the
BEAR BONES
UBC Department of Family Practice Research Office

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Publications, Grants, Awards & Presentations
Submissions from January 1 to June 30, 2010 listed on pages 26-37

Research Reconsidered
Whole person, whole system approaches to engaging complex issues
by Dr. Robert F. Woollard

One-On-One Colleague Interviews
The Bear Bones *sits down with Clinician Scholar, Dr. Maureen Mayhew and Community-based Clinician Investigator, Dr. Sonia Singh*

A Conversation with Dr. Iona Heath
UK general practitioner and President of the Royal College of General Practitioners in Great Britain

UBC Department of Family Practice welcomes new Head, Dr. Martin Dawes

On September 1, 2010, Dr. Martin Dawes, Professor, family physician, and researcher, became Head for the Department of Family Practice. Dawes has strong interests in practice, research, and administration, and will work with primary care providers and Health Authorities across the province to ensure that the Department's education and research programs both serve and remain relevant to the health care needs of British Columbians.

Career

Dawes began his career in the United Kingdom, studying for his MD at the London Hospital in 1978. He completed a primary care-focused postgraduate education in 1983. In 1992, he completed his PhD at Oxford studying the effects of weight gain in pregnancy.

Dawes' current research interests include information retrieval, hypertension, and pharmacogenomics in primary care. He is an active participant with six funded research projects and is the Principal Investigator on a seventh funded study. In addition to his research and practice interests, Dawes has considerable expertise and passion for the development of training programs that allow clinicians to engage in Masters level research.

Dawes currently chairs the Scientific Program Committee for the North American Primary Care Research Group (NAPCRG).

Vision for the Department

Dawes is committed to working with communities of practice to deliver and apply the results of primary care research into office practices where it can benefit patients most. He notes that family physicians can "help drive [the] agenda for improved quality [of care]." Dawes also intends to work closely with government to ensure appropriate funding for primary care including the academic activities.

Additionally, Dawes will also be focusing on training clinicians to acquire advanced research skills. He feels that the Department needs "a clearer academic track for these professionals who practice clinically, but also want to undertake research."

A special thanks to the outgoing Interim Leadership Team

Thank you to Drs. Louise Nasmith and Ian Scott, members of the Department of Family Practice's Interim Leadership Team (ILT), for their support of the Department's Research Office and its researchers. A special thanks also goes to Dr. Gurdeep Parhar who was an integral part of the ILT until September 2009, when he was appointed Associate Dean, Equity and Professionalism with the Faculty of Medicine.

We appreciate the ILT's dedicated efforts to support and enhance family practice research both internally within the Department, and externally on provincial, national and global stages. We are especially grateful to Drs. Nasmith, Scott and Parhar for their time and insight during last year's meetings with the BC Ministry of Health Services and local Health Authorities. Their presence alongside members of the Research Office, Community-based Clinician Investigator Program, and Clinician Scholar Program greatly contributed to discussions around primary care renewal, unattached patients, and primary health care research.

Given their vast volume of day-to-day commitments and requests, it is remarkable that the ILT's marvelous sense of humour and generosity never waned – even when presented with the 'occasional' request for a last minute grant signature. We were always met with a gracious understanding that "sometimes it happens."

On behalf of the Research Office and its affiliated researchers, we would like to wish Drs. Nasmith, Scott and Parhar well in their future endeavours.

(left to right) Dr. Ian Scott, Dr. Louise Nasmith, Dr. Gurdeep Parhar

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Cover Image
Waiting Room Fatigue – Jawand, Afghanistan
Photo by Maureen Mayhew

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Dr. Maureen Mayhew

FAMILY PHYSICIAN AT THE VANCOUVER COASTAL HEALTH BRIDGE CLINIC, RESEARCHER, AND CLINICIAN SCHOLAR

Dr. Maureen Mayhew has been providing primary health care in rural and remote locations in Canadian and international settings for two decades. Currently she provides care for refugees in Vancouver, does mixed-methods research on this population's access to primary care, and consults in public health both internationally and in northern Canada. She has a medical degree from McGill University and a Master's in Public Health from Johns Hopkins Bloomberg School of Public Health. She has spent the last ten years helping to revive Afghanistan's battered health system, initially through frontline work in maternal and child health, then later through evaluations and strategy development at a national level. As UBC clinical faculty, she has taught and mentored medical students and residents in the classroom, in the clinic and in research; she developed and taught a graduate level course on rural and remote health, and has converted this course into a distance learning course; and she co-leads the Global Health R3 program.

When I go somewhere I do not believe that I have all the knowledge. I go and I create common knowledge with the people. I am never going to tell people that they cannot do something.

Roads in Afghanistan are an important determinant as to whether people access healthcare or other services. | Photo by Maureen Mayhew

TBB: Can you tell me about the research you are doing with the Clinical Scholar Program?

MM: I work as a physician for refugees at the Bridge Clinic here in Vancouver. One of the questions that came out of my work was, "Where do people go when they 'graduate' from the Bridge Clinic?" The clinic has a capacity of three thousand five hundred active patients and we get about two thousand new refugees each year. That means that we have to move people on to other sources of healthcare. We do not do it very well because it is difficult and time-consuming to find family doctors that accept refugees. We have been trying to identify people or clinics where we can move them on to. We give people a list of family doctors and a list of walk-in clinics, but we never actually know what happened to these refugees – whether they found regular primary care or whether they visited emergency rooms. That is where the idea for the research came from.

The research that we are doing is a mixed-method study. The quantitative part involves a survey of Government Assisted Refugees (GAR) who arrived in Vancouver between 2005 and 2007. We are only surveying GARs because they are the easier group to find. Refugee claimants who claim refugee status at the border are much more likely to have moved on and are very difficult to find two to three years after arrival. Our goal is to find out what proportion of these GARs are still at Bridge Clinic and what proportion of them have moved on to family doctor clinics in the areas that they live. We also want to know if they do not have a family doctor, how and where they are seeking care and what their health status is. We wanted to compare some resultant data to the Canadian Community Health Survey (CCHS) data for the Greater Vancouver area.

I believe that quantitative studies never give us quite enough information, so we decided to have a qualitative component that looked at those who succeeded in acquiring a family doctor and those who did not acquire a family doctor. What were the psycho-social differences or other characteristics of those who succeeded? What qualities did they possess that facilitated them acquiring a family doctor? And, are there any lessons we could learn for future groups?

