

MCISc 40th Anniversary Celebration Symposium

Saturday, September 23, 2017

8:00 am – 4:45 p.m.

Western Centre for Public Health and Family Medicine

Learning Objectives:

1. To recognize the genesis of academic family medicine at Western University and its global influence.
2. To recognize the contributions of an advanced training program to building the academic discipline of family medicine at the national and international levels.
3. To understand the impact of the Family Medicine MCISc Program in education, research and leadership for the past, present and future of family medicine.
4. To facilitate knowledge translation in the areas of education, research and leadership through sharing the unique contributions made by MCISc graduates and teachers to the discipline of family medicine.

Accreditation Statement:

This Group Learning program meets the certification criteria of the College of Family Physicians of Canada and has been certified by Continuing Professional Development, Schulich School of Medicine & Dentistry, Western University for up to **5.75 Mainpro+ credits**.

Each participant should claim only those hours of credit that he/she actually spent participating in the educational program.

This program has no commercial support.

MCISc 40th Anniversary Celebration Symposium
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At a Glance Schedule

Time	Presenter	Presentation & Room
8:00 – 9:00 a.m.	Registration, coffee & light refreshments WCPHFM Atrium, 1 st Floor	
9:00 – 9:30 a.m.	Dr. Judith Brown & Dr. Steve Wetmore	Welcome / Opening Remarks and History of the MCISc Program Room 1150
9:30 – 10:15 a.m.	Dr. Bill Hogg	Keynote Speaker It takes a village: with your help family medicine researchers can succeed. Room 1150
10:15 – 10:45 a.m.	Coffee Break - WCPHFM Atrium, 1 st Floor	
10:45 – 11:05 a.m.	Dr. Gustavo Gusso	Distinguished Presenter – Vision of Primary Health Care at a Global Level Room 1150
11:05 – 11:25 a.m.	Dr. Eric Wong	Distinguished Presenter – Vision of the future of Primary Care Education Room 1150
11:30 a.m.– 12:30 p.m.	Concurrent Session A	Oral Presentations – Room 1150
11:30 a.m.– 12:30 p.m.	Concurrent Session B	Oral Presentations – Room 1120
11:30 a.m.– 12:30 p.m.	Concurrent Session C	Oral Presentations – Room 2005
12:30 – 1:30 p.m.	Lunch - WCPHFM Atrium, 1 st Floor	
1:30 – 1:50 p.m.	Dr. Linda Lee	Distinguished Presenter – Relationship between Clinical Practice and Research Today in Family Medicine Room 1150

Time	Presenter	Presentation & Room
1:50 – 2:10 p.m.	Dr. David Snadden	Distinguished Presenter – Vision of the future of Primary Health Care and the Role of Graduate Education in Family Medicine in Leadership Development Room 1150
2:10 – 2:40 p.m.	Coffee Break - WCPHFM Atrium, 1 st Floor	
2:40 – 3:40 p.m.	Concurrent Session D	Oral Presentations – Room 1150
2:40 – 3:40 p.m.	Concurrent Session E	Oral Presentations – Room 1120
3:45 – 4:30 p.m.	Drs. Saadia Hameed, Sudha Koppula, Tesshu Kusaba, Katherine Stringer	Fireside Chat – Panel The Future of Family Medicine Room 1150
4:30 – 4:45 p.m.	Closing Remarks / Evaluations Dr. Judith Brown Room 1150	
6:30 – 10:00 p.m.	Formal Dinner Green Leaf Café at Somerville House on Campus	

25% of this program is dedicated to participant interaction

Concurrent Session A: Oral Presentations – WCPHFM 1150

Time	Presenter	Presentation
11:30 – 11:45 a.m.	Dr. IkeOluwapo O. Ajayi	Effect of Family Function on Teenage Pregnancy as Seen Among Teenagers Presenting at Two Hospitals in Ibadan, Nigeria
11:45 a.m. – 12:00 p.m.	Dr. Tom Freeman	Comparing Abdominal Pain Symptoms and Their Clinical Implications: A Study Using Electronic Medical Record (EMR) Data from the Deliver Primary Healthcare Information (Delphi) Database
12:00 – 12:15 p.m.	Dr. Joe Moran	Investigation of the relationship between patient empowerment and metabolic control in patients with type 2 diabetes: a cross-sectional analysis

Dr. IkeOluwapo O. Ajayi, MB;BS, M.Cl.Sc, MPH, PhD, FMCGP, FWACP
College of Medicine, University of Ibadan, Nigeria

Co Authors: Oluwatoyin A. OKUYELU; Amos O. OKEDARE

Effect of Family Function on Teenage Pregnancy as Seen Among Teenagers Presenting at Two Hospitals in Ibadan, Nigeria

Learning Objectives:

At the end of this presentation participants should be able to identify:

- family functionality as a crucial factor in teenage pregnancy outcome
- the need to advocate parental support and attitudinal change towards teenage pregnancy

Context: There were limited studies on family functionality on teenage pregnancy and its outcome in Nigeria. **Objective:** To determine effect of family function on outcome of teenage pregnancy and effect of teenage pregnancy on the family. **Design:** Descriptive cross-sectional; mixed method was used for data collection. **Setting:** State and Mission owned hospitals.

