The 27th Annual Rural and Remote Medicine Course • April 4-6, 2019
Halifax, NS. • *COASTAL CONNECTIONS*
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Session: Thursday	
Session: 100 A - Plenary ***Christy Simpson***	**Urban Mistakes about Rural Care: Rethinking Rural Health Ethics**
Session: 100 B - Plenary ***TBD***	
Session: 100 ***Andrew Kotaska***	**VTE Guidelines Ignore the Lessons of EBM: Snake Oil and Conflict of Interest** **Most DVT identified in screening studies of hospitalized patients remain clinically insignificant. These studies markedly overestimate the risk of clinical VTE and the benefit of heparin prophylaxis, yet form the basis of the "Getting Started Kit" recommended by Accreditation Canada to help hospitals develop VTE guidelines. In compliance, most Canadian hospitals have instituted VTE guidelines that vastly over-recommend low molecular weight heparin. Most hospitalized patients have a risk of clinical VTE lower than the bleeding risk from heparin. They should not receive heparin until and unless randomized controlled trials demonstrate more benefit than harm. The author of the Getting Started Kit was restricted from involvement with the latest edition of the American College of Chest Physicians VTE Guidelines because of conflict of interest, including financial ties to six companies that produce anticoagulants. These conflicts of interest were not declared in the Getting Started Kit.** *1. State the approximate magnitude of clinical VTE risk in typical hospitalized patients.* *2. List the five highly important risk factors that warrant thromboprophylaxis.* *3. Describe standard tools of evidence-based medicine tools and apply them to a critical analysis of VTE guidelines.* *4. Estimate the magnitude of benefit and harm from low-molecular weight heparin in typical hospitalized patients.* *5. Explain why it is critical for real and potential conflicts of interest to be openly declared by academic clinicians and guideline authors.*
Session: 101 ***Peter Vaughan***	**Digital Rural Health** *1. Describe how digital health technology will disrupt the status quo in the delivery of health care.* *2. Evaluate opportunities for real-time information and "big data" analytics to improve the timeliness, equity and effectiveness of public health and patient care.* *3. Analyze how emerging information technologies will enable patients to exert control over their personal health information and proactively manage their health and health care.* *4. Expose the paradox of rural digital health: those communities most in need of improved digital connectivity to compensate for their remoteness are the least connected and included.* *5. Describe the need for a pan-Canadian digital health strategy and regulation.* *6. Define a broader understanding of digital public health ecology. That is, the impact of digital health on and between people and the transformation and flux of energy and matter.*
Session: 102 ***Gary Eugene***	**Serving With the Heart: A Perspective on Care Delivery to First Nations Clients** **The aim of this workshop is to provide a perspective on care delivery to First Nations Clients. At the end, the participants will demonstrate a working knowledge of BC First Nations Health and Wellness. The practitioners will be able to self-reflect on their own bias as a life-long learner. They will learn some of the elements in traditional healing practices. This workshop will be**

	helpful for any health practitioner working with First Nations clients or is interested to work in First Nations environment. It will provide some tools to create a lasting impact on their patient experiences and health outcomes. *1. Develop a cultural understanding of First Nations Perspective on Health and Wellness.* *2. Describe the impact of the Residential Schools System.* *3. Identify some of the elements of the Traditional Health and Wellness Framework of BC First Nations.* *4. Raise awareness of the Cultural safety and Humility at work.* *5. Create a safe environment.* *6. Improve active communication.* *7. Explore Self-Compassion and Compassion.* *8.Small Group Activities*
Session: 103 ***Sarah Giles***	**How to Get Your Non-Fiction Writing Published** **Could your email rants be the makings of an Op Ed? Do you write non-fiction but leave it to sit in a file on your computer? Come to this session for tips on how to move your writing from your computer to the pages of magazines and newspapers.** **Sarah Giles is a rural/remote family/ER/humanitarian doctor and former a fellow in global journalism at the Munk School of Global Affairs at the University of Toronto.** *At the conclusion of this activity, participants will be understand various options for publishing non-academic non-fiction.* *1. Participants will identify venues for pitching non-academic non-fiction.* *2. Participants will be able to formulate a pitch.* *3. Participants will demonstrate an ability to distinguish an opinion piece from a reported piece.* *4. Participants will understand the process of working with an editor once a pitch is accepted.*
Session: 104 ***Jared Van Bussel***	**Surgical and Obstetrical Networks in the Western Provinces**
Session: 105 ***Samantha Chittick***	**The Infrequent Travel Medicine Consult - Tips, Tricks and Resources** **An approach to the infrequent travel medicine consult, with a focus on common travel vaccinations and medications, and touching upon special populations (pregnant women, children, immunocompromised, and visiting friends and relatives), other infectious disease/injury prevention counseling information, and easy-access resources for you as the health care provider. Samantha Chittick is a recent graduate doing rural Family Medicine locums in Southwestern Ontario. She volunteers a couple months a year (a cumulative 8 months so far) at a small rural hospital in West Africa. In the last few years she has undergone approximately 1000 hours of in-person and online coursework, modules, and study in tropical medicine through the University of Minnesota, to obtain a Clinical Certificate of Knowledge in Clinical Tropical Medicine and Travelers' Health (CTropMed) through the American Society of Tropical Medicine and Hygiene (ASTMH).** *1. Become comfortable with an overall approach to pre-travel care and the travel medicine consult in your office.* *2. Review indications, contraindications, and use of different travel vaccinations.* *3. Review indications, contraindications, and use of prescription and non-prescription travel medications.* *4. Review travel vaccinations, medications, and recommendations for pregnant women, pediatric patients, immunocompromised patients, and those visiting friends and relatives (VFR).* *5. Discuss how to appropriately counsel travelers. 6. provide some point of care resources for you in your office.*
Session: 106	

Session: 107 ***Melissa Holowaty***	**SBI(R)T for Alcohol Use Disorder** **Screening, brief intervention, and referral for treatment is a paradigm of care to identify patients along a spectrum of alcohol use from those at risk of harm to those already suffering from a severe use disorder. Using a motivational interviewing framework, patients at risk of harm are provided with information in keeping with their stage of change. Those patients identified with a moderate to severe use disorder were typically referred for treatment. However, medical alcohol treatment is difficult to access, and the medications used for treatment are easy to prescribe and monitor by the family physician. Use of various screening strategies, how to provide feedback and how to prescribe anti-craving medications will be discussed.** *1. Effectively and efficiently apply screening techniques for alcohol use disorder.* *2. Provide feedback and information regarding alcohol use, respecting the patient's stage of change.* *3. offer appropriate medical therapy for treatment of moderate to severe alcohol use disorder.*
Session: 108 ***Anne Robinson***	**Introduction to Management of Opioid Use Disorder** **We are in the midst of an opioid epidemic that is causing countless preventable deaths. You almost certainly have patients in your practice who are opioid-addicted or are demonstrating "red flags" for opioid abuse. Many of our rural and remote patients cannot access Addictions Clinics. Family physicians are ideally situated to identify and manage patients with OUD – referral to addictions specialists is rarely needed. This workshop will get you started with the basic skills and knowledge you need to treat OUD in a low resource setting.** *1. List the key criteria for diagnosis of OUD.* *2. Define "pseudoaddiction".* *3. Describe the basic pharmacology of buprenorphine/naloxone (bup/nlx), its mechanism of action, and safety profile.* *4. Outline the approach to bup/nlx induction and the key elements of ongoing follow-up.* *5. Describe the process for establishing a treatment program in communities that do not have a pharmacy or on-site pharmacist.*
Session: 109 ***Fraser Turner***	**What is Real? How the History and Personalities of Quantum Mechanics Affect our Understanding of Reality**
Session: 110 ***Mike Herman***	**Pulmonary Embolism: Diagnosis, Management, and Controversies** **My talk aims to summarize the state of the art of diagnosing and treating pulmonary embolism, with a focus on streamlining diagnosis and decision making in a resource-limited setting. Spanning the usage of laboratory markers and diagnostic imaging (including bedside point-of-care ultrasound), to choosing the appropriate treatment for your patients, I hope to concisely but thoroughly review the ins and outs of pulmonary embolism. I also will review some of the newest literature and controversies in pulmonary embolism management in the hopes that you can take this new information back in to your own practice.** *1. Review the risk factors and diagnostic algorithm of pulmonary embolism.* *2. Review the strengths and weaknesses of imaging for pulmonary embolism, including point-of-care ultrasonography.* *3. Review the treatment of pulmonary embolism, including use of thrombolytics, DOACS.* *4. Review some of the latest research and controversies in pulmonary embolism, including home treatment, workup in pregnancy, adjustments to the D-Dimer threshold, and sub-segmental pulmonary embolism.*
Session: 111 ***Michael Parsons***	**Ultrasound Guided Procedures**
Session: 112 ***Hassanali Kapasi***	**A Checklist Manifesto for the Rural ER Doc** **Atul Gawande in his book The Checklist Manifesto says "...the volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably." He argues that checklists can improve the ability of medical professionals to deliver safer and more reliable care.**

	Though checklists are found everywhere in medicine (including life support algorithms, standardized admission orders, triage and nursing notes, anesthesia records, etc) the emergency department history and physical record remains a bastion of blank lines and space. **This talk will discuss how presentation-specific checklists can augment your history and physical to, as Gawande says, "...provide reminders of only the most critical and important steps--the ones that even the highly skilled professional using them could miss"** *1. Discuss the presenter's journey towards using checklists for the ER history and physical.* *2. Discuss the rationale for using checklists in the ER.* *3. Review several examples of checklists used routinely by the presenter.*
Session: 113 ***Paul Dhillon and Simon Moore***	**Smart Studying for the CCFP Exam - Tips, Tricks, and Strategies** **Using their energetic and engaging teaching style and a dynamic two-speaker presentation format, Dr. Moore & Dr. Dhillon will review important medical updates and need-to-know content for anyone about to write the certification examination in Family Practice and practice in a rural context. As well, important exam strategies and tools to help increase exam performance will be reviewed. This session is highly interactive, making use of mock quizzes, audience involvement, and question-and-answer sessions. In order to respect the confidential nature of actual exam content, the content, tools and techniques have been developed solely based on the publicly-available free CCFP exam content available on the CFPC's website.** **Dr. Moore & Dr. Dhillon are recent CCFP graduates who help residents prepare for the CCFP exam. Dr. Simon Moore is heavily involved in medical student and postgraduate medical education. He has consistently received outstanding teaching evaluations including at FMF since 2011. His topics have included "Starting Insulin in Type 2 Diabetes WITHOUT Losing Sleep at Night", "I'm Not Injecting Poison Into My Child: How to confidently debunk your patients' anti-vaccination myths", and "From Great to Outstanding: Take your medical presentations to the next level." He has also delivered these and many other presentations at multiple provincial and national conferences including FMF and the OCFP Annual Scientific Assembly; he has practiced in rural and urban BC, Ontario, and Northwest Territories. Dr. Paul Dhillon is the Editor of the book The Surprising Lives of Small Town Doctors and enjoys practicing rural and remote medicine both in Canada and Internationally.** *1. Master simple, easy-to-remember tools to understand and efficiently apply the Patient-Centred Approach that underlies the CCFP exam.* *2. Identify recent guideline changes to major family practice topics and rural family medicine topics, and apply these to sample written exam questions during the session.* *3. Augment performance by implementing in-exam techniques that increase mental performance and aid in easily identifying common CCFP exam errors.*
Session: 120 ***Nicole Currie, Sarah Gower and Stacy Desilets***	**Mifegymiso in a Rural Community - How to Make it Work** **The introduction of Mifegymiso to Canadian women in 2017 heralded a significant step forward in women's reproductive rights. Prior to this many rural Canadian women facing an undesired pregnancy had significant barriers to accessing timely and safe options for terminating a pregnancy. In this workshop we review the use of Mifegymiso in two rural Ontario communities where maternity and women's health services are offered largely by family physicians. We will explore how the medication works, and share how our communities developed efficient methods of ensuring women who present both in clinic and emergency departments receive timely care. Initial statistics from our programs will be shared for discussion.** *1. Understand the differences between medical and surgical abortions.* *2. Learn about the legislation and regulations governing use of Mifegymiso.* *3. Understand the pharmacology, risks and benefits of use, and effectiveness of Mifegymiso.* *4. Understand how to safely use Mifegymiso.* *5. Explore real life experiences using Mifegymiso in rural communities.*
Session: 121 ***Peter Montesano***	**Advances in Diabetes Management - Devices to Medications to Philosophy**
Session: 122	**Being Culturally Safe: Reducing Barriers to Care for Onkwehonwe Patients** **This workshop will discuss experiences of racism within the healthcare system for Onkwehonwe people - patients, their**

