Pediatric Care in Family Medicine

PRA-BC Centralized Orientation

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Adapted from slides by Dr. Gail Dodek Wenner

Spring 2026

Who Am I?

I am the Medical Director of the UBC Health Clinic

- We are a unique resident teaching clinic where our family practice learners provide the majority of primary care to our patients
- We are supported by a team including Internal Medicine, Pediatrics, Psychiatry, OB, Sports Med and Pharmacy
- In addition, I care for my own longitudinal panel of 12-1300 patients
- Prior to medicine, I was a rural and remote emergency room nurse who worked and taught internationally
- I fell in love with primary care working in Vancouver's downtown Eastside which eventually led me to my career in medicine

University of Victoria

UBC





Introduction

Conflicts of Interest: I have no commercial affiliation with any products or websites mentioned in this presentation.

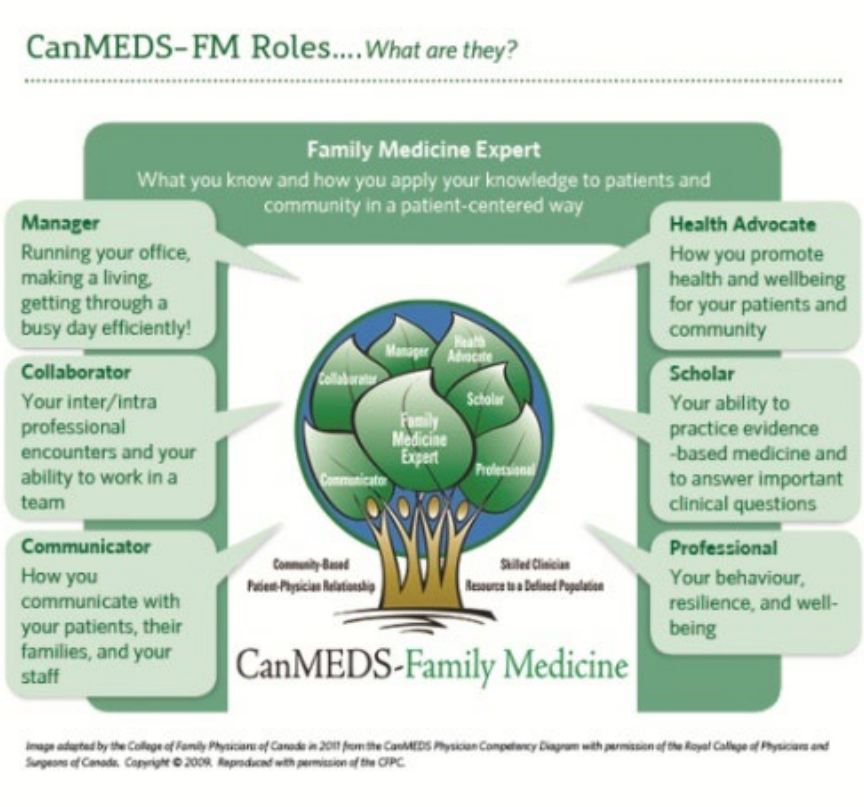
Today's Objectives

- Provide an overview of the medical culture of British Columbia and Canada in the context of pediatric care in family medicine
- Provide information on best-practice approaches to common pediatric topics presenting in the office
- Provide evidence-based resources in the care of children and adolescents

CanMEDS — Family Medicine Competencies

Considerations for family physicians in BC:

- **Community-based care**
- Building lasting patient–physician relationships
- **Skilled clinician**
- Providing comprehensive care across the lifespan
- **Resource to a defined population**
- Serving the unique needs of children, adolescents, and families



OPENING QUESTION

What are you hoping to get out of today's session?

Discussion prompts:

- What areas of paediatric care have you had the most experience with?
- What is different about paediatric practice in your country of origin vs. what you expect here in Canada?
- What would you most like to learn today?

Pediatric vs. Adult Medicine: The Three Cs

Culture · Consent · Communication

Culture: General Principles for BC Practice

Canada is a multicultural society. Keep these principles front of mind:

Respect other belief systems

Families hold a wide range of values about health, illness, and the role of the physician.

Recognize diverse family structures

There are a variety of gender roles within families — avoid assumptions about who is the primary caregiver or decision-maker.

Collaborate with patients

Shared decision-making is the norm in Canadian family medicine.

Non-judgmental approach

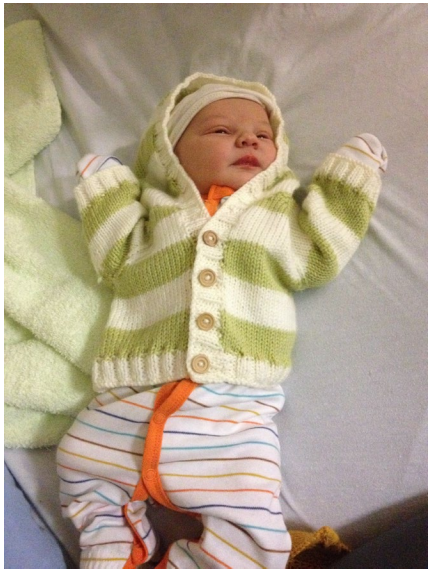
This is foundational to building trust, especially across cultures.

Privacy across all ages

Children who have not reached the age of majority retain privacy interests that require careful navigation.