TBB: How do the surveys take place?

MM: Because of ethics requirements we send out letters first. Fifty-three percent of the letters were returned so we follow-up with a telephone call by interpreters. All telephone surveys are done through interpreters, because people do not necessarily speak English. We have twenty-two languages in the sample of two hundred and fifty people.

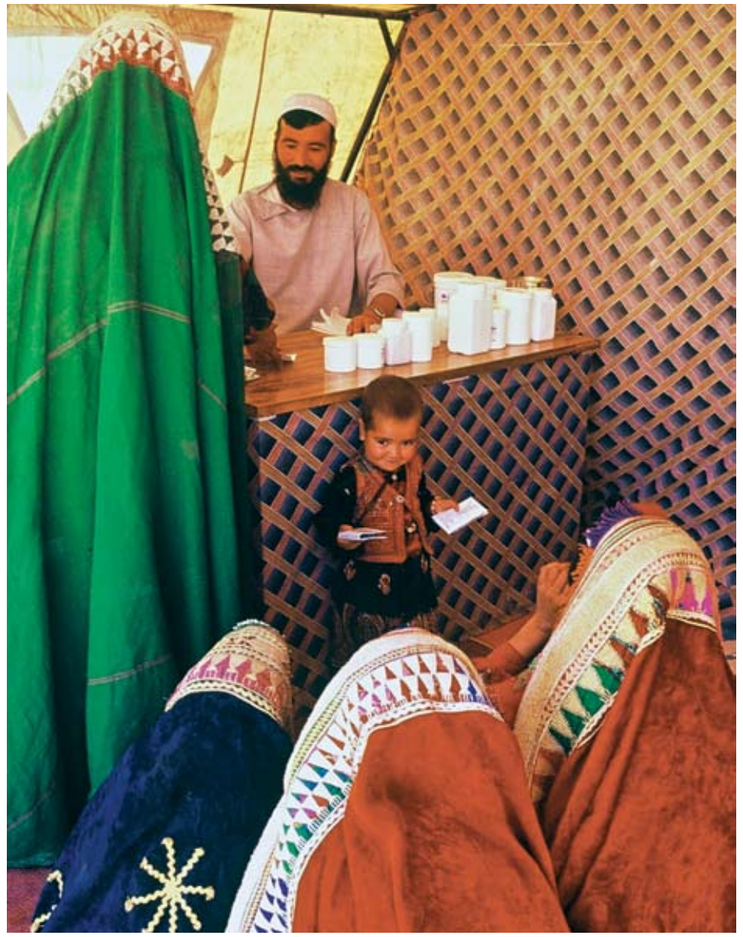
From an administrative database, we randomly select one person per household who is older than sixteen years of age and whose birthday is closest to April 1st. Our contact rate so far is sixty percent, so we have to sample several more households to get to our target of two hundred and fifty. From the final two hundred and fifty surveyed individuals, a purposive sample of those who have agreed to participate in focus group discussions, will be selected and divided into five focus groups, using the five most common languages in the sample. The focus groups will have five to eight participants each, all whom speak the same language. I am working with two co-investigators who do qualitative research so they are going to lead this part of the study.

TBB: What sparked your interest in research?

MM: Questions. I have a lot of questions in terms of health services research and health policy. My trajectory was rural-remote medicine in Canada – I crossed the country from Newfoundland, up to the Arctic, and over to Vancouver – and then to Afghanistan in 2000. When I worked in Afghanistan, I questioned whether we could do this better. It led me to do a Masters degree at Johns Hopkins University in 2005. This sparked my interest, and my skills, to do research. After I finished my Masters, I went back to Afghanistan and worked with the Johns Hopkins' group that was doing health services, primary health care, and health systems research in Afghanistan. At the time, we were doing a primary healthcare survey nationwide.

TBB: What was your role with the Johns Hopkins' research group in Afghanistan?

MM: I was one of the coordinators for the survey in the western part of Afghanistan. I went out to Herat which is one of the bigger cities in the west and taught the surveys to the people who were going out to do the surveys. I was the back-up teacher because I am not fluent in Dari. I can speak it, but not very well. We randomly selected a specified number of Basic, Comprehensive Healthcare Clinics, as well as District Hospitals, in each of the provinces. The study is ongoing and has resulted in several publications. I published an article on skilled birth attendants at deliveries from that data.



A temporary pharmacy in temporary primary care clinic – Khairkhane, Afghanistan. | Photo by Maureen Mayhew

TBB: What are the most pressing health concerns for women in Afghanistan?

MM: There are a lot of health concerns for Afghan women. How they are defined depends on who you are and how you look at things. The maternal mortality ratio in Afghanistan, which is averaged from four districts of four provinces from 2002 data, is sixteen hundred per one hundred thousand live births. Using the fertility rate to calculate the number of women who die from childbirth-related causes, gives you one in nine women who die of childbirth-related causes. That is huge. Seventy-eight percent of the deaths recorded could have been prevented through relatively simple means of care. They die of sepsis, hemorrhage, obstructed labor, hypertension in pregnancy. Those are the big causes of death – all preventable.

TBB: What are some ways of preventing the death of women during childbirth?

MM: By 2006, they had trained twelve hundred community midwives, a type of skilled birth attendant. They had also trained roughly two thousand community health workers – not to deliver babies but to do antenatal and postnatal care and to refer women for deliveries. The social norm in Afghanistan is home delivery by a sister, a mother-in-law, or the lady down the street. So how do you change the norm? You can train all the skilled birth attendants you want, but if they do not go to the home, the problem persists. The skilled birth attendant rate at births had gone up from eight percent nationwide in 2002 to about sixteen percent in 2007. What we tried to do in developing the national health strategy was to focus on ways of increasing demand for services by social marketing and behavior change communication campaigns, but it is a hard thing to do and it takes time. The other thing that we really wanted to do was to get families to start planning for deliveries. If the woman was pregnant, what could they do? They could plan who to call if there was a problem and they could be given safe delivery kits. As well, we did a pilot study on using routine misoprostol which is a post-partum hemorrhage prevention measure.

TBB: How does behavioural change occur?

MM: What I have learned from working in rural and remote Afghanistan is that you have to access the men in order to access the women. Certainly in the urban areas it is different, but no matter how you look at it, there is a negotiation between the husband, the wife, and the mother-in-law as to what happens and who can access members within the household. I started influencing the men which was very useful in getting into households in order to meet women. Women are not going to decide on their own, they are going to decide with their husband and their mother-in-law. That is the reality, so I work with it.

