners, and supervisors may contribute to assessment.

Assessment form collects information on:

- Settings: family medicine clinic; outpatient clinic; community health clinic; shelter or outreach program; home visit; long-term care facility; hospital ward; ED; urgent care; simulation
- Patient population (select all that apply): culturally or linguistically diverse patient; refugee or asylum seeker; migrant or undocumented patient; patient living in poverty/unemployment; patient with housing or food insecurity; patient with low health literacy; patient with developmental disability; autism spectrum disorder; intellectual disability; sensory impairment; patient requiring caregiver-supported care; socially isolated patient; patient with barriers to healthcare/insurance access; people on determination; abused; other (write in)
- Clinical encounter (select all that apply): interpreter-mediated encounter; culturally influenced health beliefs; medication nonadherence due to financial barriers; developmental disability with chronic disease management; preventive care requiring accommodations; behavioral or mental health concerns in vulnerable populations; transition from pediatric to adult care; safeguarding/protection concerns; consent/capacity assessment with substitute decision-maker; chronic disease management affected by social determinants; refugee health assessment; substance use with social vulnerability; other (write in)
- Complexity: straightforward visit with minor accommodations; communication barriers; psychosocial complexity; competing cultural or social priorities; cognitive or functional limitations; multiple social determinants affecting care access and outcomes

Basis on formal entrustment decisions:

Collect a minimum of 5 observations of achievement:

- At least 2 cases involving cultural or language barriers
- At least 2 cases involving significant social determinants of health or poverty-related barriers
- At least 1 case involving developmental disability, cognitive impairment, or functional communication adaptations
- Minimum 3 supervising physicians or assessors, including interdisciplinary input where feasible

When is unsupervised practice expected to be achieved: PGY 3

Relevant task components:

CanMEDS

1. ME 2.4 Establishes patient-centered care plans recognizing patient priorities, social context, and the roles of caregivers and healthcare providers
2. ME 4.1 Works collaboratively with patients, caregivers, healthcare professionals, and community partners to provide comprehensive care
3. ME 6.2 Seeks to understand and respect culturally based health beliefs and practices
4. Com 1.1 Establishes therapeutic relationships characterized by trust, empathy, honesty, compassion, and respect
5. Com 1.3 Respects confidentiality, privacy, autonomy, and dignity
6. Com 1.6 Adapts communication to the unique developmental, cognitive, linguistic, cultural, and functional needs of patients
7. Com 2.1 Engages patients and caregivers to understand symptoms, concerns, beliefs, expectations, and the impact of illness on daily life
8. Com 3.1 Shares information clearly, accurately, and in a timely manner while checking understanding
9. Com 4.1 Facilitates respectful, inclusive, culturally safe discussions using interpreters or cultural mediators when appropriate
10. Com 4.3 Recognizes and respects diversity and the impact of culture, religion, gender, race, disability, and social context on healthcare decisions
11. Col 2.2 Engages others in shared decision-making and collaborative care planning
12. Col 3.1 Facilitates transitions and continuity of care when required
13. HA 1.1 Works with patients to address determinants of health affecting access to services and health outcomes
14. HA 1.2 Supports patients and families in adopting healthy behaviors within their lived realities and capacities
15. HA 2.4 Identifies needs of underserved and vulnerable populations and works to reduce barriers to culturally appropriate care
16. L 2.3 Uses healthcare resources judiciously, including referrals and community services
17. P 1.1 Demonstrates professionalism, cultural humility, integrity, compassion, accountability, and respect for diversity
18. P 3.1 Adheres to professional and ethical standards governing equitable and inclusive care

ACGME

1. ICS1: Adapts communication to cultural, linguistic, developmental, cognitive, and health literacy needs while building trust and shared understanding
2. ICS2: Collaborates effectively with interpreters, caregivers, allied health professionals, social work, educators, and community agencies
3. ICS3: Documents communication needs, accommodations, social determinants, and follow-up plans to ensure continuity of care
4. PC3: Provides preventive care, counselling, and health promotion tailored to patient context and barriers

5. PC4: Provides longitudinal, patient-centered care adapted to social complexity, disability, and vulnerable populations
6. MK2: Integrates cultural, developmental, cognitive, socioeconomic, and contextual factors into clinical reasoning and decision-making
7. SBP2: Coordinates access to healthcare, community resources, accommodations, interpretation services, social supports, and advocacy systems
8. PROF1: Demonstrates respect, cultural humility, ethical care, equity, accountability, confidentiality, and professional boundaries
9. PBLI1: Applies evidence-based approaches to culturally safe and equitable care and improves practice through feedback, reflection, and simulation

Family Medicine

EPA 19: Managing adults and older adults with multiple coexisting medical conditions

Key Features: This EPA focuses on providing comprehensive, patient-centered care for adults and older adults with multiple coexisting medical problems, including combinations of chronic diseases, intermittent acute exacerbations, polypharmacy, functional limitations, and psychosocial complexity.