Yotakahron Jonathan	**families, medical students, residents, and physicians. By examining a few case studies, we as a collective can discuss what went wrong and how we may be able to prevent incidents of harm and improve patient safety.** *1. Witness stories of harm, racism, and violence that Indigenous people face within the health care system.* *2. Develop an understanding of Indigenous peoples' experience and barriers to accessing care.* *3. Discuss the harms of indifference in Canadian society when it comes to Indigenous issues.* *4. Develop and discuss ways forward.*
Session: 123 ***Sarah Giles and Joni Guptill***	**Incorporating Humanitarian Medicine in Your Rural/Remote Career** **Though many rural and remote physicians possess skills that would transfer well to the humanitarian sector, many cannot visualize how to incorporate humanitarian work into their careers.** *1. Understand the pros and cons of short-term "volun-tourism" and humanitarian work.* *2. Appreciate the benefit of further education in tropical disease management.* *3. Learn about well-known and novel ways to take time away from your practice.* *4. Learn about different options for participating or supporting humanitarian work.*
Session: 124 ***Sean Ebert***	**Continuous Quality Improvement in Rural Low Volume Surgical Programs** **Participants will have an opportunity to examine and discuss the application of quality improvement principles, processes and structures as well as specific challenges in the development of the BC Rural Surgical and Obstetrical Networks program.**
Session: 125 ***Bill Ehman***	**Big News in Canadian Intrapartum Fetal Surveillance: The new Guideline! (To be Repeated on Friday.)** **This presentation will review the significant changes in the new 2019 SOGC Intrapartum Fetal Surveillance guideline. Using clinical examples, the focus will be on importance of interpreting the classified Intermittent Auscultation (IA) or Electronic Fetal Monitoring (EFM) in light of the total clinical situation before responding. A brief review of the method and classification of IA and EFM will be provided followed by a review of the changes in the definition of abnormal IA, the significance of tachysystole and new definitions of complicated variable decelerations. Effective strategies for responding to abnormal surveillance will also be discussed.** *1. Identify the changes in the 2019 SOGC Intrapartum Fetal Surveillance Guideline.* *2. Discuss the new focus of the principles of Intrapartum Fetal Surveillance.* *3. Describe IA and EFM classification, interpretation and response.* *4. Describe the new indications for EFM and changes to definitions of complicated variable decelerations.*
Session: 126 ***TBD***	**CaRMS Survival Tips**
Session: 127 ***Melissa Holowaty***	**Creating a Chronic Pain Self-Management Program on a Shoestring** **Chronic pain is present in everyone's practice. Self-management allows patients to take control over their pain without relying on external sources – such as medication or health care professionals. However, you don't have to be an expert in chronic pain management to be able to assist your patients become managers of their own pain journey. Using both real world cases, didactic, and demonstrative methods, you will learn how to discuss chronic pain in a patient-friendly manner, demonstrate a variety of techniques that can be utilized by patients without any outside assistance, and be able to recommend different strategies based on the characteristics of your patients' profile. No matter where you are, or how much funding you or your population has access to, patients can use self-management strategies with a little help.** *1. Discuss three self-management strategies.* *2. Demonstrate two techniques that can be done by patients at home. 3.Recommend different self-management strategies to individual patients based on their unique profile.*

Session: 128 ***Anne Robinson***	**Case Discussions in Management of Opioid Use Disorder** **This workshop will allow the participant to discuss management of various issues that commonly occur in the treatment of opioid use disorder. Common case scenarios will be reviewed, but participants are also welcome to bring their own clinical cases for discussion** *1. Describe a therapeutic approach to the patient with persistent positive urine drug screens.* *2. Discuss diversion behaviour with a patient.* *3. Outline key considerations for management of opioid use disorder in pregnancy.* *4. List some options for managing acute pain in patients who are taking buprenorphine/naloxone.*
Session: 129 ***Gerard MacDonald***	**The Microbiome: We Are Not Alone** **A general interest talk on one of the hottest topics in biology today and its implication for patient care. A brief overview of the history of how we got here, and how this may change the paradigm on how we may manage conditions such as obesity, diabetes, bowel disorders , allergies, malignancies, and pregnancies, as looking at what the literature has to say about probiotics.** *1. An introduction to our current understanding of the Human Microbiome.* *2. Review current evidence based research and role of Human Microbiome in managing health and disease now and in the future.*
Session: 130 ***Carrie Herman***	**Introduction to the Court Room - A Legal Primer for Doctors** **This talk will focus on the role of a doctor subpoenaed to testify as a Crown witness in a criminal trial. It is my hope that this talk will help to ease anxieties for doctors who have never been subpoenaed to testify before and are unfamiliar with the trial process.** *Participant will learn about:* *1. The types of criminal cases for which a doctor might be required to give testimony.* *2. Distinctions between eyewitness testimony and expert testimony.* *3. How to gather information after receiving a subpoena, in order to prepare for trial.* *4. Basic courtroom procedure, with explanations of the roles of Crown counsel, defense counsel, and the judge.* *5. The types of questions asked during direct examination and cross-examination.*
Session: 131 ***TBD***	**Rural Critical Care – Obstetrical Emergency Delivery**
Session: 132 ***Shira Brown***	**Approaching the Difficult Airway in a Variety of Hospital Settings**
Session: 133 ***John Pawlovich***	**Transforming Telehealth in Rural & Remote BC – Calling Codi!** **The rural & remote emergency room (ER) remains one of the leading health care challenges in Canada and around the world. Geographic and human isolation, low resources, climate, daily anxiety and fear, fatigue, minimal specialist back up, etc., are just a few of the obstacles that relentlessly erode the spirit and confidence of rural physicians. Life for a rural and remote physician is not easy. For many, the mountain to cross over to a successful and enjoyable life is often the rural emergency room. Simply, Codi is the thoughtful integration of technology and the "right people" to help support rural physicians during some of their most stressful and challenging times in the emergency room. It is an "on-demand", "24/7" critical care strategy through a secure APP on a smart phone. Literally, it is an "intensivist in your pocket" that can be accessed no differently than a Face Time call. There is no bridge, switchboard or middle agency between the rural physician and intensivist. Codi's simplicity is what makes it so powerful. Through the touch of a virtual button on a most familiar device, people are connected in real time to work together through complex, intimidating and anxiety filled situations. Virtual critical care consults are dictated and sent on for transcription all through the secure APP. Medical reports flow back to the rural physician in an extremely timely fashion where they can be integrated into the patient's chart. No one has to refresh their relationship with the technology (smartphone)**

	as it is something all physicians in the 21st century know intimately, use daily and keep near them. Codi specialists are selected for their knowledge and skill, compassion and empathy, rural awareness and willingness to help. *1. Participants will experience a live demonstration of the Codi smartphone App.* *2. Participants will see and hear how are rural physicians in British Columbia are using Codi at the point of care.* *3. Participants will learn how education and clinical support are merged at the point of care.* *4. Participants will learn about the history of Codi and where the future is headed with respect to real time support using the Codi App.* *5. Participants will be able to engage in a question and answer period.* *6. Participants are encouraged to watch the Codi video prior to the presentation at https://vimeo.com/310895903.*
Session: 139 - Lunch ***Stu Iglesias***	**ESS/OSS Networking Lunch**
Session: 140 ***Andrew Kotaska***	**Informed Consent & Refusal in Obstetrics: A Practical Ethical Guide** **Birth is a normal physiological process that usually occurs without intervention. When intervention in childbirth is indicated, a woman's informed consent is required. Yet threats to informed consent exist: over-estimation of risk, imbalance of authority, and restrictive administrative policies can all coerce women into undesired interventions. When there is a conflict between caregivers' recommendations and a woman's informed choice, should autonomy or beneficence prevail?** **This presentation addresses the ethical concepts of autonomy, beneficence, and non-maleficence as they relate to the process of informed consent and develops a framework for optimal informed consent that includes: a woman's right to complete unbiased information regarding all clinical alternatives, including no intervention; her right to access her chosen alternative; her right to decline any recommended treatment without prejudice, and nonetheless to receive excellent care in accordance with her values and choice; and her ethical and legal responsibility for adverse outcome associated with informed refusal.** **Dr. Kotaska will discuss the critical value of the therapeutic alliance and challenge caregivers to preserve it, even when women's choices diverge from guidelines or caregivers' recommendations. He will provide practical advice on risk estimation and highlight the difference between "offering" and "recommending" intervention. The integral role of clinician objectivity, humility, and self-awareness to achieving truly informed consent will be explored.** *1. Define autonomy, beneficence, and non-maleficence.* *2. List the essential components of informed consent.* *3. Appreciate the "fuzzy" nature of clinical decision making and the difference between "offering" and "recommending" intervention.* *4. Identify their own values and biases that might interfere with informed consent.* *5. Better understand the context of risk.* *6. Outline the critical value of the therapeutic alliance and the integral role of the clinician in achieving informed consent.*
Session: 141	
Session: 142 ***Mike Kirlew***	**SAMP Prep**
Session: 143	**MD Advocacy on Climate Change** **It is becoming increasingly evident that the climate crisis has serious implications for ecosystems, communities, and civilization itself. To date, the health frame has been underused as a method of creating understanding and engagement on the issue.**

Joe Vipond	**Health professionals, as trusted members of society, can play an outsized role in creating the changes needed to allow for the speedy transformation of our energy systems. Case studies using the Alberta Coal Phase Our, Canadian Coal Phase Out, and creation of Alberta Health Service's Office of Sustainability will illustrate the discussion** *1. To gain a greater understanding of the health implications of climate disruption and the health benefits from mitigation of greenhouse gas emissions.* *2. To understand the role health and medical professionals can play in successful advocacy on the climate crisis.*
Session: 144 ***Ryan Falk and Nicole Ebert***	**Careers in Rural Surgery (ESS/OSS) for Family Physicians** **Surgical services in rural and remote communities are often provided by family physicians with additional surgical training. These physicians either provide a broad scope of services which includes cesarean sections, appendectomies, hernia repairs, laparoscopic tubal ligations, etc (Enhanced Surgical Skills - ESS), or they provide surgical obstetrics alone (Obstetrical Surgical Services - OSS). This is an exciting career path for rural family physicians who want to support and maintain rural hospital programs and is soon to be designated a Category 1 program with its own Certificate of Added Competence, on par with Family Practice Anaesthesia.** *Participants will learn:* *1. What Enhanced Surgical Skills is in rural Canada.* *2. What a "a day in the life" as an ESS and OSS physician is like.* *3. What training options are available for those interested in ESS.* *4. What a Category 1 Program and Certificate of Added Competence mean.*
Session: 145 ***Vicki Van Wagner***	**Maternal Newborn Gap Analysis: Rural and Remote OB Services in Ontario** **This talk will review the findings of a 2018 qualitative and quantitative analysis of rural and remote intrapartum services in ON including innovative approaches to serving Indigenous communities and collaborative models with family physicians and midwives. Participants will discuss and debate best practices for access and sustainability.** *1. Recognize the impacts of Ontario geography on access to care.* *2. Describe patterns of care in rural and remote communities in Ontario.* *3. Identify variations in models of care, staffing models and human resources strategy that help support rural intrapartum care.* *4. Discuss the potential for regional maternal-child networks to contribute to sustainable intrapartum services.*
Session: 146 ***Roy Kirkpatrick***	**Hernias - Investigation and Treatment** **This talk will discuss the history and evolution of hernia surgery and current methods of hernia repair. Practical approaches to investigation and diagnosis will be addressed.** *1. Outline history and evolution of hernia care.* *2. Discuss appropriate investigation of hernias.* *3. Discuss the global burden of disease and innovative means of meeting that burden.* *4. Evaluate the controversy around the use of mesh in hernia repair.*
Session: 147 ***Jon Witt***	**Code Orange Rural Preparedness: Lessons learned from the Humboldt Bus Crash** **Dr Witt will review the events of the Humboldt bus crash Mass Causality Incident (MCI) including EMS on-scene triage, the rural hospital response and the ultimate evacuation of patients to tertiary care. Lessons learned from this experience will be shared with participants with the goal of improving the rural hospital MCI response. There will be opportunity for questions and discussions.** *1. At the end of this presentation participants will have an improved understanding of MCI triage and the 'disaster mindset'.* *2. Participants will gain a greater understanding of communication pitfalls in the MCI; strategies to avoid these pitfalls will be explored.* *3. Participants will be aware of the importance of Critical Incident Stress Management for healthcare providers in the period following the MCI event.*

