London Health Sciences Centre
Southwest Ontario Regional Base Hospital Program

Leadership of optimal prehospital care systems

SWORBHP LINKS

VOLUME 23 MAY 2016

Inside this issue:

Celebrating Paramedic Services Week
Thank you for the brave and life saving work you do!

2016 PARAMEDIC SERVICES WEEK

ENHANCING CARE – CHANGING LIVES

May 22nd to 28th

Visit our web and social media pages during Paramedic Services Week for more information and your chance to win daily prizes!

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Happy Spring !

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Facilitating the delivery of excellent prehospital care while advancing safe practice and preparedness in our communities through collaborative partnerships and innovation.

Ontario Award for Paramedic Bravery

On Thursday, May 12th, Dr. Mike Lewell and I had the distinct honour as Chairs of the Ontario Base Hospital Group Medical Advisory and Executive Committees to participate in the Second Annual Ontario Award for Paramedic Bravery ceremony at the Toronto Legislative Building. This award honours paramedics who have performed an act of exceptional courage - on the job or off duty - in the face of grave, personal danger.

Twenty-one paramedics from seven services were honoured during the ceremony hosted by Dr. Eric Hoskins, Minister of Health and Long-Term Care. We were extremely pleased to learn that four SWORBHP paramedics were among the honourees. A huge congratulations goes out to Matthew Breadner, Tiffany Shaw, Nick Maus and Kyle Stewart from Grey County Paramedic Services!

Matthew and Tiffany witnessed a head-on collision south of Owen Sound on August 30, 2015 and were honoured for rescuing a person trapped in their car moments before it became engulfed in flames. Nick and Kyle were honoured for entering a burning building and rescuing two people in Owen Sound on August 10, 2015.

Congratulations Matthew, Tiffany, Nick and Kyle for your outstanding acts of bravery. We are very proud of you!

For a complete list of all award recipients and to read more about this award, please visit the links below.
Recipients of the Second Annual Ontario Award for Paramedic Bravery
https://news.ontario.ca/mohltc/en/2016/05/ontario-recognizes-outstanding-bravery-of-paramedics-2.html

Susan Kriening, RN, BScN, MHS, ENC(C)
Regional Program Manager

Above - L to R: Dr. Eric Hoskins, Tiffany Shaw, Matthew Breadner, Mike Muir

Above - L to R: Dr. Eric Hoskins, Nick Maus, Kyle Stewart, Mike Muir

STEMI Diagnosis

The recently released Ontario STEMI Protocol states that accurate diagnosis of a STEMI can be done through a clinical assessment and paramedic interpretation of a diagnostic 12-lead ECG. In other words, relying solely upon the computer ECG interpretation software for the diagnosis of STEMI should not be the standard of care in Ontario. Your clinical expertise, as it has always been, is essential.

It is very important to note that this advanced paramedic assessment of the ECG for possible STEMI is critical not just in geographies that participate in STEMI Bypass to PCI capable centres. In fact, paramedic recognition of STEMI on the 12-lead ECG leads to reduced time to reperfusion and saves lives. Mortality is reduced by nearly one-third when paramedics recognize STEMI early and transport directly for reperfusion – for either fibrinolysis of primary PCI (Nam et al, 2014). In non PCI centers, it is the early identification and notification of the receiving ED staff that shortens the "door to needle time".

Recently the SWORBHP Medical Directors have received feedback from interventional cardiologists involved with STEMI Bypass for PCI related to an increase in false positive STEMI cath lab activations. In reviewing a number of recent cases, it appears that patients have been transported directly to the cath lab for consideration of PCI yet unfortunately no STEMI was present on the original ECG or a contraindication existed (left bundle branch block).

The computer software for ECG interpretation is very sensitive for ST segment elevation. As you know however, not every ST elevation noted by the software is related to STEMI. It is very important that when the software notes ST change that you confirm using your ECG interpretation skills and the clinical correlation of the patient condition (chest pain consistent with STEMI) that you believe that ST change relates to a STEMI as opposed to an imitator of STEMI.

The good news is that it is relatively infrequent that this same sensitive ECG interpretation software will miss a true STEMI. That being said, if you are convinced that you note ST elevation that fits with a STEMI picture despite a negative computer interpretation, absolutely follow the appropriate next steps depending upon your geography: notify the receiving ED as to your suspected STEMI in non-PCI sites so that fibrinolysis considerations can begin as soon as you arrive or follow your site specific STEMI Bypass protocol.