TBB: How did you influence the men?

MM: I started by influencing the men that I worked with. I have a story of the guard who taught me to speak Dari. Every night we would meet because there was not a whole lot to do in rural Afghanistan during the Taliban regime. There were two night-guards and every night they gave me a lesson in Dari and I would give them a lesson in English. There were no dictionaries at the time so we created our own phonetic spelling in familiar characters.

One of the guards was married with two wives. He had been married three times, but one wife had died in childbirth. After about six months, we had shared a lot about our cultures and had developed a surprising level of trust. He said, "Maureen,

Dr. Maureen Mayhew traveled on horseback to investigate the needs of a small Afghanistan community with no road access. | Photo by Maureen Mayhew

It was interesting to see how a very religious man had been able to reconcile the idea that in order to keep his wife healthy enough to have more children, birth spacing was necessary.

you know, I have this problem. My younger wife is weak and she gets pregnant too often. What should I do?" I said, "There are ways of spacing out those pregnancies so that she does not have to get weak each time she gets pregnant and then the babies will be healthier." I told him all the ways that were accessible in that location. He said, "Oh, I do not like hormones. I do not agree with that." He decided to do the rhythm method instead. "Be careful because you have two wives and how will you keep track of all of that counting?" I said. He came back the next day and said "I do not think this method is going to work, how about if we try the pills?" I gave him a prescription for the pills and he came back and said "[his wives] do not want to take the pills. They do not think that they will remember." Ultimately, we decided on the injection.

I went to the house and the two wives were there and they were excited because this was a new thing. The older wife spoke Dari and Pashto, while the younger wife only spoke Pashto. I spoke Dari, the older wife translated for the younger wife, and then we gave her the injection. It was interesting to see how a very religious man had been able to reconcile the idea that in order to keep his wife healthy enough to have more children, birth spacing was necessary. That is a message I learned that worked well, so I use it at Bridge Clinic here in Vancouver. I have used the knowledge that I gained early on each time I have gone back to Afghanistan, probably eight times in the last ten years.

TBB: How did the Afghan people view you as a physician from the West?

MM: I did not fit – I was not married, I had been to university, I had short hair, I am small and have kind of a masculine build, but I wore female garments. If I went to a house I would sometimes eat with the men and sometimes I would eat with the women. Sometimes I would eat

with the men and once I finished, I visited with the women. In some households, the preference was for me to eat with the women and then I could visit with the men.

TBB: Why is that?

MM: It was purely because I was Western and they were wondering if they were going to offend me. I was a guest, so where do you put the guest? You put the guest in the guestroom with the other guests, but I am not a man so then where do I fit? It was a recurrent issue for them to resolve. Also, having a foreigner visit one's family was prestigious, giving them higher status in their community.

TBB: We see images of Afghanistan in the media and many think there is anti-Western sentiment. What you are saying seems to contradict that.

MM: They are very welcoming, but it all depends where you are in Afghanistan, the politics, and who is in charge. I was there first in 2000 when most of Afghanistan was Taliban occupied. The rules were strict. It was stupid to break the rules when you do not know which ones can be broken, because the penalties are severe. There is sometimes death by stoning. Eventually I learned the rules that I could and could not break. So even during the Taliban rule, the strictest timeframe that Afghanistan has known, I was free to do a whole variety of things and people welcomed me.

Fast-forward to May 2009, which is the last time I went to Kabul. I was less welcome in households. The main reason was because people were openly threatened. There are a lot of Westerners in Afghanistan now, compared to when I was there in 2000 when we were the only Westerners for a two-day drive. We were not a threat and we did the appropriate politicking with the commander and the governor to make sure that they realized we were doing good things and they gave us protection. Afghanistan is by and large very welcoming. They open their home and hospitality to you if you are not the enemy. You are protected if you are in their house

A woman and her family in clinic waiting room. Men wait outside the walls because only women and children are allowed into this part of the clinic. | Photo by Maureen Mayhew

– that is one of the Pashtun laws and also the Dari speakers I knew believe in those laws as well. I have benefitted from this law when I stayed with people.

TBB: What motivates you to participate in global health projects?

MM: I like to understand different perspectives. I do not believe that we do things best, so for me it is a learning process. I go to Afghanistan to learn how they look at things. When I go somewhere I do not believe that I have all the knowledge. I go and I create common knowledge with the people. I am never going to tell people that they cannot do something. I am going to try and help them do it in a safer way that is going to work for them. It is a community-based approach. I have done community-based work with Dr. Carl Taylor, who taught me at Johns Hopkins University. His mantra was that you need to figure out where the people are at and help them to go to where they want to go. You can influence that to some degree, but it has to be a commonly-viewed problem and a commonly-viewed solution. If the problem you see is not the problem they see, then you are not going to succeed.

I did a survey for Dr. Taylor where we asked "Where do you want to deliver your next baby?" Every single woman said they wanted to deliver at home. I have spent time in their hospitals and I would never want to deliver in their hospitals either. I believe we should encourage safer home births and some well thought out mechanism for referral. It is the creative solution-finding that I find very interesting. It is outside the norm, it's on the edge. I like being on the edge.

TBB: How do you define creativity within medical research?

MM: Creativity is taking the evidence that exists and building upon it because the evidence is often insufficient. Creativity in medicine involves not being prescriptive; it requires taking the knowledge-base that can be found and building new knowledge – sometimes that is published knowledge and sometimes that is practiced knowledge. For me, that is why research is interesting – it is building new knowledge on old knowledge.

PRIMARY HEALTH CARE FOR NEWCOMERS TO CANADA AT BRIDGE COMMUNITY HEALTH CLINIC

RESOURCES

Healthcare for marginalized and vulnerable populations

Since 1994, **Bridge Community Health Clinic** has provided immediate access to primary and preventative healthcare services for government assisted refugees and refugee claimants in BC. The name "Bridge" conveys the clinic's mandate to provide a bridge or temporary transition to medical services in the Vancouver area during the first year the refugee lives in BC.

The adherence of transition services is crucial to the functioning of the clinic because each year British Columbia accepts ~850 government assisted refugees and roughly 1,150 refugee claimants in BC. Because the capacity of the clinic is limited, Bridge Clinic has developed expertise in "stabilizing" refugees and teaching them how to use the healthcare system during their first year in Canada so that by the end of that first year, they can be successfully transferred to family doctors in the community.