Culture: Expectations & the Many Parties in Paediatrics

- **Different cultural groups have different expectations of their doctor**
- How questions are posed can be perceived very differently by patients — be thoughtful about phrasing
- Some parents may expect their family physician to help guide their parenting (e.g., 'What will Dr. Lynch suggest?')
- Physicians can easily overstep boundaries — avoid being either too casual or too dogmatic
- **Paediatric medicine involves treating many parties:**
  - You will often be treating the parents and siblings alongside the child
  - Schools, teachers, and educational psychologists are frequently involved
  - This collaborative approach is different from adult medicine



Consent: The Mature Minor Doctrine

In BC, consent for minors is governed by the Infants Act and relies on the mature minor doctrine.

What this means in practice:

- There is no fixed age at which a child gains decision-making capacity — it is always assessed individually
- Capacity is treatment-specific: a young person may have capacity to consent to some treatments but not to complex psychiatric treatment
- A 14-year-old's cognitive ability does not automatically equal adult capacity for all decisions but we generally use it as a benchmark age in which the child starts to assume more responsibility in their care (i.e. contraception)
- The physician's role is to assess whether this patient understands this proposed treatment

Resource: CPSBC Consent of Minors (Infants Act) — cpsbc.ca

Consent: What Makes Consent Valid

Three requirements for valid consent:

1

Understanding of the proposed intervention

The patient must understand what is being proposed — its nature, purpose, and process.

2

Understanding of the consequences

The patient must understand what will happen if they consent, and what will happen if they refuse.

3

Consent must be voluntary

Consent must be given freely, without coercion or undue pressure from parents, caregivers, or the physician.

Education of the paediatric patient is essential — always take time to explain before seeking consent.

Communication: Talking with Children & Adolescents

- **If able, talk directly to the child**
  - Even young children benefit from age-appropriate explanations of what you are doing
- **During the exam, narrate what you are doing**
  - This reduces anxiety and builds trust over time
- **Does the patient want a parent present or not? (especially teenagers)**
  - Offer adolescents private time — this applies equally to in-person visits and televisits
- **Build the child's capacity for self-advocacy**
  - Over time, gently encourage the child to speak for themselves — gradually ease the parent out of the examination room
- **Duty to report**
  - If a patient discloses a risk to themselves or others, you have a legal obligation to report to MCFD or the relevant Indigenous Governing Body

QUESTIONS

Questions & Check-In

Pause for group discussion — 5 minutes

- Have any of you already had to take your own children to see a doctor here in Canada? How was that experience?
- What are your expectations in a doctor's office in Canada?
- What surprised you most about the Three Cs framework compared to your previous experience?

Well Baby & Child Visits

0–5 Years

Developmental Assessment: Rourke Baby Record 2024

Use the 2024 Rourke Baby Record as your primary guide for all well-baby and well-child visits birth to 5 years. Free at: rourkebabyrecord.ca

2024 Edition highlights:

Culturally safe care:	A new foundational element throughout the record — guidance on anti-racist, inclusive, and culturally humbling practice
Early relational health:	Moves beyond checklist completion toward facilitating meaningful conversations about family wellbeing
Revised developmental surveillance:	Updated age-of-achievement expectations for milestones, using current evidence
New visit guide:	A formal 'within 1 week' visit guide now exists in addition to the 2-week guide
BMI from age 2:	Use WHO Growth Charts to age 2; BMI-for-age charts from age 2 onward

Save | Save and Exit | Exit
Print | About

Rourke Baby Record: EVIDENCE BASED INFANT/CHILD HEALTH MAINTENANCE GUIDE I

Name: FUDD, ELMER | Birth Date (d/m/yyyy): 04/08/1930 | Age: 34951 days (Male) | Forward Sorting Area: V6V

Birth remarks: ○ Premature ○ High Risk ○ No Concerns

Date of start of pregnancy: | Length: cm | Head Circ: cm | Birth Wt: kg | Discharge Wt: kg

Risk Factors
☐ 2nd hand smoke exposure

Substance abuse in utero
☐ Alcohol
☐ Drugs

APGAR
1 min. Not Set
5 min. Not Set

Family history

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Rourke Baby Record: EVIDENCE BASED INFANT/CHILD

Name: FUDD, ELMER | Birth Date (d/m/yyyy): 04/08/1930

Date of Visit	within 1 week	2 weeks (optional)	1 month (optional)	2 months	4 months
DATE					
GROWTH* Correct percentiles until 24-36 months if < 37 weeks gestation	Ht. (cm) / Wt. (kg) / Head circ. (cm)	Ht. (cm) / Wt. (kg) / Head circ. (cm)	Ht. (cm) / Wt. (kg) / Head circ. (cm)	Ht. (cm) / Wt. (kg) / Head circ. (cm)	Ht. (cm) / Wt. (kg) / Head circ. (cm)
PARENT/CAREGIVER CONCERNS					
NUTRITION*:	✓ X No Not Discussed	✓ X No Not Discussed	✓ X No Not Discussed	✓ X No Not Discussed	✓ X No Not Discussed
	○ ○ ○ ◉ Breastfeeding (exclusive)*	○ ○ ○ ◉ Breastfeeding (exclusive)*	○ ○ ○ ◉ Breastfeeding (exclusive)*	○ ○ ○ ◉ Breastfeeding (exclusive)*	○ ○ ○ ◉ Breastfeeding (exclusi
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	○ ○ ◉ Stool pattern & urine output	○ ○ ◉ Stool pattern & urine output	○ ○ ◉ Stool pattern & urine output	○ ○ ○ ◉ Supplementation: Solids	○ ○ ○ ◉ Supplementation: Solic
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	○ ○ ○ ◉ Supplementation: Other Fluids	○ ○ ○ ◉ Supplementation: Other Fluids	○ ○ ○ ◉ Supplementation: Water ○ ○ ○ ◉ Supplementation: Other Fluids	○ ○ ○ ◉ Supplementation: Other Fluids	○ ○ ○ ◉ Supplementation: Othe