Thank you for continuing to critically assess and manage patients with cardiovascular disease in our communities. Through initiating care early and enhancing integration of paramedic services directly into the traditional hospital based systems of care, we are improving the health and outcomes of all of our patients.

Michael Lewell, B.Sc., M.D., FRCP(C)
Regional Medical Director

Reference

Nam, J., Caners, K., Bowen, J.M., Welsford, M., O'Reilly, D. (2014). Systematic review and meta-analysis of the benefits of out-of-hospital 12-lead ECG and advance notification of ST-segment elevation myocardial infarction patients. *Annals of Emergency Medicine.* 64(2): 176-186.

Introducing Our New SWORBHP Staff

Debbie Janssen joined SWORBHP in February 2016 as the Coordinator for Quality Assurance and Business Functions.

Prior to joining SWORBHP, Debbie was a Business Analyst and Team Leader for the Web Development Team in Information Technology Services at St. Joseph's Health Care and London Health Sciences Centre for over 28 years. She was instrumental in leading her team through the planning, development, implementation and on-going support of all web development for London's hospitals and our regional partners.

Debbie holds a Bachelor of Management and Organizational Studies with a specialization in Finance and Administration from the University of Western Ontario, a diploma in Computer Programming from Fanshawe College and several technical certifications. She is currently working on acquiring Project Management Professional certification.

The Importance of Continuing Education

Almost all careers require some type of education prior to beginning "the job". Once the minimum standard is met, does education ever need to be considered again?

Since most industries are constantly changing, continuing education is required to keep up with the latest developments, technology and skills. Many professions make continuing education mandatory. In our world of EMS this would constitute annual in-service training or Base Hospital recertification. We are not alone! In fact we're among one of many professions required to complete mandatory educational programs.

"When people continue their education they grow…"

Health care workers, at every stage in their careers, must continue learning about enhancements in research and treatments in their field. In the fast-paced world of prehospital medicine, education is imperative for certification. In addition to the mandatory requirements, have you ever considered pursuing educational opportunities outside the minimum requirements?

Continuing education does not mean one must go back to the classroom or enroll in a college or university program. It also doesn't mean that the topic must be directly related to your career. Consider educational programs related to an interest or a hobby. Non-traditional higher and continuing education programs are available now to a greater degree than ever, with many being easily accessible and accommodating to both work schedules and busy life styles.

If people believe their education is complete, it will slowly dissipate. Today's professionals must commit to a life-long learning philosophy that enhances the most current advancements, and most importantly, never ends.

Despite the profession, continuing education is important, not only to maintain certification, but for overall career satisfaction. When people continue their education they grow, they become more interested and interesting, they enhance skills and are informed and engaged in the world around them.

So don't wait for the next recert to come around - go out and join an educational opportunity!

Jennifer Robson, BaCP(P), AEMCA
Prehospital Care Specialist

The Yearly Recert Process

As the interim Education Coordinator, I wanted to reach out and give an update on what is happening with the 2016-2017 recerts and the recert process in general. Your Prehosptial Care Specialist (PCS) team of Pete, Jenn, Dwayne, Cindy, Patty, Mike K, Mike R, your Medical Director of Education, Dr. Matt Davis and your EMS Fellow, Dr. Lauren Leggatt, have been hard at work designing a fantastic pre-course and recert day for you. This year the pre-course will be similar to last year's based on the positive feedback from you, the paramedics.

The in-class day will be very much like a lab day, basically all hands on. With the arrival of some new mannequins to SWORBHP, be prepared to get your hands dirty (metaphorically speaking of course), as most of the day will consist of skills stations, scenarios and some fun and challenging games. Once again there will be no formal written test during the recert day. The topics covered will be AHA and ALS PCS changes, an ECG review, the new Endotracheal and Tracheostomy Suctioning Medical Directive, undifferentiated respiratory and endocrine emergencies, sharpening patching skills and Free Open Access Medical Education (FOAMed).

So why does the recert process change from year to year? The simple answer is that it is a flexible process that anticipates needs. To expand on this point, the recert process planning and implementation takes into account a number of pieces of information, for example, changes to the ALS PCS, variances, communication line reports, askMAC questions. These are just some of the things considered in the design. One of the most important tools we use however, is feedback from you. The course evaluations are all carefully read, analyzed and discussed and then the information is used to implement changes. This just culture approach is now a standard operational model at SWORBHP. For this reason, I ask that you take a few minutes to fill out this very important document for us, upon completion of your recert day.

On behalf of your Education Team.