- It includes a whole-person assessment integrating multisystem history, medication reconciliation, targeted physical examination, functional and cognitive assessment, psychosocial evaluation, and identification of interactions between diseases, treatments, and social determinants of health.
- The resident identifies exacerbations, complications, treatment burdens, medication-related harms, and competing priorities, and develops individualized management plans aligned with patient goals, quality of life, functional status, and expected benefit.
- The resident prioritizes interventions based on urgency, severity, frailty, prognosis, and patient preferences while balancing evidence-based recommendations across multiple conditions.
- It includes optimization, rationalization, and deprescribing of medications when appropriate, with attention to polypharmacy, renal/hepatic function, drug interactions, adherence, and age-related pharmacokinetics.
- The resident manages common acute exacerbations within scope, monitors disease progression and functional outcomes, and recognizes situations requiring escalation or specialist involvement.
- It requires coordination with specialists, allied health professionals, caregivers, community resources, and support services to integrate recommendations into a coherent longitudinal care plan.
- The resident provides patient and caregiver education, counselling, and shared decision-making regarding treatment goals, trade-offs, adherence, prevention, self-management, and advance care planning when appropriate.
- This EPA excludes isolated life-threatening emergencies requiring resuscitative care, highly specialized interventions beyond primary care scope, complex surgical management, and experimental or research-based therapies.

Assessment Plan:

Direct or indirect observation with review of consultation documentation and/or chart review for longitudinal and coordinated care by supervisor.

Assessment form collects information on:

- Settings: family medicine clinic; outpatient hospital clinic; inpatient, geriatric clinic; long-term care facility; rehabilitation setting; home visit, urgent care.
- Patient age: adult (18–64 years); older adult (≥ 65 years)

- Case mix (select all that apply): diabetes with hypertension or CKD; heart failure with atrial fibrillation; COPD with ischemic heart disease; polypharmacy review/deprescribing; multimorbidity with acute exacerbation; frailty with functional decline; chronic pain with medication risks; depression/anxiety with chronic disease; mild cognitive impairment or dementia with caregiver stress; recurrent falls; post-hospital discharge reconciliation and follow-up; social vulnerability or caregiver burden; other (write in)
- Complexity: multiple interacting chronic conditions; multimorbidity with acute issues; polypharmacy management; frailty; conflicting or competing treatment priorities; functional or cognitive limitations; psychosocial or socioeconomic complexity; coordination with multiple healthcare providers

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement:

- At least 3 cases involving stable multimorbidity
- At least 3 cases involving mild acute exacerbations within multimorbidity
- At least 3 cases involving polypharmacy review, medication adjustment, or deprescribing
- At least 2 cases involving psychosocial, cognitive, or functional complexity
- Minimum 3 supervising physicians

When is unsupervised practice expected to be achieved: PGY 4

Relevant task components:

CanMEDS

1. ME 2.2 Elicits history, performs physical examination, selects appropriate investigations, and interprets results for diagnosis and management
2. ME 2.4 Develops individualized care plans collaboratively with patients, caregivers, and healthcare professionals
3. ME 2.6 Manages complex co-existing clinical and contextual issues, including multimorbidity and uncertainty
4. ME 4.1 Works collaboratively with patients, families, healthcare professionals, and community resources to provide comprehensive care
5. ME 4.2 Ensures continuity of care through monitoring, reassessment, follow-up, and referral when needed
6. Com 1.1 Establishes positive therapeutic relationships characterized by trust, respect, and compassion
7. Com 2.1 Engages patients to understand symptoms, concerns, expectations, and illness impact
8. Com 2.5 Engages families and caregivers to support understanding and care planning
9. Com 4.1 Facilitates respectful, inclusive, and culturally safe discussions regarding care planning and goals of care