Refugees have amazing stories of resilience and strength of character. In essence, they provide the opportunity to practice global health in the comfort of a Vancouver office. The clinic is constantly looking for family doctors who are willing to accept even one family per year.

Development of community partnerships

The clinic, which is part of the Vancouver Coastal Health Authority, offers both medical and social/community services. Bridge Clinic cannot offer the array of healthcare without valuable partners such as Immigrant Services Society of BC (ISSofBC), Family Services of Greater Vancouver, Victims of Torture (VAST), Canadian Red Cross, Fraser Health Authority, Diversity, Cross-cultural Mental Health and BC Multicultural Health Services Society.

Inter-professional and holistic health care

Bridge Clinic offers a well-trained, experienced inter-professional team including physicians, nurses, nurse practitioners, interpreters, interpreters and settlement workers as well as a nutritionist, counselor, psychologist, pediatrician, internal medicine specialist and psychiatrist.

The clinic is open Monday to Friday from 9:00 am - 4:30 pm

Services include: primary health care; screening for infectious and/or chronic diseases; immunization; chronic disease management; pediatric, psychiatric and internal medicine consultation; outreach/health education; mental health services; and, settlement services. Services are available at no cost to eligible clients and no referral is necessary to access services at Bridge Clinic.

Drop-in clinic Monday to Friday from 1:00 pm - 4:00 pm

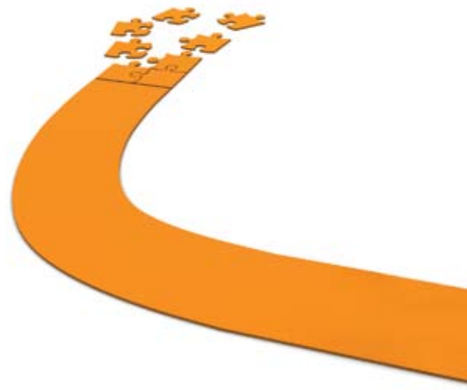
Offers routine physical examinations, communicable disease screening, health promotion, disease prevention, well-baby and well-woman services, family planning, and urgent primary care.

Services by appointment

Includes prenatal services, Newcomer Pediatric Health Clinic, psychiatric consultation, internal medicine consultation, mental health counseling, nutritional counseling, respiratory therapy, speech language pathology, and regular primary care.

For further information contact the Bridge Community Health Clinic

Raven Song Community Health Centre
2450 Ontario Street
Vancouver, BC V5T 4T7
Phone: 604.709.6540
Fax: 604.879.9173



Dr. Sonia Singh

EMERGENCY DEPARTMENT PHYSICIAN, OSTEOPOROSIS CONSULTANT, RESEARCHER, AND COMMUNITY-BASED CLINICIAN INVESTIGATOR

Dr. Sonia Singh has been a family physician for twenty-three years and currently works as an Emergency Department Physician and Osteoporosis Consultant at Peace Arch Hospital in White Rock, BC. In 2000, she went back to school to complete a Masters of Health Science in the Department of Epidemiology at the University of British Columbia. She developed the first multidisciplinary osteoporosis clinic in the Fraser Health Authority. In addition, she is the team leader of the Fraser Health Falls and Fracture Prevention Research Team, which was initially grant funded from the BC Network for Aging Research. She is involved in clinical research in the area of falls, fracture prevention / osteoporosis, and health economics.

TBB: What was the main research project that you were working on for the Community-based Clinician Investigator (CBCI) program?

SS: The main research project that I have focused on for the CBCI program is called "Can a Mobile Falls Prevention Clinic Reduce the Risk of Falling in Community Dwelling Seniors?" This project is designed to evaluate the benefits of a Mobile Falls Prevention Clinic for seniors living in seniors' residences, assisted living, or independently in the community. The clinic does not contain any new assessment tools or treatments; everything that is in the clinic has been previously tested in clinical trials. What is new and innovative, however, is the model of delivering these interventions. Most falls prevention clinics tend to be in a single location – perhaps at a hospital or an outpatient clinic. Patients come to the clinic to access services and if they live far from these specialized services, access is quite limited. Our model, being fully mobile, takes the clinic to the patient's community. We go out to the various communities and we set up the clinic in a seniors' residence, a church, or a community centre – at times bringing the clinic to remote communities that normally would have no access to any specialized geriatric services.

Developed by Dr. Fabio Feldman, Fraser Health (FH) Manager for Seniors Falls and Injury Prevention, the Mobile Falls Prevention Clinic travels from community to community within the geographic area of the Fraser Health Authority (FH). The Clinic was funded as a pilot feasibility project in 2007. With feasibility and acceptability well established, we wanted to do a more comprehensive evaluation of the Mobile Falls Prevention Clinic in order to inform future planning around falls prevention initiatives. At the moment, we know from surveys that participants and health providers are very satisfied with the clinic, but we do not know what happens to the participants after they leave the clinic. Do they act on the recommendations? Do they discuss the recommendations with their family physician? Is there any improvement in their fall risk over the next year? Is there a reduction in falls amongst patients attending the falls prevention clinic? Is the clinic cost effective? These are questions we hope to answer in our mixed-methods study.

TBB: Can you describe how the clinic works? What would a person expect as they go through the clinic?

SS: The Mobile Falls Prevention Clinics are run in partnership with each local community, municipality, or facility with the community sponsors providing a large room to set up the clinic. The clinics run from 9 am to 4 pm, see about twenty patients per clinic, and each participant attends the clinic for about one hour and fifteen minutes. Each patient is assessed by a nurse, pharmacist, dietician, physiotherapist and kinesiologist during his or her clinic visit. Evidence-based risk factors for falls are assessed at each station, and include postural blood pressure, review of medications implicated in falls, diet with a focus on vitamin D and calcium, a home safety checklist, and Physiological Profile Assessment (PPA). The PPA, developed by Stephen Lord from Australia, is a validated falls assessment tool that not only predicts a person's risk of having a fall over the next year, but also provides a breakdown of specific impairments in vision, peripheral sensation, muscle strength, reaction time, and balance that may be affecting the person's falls risk. The PPA, by assessing functional performance in a number of areas that have been clearly linked to falls risk, can help identify appropriate interventions that could prevent falls in the future.