John Gyuran, B.P.H.E., ACP
(Interim) Education Coordinator

Revolutionizing Knowledge Translation

Social media has transformed the way in which information is being spread. Twitter, Facebook, Instagram, YouTube and Periscope, blogs and webcasts are just a few of the examples of platforms people use to disseminate information. The power of these platforms to utilize knowledge translation (the development of and dissemination of information) was soon recognized within the world of Emergency Medicine. In 2012, the term FOAMed was created: Free Open Access M(edical) Ed(ucation) and its use has been rapidly expanding in the world of Emergency and Critical Care. It can be thought of as a dynamic collection of resources and tools for lifelong learning in medicine and a community to discuss this.

It is important to remember that FOAM is not scientific research, but rather a way of sharing, discussing, and analyzing the products of research. One still must critically appraise FOAMed and delve into the discussion surrounding the topic at hand. It has been said that FOAM opinions and arguments "live or die by being hammered on the anvil of truth that is free and open debate and discussion". One also must remember that FOAM is an adjunct to existing medical education approaches and is not a replacement. A solid knowledge base needs to be present to build upon and without this foundation, FOAMed often cannot be rooted and only provides a part of the story.

Another common issue with consumers of FOAMed is the tendency to drown in the amount of information being shared. The number of blogs, sites, and resources is growing at an astonishing pace. I often have learners ask "how do I keep up with all of this?" or "what ones should I be using?". My advice is to limit yourself to only a handful of resources, ensuring one of those is a platform that does the work for you. For instance, Life in the Fast Lane pushes out a summary of the "best of what's out there" weekly and can help focus the learner on specific or relevant resources. As you delve into the world of FOAMed, I suspect you will also develop your own personal preference for writing styles, how the information is being shared and level of content. As this occurs, these may be the resources that you focus your energies on.

The world of FOAMed will be explored in further depth at recerts this year. If you haven't had a chance to take a look at the world of FOAMed, I encourage you to give it a try, or even ask a colleague to show you some of what this great education resource has to offer.

Matthew Davis, M.D., M.Sc., FRCP(C)
(A) Local Medical Director

Success at CAEP

Congratulations to our SWORBHP Evidence of Practice team for having six abstracts accepted at the Canadian Association of Emergency Physicians Conference (June 2016). The six abstracts are listed below:

1. Problems in Paramedic-Physician Telecommunication — Eby, D., Robson, J., Columbus, M.
2. How Frequently is Hypoglycemia Found in Ambulance Calls for 'Seizure'? — Eby, D., Robson, J., Columbus, M.
3. What are the Frequencies of Interventions Performed by Paramedics During Seizure Calls? — Eby, D., Robson, J., Columbus, M.
4. Comparison of vital sign documentation for pre-hospital 'lift-assist' calls and non 'lift-assist' calls. — Leggatt, L., Columbus, M., McGuire, J., Spadafora, A., Davis, M.
5. Factors predicting morbidity and mortality associated with pre-hospital lift assist calls. — Leggatt, L., Klingel, M., McLeod, S.L., Columbus, M., VanAarsen, K., Dukelow, A., Lewell, M., Davis, M.
6. Emergency Medical Services (EMS) assist-requiring hypoglycemia in Southwest Ontario — Peddle, M., Liu, S., Reid, H., Columbus, M., Mahon, J., Dukelow, A., Spaic, T.

Any paramedics, students or Paramedic Service leadership team members interested in collaborating on research with SWORBHP, please contact Adam Dukelow (adam.dukelow@lhsc.on.ca)

Adam Dukelow, M.D., FRCP(C), MHSC, CHE
Medical Director of Innovation & Research

SWORBHP Communication

At SWORBHP, we pride ourselves in our communication and look forward to hearing from the Paramedics we serve!

We have developed a new online communication form, which will be available on our website Monday, May 16th. This new form will provide you with the ability to securely communicate with us. Upon submission, the Prehospital Care Specialist designated to audit for your service will be notified immediately of your request and the information you provide will help us in assisting you as quickly as possible. For security and privacy reasons we ask that you refrain from sending us "call" related requests via email as any patient information sent would breach Provincial legislation.

Our Prehospital Care Specialists are trained and available to assist you with a variety of topics, which could include but are not limited to:

- Reporting of exceptional performance on challenging calls,
- Notable avoidance or recovery from "near-miss" situations,
- Peer-recognition for jobs well done,
- Non-urgent service requests for the review of a call.