10. Com 4.4 Addresses challenging communication issues such as behavior change, adherence, emotional distress, and treatment trade-offs
11. Col 3.1 Facilitates transitions of care and referral when indicated
12. HA 1.1 Addresses determinants of health and barriers to care
13. HA 1.2 Supports patients, families, and caregivers in maintaining healthy behaviors and independence
14. HA 2.4 Identifies needs of underserved or vulnerable populations and improves access to care and resources
15. L 2.2 Provides evidence-based and cost-conscious care
16. S 3.2 Identifies and uses relevant evidence-based guidelines and clinical resources
17. P 1.1 Demonstrates professionalism, integrity, compassion, accountability, and ethical practice

ACGME

1. PC4: Provides longitudinal management of complex multimorbidity, reassessment, continuity, and coordinated follow-up over time
2. MK2: Prioritizes problems, integrates competing guidelines, recognizes treatment interactions and harms, and adjusts management plans appropriately
3. ICS1: Communicates effectively regarding shared decision-making, treatment trade-offs, goals of care, adherence, and self-management with patients and caregivers
4. ICS2: Coordinates collaborative care plans across multiple healthcare providers and services
5. ICS3: Ensures accurate documentation, medication reconciliation, longitudinal care plans, and reliable follow-up
6. SBP2: Coordinates referrals, transitions, community resources, and support services to optimize patient-centered care
7. PROF1: Demonstrates accountability, medication safety, ethical decision-making, and recognition of limits of competence
- 8. PBLI1: Applies evidence thoughtfully in multimorbidity and refines care based on outcomes, feedback, and evolving evidence**

Family Medicine

EPA 20: Providing assessment and initial care of an adult/elderly patient with an acute serious presentation

Key Features: This EPA focuses on rapid assessment, initial stabilization, and safe management of adults and older adults presenting with urgent or potentially life-threatening conditions in primary care, ambulatory, emergency, or community settings.

- It includes focused history-taking, medication review, targeted examination, recognition of red flags and atypical presentations, and rapid triage and prioritization of high-risk conditions.
- The resident considers age-related physiology, frailty, comorbidities, cognitive status, and polypharmacy when assessing and managing older adults with acute illness.
- The resident initiates evidence-based immediate interventions addressing airway, breathing, circulation, pain control, altered mental status, and vital sign abnormalities, while closely monitoring clinical response.
- It includes initial management of acute exacerbations of chronic disease within scope, including respiratory, cardiovascular, metabolic, neurologic, infectious, toxicologic, psychiatric, and trauma-related presentations.
- The resident makes timely decisions regarding escalation, urgent referral, hospital transfer, emergency activation, or specialist consultation, and coordinates effectively with emergency services, multidisciplinary teams, caregivers, and consultants.
- Competence in rare or high-risk presentations may be demonstrated through direct clinical observation or simulation when case exposure is limited.
- It requires clear, compassionate communication with patients and families, structured handover and transfer communication, concise documentation of findings and interventions, and appropriate safety-netting.
- This EPA excludes specialized ICU-level management, highly specialized emergency or geriatric interventions beyond primary care scope, advanced surgical interventions, and long-term chronic disease management.

Assessment Plan:

Direct or indirect observation with review of consultation documentation by supervisor.

Assessment form collects information on:

- Settings: family medicine clinic; ambulatory care; outpatient clinic; inpatient, ED or urgent care; home visit; simulation
- Patient age: adult (18–64 years); older adult (≥ 65 years)
- Case mix (select all that apply): chest pain/possible ACS; acute shortness of breath; asthma/COPD exacerbation; acute heart failure/pulmonary edema; anaphylaxis; severe allergic reaction; suspected stroke/TIA; syncope with red flags; arrhythmia/palpitations; hypertensive emergency; sepsis/suspected severe infection; acute severe headache; meningitis concern; severe dehydration/electrolyte disturbance; diabetic emergency; Addison crisis; altered mental status/delirium; acute GI bleed; severe

abdominal pain/possible surgical abdomen; seizure/status epilepticus; overdose/toxic ingestion; fall with head injury or suspected fracture; acute urinary retention; medication toxicity/adverse drug event; acute psychosis or suicidal ideation with imminent risk; other (write in)

- Complexity: high acuity or rapidly evolving presentation; multi-system involvement; frailty or polypharmacy complicating assessment; need for rapid prioritization, triage, and escalation

Basis on formal entrustment decisions:

Collect a minimum of 8 observations of achievement:

- At least 4 different acute medical presentations
- At least 2 cases involving acute exacerbations of chronic disease
- At least 2 cases involving trauma, falls, medication-related harm, or altered mental status
- At least 3 older adult encounters (≥ 65 years)
- Minimum 3 supervising physicians (including family physicians and emergency physicians)