At the end of the clinic, each patient leaves with a summary of their assessment, including a copy of their personal PPA score, and a set of personalized recommendations that they are expected to discuss with their family physician and act upon. These recommendations may also be specific referrals to local community programs such as exercise programs or recommendations to make modifications to their home that will create a safer environment. A copy of the summary is sent to their family physician. Since no physicians are involved in the clinic and the communities partner with the health authority to provide space, advertising, and a pharmacist, the Mobile Clinic can be offered for a very low cost to the FH (~$60 per patient).

Because clinics occur in community settings such as a community centre or a religious centre where seniors naturally gather, there is often a celebratory atmosphere – it is a social gathering. We work closely with the community, so quite often the

Our model, being fully mobile, takes the clinic to the patient's community… at times bringing the clinic to remote communities that normally would have no access to any specialized geriatric services.

Fraser Health Falls and Fracture Prevention Research Team *(left to right)* Michael Wasdell, Dianne Symonds, Sonia Singh, Lori Hughes *(back row)* Marcia Carr, Vicky Scott, Fabio Feldman

Photo by Kathleen McAuliffe

Dietician consulting with senior at The Mobile Falls and Injury Prevention Clinic.

community will provide volunteers that will make sure seniors know where to go and provide coffee and food for both for our staff as well as participants. It makes it less of a medical thing.

TBB: What does the research involve and how do you select the participants for the study?

SS: The study is a mixed-methods study involving a prospective cohort study of 400 patients followed for one year after attending the clinic, an economic analysis and a qualitative focus group study. Not everybody who goes through the clinic is part of our research study. To be included in the cohort study, participants must be sixty-five years or older, have had a fall in the last six months and/or be using a walking aid. The primary outcome of the study is the proportion of clinic recommendations acted upon at one year of follow-up. This is determined by a self-reported questionnaire. Secondary outcomes are changes in PPA scores, rate of falls and fall-related injuries, and quality of life (SF-36 Questionnaire). Patients are followed by phone calls to track falls and injuries at one, three, and nine months. Uptake of recommendations, PPA, falls and fall-related injuries, and quality of life are measured at six and twelve months during in-person assessments.

The cohort study has been running for eleven months and we have recruited about 250 study subjects with about fifty having completed the six month follow-up.

TBB: You spoke about the benefits for seniors, but are there potential benefits for the health care system as well?

SS: It is estimated that over thirty percent of community dwelling individuals and fifty percent of nursing home residents over age sixty-five fall at least once each year. Consequences of falls include fractures, head concussions, bruises, and lacerations. In BC in 2004-2005, falls in seniors resulted in 853 deaths, over 10,000 hospitalizations at an estimated cost to the health care system of $151 million (BC Ministry of Health 2006). Even when no injury occurs, falls can have negative psychological effects on the life of the individual. The 'fear of falling' results in restricted activity, dependency on others, and a decrease in social interaction. The Mobile Falls Prevention Clinic helps seniors understand their personal risk for falling, gives them recommendations and tools to decrease their risk of falling, and therefore has the potential to decrease falls-related injuries and reduce the overall cost of falls in the elderly to the health care system.

TBB: Have you had any feedback from participants in the study or is it too early to comment?

SS: We have not analyzed any results from the study yet; it is too early in our data collection. However, satisfaction surveys in forty-three people going through the clinic found that ninety percent of patients rated the clinic as excellent and ninety-five percent said they would use all of the recommendations made to them. In addition, we have a very low drop out rate from our study, (<10%) considering that the median age of study participants is eighty years.

The feedback that we have got from the people who have been phoning the patients is that the participants are very excited about the recommendations and are eager to act on them. They feel empowered – now they have something they can do to prevent them from falling in the future, to improve their mobility, and to improve their ability to be more physically active.

TBB: What excites you about your research?

SS: I really find knowledge translation research exciting. Most of my research revolves around how to ensure that the latest knowledge in the areas of osteoporosis and falls prevention is incorporated into clinical practice at a primary care level. My research is mostly health services and program evaluation research. I find it very challenging and rewarding to work with other health professionals to develop care plans, clinical pathways, and be able to incorporate research into that process.

TBB: Does you research influence your daily work?

SS: My research is tied closely to my daily work as an emergency physician. I see the fall-related injuries in seniors all the time, but the way I approach them clinically is certainly different now that I have become involved in research. Previously, when I worked in the emergency room, my focus was to fix the acute problem – if they had a gash in their forehead I would stitch it up or if a bone was broken I would treat the fracture and send them home. Now that I have been working in the field of falls and fracture prevention research, I am much more aware that I am seeing the tip of the iceberg. As part of my assessment, I will always ask patients: When was the last time they had a fall? How many falls have they had in the last six months? Have they had fractures before? I have started, with the limited time that I have to spend with the patient in the emergency room, to go that one step further in terms of prevention of the next fall. I will often get our emergency room geriatric nurse involved in organizing further follow-up and assessment. The research has definitely affected how I deal with patients clinically and vice-versa.

TBB: What do you see as important areas of research moving forward?

SS: I have been fascinated by the development of participatory research methods and have watched the research of my colleagues Ellen Anderson and Ruth Elwood Martin as their participatory action research projects have been so successful. I finally took the plunge myself and applied for a research grant from the Vancouver Foundation to work with three First Nations Bands in Fraser Health to develop, implement, and evaluate a community fall prevention program using participatory research methods. If the grant is funded I will develop a new skill set in research methods and have my first experience working with First Nations communities. I am very excited about this new direction in my research.

Dr. Fabio Feldman, Fraser Health Authority Program Manager, researcher, and designer of The Mobile Falls and Injury Prevention Clinic.

TBB: Much of your research is done in a team-based setting. How do you find working with a research team rather than as an individual researcher?

SS: When I first started doing community-based research, I really felt that I was working in isolation. No other physicians or allied health providers I worked with were doing research. I found doing research was difficult and slow moving. Once I was able to work with a core group of people, we were able to share ideas, knowledge, and expertise. The development of the FH Fall and Fracture Prevention Research team over the last three years has been a huge part of my success in terms of grants and getting my research published. I feel that I can move forward as a community-based researcher and I do not think I would have been able to do that if I had not been part of a cohesive and dynamic research team.

TBB: What are some of the things you considered when you were building your research team?

SS: We brought together various people who we knew had interest in working with seniors around falls and injury prevention. Each one of us was fairly strong in our own right and had our own specific interests. It was important to make sure there was an equitable way of exchanging information and of working on grants and papers. We discussed aspects around ownership of projects making sure that different people got the opportunity to be lead on different projects as well as authorship of papers. We have re-visited our mission statement, our vision, our goals and strategies, and had a discussion on the direction we want to go forward in over the next five years.