Session: 148 ***Shirley Lee***	**Is No News Good News? Build a More Reliable Follow-up System for Test Results (2 hours)** **This 2 hour interactive case-based session is designed to help physicians improve a more reliable follow-up system for test results in their practice** *1. Describe the legal and professional responsibilities related to follow-up of test results.* *2. Identify opportunities for improvement of test results management in one's own practice.* *3. Formulate a plan to implement a reliable test results management system.*
Session: 149 ***Gerard MacDonald***	**Common ENT Urgent Problems** **A workshop combining both slide presentation and practical hands on management of conditions you will deal with frequently. Ample opportunity for Q&A!** *1. A review of common urgent ENT problems presenting in the office and ER.* *2. Clinical pearls to help you manage in a timely fashion.* *3. Knowing when you should refer.*
Session: 150 ***Sara Goulet***	**Truth and Reconciliation Calls to Action: How are we Doing as Family Docs in Canada** **The Truth and Reconciliation committee examined the lasting and extensive negative impacts of residential schools in Canada. On Dec 15, 2015, they released the '94 calls to action' outlining the steps needed to be taken by all levels of government, religious institutions, civil groups and ALL Canadians, in a variety of programming areas, including health. This talk will examine where we are in Manitoba with regards to government, university and other organizations response to date. We will then explore how to 'act' in our own office practice in a manner aligned with the TRC's calls to action, including how to access resources to strengthen our skills as culturally safe and trauma informed care givers. There will be time for questions and group discussion in this session.** *1. Review some projects, initiatives by government, university and institutions in Manitoba around ca calls to action.* *2. Review the gaps in meeting the '94 calls to action' at variety of levels in health care system.* *3. Review what we can do as health care practitioners in our office day to day to meet the 'calls to action'.*
Session: 151 ***Wade Mitchell, Peter Wells and Matt Distefano***	**Advanced Skin Excision/Repair (2 hours)** **This 2 hour workshop is ideally for those who have already developed some skills in advanced skin repair (flaps) but wish to extend their knowledge and capacity. Extensor tendon repair will also be covered. The session will attempt to address the needs of the group and provide case-based approaches to these topics - ie) technique/ suture choices/ needles etc./ subcutaneous buried sutures to reduce tension – improve healing./ scar. Advanced repairs: V on Y ? Rotational Flap/ Advancement /Burrows /Bi-lobed/ Ext Tendon Repair – Discuss 'danger areas' Temporal Artery /parotid gland / lips – vermilion border/ strategies for upper lip/ perilip/nasal repairs.** *Goal: for each attendee to leave with 2-3 new skills by end of the session.*
Session: 152 ***Danny Kim***	**Quality Improvement in Rural Research** **One of the strategic goals of the Office of Distributed Education is to increase the research capacity of physicians across the Schulich School of Medicine & Dentistry's distributed sites. To better understand the needs of its decentralized faculty a research initiative was created to identify barriers and facilitators to research engagement for decentralized faculty. A total of 54 in-person interviews were conducted with faculty located in distributed sites. Barriers most commonly included time, lack of skills and the unique practice context many physicians in distributed sites face. Improvements to patient care and personal interest were the most common facilitators. Quality Improvement (QI) may address these concerns while also increasing the research capacity of our decentralized physicians. QI presents an approachable methodology for physicians with limited institutional resources to engage in rigorous research. While QI has been utilized in healthcare for several decades, many physicians are unclear as to its role in a clinical setting, how to best implement QI and how QI may differ from traditional research. This workshop will function to introduce the concept of QI, highlight similarities and differences to research, use a case-study approach to critique QI initiatives and formulate QI projects for the participants. This workshop is intended for participants who: are interested in pursuing an approachable research project, want a deeper understanding of QI methodology or have clinical inefficiencies they want to address.** *1. Define QI.* *2. Explain the differences and similarities between QI and research.* *3. Review and critically appraise QI projects.*

	4. Propose a QI project given a case study.
Session: 153 ***Luis Rivero Pinelo***	**Colorectal Cancer**
Session: 160 ***Magnus McLeod***	**Approach to Abnormal Liver Injury Tests** **This discussion will highlight the importance of relating the history, exam, presentation, and pattern of liver tests to determine the course of action which includes diagnosis and prognosis. I will not be discussing any treatments for liver disease.** *1. General approach to liver injury tests.* *2. Cases: a)Acute Cholestasis b)Chronic Cholestasis c)Acute Hepatocellular Injury d)Chronic Hepatocellular Injury.* *3. When to Refer.* *4. Questions.*
Session: 161 ***Camille Gagnon***	**Too Much of a Good Thing? How to Successfully Deprescribe** **National drug claim reports indicate that older adults living in rural areas use more potentially inappropriate medications than seniors living in urban areas (CIHI 2018). This can be explained by a variety of factors, such as limited access to safer non-pharmacological therapies. This case-based session will discuss strategies adapted to the rural context for successfully tackling polypharmacy. We will identify which medications to deprescribe in older patients, integrating highlights from the 2019 American Geriatrics Society 2019 Updated Beers Criteria. Evidence-based tools and tips will be shared to help guide physicians, from initiating conversations about deprescribing sedative-hypnotics with patients and colleagues through to safely managing the taper and substitution with non-drug therapies. By overcoming barriers to deprescribing, every physician can become an effective deprescriber.** *1. Describe practical deprescribing strategies in inpatient and outpatient settings.* *2. Develop a customized approach to deprescribing in your practice setting.* *3. Familiarize the audience with the evidence-based tools available to assist in the deprescribing process.*
Session: 162 ***MUN RMIG***	**Experience Rural Newfoundland & Labrador**
Session: 163 ***Joe Vipond***	**Practical MD Advocacy** **Successful advocacy means changing minds, either individually sitting across the table, or at a society level, through media engagement. Learn some of the ins and outs of meeting management, engaging with your counterpart so that they understand why your priority is their priority. Engaging with media is an art form that can be learned. What are some of the basics of a media interview, either by video or radio? How can you write an effective op/ed? These are the tricks that allow one to change the hospital, the health system, or the world.** *1. Learn the background for successful political advocacy: choosing the right target, making many partners, and message framing.* *2. Learn how to run a successful meeting to engage participants and change minds.* *3. Practical learnings on media. How to write an op/ed and do a tv or radio interview.*
Session: 164 ***Stu Iglesias and Roy Wyman***	**CAC's for ESS and OSS - A Good Fit for Generalism?** **The last three years have seen the introduction of a new Certificate of Added Competence in Enhanced Surgical Skills. Its proponents feel that this will provide a high level of credentialing for Family Physicians wishing to offer an advanced skill set. By so doing, they build capacity in Family Medicine that benefits both their colleagues and their patients. Yet others are concerned about fragmentation in Family Medicine. In this workshop, attendees will learn about the implementation of this new CAC and to discuss ways to ensure the CAC meets the needs of patients communities and practitioners as well as the practice of family medicine as a whole.**

Session: 165 ***Gillian Sheppard***	**IVF Related Emergencies** **A case based discussion of life-threatening conditions in patients who have undergone in vitro fertilization (IVF).** *1. List three life-threatening complications of IVF.* *2. Discuss the role of point of care ultrasound in diagnosing IVF related complications.* *3. Compare and contrast the management of IVF related emergencies in rural vs urban emergency departments.*
Session: 166 ***Charlene Fitzgerald***	**Group Prenatal Care in Sheshatshiu: Experience to Date** **There are significant challenges providing prenatal care and enabling mothers to have healthy pregnancies in some rural Indigenous communities. In order to improve child and maternal health in the community of Sheshatshiu Innu First Nation in Labrador, the community's clinic has begun delivering the CenteringPregnancy program as an alternative to conventional prenatal care. The program provides group visits that combine health assessment, interactive learning and community building, with the aim of empowering mothers to play an active role in their health during pregnancy and into motherhood. However, there is still much to be learned about adapting the program to be culturally relevant and effective in improving health outcomes for mothers and children in Sheshatshiu. This workshop will bring together practitioners working to improve prenatal care in Indigenous communities, to share knowledge and experience, identify common and unique barriers and opportunities, and to develop ideas about the best ways to deliver prenatal care. The facilitator will share her experiences providing prenatal care in the community of Sheshatshiu, and provide findings from interviews which has assessed mothers' experiences with the CenteringPregnancyÒ program and their prenatal care experience more generally. Providers have aimed to identify ways to adapt the program to be effective and beneficial for both participants and practitioners, and culturally relevant for the community.** *1. To learn from the Sheshatshiu experience about the efficacy of employing a program such as CenteringPregnancy.* *2. To learn from insights provided by pregnant women regarding their experience with prenatal care.* *3. To learn together, through sharing of ideas and knowledge, ways of improving prenatal care and patient outcomes in rural remote and indigenous communities.*
Session: 167 ***Christopher Cox***	**Advanced PoCUS Modalities to Make Diagnosis in Resource Limited Settings**
Session: 168 ***Shirley Lee***	**Is No News Good News? Build a More Reliable Follow-up System for Test Results (2 hours)** **This 2 hour interactive case-based session is designed to help physicians improve a more reliable follow-up system for test results in their practice** *1. Describe the legal and professional responsibilities related to follow-up of test results.* *2. Identify opportunities for improvement of test results management in one's own practice.* *3. Formulate a plan to implement a reliable test results management system.*
Session: 169 ***Laura Soles***	**Pride and Peril** **A low key session for anyone who has a rural doc in their life. We will be having discussions about the successes and challenges of living in a rural community. This will be a safe place for people to meet, connect and share with each other. Everyone welcome.** *1. Participants will meet others who have a rural doc in their lives and hopefully develop lasting connections.* *2. Participants will have opportunity to seek solutions for their challenges.* *3. Participants will learn about the supportive resources available to them.* *4. Participants will leave feeling they are part of the "family" that is rural medicine.*
Session: 170 ***Sara Goulet***	**Recruitment and Retention in Rural and Northern Areas** **Communities in rural and northern areas struggle to recruit and retain physician services in their areas. The health and wellness of these communities are negatively impacted by shortage of this resource. This talk will examine the steps taken by Northern Medical Unit (now known as OHS, Ongamazwiin Health Services) at the University of Manitoba to move to an organization with more physicians than jobs to accommodate them! What key principles can be learned for any organization on how to**

	recruit and retain satisfied physicians for more than 30 years. Time will be allotted for group discussion and questions in this session. *1. Review the history of the Northern medical unit (know named OHS) with respect to establishing physician resources in northern isolated remote communities which are traditionally challenging to staff.* *2. Review the key lessons learned in recruiting physicians to northern communities.* *3. Review the key lessons learned in retaining physicians as resources to northern communities for 10, 20, 30 years and beyond.*
Session: 171 ***Wade Mitchell, Peter Wells and Matt Distefano***	**Advanced Skin Excision/Repair (2 hours)** **This 2 hour workshop is ideally for those who have already developed some skills in advanced skin repair (flaps) but wish to extend their knowledge and capacity. Extensor tendon repair will also be covered. The session will attempt to address the needs of the group and provide case-based approaches to these topics - ie) technique/ suture choices/ needles etc./ subcutaneous buried sutures to reduce tension – improve healing./ scar. Advanced repairs: V on Y ? Rotational Flap/ Advancement /Burrows /Bi-lobed/ Ext Tendon Repair – Discuss 'danger areas' Temporal Artery /parotid gland / lips – vermilion border/ strategies for upper lip/ perilip/nasal repairs.** *Goal: for each attendee to leave with 2-3 new skills by end of the session.*
Session: 172	**Oral Research Presentations - Original Primary Care Solutions**
Session: 173 ***Luis Rivero Pinelo***	**Hepatitis Viral C - No Longer a Tabu for Family/Rural Docs**
Session: 180 ***Paul Dhillon and Simon Moore***	**THE MEDICAL CIRCUS - A Humourous Review of What's New and Need-to-know for Primary Care from Coast to Coast** **Watch Dr. Moore & Dr. Dhillon canoe across Canada, surmounting inter-provincial barriers while reviewing all of the latest in Canadian guidelines and important articles that affect your clinical practice. Using their energetic and engaging teaching style, with a splash of humour, Dr. Moore & Dr. Dhillon will review important medical updates and need-to-know content for anyone practicing Family Medicine in Canada. Dr. Moore & Dr. Dhillon are the Founders of The Review Course in Family Medicine, Canada's only national review of the latest and greatest in Family Medicine, Rural Medicine, and Hospital Medicine.** **Dr. Simon Moore (www.DrMoore.ca) is heavily involved in medical student and postgraduate medical education. He has consistently received outstanding teaching evaluations including at FMF since 2011. His topics have included "Starting Insulin in Type 2 Diabetes WITHOUT Losing Sleep at Night", "I'm Not Injecting Poison Into My Child: How to confidently debunk your patients' anti-vaccination myths", and "From Great to Outstanding: Take your medical presentations to the next level." He has also delivered these and many other presentations at multiple provincial and national conferences including FMF and the OCFP Annual Scientific Assembly; he has practiced in rural and urban BC, Ontario, and Northwest Territories. Dr. Paul Dhillon is the Editor of the book The Surprising Lives of Small Town Doctors and enjoys practicing rural and remote medicine both in Saskatchewan, BC, NWT, and Internationally.** *1. Understand recent guideline changes to major family practice topics and rural family medicine topics.* *2. Apply unique mnemonics from the latest Canadian guidelines, e.g. Diabetes and Marijuana use in relation to driving.* *3. Enjoy learning primary care updates in a non-didactic teaching style*
Session: 181 ***Ryan Falk***	**Enhanced Surgical Skills: CPD Workshop** **The Enhanced Surgical Skills Committee for Continuing Professional Development was founded in 2018 following the Banff meeting. This workshop is intended to provide the committee members and any other interested individuals the opportunity to participate in discussions related to CPD for ESS.**
Session: FRIDAY	