When is unsupervised practice expected to be achieved: PGY 4

Relevant task components:

CanMEDS

1. ME 1.3 Provides care across the spectrum of acute illness, chronic disease, rehabilitation, supportive care, and palliation
2. ME 2.2 Elicits focused history, performs physical examination, selects investigations, and interprets urgent clinical data for diagnosis and management
3. ME 2.6 Manages complex acute and chronic issues in situations of uncertainty
4. ME 3.1 Determines the most appropriate urgent procedures or therapies
5. ME 3.3 Prioritizes interventions according to safety, urgency, and available resources
6. ME 3.4 Performs procedures and emergency interventions safely and adapts to changing clinical circumstances
7. Com 1.3 Respects confidentiality, privacy, and autonomy during urgent care situations
8. Com 3.1 Shares information clearly, accurately, and promptly with patients, caregivers, and healthcare teams
9. Com 4.4 Addresses challenging communication situations including crises, emotional distress, and urgent decision-making
10. Com 5.1 Maintains timely, accurate, and appropriate documentation of acute presentations and interventions
11. Col 3.1 Facilitates urgent transitions of care, escalation, and transfer when required
12. L 2.3 Uses healthcare resources appropriately and efficiently during acute care situations
13. S 3.5 Integrates evidence into emergency and acute care decision-making

- 14. P 1.1 Demonstrates professionalism, integrity, accountability, and compassion in urgent care settings
- 15. P 1.3 Recognizes and responds appropriately to ethical issues encountered in emergency and high-risk situations

ACGME

- 1. PC1: Performs rapid assessment, stabilization, initiation of treatment, recognition of deterioration, and escalation or transfer of acutely ill patients
- 2. MK2: Identifies red flags and atypical presentations, prioritizes life-threatening conditions, interprets urgent clinical data, and accounts for age-related risk and medication harms
- 3. ICS1: Communicates clearly and compassionately with patients and caregivers during urgent situations and provides appropriate safety-netting
- 4. ICS2: Coordinates effectively with emergency services, consultants, and multidisciplinary teams during acute care situations
- 5. ICS3: Provides structured handover, accurate documentation, and safe transfer of critical information across settings
- 6. SBP2: Activates emergency pathways and coordinates transfers and urgent referrals appropriately
- 7. PROF1: Demonstrates accountability, patient safety, ethical practice, and recognizes limits of competence in emergency care
- 8. PBLI1: Uses feedback, simulation, drills, and reflective practice to improve management of rare or high-risk acute presentations

Family Medicine

EPA 21: Performing core procedures in family medicine practice

Key Features: This EPA focuses on safely and effectively performing common office-based and acute care procedures within the scope of family medicine practice, including patient assessment, preparation, informed consent, procedural performance, post-procedure management, and documentation.

- It includes patients of all ages requiring diagnostic, therapeutic, preventive, or urgent procedures commonly encountered in family medicine, outpatient, urgent care, and community settings.
- The resident confirms indications, contraindications, and procedural appropriateness; reviews relevant medical history, medications, allergies, anticoagulation status, and risk factors; obtains informed consent; and prepares the patient, equipment, monitoring, analgesia/anesthesia, and sterile field appropriately.
- The resident performs procedures using aseptic technique, standardized procedural steps, and appropriate patient positioning while monitoring patient comfort, response, and safety throughout the procedure.
- It includes common office and acute care procedures such as laceration repair, incision and drainage of abscesses, skin biopsy or excision, cryotherapy, joint aspiration and injection, wound care, splinting, urinary catheterization, intravenous access, contraception procedures, ear irrigation, ingrown toenail management, and basic airway support within family medicine scope.
- The resident recognizes and manages common procedural complications, including bleeding, infection, pain, allergic reactions, failed procedures, or equipment-related issues, and escalates care appropriately when complications exceed scope or patient instability develops.
- It includes providing clear aftercare instructions, pain management advice, safety-netting, pathology follow-up where applicable, and continuity planning, including referral when further procedural or specialist care is needed.
- The resident documents indications, consent, technique, findings, complications, patient response, and follow-up plans clearly and accurately.
- Competence in low-frequency or higher-risk procedures may be demonstrated through direct clinical observation or simulation when clinical exposure is limited.
- This EPA excludes major surgery, advanced operative procedures, advanced airway management beyond basic support, procedural sedation requiring specialist expertise, and procedures requiring operating room or ICU-level resources beyond family medicine scope.

