P400-6th ANNUAL FAMILY MEDICINE RESEARCH DAY
P400-6e JOURNÉE ANNUELLE DE RECHERCHE EN MÉDECINE FAMILIALE

	RESEARCH DAY • JOURNÉE DE RECHERCHE			
0815-0830	**WELCOME / BIENVENUE**			
	FREE-STANDING RESEARCH PAPERS			
0830-0850	Physician self-care and wellness: 21-year trends in Alberta family medicine graduates	Rural birth narratives: The Marathon Maternity Oral History Project Objective	Do-Not-Resuscitate awareness: Are patients well-informed?	CPCSSN: Practice recruitment and retnetion process
0850-0910	The impact of less than collegial workplace interactions for Canadian family physicians	Epidemiology of obstetrical outcomes for rural women: An examination of residential proximity and hospital level of service	Physicians' knowledge, experience and practice about mood and sexual effects from hormonal contraception	CPCSSN: Discussion of ethics and privacy
0910-0930	"No, I don't have a family doctor." Rural physicians' experiences with orphaned patients in Southwestern Ontario	HIV self-management support for Aboriginal and non-Aboriginal peoples living in Vancouver's Downtown Eastside	Do family physicians correctly estimate the benefits and risks of common therapeutic and preventive interventions?	CPCSSN: Preliminary results from the CPCSSN project: A work in progress
0930-0950	Patients' perspectives on utilization of and access to academic family health teams	A comprehensive needs assessment of BC physicians' self-reported practices, barriers, and attitudes re: recommended cancer screening	Building access through expertise	CPCSSN: How to harmonize CPCSSN's research and surveillance agendas
0950-1010	Coronary artery disease screening and primary prevention: Evidence review and tool identification for The BETTER Project	Managing illness on-site: A survey of residential care facilities in one large health authority in British Columbia	Qualitative analysis of commitment-to-change statements: Can they predict implementation of new practice behaviours?	
1010-1100	**BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES***			
1100-1120	A survey of practice models and payment preferences of recent family medicine residency graduates in BC	A comparison of diabetes and cardio-metabolic outcomes between T2D patients under specialists' care and primary care	Diabetes screening and primary prevention: Evidence review/tool identification for The BETTER Project	
1120-1150	Experiences from the forefront of EMR implementation and use in Canadian primary care			
1200-1330	**Section of Researchers AGM and Lunch**			
1330-1500	Presentations by Award winners			
1500-1530	**BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES***			
1530-1545	Family physicians as mentors: Passing on the torch	Improving the success of your application to the CIHR Knowledge Review and Synthesis Panel	The play's the thing: Using research-based theatre to increase empathy and disseminate research findings	Successful grants at CIHR: A peer reviewer's perspective
1545-1600	Conquering the acculturation process: The IMG experience			
1600-1615	The number and types of problems managed by family medicine residents during patient encounters			
1615-1630	The Family Medicine Longitudinal Experience (FMLE): The follow up			

0800-0815 WELCOME / BIENVENUE

0830-0850:

Physician self-care and wellness: 21-year trends in Alberta family medicine graduates

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Context: Physician health and wellness is receiving increasing attention in medical education and practice. **Objective:** To examine trends in preparedness for dealing with physician self-care and wellness of family medicine graduates in Alberta, Canada. **Methods:** Cross-sectional surveys were conducted in 1997, 2002 and 2007 of graduates who completed the family medicine residency training program at University of Alberta or University of Calgary between 1985 to 2005. Some questions were common to the 3 surveys including 'Please indicate the degree to which the residency program prepared you for dealing with physician self-care and wellness'. The data from the 3 surveys has been pooled to analyze trends over 21 years. For analytical purposes, four cohorts were created: Cohort 1 (1985-90) 218 (22.6%), Cohort 2 (1991-95) 222 (23.0%), Cohort 3 (1996-2000) 282 (29.3%) and Cohort 4 (2001-05) 242 (25.2%). SPSS 16 is being used for descriptive analysis (frequency, crosstabs), along with Chi-square. Alpha has been set at 0.05. **Results:** A total of 1448 graduates were mailed the questionnaire. 966 completed the survey, representing

a pooled response rate of 66.7%. There was a statistically and educationally significant incremental increase in preparedness for physician self-care and wellness from 47.2% of cohort 1 (1985-90) to 78.2% of cohort 4 (2001-05) ($p < .05$). An increase in preparedness for self-care was also observed for age when younger (<30) and older (= 30) respondents were compared, (60.6% vs. 69.9%; $p < .05$). There was no difference in self care preparedness by gender or practice location. Additional data analysis is currently underway. **Conclusion:** Preparedness for physician self care and wellness has not only increased significantly and incrementally over the 21 year span, but with age of respondent as well. While gratifying, the precise reasons for these changes are not self evident and are likely multi-factorial. Further investigation is required.

Rural birth narratives: The Marathon Maternity Oral History Project Objective

Aaron Orkin, MD, CCFP, *Hamilton, ON* *Sarah Newbery,* MD, CCFP, FCFP, *Marathon, ON*

This project is about listening and bearing witness to birthing stories. The project aims to uncover how maternity care is understood and by members of a small community where those services are provided by family physicians, and to place these stories within the context of rural maternity services in Canada. Through the personal narratives of women and healthcare providers, the project aims to generate discussion, inspire others, share emotions and ideas, and offer readers new insights about their own birthing experiences, communities, and relationships. **Design:** The project developed and employed a novel oral history and narrative medicine research methodology. **Setting:** The project was conducted in Marathon, Ontario, a community of approximately 3500 people on the north shore of Lake Superior, in cooperation with the Wilson Memorial Hospital, Marathon Family Health Team, and Northern Ontario School of Medicine. **Participants:** Participants included a purposive selection of mothers, grandmothers, nurses, and physicians in the Marathon medical catchment area. **Method:** Unstructured depth interviews were conducted with all participants. Interviews were conducted non-anonymously. Interview transcripts were edited into short narratives. Participants read and reviewed the narratives prior to publication. The narratives are to be presented as a book-form anthology. **Main findings:** Twelve narratives were developed, each revealing unique ideas, emotions, personality and analysis. Each narrative describes a specific range of personal experiences and findings. Narratives re-personalize and humanize medical research by offering researchers and practitioners the opportunity to bear witness to the personal stories affected through medical decision-making. **Conclusion:** Oral histories offer perspectives not revealed in other quantitative or qualitative research methodologies. Marathon's stories may contribute to understanding the meaning and challenges of local birthing, and the implications of losing maternity services in rural Canada. Sharing personal birthing experiences may inspire others to re-evaluate and reconsider birthing practices and services in other communities.

Do-Not-Resuscitate awareness: Are patients well-informed?

Claire Robinson, MD, CCFP, *Vancouver, BC* *Sharlene Kolesar,* MD, CCFP, *Vancouver, BC*

Background: The 'Do-Not-Resuscitate' (DNR) order is one of the most important decisions in patient care, yet it is an area that often lacks physician patient communication. **Objective:** To explore outpatient understanding and prior experience with Do-Not-Resuscitate (DNR) decisions, and to determine if, when, and with whom patients prefer to have this discussion. Design: Cross sectional survey. **Setting:** Primary care physician offices in Vancouver, British Columbia. Participants: Consecutive family practice patients aged 40 and up presenting for routine care. **Methods:** Between March and May 2009, 429 surveys were offered to eligible primary care patients in 4 outpatient offices. **Main outcome measures:** Questions examined awareness and knowledge of the term DNR, when, where, and with whom patients wish to have a DNR dialogue. Sex, age, and ethnicity of respondents were compared with responses by using chi square tests to analyze cross tabulations. **Results:** Overall response rate was 90% (386/429 surveys). 83% of those surveyed had an accurate understanding of what DNR means. 69% had contemplated DNR for their own care and this was determined by age (p 0.02). 83% felt that discussions about DNR should occur with their family physician. 8% had discussed this with a health care provider. 56% felt that such a discussion should occur when they are healthy. 46% reported discussion should take place in the office setting. 16% of patients found this topic stressful. **Conclusion:** The majority of respondents were aware of the term 'DNR' and understood the concept, but had not discussed it with their health care provider. Based on our findings, patients wish to discuss DNR with their family physician and do not find the topic stressful. Family physicians need to initiate DNR discussions with our patients earlier and when patients are still leading a good quality of life.

The Canadian Primary Care Sentinel Surveillance Network: Practice recruitment and retention project

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CPCSSN is the first pan-Canadian primary care based surveillance network, currently focused on chronic diseases. Data is provided by sentinel family physicians across the country that use EMRs. These physicians allow CPCSSN to collect specific information about their patients and transfer the de-identified data to a secure central server allowing for collation of the data from multiple sites into a single database. We will discuss issues around the process of recruitment of family physicians into this innovative project. Issues include: i) How physicians are approached and informed about the privacy and security of their patients data; ii) the physician and practice information that is collected, iii) the practice profile feedback reports provided to the physicians each quarter with comparisons to local and national peer groups; iv) the Mainpro-C process that can be utilized by physician sentinels, and v) recruitment strategies that maximizes representativeness such as male/female (physicians and patients), rural vs. urban, SES, etc.