Session: 200 A - Plenary ***Pat Crosskerry***	**Teaching the Scarecrow: Improving Thinking to Improve Clinical Decision Making**
Session: 200 B - Plenary ***TBD***	
Session: 200 ***Mike Allan, Mike Kolber and Tina Korownyk***	**PEER Simplified Guideline for Opioid Use Disorder** **In this session we will examine common challenges to managing opioid use disorder in primary care. We will discuss the difficulty in making the diagnosis and how to screen for opioid use disorder. We will review the options for management, including Opioid Agonist Therapy and its practical application. Next, we'll consider the treatment of co-morbid conditions and adjunctive therapies like counseling. The talk will end with practical tools and recommendation from one of our upcoming primary care guidelines.** *1. Learn a simple tool to help identify Opioid Use Disorder patients in your practice.* *2. Understand the options for Opioid Used Disorder and how to apply Opioid Agonist Therapy.* *3. Apply the evidence-based approach for varying adjunctive measures like contract writing and urine testing.*
Session: 201 ***Tignish Collaborative Family Practice***	**Collaborate to Survive** **Members of an effective collaborative practice in rural PEI use story-telling, humour and multi-media clips to demonstrate the value of collaboration. No-one person is perfect, but a team can be a lot less imperfect. And a team might survive the loss of one member while a one-person service is toast if that person leaves.** *1. Achieve high level of interaction—COME IN, SIT DOWN AND SPEAK UP!* *2. Share experiences of collaboration—the good, the bad and the ugly—in a safe and relaxed atmosphere.* *3. Work out the kinks.* *4. Share tips for efficient working.*
Session: 202 ***TBD***	**Peds Sim**
Session: 203 ***Ryan Falk***	**Global Perspectives in Rural Surgical Services** **"Global Surgery" is a relatively new term which describes the provision of surgical services in under-serviced communities around the world. The development of primary health systems at the first-hospital level is crucial to the delivery of surgical services and a new focus in global health to address this unmet health need. As rural physicians, we already practice global surgery, whether managing traumas or performing cesarean sections in low-resourced areas in Canada. This workshop aims to look at rural (surgical) services from a much larger perspective.** *Participants will gain an understanding of:* *1. The major global public health trends which have lead to a refocus on primary care.* *2. The global burden of surgical disease.* *3. The role of emergency and essential surgical services at the first-level hospital within a health care system.* *4. The parallels between low-resource international settings and rural Canada.*
Session: 204 ***Stu Iglesias, Gisela Becker, Lee Yeates, Sarah***	**Boundary Spanning- Solutions to Rural Maternity Care (2 hours)** **More than 2 decades after publication of the initial Joint Position Paper on Rural Obstetrics, the attrition of rural maternity care programs continues unabated. The intention of this workshop is to initiate a a high level conversation between all the stakeholders - FP's, OB's, midwives, RN's, learners, families- that could encourage a true community of practice that would support sustainable maternity care. The format will include a few stories from communities across Canada, presented to a**

Lesperance and Kim Williams	**"leadership" panel drawn from across the professional providers. This workshop is scheduled for 2 hours with at least 50 % of the time allocated to an interactive conversation with the attendees.**
Session: 205 ***Ajantha Jayabarathan, David Zitner, Karim Keshavjee, David Goranson and Mary Johnson (Moderator)***	**Health Information and Communication Technology (2 hours)**
Session: 206 ***Archna Shah***	**Pediatric Resuscitation Cases** **Use of a case based approach to address some common resuscitative scenarios and strategies for managing the critically ill child. Case presentations include airway management, respiratory distress, shock and trauma.** *1. Review of current PALS guidelines applicable to the cases.* *2. Review of current guidelines from ATLS for the management of pediatric trauma, applicable to the cases.* *3. Review of available pediatric emergency medicine resources and tools, such as TREKK.*
Session: 207 ***Tom Goddard***	**Doctor I am Seeing Double - What's Wrong with Me?** **A practical approach to diplopia. Participants will learn what can't be missed. We will use case examples.** *1. What you can't miss as an EM provider as the cause of diplopia.* *2. Which patients need CT, CTA or MRI and how soon.* *3. Approach to double vision complaint in the ED.* *4. CN 3, 4 and 6 causes of diplopia with case examples.*
Session: 208 ***Jim Rourke and Ruth Wilson***	**Rural Road Map Implementation Committee (RRMIC): Progress and Consultation (2 hours)** **Struck in February 2018, RRMIC's key mandate is to work collaboratively to implement the Rural Road Map for Action (RRM). The RRM provides a strategy with recommendations for how to improve equitable access to safe, quality health care closer to home for rural Canadians. Key initiatives seek to advance rural education to support family physicians ready to practice in rural Canada, facilitate national forum on competencies for use to enhance Indigenous Health, advocate for exploration of a national rural physician licence, work with key stakeholders to improve the transitions of care between rural and urban centres through development of standards and referral processes, ensuring inter-operability of distance technology among rural health care settings and advocate for the establishment of a rural health research infrastructure across all jurisdictions. Through small group and large group exercises, participants will be able to learn about emerging key initiatives on priority actions and provide input on how these initiatives impact their environments. Participants will provide feedback to RRMIC on further engagement and opportunities for RRM uptake.** *1. Identify key initiatives on progress made across Canada related to the implementation of the Rural Road Map within the health and education systems.* *2. Apply the Rural Road Map to various settings by identifying actions that can be undertaken in participants' individual roles.* *3. Engage in interactive discussion on emerging initiatives such as rural patient transfers, Indigenous health competencies, and national rural medical licensure as they relate to key actions impacting on rural and remote settings.* *4.Identify challenges and opportunities for collective support in the use of RRM and what can be achieved by 2020.*
Session: 209 ***Fraser Turner***	**Spousal Working Group (2 hours)**

Session: 210 ***Bev Karras***	**Bumps on the Road to Successful Breastfeeding** **This session will look at the underlying pathophysiology of breastfeeding to promote understanding of potential issues during establishing and maintaining breastfeeding and the assessment and support to aid the successful breastfeeding dyad.** *1. What is Normal?* *2. How do we define success in breastfeeding?* *3. Assessing the Mother-Infant Dyad.*
Session: 211 ***Allison Scott***	**Slitlamps (2 hours)**
Session: 212 ***Kristy Penner and Aaron Johnston***	**See One, Do One, Plan One: Simulation of a Successful Rural Faculty Development Event** **Workshop participants will simulate a rural faculty development committee to develop a brochure for a rural faculty development CME event. Workshop participants will work in teams to simulate the planning of an event based on a faculty development conference for rural educators that is well over a decade in existence.** *1. Understand how to develop a faculty development CME workshop outline using a needs assessment tool.* *2. Learn the CFPC and Royal College requirements for accreditation of a faculty development CME event.* *3. Plan a plenary speaker event from the participants in the room.*
Session: 213 ***Fred Ross***	**Distributed Medicine National Education Administrators Group - Business Meeting**
Session: 220 ***Mike Allan, Mike Kolber and Tina Korownyk***	**New, True and Poo: New Studies Relevant to Primary Care** **In this session, we will review ten studies, which can impact primary care, from the past year. Topics will vary depending on recent studies. The presentations include questions and article reviews that focus on clinical application of the newest available information. We will discuss whether the research implications of these studies are practice-changing or re- affirming or whether they should be ignored.** *1. Briefly review evidence that highlights a new diagnostic test, therapy or tool that should be implemented into current practice.* *2. Briefly review articles and evidence that may reaffirm currently utilized diagnostic tests, therapies or tools.* *3. Briefly review articles that highlight diagnostic tests, therapies or other tools that should be abandoned.*
Session: 221 ***Dan Reilly***	**Accessing the Uterus: IUD Insertion and Endometrial Sampling** **Participants will practice IUD insertions and endometrial sampling on models.** *1. Participants will understand the indications for, and contra-indications to, IUD placement and endometrial sampling.* *2. Participants will use models to practice IUD placement and endometrial sampling.*
Session: 222 ***TBD***	**Peds Sim**
Session: 223 ***Peter Miles, Lauren Smithson and Roy Kirkpatrick***	**Surgical Pearls for ESS**

Session: 224 ***Stu Iglesias, Gisela Becker, Lee Yeates, Sarah Lesperance and Kim Williams***	**Boundary Spanning- Solutions to Rural Maternity Care (2 hours)** **More than 2 decades after publication of the initial Joint Position Paper on Rural Obstetrics, the attrition of rural maternity care programs continues unabated. The intention of this workshop is to initiate a a high level conversation between all the stakeholders - FP's, OB's, midwives, RN's, learners, families- that could encourage a true community of practice that would support sustainable maternity care. The format will include a few stories from communities across Canada, presented to a "leadership" panel drawn from across the professional providers. This workshop is scheduled for 2 hours with at least 50 % of the time allocated to an interactive conversation with the attendees.**
Session: 225 ***Ajantha Jayabarathan, David Zitner, Karim Keshavjee, David Goranson and Mary Johnson (Moderator)***	**Health Information and Communication Technology (2 hours)**
Session: 226 ***Lindsay Crowshoe***	**Indigenous Diabetes Social and Cultural Care Approach**
Session: 227 ***Sarah Giles and Sarah Mathieson***	**Real Talk About Emotional Fallout in the ER** **Everyone who practices any sort of medicine will eventually have a case that has a bad outcome or is emotionally difficult. Difficult cases in smaller communities present special challenges. In this frank discussion, we will review our personal experiences with difficult cases, attempt to normalize some of the feelings healthcare providers might have after a difficult case, and looks at ways of prospectively preparing for the inevitable.** *By the end of this discussion, participants will be familiar with: 1. Imposter syndrome and self-doubt. 2. Several coping mechanisms for dealing with difficult cases. 3. Strategies to help prospectively prepare for difficult cases.*
Session: 228 ***Jim Rourke and Ruth Wilson***	**Rural Road Map Implementation Committee (RRMIC): Progress and Consultation** **Struck in February 2018, RRMIC's key mandate is to work collaboratively to implement the Rural Road Map for Action (RRM). The RRM provides a strategy with recommendations for how to improve equitable access to safe, quality health care closer to home for rural Canadians. Key initiatives seek to advance rural education to support family physicians ready to practice in rural Canada, facilitate national forum on competencies for use to enhance Indigenous Health, advocate for exploration of a national rural physician licence, work with key stakeholders to improve the transitions of care between rural and urban centres through development of standards and referral processes, ensuring inter-operability of distance technology among rural health care settings and advocate for the establishment of a rural health research infrastructure across all jurisdictions. Through small group and large group exercises, participants will be able to learn about emerging key initiatives on priority actions and provide input on how these initiatives impact their environments. Participants will provide feedback to RRMIC on further engagement and opportunities for RRM uptake.** *1. Identify key initiatives on progress made across Canada related to the implementation of the Rural Road Map within the health and education systems.* *2. Apply the Rural Road Map to various settings by identifying actions that can be undertaken in participants' individual roles.* *3. Engage in interactive discussion on emerging initiatives such as rural patient transfers, Indigenous health competencies, and national rural medical licensure as they relate to key actions impacting on rural and remote settings.* *4.Identify challenges and opportunities for collective support in the use of RRM and what can be achieved by 2020.*
Session: 229 ***Fraser Turner***	**Spousal Working Group**

Session: 230 ***Joe Vipond***	**Evidence Based Analgesia** **The majority of physicians glean their preferred acute pain management algorithms from mentors as they train. But there is a wealth of evidence which can inform our oral analgesic prescribing practices. Using the Cochrance Database of Systemic Reviews as a guide, we'll look at why acetaminophen with codeine, and ketorolac, should not be our go-to meds. Also, we'll look at ways to minimize narcotic prescribing without sacrificing the effectiveness of our analgesia and, in turn, minimize the risk of addiction in our vulnerable patients.** *1. Learn the most effective oral medications to be used for pain management in the acute setting.* *2. Learn some of the tricks for the most effective management of acute pain in the emergency department.* *3. Learn ways of minimizing the risk of opioid overuse and dependency from acute pain management.*
Session: 231 ***Allison Scott***	**Slitlamps (2 hours)**
Session: 232 ***Chris Patey and Paul Norman***	**Rewiring in Flight** **Emergency departments (EDs) in Canada are being challenged by aging populations, decreasing community primary care options, and increased demand on emergency services. This has resulted in subpar ED metrics, overcrowding and extensive patient wait times. As health professionals grapple with this downturn, the balance between meaningful work and meaningful life becomes difficult to manage. In this session, we will present ten golden best practices developed through humble, grassroots practice in rural Newfoundland, that drastically reduce patient wait times while cultivating a culture of meaningful practice. In so doing we will help attendees advance patient and professional quality, and reflect on how life as an ED practitioner, melds with other aspects of life.** **This session is suitable for anyone interested or possibly intrigued by rural emergency medicine, but especially medical learners, rural nurses (registered and practitioner), and active family physicians who wish to improve their day to day practice involvement in emergency medicine.** **This session presents ten improvement strategies utilized by a rural family physician and nurse enriched with discussion activities. It is a combined emergency physician and nurse presentation. Previous experiences of the RN/MD combined presenter is an extremely receptive method for learner engagement, enjoyment and clarity.** *After this activity, participants will be able to:* *1. Apply take home methods and themes to help reduce wait times in their ED.* *2. Measure key performance metrics and use that information to assess patient care quality and staff satisfaction.* *3. Recognize the link between streamlined patient flow and a meaningful emergency practice.*
Session: 233 ***Lisa DeLong***	**Distributed Medicine National Education Administrators Group - Human Rights and Equity**
Session: 239 - Lunch	**Rural Maternity Care Networking Lunch**
Session: 240 ***Dan Eickmeier***	**Aggressive Patient**
Session: 241	**Early Prenatal Care Tips for Primary Care** **High quality early prenatal care is vitally important to ensure health pregnancies anywhere in Canada. As Canadian women experience more identifiable risk factors in pregnancy, providing this care has become challenging. This is especially true in**