Assessment Plan:

Direct or indirect observation with review of consultation documentation by supervisor. Chart review may be used to assess procedural documentation, pathology follow-up, complication management, and continuity of care.

Assessment form collects information on:

- Settings: family medicine clinic; outpatient clinic; urgent care clinic; ED; hospital ward; minor procedure room; home visit; simulation
- Patient age: pediatric; adult; geriatric
- Case mix (select all that apply): acute abscess; simple laceration; suspicious skin lesion; benign skin lesion; warts; ingrown toenail; cerumen impaction; joint pain/swelling; dehydration requiring IV fluids; acute urinary retention; respiratory distress requiring oxygen support; contraception procedures; minor wound care; superficial foreign body; epistaxis; minor trauma; postoperative wound care; other (write in)
- Procedures (select all that apply): simple laceration repair (sutures/skin adhesive); incision and drainage of abscess; skin biopsy (punch/shave) or simple excision; cryotherapy; joint aspiration or injection; intramuscular or subcutaneous injection; venipuncture and IV cannulation with IV fluids; urinary catheterization; wound care and dressing changes; splinting for minor injuries; ear irrigation; ingrown toenail management; contraceptive implant insertion/removal; IUD uncomplicated insertion/removal; suture or staple removal; nasogastric tube insertion; basic airway support (oxygen delivery, bag-mask ventilation); pap smear; high vaginal swab; other (write in)
- Complexity: routine uncomplicated procedure; anxious patient; pediatric patient; patient with comorbidities; anticoagulation or bleeding risk; anatomical challenges; urgent or unstable clinical context.

Basis on formal entrustment decisions:

Collect a minimum of 12 observations of achievement:

- At least 2 observations for each major procedural category (e.g., skin and soft tissue, Musculoskeletal, women health procedures, office-based, Vascular Access and Medication Administration, acute stabilization procedures)
- At least 6 different procedure types
- At least 2 acute care procedures performed in urgent or unstable clinical settings
- At least 2 office-based diagnostic or preventive procedures
- Minimum 4 supervising physicians

When is unsupervised practice expected to be achieved: PGY 4

Relevant task components:

CanMEDS

1. ME 3.1 Determines the most appropriate procedures or therapies
2. ME 3.2 Obtains and documents informed consent, explaining risks, benefits, and rationale for procedures
3. ME 3.3 Prioritizes procedures accounting for patient safety, urgency, and available resources

4. ME 3.4 Performs procedures skillfully and safely while adapting to changing clinical circumstances
5. ME 5.1 Recognizes healthcare delivery risks and procedural safety concerns and acts to prevent harm
6. Com 1.1 Establishes therapeutic relationships characterized by trust, empathy, and respect
7. Com 1.6 Adapts communication to patient needs, developmental stage, and procedural context
8. Com 3.1 Provides clear explanations regarding procedures, risks, aftercare, and follow-up
9. Com 4.1 Facilitates respectful and culturally safe discussions about procedural care
10. Com 5.1 Maintains timely, accurate, and appropriate procedural documentation
11. Col 2.2 Engages others in shared decision-making and procedural planning
12. Col 3.1 Facilitates transitions and continuity of care when referral or escalation is needed
13. Col 3.2 Communicates responsibilities and follow-up plans effectively to optimize patient safety
14. L 2.3 Uses healthcare resources judiciously, including referrals and investigations
15. S 3.3 Accesses and applies appropriate procedural resources at the point of care
16. S 3.5 Integrates evidence into procedural decision-making and practice
17. P 1.1 Demonstrates professionalism, accountability, compassion, integrity, and respect for diversity

ACGME

1. PC5: Performs office-based and acute care procedures safely and effectively while recognizing complications and limits of competence
2. PC1: Performs procedures required in urgent stabilization and acute care settings
3. MK2: Selects appropriate procedures, assesses contraindications, recognizes complications, and adapts management appropriately
4. ICS1: Obtains informed consent and provides clear procedural explanations, aftercare instructions, and safety-netting
5. ICS2: Coordinates effectively with healthcare teams during procedures and escalation of care
6. ICS3: Maintains accurate and timely procedural documentation and follow-up communication
7. SBP2: Coordinates referral pathways and continuity for procedures beyond family medicine scope
8. PROF1: Demonstrates accountability, ethical consent practices, patient safety, and professionalism during procedural care
9. PBL1: Improves procedural competence through evidence-based practice, feedback, deliberate practice, and simulation for low-frequency or high-risk procedures