0850-0910:

The impact of less than collegial workplace interactions for Canadian family physicians

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Vivian Ramsden, RN Ph, *Saskatoon, SK* *Donna Manca,* MD, MClSc, CCFP, FCFP, *Edmonton, AB*
Francine Lemire, MD, CCFP, FCFP, *Mississauga, ON* *Ryan Hamilton,* MSES, *Fredericton, NB*

Objective: To determine the incidence and impact of workplace abuse toward family physicians from colleagues and co-workers. **Design:** A mixed methods study which included a seven page survey and telephone interviews. The survey was sent to family physicians in active

practice, and it included an invitation for an interview. **Participants and Setting:** The CFPC membership list was used to randomly select family physicians to whom 3802 surveys (536 French & 3266 English) were mailed. **Main outcome measures:** Incidence of abusive encounters at the hand of colleagues or co-workers and qualitative data derived from the interviews. **Results:** A total of 770 (20.3%) completed surveys were returned (56% female) and 37 interviews were conducted (four in French). The majority of individuals who abused physicians were patients and patients' families. In addition to this, 14.5% of the respondents reported they had been abused by a colleague (8.7%) or a co-worker (5.8%) at least once; and half of the respondents indicated that they had been abused by the same colleague or co-worker more than once. The majority of abuse by colleagues was perpetrated by males (77.6%) while the majority of abuse by co-workers was perpetrated by females (76.7%). In the majority of cases, the abuser was not in a position of authority (37%) and some of the abuse occurred over the telephone (11.9%). Family physicians who had been abused told stories of being made to feel humiliated, unappreciated, depressed and extremely stressed by the experiences. Some of the physicians terminated their employment at a given workplace, or refused to participate in certain work shifts as a result of the abuse. **Conclusion:** A small number of family physicians experience abuse by colleagues and co-workers. This abuse can have a significant impact on their careers, their mental health and their general sense of well-being. **Acknowledgement:** Research was funded by CIHR grant MOP-86475.

Epidemiology of obstetrical outcomes for rural women: An examination of residential proximity and hospital level of service

F. Kris Aubrey-Bassler, MSc, MD, CCFP, *St. John's NL* *Richard Cullen,* MSc, *St. John's, NL*

Introduction: Research suggests that adverse obstetrical outcomes are all greater for women with poor access to obstetrical care at their home hospital, even though those women are usually travelling to deliver at high volume, specialized centres. Thus, in determining the obstetrical outcomes for rural women, it appears as though proximity to care is more important than the level of service offered. Despite this, obstetrical programs in small rural hospitals are closing. This project is designed to determine the factors contributing to obstetrical outcomes in Canadian communities of all sizes, ranging from those with no services locally to those with the most highly specialized hospitals. For the current presentation, we will examine epidemiological data on the location of obstetrical deliveries (the delivering hospital's level of service [hospital volume, specialties of care providers, provider volumes, level of pediatric care] and its road distance from a woman's home). **Method:** Descriptive analysis of retrospective Canadian obstetrical and neonatal administrative data from April 1, 2006 to March 31, 2008. Hospital remoteness variables will be calculated using a geospatial digital road network. Outcome measures will be derived from a descriptive analysis of obstetrical data: percentage of women living within a given distance of different levels of hospital and percentage of women delivering at different levels of hospital. **Results:** The data provider is currently compiling the data. We hypothesize that a large percentage of rural women travel long distances to deliver at hospitals providing obstetrical services. Discussion will focus on the importance of offering obstetrical services in rural locations, despite the availability of these services in distant urban centres. **Conclusions:** Policymakers should consider the possibility of increased health risks when deciding to remove obstetrical programs from rural hospitals.

Physicians' knowledge, experience and practice about mood and sexual effects from hormonal contraception

Ellen Wiebe, MD, CCFP, *Vancouver, BC*

Objectives: The purpose of this study was to examine knowledge, experience and practice of physicians about mood and sexual side effects of hormonal contraception. **Method:** This was a mixed method study with a questionnaire survey of a random sample of family doctors and gynecologists plus their residents and interviews with a sub-sample. They were asked about the rates of mood and sexual side effects in the population and how they informed and advised patients about these side effects. The interviews were analyzed for themes. **Results:** There were 79 residents and 74 practicing physicians who completed the questionnaires (response rates of 42% and 54% of eligible residents and physicians). When asked what percentage of women complain of mood and sexual side effects, only 2 (1.3%) and 13 (8.2%) physicians gave the rate of "less than 1%", which is consistent with the product monographs. Practicing doctors were more likely to ask about sexual and mood side effects than residents at least sometimes (81.1% vs. 24.1 % for sexual and 86.3% vs. 40.5% for mood side effects. p=<.001). Practicing doctors were more likely to recommend switching to non-hormonal methods than residents (p<.001) and more likely to give more responses to this question (p=.001). Of the 92 women physicians who had previously used hormonal contraception themselves, 19 (20.7%) said they had mood side effects and 29 (31.5%) said they had sexual side effects. In the interviews, doctors discussed how they learned about side effects from their patients and how this changed their practice. **Conclusion**: Physicians' perceived rate of sexual side effects from hormonal contraception in the general population was higher than the <1% quoted in the product monographs. In the interviews, doctors talked about how they learned from their patients' experience.

The Canadian Primary Care Sentinel Surveillance Network: Discussion of ethics and privacy

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CPCSSN is the first pan-Canadian primary care based electronic record surveillance network, currently focused on chronic diseases. Sentinel family physicians across the country have agreed to allow CPCSSN to collect specific information about their patients from their EMR's. The aim is to extract health information while respecting patient privacy and to establish a data repository for the conduct of primary care surveillance and research. The de-identified data is transferred using high security data transmission methods, thus protecting the patients' privacy. The need to extract patient data from multiple EMRs, and multiple sentinel networks across Canada required the CPCSSN study to undergo rigorous ethical review by numerous jurisdictions. The sensitive nature of the patient information extracted, and the extensive scope of the study have combined to make CPCSSN's ethical considerations a unique and complex topic. This presentation will showcase the lessons learned from the process of obtaining ethical approval for the CPCSSN study.

0910-0930:

"No, I don't have a family doctor": A rural physician's experiences with orphaned patients in Southwestern Ontario

Rochelle L. Dworkin, MD, MClSc *(Candidate), London, ON* *Judith Belle Brown,* PhD, *London, ON*

Objective: To provide insights into the unique experiences of rural family physicians who provide medical care to patients in their communities who do not have a family doctor (orphaned patients). **Design:** Qualitative methods using in-depth interviews. **Participants:** Ten rural family physicians (6 males/4 females) in Southwest Ontario who work in their local hospital emergency departments. **Method:** This qualitative study used in-depth interviews that were audio taped and transcribed verbatim. The analysis was both iterative and interpretive. **Main findings:** The majority of participants identified the late 1990's as the beginning of the orphaned patient phenomenon, related to a diminution in primary health care physician resources. The participants articulated several challenges that they perceived orphaned patients were experiencing within the health care system, i.e. access to care, differentiated care and lack of continuity of care. The participants recognized the potential for less than optimal health outcomes for orphaned patients. The study participants also expressed both the personal and professional stress they have experienced in caring for orphaned patients. Finally the participants articulated solutions and strategies at both a systems and individual level. Chief among these solutions was the need for recruitment of more rural family physicians. **Conclusions:** Rural family physicians are in a position to treat orphaned patients throughout the spectrum of care and have recognized the challenges in dealing with this patient population. The stress of this situation raises the spectre of burnout and further diminution of health care resources. Strategies have been developed by these physicians to help resolve the orphaned patient phenomenon.

HIV self-management support for Aboriginal and non-Aboriginal peoples living in Vancouver's Downtown Eastside - the impact on antiretroviral adherence and uptake

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Paul Gross, MDCM, CCFP, *Vancouver, BC* *Tiffany Tam, Burnaby, BC* *Jeannette S. Pedersen, Vancouver, BC*
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Objective: Marginalized Aboriginal and non-Aboriginal peoples living with HIV face numerous health challenges and often lack the voice or power to effect meaningful change. The benefits of self-management support interventions have not been well examined in HIV. To improve HIV care outcomes, we created an HIV self-management support (PSMS) program based on principles of chronic disease management and traditional Aboriginal healing theory and have trained both peer and medical professional self-management coaches. The research objective is to evaluate the impact of an HIV PSMS program in an inner city setting on Antiretroviral (ARV) adherence and uptake. **Design:** Prospective Randomized Control Trial **Setting:** Inner city medical clinic, Vancouver BD (Vancouver Native Health Society) **Participants:** HIV-positive, 19 years or older, and on antiretroviral therapy or having a CD4 count < 350 cells/mm3. **Intervention:** Participants were randomized to one of three groups: (1) peer based coaching; (2) medical professional based coaching or (3) standard care. **Main outcome measures:** Antiretroviral (ARV) adherence and uptake. Adherence scores (based on the past 3 months of ARV pharmacy data) were measured at baseline, and again for the 3 months post PSMS intervention. A "change" in adherence was calculated for each participant. **Results:** 180 patients have been enrolled--54% Aboriginal, 27% female, 35% with stable housing. At base line, the median CD4 was 300, 79% were on ARVs, and the average adherence score was 73%. Preliminary results of the treatment groups show a 9% improvement in adherence, 20% increase in stable housing, 13% decrease in intravenous drug use, 13% increase in participants who received Pneumococcal vaccination, and a 6% increase self-efficacy score. **Conclusions:** Preliminary analysis indicates clinical and social benefit; however, completion of post intervention analysis is needed to determine the degree of PSMS effectiveness in the care of HIV.

Do family physicians correctly estimate the benefits and risks of common therapeutic and preventive interventions?