Well Baby Check-Ups: Newborn to 2 Months

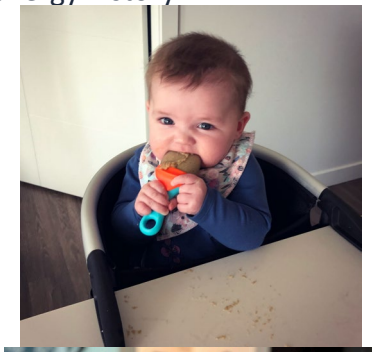
- **3 days of age (earliest post-discharge):**
  - Evaluate weight, feeding, hydration, hyperbilirubinemia
- **1 week:**
  - Evaluate weight, feeding, sleep for baby and parent
- **2 weeks:**
  - Baby should have regained birth weight; check maternal mental health
- **1 month:**
  - Weight, feeding, sleep patterns; maternal wellbeing and breastfeeding support
- **2 months:**
  - **First immunizations; developmental assessment, weight check****

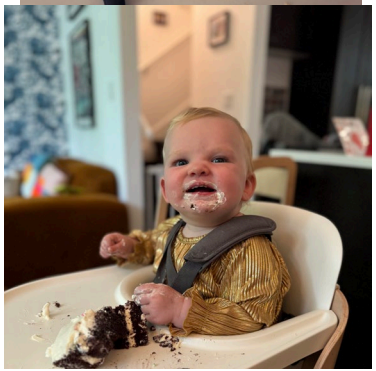
Well Baby Check-Ups: 2 Months to 2 Years

4 months	Second immunizations; developmental assessment; discuss introduction of solids
6 months	Third immunizations; developmental assessment; discuss flu and COVID vaccinations
9 months	No routine immunizations (except influenza in season); developmental assessment
12 months	Immunizations (1st MMR); developmental assessment
18 months	Immunizations; developmental assessment
4-5 years	Finish primary vaccine series and prepare records for transfer to Public Health via Kindergarten registration

Feeding, Nutrition & Behaviour

- **Baby-led weaning**
  - Introduce textured foods at approximately 5-6 months, including nut butters — even for families with allergy history
  - Stress early and frequent introduction of allergenic foods
  - No honey and no milk until 12m, introduce allergens during the day
- **Food allergies vs. food intolerances**
  - Food intolerance: usually resolves after waiting 1-2 weeks and re-introducing the food
  - True food allergy: rare, serious and there is time to call for help
  - Most common allergens: egg, milk, peanut, soy, fish/shellfish, tree nuts, wheat
  - No increased risk for siblings of children with allergies — introduce allergenic foods early for all infants
- **Constipation**
  - Often begins with introduction of pablum / iron-fortified cereals
  - Laxative of choice: PEG-3350 (polyethylene glycol) ~0.4–1g/kg/day
- **Behavioural & parenting issues**
  - Common at this age — normalize and support parents





Upper Respiratory, GI, Dermatology & Hearing

- **Upper respiratory infections (influenza, common cold)**
  - 95% of the time, these are viral
  - Avoid OTC cough medicines in children under 6 years (Health Canada)
- **Gastrointestinal infections (Giardia, Campylobacter)**
  - Investigate for other causes when symptoms are prolonged or severe
- **Dermatology (Molluscum, eczema, bites)**
  - Assess eczema for food allergy — though food allergies do not cause eczema but they often co-occur
  - Review skin hygiene; frequent bathing can exacerbate eczema
- **Childhood immunizations**
  - Current BC schedule: January 2026 — healthlinkbc.ca/health-library/immunizations/schedules/children
- **Hearing and speech**
  - Free vision, audiology, and speech assessments through Health Units before school age 5
  - After age 5: you can refer for audiology until age 18 but SLP services are access through school

Resources: 0–5 Years

For parents:

- Baby's Best Chance — healthlinkbc.ca/babys-best-chance
- Toddler's First Steps — healthlinkbc.ca/toddlers-first-steps
- Toilet training: kidshealth.org
- Child of Mine — Ellen Satter (book)
- Baby-led Weaning — Gill Rapley (book)
- Between Parent and Child — Dr. Haim Ginott (book)

For physicians:

- Rourke Baby Record (2024 edition) — rourkebabyrecord.ca
- BC Immunization Schedule (January 2026) — healthlinkbc.ca/health-library/immunizations/schedules/children
- Lifetime Prevention Schedule — BC Ministry of Health
- Confident Parents, Thriving Kids — welcome.cmhacptk.ca (ages 3–12, requires referral)
- BC Poison Control: 1-800-567-8911

Elementary School-Age Children

6–12 Years

SCHOOL AGE 6–12

Yearly School-Age Check-In

Regular school-age check-ins are an opportunity to inquire about:

- Academic performance and learning
- Fine motor skills, physical coordination
- Sports participation and physical activity
- Social relationships and peer dynamics
- Healthy eating habits
- Emerging concerns about drugs, alcohol, and sexual health (age-appropriate, introduced gradually)

Lifetime Prevention Schedule (BC Ministry of Health)

SCHOOL AGE 6–12

Greig Health Record — 2025 Edition

Use the 2025 Greig Health Record for all preventive care visits ages 6–17. Available at: greighealthrecord.ca

Poverty screening

Ask: 'Do you ever have difficulty making ends meet by the end of the month?' — nearly 1 in 7 Canadian children lives in poverty

Contraception

Updated to include LARCs (long-acting reversible contraceptives) per SOGC guidelines

Confidentiality & consent

Updated section aligned with the mature minor doctrine — directly relevant to our discussion of capacity

MenB vaccine

Updated dosing guidance now included

Menstrual health history

New standard section — should be part of every adolescent assessment

New sections

Adverse Childhood Experiences, Eating Disorders, 2SLGBTQI+ Resources, Mpox, TB Screening, Refugees & Newcomers

Resources: 6–12 Years

For parents:

- Confident Parents, Thriving Kids (ages 3–12) — welcome.cmhacptk.ca
- Free for BC families with behavioural or anxiety concerns
- Requires physician referral

For physicians:

- Greig Health Record (2025 edition) — greighealthrecord.ca
- BC Guidelines — bcguidelines.ca
- Caring for Kids (CPS) — caringforkids.cps.ca

Also relevant to this age group:

- Child Health BC — childhealthbc.ca (mental health resources, vital signs, pathways)
- UBC CPD Foundations of Pediatric Care — ubccpd.ca/course/pediatric-foundations (excellent review 0–18 years)

Adolescent Health

13–18 Years

Structure of Adolescent Visits

- **Offer private time — always**
  - Offer the adolescent time alone for at least part of the appointment, whether in-person or via televisit
- **Invite parents in after speaking privately with the adolescent**
  - If parents are present with the adolescent's consent, remind the patient that whatever you discuss, the parents will know about
- **Option to ask the parent to step out**
  - This shift in dynamic often opens important conversations the adolescent would not have in front of their parents
- **Build self-advocacy**
  - Teach the adolescent to become their own health advocate

Key Principles of Adolescent Care

- **Confidentiality builds trust**
  - Be explicit about the limits of confidentiality before sensitive conversations begin
  - Duty to report always applies: if a patient discloses a risk to themselves or others, you have an obligation to report
- **HEADSSS framework — use as a guide for psychosocial interview**
  - Home, Education/Employment, Activities, Drugs/Dieting, Sexuality, Suicide/Depression, Safety/Violence
- **Televisit considerations**
  - Confirm the adolescent is alone and can speak freely before beginning sensitive portions of a televisit
- **Cultural considerations**
  - Children often do not want to be disrespectful to parents; parents feel responsible for children's health
  - Navigate the parent–child dynamic in the room with cultural sensitivity and respect

CASE STUDY

Case Study: Jessica (16 years old)

The scenario:

Jessica (16) has an appointment with you, her family physician. She comes into your office with her mother Barbara.

Jessica is sitting in the corner on a stool. Barbara is sitting closer to you. You ask Jessica what brings her in today. Jessica mumbles to her mother: 'You tell her.'

Barbara tells you that things have not been going well at home. Jessica doesn't want to go to school and stays in her room on her phone all day. At which point, Jessica rolls her eyes at her mother.

You notice this interaction and ask Jessica if there is anything she would like to tell you. Jessica responds with another mumble.

BREAKOUT SESSION

Discussion: What Would You Do?

Discuss in small groups, then report back:

- How would you approach this appointment?
- How would you manage the parent–child dynamic in a way that is respectful of both parties?
- What cultural factors might be at play, and how would you navigate them?
- At what point, if any, would you ask Barbara to leave the room?
- What concerns would you want to screen for with Jessica privately?

Resources: Adolescent Health

For parents & adolescents:

- Foundry BC (mental health support, 12–24) — foundrybc.ca
- Kelty Mental Health (BC Children's) — keltymentalhealth.ca
- Sexual health — sexandu.ca
- HPV information — hpvinfo.ca
- Crisis Centre BC — crisiscentre.bc.ca

For physicians:

- Greig Health Record (2025 edition) — greighealthrecord.ca
- COMPASS - https://www.bcchildrens.ca/clinics-services/compass-mental-health
- Provincial Eating Disorders Program: https://www.bcchildrens.ca/clinics-services/eating-disorders
- TransCare BC: https://www.transcarebc.ca/

Common Reasons for Pediatric Visits in Family Practice

Common Reasons for Pediatric Visits

What have you seen in your practices?