Stacy Desilets and Brittany Baron	**rural communities where access to specialty and allied health care provider support can be limited. As complexity of prenatal care increases, some primary care providers have opted not to provide prenatal care to Canadian women. In rural communities this further restricts access to already underserved populations. This workshop will provide a review of early prenatal care with a goal of increasing the comfort level among primary care providers in continuing to care for pregnant women and to provide high quality care while doing so.** *1. Provide high quality prenatal care for women in first and second trimester.* *2. Identify patients who would benefit from ASA supplementation early in pregnancy.* *3. Explain first and second trimester genetic screening to all women.* *4. Organize appropriate investigations for women in early pregnancy.*
Session: 242 ***TBD***	**Peds Sim**
Session: 243 ***Mike Kirlew***	**Practice Changing Publications**
Session: 244 ***Andrew Kotaska***	**Surgical Obstetrics in the Hinterland: The evidence and the Art** **A potpourri of evidence and art behind operative obstetrics for physicians working in rural and remote settings.** *At the end of this session, FPs with OSS will have a greater chance of remaining confident when excrement hits the fan.*
Session: 245 ***Claudette Chase***	**The Art and The Science, The Sound and the Fury of Referring to Specialists**
Session: 246 ***Len Kelly***	**Rural Obesity Care** *1. Present the literature on intermittent fasting for weight loss.* *2. Present the literature on low carb diets and weight loss.* *3. Present interim results of a rural community's prospective weight loss study (NOT-FED study)*
Session: 247 ***Emily Hildebrand***	**Subarachnoid Hemorrhage - An Overview** **This session aims to give a brief overview on subarrachnoid hemorrhage. We will focus on patient identification, testing and parameters for diagnosis as well as management of the patient with subarrachnoid hemorrhage and the complications that can arise in the acute phase.** *1. Increase comfort with identifying those patients who require a workup for SAH.* *2. Provide a clear schematic on how to work up SAH, which tests to order and when.* *3. Management of SAH and the possible complications that can arise.*
Session: 248 ***Brent Kvern, Nancy Fowler and Ivy Oandasan***	**Rural Competence: Would You Know It If You Saw It?** **In 2018 the CFPC released the "Priority Topics for the Assessment of Competence in Rural and Remote Family Medicine". This is the culmination of several years of work done by rural family physicians to identify the distinguishing features of skillful family physicians practicing in the rural context. One of the competencies – Clinical Courage – stands out as new and novel, still requiring more development for use by clinical teachers. When presented at the FMF Rural Educators Forum, participants gravitated to this competence as "the lens through which all of the other competencies can be understood". In this interactive workshop, we will present the 'Rural Key Features' document and use a directed story-telling approach for a deeper exploration of clinical courage. We pose these questions and others: What is clinical courage? Is rational risk taking a better**

	phrase? Are they the same thing? How to balance clinical courage with over-confidence? How would you recognize and nurture clinical courage in all learners? What are the markers? How do we teach it – is there more than just role modelling? *1. Become familiar with the CFPCs "Priority Topics for the Assessment of Competence in Rural and Remote Family Medicine" and understand their application for clinical teaching.* *2. Engage with CFPC leadership to further develop an understanding of "clinical courage" and how to recognize, teach and assess it in everyday practice with learners.* *3. Reflect on their own career and the lived experience of clinical courage.*
Session: 249 ***Patti Kemp***	**SRPC Reads** **Join us for the inaugural meeting of the SRPC Book Club. We only meet once a year, but like every good book club, we'll talk about books and enjoy good fellowship. This year, we will discuss books from CBC's Canada Reads. Read one, read none or read them all – it doesn't matter! Come out for a lively and engaging chat about books, Canada Reads and Canada's literary landscape.** *Participants will have the opportunity to:* *1. Engage in a wellness-related activity to enhance their experience at the conference.* *2. Reduce practice-associated isolation and encourage social bonds with fellow book club members.* *3. Build a sense of continuity from one conference to the next through an annual session.*
Session: 250 ***Dharm Singh***	**Overactive Bladder**
Session: 251 ***Allison Scott***	**Slitlamps (2 hours)**
Session: 252 ***Chris Patey and Paul Norman***	**'Nan's Kitchen' - CIRRIS - A Research Hub in a Rural Community** **Communities are the strength of our nation. It is therefore essential that we are fully aware of community needs and conduct applicable research to improve local health. Family physicians play a vital role in communities however their involvement in medical research is often extremely complex and daunting. The layering of research into primary care therefore must be seamless, well supported and rewarding. The natural progression from an individual primary care clinician who has an interest in research to a network of provincial rural research units will also positively impact the health of local rural populations. By removing barriers, guiding the process and connecting primary care clinicians to academic expertise we hope that community research will flourish. CIRRIS, the Carbonear Institute for Rural Research and Innovation by the Sea, is a rural medical research unit with a primary goal of improving the community through the support of rural research. While providing a site and physical presence in the community, we assist and guide clinician researchers to increase and optimize research connectivity and outcomes. With the cultural promotion of rural research, we hope to entice present and future practitioners by increasing opportunity for academia into rural areas while remaining a vital component of the community. Ultimately our goal is to improve local healthcare, assist with retention and recruitment of clinicians and inspire global health improvements from a community perspective.** **This session is suitable for anyone interested in improving their community and strengthening community relations and outcomes through research. We welcome medical learners, rural nurses (registered and practitioner), and active family physicians who have an interest in community research.** **This session will be an interactive PowerPoint presentation. It is a combined family physician and nurse presentation. Previous experiences of the RN/MD presenter model is an extremely receptive method for learner engagement, enjoyment and clarity.** *After this activity participants will be able to:* *1. Appreciate a collaborative model to conduct research in a community setting.* *2. Realize the impact on research on the broader community.* *3. Recognize the connection between local research and improving health systems.*

Session: 253 ***Mat Litalien***	**Distributed Medicine National Education Administrators Group - Community Engagement**
Session: 260 ***Cornelius Woelk***	**Cancer Immunotherapy and its Complications** **The prevalence of cancer is increasing, mainly due to increased survival. A major cause for this has been the development of new drugs. One of the latest is the class of immunotherapy agents. Since the development and approval of the use of ipilimumab for melanoma, monoclonal antibodies directed against immune checkpoints are increasingly used in the first line or relapsed setting for a rapidly expanding list of indications, including melanomas, lung cancers, renal cell cancers, and more! While there are stories of spectacular success in significantly extending survival, their use has also been marked by the emergence of a wide range of immune-related adverse events affecting nearly every organ system. These side effects may occur during or after treatment, and their timely diagnosis and treatment can spare considerable morbidity and even mortality. This session is partially based on a Learning Module developed by CancerCare Manitoba. It is applicable to all physicians providing care to patients that might receive, are receiving, or have received immunotherapy as part of their cancer treatment. While therapy is delivered in, or coordinated through cancer units in or outside of rural communities, patients return to their home communities, and may develop adverse effects at home, and present to family physicians in clinics or local rural hospitals.** *1. Describe the basics of the immune system's involvement in tumour control.* *2. Recognize the constellation of signs and symptoms for which immune-related adverse events (irAE) should be considered in the differential diagnosis.* *3. Explain the work up of suspected irAEs of the endocrine system, skin, GI tract, lung and liver.* *4. Describe those circumstances in which the primary care clinician should initiate urgent communication with the medical oncologist of a patient who is being or has been treated with an immune checkpoint inhibitor.*
Session: 261 ***Teri Price***	**Falling Through the Cracks - Greg's Story (2 hours)** **Greg Price was a healthy 30 year-old man until he found out he had an abdominal mass that was causing his back pain which had previously been attributed to a 'pulled muscle'. Tragically he died after falling through many healthcare system cracks, before being given a chance to receive treatment for a highly treatable condition (testicular cancer). Falling Through the Cracks: Greg's Story is a short Canadian film on Greg Price's journey through the healthcare system. The film gives a glimpse of who Greg was and focuses on the events of his healthcare journey that ended in his unexpected and tragic death.** **In spite of the sadness of Greg's Story, the message of the film is intended to inspire positive change and improvement in the healthcare system. This session will review the film and the role it can play in motivating health systems to address issues of improving teamwork, continuity of care and continuous improvement. We believe the film will resonate with the attendees and create a platform for further dialogue and overall healthcare improvement efforts. Through this presentation attendees will feel empowered to challenge the status quo of the current healthcare system creating better health care with improved outcomes.** *1. Understand the power of a patient story to create a burning platform for change.* *2. Learn how a patient story has been used to engage the entire health system.* *3. Learn about the curriculum and workshops that use the film and additional teaching scenes to reinforce the critical importance of teamwork and communication in healthcare.* *4. Learn about how the film has been used to spark conversation, train new and existing health professionals and engage the public to improve awareness and change culture.*
Session: 262 ***TBD***	**Peds Sim**
Session: 263 ***Jay Shanahan and Jess McCann***	**Rural Residency Tour – Program Fair for Medical Students (2 hours)**

Session: 264 ***Bill Ehman***	**Big News in Canadian Intrapartum Fetal Surveillance: The new Guideline! (Repeat)** **This presentation will review the significant changes in the new 2019 SOGC Intrapartum Fetal Surveillance guideline. Using clinical examples, the focus will be on importance of interpreting the classified Intermittent Auscultation (IA) or Electronic Fetal Monitoring (EFM) in light of the total clinical situation before responding. A brief review of the method and classification of IA and EFM will be provided followed by a review of the changes in the definition of abnormal IA, the significance of tachysystole and new definitions of complicated variable decelerations. Effective strategies for responding to abnormal surveillance will also be discussed.** *1. Identify the changes in the 2019 SOGC Intrapartum Fetal Surveillance Guideline.* *2. Discuss the new focus of the principles of Intrapartum Fetal Surveillance.* *3. Describe IA and EFM classification, interpretation and response.* *4. Describe the new indications for EFM and changes to definitions of complicated variable decelerations.*
Session: 265 ***Dale Dewar***	**The Medical Response to Nuclear War**
Session: 266 ***Chris Parfitt***	**Clinical Injections (2 hours)** **In this workshop the participant will learn the science behind MSK joint injections and learn the clinical techniques of how to give joint injections.** *Learn the why and how of MSK joint injections.*
Session: 267 ***Casey Wong***	**A Review of STEMIs & Equivalents** **A review of can't miss ECGs in the rural ER including non-classic STEMI equivalents that warrant acute re-perfusion therapy.** *1. Briefly review of current guidelines on classic STEMIs.* *2. Identify non-"classic STEMI"/STEMI equivalent ECG patterns that require stat re-perfusion and/or close consultation with cardiology.* *3. Identify non-guideline ECG patterns that require consideration of urgent re-perfusion strategies and/or very close monitoring.*
Session: 268 ***Jill Konkin and Roger Strasser***	**Supporting Rural Generalism in Medical Education (2 hours)** **Rural generalism is a growing movement internationally. It acknowledges that rural health professionals, including physicians, have a significantly broader scope of practice than their metropolitan counterparts. If Canada is to have a fit-for-purpose medical workforce with the right mix and distribution within and between medical disciplines, as well as geographically, changes in both medical education and the health delivery system are necessary. The content and context of medical education - what is taught, where it's taught and by whom- must change to ensure a sufficient number of medical graduates become comprehensive generalists. A background document will be circulated prior to the conference. At the workshop, participants will explore, discuss and recommend the changes and implementation strategies necessary in medical education and in the health system to allow generalism and generalist physicians to flourish and how rural generalists can contribute to these changes.** *1. Identify key changes necessary in medical education and the health system to support generalism and increase the number of generalists.* *2. Recommend implementation strategies to accomplish these changes.* *3. Develop strategies for rural generalists to contribute to facilitating these changes in medical education and the health delivery system.*
Session: 269 ***Michael Young***	**Pediatric Sedation and Analgesia**