Participants: They were 260 female teenagers aged 13 and 19 years who presented consecutively with pregnancy or post abortion. Those referred were excluded. For the qualitative study, guardians/parents who consented were purposively selected for key informant interview.

Instrument: An interviewer administered questionnaire and key informant guide were used. APGAR score was used to assess family functionality. **Results:** Two hundred and thirty six teenagers (90.8%) presented with pregnancy while 24 (9.2%) presented with post abortion complications; 233 (98.7%) had term delivery; 216 (91.5%) delivered spontaneously. One hundred and ninety six (75.4%) teenagers were from dysfunctional families. Proportion with dysfunctional families increased from 58.8% before pregnancy to 75.4% during pregnancy. All teenagers from dysfunctional families had spontaneous vaginal delivery compared with 64.3% from functional families ($\chi^2 = 1.013$, $p < 0.0001$). Higher proportion (77.8%) of teenagers from dysfunctional families had low birth weight babies compared with 35.7% of teenagers from functional families ($\chi^2 = 7.834$, $p < 0.020$). Parents of the teenagers were angry, disappointed, and unhappy. Family therapy was not supported by most of the respondents because it was regarded un-cultural.

Conclusions: Family functionality influences outcome of teenage pregnancy. Change in parental attitude and counselling for support of pregnant teenagers is needed.

Dr. Tom Freeman, MD

Western University, London ON

Co Authors: H. Maddocks, PhD, M. Stewart, PhD, D. Leger, MD, I. Hons, MD, J. Jordan, MD, J. Copeland, MD

Comparing Abdominal Pain Symptoms and their Clinical Implications: A Study Using Electronic Medical Record (EMR) Data From The Deliver Primary Healthcare Information (DELPHI) Database

Statement of Purpose: Three types of abdominal pain include: localized, cramps and epigastric pain. Knowing the differences in pre-encounter characteristics, within and post-encounter outcomes may assist clinical practice.

Methods: Retrospective analysis of International Classification of Primary Care (ICPC-2R) coded encounters (2006-2010) in the DELPHI database. Symptoms of Abdominal Pain Localized (n=143 encounters), Cramps (n=116), and Epigastric (n=97) were investigated for pre-encounter characteristics including: prior chronic conditions, and musculoskeletal, psychological conditions, or social/relationship problems in the previous year. Encounter characteristics included: sex and age of patients, first encounter for abdominal pain and co-occurring symptoms as well as within encounter lab tests, investigations and referrals ordered. At the end of visit the symptom remained, a new diagnosis, or a pre-existing diagnosis was coded.

Results: The three types of abdominal pain were similar on: majority female (67-72%) and under 65 years (58-70%); 63-69% were the first encounter and 34-49% had co-occurring symptoms. Prior social/relationship problems (10-16%), labs (6-11%), investigations (18-31%) and referrals (16-24%) were also similar. Differences were found in pre-encounter musculoskeletal conditions (11% of cramps vs. 54% of localized, $p=.000$), and psychological conditions (10% of cramps, and 27% of localized, $p=.000$). The symptom remained at the end of the encounter (20% of cramps and 47% of localized, $p=.000$), whereas a pre-existing diagnoses were coded in 35% of cramps and only 16% of localized abdominal pain ($p=.000$).

Conclusions: Characteristics and clinical outcomes vary between cramps, epigastric and localized abdominal pain, and a substantial proportion remain undiagnosed.

Dr. Joe Moran, MbBch, MCISc
University College Cork. Ireland

Co Authors: M Fitzgerald, C O'Tuathaigh

Investigation of the relationship between patient empowerment and metabolic control in patients with type 2 diabetes: a cross-sectional analysis

Learning Objectives: To explain the concept of patient empowerment and encourage participants to critically evaluate the role of patient empowerment in diabetes management.

Context: Clinical practice models place great emphasis and resources into improving patient empowerment in the management of type II diabetes mellitus (T2DM). We sought to determine the efficacy of these interventions in patient management.

Objective: To determine the association between patient empowerment in terms of the primary outcomes of metabolic control as measured by glycaemic control (glycated haemoglobin, HbA1c), high-density lipoprotein (HDL), low-density lipoprotein (LDL), total cholesterol (TC) and triglycerides in T2DM management.