TBB: What do you think is important to succeed as a researcher?

SS: The three most important supports for me to develop as a researcher were superb mentorship, great research team members, and protected research time in the form of salary support to do my research. I have had number of great mentors including my Masters Supervisor Dr. Aslam Anis, who then introduced me to Dr. Karim Khan, who has been a fabulous mentor to me over the last five years. I have had great support from the UBC Department of Family Practice – from Dr. Stefan Grzybowski, who supported my first Clinical Investigator position, to Dr. Janusz Kaczorowski, David Adams, and Debra Hanberg. I have great research team members that I value and who value me. I also think that to be successful at research you have to have passion; passion to learn, passion for your area of interest, and passion for the people who could benefit from your research.

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Research RECONSIDERED

Whole person, whole system approaches to engaging complex issues

Dr. Robert F. Woollard

research *n&v* ***1 a.*** *the systematic investigation into and study of materials, sources, etc., in order to establish facts and reach new conclusions.* ***b.*** *an endeavour to discover new or collate old facts etc. by the scientific study of a subject or by a course of critical investigation…* *(Oxford English Reference Dictionary)*

The world of research is changing almost as fast as research is changing the world. The results of research have fuelled events that have changed the very fabric of our lived lives in virtually every corner of the planet—consider the once easy proposition of escaping your email that has now reached the point where absences from immediate response seem culturally inexcusable whether you are in the mountains of Nepal, on the bus in Vancouver or on the commode at home. We daily are confronted with the accusatory phrase "…well, I sent you an email!" when we admit to not knowing what someone is talking about.

Simultaneously, science has contributed to the vast numbers of us who are living beyond our ecological means by drawing on the fruits of other people, other places and other times—some as remote as the age of dinosaurs, long before we were a gleam in evolution's eye. It is therefore well to consider the working definition of research and reflect on how it must in turn adapt to the new world to which it has contributed so much—for both good and ill.

After a century-long dalliance and uncritical love affair with increasing technology, increasing hyper-specialization of medical practice and increasing fractionalization of knowledge, there is a dawning realization that a price is being exacted on our environment and our social cohesion—we are beginning to challenge the very Victorian notion of 'progress' of the human prospect. At a time when Google gives us access to functionally unlimited amounts of information, it is helpful to remember that almost a century ago, T. S. Eliot wistfully asked in *The Rock*:

Where is the wisdom we have lost in knowledge?
Where is the knowledge we have lost in information?

In information, as in so many other aspects of our 21st century lives, we have abandoned the idea of

enough and function as if the search for *more* is both good and without cost or risk— neither of which is true.

So should we suspend research? Abjure technology? Find the lead-lined room where email cannot reach us? No. We simply must be less promiscuous in our consumption and prioritize information that gains us knowledge and then seek knowledge that leads to wisdom. Here is where we arrive at primary care and ecohealth research and its essential role in addressing the complex challenges that our society faces—or, in the sad case of contemporary Canada, refuses to.

Over the last two decades, the Department of Family Practice has witnessed a sea change in both the amount and the stature of primary care research and the virtual invention of ecosystem approaches to health. Anticipated to some extent in the 1990s, the trends here in Canada—while frustratingly slow in their arrival—have allowed members of the Department to contribute to some of the cardinal issues of our society. The range and relevance of current activities within our own department is impressive:

Range and Relevance of DFP Research (limited list)

- from dealing with death and loss to evaluating nutritional consequences of colonization on the health of aboriginal people
- from changing our fundamental understanding of exercise-related pain in young (and not so youthful) bodies to the impact of privatization of institutional care on the quality of care in the frail elderly
- from access to sensitive reproductive choice in large cities to an understanding of the factors and consequences of loss of birthing services in small communities
- from the animation and prevention of obese youth to the prevention of falls in the elderly
- from developing engaged research capacity in prisons to collaborations on the assessment of major national initiatives on hypertension of the population at large
- from sustainability research on Bowen Island to global projects on the application of ecosystem approaches to health
- from understanding inter-professional teaching to exploring service learning and the teaching of professionalism and advocacy

Exciting as the Department's work may be, it behooves us to consider how it came about and whether we are responding to Eliot's admonition about wisdom as we move forward together. It is clear that primary care research has only recently been seen as a significant contributor to society's thirst for and need of knowledge. In spite of heavy lobbying, the Canadian Institutes of Health Research (CIHR) and the Michael Smith Foundation (MSF) did not establish an Institute for Primary Care nor create effective receptor sites for community-based clinician scientists, the very backbone of primary care practice and the venue where knowledge is applied—hopefully with ever increasing wisdom. That deficit is gradually being corrected as support for networks (wherein our researchers have been particularly successful) has developed to address issues relevant to where and how primary care is practiced. A call from the CIHR should give further impetus over the next year. At the same time, the provincial Health Authorities (HAs)—who were once dismissive of any role in supporting and participating in research—are increasingly looking to partnerships to assist with evidence-based policy development. The Centre for Rural Health Research was seminal in developing relevant tools with the HAs and the Ministry of Health is showing increasing interest in having a better base of primary care research as health system changes are contemplated.

Research support is starting to change in exciting ways, but much needs yet to be done—both here and internationally.

In the realm of interdisciplinary research (a foundational requirement to address complex problems) there is much rhetoric and a gradual increase in achievement. We must keep in mind that the original impetus for seriously interdisciplinary work did not arise from the academy, but rather from the public service. In the early '90s, the first tri-council initiative on sustainable development arose from the frustration of governmental organizations at getting help from the universities on the salient issues that they had to address—complex issues such as environmental degradation, persistent poverty and fisheries collapse. The academic research community, after nearly a century of fractionation and specialization was (and to some extent remains) ill-suited to contribute to the second definition (1b) of "research"—provided at the beginning of this article: "an endeavour to discover new or **collate old facts** etc. by the scientific study of a subject or by a course of **critical investigation**" (emphasis added). The first definition (1a) of research remains the central focus for the current overwhelmingly biomedical research culture. When we look at the new culture of primary care and ecosystem approaches to research, we find that the capacity to integrate existing threads of knowledge into a coherent approach to understand *whole* problems is remarkably akin to our daily practice of trying to understand and treat *whole* patients rather than symptomatic parts we can examine in isolation. To this end, the Department has led in the expansion of the definition of "scholarship" to embrace *integration*, *application*, and *engagement* in addition to the traditional notions of research and teaching. This shifts the idea of research in a way that changes its very function and methodology. It also allows research to catch up with the complex challenges that uncritical science and technology have unleashed upon our times.