Session: 270 ***Dharm Singh***	**Hematuria**
Session: 271 ***Allison Scott***	**Slitlamps (2 hours)**
Session: 272	**Oral Research Presentations - Medicine on the Farm**
Session: 273 ***Carrie Grigg, Maria Shibish and Kris Bowes***	**Distributed Medicine National Education Administrators Group - Housing Part II**
Session: 280 ***Cornelius Woelk***	**Managing Dyspnea in Palliative Care** **Dyspnea is a common symptom for individuals approaching the end of life. Its causes are multifactorial. Treatment of dyspnea may target a specific cause, or especially nearing the very end of life, treat the symptom itself. It is an art, as much as a skill, to understand and know when and how to use interventions or medications for a patient in the palliative care trajectory. This session will review a palliative approach to dyspnea, noting how it might change during various stages of advancing illness. It will review the evidence and present current guidelines for the specific management of the symptom, but also discuss the real life issues that have less robust evidence.** *1. Identify the importance of dyspnea in the context of advancing disease.* *2.Recognize the broad differential diagnosis of dyspnea and determine when to address specific causes and when to address the symptom directly.* *3. Understand the roles of oxygen and medications such as opioids and feel comfortable using them to treat dyspnea in the various points of the palliative care trajectory.*
Session: 281 ***Teri Price***	**Falling Through the Cracks - Greg's Story (2 hours)** **Greg Price was a healthy 30 year-old man until he found out he had an abdominal mass that was causing his back pain which had previously been attributed to a 'pulled muscle'. Tragically he died after falling through many healthcare system cracks, before being given a chance to receive treatment for a highly treatable condition (testicular cancer). Falling Through the Cracks: Greg's Story is a short Canadian film on Greg Price's journey through the healthcare system. The film gives a glimpse of who Greg was and focuses on the events of his healthcare journey that ended in his unexpected and tragic death.** **In spite of the sadness of Greg's Story, the message of the film is intended to inspire positive change and improvement in the healthcare system. This session will review the film and the role it can play in motivating health systems to address issues of improving teamwork, continuity of care and continuous improvement. We believe the film will resonate with the attendees and create a platform for further dialogue and overall healthcare improvement efforts. Through this presentation attendees will feel empowered to challenge the status quo of the current healthcare system creating better health care with improved outcomes.** *1. Understand the power of a patient story to create a burning platform for change.* *2. Learn how a patient story has been used to engage the entire health system.* *3. Learn about the curriculum and workshops that use the film and additional teaching scenes to reinforce the critical importance of teamwork and communication in healthcare.* *4. Learn about how the film has been used to spark conversation, train new and existing health professionals and engage the public to improve awareness and change culture.*
Session: 282	**Global Health in the SRPC** **From International to Global, Rural to Equity? Working on threading the needle together. At the last SRPC Council the International Committee's name was changed to Global Health Committee reflecting a change in intent. This intent is keeping a**

Ray Markham	**strong rural perspective while looking for synergy in other areas in the health system including international health equity work, marginalised and disadvantaged urban populations and First Nations health to name a few. We hope to be able to connect with interested rural docs to help shape next steps in not trying to boil the ocean and find areas of work that have a bi-directional value proposition. Opportunities that have been suggested include putting our shoulder to the Generalism Movement globally to specific projects in urban or internationally disadvantaged communities**
Session: 283 ***Jay Shanahan and Jess McCann***	**Rural Residency Tour – Program Fair for Medical Students (2 hours)**
Session: 284 ***Andrew Kotaska***	**PCOS Made Simple, For Doctors and Patients** **PCOS can be confusing for clinicians and patients: cysts, androgens, infertility, acne, endometrial hyperplasia, obesity… But where does it all start. This Socratic presentation presents a basic understanding of the pathophysiology of PCOS that provides a framework for guiding treatment of patients with PCOS at all stages of their reproductive life and gives clinicians tools to counsel patients with PCOS in a manner that is efficient, non-judgmental, and easy to understand.** *1. Describe the fundamental pathophysiological abnormality underlying PCOS.* *2. Address the varying needs of patients with PCOS across their reproductive life.* *3. Counsel patients with PCOS in a manner that is: pragmatic, efficient, easy to understand, and non-judgemental.*
Session: 285 ***Monica Kidd***	**The Teller and The Told: The Uses of Narrative in Medicine** **In this one-hour discussion and workshop, family doctor and writer Monica Kidd will review the rise of Narrative Medicine, with a critical eye to its claims and limits. She will discuss how art can make things strange, and how discomfort with truth can be helpful in clinical care. Examples of how the work can be done, and potential applications to community-based practices, will be discussed** *1. To examine the claims and limits of narrative in medicine.* *2. To demonstrate the value of discomfort.* *3. To explore opportunities for the uses of narrative in medicine.*
Session: 286 ***Chris Parfitt***	**Clinical Injections (2 hours)** **In this workshop the participant will learn the science behind MSK joint injections and learn the clinical techniques of how to give joint injections.** *Learn the why and how of MSK joint injections.*
Session: 287 ***Yasmine Mawji***	**The Supplemental Emergency Medicine Experience (SEME) Program** **The SEME program is a three month continuing professional development program in Emergency Medicine that is funded by the Ontario MOHLTC and administered by the Department of Family and Community Medicine at the University of Toronto. The program was first developed in 2011 in response to a staffing crisis in rural Ontario emergency departments. The intention of the SEME program was to provide a practical option to enhance acute care skills for family physicians providing emergency care in rural and semi-rural communities. To date 119 physicians have successfully completed the program.** *1. Outline the components and the curriculum of the SEME program.* *2. Review the successes and the challenges experienced by the SEME program.* *3. Discuss the impact of the SEME experience on physician participants.*
Session: 288 ***Jill Konkin and Roger Strasser***	**Supporting Rural Generalism in Medical Education (2 hours)** **Rural generalism is a growing movement internationally. It acknowledges that rural health professionals, including physicians, have a significantly broader scope of practice than their metropolitan counterparts. If Canada is to have a fit-for-purpose medical workforce with the right mix and distribution within and between medical disciplines, as well as geographically, changes in both medical education and the health delivery system are necessary. The content and context of medical education - what is taught, where it's taught and by whom- must change to ensure a sufficient number of medical graduates become comprehensive generalists. A background document will be circulated prior to the conference. At the workshop, participants will explore, discuss and recommend the changes and implementation strategies necessary in medical education and in the**

	health system to allow generalism and generalist physicians to flourish and how rural generalists can contribute to these changes. *1. Identify key changes necessary in medical education and the health system to support generalism and increase the number of generalists.* *2. Recommend implementation strategies to accomplish these changes.* *3. Develop strategies for rural generalists to contribute to facilitating these changes in medical education and the health delivery system.*
Session: 289 ***Ashley White***	**Providing Medical Assistance in Dying (MAiD) in the Country: Joy, Bureaucracy and Burnout** **Medical assistance in dying (MAiD) has been legal in Canada for over two years. Yet, there exists no reliable, coherent system for ensuring that rural Canadians have access to timely, organized assisted death. This is particularly true for home deaths. The provision of rural MAiD is reliant on individual rural practitioners operating MAiD practices off the corners of their desk. This is a recipe for burnout and disenchantment. Yet, MAiD can be a rewarding and even joyful part of a rural generalist practice. I will use a series of cases from my own practice to share the joy of this work while also highlighting the system gaps up in which I have been tangled.** *1. Sharing insights from a growing rural MAiD practice through a series of cases.* *2. Articulating the system gaps made clear by these cases.* *3. Provide support to any rural providers interested in incorporating MAiD into their practice.*
Session: 290 ***Michael Fernando***	**Vasculitis - A Common Rare Disease** **Vasculitis as a group of diseases are surprisingly prevalent. We think of vasculitic diseases as rare but this is partly due to the way such diseases are classified. If you are a GP with a large practice, you likely have a handful of vasculitis patients even though you might not know it. As vasculitides are systemic diseases, their symptoms tend to be highly variable and they often take much longer to diagnose than other diseases. As a GP, particularly in the rural setting, you will be required to make the diagnosis most of the time. This talk outlines the major types of vasculitides, a simple path to diagnosis, how to treat them and when to refer.** *1. Background information on vasculitis - ie history and classification of vasculitides.* *2. Common presentations of vasculitides.* *3. How to diagnose vasculitis.* *4. How to begin treatment and when to refer.*
Session: 291 ***Margo Wilson***	**Rural Critical Care - Basic Airways**
Session: 292	**Oral Research Presentations - Fresh Approaches**
Session: 293 ***Fred Ross and Pamela Bourque***	**Distributed Medicine National Education Administrators Group - Hot Topics in Distributed Education**
Session: Social	**Reception for ESS, OSS, CAGS and SOGC**

Session: Saturday	
Session: 300 A - Plenary ***Nandine Caron***	**Challenges and Opportunities in Healthcare Delivery in Indigenous Communities**
Session: 300 B - Plenary ***TBD***	
Session: 300 ***Nancy Fitch and Megen Brunskill***	**Office Based Urine Drug Testing Toolkit for Safer Opioid Prescribing** **Over the last 5 years we have developed a clinic-based Opioid Prescribing Program that allows all affiliated health care providers (including NPs) to have a unified approach to prescribing and monitoring opioids for chronic non-cancer pain. This workshop presents a toolkit you can take home and incorporate clinic wide. We will present evidence for urine drug screens as a part of ALL chronic opioid Rxs, practice some UDT interpretation together to highlight potential pitfalls, and describe a simple approach for all prescribers to use for unexpected UDT results.** *1. Review the evidence for value of Urine Drug Testing (UDT) for ALL chronic non-cancer pain opioid prescriptions.* *2. Introduce an Opioid Prescribing Program for a clinic setting that all health care providers can uniformly use.* *3. Dispel barriers to clinic-based UDT including financial and clinical.* *4. Enhance confidence re: management of unexpected UDT results.* *5. Provide a take-home toolkit to support local Opioid Prescribing Program approaches that will enhance incorporation of UDT and consistent management of UDT results.*
Session: 301 ***Andrew Kotaska and Gale Payne***	**Obesity and Diabetes in Pregnancy: a Pragmatic, Unconventional Approach (2 hours)** **Rates of both obesity and gestational diabetes are higher in Indigenous peoples, who make up 52% of the population of the Northwest Territories. We will look at the impact of obesity and diabetes on pregnancy, and discuss our recommendations regarding weight gain in obese pregnant women that differ from those of the Institute of Medicine. We will review how we have implemented early screening for gestational diabetes in the NWT and initial treatment routinely with metformin if needed, instead of insulin. We will also discuss our territory-wide approach to managing gestational diabetes in a pragmatic and collaborative way, and share some of the data we have gathered over the last three years.** *1. Describe why avoiding weight gain in obese pregnant woman is advisable.* *2. Explain the relationship between early screening for gestational diabetes and birth outcomes.* *3. List the advantages of metformin compared with insulin as initial medical treatment of GDM if diet and exercise are inadequate.* *4. Appreciate the advantages of a centralized, no frills approach to diabetes management in pregnancy.*
Session: 302 ***Lyn Power, Chris Patey and Paula Slaney***	**Layering of Learners in Rural Sites: Identifying Challenges and Finding Solutions** **The concept of " layered learning" is sometimes met with resistance and or/apprehension amongst preceptors. "Layered learning" refers to the process of having multilevel medical learners (i.e.medical student, clinical clerk, resident) in a clinical setting at one time. The same preceptor may supervise all these learners. Senior learners are often utilized to help teach the more junior learners.** **Capacity issues are no secret to medical schools trying to find meaningful clinical placements for their learners. Memorial University has recently increased its overall undergraduate and Family Medicine postgraduate enrolment. It has also increased the amount of rural placements in Family Medicine across the undergraduate curriculum, to 14 weeks. Many sites and preceptors have expressed resistance to having more than one learner at a time regardless of the level of training. More exposures to rural medicine helps recruitment of medical students and residents to rural training and practice.**

	The purpose of this workshop is to gather information about barriers/challenges and strategies/solutions to this concept of multilevel learners in a clinical setting and then to offer techniques or ideas to help overcome these barriers. **Following a brief presentation of perceived barriers and challenges identified in the literature participants will be given an opportunity in break out groups to discuss two questions. Firstly participants will be asked to identify and discuss barriers or perceived barriers. These ideas will be brought back to the entire group for further discussion. Next participants will be asked to reflect on these barriers and challenges and to offer suggestions/solutions to overcome these challenges. Finally participants will be offered suggestions and tips (both from the literature and personal experience) to help them succeed in layered learning in their clinical setting.** *1. To understand and identify challenges associated with multilevel learners in a rural clinical setting.* *2. To develop strategies to help overcome barriers to multilevel learners in a rural clinical setting.* *3. To describe and utilize teaching techniques useful for physicans and medical learners to use in a rural clinical settings with multilevel learners.*
Session: 303 ***Mike Johnston***	**They Way We Were 30 Years Ago - Tails from a Rural General Hospital** *1. To look at how medicine was practiced in a rural hospital prior to Regionalization and Health Authorities.* *2. Circumstances remembered while looking over each of 676 admissions and discharged summaries.* *3. What were the actual diseases that were admitted and discharged as per the International Classification of Disease at that time.* *4. Which diseases were more common and which diseases were more difficult and why.* *5. Some thoughts on the comprehensiveness i.e., the range of problems generally handled by all the doctors at our rural Hospital in northern New Brunswick.*
Session: 304 ***Doug Hedden***	**Access to Specialist Care in Rural and Remote Communities**
Session: 305 ***TBD***	**Advocacy Session**
Session: 306 ***Stefan Grzybowski***	**Sustaining Yourself in Rural Practice**
Session: 307 ***TBD***	**Non-Accidental Trauma**
Session: 308 ***Dr. Joan Flood***	**Evidence-based Assessment and Management of ADHD in Primary Care (2 hours)** **Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder affecting 5 - 9% of children and 3 - 5% of adults worldwide. Despite its incidence, ADHD is given less 'attention' in primary care in comparison to other commonly treated conditions like depression and anxiety.** **The recognition of ADHD can be life-changing and is well within the scope of primary care. Misconceptions about ADHD and its treatment persist. Contrary to public belief, ADHD is not over-diagnosed. Psycho-educational testing is seldom needed to distinguish ADHD. Current medications and treatment regimens are neither dangerous nor difficult to implement, yet a**