Design: Retrospective cross-sectional analysis. Setting: National database (Diabetes Federation of Ireland) utilizing information from participants enrolled in the Community Orientated Diabetes Education (CODE) Programme.

Participants: 569 patients with type II diabetes. Exposures: Patient empowerment levels, as measured by the Diabetes Empowerment Scale-Short Form. Additional information collected included patients' gender, age, body mass index (BMI), smoking status and number of years with diabetes.

Outcome measures: HbA1c, HDL, LDL, TC and triglycerides values. Results: There is no association between degree of patient empowerment and HbA1c ($p=0.32$), HDL ($p=0.95$), LDL ($p=0.77$), TC ($p=0.49$) or triglycerides ($p=0.77$) using partial correlation analyses. Patient empowerment score was not a significant predictor of HbA1c (measured using logistic regression analysis). Time since T2DM diagnosis was associated with increased HbA1c levels. Age and gender were significant predictors of HDL and LDL levels, while gender and age were associated with changes in TC and triglycerides levels, respectively.

Conclusions: There is no significant association between patient empowerment levels and measures of T2DM control. Further research into the short-term and long-term outcomes of the empowerment model, at different levels of disease management, and across different settings, is required to evaluate its value in the management of patients with diabetes.

Concurrent Session B: Oral Presentations – WCPHFM 1120

Time	Presenter	Presentation
11:30 – 11:45 a.m.	Dr. Sudha Koppula	The Fundamental Teaching Activities Framework for Teachers in Family Medicine: a tool for teachers and programs
11:45 a.m. – 12:00 p.m.	Dr. Amanda Pendergast	How to engage learners in a geographically dispersed residency program: evaluating one possible solution using small online learning groups (SOLG).
12:00 – 12:15 p.m.	Dr. David Snadden	Distributed Undergraduate Medical Education in BC contributes to Family Medicine and Rural Residency choices.
12:15 – 12:30 p.m.	Dr. Roger Strasser	The Needs of the Many: NOSM Students' Experience of Generalism and Rural Practice

Dr. Sudha Koppula, BSc, MD, MCISc, CCFP, FCFP
Department of Family Medicine, University of Alberta

Co Authors: Cheri Bethune

The Fundamental Teaching Activities Framework for Teachers in Family Medicine: a tool for teachers and programs

LEARNING OBJECTIVES:

1. Describe the need for development of the Fundamental Teaching Activities Framework.
2. Explain the potential utility of this Framework for clinical teachers. **CONTEXT:** The College of Family Physicians of Canada (CFPC) recognized the importance of supporting teachers as competency-based curricula were adopted nationally. Teachers need a clear understanding of the expectations and opportunities within their roles and faculty development to guide their professional growth. Educational institutions need direction in developing and organizing curricula and resources to support this professional development.

OBJECTIVE: To describe the development of the CFPC Fundamental Teaching Activities Framework and how it can be applied to the professional development of Family Medicine teachers.

METHOD: A fundamental teaching activity is defined as a holistic description of what a teacher actually does, and includes a number of different competencies. A framework articulating the fundamental teaching activities of teachers in family medicine settings was developed based on the concept of Entrustable Professional Activities (EPAs). Beginning with a literature review, and using an iterative process including teachers, faculty developers, program leads, residents, and medical students, three domains were described: Clinical Preceptor; Teacher Outside the Clinical Setting; and Educational Leader. Within each domain, tasks were identified, each broken down into several fundamental activities. A developmental trajectory was described for each activity, permitting teachers to identify next steps in their professional development.

RESULTS: The Framework was well received by the reviewing groups of teachers, program leaders and faculty developers. Teachers were able to identify with the Fundamental Teaching Activities. Departments and Programs in Canada have been using the Framework in faculty development.

CONCLUSION: A framework of teaching activities is being launched by the CFPC. The concept of Fundamental Teaching Activities (FTAs) is intuitive for teachers and useful in understanding teacher development and in planning faculty development activities.

Dr. Amanda Pendergast, BSc, MD
Memorial University

Co Authors: Dr. Susan Avery, Patti McCarthy

How to engage learners in a geographically dispersed residency program: evaluating one possible solution using small online learning groups (SOLG).

Learning Objective: Participants in this session will be able to evaluate the benefits and challenges of online learning in a family medicine residency program.

Context: The family medicine residency program at Memorial University is geographically dispersed. The current academic half day format is a combination of in person and online teaching. Family medicine residents expressed dissatisfaction with the current format as they felt the sessions were not interactive, did not encourage critical thinking and there was no incentive to participate. The residents' learning needs were explored, and the decision was made to trial asynchronous, online learning groups.

Objective: To evaluate online learning groups in the context of a geographically dispersed family medicine residency program.