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Marie-Ève Larivière, MD, *Québec, QC* *Juan Carlos Ochoa,* MD, *Québec, QC* *Merlin Njoya,* MSc, *Québec, QC*

Introduction: Sharing information with patients about benefits/risks of therapeutic and preventive options is essential to the practice of evidence-based medicine and shared decision making. **Objective:** To determine the extent to which family medicine teachers and residents accurately perceive the benefits and risks of interventions commonly prescribed in family practice. **Methods:** All R1 and R2 from a family medicine residency program and teachers from a large urban family medicine unit were invited to complete an anonymous 36-item questionnaire before attending a class or meeting. Ten clinical scenarios, presenting 33 questions, covered common therapeutic/preventive interventions in primary care. Each question sought the physician's best estimate of the probability of a clinical event occurring within a specified time frame, with/without intervention, in a hypothetical population (N=1000). Based upon systematic reviews of RCTs, responses were deemed correct if they fell within the 90% confidence limits of the exact answer. Three more questions tested the participants' statistical literacy. **Results:** 122 physicians (18 teachers, 60 R1s, 44 R2s) completed the questionnaire. The mean score was 25% ± 12%, range: 0% to 52%. The teachers' mean score tended to be higher than those of the R1s and R2s (31% ± 7% vs. 24% ± 13% vs. 25% ±12%, p=0.09). The 91 respondents (75%) who correctly answered and the 31 (25%) who failed to correctly answer the three statistical literacy questions had similar mean scores (25% ± 11% vs. 25% ± 14%; p= 0.99). **Conclusion:** The physicians' poor estimates of the benefits and risks of commonly prescribed interventions in family medicine are a barrier to the implementation of shared decision making in primary care practice. Strategies to improve physician access to balanced clinical information, and tools to help them clearly translate this information to patients could foster better shared decision making in family practice.

The Canadian Primary Care Sentinel Surveillance Network: Preliminary results from the CPCSSN Project: A work in progress

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The Canadian Primary Care Sentinel Surveillance System began in 2008 and has expanded to 9 primary care research networks in 6

provinces. The first data extraction was done in June 2009 and there have been 3 successive data extractions of de-identified patient health information from electronic medical records of about 100 sentinel physicians across the country. This presentation will present data on patients with five chronic diseases from the third data extraction. Disease case definitions developed for the project for chronic obstructive lung disease, depression, diabetes, hypertension and osteoarthritis will be presented. Demographic data on sentinel patients will be provided as well as Initial findings of disease prevalence using the corrected yearly contact group method to calculate denominator, multimorbidity, risk factors and medication use. Implications and potential uses of this data will be discussed.

0930-0950:

Patients' perspectives on utilization of and access to academic family health teams

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K Kay, R Moineddin, A Otto, J Permaul, BSc(Hons), CCRP, D Telner, MD, MEd, CCFP S Tobin, MHSc, DFCM, University of Toronto, Toronto, ON

Objective: To explore the influence of early academic Family Health Team (FHT) implementation on patients' perceptions of and satisfaction with utilization and access to care. **Design:** Self-completed questionnaire. Randomized rotating survey administration among FHT sites in 2008. **Setting:** Waiting rooms of 6 academic Toronto FHTs affiliated with the University of Toronto Department of Family & Community Medicine. These FHTs had been funded from 14-19 months and FHT business plan implementation scores ranged from 5-9/10 (1=none to 10=full) as indicated by FHT administrators. **Participants:** FHT patients = age 18 attending appointments. **Intervention:** The FHT Patient Perceptions of Care questionnaire with questions from the Primary Care Assessment Tool (PCAT), Primary Care Access Survey (PCAS) and questions developed by the research team. **Main outcomes:** Responses to PCAT, PCAS and researchers' questions regarding utilization and access to academic FHT. **Results:** Response rate: 47% (1026/2167). 98% of responding patients would definitely/probably go to their FHT for general checkups, 85% for urgent problems. 67% indicated someone from their FHT would definitely/probably see them the same day if they were sick. 57% could definitely/probably get advice quickly by phone, and 14% indicated it was definitely/probably difficult to get medical care from their primary health care provider (HCP). If their regular HCP was unavailable, 73% would see another FHT physician while 48% would see an allied HCP for routine/follow-up visits. 88% would see another FHT physician and 55% an allied HCP for urgent visits. 75% were very satisfied/satisfied with access to their regular HCP. **Conclusions:** Early indicators of utilization and access indicate room for improvement in access particularly for urgent problems. Follow-up studies should document efforts to improve access and the effect on these indicators as well as whether willingness to see allied HCPs increases as patients become more familiar with team roles and functioning.

A comprehensive needs assessment of BC physicians' self-reported practices, barriers, and attitudes towards recommended cancer screening

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Lisa Kan, MSc, *Vancouver, BC Ruth Elwood Martin,* MD, FCFP, MPH, *Vancouver, BC Laura Sware,* RD, MHA, *Vancouver, BC*
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Background: Studies show physician recommendations have the greatest influence on patient behaviour and screening for certain cancers leads to earlier detection and reduced morbidity and mortality. Little data exists about the practices, attitudes, and barriers of BC primary care physicians on cancer screening issues. **Objective:** To determine BC primary care physician practices, barriers, and attitudes towards screening for breast, cervical, colorectal, prostate cancers, and hereditary predisposition to cancer. **Methods:** The province-wide needs assessment utilized a quantitative and qualitative survey (available online and paper form) sent to all BC primary care physicians, and was completed by 887 physicians. Cross tabulations by region, gender, and years in practice were used to determine response differences, analyzed quantitatively using a level set at 0.05. **Results:** There was better understanding and compliance with BC screening recommendations for cervical and breast cancer. A wider range of practice and belief for colorectal and prostate cancer screening and a lower awareness about screening for hereditary predisposition was observed. Compared to urban physicians, rural physicians found geography (76% vs. 36%) was more and language (35% vs. 56%) was less of a barrier in encouraging cancer screening. Compared to female physicians, male physicians reported having more patients requesting PSA tests (64% vs. 41%), greater comfort in performing DRE (76% vs. 53%) but were less comfortable with Pap tests (78% vs. 93%). Compared to physicians in practice 30 years or longer, physicians in practice 10 years or less reported their knowledge in discussing the pros and cons of cancer screening was a barrier (51% vs. 39%) and were less comfortable performing breast screening procedures (46% vs. 79%) and DRE (50% vs. 80%). **Conclusions:** Significant knowledge deficits and care gaps were identified in cancer screening practices. The findings may focus educational programming to support improved cancer screening practices of primary care physicians.

Building access through expertise

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Karen Smith, MD, FRCPC, *Kingston, ON Marshall Godwin,* MD, MSc, CCFP, *St. John's, NL Sam Shortt,* MD, PhD, CCFP, *Ottawa, ON*

Introduction: Despite the significant advances in primary care in recent years, patients with severe physical or cognitive disabilities still experience difficulty in accessing high quality primary care for their particular conditions. This project was designed to explore and pilot test three ways of achieving this without placing unrealistic expectations or burdens on family physicians. **Methods:** The literature on models of introducing specialized expertise into the primary care setting was reviewed and three models selected for pilot testing: shared care (specialty clinics on site at FP office), case-management (OT assigned to develop care plans) and community based rehabilitation (CBR – community based support worker assigned to patients). A mixed methods evaluation of the pilots was conducted that included surveys of patients, a chart audit for quality of care and office accessibility, and individual interviews with providers and patients. **Results:** The shared care pilot involved 27 patients of 11 family physicians. Only about half met the intended inclusion criteria, while the others were mostly chronic pain patients. The qualitative data from provider interviews showed this to be the model most preferred by physicians. The case management

pilot suffered from significant logistical challenges and was largely unsuccessful. The CBR pilot recruited 14 patients, all of whom met the intended inclusion criteria. It was the most popular with patients, who perceived clear benefits for themselves from this model of support. **Conclusions:** There was difficulty in identifying those patients who clearly suffered from severe physical or cognitive disabilities in both models that used primary care practices as a basis for recruitment, which raises questions about where these patients are accessing care and highlights the limitations many practices face in identifying specific patient groups for targeted interventions. Shared care and CBR both demonstrate potential for further study on a larger scale. The case management model requires further development prior to additional study.

The Canadian Primary Care Sentinel Surveillance Network: How to harmonize CPCSSN's research and surveillance agendas

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CPCSSN is the first pan-Canadian primary care (PC) based electronic medical record (EMR) surveillance network, currently focused on five common chronic diseases. The data is provided by a group of sentinel family physicians from across the country, who have agreed to allow CPCSSN to collect, on a longitudinal basis, specific information about their patients from their EMR's. The de-identified data is transferred to a central repository using high security data transmission methods, thus protecting the patients' privacy.

The availability of sociodemographic, administrative and clinical data, as well as the capacity to longitudinally follow participating PC practice populations over extended periods of time provide us with an opportunity to study the development and progress of chronic diseases in primary care. Issues related to sample representativeness, proper comparison groups, appropriate denominators as well as the type of research questions that can be answered by this observational dataset will be discussed.

