

resource management (CRM) has been shown to produce improvements in skill acquisition, communication and team behaviors. Simulation has become a key component of most Family Practice (FP) residency programs and many programs are moving towards developing formal simulation curriculums. The Coastal FP Residency is a relatively new and unique program with a large emphasis on rural medicine. Graduates have gone on to practice in remote areas with less access to supports for critically ill patients. Therefore, an effective simulation curriculum, focused on Emergency Medicine, is of great importance to this program.

**Methods:** To develop our curriculum, Kern's framework for medical education was selected given its prior success in similar endeavors. The first step of this approach involves a needs assessment, which we accomplished in the form of an online survey. The questionnaire included pre-defined topics pertaining to the training needs of FP Residents destined for Rural Practice with respect to technical skills, CRM skills, specific medical conditions and categories of medical conditions. Classification of answers included multiple choice, 5-point Likert scales as well as an option for free-text answers. The survey was distributed to pre-identified participants including stakeholders/educators within the Coastal FP residency program as well as simulation education leads for FP residencies throughout British Columbia (BC). Current residents, as well as program graduates were also asked to complete the survey. **Curriculum, Tool, or Material:** The results of this survey were used to develop formal goals and objectives which were in turn used to write or adapt 24 cases for the curriculum. Cases from categories (e.g. Pediatrics) rated as "Extremely Important" on the Likert scale were included proportionally more in the curriculum. The cases were also designed to assess/practice a higher proportion of CRM elements considered important and to address commonly identified difficulties in resuscitation. Cases were developed, where possible, using local or national guidelines and are currently in the stage of peer review (by a minimum of two peers). **Conclusion:** The curriculum will be implemented in July 2017 and we will transition towards the evaluation phase. Our goal is to develop and distribute formalized needs assessments to rural FP residencies across BC so that they may develop dynamic, formal curriculums of their own.

**Keywords:** innovations in emergency medicine education, simulation, curriculum development

#### P065

##### The history of emergency medicine in Ottawa

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**Introduction/Innovation Concept:** There is a paucity of peer-reviewed works investigating the History of Emergency Medicine (EM) in Canada, and none examining a single centre. This study analyzed the academic and clinical evolution of EM in the City of Ottawa from its origins to present. **Methods:** The study comprised primary and secondary historical research and an oral history methodology. A literature review was performed on the following databases: PubMed, Medline, EMBASE, JSTOR, Web of Science, Historical Abstracts; five medical history journals were also searched. Data were collected from City of Ottawa Archives, Archives of the Sisters of Charity of Ottawa, The Ottawa Hospital Libraries, University of Ottawa Libraries, RCPSC and CFPC Archives, Historical Society of Ottawa documents, Ottawa newspaper archives, and professional correspondences. The oral history component consisted of formal interviews with seven practicing and retired Emergency Physicians in Ottawa. Ethics approval was not required though consent was obtained from

respondents. **Curriculum, Tool, or Material:** The literature review yielded the following: PubMed: 218 results, 180 excluded for non-relevance, 3 papers included in analysis. Historical Abstracts: 1 result, overlap with PubMed. Other databases and medical history journals yielded no papers. Along with extensive archival data, these results were used to construct a detailed timeline of EM history in Ottawa and Canada more broadly. Residency training in EM in Ottawa was initiated in 1972 at the impetus of the Board of the Ottawa Civic Hospital. Two main themes recurred in the interviews: resistance from existing specialties to EM becoming a specialty, and early Emergency Rooms staffed by the least trained people treating the least differentiated patients. Early EM physicians were not viewed positively by other specialists. **Conclusion:** Pioneering EM physicians were forced to validate the specialty as distinct, rigorous, and credible. In Ottawa this was achieved by developing strong core academics and research. Nationally, this has been instrumental in establishing EM as a viable standalone academic specialty. Modern consult pushback may have evolved from existing specialists fighting against the creation of EM combined with their negative perception of EM physicians. These data could be incorporated into learning modules for EM residency academic programs, and the methods applied to other centres.

**Keywords:** innovations in emergency medicine education, history of emergency medicine, history of medicine

#### P066

##### Outcomes of non-operative versus operative management in pediatric acute uncomplicated appendicitis

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**Introduction:** The purpose of this study was to look at outcomes of pediatric patients with early, acute appendicitis who were treated with non-operative management (NOM) with antibiotics. Primary outcomes were subsequent appendectomy or Emergency Department (ED) visits. **Methods:** The method used for this study was a retrospective chart review of children under the age of 18, looking at outcomes of those who received non-operative management (NOM) for early acute appendicitis between April 2014-April 2015. The inclusion criteria included: (a) Age 0-17, (b) US or CT suggested acute uncomplicated appendicitis (c) Final diagnosis of appendicitis during April 2014-2015. Outcomes that were investigated were repeat ED visits and need for subsequent appendectomy. **Results:** Data extracted from the EMR found 209 charts with an ED diagnosis of appendicitis. Two charts (.9%) were excluded as they were duplicates. Sixty-seven patients (32%) were excluded after appendicitis was ruled out. One hundred and forty patients (67%) had a final diagnosis of appendicitis, 124 patients (88.6%) were taken directly to the operating room for appendectomy, 16 patients (11.4%) were treated with antibiotics instead of operative management. Three patients who received non-operative management had complex appendicitis, 13 had acute uncomplicated appendicitis. Six patients out of 13 (46%) were successfully treated with antibiotics with no repeat visits to the ED or Pediatric Surgery for appendectomy, 7 patients (54%) required appendectomy after initial treatment with antibiotics. Two patients who underwent appendectomy after initial NOM had no evidence of clinical appendicitis, one patient was taken to the OR based on parent preference and one patient had an episode of abdominal pain that prompted an interval appendectomy four weeks post the episode of abdominal pain. **Conclusion:** Treatment of acute uncomplicated appendicitis with NOM remains a management option in the pediatric population. Further studies and long term follow up are required to better identify appropriate patients for non-operative management versus operative management.

**Keywords:** appendicitis, non-operative management, antibiotics