Design: An eight week curriculum was developed based on content from McMaster University's Practice Based Learning Program Modules. The residents alternated as lead for the week. A faculty member with online learning experience moderated each group, mentoring both resident leads and prospective faculty moderators.

Participants: Fourteen first and second year residents were recruited and divided into two online groups.

Intervention: The study group participated in online learning modules which paralleled content of traditional academic half day.

Measures: The program was evaluated using pre and post program surveys of the residents, weekly formative assessments, weekly narrative reflections, and focus groups of residents and faculty.

Results: Analysis revealed the residents enjoyed learning through cases, appreciated the resources and found the online format to be more engaging, especially to those at peripheral sites. Residents preferred more faculty involvement.

Conclusions: The small online learning group model is an asynchronous learning environment which is suitable for family medicine resident learners in a geographically dispersed residency program with non-parallel schedules. Further studies should be considered to explore this option.

Dr. David Snadden, MB ChB, MCISc, MD
UBC

Co Authors: Paul Winwood, Helen Hsu, Claire Wooton, Chris Lovato

Distributed Undergraduate Medical Education in BC contributes to Family Medicine and Rural Residency choices.

Background

To address the geographical maldistribution and shortage of family physicians in British Columbia, UBC created a provincial model of distributed medical education (DME). This presentation shows the data on the impact of DME on Residency choices for family medicine and rural programs for the first 7 years.

Methods

Administrative data were analysed for students entering the UBC MD undergraduate program between 2004 and 2011 and compared residency choices of students at the main Vancouver (Vn) campus (196 per year) with students in 2 distributed sites in Victoria (Vic) and Prince George (PG) (32 students per year per site). Data were collected retrospectively from annual CaRMS reports.

Results

The proportion of students choosing family medicine residency programs increased from 36% to 38% post-distribution with a higher proportion from Vic and PG than from Vn; 47 and 58% compared to 34%, mostly in local programs. Of these, 9% of students from Vic, 26% of students from PG and 9% of students from Vn entered rural family medicine residency programs across Canada. Of those who entered family medicine programs in BC, 64% from PG entered rural or northern family medicine programs compared to 12% of students from Vic and 18% of students from Vn.

Conclusions

The proportion of students choosing family medicine and rural residency programs has increased since distribution mainly due to graduates from distributed sites. These results suggest that DME is contributing to addressing gaps in family and rural practice in BC. This suggests that the varying contexts of distributed sites influence residency choices.

Dr. Roger Strasser, MBBS, BMedSc, MCISc, LLD(hon), FRACGP, FACRRM, FRCGP(hon).
Northern Ontario School of Medicine

Co Authors: Hoi Cheu PhD

The Needs of the Many: NOSM Students' Experience of Generalism and Rural Practice

Learning Objectives: After this presentation, participants will be able to:

- Describe NOSM students' experience of generalism
- Outline key elements of generalism in rural practice

Context: Northern Ontario School of Medicine (NOSM) opened in 2005 with a social accountability mandate focused on improving the health of Northern Ontarians. NOSM recruits students from Northern Ontario or similar backgrounds and provides Distributed Community Engaged Learning in over 90 community settings located in a vast underserved rural part of Canada.

Objective: In the context of a growing discourse on generalism, this paper explores the NOSM student and graduate experiences of generalism in rural practice.

Methods: NOSM tracking studies use mixed methods drawing on data from various sources including interviews of students, graduates and other informants. This paper reports analysis of semi-structured interviews involving 37 graduating medical students and 9 practising NOSM graduates.

Results: Key themes from student observations include an affinity for Northern Ontario and a recognition that rural medicine involves a broad scope of practice. NOSM students consider generalist care as a comprehensive service with a strong focus on responding to the health needs of the community. Beyond primary care, a rural medicine "true generalist" is viewed as a complete package, a physician who provides care ranging from promoting prevention to performing specialist tasks.

Conclusion: Rural practitioners, particularly in family medicine, are extended generalists with a broad scope of practice guided by the health needs of the communities they serve. NOSM students' and graduates' experience of rural generalism is positive and highly influential in determining their career direction including specialty, scope and location of practice. NOSM's generalist approach may be effective beyond rural applications and an advantageous approach for foundational medical education. Students and graduates report that the NOSM Distributed Community Engaged Learning prepares them well for rural generalist practice.

Session C: Concurrent Oral Presentations – WCPHFM 2005

Time	Presenter	Presentation
11:30 – 11:45 a.m.	Dr. John Payne	Understanding the Nature of Family Medicine Using the Metaphysics of Quality
11:45 a.m. – 12:00 p.m.	Dr. Steve Wetmore	Comprehensive Family Medicine: Is it time for a family doctor job description?
12:00 – 12:15 p.m.	Dr. Mark Yaffe	Patients' unsolicited written correspondence to doctors: A novel window onto the doctor-patient relationship

Dr. John Payne, BA 1969 MD 1974 M Clin Sci (Family Medicine) 1992
Schulich School Of Medicine, Adjunct Professor.