- Allergies / Asthma
- Eczema
- Acne
- Fever
- Upper respiratory infection
- Lice
- Urinary tract infection
- Musculoskeletal injuries
- Head injuries / Concussion
- Weight-related health
- Gastrointestinal infection
- New-onset Celiac disease
- New-onset Juvenile Diabetes Type I
- Juvenile-onset arthritis
- Eating disorders
- Depression
- Anxiety / ADHD
- Toileting

COMMON REASONS

Fever & Upper Respiratory Infections

- **Fever in infants under 2 months — unique risk**
  - Unique risk for serious bacterial infection; full workup indicated: LP, UA, CBC, CXR, stool culture (if diarrhea with blood/mucus)
  - History: immunization status, exposures, birth history
- **Upper respiratory infections**
  - 95% of the time these are viral — antibiotics are not indicated
  - Avoid OTC cough medicines in children under 6 years (Health Canada)
  - Otitis media: observe 48–72 hours with pain management; treat with antibiotics if worsening
  - Pain management: ibuprofen AND acetaminophen can be used, but keep a log of time and dose

Eczema

- **Assessment:**
  - Assess for food allergies (though food allergies do not cause eczema)
  - Review skin hygiene — frequent bathing can exacerbate eczema
- **Treatment options:**
  - Betamethasone 0.1% for short periods
  - Protopic / Elidel (no lymphoma causation established)
  - Eucrisa (crisaborole)
  - OTC options: CeraVe, Aveeno Eczema Care, avocado oil
- **Education, education, education**
  - Families need to understand triggers, bathing technique, and moisturizer application
  - UBC CPD Atopic Dermatitis module — ubccpd.ca

Lice Infestations

- **Treatment:**
  - 1% permethrin cream rinse — repeat at 7 days
  - Nit-picking is easier on wet hair with lots of conditioner
- **Environmental management:**
  - Cleaning of fomites (bedding, hats, brushes)
  - Treat all close family members simultaneously
- **Important point for parents:**
  - Nits are NOT a reason for exclusion from school or daycare

Urinary Tract Infections

- **First-line treatment:**
  - Cephalexin 50–100 mg/kg/day in 2 divided doses
  - Note significant resistance to Septra and Amoxicillin — check local antibiogram
- **Investigations:**
  - Renal bladder ultrasound after second febrile UTI OR in any child under 2 years with a febrile UTI
  - Voiding cystourethrogram (VCUG) if indicated by ultrasound findings
  - Prophylactic antibiotics: NOT recommended for recurrent infections

COMMON REASONS

Acne

Don't let kids scar — treat early and effectively

Three topical medication families:

- Antibiotics: clindamycin or erythromycin 2% ± hydrocortisone 1% in Cetaphil
- Retinoids: e.g., Retin-A
- Benzoyl peroxide or combination (e.g., TactuPump/TactuPump Forte)

Three oral medications:

- Antibiotics: doxycycline 100 mg daily × 3 months (max 6 months)
- Retinoids: Accutane 10–40 mg daily × 3–6 months — use flow sheet with monthly bloodwork
- Oral contraceptive (female patients): consider OBCP in girls older than 12

Can use both topical and oral retinoids in children older than 12. No food causality has been established for acne.

UBC CPD Atopic Dermatitis module: ubccpd.ca

COMMON REASONS

Closed Head Injury & Concussion

First priority: remove from play immediately

Assessment tools:

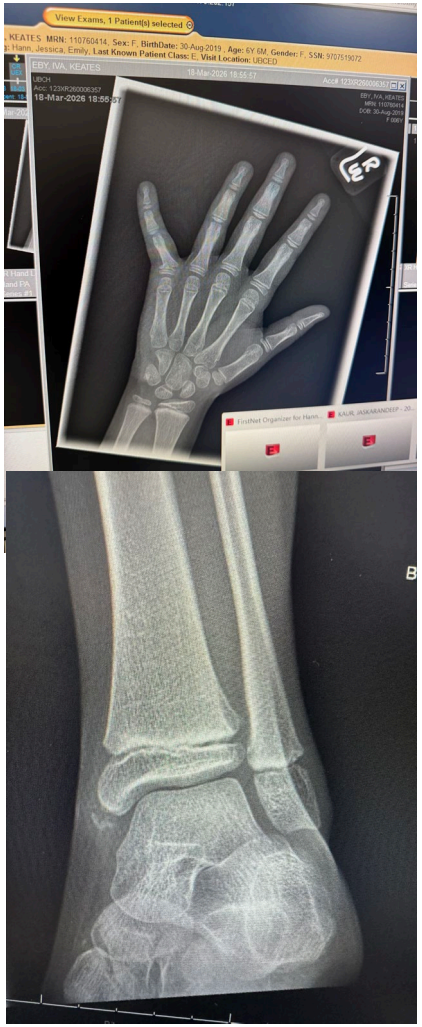
- **Child SCAT6 (ages 8–12):**
  - Use within 72 hours (ideally), up to 7 days post-injury. Free at cattonline.com
- **SCAT6 (age 13+):**
  - Same timeframe. Also at cattonline.com
- **If >7 days post-injury:**
  - Use the SCOAT6 (Sport Concussion Office Assessment Tool 6)

Return to activity (staged protocol):

1. Remove from play	**2. Reduce stimuli (24–72 hrs max)**	**3. Return to learn first**	**4. Light exercise → practice → game**

Musculoskeletal Injuries

- **Core principle: when in doubt, x-ray**
  - Fractures are more common than sprains before the growth plate closes
  - Mechanism of injury matters — always take a careful history
- **Red flags for non-accidental injury:**
  - 9–36 months: child refusing to weight-bear with minimal or no trauma → x-ray
- **Ottawa Ankle Rules:**
  - 98.5% sensitive in children older than 6 years — use confidently in this age group



COMMON REASONS

Weight-Related Health

- **Use BMI as a screening tool from age 2 onward — not as a standalone diagnostic metric**
- BMI must be interpreted alongside physiological and functional health indicators
- Catch excess adiposity early — but frame conversations around health behaviours, not weight
- **5-2-1-0 guidance (for young children):**
  - 5 fruits & vegetables daily
  - Under 5 years: limit screen time (≤1 hr/day for ages 2–5; none under 2)
  - Ages 5+: CPS 4 M's framework — Manage, Meaningful, Model, Monitor
  - 1 hour of active play daily
  - 0 sweetened beverages; no more than 6 added tsp sugar/day in processed foods
- **Involve parents — model healthy behaviours at home**
- Address social determinants of health — poverty, food security, and neighbourhood affect weight

DISCUSSION

What Have You Seen in Your Practices?