	reluctance to treat ADHD mistakenly exists. Diagnosis rests on recognition of the DSM-5 criteria, easily identified by clinical interview and simple screening tools. **CADDRA - Canadian ADHD Resource Alliance is a non-profit, membership association, established by health professionals to guide and support those working with ADHD patients and their families. In 2018, CADDRA released its 4th edition of the Canadian ADHD Practice Guidelines which review the diagnosis, assessment and treatment of ADHD across the lifespan. The goal of this two-hour session is to demystify the diagnosis and management of ADHD, and familiarize participants with the user-friendly Canadian ADHD Practice Guidelines. At the end of this session, participants should have a more confident approach to treating ADHD. Real case scenarios and small group discussions will be offered in the second part of this session to facilitate primary care management of ADHD.** *1. Identify common misperceptions about ADHD that prevent many primary care physicians from confidently treating ADHD.* *2. Apply 2018 Canadian ADHD Practice Guidelines to the assessment and management of ADHD in primary care.* *3. Review ADHD cases that are common presentations seen in primary care.*
Session: 309 ***Patti Kemp***	**Trading Places: Immigration and Human Rights Law** **Join Patti Kemp, a qualified lawyer in England and Canada, as she talks about her experiences working in immigration and human rights law in the UK, the history of immigration in Canada and the relationship between domestic immigration laws and international human rights instruments. Her talk will be of interest to anyone who would like to gain a greater understanding of refugee and humanitarian immigration or for those who seek a better understanding of refugee or vulnerable immigrant patients.** *Participants will gain:* *1. An overview of the history of immigration in Canada.* *2. A general understanding of the relationship between immigration law and international human rights instruments.* *3. Enhanced understanding of immigrant and refugee experiences which could be useful when seeing those patients in a clinical setting.*
Session: 310 ***Mike Allan, Mike Kolber and Tina Korownyk***	**Jeopardy by PEER: Rapid Answers to Common Clinical Problems** **This talk will be presented by the PEER group, and is a fast-paced review of answers to common clinical questions. The audience will select the questions from a list of 32 possible topics. For each answer the audience will be asked to consider a true or false question and then one of the presenters will review the evidence and provide a bottom-line, all in less than five minutes. Topics will include management issues from pediatrics to geriatrics including a long list of medical conditions that span the breadth of primary care.** *1. Learn some quick Pearls in the management of pediatric patients.* *2. Understand some of the research around vitamins, supplements and food.* *3. Increase awareness of actual benefits/harms (e.g. NNT) of commonly prescribed interventions.*
Session: 311 ***John Soles***	**Rural Critical Care - Chest Tube Insertion (To be repeated)** **Participants will learn how to place chest tubes using Seldinger technique. There will be opportunity to practice this technique.** *1. To list the indications for closed chest drainage.* *2. To recognize when Seldinger technique is appropriate.* *3. To demonstrate the technique in a model.* *4. To gain better interpretation of the use of 'underwater' drainage systems.*
Session: 312 ***Martha Riesberry***	**Mcgyver Fixes in Rural Medicine**
Session: 313 ***Brendan Munn***	**Conservative Airway Management — Is Non-Intubation Indicated?**

	1. Highlight existing dogma contributing to the intubation of select emergency patients purely for aspiration prevention. *2. Identify liability concerns regarding perceived standard of care in these cases.* *3. Review aspiration risks in the unresponsive patient.* *4. Review the evidence for aspiration prevention as an indication for intubation.* *5. Discuss the need for a risk/benefit evaluation when intubating purely for aspiration prevention and other specific cases.* *6. Highlight the value to rural, remote and austere environments in particular in developing evidence supporting conservative management strategies.*
Session: 320 ***Dennis Pashen***	**Developing a Quality and Safety Framework for Rural and Remote Health** **In Australia, the attributes of standards for Quality and Safety for medical practice are usually underpinned by models of care exemplified in metropolitan settings. The regulation of quality and safety standards is imposed upon practitioners via governmental or institutional impost which rarely take into consideration the unique environments that face rural and remote doctors. In 2014, ACRRM established a new Council on Quality and Safety in Practice to provide advice regarding key safety and quality issues affecting the care that patients receive in rural and remote settings. This included the development of policy directions and advocacy for the College, rural generalist practice standards, models of care ensuring high quality and safe outcomes for people in rural and remote Australia, professional standards and reporting for competency and continuing professional development, and evidence based tools and resources to improve delivery of care. This paper describes the progress to date in implementing a fit for purpose, rural-centric approach to quality and safety standards. It also describes the organizational structure that has been developed to implement these standards and the integration of the principles across the college including programs and standards.** *1. To outline a process for a Professional College to develop a Q&S framework.* *2. To workshop a number of topics that can be incorporated into a framework and develop an implementation strategy for each.*
Session: 321 ***Andrew Kotaska and Gale Payne***	**Obesity and Diabetes in Pregnancy: a Pragmatic, Unconventional Approach (2 hours)** **Rates of both obesity and gestational diabetes are higher in Indigenous peoples, who make up 52% of the population of the Northwest Territories. We will look at the impact of obesity and diabetes on pregnancy, and discuss our recommendations regarding weight gain in obese pregnant women that differ from those of the Institute of Medicine. We will review how we have implemented early screening for gestational diabetes in the NWT and initial treatment routinely with metformin if needed, instead of insulin. We will also discuss our territory-wide approach to managing gestational diabetes in a pragmatic and collaborative way, and share some of the data we have gathered over the last three years.** *1. Describe why avoiding weight gain in obese pregnant woman is advisable.* *2. Explain the relationship between early screening for gestational diabetes and birth outcomes.* *3. List the advantages of metformin compared with insulin as initial medical treatment of GDM if diet and exercise are inadequate.* *4. Appreciate the advantages of a centralized, no frills approach to diabetes management in pregnancy.*
Session: 322 ***Peter Wells and Michelle Hunter***	**Key Ingredients in Community Medical Education**
Session: 323 ***Mary Johnston***	**Doctor Heal Thyself - Doctors Receiving Medical Care in Today's Health Care System** *1. When, how, a medical education and patient experience leads you to confusion; self diagnosis always dangerous.* *2. When, how, why, DENIAL of self and symptoms dangerous.* *3. Where being a doctor hurts your ability to receive quality care.*
Session: 324	**Rural Specialists Meeting** **This will be a combined formal and informal session during which a power-point presentation would be made about the Specialist group. It would highlight its composition, and activities over the past year. In addition, there would be a presentation**

Kweku Dankwa	**on Rural Road Map as seen by rural Specialists. This latter presentation would be interactive and seek further input for submission to council.** *1. Share with participants the aims of the Specialist Section of the Society of Rural Physicians.* *2. Advise on representatives on the steering committee and seek more members.* *3. Learn about and summarize the activities of the group.* *4. Learn about Rural Specialists' perspective on the Rural Road Map and seek input.* *5. Discuss students' and residents' interest in the group.*
Session: 325 ***TBD***	**Advocacy Session**
Session: 326 ***Stefan Grzybowski***	**Rural Locum Work: Building a New Vision in BC**
Session: 327 ***TBD***	**TREKK Update: TREKK Resources, Quick Updates: Sepsis, DKA**
Session: 328 ***Dr. Joan Flood***	**Evidence-based Assessment and Management of ADHD in Primary Care (2 hours)** **Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder affecting 5 - 9% of children and 3 - 5% of adults worldwide. Despite its incidence, ADHD is given less 'attention' in primary care in comparison to other commonly treated conditions like depression and anxiety.** **The recognition of ADHD can be life-changing and is well within the scope of primary care. Misconceptions about ADHD and its treatment persist. Contrary to public belief, ADHD is not over-diagnosed. Psycho-educational testing is seldom needed to distinguish ADHD. Current medications and treatment regimens are neither dangerous nor difficult to implement, yet a reluctance to treat ADHD mistakenly exists. Diagnosis rests on recognition of the DSM-5 criteria, easily identified by clinical interview and simple screening tools.** **CADDRA - Canadian ADHD Resource Alliance is a non-profit, membership association, established by health professionals to guide and support those working with ADHD patients and their families. In 2018, CADDRA released its 4th edition of the Canadian ADHD Practice Guidelines which review the diagnosis, assessment and treatment of ADHD across the lifespan. The goal of this two-hour session is to demystify the diagnosis and management of ADHD, and familiarize participants with the user-friendly Canadian ADHD Practice Guidelines. At the end of this session, participants should have a more confident approach to treating ADHD. Real case scenarios and small group discussions will be offered in the second part of this session to facilitate primary care management of ADHD.** *1. Identify common misperceptions about ADHD that prevent many primary care physicians from confidently treating ADHD.* *2. Apply 2018 Canadian ADHD Practice Guidelines to the assessment and management of ADHD in primary care.* *3. Review ADHD cases that are common presentations seen in primary care.*
Session: 329 ***Lynne Thériault Sehgal***	**Curly/Wavy Girl Method - Frizz is a Curl Waiting to be Discovered!** **An interactive session learning how to polish your look and love your curls/waves.** *How it could help medical professionals (or any professional):* *1. A more polished look for women and men with wavy and curly hair.* *2. Self care.*

	3. Learning to love your natural hair and learn how to deal with it and take care of it. *3. Going longer between wash days (time saving).* *4. Going longer between hair cuts.*
Session: 330 ***Mike Allan and Tina Korownyk***	**PEER's Medical Cannabinoid Guideline: Doobie-ous Evidence or Smokin' Results** **In this session, we will review the primary care prescribing guideline for medical cannabinoids. We will start with the review of challenges present in the medical literature around cannabinoids. We will then focus on four conditions for which there is reasonable evidence of potential benefit: neuropathic pain, cancer pain nausea and vomiting from chemotherapy and spasticity. We will reflect on the recommendations from the guideline, with a discussion of specific prescribing such as dosing and cost. We will leave the participants with some discussion tools and potential resources to address patients considering medical cannabinoids.** *1. Understand the limitations and challenges of evidence for medical cannabinoids.* *2. Describe the typical benefits for the key medical conditions (neuropathic pain, cancer pain, nausea/vomiting post chemotherapy, and spasticity) for which there is adequate evidence and explain the side-effects common to medical cannabinoids.* *3. Learn and apply the key recommendations from the medical cannabinoid guideline.*
Session: 331 ***John Soles***	**Rural Critical Care - Chest Tube Insertion (Repeat)** **Participants will learn how to place chest tubes using Seldinger technique. There will be opportunity to practice this technique.** *1. To list the indications for closed chest drainage.* *2. To recognize when Seldinger technique is appropriate.* *3. To demonstrate the technique in a model.* *4. To gain better interpretation of the use of 'underwater' drainage systems.*
Session: 332 ***Wendy Graham***	**How and Why to Write in Rural Medicine** **Writing is an essential skill that gives a voice to the under-documented realities of rural Canada, creates an introspective respite from the demands of rural practice, and facilitates inter-professional connections that transcend remote isolation. Ironically, writing is often unexplored by rural physicians due to these same challenges. This session, taught by scholarly writing experts from 6for6 (a research training program for rural doctors) will demonstrate how and why physicians should write in rural practice. Attendees will participate in small-group breakout activities and large-group discussions to strengthen their writing skills with free writing, plan their project with mind mapping, and discuss the benefits and rationale for writing in rural practice.** *1. Recognize why a rural physician should write.* *2. List strategies for writing as a busy clinician.* *3. Develop a conceptual framework for their own writing project.* *4. Identify next steps in their own writing project.*
Session: 333 ***Tom O'Neil***	**Hemorrhagic Shock** **The purpose of this presentation is to present practical facts which will help in the management of the patient in hemorrhagic shock.** *1. The clinical recognition of Hemorrhagic Shock.* *2. The practical management.* *3. Controversies in Fluid Resuscitation.* *4. The Rapid Infusion Catheter.*
Session: 339 - Lunch	**Rural Generalists Specialist Networking Lunch**

Session: 340 ***Wade Mitchell***	**Skin Cancer 101** **General overview of an approach to skin lesions ie) benign/malignant (not rashes) in rural primary care practices.** *1. Provide an overview of basic dermoscopy and how it can aid in determining which lesions to biopsy or simply follow.* *2. Review benign vs malignant lesions both non-pigmented and pigmented.* *3. Discuss approaches to biopsy and treatment - current consensus on margins for different skin cancer types.*
Session: 341 ***Chris Parfitt***	**Comprehensive Fracture Management and Casting Techniques (3 hours)** **In this comprehensive presentation the participant will learn not only an approach to all fractures, but also the management of specific fractures, including casting techniques.** *Learn a comprehensive approach to the management of fractures, from hand to foot including hands on casting techniques.*
Session: 342 ***Cathy MacLean***	**Patient Education Practical Pointers** **This is an interactive session that is very practical with some handouts and opportunities to test out sites and approaches to patient education. It is recommended you bring a computer to this session and favourite sites can be bookmarked throughout the presentation.** *1. Apply health literacy approaches to day to day practice.* *2. Use patient education approaches such as teach back and web scripts with patients.* *3. Access resource materials (online and apps) that can be useful in patient care.*
Session: 343 ***Layla Ali, Brenna Hansen and Cassie Poole***	**History of 'Indian Hospitals' and Modern Day Reconciliation** **Together we will explore the Canadian history of "Indian Hospitals" and how that history impacts modern day interactions between Indigenous patients and the healthcare system. Healthcare professionals will be prompted to reflect on their own notions and experiences working with Indigenous communities. Indigenous perspectives on the journey of health and healing will be explored. Patient cases and reflective questions will be discussed in the context of building a greater understanding of the healthcare needs of Indigenous patients.** *1. Explore the Canadian history of Indian hospitals.* *2. Discuss how this history impacts modern day interactions between Indigenous patients and healthcare professionals.* *3. Reflect on real life interactions between Indigenous patients and healthcare professionals.* *4. Explore Indigenous perspectives on the journey of health and healing.*
Session: 344 ***Linda Strik and Stu Iglesias***	**The New SOGC Attendance at and Resources for Delivery of Optimal Maternity Care** **The SOGC would like to present the updated its Attendance at Labour Position Statement – now entitled Attendance at and Resources for Delivery of Optimal Maternity Care. The original statement was from 2000, and badly out of date. Both the original and updated statement were reviewed by numerous national societies for their input. This updated version is a consensus statement, with significant input from rural stakeholders to include relevant issues for maternity care to providers at all levels of care and in all geographic locations.** *Highlights to be discussed include:* *1. SOGC's desire to develop national standards and definitions of levels of care.* *2. Need to support enhanced skills training for surgeons and family doctors.* *3. The importance of supporting small remote hospitals against closure.* *4. The importance of returning birth to the community and keeping families together for the birth experience.* *5. The importance of mother's choice in these decisions.* *6. How should families and providers make decisions about where they deliver?* *7. Risk assessment and risk management.* *8. The 30 minute "time to decision" recommendation as it applies to both rural and urban settings.*