Understanding the Nature of Family Medicine Using the Metaphysics of Quality

Zen and the Art of Motorcycle Maintenance - An Inquiry into Values was chosen by Dr. Ian McWhinney for the 1983 book list for his Foundations of Family Medicine Course. This book and its sequel Lila -an Inquiry into Morals explain Robert Pirsig's Metaphysics of Quality. This presentation will explain how the MOQ works and how it can be used to understand complex issues and prioritize the components of Family Medicine in the 21st century. The presentation is the result of multiple readings of these books and relating them to 39 years of small town family practice and the writings of other authors including Marshall McLuhan, Edward O Wilson, Kurt Vonnegut, John Steinbeck, Joseph Campbell and Leonard Cohen. Some knowledge of the two books will be helpful but not necessary.

Dr. Stephen Wetmore, MD, MCISc
Western University

Comprehensive Family Medicine: Is it time for a family doctor job description?

Context: Much has been written about the change in scope and practice of family medicine over the years.^{1,2} Some are deploring the fragmentation of family medicine into mini-specialties.^{3,4} Family doctors are the key players in primary care and primary care is an important cornerstone of a high functioning healthcare system. Access to care and continuity of care with family physicians have become important indicators of practice quality and patient satisfaction.⁵ Team -based care within the concept of the Patients Medical Home is being promoted as the way comprehensiveness will be delivered in the future.⁶ The College of Family Physicians of Canada is attempting to define a responsibility profile for Canadian family physicians.⁷

Objective: To review the past and current state of family medicine practice, its scope and practice profile and to propose a practice scope and profile that focuses on generalism and responsibilities to our patients and communities.

Methods and Setting: This is a descriptive report containing a brief review of the literature related to scope and responsibilities of family doctors, some discussion of generalism and comprehensiveness and leading to a job description for comprehensive family doctors. This could be applied anywhere that family physicians practice but the context is generally within the province of Ontario.

Conclusions: The practice of family medicine is changing with a general decline in comprehensiveness, continuity and less appreciation of practice responsibilities. A job description for a family doctor focusing on generalism and practice responsibilities would clarify the situation for governments, training programs and the public. This may also lead to future research ideas.

Dr. Mark Yaffe, B.Sc., M.Cl.Sc., M.D., C.M.
McGill University

Co Authors: Richard Hovey; Charo Rodriguez

Patients' unsolicited written correspondence to doctors: A novel window onto the doctor-patient relationship

Context: Doctor-patient relationships are traditionally analyzed using of audio / video recordings, case studies, and focus groups. This presentation discusses an uncommonly cited means to identify what patients appreciate in medical care.

Objective: To examine how, when, and in what context patients / family members express appreciation of physician care.

Design: A sentinel event (to be described) was the impetus for the presenter to retain, over years, correspondence from patients/families. Analysis of it has been exploratory, predominantly qualitative, and aiming to provide a semantic interpretation of patient / family experience of care.

Participants: Adult patients / family members with varying contact over 39 years with an academic, community hospital-based family practitioner seen in office / hospital / home settings.

Intervention: Analysis of 140 notes, cards, and letters written by patients /family members.

Outcome Measures: Type of correspondence, likely context for writing, gender of writer, and predominant feelings /ideas expressed. Findings: 33/140 acknowledged physician care either in a newspaper obituary or in association with a charitable donation. These were excluded from further consideration since no additional information could be gleaned. Of the remaining 107, 54.2% were handwritten letters /notes; 29.9% handwritten thoughts included within a commercially created card; and 15.9% typed notes/ letters. Of the 107, 74.8% were signed by women. Reasons for corresponding can be summarized as occurring in conjunction with secular /religious holidays, life cycle events (birth, illness recovery, death), on-going self-reflection about needs, and geographical move away from practice. Descriptors of experienced care will be presented, and include authentic, professional, knowledgeable, sensitive to suffering, compassionate, offering hope, and presence.

Conclusions: Data presented is not intended to focus on cited attributes of a particular physician; rather, the writings bear witness to patients/families' appreciation of when Hippocratic and Aesclepien traditions overlap and complement each other.