0950-1010:

Coronary artery disease screening and primary prevention: Evidence review and tool identification for The BETTER project

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Kelly Lang-Robertson, MLIS, Toronto, ON *Stephanie Bell, MSc, Toronto, ON* *Jess Rogers, BA, Toronto, ON*
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The building on existing tools to improve chronic disease prevention in family practice (BETTER project) is a pragmatic randomized controlled trial studying patient and practice level interventions to optimize screening and primary prevention in primary care. One of the target conditions is coronary artery disease (CAD). The first stage of the project was a structured evidence review identifying robust recommendations and existing tools for translation into practice. **Methods:** Using the components of the AGREE instrument for quality assessment of clinical practice guidelines, the high quality clinical practice guidelines that met the criteria were the Scottish Intercollegiate Guideline Network (SIGN, 2007) and Canadian Cardiovascular Society (CCS 2009). A clinical filter was applied with three independent clinicians reviewing the recommendations; debate was resolved with consensus. There was a subsequent review by the clinical working group for clinical applicability and acceptance in primary care. Where applicable, more recent literature was considered in the interpretation of the recommendations. Tools for practice level and patient level interventions were reviewed from the AHRQ, the Canadian best practices portal for health promotion and chronic disease prevention, and Canadian and American professional sites. A clinical filter was applied for the type, usefulness, quality, and applicability of the tools. **Results and Conclusions:** A structured care pathway for screening and primary prevention of CAD encompassing risk calculation (Framingham, UKPDS (DM)), physical activity, smoking and dietary recommendations, diabetes, hyperlipidemia and hypertension management recommendations was derived. To facilitate implementation, tools for risk calculation, patient discussions about statin choice, hypertension education, DASH diet, and acute coronary syndrome education were identified. These will be integrated into existing community and allied health supports and resources, as well as the ongoing management the patient's family physician

Managing illness on-site: A survey of residential care facilities in one large health authority in British Columbia

Margaret J McGregor, MD, MHSc, *Vancouver, BC* *Kia Salomons,* MSc *Michelle B Cox,* MSc *Jan Volker,* MEd *Shannon Berg,* MSW
Judith Globerman, PhD *Jennifer Baumbush,* PhD *Kimberlyn McGrail,* PhD *Riyad B Abu-Laban* MD, MHSc *Dug Andrusiek,* MSc
Marcy Cohen, MEd *Penny Brasher,* PhD, *Vancouver, BC*

Objective: Residential care facilities provide care to frail elders. When ill, facility residents are often transferred to the nearest emergency room. These transfers strain health care resources and are often of questionable value for the patient. We examined facility characteristics that in earlier studies were associated with emergency room transfers. **Design:** Cross sectional survey. Survey questions were developed by reviewing the literature, through discussions with facility managers and nursing experts, and by piloting the survey instrument. Participants could choose to self-administer the survey or participate in a telephone interview. **Participants:** Directors of Care or managers of all for-

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profit, non-profit and public residential care facilities in one large health region in Vancouver, British Columbia. Main outcome measures: **Outcome measures included:** staffing characteristics, staffing levels, staffing organization; facility access to family physicians; organization of and staff training in end of life care; resident involvement, volunteer involvement and survey respondent opinions on the factors that affect emergency room transfers**. Results:** Sixty-two Directors of Care were invited to complete the survey and forty-five responded (73%). Facilities had a mean of 1.7 physicians for every 10 residents (SD 1.2). Almost two-thirds of facilities (67%) reported telephone access to a resident's usual physician as easy. However, a similar proportion (64%) reported that timely on-site physician access was somewhat difficult or difficult. Most facilities (73%) reported that few or none of the physicians attended residents' annual care conferences. Less than one-half of facilities (40%) had standing orders for palliative care. Family preference and a resident's degree of intervention were the two most frequently noted non-medical factors influencing emergency room transfer. **Conclusion:** Timely on-site access to a resident's usual physician and end of life palliative care, factors both known to be associated with higher transfer rates to hospital, are services that need improvement.

Qualitative analysis of commitment-to-change statements: Can they predict implementation of new practice behaviours?

Heather Armson, MD, MCE, CCFP, FCFP, *Calgary, AB* *Stefanie Roder,* PhD, *Hamilton, ON* *Sarah Kinzie* MD, CCFP, *Hamilton, ON*
Tom Elmslie MD, CCFP, FCFP, FRCP, *Ottawa, ON* *Jacqui Wakefield,* MD, CCFP, FCFP, *Hamilton, ON*

Objective: Commitment-to-change statements (CTCs) are used in a variety of educational activities to promote and document practice change. The components of CTCs that contribute to implementation of new practice behaviours are not known. The present study describes the development of a categorization framework to identify aspects of CTCs that predict practice change. **Design:** Qualitative – grounded theory methodology. **Setting:** Practice-based small group learning sessions across Canada. **Participants:** Family physicians reviewing one of three educational modules followed by group discussion. **Intervention:** Personal practice reflection tool (PRT) that is completed after a learning session. **Methods:** Family physicians documented the outcome of their learning session on a PRT. This included identifying the "compelling information" and "gap in my practice" followed by guided CTCs (will change, considering change, confirmed practice). All statements were analyzed using the principles of grounded theory to identify emerging themes/concepts and link them to Models of Physician Change. A three month follow up of proposed practice changes were compared to the categorization of the original CTCs. **Main findings:** Linking statements to the cognitive levels of Bloom's Taxonomy suggested that the PRT structure directs physicians through a hierarchy of learning. The outcome of a learning session differed depending on where the physicians started with respect to existing practice and how they assessed the relative value of a practice change. Grounded analysis of the statements suggested five categories of outcomes that are related to the starting place – unaware, scattered, systematize/construction, fine-tuning, confirmation. Three months follow up of planned practice changes supported a link between the categories of outcomes and reported practice changes made or not made. **Conclusions:** A categorization framework has been developed that can help predict a physician's follow through with planned practice changes.

1010-1100 BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES*

1100-1120:

A survey of practice models and payment preferences of recent family medicine residency graduates in BC

Vanessa Brcic, MD, CCFP, R3 Clinician Investigator, *Vancouver, BC* *Margaret McGregor,* MD, CCFP, *Vancouver, BC* *Serena Verma,* MD, CCFP, *Vancouver, BC*

Objective: The majority of family physicians in British Columbia are currently reimbursed under a fee-for-service model. The objective of this study is to assess payment preferences of recent graduates from the Family Medicine Residency program at the University of British Columbia. **Setting:** British Columbia. **Participants:** 430 UBC Family Practice residency graduates from 2000-2009 who are members of a postgraduate administrative listserve. **Design:** Cross-sectional web-based survey. **Intervention:** An 11-item survey was collaboratively developed by UBC faculty and new residency graduates to assess the practice and payment preferences of recent graduates. **Main outcome measures:** Payment models under which physicians are practicing, exposure to different practice and payment models, future practice and payment preferences, and the importance of various models on new physicians' career choices. **Results:** 133 physicians responded to the survey with an estimated response rate of 31%. The majority of respondents were working as locums (53%); 40% of respondents had their own practice. 86% of respondents identified the payment model as very or somewhat important in their choice of future practice. 70.5% preferred non-Fee-for-Service practice models. 69% of respondents preferred group practice models; 52.7% preferred interdisciplinary practice models. Principal themes identified in qualitative analysis of open-ended questions and comments included quality of patient care, physician work satisfaction, and choice of practice style. This qualitative data will be presented in detail during the session. **Conclusion:** Recent graduates generally prefer alternate funding models including salary, capitation, or blended models while recognizing the strengths and weaknesses of both alternate and Fee-For-Service models. The limited availability of choice in practice models and payment modalities remains a major deficiency of primary care reform in BC.

A comparison of diabetes and cardio-metabolic outcomes between Type 2 Diabetes patients under specialists' care and primary care

James Leung, MBBS, CCFP, FCFP, MRCGP, *Toronto, ON* *Andrea Leung, Toronto, ON* *Ling Chen, Toronto, ON* *Emily Lau, Toronto, ON*

Objective: To determine the differences in outcomes in glycemic and cardio-metabolic controls between type 2 diabetes patients under specialists care and family physician care. **Design:** Retrospective chart review of 157 type 2 diabetes patients using data from their last 2 consecutive annual physical results. **Setting:** Community family physician office in Toronto. **Participants:** 157 patients including 119 patients under the care of a family physician and 38 patients under the care of 11 diabetes specialists (5 community based and 6 hospital based). **Main outcome measures:** HbA1C, fasting glucose, systolic BP, diastolic BP, body mass index, waist circumference, LDL, HDL, triglyceride, TC:HDL ratio, ACR and eGFR. **Results:** The mean ages for 38 patients under specialists care (SC) and 119 patients under primary care (PC) were 66.9 and 66. HbA1C control was modestly better in the PC group than SC group (7.5% vs. 8.0%, p=0.05) but not in fasting glucose (PC 7.7 vs. SC 7.9, p=0.46). The 2 groups were neither inferior nor superior to each other in other cardio-metabolic data.

Comparing 2 consecutive check up results revealed both groups improved in diastolic BP but not in other areas. Both groups had inadequate target achievements. Targets achieved for PC group in HbA1C, fasting glucose, systolic BP, diastolic BP and LDL were 35%, 39%, 47%, 39%, and 39% respectively. For SC group, these data was 28%, 41%, 60%, 45% and 41% respectively. **Conclusions:** Community type 2 diabetes patients under the care of specialists did not show a better glycemic and other cardio-metabolic outcomes than under primary care. Large studies that clearly define the roles of specialists and family physician in the diabetes care are required for the development of a clear cut team model. Both groups should need further improvements in the treatment targets

Diabetes screening and primary prevention: Evidence review and tool identification for The BETTER Project

Michelle Greiver, MD, CCFP, *Toronto, ON* *Denise Campbell-Scherer,* MD, PhD, *Edmonton, AB* *Kelly Lang-Robertson,* MLIS, *Toronto, ON*
Stephanie Bell, BAH, MSc, *Toronto, ON* *Jess Rogers,* BA, *Toronto, ON* *Donna Manca,* MD, MClSc, CCFP, FCFP, *Edmonton, AB*
Eva Grunfeld, MSc, MD, DPhil, FCFP, *Toronto, ON*

The building on existing tools to improve chronic disease prevention in family practice (BETTER project) is a pragmatic randomized controlled trial studying patient and practice level interventions to optimize screening and primary prevention in primary care. One key target condition is diabetes mellitus type 2. The first stage of the project was a structured evidence review identifying robust recommendations and existing tools for translation into practice. **Methods:** Using the components of the AGREE instrument for quality assessment of clinical practice guidelines, the Canadian Diabetes Association (2008), the American Diabetes Association (2009), and recommendations from the U.S. Preventive Services Task Force (2008) met the criteria. A clinical filter was applied with two independent clinicians reviewing the recommendations. There was a subsequent review from the larger clinical working group with specific attention to clinical applicability and acceptance in primary care. Where applicable, more recent literature was considered in the interpretation of the recommendations. Tools for practice level and patient level interventions were reviewed from the AHRQ, the Canadian best practices portal for health promotion and chronic disease prevention and Canadian and American professional sites. A clinical filter was applied for the type, usefulness, quality, and applicability of the tools. **Results and Conclusions:** A clinical care pathway for screening and primary prevention of diabetes was derived. Elements of history for risk factors, and routine physical examination for documentation were identified. Frequency of screening with fasting blood sugar and Framingham cardiovascular risk calculator is q3 years, and q1 year with impaired fasting glucose or with specified risk factors. Tools for risk calculation, patient education, and self-management will be used. Recommendations for weight loss, nutritional counseling, smoking cessation, and exercise will be implemented with existing community programs and allied health professionals in the practices, as well as the ongoing management with the patient's family physician.