- What common paediatric presentations have been most familiar from your training?
- Which conditions listed are less common in your country of origin — and which might be more common here in Canada?
- What clinical approaches feel similar, and what feels different?

Challenging Pediatric Visits in Family Practice

Mental Health: Anxiety & Depression

Screening tools:

- Anxiety: GAD-7 and SCARED Questionnaire
- Depression: PHQ-9 (or PHQ-2 as initial screen)
- Both: Kutcher Adolescent Depression Scale (KADS)

Key resources:

- Kelty Mental Health — keltymentalhealth.ca
- Foundry BC (12–24) — foundrybc.ca
- Taming the Worry Dragons — Dr. Jane Garland (book)

COMPASS MENTAL HEALTH
https://compassbc.ca/
1-855-702-7272

ADHD & Autism Spectrum Disorder (ASD)

ADHD — Canadian ADHD Resource Alliance (CADDRA)

- CADDRA questionnaire available at caddra.ca — helps differentiate ADHD from ASD
- Comprehensive assessment guidelines and tools for primary care
- Consider co-morbidities: learning disabilities, anxiety, and mood disorders frequently co-occur

Autism Spectrum Disorder (ASD)

- Autism BC — autismbc.ca
- Autism Canada — autismcanada.org
- Psychoeducational assessments: available through school systems or privately
- School counsellors are key partners in the assessment and support process

Learning Disabilities & Giftedness

- **Learning disabilities:**
  - Often identified through school performance — involve teachers and school counsellors early
  - Psychoeducational assessment: can be provided by the school board or arranged privately
  - Family physician's role: provide medical context, rule out contributing conditions (vision, hearing, sleep), advocate for assessment
- **Giftedness:**
  - Can be as challenging as learning disability — giftedness can mask or co-occur with learning difficulties
  - School counsellors and educational psychologists are the primary support
- **Resources:**
  - School counsellor — first point of contact
  - Psychoeducational assessment (school-provided or private)

Bullying, Gender Identity & Sexual Health

- **Bullying:**
  - Screen for bullying (including cyberbullying) at every adolescent visit — it is common and underreported
- **Gender identity:**
  - Use preferred pronouns and names; non-judgmental approach essential
  - 2SLGBTQI+ youth have significantly higher rates of mental health concerns — screen proactively
  - Resources: Foundry BC, Kelty Mental Health, TransCare BC
- **Sexual health and contraception:**
  - Introduce age-appropriately from early adolescence; discuss STI prevention and contraception proactively
  - STI resources: BCCDC — bccdc.ca/health-info/diseases-conditions/sexually-transmitted-infections

Substance Use: CRAFFT Screening (Version 2.1)

CRAFFT 2.1 — Use the self-administered version. Score ≥2 warrants further assessment. crafft.org

Part A — Ask about use in the past 12 months:

- Alcohol (more than a few sips)
- Marijuana or cannabis — including vaping or edibles
- Other substances (prescription misuse, illicit drugs)

Part B — The CRAFFT questions (if any Part A use, or for Car question always):

C — Car: ridden in a car with someone who was high or had been using?	F — Forget: forget things you did while using?
R — Relax: use to relax, feel better, or fit in?	F — Friends/Family: told you should cut down?
A — Alone: use while alone?	T — Trouble: gotten into trouble while using?

DISCUSSION

Questions: Challenging Pediatric Visits

- What challenging paediatric visits are you most likely to encounter here in BC?
- How does the approach to adolescent mental health differ from your previous practice context?
- What surprised you most about the resources available in BC for children and youth?

Topics of Controversy in Paediatrics

CONTROVERSY

Immunization Refusal

Communication approach:

- **Your recommendation is the single strongest factor in a parent's decision to vaccinate**
- Start with a positive, presumptive statement — assume the child will be vaccinated
- Be non-judgmental; ask about specific worries rather than making assumptions
- Frame benefit primarily to the individual child, not to herd immunity
- Acknowledge common side effects honestly — such as muscle pain or injection area redness
- For firmly opposed parents: state your recommendation clearly, then leave the door open

Resources:

Immunization Communication Tool for Immunizers (BC) — immunizebc.ca (note: content now at HealthLink BC) · Immunization schedule: healthlinkbc.ca/health-library/immunizations/schedules

CONTROVERSY

Circumcision

- **Non-therapeutic circumcision is not covered by MSP in BC**
- Cost: approximately $500–$1,000
- **If performed:**
  - Best done early, by an experienced practitioner
  - Adequate pain management is essential — both topical and subdermal
- **CPS position statement on circumcision:**
  - cps.ca/documents/position/circumcision
- **Group discussion:**
  - How does the approach to circumcision differ from your countries of origin?