Session D: Concurrent Oral Presentations – WCPHFM 1150

Time	Presenter	Presentation
2:40 – 2:55 p.m.	Dr. Nusrat Jamil	Lung cancer screening practices and factors influencing the decision-making of family physicians in Saskatchewan
2:55 – 3:10 p.m.	Dr. Donna Manca	BETTER WISE: Building on Existing Tools to Improve Cancer and Chronic Disease Prevention and Screening in Primary Care for Wellness of Cancer Survivors and Patients
3:10 – 3:25 p.m.	Dr. Susan McNair	Prevalence of Adult Female Genital Trauma Following Acute Sexual Assault: Need for a Universal Definition of Trauma
3:25 – 3:40 p.m.	Dr. Kamila Premji	Understanding Ontario patients' perceptions of access to primary care: A multi-dimensional approach

Dr. Nusrat Jamil, MBBS, MCISc

Department of Family Medicine, University of Saskatchewan

Co Authors: Nusrat Jamil, MBBS, MCISc, LMCC, CCFP; Thomas R. Freeman, MD, MCISc, FCFP; Bridget L. Ryan, PhD

Lung cancer screening practices and factors influencing the decision-making of family physicians in Saskatchewan

LEARNING OBJECTIVES: Self-reflection on lung cancer screening practice versus conceptual physician decision-making model and study results; awareness some factors can override evidence-based inclination; exposure to survey research using clinical vignettes; implications to healthcare cost, patient care, CME.

CONTEXT: Variation in family physicians' lung cancer screening practices leads to unnecessary costs, has potential to cause harm given that the Canadian Task Force on Preventive Health Care (CTFPHC) specifically recommended against screening with chest X-ray (CXR).

OBJECTIVE: Determine family physicians' lung cancer screening practices and factors associated with these practices. **DESIGN:** Cross-sectional survey with two components: Single item questions designed to measure physicians' self-reported perception of guidelines, attitudes and behaviour; Hypothetical clinical scenarios designed to measure physicians' intended screening decisions in different clinical situations.

SETTING: Family medicine clinical practice in urban, rural, regional and academic settings in Saskatchewan.

PARTICIPANTS: Stratified random sample (n=49) of full time family physicians.

INSTRUMENT: Survey instrument including single-item questions and hypothetical case scenarios (clinical vignettes) was used to study family physician screening practices and factors influencing their decision-making.

MEASURES: Based on their self-reported screening behaviour physicians were dichotomized into Screeners and Non-Screeners; Based on different clinical scenarios, intended decision to order a lung cancer screening test (CXR, sputum cytology, CT) with dichotomous variables.

RESULTS: Wide variations in family physicians' lung cancer screening practices exist both in the decision to screen and choice of screening test. Certain physician, patient and non-medical factors influenced family physician decision-making against their perception of guidelines.

CONCLUSIONS: High self-reported prevalence and measured inclination to screen in clinical scenarios against prevailing guidelines adds unnecessary health care costs and has potential to cause harm. This study contributes to the literature about existing family physicians' practices and decision-making regarding lung cancer screening and highlights implications to health care cost, patient care and CME initiatives.

Dr. Donna Manca, MD, BSc, MCISc, FCFP
University of Alberta

Co Authors: Donna Manca, Carolina Aguilar, Kris Aubrey-Bassler, Denise Campbell-Scherer, Aisha Lofters, Melissa Shea-Budgell, Nicolette Sopcak, Eva Grunfeld

BETTER WISE: Building on Existing Tools to Improve Cancer and Chronic Disease Prevention and Screening in Primary Care for Wellness of Cancer Survivors and Patients

Family physicians lack time, resources, and tools to address cancer and chronic disease prevention and screening (CCDPS). Although most patients have multiple risks, guidelines and resources are focused on one specific disease, organ system, or lifestyle risk. Furthermore, cancer survivors and patients affected by poverty achieve fewer prevention and screening goals. BETTER WISE (Building on Existing Tools to Improve Cancer and Chronic Disease Prevention and Screening in Primary Care for Wellness of Cancer Survivors and Patients) builds on the BETTER trial, which demonstrated the effectiveness of the BETTER approach. A healthcare provider with enhanced skills in CCDPS, the Prevention Practitioner (PP), meets with patients one-on-one, develops a tailored "Prevention Prescription" with them, helps them set S.M.A.R.T. (specific, measurable, attainable, realistic, time-based) goals for their health, and links them to community resources, as appropriate.

The main objectives of BETTER WISE are to proactively target cancer survivors and patients to comprehensively address CCDPS, improve clinical outcomes, reduce the burden of chronic disease, and improve the sustainability of the healthcare system through improved CCDPS and cancer surveillance in primary care.

Using the BETTER toolkit, which includes blended care pathways for cancer survivors and CCDPS, including behavioural lifestyle risk factors and a brief poverty screen, the PP determines which CCDPS maneuvers patients 40-65 years of age are eligible to receive.

The BETTER trial demonstrated that the addition of a PP improved uptake of CCDPS in urban primary care settings as compared to usual care (54% vs. 21%, $p < 0.001$). Similar improvements in CCDPS outcomes have also been observed in community settings in Newfoundland & Labrador.