In the event that you're unable to complete the online form, the Communication line (1-888-997-6718) will still be available. If/when you contact us via phone; we ask that you please provide the following information to assist us with expediting your request.

1. Your name
2. Service you are working for
3. Run number of the call in question
4. Date and approximate time of day of the call
5. Description of the event
6. Hospital the patient received by
7. Any known adverse effects experienced by the patient
8. Any other details you feel are relevant

Online Form: https://apps.lhsc.on.ca/?q=sworbhp-communication
Telephone: 1-888-997-6718

When reporting a potentially adverse event (including a medication error) to the SWORBHP communication line, the paramedic must also inform the receiving facility of the occurrence and any known or potential complications as soon as possible.

Question or Comments?
If you have any questions or comments about using either of our communication tools, please contact us at:
Tel: 519-667-6718
Toll Free: 1-866-544-9882

Debbie Janssen, BMOS
Coordinator, Quality Assurance & Business Functions

Visit us on the Web
www.lhsc.on.ca/bhp

SWORBHP MedList - Antihypertensives

Lifestyle modification is the first recommendation for managing hypertension. Medications are prescribed with consideration given to causes, contraindications, and comorbidities, (Madhur, 2014) and may include:

Diuretics—cause a loss of excess salt and water from the body by the kidneys with resulting drop in preload, stroke volume, and eventually peripheral vascular resistance
Beta-blockers—decrease cardiac output and inhibit renin secretion from kidneys to lower BP
Angiotensin-converting enzyme (ACE) inhibitors—suppress renin-angiotensin-aldosterone system that raises blood pressure through sodium and water retention
Angiotensin receptor blockers (ARB)—blocks renin-angiotensin-aldosterone system (as above)
Calcium channel blockers (CCB)—reduce peripheral vascular resistance by inhibiting the contractility of vascular smooth muscle (Sanders, 2007)

The specific medication prescribed varies depending on underlying comorbidities:

- Heart failure: Diuretic, beta-blocker, ACE inhibitor, ARB, aldosterone antagonist
- Post-myocardial infarction: Beta-blocker, ACE inhibitor, aldosterone antagonist
- Coronary artery disease risk: Diuretic, beta-blocker, ACE inhibitor, CCB
- Diabetes: Diuretic, beta-blocker, ACE inhibitor, ARB, CCB
- Chronic kidney disease: ACE inhibitor, ARB
- Recurrent stroke prevention: Diuretic, ACE inhibitor

Brand Name	Generic / Chemical Name	Class
Microzide	Hydrochlorothiazide (HCTZ)	Thiazide diuretic
Furosemide	Lasix	Loop diuretic
Captopril	Captoril	ACE inhibitor
Ramipril	Altace	ACE inhibitor
Enalopril	Vasotec	ACE inhibitor
Lisinopril	Prinivil, Zestril	ACE inhibitor
Quinapril	Accupril	ACE inhibitor
Losartan	Cozaar	Angiotensin receptor blocker
Valsartan	Diovan	Angiotensin receptor blocker
Tenormin	Atenolol	Beta-blocker, beta-1 selective
Lopressor	Metoprolol	Beta-blocker, beta-1 selective
Inderal	Propranolol	Anti-dysrhythmic, beta-blocker, antianginal, anti-migraine
Monocor	Bisoprolol	Beta-blocker, beta-1 selective
Trandate	Labetolol	Beta-blocker, alpha-activity
Sectrol	Acebutolol	Anti-dysrhythmic, beta-blocker, intrinsic sympathomimetic
Hydralazine	Hydralazine	Vasodilator
Procardia, Adalat	Nifedipine	Calcium channel blocker
Norvasc	Amlodipine	Calcium channel blocker, antianginal
Cardizem	Diltiazem	Anti-dysrhythmic, calcium channel blocker
Isoptin, Covera HS	Verapamil	Anti-dysrhythmic, calcium channel blocker
Aldactone	Spironolactone	Aldosterone antagonist, potassium sparing diuretic
Minipress	Prazosin	Alpha-blocker, antihypertensive
Cardura	Doxasoxin	Alpha-blocker
Multiple examples	Combined preparations	Antihypertensive combinations

Cindy Harrison, MA (Ed), ACP
Prehospital Care Specialist

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Madhur, M.S. (2014). Hypertension. Retrieved from http://emedicine.medscape.com/article/241381-overview
Sanders, M. (2007). *Mosby's Paramedic Textbook Revised Third Edition*. Missouri: Elselvier. pp 365-368

Mechanism of Death and Cause of Death - What is the Difference?