1120-1150:

Experiences from the forefront of EMR implementation and use in Canadian primary care

Kevin Leonard, MBA, PhD, CMA, *Toronto, ON* *Nicola Shaw,* PhD, FBCS, CITP, *Edmonton, AB* *Maryan McCarrey,* MA, *Ottawa, ON*
Elisabeth Delisle, MSc, *Université de Sherbrooke* *Andrew Grant,* MD, PhD, *Université de Sherbrooke*
Grace Paterson, PhD, *Dalhousie University* *Shelby Mitchell,* MA, *University of Alberta* *Bill Pascal,* PEng, *Canadian Medical Association*
Nancy Kraetschmer, MBA, PhD, *Canada Health Infoway*

This research provides physicians with practical information on best practices and lessons learned regarding implementation/use of EMR systems in ambulatory clinical practice settings in Canada. This is the first analysis of EMR-use using case study methodology to document success stories and challenges of EMR implementation/use as experienced by physicians and their staff in a range of primary care settings. Twenty sites were chosen for variability in EMR experiential use, practice type, and location. Senior academics across Canada partnered with the Canadian Medical Association and received financial support from Canada Health Infoway to complete this project.

1200-1330 AGM AND LUNCH

1330-1400	**Presentation of research by Family Medicine Researcher of the Year**
1400-1415	**Presentation of research by Research Award for Family Medicine Residents winner**
1415-1430	**Presentation of research by Research Award for Family Medicine Residents winner**
1430-1445	**Presentation of research by CFPC Outstanding Family Medicine Research Article** *(published in 2009)*
1445-1500	**Presentation of research by *Canadian Family Physician* Best Original Research Article winner**

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1500-1530 BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES*

1530-1545:

Family physicians as mentors: Passing on the torch

Judith Belle Brown, PhD, *The University of Western Ontario, London, ON Cathy Thorpe,* MA, *London, ON*
Jan Kasperski, RN, MHSc, *Toronto, ON*

Context: Experienced family physicians are often called upon to serve as mentors to their students and junior colleagues. But why do they become a mentor and how is this role enacted? **Objective:** The purpose of this study was to examine the motivations and mentoring experiences of experienced family physicians. **Design:** A descriptive qualitative study using in-depth semi-structured interviews and one focus group; the analysis of the verbatim transcripts was both iterative and interpretive. **Setting:** The province of Ontario. **Participants:** 25 experienced family physicians. **Findings:** Three main themes emerged from the analysis: 1. why be a mentor; 2. how to be a mentor; and 3. challenges or barriers to mentoring. Reasons for becoming a mentor included a desire to give back to the profession as others had done before them—therefore passing on the torch. To be a mentor, participants described the need to be open, approachable and committed to the process. Self-awareness was another key attribute. It was also important to role model the balance between personal and professional responsibilities. Finally, potential barriers to the mentoring process included time, physical space limitations (and lack of privacy), and adequate remuneration. Conclusions: Experienced family physicians are committed in their desire to give back to the profession by mentoring medical students, residents and new family physicians. In order to enhance their ability "to pass on the torch", barriers to successful mentoring need to be addressed.

1530-1630:

Improving the success of your application to the CIHR Knowledge Review and Synthesis panel

Andrew Cave, MB ChB, MSc, FCFP, FRCGP, *Professor, Department of Family Medicine, University of Alberta, Edmonton, AB*

The Knowledge Review and Synthesis program of the CIHR differs from other programs in several ways. The most important of these is that applicants must be paired researchers and knowledge users. There is an emphasis on the knowledge translation component of the study which in other programs may be almost minimal. Many of the subjects that are relevant to primary care cannot be researched by clinical trials. There is a developing field of methodologies for reviewing evidence from a variety of other sources and the expectation is that these will be employed in systematic reviews of non-RCT data. This session will explain the current expectations of the review panel for high scoring applications.

The play's the thing: Using research-based theatre to increase empathy and disseminate research findings

Yvette Lu, MD, CCFP, *Vancouver, BC*

1. Introduce drama as a method of increasing empathy towards people with chronic illness.
2. Examine the use of theatre as a means of disseminating research findings.
3. Explore the creation of a research-based play about the experiences of young women living with chronic illness.

Theatre is an innovative tool in medical research and education. It provides an interactive and accessible forum through which to distribute research findings by allowing audience members to engage with the material. It is also particularly suitable as a means of presenting qualitative research findings because it is able to evoke emotional and sensory experiences that were present in the data-gathering encounter, but which are difficult to capture in a written report. We will hear excerpts from and examine the creation of a research-based play.

Successful grants at CIHR: a peer-reviewer's perspective

Michael Green, MD, MPH, CCFP, *Kingston, ON* *Richard Glazier,* MD, MPH, CCFP, FCFP, *Toronto, ON*

Introduction: Obtaining funding for research projects at CIHR can be a daunting task. With about only 1 in 5 of submitted applications being successful the competition is fierce. So what makes a successful grant? The presenter has served on a number of different review panels at CIHR and will discuss the review process and what makes a grant successful (or not). The discussion will include a "walk through" of the different parts of a typical application from background and research questions to methods and budgeting. Examples of common mistakes that can swiftly send an application to the dreaded "triage" pile and best practices that can vault an application into the top ranks will be provided for each key component of the application.

1545-1600:

Conquering the acculturation process: The IMG Experience

Judith Belle Brown PhD, *London, ON* *Lynn Brown* MSW, RSW, *London, ON* *Leslie Boisvert,* MPA *Larry Schmidt* MD, CCFP, FCFP

Context: As more International Medical Graduates (IMGs) seek opportunities for requalification around the globe, educators need to be cognizant of the complex acculturation process they face. The purpose of this study was to explore the acculturation experience of International Medical Graduates in the requalification process in Canada. **Design:** This was a phenomenological qualitative study using in-depth interviews to examine the experiences of IMGs. Setting: Ontario, Canada. **Participants:** There were 16 IMGs who were either first year (5), second year (6) residents or recent graduates (5) at the University of Western Ontario. **Methods:** The audio taped interviews were

transcribed verbatim and analyzed using an iterative and interpretative process, through both individual and team analysis. **Main findings:** The findings revealed three distinct but interwoven aspects of the participants' challenges in their cultural adaptation including personal and professional elements and characteristics of the acculturation process itself. Personal elements focused on family issues such as differing child rearing practices and care of the elderly. On a professional level participants identified the key challenges as the unfamiliar role of the family physician, the hierarchical differences in the patient-doctor relationship and learner-teacher relationship. Aspects of the medical system also posed challenges including culturally mediated differences in mental health diagnoses. Participants suggested two inter-related dimensions in the acculturation process: degree of ease or difficulty of adjustment and the time involved in adjusting. Their suggestions included that they be asked more often about their personal backgrounds including religious, educational, and cultural underpinnings. **Conclusions:** This study provides a deeper and more detailed understanding of the personal and professional acculturation challenges face by IMGs. This study gives rise to suggestions from IMGs for changes that could improve the educational experience particular to acculturation.

1600-1615:

The number and types of problems managed by family medicine residents during patient encounters

Eric Wong, MD, MCISc(FM), CCFP, *London, ON*

Objective: To describe the number and types of problems that family medicine residents manage during patient encounters. **Design:** Each participating resident was asked to record information on a random sample of 20 consecutive encounters in the office after each of these encounters. The International Classification for Primary Care– 2nd edition (ICPC-2) was used to code problems in the encounters. **Settings:** Four academic family medicine outpatient teaching sites (three urban, one rural) at the University of Western Ontario. **Participants:** Family medicine residents in first or second year of training. **Main outcome measures:** Number of different problems managed per encounter, frequencies of occurrence of different types of problems. **Results:** 48 residents managed 2089 problems in 889 encounters. An average of 2.4 (standard deviation = 1.3) problems were managed per encounter. Two or more problems were managed in 69.7% of encounters. The number of problems managed per encounter was positively correlated with patient age ($P < 0.001$) but not associated with resident age, training year or gender. It was higher if the patient was a regular patient of the resident's team ($P = 0.016$) and if the presenting complaint was about follow-up or wellness care as opposed to a new complaint ($P < 0.001$). The most frequent five ICPC-2 categories were process (21.6%), cardiovascular (11.9%), endocrine/metabolic and nutritional (11.4%), musculoskeletal (8.9%) and skin (8.8%). The least frequent five ICPC-2 categories were social problem (1.0%), male genital (1.0%), eye (1.1%), pregnancy, childbearing, family planning (1.1%) and blood, blood forming organs and immune mechanism (1.1%). **Conclusions:** Family medicine residents often manage multiple, concurrent problems and certain types of problems may be encountered infrequently. A system that can adequately train residents in managing multiple, concurrent problems and monitor and respond to residents' varying exposures to different types of problems may assist residents in achieving adequate competencies.