The BETTER WISE approach addresses the CCDPS needs of patients, including cancer survivors, and involves screening for poverty. BETTER WISE provides a framework for an adaptable, collaborative, patient-centred approach that is grounded in evidence.

Dr. Susan McNair, BA MD CCFP MCLSC(FM) FCFP

Dept of Family Medicine, Western University and St Joseph's Hospital, London, Ontario

Prevalence of Adult Female Genital Trauma Following Acute Sexual Assault: Need for a Universal Definition of Trauma

This presentation will address the topic of female genital trauma related to sexual assault and will challenge the audience to consider the need for a universal definition of genital trauma.

The literature will be reviewed to illustrate how individual injury types and combinations of injury types, constituting genital trauma, vary across studies and contribute to the difference in the reported prevalence of genital injuries in sexual assault research.

A retrospective research study looking at genital trauma in a population of adult female victims in a large sexual assault treatment centre in London, Ontario will be presented. The study illustrates how the manner in which we define sexual assault trauma, through the inclusion or exclusion of various injury findings, some more subjective than others, has a profound impact on the prevalence of injuries reported to have been sustained in a population of sexual assault survivors.

The audience will recognize that the ability to accurately identify and interpret findings in cases of acute sexual assault are primary building blocks in defining genital trauma. However, consideration to which findings to include in a universal definition of trauma, or at least consider ways to present findings in a way that reflects the diversity of findings, would greatly enhance our ability to compare research in genital trauma across populations, to offer expert evidence in court when challenged with questions around the prevalence of genital trauma in sexual assault and to offer expert opinion on post-mortem findings when many definitions of trauma in the literature lack relevance in the post-mortem setting.

Dr. Kamila Premji, BSc, MD, CCFP, CAC (Clinician Scholar)

Western University and the University of Ottawa

Co Authors: Bridget L. Ryan, William E. Hogg, Walter P. Wodchis

Understanding Ontario patients' perceptions of access to primary care: A multi-dimensional approach

CONTEXT: Ontario has been criticized for poor access to primary care following reports from the Commonwealth Fund Study and Health Quality Ontario. These findings are based primarily on the metric of same-day/next-day access.

OBJECTIVE: We sought to attain a more comprehensive understanding of Ontario patients' experiences accessing primary care by applying a multi-dimensional approach.

DESIGN: Cross-sectional analysis of the Quality and Costs of Primary Care (QUALICO PC) Patient Experiences Survey.

SETTING: Ontario primary care practices.

PARTICIPANTS: 1,698 adult primary care clinic attenders participating in the QUALICO PC study.

INTERVENTION: None.

MEASURES: Eleven access-related survey items were analysed both individually and as a Composite Access Score (CAS).

RESULTS: The mean Composite Access Score was 1.78 (SD 0.16) (highest possible CAS was 2, lowest was 1). Most patients (68%) waited more than one day for their appointment. The majority (96%) stated it was easy to obtain their appointment and that they obtained that appointment as soon as they wanted to (87%). Higher CAS was associated with being older, being born in Canada, better self-reported health, and increased frequency of visits to a doctor.

CONCLUSION: Although not representative of certain marginalized populations who may not have any access, most participants felt favorably about their access, a finding that is distinctly at odds with the prominently used metric of same-day/next-day access. Future research is warranted to better understand what access means to patients and to appropriately design reforms and quality assurance targets. Policymakers should consider multiple dimensions and multiple data sources when targeting access, and bear in mind the differences between patients with and without a primary care attachment.

Session E: Concurrent Oral Presentations – WCPHFM 1120

Time	Presenter	Presentation
2:40 – 2:55 p.m.	Dr. Tesshu Kusaba	The orientation for patient-centered medicine and the satisfaction for doctors in Japan
2:55 – 3:10 p.m.	Dr. Caroline Rebicki	Management of Hypoglycemia in Primary Care, a secondary analysis of the InHypo-DM Study Family Physician data
3:10 – 3:25 p.m.	Dr. Katherine Stringer	Patient Centred Care of Adults with Severe or Profound Developmental Disabilities: The patient-physician relationship
3:25 – 3:40 p.m.	Dr. David Snadden	Working hard but working differently, the impact of generational change on rural family practice

Dr. Tesshu Kusaba, M.D.

The Hokkaido Centre for Family Medicine

The orientation for patient-centered medicine and the satisfaction for doctors in Japan

Learning Objectives: On completion of this session, participants should be able to describe the three factors of preferences of patients for patient centered approach to consultation in primary care, understand the association between patient's characteristics and preferences for patient centered approach.

Context: In Japan, the specialty of family medicine has been just established. We have to show the components of family medicine such as comprehensive care, coordinated care and patient-centered approach can be accepted by Japanese patients like other countries. **Objective:** To show what components of patient-centered medicine are preferred for Japanese people and its association with the satisfaction for doctors.