Confusion exists between two concepts – mechanism of death and cause of death. Mechanism of death refers to the final event or patho-physiologic mechanism from which a person dies. Thus cardiac arrest, respiratory failure, congestive heart failure, and arrhythmia are examples of mechanisms of death - they are not causes of death. A cause of death refers to the underlying disease process or trauma that sets in motion a series of events that ultimately results in a mechanism from which a person dies. Mechanisms of death are the final common pathway that results in death but does not cause it. For example, someone could die from respiratory failure (the mechanism) caused by pneumonia, pulmonary fibrosis, drowning, burns of the airway, etc. (the causes).

The medical termination of resuscitation directive is based on a clinical rule developed and validated in Ontario. (Verbeek et al., 2002), (Morrison et al., 2006, 2014). To be used, this rule contains a criterion that the cardiac arrest has to be from a "presumed cardiac cause" i.e. that there is presumed cardiac disease present. Over the years the meaning of this phrase has become slurred to include anything that causes a "medical" cardiac arrest. The phrase "presumed cardiac cause" is no longer even contained in the medical directive. The rule was not intended to be used this way.

I recently reviewed a patch tape where a paramedic requested a termination of resuscitation. He told the patch physician the patient had a "cardiac cause" for the cardiac arrest. The patient had pulled his car over to the side of the road and proceeded to vomit a large amount of blood prior to going unconscious. Although the patient ultimately had a cardiac arrest, it was secondary to hypovolemia. The "cause" of death was not "cardiac" in origin. The misuse of the expression "cardiac cause" led the physician to question whether the paramedic knew what he was talking about.

It is important for all of us to use the concepts of mechanism of death and cause of death correctly during communications with each other.

Don Eby, M.D., PhD., CCFP(EM), FCFP
Local Medical Director
Grey, Bruce, Huron, Perth

References

Verbeek, R., Vermeulin, M., Fahim, A., Messenger, D., Summers, J., Morrison, L. Derivation of a Termination-of-resuscitation Guideline for Emergency Medical Technicians Using Automated External Defibrillators. *Academic Emergency Medicine*. 2002;9 (7):671-8.

Morrison, L., Visentin, L., Kiss, A., Theriault, R., Eby, D., Vermeulin, M., et al. Validation of a Rule for Termination of Resuscitation in Out-of-Hospital Cardiac Arrest. *New England Journal of Medicine*. 2006;355(5):478-85.

Morrison, L., Eby, D., Veigas, P., Zhan, C., Kiss, A., Archieri, V., et al. Implementation trial of the basic life support termination of resuscitation rule: Reducing the transport of futile out-of-hospital cardiac arrests. *Resuscitation*. 2014;85:486-91.

Trivia

Did you know?

- Canada is an Indian word meaning 'Big Village'.
- A cluster of bananas is called a hand and consists of 10 to 20 bananas, which are known as fingers.
- Only female mosquitoes bite. Females need the protein from blood to produce their eggs.
- A fetus acquires fingerprints at the age of three months.
- A typical lightning bolt is two to four inches wide and two miles long.
- Any month that starts on a Sunday will have a Friday the 13th in it.

Reference:
www.corsinet.com/trivia

Continuation of the EPIC Program in Grey County

The Expanding Paramedicine in the Community (EPIC) program started in 2013 as a research study developed by Rescu (a research program at St. Michael's Hospital in Toronto) and York Region Paramedic Services. In the fall of 2014, funding was secured for an expansion of the study into Grey County through the Ministry of Health and Long-Term Care's $6 million provincial Community Paramedic initiative.

In November 2014, two full-time IV-certified Grey County Primary Care Paramedics (PCPs) and the Manager of Operations spent seven weeks in training provided by Centennial College. The focus of the intensive training program was on the major chronic disease processes that are the underlying causes of most ER visits – diabetes, CHF, and COPD.

"The goal of EPIC is to determine whether the rate of acute care hospitalization and emergency department visits can be reduced by training paramedics in chronic disease management and having them conduct home visits to assess and treat patients under medical delegation of the patients' primary care physicians. Our objective is to perform a randomized controlled trial to answer this question in a rigorous and standardized way.

Paramedics are highly trained healthcare practitioners who can be utilized to better address the needs of patients and reduce the burden placed on hospitals and primary care providers.