1615-1630:

The Family Medicine Longitudinal Experience (FMLE): The follow up

Kymm Feldman, MD, CCFP, MHSc, Department of Family and Community Medicine, *University of Toronto, Toronto, ON*
Jennifer McCabe, MD, CCFP, *Toronto, ON* *Ivy Oandasan* MD, CCFP, MHSc, FCFP, *Toronto, ON* *Lesley Gotlib, Conn* PhD, *Toronto, ON*
Lynn Wilson MD, CCFP, FCFP, *Toronto, ON* *Martin Schreiber* MD, MEd, FRCPC, *Toronto, ON* *Jay Rosenfield* MD, MEd, FRCPC, *Toronto, ON*

Background: The Family Medicine Longitudinal Experience (FMLE) is a community based clinical preceptorship that was piloted (n=35) in 2008 at the University of Toronto. Results have been encouraging in the 2008/09 (n=135) and 09/10 (n=155) academic years. Early clinical experience and role modeling may play a role in medical student career choice which is important in the face of declining student interest in generalist specialties and Family Medicine (FM) in particular. **Purpose:** The FMLE is being evaluated in an ongoing way to assess its impact on medical student attitudes to FM as a career choice. The FMLE matches medical students with community family physicians for 6 half days per week over a three month period in their second pre-clinical year. Similar programs are being undertaken nationally but evidence as to the effects of these large scale programs has so far been anecdotal. It is vital to assess the effect of the FMLE on student career choice and on attitudes toward FM as a discipline as the FMLE becomes mandatory in 2010/11. **Methods**: Survey data has been collected relating to FMLE participants' attitudes towards family medicine as a career choice before and after the FMLE in comparison with their peers who did not elect to take part in the program. Those that did participate will be compared among those assigned to community based family physicians versus those assigned to family medicine residents. **Results/conclusions:** Interest in FM as a career choice, perceived prestige of FM and knowledge about FM as a career will be assessed pre to post for FMLE participants versus a non-interested control group for the 2009/10 iteration. One year follow up data will also be presented on the 2008/09 participants. The experience of having a family physician preceptor will also be compared to those with family medicine resident preceptors

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P500-FAMILY MEDICINE EDUCATION FORUM (FMEF)
P500-FORUM SUR L'ÉDUCATION EN MÉDECINE FAMILIALE (FEMF)

	FAMILY MEDICINE EDUCATION FORUM FORUM SUR L'ÉDUCATION EN MÉDECINE FAMILIALE				
0830-1015	**FMEF Plenary / *Plénière du Forum sur l'éducation en médecine familiale (FEMF)*** Delivery of faculty development – Faculty development for every teacher everywhere: Challenges and strategies *Offrir du perfectionnement professoral - Perfectionnement professoral pour chaque enseignant partout : Défis et stratégies*				
1045-1100	**BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES***				
1100-1120	**FMEF Plenary / *Plénière du Forum sur l'éducation en médecine familiale (FEMF)***				
1120-1150	**continued / *suite***				
1150-1200					
1200-1230	**FMEF Lunch & Murray Stalker Lecture / *Déjeuner du Forum sur l'éducation en médecine familiale et présentation du Prix Murray Stalker***				
1230-1300					
	FMEF WORKSHOPS 1300-1500				
1300-1330	Extracting your foot from your mouth: Equity and diversity goes to the movies	Building a Triple-C Curriculum from scratch: The Belleville experience	Who did they send me? The 'Generation Me' learner: What you thought you knew and what you ought to know	Ethics for family physicians: Curriculum goals and resources	Publications, presentations, and posters! - Oh my! Finding research opportunities in your teaching
1330-1500					
1500-1530	**BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES***				
1530-1600	Education Free-Standing Papers				
1600-1630					
1630-1700	Show and Tell / *Séance d'expression libre* - Reception / Réception				

0830-1200 FMEF PLENARY / PLÉNIÈRE DU FORUM SUR L'ÉDUCATION EN MÉDECINE FAMILIALE

Delivery of faculty development - faculty development for every teacher everywhere: Challenges and strategies

Topics to be discussed:

1. Strategies to encourage/enhance faculty development participation
2. Reaching teachers where they are
3. Linking evaluation of faculty/teachers to faculty development: Can it be done? How can it be done?
4. Seeing R2's as teachers in the making: How can best prepare residents to be clinical teachers in the community
5. The "Triple C" curriculum: How can we deliver this to teachers "in the trenches"

Offrir du perfectionnement professoral - Perfectionnement professoral pour chaque enseignant partout : Défis et stratégies

Sujets abordés :

1. *Stratégies pour encourager / stimuler la participation aux activités de formation professorale*
2. *Joindre les enseignants là où ils sont*
3. *Lier l'évaluation des enseignants / professeurs à la formation professorale : est-ce possible? Comment y arriver?*
4. *Considérer les R2 comme des enseignants en devenir : Comment préparer le mieux possible les résidents à être des enseignants cliniques dans la communauté*
5. *Le cursus « triple C » : Comment l'offrir aux enseignants « dans les tranchées »*

1045-1100 BREAK AND POSTER VIEWING / PAUSE ET VISITE DES AFFICHES

1200-1300 FMEF LUNCH AND MURRAY STALKER AWARD PRESENTATION - *DÉJEUNER DU FORUM SUR L'ÉDUCATION EN MÉDECINE FAMILIALE ET PRÉSENTATION DU PRIX MURRAY STALKER*

1300-1500:

Extracting your foot from your mouth: Equity and diversity goes to the movies

Konia Trouton, MD, MPH, CCFP, FCFP, *Victoria, BC* *Francine Lemire,* MD, CCFP, FCFP, *Mississauga, ON*

Using clips from YouTube, movies, TV and other media, clinical vignettes exploring sensitive issues will be discussed.

Scenarios will include:
1. improving practice to care for patients with physical limitations and disabilities
2. accommodating colleagues' absenteeism or need for time away from clinical practice,
3. addressing "inappropriate assumptions" (e.g. sexual orientation, racial/cultural background) of a patient,
4. managing boundary issues in personal and professional relationships,
5. responding to patient stereotyping of particular physicians.

Visuals, humour, best evidence, case studies and discussions will be used to address such issues. "Pearls" from each scenario will be summarized.

Learning objectives:
1. to enhance participants' knowledge and skills of how to respond to awkward clinical encounters
2. to share with others your experiences and lessons learned
3. to have practical "take home" pearls for avoiding or addressing various scenarios that can be awkward

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Building a Triple-C Curriculum from scratch: The Belleville experience

Jonathan Kerr, BScH, MD, CCFP, *Belleville, ON* *Robert Webster,* BSc, MD, CCFP, *Belleville, ON*

To accommodate an increase in the number of family medicine residents, the Queen's University Family Medicine Residency Program has developed distributed learning sites, including one in Belleville, Ontario. The new faculty in Belleville has used the CFPC's comprehensive, competency-based, family medicine-centred (Triple-C) framework to develop a curriculum from scratch.
This session will provide a detailed step-by-step guide of how to create (or modify) a family medicine residency curriculum to meet the Triple-C framework. Specific focus will be placed on utilizing horizontal scheduling, developing learning experiences based on desired competencies, reaching win-win solutions with specialist preceptors, and faculty development in a distributed site.

Learning objectives:
1. understand the rationale for developing a comprehensive, competency-based, family medicine-centred (Triple-C) curriculum.
2. obtain a step-by-step guide to create (or modify) a curriculum to meet the Triple-C framework.
3. learn strategies to strengthen a new faculty in a distributed learning site.

Who did they send me? The 'Generation Me' learner: What you thought you knew and what you ought to know

George Kim, MD, CCFP, *London, ON*

In this workshop, participants will be introduced to the "generation me" learner, as described by Professor Jean Twenge of San Diego State University and acclaimed author of Generation Me. Specifically, traits of this generation and how they apply to a clinician teacher's experience in the classroom and the bedside will be explored. With the use of vignettes, developed from real experiences gathered by the presenter, participants will explore what they would usually do, and then what they might do, having been introduced to the Generation Me learner.

Learning objectives:
By the end of today's session, participants will have:
1. been introduced to the "generation me" learner
2. reflected on their own experiences with learners in their clinic, that they felt "disconnected" from
3. identified strategies to help with "generation me" learners

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Publications, presentations, and posters - Oh my! Finding research opportunities in your teaching

Shelley Ross, PhD, *Edmonton, AB* *Sudha Koppula,* MD, CCFP, *Edmonton, AB*

Don't fear research, embrace it! Balancing teaching and clinical practice can make the thought of doing research overwhelming. Physicians who teach are often doing innovative things that others would love to hear about. This workshop will help participants to see where they are already carrying out scholarly activity. Issues of ethics, research methodology, and finding the right venues for dissemination will be discussed. Small group interactions will help participants recognize where they are being innovative. The larger group discussion at the end of

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the workshop will help participants set goals for next steps in turning their innovations into scholarly product.

Learning objectives:
Participants will:
1. understand how to identify opportunities for scholarly activity in their teaching
2. recognize where they are already carrying out scholarly activity in their work with students and residents
3. apply ideas and examples from the workshop to their own education innovations and teaching tips

Ethics for family physicians: Curriculum goals and resources
William Sullivan, MD, CCFP, PhD, *Toronto, ON* *Susan MacDonald,* MD, CCFP, MA, *Kingston, ON*

The CFPC's Committee on Ethics has recently developed curriculum goals and core competencies in ethics for family medicine residents. This workshop is aimed at exploring ways in which these goals have and can be achieved and evaluated. The workshop will focus on resources available to teachers to assist them, including modules involving typical family medicine cases, curriculum plans, and evaluation strategies. A sample ethics module on ethical issues in providing end-of-life care will be provided.