	9. The 30 minute "time to incision" recommendation as it applies to both rural and urban setting.
Session: 345 ***Kirk Mccarroll***	**PICC Workshop**
Session: 346 ***TBD***	**Electives Planning**
Session: 347 ***TBD***	**PEM Pearls**
Session: 348 ***Jay Shanahan***	**Perineal Repair**
Session: 349 ***Stephen Loden***	**Running in Medicine - Lessons Learned Qualifying for Boston** **The main goal of this presentation is to discuss a practical approach to marathon training with a focus on improving finish times. It will be appropriate to runners of all levels, including those interested in the sport. It will be appropriate for health professionals and their spouses. I am hoping for the presentation to be light hearted and interactive, with plenty of time for questions and discussion from the audience. I hope we can all learn from the collective wisdom in the room.** *1. Describe components of a successful marathon training plan.* *2. Discuss strategies and time lines for reasonable goal setting.* *3. Learn how to select a reasonable goal marathon finishing time.* *4.Review how to avoid injury.* *5. Discuss practical examples of how to train as a busy rural physician.*
Session: 350 ***Francisco Garcia***	**How to Have Sex in a Canoe - Canoe Maintenance and Troubleshooting** **Presenting a practical approach to female sexuality and sexual medicine for the generalist. Update on current practices and understanding in female sexual medicine, review of current therapies and management. There will be a strong focus on what diagnoses and therapies are available in an outpatient scenario, with a brief review of the rare instances when referral may be necessary. Emphasis will be placed on demographics, prevalence, interdisciplinary medicine and disease awareness** *1. Be familiar with the domains of female sexual dysfunction (FSD).* *2. Be able to identify common disorders of each sexual domain.* *3. Be familiar with the current understanding of female anatomy as it pertains to FSD.* *4. Be familiar with the non-linear female sexual response cycle.* *5. Be able to educate patients on their disorder/dysfunction.* *6. Be able to initiate 1st line therapies for common FSD diagnoses.* *7. Understand the importance of multidisciplinary medicine in FSD.* *8. Discuss importance of sexual quality of life at different life stages*

Session: 351 ***Margo Wilson***	**Rural Critical Care - Basic Airways**
Session: 352	
Session: 353 ***Paul Mackey***	**Anaphylaxis in Anesthesia** **Peri-operative anaphylaxis occurs in 1 in 10,000 anesthetics. (NAP6). This compares to Malignant Hyperthermia which is estimated to range somewhere between 1 in 5000 to 1 in 100,000 anesthetics. Anaphylaxis is the commonest cause of anesthetic death (ANZCA). We all have an MH box. Should we all have an anaphylaxis box? This session will outline the causes of anaphylaxis in the peri-operative setting, how to recognize it, manage it, and investigate afterwards. Resources for a simple pathway and kit will be linked to. And finally, reasons as to why Canadian GPAs seemingly have dodged this complication will be discussed.** *This session will outline:* *1. The causes of anaphylaxis in the peri-operative setting.* *2. How to recognize it, manage it, and investigate afterwards.* *3. Resources for a simple pathway and kit will be linked to.*
Session: 360 ***Yogi Sehgal***	**Unusual Papers That Might Change Your Practice - ER Edition**
Session: 361 ***Chris Parfitt***	**Comprehensive Fracture Management and Casting Techniques (3 hours)** **In this comprehensive presentation the participant will learn not only an approach to all fractures, but also the management of specific fractures, including casting techniques.** *Learn a comprehensive approach to the management of fractures, from hand to foot including hands on casting techniques.*
Session: 362 ***Cathy MacLean***	**Resources for Clinical Teaching** **This interactive session is based on an up to date collection of sites from medical students, residents and family physicians highlighting common resources including podcasts, clinical practice guidelines and medical websites. Please bring a computer to this session and we will share some great resources to use in practice and when teaching!** *1. Utilize great online resources in day to day practice when teaching residents.* *2. Access useful websites that can be used in patient care and for teaching.* *3. Explore strategies to share favourite sites, podcasts and other best practice references with colleagues and learners.*
Session: 363 ***Andrew Samis***	**Dietary Fats and Cardiovascular Disease – Then and Now** **In today's world one can find studies, guidelines, and popular press articles both espousing the benefits of reduced saturated fat as a means of reducing cardiovascular disease, as well as advocating that saturated fat is unrelated to heart attack and stroke or in some cases even beneficial in preventing these diseases. It comes as no surprise that these strongly expressed opposing viewpoints create a sense of confusion. But what is the evidence? This presentation will take a step by step historical approach to review how the concept of reducing dietary fat became world-wide public policy, starting in the early 1900's and tracing it though until today. With an evidenced-based approach, the consumption of dietary fat and its relationship to cardiovascular disease will be reviewed, as will specific dietary elements such as cholesterol, dairy saturated fat, butter, and eggs. Current food guidelines will be discussed, including Canada's New Food Guide.** *1. To understand the history of dietary guidelines advising lowering total dietary fat and saturated fat.* *2. To review some of the evidence relating to specific dietary components and cardiovascular disease.*

	3. To discuss what we should tell our patients about a healthy diet and cardiovascular risk from an evidenced-base perspective.
Session: 364 ***KS. Joseph, Kim Williams and Stu Igesias***	**Regionalized Perinatal Care - Does it Work? (2 hours)** **Perinatal health care regionalization was embraced and implemented in Canada in the late 1960s and 1970s. Although such regionalization represents a rational approach for delivering health care, significant challenges continue to plague the delivery of perinatal health services. In rural and remote regions of Canada, the closure of small hospitals and the attrition of small-volume surgical programs has resulted in women having to travel long distances for antenatal care and childbirth. Other challenges to regionalized perinatal care include those due to geography, climate, emergency transport, organizational differences between provinces in the provision of care for pregnant women and newborn infants at different levels of perinatal risk, and the absence of a national program for evaluating and improving regionalization across Canada. There is a need to evaluate the structure, processes and outcomes of perinatal regionalization in order to encourage knowledge-based improvement. Participants in this workshop will review information on perinatal health care regionalization in Canada, especially as it pertains to rural maternity services. Regionalization will be examined in terms of its structure, processes and outcomes. A preliminary analysis of hospital deliveries recorded in the Discharge Abstract Database of the Canadian Institute for Health Information (2013-2015) will be used to inform the discussion.** *At the end of the session, participants will be able to describe the structure, processes and outcomes of perinatal care regionalization in Canada with regard to: (i) Tiers of hospital service (including perinatal education) and (ii) Care provision in rural and remote communities.*
Session: 365 ***Kirk Mccarroll***	**PICC Workshop**
Session: 366 ***Chris Patey, Paul Norman and Susan Snelgrove***	**Improving Team Dynamics in the Era of True Multidisciplinary Collaboration** **Centers for medical education (paramedicine, nursing, nurse practitioner, physicians) realistically exist in silos. Students are trained independently and are eventually required to incorporate and work simultaneous and harmoniously in our present healthcare model. Multidisciplinary crossover occurs without clear knowledge of how to best incorporate individual strengths to maximize and create the highest functioning workplace. High-functioning clinical teams typically empower non-physician clinicians to take on a wider range of responsibilities, allowing physicians to focus on complex diagnoses and patient communication. This in turn is likely to make physicians feel more capable and more satisfied with their work. Therefore, anything leaders can do to foster teamwork, ensuring that nurses, physicians, and nurse practitioners are working to their greatest skill, and communicating expectations about collaboration — is likely to pay off in higher capability. Clinicians also have a more positive experience if they work in groups that have a team orientation. It has also been shown that physicians who are in high functioning teams are less likely to experience significant signs of burnout. Evidence has shown that physicians and nurses in true teams are more likely to self-assess as capable and be more engaged, and be more willing to go above and beyond in their careers.** **A multidisciplinary session to review the dynamics of healthcare teams and how best to improve.** **This session presents improvement strategies to increase team dynamics that are utilized by a rural family physician, nurse practitioner and nurse enriched with discussion activities.** *After this activity participants will be able to:* *1. Better understanding of how to create a collaborative multidisciplinary workplace.* *2. How best to wrap the full care team around the patient.* *3. Develop strong clinical teams.*
Session: 367 ***TBD***	**Fever in Young Infants – Practice and Evidence**
Session: 368 ***Constance Leblanc***	**ECG Workshop** **In this interactive ECG-based session, ST and T wave abnormalities and their causes will be reviewed. Practice on ECGs with very brief vignettes will complete the session.** *By the end of this session participants will:*

	1. Recognize both common and rarer causes of ST segment changes. *2. Have a case-based differential diagnosis for ST and T wave changes.* *3. Recognize the bizarre ECG as an entity.*
Session: 369	
Session: 370 ***Francisco Garcia***	**How to Have Sex in a Canoe - Oar Maintenance and Troubleshooting** **Presenting a practical approach to male sexuality and sexual medicine for the generalist. Update on current practices and understanding in male sexual medicine, review of current therapies and management. There will be a strong focus on what diagnoses and therapies are available in an outpatient scenario, with a brief review of the rare instances where referral may be necessary. Emphasis will be placed on demographics, prevalence, early disease management and patient/partner education.** *1. Be familiar with the domains of male sexual dysfunction (MSD).* *2. Be able to identify common disorders of each sexual domain.* *3. Be able to educate patients on their disorder/dysfunction.* *4. Be able to initiate 1st line therapies for common MSD diagnoses.* *5. Be familiar with erectile dysfunction as a cardiac marker.* *6. Be familiar with anatomical diseases of the penis.* *7. Be familiar with low testosterone diagnosis, risks and therapy.*
Session: 371 ***Martha Riesberry and Dale Dewar***	**Rural Critical Care - Suturing for Dummies (2 hours)**
Session: 372	**Oral Research Presentations - Focus on the Patient**
Session: 373 ***James Kim and Kirk McCarroll***	**Breaking Down Silo's: UBC's Clinical Coaching for Excellence** **A presentation on the development and implementation of a clinical coaching and mentoring program by the University of British Columbia Continuing Professional Development and the Rural Coordination Center of British Columbia that was designed to address some of the challenges in the profession of family practice anesthesia in rural BC.** *1. To discuss some of the challenges that family practice anesthesiologists face in their profession.* *2. To discuss the concept of clinical coaching and mentoring as a successful form of CME.* *3. To describe the pilot program that was developed to address the need.* *4. To highlight the benefits of the program in BC.* *5. To describe outcomes of the program including first hand experiences from a coach and coachee of the program.*
Session: 380 ***Yogi Sehgal***	**Unusual Papers That Might Change Your Practice - Primary Care Edition**

Session: 381 ***Chris Parfitt***	**Comprehensive Fracture Management and Casting Techniques (3 hours)** **In this comprehensive presentation the participant will learn not only an approach to all fractures, but also the management of specific fractures, including casting techniques.** *Learn a comprehensive approach to the management of fractures, from hand to foot including hands on casting techniques.*
Session: 382 ***David Kuhns and Christiane Lonergan***	**A Rural Doctor's Guide to Working with Physicians Assistants**
Session: 383 ***Olga Ward***	**Aussie Skin Cancers and Other Conditions**
Session: 384 ***KS. Joseph, Kim Williams and Stu Igesias***	**Regionalized Perinatal Care - Does it Work? (2 hours)**
Session: 385 ***Kirk Mccarroll***	**PICC Workshop**
Session: 386	
Session: 387 ***TBD***	**Neonatal Emergencies**
Session: 388	
Session: 389	
Session: 390	
Session: 391 ***Martha Riesberry and Dale Dewar***	**Rural Cricitcal Care - Suturing for Dummies (2 hours)**

Session: 392	**Oral Research Presentations - The Practice of Medicine**
Session: 393 ***James Kim***	**The Difficult Airway - All You Need to Know in 60 Seconds**