*Consenting patients were randomized to one of two groups: control or treatment. The control group received usual care from their family health team (FHT). The intervention group patients were assessed and treated in their homes by community paramedics working closely with their primary care physicians. Community paramedics ensured that appropriate appointments are scheduled and helped to improve coordinated patient care by working closely with Community Care Access Centres (CCAC) and FHT physicians. If this study proves to be both feasible and effective, this care model could be expanded to cover other regions and medical conditions to better manage our medical resources and time." (*Rescu, 2016)

Grey County's Community Paramedics are trained to perform blood draws & iStat analyzer testing, clinical physical assessments, lab value interpretation, cognitive and neurological assessments. Their expanded drug bag includes the current symptom relief medications plus: rapid insulin, nitroglycerin transdermal patches, furosemide, potassium, ipratropium, prednisone, amoxicillin, clarithromycin, cefuroxime, trimethoprim/sulfamethoxazole, doxycycline, moxifloxacin & amoxicillin/clavulanate.

Treatments are provided by Community Paramedics in the patient's home under medical directives in consultation with the Owen Sound Family Health Team nurse practitioners and physicians as required. If the patient's condition warrants it, the Community Paramedics will activate the '911' system and switch to the traditional PCP role and treatments.

The EPIC study portion concluded at the end of November 2015 and included a total of 160 patients in Grey County, with 78 in the treatment group. Rescu is now compiling the data and plans to publish their findings later this year. Two additional Grey County paramedics were trained for the EPIC program to cover vacation/sick time. The province has renewed funding for the ongoing EPIC program in Grey County until March 31, 2017. Currently there are approximately 100 patients in Grey County's EPIC program.

"This program has been ground-breaking. We've never seen the response that we've had from the patient group that we're dealing with. They're very happy. They were really quite concerned when we were telling them that we might have to shut down and so we're really quite pleased that we're able to continue on." (Muir, 2016).

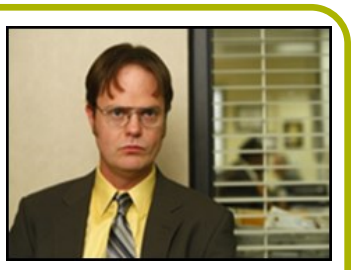
Rick Trombley, PCP-IV
Community Paramedic
Grey County Paramedic Services

References

St. Michael's Hospital Research Program. (2016, February). Rescu Study. Toronto, ON. Retrieved from: http://stmichaelshospitalresearch.ca/research-programs/rescu/our-research/community-care/

Muir, M. (2016, April). Grey excited about continuation of EPIC. *Owen Sound Sun Times*. http://www.owensoundsuntimes.com/2016/04/07/grey-excited-about-continuation-of-epic

EMS Fellow Facts



I can't believe my year of "EMS fellowship" is almost over. It's been a phenomenal learning experience for me and I've had a truly amazing time experiencing and getting to know more about the prehospital world. I could gush on-and-on (and would if you'd let me), however, I thought instead I would leave you with some facts I've learned this year, a la Dwight Shrute from The Office.

The fastest way to a man's heart is through his stomach? FALSE. It's through his sternum.

Reality is stranger than fiction? FALSE. You could not even dream up some of the things that happen in the real world (especially prehospital). You cannot make this stuff up. Especially some of Rick St Pierre and Pete Morassutti's experiences).

It's raining cats and dogs? FALSE. Precipitation consists almost entirely of water.

Research is boring? FALSE. Together we are developing research and disseminating information that's making a difference and changing practice: The ROC trials, Prehospital ECGs, Lift Assist (shameless plug), up-and-coming Procedural Sedation, Prehospital Hypoglycemia and Patching. It's an exciting time because not only are paramedics helping gather data, they are increasingly involved in every step of the process, as evidenced by our most recent SWORBHP Research meeting.

Grass is greener on the other side? FALSE. Grass is greener where there's fertile soil and optimal sunlight.

Thunder Bay is cold? FALSE. At least during the OBHG Annual meeting this past February. It was balmy and a great time. Under the leadership of our very own, Dr. Mike Lewell, and Susan Kriening, information was shared, decisions were made, and Persians (Thunder Bay pastry) were enjoyed!

They say the best offense is a good defense. FALSE. The best offense is offense.

To part ways is such sweet sorrow? FALSE. You'll be seeing me around the emerg and prehospital world for at least another year as I finish up my emergency medicine residency (and hopefully beyond).

Thanks everyone for such a great year and thank you for all you do!

Lauren Leggatt, BHSc., M.D.
SWORBHP EMS Fellow

Comments?

If you have comments or feedback on the newsletter, or have an article you would like to have considered for publication in a future edition of LINKS, please send to:

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