Child Physical Abuse & Neglect

Reporting Child Abuse: MCFD & Indigenous Governing Bodies

Required by law to report possible child abuse up to age 19.

Who to report to — determine jurisdiction first:

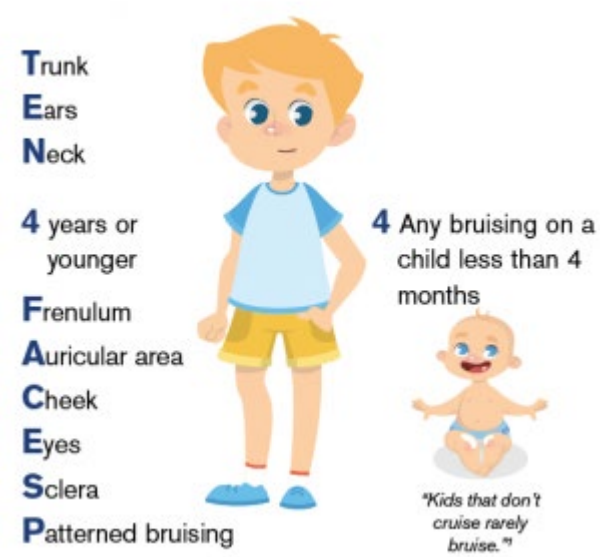
- **For Indigenous children:**
  - BC Bill 38 (2022) recognizes the inherent jurisdiction of Indigenous Governing Bodies (IGBs) over child and family services. Before defaulting to MCFD, determine whether the child is Indigenous and whether an IGB holds jurisdiction.
  - Where an IGB has assumed jurisdiction, report to that body such as VACFASS
- **For non-Indigenous children, or where no IGB jurisdiction applies:**
  - Report to Ministry of Children and Family Development (MCFD)
  - Provincial Centralized Screening: 1-800-663-9122 (24 hours)
- **Five SCAN teams in BC:**
  - For Suspected Child Abuse and Neglect
  - Vancouver, Surrey, Kamloops, Nanaimo, Prince George — consult when in doubt

Child Physical Abuse & Neglect: Red Flags

Identify and intervene before escalation.

- An unexplained or implausible mechanism of injury in a child
- Injury pattern inconsistent with the child's developmental stage
- Multiple injuries at different stages of healing
- Delay in seeking medical care
- Child's affect, behaviour, or disclosure

- HELPLINES
  - Ministry of Children and Families: 1-800-663-9122
  - Helpline for Children: 310-1234 (no area code)
  - Kids Help Phone: 1-800-668-6868 or text 686868



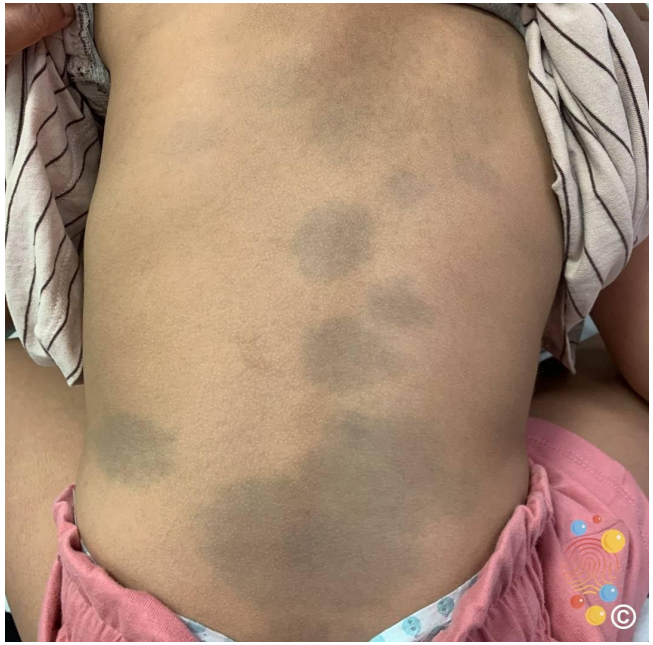
Example red flag:

An 8-year-old who 'fell off their bike' but presents with injuries inconsistent with that mechanism — always consider the possibility of abuse.

Child Abuse Imitators

Congenital Mongolian Blue Spot

- Flat, blue-grey pigmented lesion, typically on the sacral area or lower back
- Common in infants of Asian, Indigenous, Black, and Hispanic descent
- Benign — fades over time; no treatment required
- **Critical: document at birth or first well-baby visit to prevent future misinterpretation as bruising**
- If not documented at birth and discovered later, it can appear suspicious to a new provider



GROUP DISCUSSION

Child Abuse in Your Countries of Origin

- What is your experience with child abuse reporting and intervention in your country of origin?
- How does the role of the physician in identifying and reporting child abuse differ from your previous practice?
- What aspects of the Canadian/BC approach are most different from your experience?

Resource: BC Government — gov.bc.ca: search 'reporting child abuse' · Phone: 1-800-663-9122

Pediatric Emergencies

Paediatric Emergency Pearls

Swallowed battery vs. coin

Button batteries are a surgical emergency — cause rapid tissue necrosis. X-ray: battery shows a 'double ring' halo sign vs. single ring of a coin. If in doubt: treat as battery.

Appendicitis

Highly variable presentation, especially in young children. Low threshold for investigation and referral.