This claim for the newer kind of science represented by primary care and ecosystems research may seem audacious and even arrogant, but it actually arises from a place of humility when confronted with the things we need to know in order to address complex issues. This is particularly true of the kind of complex issues that confront us now as a result of the industrial and transportation technologies we have deployed in the last century—technologies that are now demonstrating the limits of a finite world and the limits to prolonging life in the face of diminishing *quality* of life. Climate change, fulfilled lives and dignified dying, a better understanding of how to effectively transition prisoners back into society, decisions about reproduction, delivering health care services equitably according to need, enhancing the quality of life throughout the life cycle—these are all *complex*, not *complicated*, issues and require a different approach in order to find solutions. Zimmerman and Glouberman articulate well the difference between the two:

Characteristics and examples distinguishing *complicated* and *complex* problems:

Complicated *Sending a rocket to the moon*	***Complex*** *Raising a child*
• sending one rocket increases assurance that the next will be OK	• formulae have a limited application
• formulae are critical and necessary	• raising one child provides experience but no assurance of success with the next
• high levels of expertise in a variety of fields are necessary for success	• expertise can contribute but is neither necessary nor sufficient to assure success
• rockets are similar in critical ways	• every child is unique and must be understood as an individual
• there is a high degree of certainty of outcome	• uncertainty of outcome remains
• optimistic approach to problem possible	• optimistic approach to problem possible

Source: http://investisseurautonome.info/PDF-Downloads/COMMENT-INVESTIR-RENDEMENT-INDEX/doc.1590-%20Zimmerman%20Glouberman%202002%20Health_Care_Commission_DP8.pdf

The classic research and specialist epistemology is very good at dealing with complicated puzzles such as the exploration of the genome. Family practitioners and ecologists on the other hand deal with the reality of complex interdependent and constantly adapting individuals, groups and environment. These variables

Men from a Nepali village transport a patient on foot over narrow gravel roads through the mountains. Many Nepali patients often travel (sometimes for several days) to larger centres to receive medical treatment. | Photo courtesy of Robert F. Woollard.

are not even in principle isolatable. Indeed, like the raising of a child, they require robust relationships and a research paradigm that is engaging and integrating as well as constantly adapting to new information, knowledge and, yes, wisdom!

How might all of this bafflegab play out in the lived life of a researcher? We might keep in mind that the distinctions between the scholarships of *discovery*, *learning*, *integration*, *application* and *engagement* are helpful but are to some extent blurred when approached with a primary care or ecohealth lens. This is not dissimilar to the blending of patient engagement, history, exam, diagnosis, health promotion, and therapeutic planning, and even population health that characterizes many visits with our patients. We can parse out these parts for teaching purposes but really from the primary complaint through to the teachable moment, the encounter with a master practitioner links them together and strengthens them all.

Expanded dimensions of scholarship

1. The scholarship of *teaching* includes transmitting, transforming, and extending knowledge.
2. The scholarship of *discovery* refers to the pursuit of inquiry and investigation in search of new knowledge.
3. The scholarship of *integration* consists of making connections across disciplines and, through this synthesis, advancing what we know.
4. The scholarship of *application* asks how knowledge can be practically applied in a dynamic process whereby new understandings emerge from the act of applying knowledge through an ongoing cycle of theory to practice to theory.

5. The scholarship of *engagement* connects any of the above dimensions of scholarship to the understanding and solving of pressing social, civic and ethical problems.

Similarly, the various parts of the various lives that comprise the Department of Family Practice might be seen as contributing to the enterprise to which we all belong. By conceiving ourselves as a whole that is more than the sum of our parts, we can enhance our collective contributions and deliver what we, as reflective practitioners, owe to the society that provides us so many privileges. After all, our job is not to be handmaidens to the status quo, but to assist society in carving out a healthful future. As Canadians, we might well keep in mind the advice of Wayne Gretzky to skate where the puck is going to be, not where it is at. It is from this perspective that one presumes to reflect on how the current changes in the research environment might be grasped by researchers and other scholars.

Living a new paradigm of research

It is worth noting the characteristics that link a generalist/family practice/ecohealth approach across research, educational and engagement realms:

The Generalist and Change

- the animating motive is *practical problem solving*
- the goal is to *reduce* uncertainty but it will never be eliminated
- *"paralysis by analysis"* is not an option
- recommended action should be designed to be *fail safe* and to include feedback and assessment loops worthy of an *approach to complex problems*
- knowing *that* we don't know is as important as knowing *what* we don't know
- *keeping the whole in mind* as we attend to the parts is an irreducible requirement—for patient care, research and teaching
- it is all and always about *relationships*
- it is *relationship-based care (research and teaching)* that endures over time and over place

What follows is a truncated review of my experiences as a late career academic, a "lapsed country doc" who was fortunate enough to ride on this wave of change in the research paradigm. It might serve to help early (and even mid-) career researchers identify where their work fits within the broader context of medicine and health, and how it might shape where the "puck" might be for practitioners as a collective whole.

In the early '90s I was privileged to lead the UBC Task Force on Healthy and Sustainable Communities and to be a Co-Investigator on

Young Ugandan boys venture out daily into the forests surrounding their villages to forage for wood for fuel. | iStockphoto.com

one of the first two large grants given during the Canadian research community's first foray into blended tri-council funding. This occurred when, through pressure from the public service, the three councils – Medical Research Council (later CIHR), Natural Sciences and Engineering Research Council (NSERC) and Social Sciences and Humanities Research Council (SSHRC) – were mandated to give integrated funding for the study of sustainable development. This took place after a similar initiative by the Science Council of BC had helped establish the Task Force. The tri-council work resulted in numerous publications including the book *Fatal Consumption: Rethinking Sustainable Development* (UBC Press). More importantly it resulted in extensive, engaged community relationships and in a larger Major Collaborative Research Initiative (MCRI) grant through SSHRC called the *Georgia Basin Futures Project* which resulted in further engagement and impact on developments at three scales: Bowen Island, Richmond and the Greater Vancouver Regional District. After a hiatus as Department Head, the threads were picked up through a substantial grant with Margot Parkes under a national initiative of the International Development Research Centre (IDRC) to develop a community of practice in ecosystem approaches to health (CoPEH-Canada: www.copeh-canada.org/index_en.php). A subsequent grant resulted in an opportunity to facilitate an initiative in England last month wherein the IDRC-sponsored CoPEHs (Middle East, North Africa, West Africa, South and Central America and the Caribbean) as well as developing communities in Asia (China, Nepal, Vietnam) came together in a desire to "become more than the sum of our parts" in influencing some aspects of the global agenda on ecological and health concerns. During this process, the perspective of generalism and the approach of complexity has been a constant source of grounding and useful contribution. It has been a privilege to be able to participate as the paradigm of research reshaped itself.