Learning objectives:
1. Learn about the new CFPC Committee on Ethics' family medicine ethics curriculum goals for family medicine residency programs.
2. Explore current and novel ethics teaching strategies used in family medicine residency programs across the country in light of curriculum goals.
3. Be aware of and apply recently updated resources to support ethics teaching and evaluation.

1500-1530 BREAK AND POSTER VIEWING / *PAUSE ET VISITE DES AFFICHES*

1530-1630 EDUCATION FREE-STANDING PAPERS

1630-1730 SHOW AND TELL / *SÉANCE D'EXPRESSION LIBRE* RECEPTION / *RÉCEPTION*

Join your colleagues to learn about new educational and research initiatives taking place at departments of family medicine across the country.
Venez vous joindre à vos collègues pour découvrir des nouveautés en éducation et en recherche présentées par les départements de médecine familiale à travers la Canada.

POSTERS / AFFICHES

Innovative intervention model to improve family medicine resident competencies and attitudes in caring for seniors in Long Term Care setting (LTC): An evaluation
David Barber, BSc MD, CCFP, *Kingston, ON; Jyoti Kotecha,* MPA, MRSC, CChem, *Kingston; ON, Willa J. Henry,* Bsc., MD, CCFP, FCFP

The benefits of being a preceptor
Steve Beerman, MD, CCFP, FRCP, *Nanaimo, BC; Jerry Hinbest,* EdD, *Nanaimo, BC; Jennifer Mullett,* PhD, *Nanaimo, BC; Sarah Fletcher,* MA, *Victoria, BC; Ann Holroyd,* RN, PhD, *Nanaimo, BC; Maggie Kennedy,* RN, MSN, *Nanaimo, BC; Piera Jung,* RN, MSN, *Nanaimo, BC*

Family practice residency training site: Value to their community
Stephen Beerman, BSc, BSR, MD, CCFP, FCFP, *Nanaimo, BC; Jennifer Mullett,* PhD, *Nanaimo, BC; Sarah Fletcher,* VIU Graduate Student, *Nanaimo BC; Mary Winder* MD CCFP, *Nananimo, BC; Teresa van der Goes* MD, CCFP, *Nanaimo, BC; Maggie Kennedy* BsN, PHD *Nanaimo, BC; Ken Harder* MD, CCFP *Chilliwack, BC; Jerry Hinbest,* PhD *Nanaimo, BC; Peira Jung,* BsN, PhD, *Nanaimo, BC*

Prolotherapy in the treatment of rotator cuff tendinopathy
Helene Bertrand, MD, CCFP, clinical instructor UBC school of family practice, North Vancouver, BC

Reducing radiation exposure in the ER: Development of a clinical decision rule to predict the need for CT diagnosis of kidney Stones
Richard Cullen, MSc, St. John's, NL; F Kris Aubrey-Bassler, MSc, MD, CCFP, St. John's, NL

Creating scientific literacy in future primary care physicians: The U of C Dept of Family Medicine Resident Research Training Program
Neil Drummond, PhD, *Calgary, AB*

Evaluating Pre-clerkship Clinical Experience: Student and preceptor perspectives
Kymm Feldman, MD, CCFP, MHSc, *Toronto, ON; Ivy Oandasan,* MD, CCFP, MHSc, FCFP, *Toronto, ON; Jennifer McCabe* MD, CCFP *Toronto, ON; Lesley Gotlib Conn* PhD *Toronto, ON; Lynn Wilson* MD, CCFP, FCFP *Toronto, ON*

Primary care data revealed: An electronic data presentation tool
Brian Forst, B. Sc., E.I.T., M. Sc., *Edmonton, AB; Dave Jackson,* B.Comm, *Calgary, AB; N. Drummond, D. Manca, K. Linton; K. Martin; K. Keshavjee*

Normative values and validity testing of the Simple Lifestyle Indicator Questionnaire (SLIQ): Final results
Marshall Godwin, MD,MSc,FCFP,, *St. John's, NL; Cheri Bethune,* MD,MCISc,FCFP, *St.John's, NL; Allison Kirby,* MA, *St. John's, NL; Andrea Pike,* MSc, *St. John's, NL*

Self-efficacy and HIV treatment literacy prior to implementation of a Patient Self-Management Support (PSMS) Program for marginalized inner city people with HIV/AIDS: A baseline analysis

Paul Gross, MDCM, CCFP, *Vancouver, BC; David Tu,* MD, CCFP, *Vancouver, BC; Doreen Littlejohn* RN, *Vancouver BC; Tiffany Tam, Burnaby BC; Jeanette S. Pedersen Vancouver BC; Mark Tyndall* MD, FRCPC, PHD, *Vancouver BC*

Cancer screening and primary prevention: Evidence review and tool identification for the BETTER Project

Tina Korownyk, MD, *Edmonton, AB; Sandy Buchman,* BA MD CCFP FCFP, *Toronto, ON; June Carroll,* MD, CCFP, FCF*P Toronto, ON; Mel Kahan,* MD, MHSc, CCFP, FRCPC, FCFP *Toronto, ON; Sheila Dunn,* MD, CCFP-EM *Toronto, ON; Denise Campbell-Scherer,* MD, PhD *Edmonton, ON; Kelly Lang-Robertson,* MLIS *Toronto, ON; Stephanie Bell,* BAH, MHSc *Toronto, ON; Jess Rogers,* BA *Toronto, ON; Donna Manca,* MD MClSc CCFP FCFP *Edmonton, AB; Eva Grunfeld,* MSc, MD, DPhil, FCFP *Toronto, ON*

The OASIS Program: A pilot supportive aging at home program

Jyoti Kotecha, MPA, MRSC, CChem, *Kingston, ON; Jane Yealland, Kingston, ON; Ms. Carly Keely; Richard V Birtwhistle,* MD, CCFP, *Kingston, ON*

Young men with obesity and hypertension: Feature of pituitary-adrenal axis

Irina Krikhely, MD, *Sankt-Petersburg, Russia; Zulfya Shafigullina,* MD, *Sankt-Petersburg, Russia*

La collaboration interprofessionnelle vers une transformation des pratiques au sein d'un GMF de deuxième vague

Julie Lajeunesse, MD, MSc, *Longueuil, QC; Marie-Dominique Beaulieu,* MD, MSc, CMFC, *Montréal, QC; Jean-Louis Denis,* PhD, *Montréal, QC*

Évaluation des connaissances et de la satisfaction des femmes concernant les tests de dépistage du syndrome de Down selon le type de suivi obstétrical

Liny Laroche, MD, CCMF, M.Ps., *Québec, QC; Jean Gékas, MD,* Ph.D, *Québec, QC; Emmanuel Bujold,* MD, MSc, FRCSC, *Québec, QC*

Relation of gamma-glutamyltransferase levels to incidence of the metabolic syndrome

Jeong Gyu Lee, MD, *Busan, Korea*

A comparison of diabetes and cardio-metabolic outcomes between Type 2 Diabetes patients on medication intervention and Diabetes/Pre-diabetes patients on lifestyle intervention

James Leung, MBBS CCFP FCFP MRCGP, *Toronto, ON; Andrea Leung, Toronto, ON; Ling Chen Toronto ON, Emily Lau Toronto ON*

Efficacy of fresh bitter melon (Momordica Charantia) juice in treating type 2 diabetes (T2DM): A feasibility study

Lawrence Leung, Kingston, ON; Richard Birtwhistle; Jyoti Kotecha; Sharon Cuthbertson , Kingston, ON

Aboriginal healing outside of the gates

Ruth Martin, MD, FCFP, MPH, *Vancouver, BC; Co-authors: Lora (Koala) Kwandibens; Amber Christie; Mo Korchinski; Cindy Worsfold; Dawn Fraser; Rose Hesketh and Catherine Wilson; participatory researchers with Women in2 Healing; Lara-Lisa Condello, MA; Nicola Valley Institue of Technology; Alison Gran*

Competencies enhanced: HIV providers building capacity for specialized patient needs

Meaghan McLaren, MD, CCFP, Enhanced Skills in HIV Primary Care, Ottawa, ON; Sharon Johnston, LL.B, MD, CCFP, Ottawa, ON

An exploratory study on improving the diagnosis and management of dementia in primary care using an innovative and collaborative approach

Jasneet Parmar, MD, CCFP, Edmonton, AB; Bonnie Dobbs, PhD, *Edmonton, AB; Tim Cooper,* BSc, *Edmonton, AB ; Alexandra Marin,* MD, CCFP, *Edmonton, AB; Rhianne McKay,* MA, *Edmonton, AB*

The use of natural health products in children: A qualitative analysis of parents experiences

Andrea Pike, MSc, *St. John's, NL; Marshall Godwin,* MD, MSC, FCFP, *St. John's, NL*

Toward patient-centered addictions care in a socioeconomically disadvantaged urban population: Research in progress

Ginetta Salvalaggio, MD, MSc, CCFP, *Edmonton, AB; K Dong,* MD, MSc, FRCP(C), *Edmonton AB; G Cummings,* BNSc, MEd, PhD, *Edmonton, AB; R McKim,* MSc, *Edmonton, AB; R Cooper,* MD, CFCP(C), *Edmonton, AB; TC Wild , MA,* PhD, *Edmonton, AB*