Testicular / ovarian torsion

Lower abdominal pain at any age is torsion until proven otherwise. Time is critical — refer to ER immediately.

Intussusception

Most common abdominal surgical emergency in children under 2. Episodic severe colicky pain with 'red currant jelly' stool — send to ER.

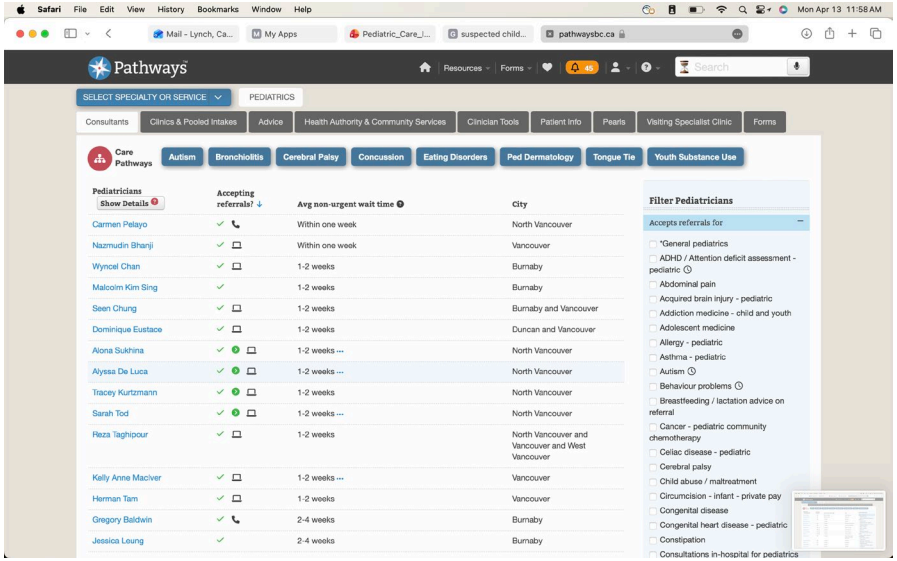
Resources

For Families and Physicians

RESOURCES

When to refer?

- Treatment has not been effective
  - Refractory to antibiotics
  - Resp symptoms despite puffer initiation
  - Persistent urinary issues
- Diagnosis is unclear
  - Poor weight gain
  - Skin concern NYD
  - Teenager not responding to SSRIs
- BC Children's has specialty clinics
  - Optho, Nephro, Ortho, Endo, etc
  - However, sometimes fastest consult is through a community Pediatrician



Resources for Parents

General:

- HealthLink BC — healthlinkbc.ca / call 8-1-1
- Safe Kids Canada — parachute.ca
- Caring for Kids (CPS) — caringforkids.cps.ca
- About Kids Health (SickKids) — aboutkidshealth.ca
- Poison Control: 1-800-567-8911
- Red Book Community Resources — redbookonline.bc211.ca
- Baby's Best Chance — healthlinkbc.ca/babys-best-chance
- Toddler's First Steps — healthlinkbc.ca/toddlers-first-steps

Mental health & support:

- Kelty Mental Health — keltymentalhealth.ca
- Foundry BC (12–24) — foundrybc.ca
- Eating disorders — nedic.ca
- Asthma Canada — asthma.ca
- HPV info — hpvinfo.ca
- Concussion awareness — cattonline.com
- Autism BC — autismbc.ca
- Sexual health — sexandu.ca
- STI (BCCDC) — bccdc.ca/health-info/diseases-conditions
- Crisis Centre BC — crisiscentre.bc.ca
- CADDRA – caddra.ca

RESOURCES

Evidence-Based Resources for Physicians

Clinical tools:

- Rourke Baby Record (2024) — rourkebabyrecord.ca
- Greig Health Record (2025) — greighealthrecord.ca
- BC Guidelines — bcguidelines.ca
- UpToDate — subscription service
- Canadian Paediatric Society — cps.ca
- BC Children's Hospital / Child Health BC — childhealthbc.ca
- BCCDC (immunizations, outbreaks) — bccdc.ca
- CADDRA (ADHD) — caddra.ca
- Pathways – pathways.ca

Education & schedules:

- Immunization schedule (Jan 2026) — healthlinkbc.ca/health-library/immunizations/schedules/children
- Lifetime Prevention Schedule — BC Ministry of Health (verify current version)
- CPSBC Consent of Minors (Infants Act) — cpsbc.ca
- UBC CPD Foundations of Paediatric Care — ubccpd.ca/course/pediatric-foundations
- Vital Signs 0–18 — childhealthbc.ca/media/224/download (verify active)
- College of Family Physicians of Canada — cfpc.ca

Summary

- **We reviewed the three key considerations for paediatric practice in BC: Culture, Consent, and Communication**
- We covered the Mature Minor Doctrine, the foundational consent framework in BC
- **We reviewed common and challenging paediatric reasons to visit the family doctor across all age groups**
- We looked at key clinical tools: Rourke Baby Record 2024, Greig Health Record 2025, CRAFFT 2.1, Child SCAT6
- **We discussed child welfare reporting, including the role of Indigenous Governing Bodies in BC**
- A comprehensive resource list has been provided — for both parents and physicians

Family physicians are in a unique position to establish long, trusting relationships with families and their children.

Regular visits at appropriate intervals build rapport.

Encourage children and their parents to become their own advocates for health.

Good luck on your path to a career in family medicine in Canada.