Design: Cross-sectional study.

Setting: Private primary care clinic giving ambulatory care by board-certified family doctors.

Participants: 40 Japanese patients who are 20 to 85 years old, not dementia, not pregnant, without disability of writing and without emergent problem.

Intervention: 2 questionnaires before and after consultation, the former is about the orientation for patient-centered medicine and the latter is about the satisfaction for doctors.

Results: Mean age of patients was 65.2 years. Patients feeling worried about the problem more strongly preferred good communication and partnership with general practitioners after having controlled for other variables such as family composition, having paid work or not, seeing regular doctor or not and feeling unwell or not. Patients expecting good communication with general practitioners were more strongly satisfied with patient-centeredness, whole person care, complete examination and overall consultation.

Conclusions: We found some type of Japanese patients really expected patient centered approach including good communication and partnership. And they felt satisfaction with the consultation provided by board-certified family doctors with patient-centered approach including patient-centeredness, whole person care and complete examination.

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Management of Hypoglycemia in Primary Care, a secondary analysis of the InHypo-DM Study Family Physician data

Context: Though the management of Diabetes and its complications are widely investigated and documented in scientific literature, little is published about how hypoglycemia is managed in a primary care setting.

Objectives: To determine the factors that influence how Family Physicians manage hypoglycemia in their patients. Key secondary objective is to examine potential differences in hypoglycemia management among physician categories; (Family Physicians; Diabetes Specialists; Endocrinologists).

Design: Secondary analysis of the Physician's data set of the InHypo-DM study. The InHypo-DM Study used a mixed-method and multi-measure approach with quantitative and qualitative methods used at different stages of the project.

Settings: Canada

Participants: 194 physicians completed the questionnaire.

Intervention: Not applicable

Measures: The outcome for the study is the extent to which physicians indicate that helping their patients manage their hypoglycemia is something they do routinely. The analysis will look at the relationship between the outcome and age, gender, location of practice, percentage of Diabetes patients, personal diagnosis of Diabetes; and other variables concerning the physician's knowledge and attitudes toward hypoglycemia management such as knowledge on hypoglycemia, preparedness to help patient; initiative to help patients; commitment to helping the patient manage their hypoglycemia and having clear goals for managing hypoglycemia. Anticipated results: This study will provide a profile of Family Physicians' management of hypoglycemia for their patients with diabetes and will identify factors associated with their management.

Conclusion: This study will provide evidence concerning the factors that influence Family physician's hypoglycemia management which may ultimately improve the management of hypoglycemia in primary care for patient with diabetes.

Learning objectives:

1. Participants will be able to indicate the extent to which Family Physicians routinely manage hypoglycemia in patients with diabetes.
2. Participants will be able to identify factors which are associated with Family Physicians' hypoglycemia management practices.

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Working hard but working differently, the impact of generational change on rural family practice

Objective: To examine the implications for rural practice of the changing aspirations of young practitioners: a qualitative study

Design: Qualitative in-depth interviews and thematic analysis

Setting: Rural NW Canada

Participants: A purposefully diverse sample of 42 practitioners, mostly family physicians, but including some specialists and nurses. The sample included early, mid and late career physicians.

Methods: A mixture of small group and one on one interviews. Data were analysed thematically by both researchers independently and then a common coding framework was developed. Initial findings were returned to respondents for validation.

Findings: There were three main themes. Environment, Scope of Practice and Generational Change. These interact together to influence the environment of practices and have major implications for the future recruitment and retention of young physicians in rural areas. Enablers are local mentorship and community support, supportive specialist networks, flexibility of contract arrangements, the ability of communities to adapt to changing working preferences, team working and collaboration.

Conclusions: Those communities that adapt to the aspirations of the next generation of physicians, who work hard but differently, may find it easier to recruit and retain young physicians. There may be potential implications in terms of educating patients and communities for care by teams, and in terms of how our professional associations negotiate on behalf of physicians.

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Patient Centred Care of Adults with Severe or Profound Developmental Disabilities: The patient-physician relationship

Adults with developmental disabilities receive most of their health care from family physicians, yet little is known of the development of the patient-physician relationship in this population. This qualitative study used a grounded theory approach to describe the development of this relationship between adult patients with severe or profound developmental disabilities and their family physicians. Semi-structured interviews were conducted with 13 caregivers and 15 family physicians of these patients. The recognition of the patient's vulnerabilities was a common starting point. Caregivers approached the patient-physician relationship as one unit with the person they cared for as part of the process of protecting them, before allowing the relationship to develop along different trajectories. Family physicians described a mutual process of acceptance—of the patient as a human being, and of the physician by the patient. Greater awareness of these processes of relationship development may improve health care delivery for patients with developmental disabilities.