Screening and primary prevention in primary care in patients with co-morbid depression: Evidence review and tool identification for The BETTER Coalition

Ginetta Salvalaggio, MD, MSc, CCFP, *Edmonton, AB; D. Campbell-Scherer,* MD, PhD, CCFP, *Edmonton, AB; L. Steele,* MD, CCFP, *Toronto, ON; V. Mozgala, Edmonton, AB; K. Lang-Robertson, Toronto, ON; S.* Bell, BAH, MSc, *Toronto, ON; J. Rogers, Toronto, ON;D. Manca,* MD, MClSc, FCFP, *Edmonton, AB; E. Grunfeld,* MD, PhD, FCFP, *Toronto, ON*

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Patient-centered care plans: The effect of multidisciplinary involvement on outcome in primary care
Karen Seigel, MD, CCFP, *Calgary, AB; Neil Drummond,* PhD, *Calgary, AB; Meghan Doraty,* BHSc, *Calgary, AB; Pat Babinec; Lorraine Bucholtz*

The effectiveness of pre-natal group medical visits on post-natal outcomes for children and mothers attending a community health center
Carmen Thompson, , Calgary, AB; Madhu Varma, MSc., *Calgary, AB; Neil Drummond, PhD Calgary AB; Sue Ross,* PhD *Calgary, AB;* Christin Hilbert, MD *Calgary AB; Gwen Moncayo, NP, Calgary AB; Bonnie Bailey* MSW, *Calgary AB; Julie Strome, Calgary AB; Tiffany Van Slyke, MD, Calgary AB; Rita Dahlke,* MD, *Calgary AB*

Development of a national knowledge translation trainee collaborative towards advancing the field of knowledge translation in Canada
Robin Urquhart, MSc, PhD *Student, Halifax, NS; Vivian Chan,* PhD *Student, Vancouver, BC; Evelyn Cornelissen,* PhD *Candidate, Kelowna, BC; Heather Colquhoun,* PhD *Candidate, Hamilton, ON, for the Knowledge Translation Trainee Collaborative*

Supporting a multidisciplinary research team towards improving access to quality colorectal cancer services in Nova Scotia
Robin Urquhart, MSc, *Halifax, NS; Amy Folkes,* MAHSR, *Halifax, NS; Eva Grunfeld,* MD, DPhil, FCFP, *Toronto, ON*

Impact sur la pratique médicale
Marie-Pier Villemure, MD (médecin résident), *B.Sc., Sherbrooke, QC*

Does physician lifestyle satisfaction vary according to practice location? A 21-year perspective of Alberta family medicine graduates
Wayne Woloschuk, PhD, Calgary, AB; Rod Crutcher, MD, MMedEd, CCFP(EM), Calgary, AB; Olga Szafran, MHSA Edmonton, AB; Chantal Hansen, MGIS Calgary, AB

P600-GLOBAL HEALTH EDUCATION IN FAMILY MEDICINE (GHE-FM)
P600-ÉDUCATION EN SANTÉ MONDIALE EN MÉDECINE FAMILIALE (ESM-MF)

Target participants:
1. Interested faculty from all Departments of Family Medicines across Canada.
2. Partners from low income countries who are experiencing the growth of FM in their own countries.
Workshop Objectives:
1. To learn about and discuss the draft GH FM educational framework with goal of developing a framework that is relevant and effective for use nationally in postgraduate FM training programmes.
2. Using the curriculum framework as a guide, to learn about innovations in GH FM both locally and internationally. These include areas of curriculum, service learning, mentorship and online resource sharing to develop these concepts.
3. To determine how the CFPC GH committee can best support a national framework for GH in FM and to set priorities for 3 year plan.

Methods:
The day will be a combination of presentations, case studies, small working groups, and large discussion groups. Interactive. We would like to hear from you. More to come!

We request that each DFM across Canada has at least one or more representatives from their department who will attend this interactive day. Please email your email contact if you are interested in being on the email list for more information and updates to Lynda Redwood-Campbell at redwood@mcmaster.ca . Global health is not just international health. Global health focuses on inequities in health both locally and globally. Many global health issues are right here in our communities and we need to determine how to best incorporate these issues within the CANMEDS-FM roles in competency based curriculums. You are welcome even if you do not think you have 'global health' experience. We will be updating this site regularly and let you know about the work that will be happening in the months leading up to the pre FMF day. Stay posted.

PRE-CONFERENCE - MAINPRO-C SESSIONS • PRÉ-CONFÉRENCE- SÉANCES MAINPRO-C

MCP1 **Airway Interventions and Management in Emergencies (AIME)**
08:00-17:00 *For more information on this MAINPRO-C session, see page 15.*

MCP2 **Mindfulness-based cognitive therapy: Professional training workshop for physicians**
09:00-15:30 *For more information on this MAINPRO-C session, see page 15.*

MCP3 **Chronic pain in family medicine: How to make it less painful**
09:00-15:30 *For more information on this MAINPRO-C session, see page 15.*

101NR **Health equity - breakfast networking session**
07:00-08:00 *Ginetta Salvalaggio,* MSc, MD, CCFP, *Edmonton, AB*

This networking session will bring together health care providers interested in health equity issues in family medicine. We will share clinical experiences and current initiatives around health equity (e.g. homelessness, poverty), and explore opportunities for further health equity

consciousness-raising and advocacy. Participants at all levels of training and experience are encouraged to attend.

Learning objectives:
1. to foster a Canada-wide connection between health care providers interested in health equity issues in family medicine
2. to explore areas for collaboration on existing and potential clinical, teaching, and research initiatives into health equity
3. to raise awareness of the importance of health equity in the practice of family medicine

102NR **Special interest group in prison medicine - breakfast networking session**
07:00-08:00 *Ruth Elwood Martin,* MD, CCFP, FCFP, *Vancouver, BC*

This session is for all family physicians, health care practitioners, residents and students with an interest in prison health. Come network with your colleagues, hear what others are doing in prison health and brainstorm how we will move forward as a Section of Family Physicians with Special Interests or Focused Practices in Prison Health.

103NR **Family and general practice anesthetists - breakfast networking session**
07:00-08:00 *Margaret Tromp,* MD, CCFP, FCFP, *Picton, ON*

To discuss the use of simulators in the emergency room and in the operating room in order to keep our resuscitation skills fresh.

Learning objectives:
1. opportunity to network with other family and general practice anesthesia
2. opportunity to review/explore the use of simulators

SS110 **BALANCE: Benefits and challenges associated with NSAIDs in clinical practice**
07:00-08:00 *Presenter(s) to be confirmed.*
PR For more information on SATELLITE SYMPOSIA, see page 27.

SS111 **New discoveries in postmenopausal osteoporosis management**
07:00-08:00 *Presenter(s) to be confirmed.*
PR For more information on SATELLITE SYMPOSIA, see page 27.

SS112 **Treating inflammation in COPD: Are we doing enough?**
07:00-08:00 *Alan Kaplan,* MD, CCFP(EM), FCFP, *Toronto, ON* *Charles Chan,* MD, FRCPC, FCCP, FACP, *Toronto, ON*
PR For more information on SATELLITE SYMPOSIA, see page 27.

MC133 **Infectious diseases in emergency medicine**
08:00-17:00 *Bruce Campana,* MD, FACEP, FRCPC, *Tsawwassen, BC* *Robert Stenstrom,* PhD, MD, CCFP(EM), *Vancouver, BC*
MC For more information on MAINPRO-C sessions, see page 15.

MC134 **CASTED: The 'hands-on' ED orthopedics course**
08:00-18:00 *Bruce Campana,* MD, FACEP, FRCPC, *Tsawwassen, BC* *Robert Stenstrom,* PhD, MD, CCFP(EM), *Vancouver, BC*
Arun Sayal, MD, CCFP(EM), *Toronto, ON*
MC For more information on MAINPRO-C sessions, see page 15.

100KC **Opening ceremonies / Cérémonies d'ouverture**
08:15-09:45 **Keynote Address / Conférence d'ouverture :**
"Exploring space: The adventures and research findings of a Canadian family physician astronaut"
« L'exploration de l'aspace : Les adventures et les découvertes de recherche d'un médecin de famille Canadien astronaute »
Robert Thirsk, MD, MCFP
For more information, see page 11. / Voir la page 11 pour de plus amples reseignements.

104WA **Colorectal cancer (CRC) red flags in primary care: An evidence-based guide for suspicious signs and**
10:15-11:15 **symptoms of CRC**
Emily Vella, PhD, *Hamilton, ON* *Marko Simunovic,* BA, MD, MPH, FRCS, *Hamilton, ON* *Bill Harris,* MD, FRCSC, MPH, *Thunder Bay, ON*
Lisa Del Giudice, MSc, MD, CCFP, *Toronto, ON* *Cheryl Levitt,* MBBCh, CCFP, FCFP, *Toronto, ON* *Amanda Hey,* MD, CCFP, FCFP, *Sudbury, ON*

Colorectal cancer (CRC) can present in vague and non-specific ways, leading to delay in presentation and referral. What signs and symptoms are most predictive of CRC? Is anemia or rectal bleeding (bright or dark) more predictive of cancer than a positive FOBT? Are two symptoms more predictive than one? Does age or gender need to be considered? What warrants more urgent referral? What lab tests and imaging should be ordered? Join us for an interactive session with the panel that developed new evidence based guidelines in Ontario for recognizing signs and symptoms of CRC.

Learning objectives:
Enhanced understanding of :
1. what signs and symptoms predict Colorectal Cancer (CRC)
2. what diagnostic investigations help workup suspected CRC
3. what's urgent and what can wait

Participants will become familiar with new Ontario guidelines for detecting and referring patients with suspicion of colorectal cancer.