Coincident with these events, further opportunities presented themselves in a number of other realms. As Co-Investigator in a five year Canadian International Development Agency (CIDA) Tier 1 grant—Localized Poverty Reduction in Vietnam (LPRV)—we worked with five Vietnamese universities and their national research centres to develop participatory research capacity through work with fifteen of the poorest communes in Vietnam to address chronic localized poverty. The models of engagement that were co-developed with our Vietnamese partners together with the lessons learned not only had an enduring impact at the communes and universities, but were seminal to the way in which the Northern Medical Program in British Columbia was initially conceived and developed in Prince George. Again, an example of how seemingly disparate work is actually united through the value and application of a generalist/complexity sensitive approach—grand words to describe what family docs do every day in their offices.

A not dissimilar approach characterizes my work in Uganda, Nepal, and Indonesia. While focused on education and the development (respectively) of disciplines, entire medical schools and national systems of accreditation, the intellectual provenance of the work is the same. Uganda, like many lower income states, has developed a health system overly focused on specialists with a dearth of primary care and a severely skewed distribution of physicians towards the urban, less needy parts of the population. Working with the four Ugandan medical schools to develop family practice (we hosted the First National Scientific Family Practice Conference in history last year and are working on the second) and also addressing accreditation and curriculum outcome assessment (under Ford Foundation Grant) has provided remarkable opportunities to link with African and EU networks in family practice and witness the birth of the first primary care scientific journal currently located in South Africa. Our work in Nepal was highlighted in earlier issues of *The Bear Bones* (July 2007)—we have now admitted our first class of medical students destined to work in rural and marginalized communities in post-civil war Nepal. The opportunity to meet them next month when I go to chair the International Advisory Group of representatives for some fifteen schools from around the world (ranging from Harvard to rural Australia) is a source of great anticipation.

In Indonesia the experience of seven years of chairing the Canadian accreditation systems for undergraduate and continuing medical education is being put to the test. We will be working on a World Bank-sponsored national initiative to build an accreditation system embracing all of the existing medical schools (seventy), nursing schools (hundreds), dental schools and midwifery schools. This opportunity to apply inter- and trans-disciplinary principles to influence the future quality of practitioners across a far flung nation is made more urgent by the explosion of for-profit schools of questionable quality. It is like walking into pre-Flexnerian North America with its nearly 200 schools a century ago this year! Again, the approach to complexity, the need to take action in the face of ongoing uncertainty (rather than succumbing to "paralysis by analysis") and the imperative of building fail-safe feedback loops (a characteristic of general practice thinking) is being grasped by the collective Deans of Indonesian schools as a worthy approach to this mammoth task. Also, as in daily practice, they realize that decisions must be made, even in the face of irresolvable uncertainty.

Next month in South Africa, I will be co hosting with Charles Boelen, a Global Consensus Conference on Social Accountability (GCSA), an event supported by an Atlantic Philanthropy grant in aid of promoting the social mission of medical schools. This gathering will bring together major international, national and regional medical educational organizations to arrive at a consensus and develop a work plan to vivify the principles of social accountability. We have conducted a Delphi process that will culminate in face-to-face work at the meeting—again an important qualitative and engaged research process that helps to shape the future.

This body of research is but one journey of many that are reflected in the lives and careers of members of our Department and many other researchers grappling with important issues and fulfilling the social obligations we bear doubly—as physicians and academicians. The true joy on this journey is having been able to observe the ever increasing horizons for family practice and ecohealth research—and in particular the remarkable cadre of developing researchers that is expanding daily to help society "…critically investigate…" its understanding of the past and present at scales ranging from our offices to the region, province and globe. It is upon these principles we can contribute to our collective effort to build a different future than the one that currently threatens the generations to follow.

the BEAR BONES

R3 Clinician Scholar Program

ADVANCED RESEARCH SKILLS TRAINING FOR PRACTICING CLINICIANS

Physicians, often in collaboration with community groups and patients, have the chance to produce research that will allow BC to excel in the creation of new knowledge and translate it into improved health for British Columbians.

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There is a growing interest among family physicians to ask clinically important questions that pertain to general practice. To help these physicians acquire the necessary skills required to conduct research in family medicine, the Department of Family Practice (DFP) Research Office at the University of British Columbia (UBC) developed the Clinical Scholar Program (CSP) – a program that provides formal research training for practicing clinicians.

Funded through the Postgraduate Dean's Office at the Faculty of Medicine, the CSP is the flagship program of the DFP Research Office. Previously known as the Clinical Investigator (CI) Program, the CSP is a structured yet flexible two-year program that provides part-time funding for family physicians to develop advanced research skills. Clinicians, often in collaboration with community groups and patients, have the chance to produce research that will allow BC to excel in the creation of new knowledge and translate it into improved health for British Columbians.

Since its inception in 1999, the CSP has supported nearly thirty family physicians, twenty-two of whom are still actively conducting research. Many former Clinician Scholars were able to secure federal and provincial grants for ground-breaking research and establish themselves as celebrated change-makers in primary care.

The CSP provides a postgraduate medical education pathway that fulfills existing College of Family Physicians of Canada (CFPC) residency training accreditation requirements for family medicine. The CFPC recently accredited the CSP in March 2010.

Program goals and objectives

The core goal of the CSP is to assist in the career development of family physicians in research and scholarly activities in various clinical and academic fields. The CSP is based on five general objectives:

- to support the development and enhancement of core research skills among family physicians;
- to cultivate scholarship within family medicine;
- to contribute to the knowledge base of family practice and primary health care;
- to engage practicing family physicians in conducting research; and,
- to foster innovative, interdisciplinary, and community-based research.

Program structure

The structure of the CSP aims to flexibly accommodate and integrate a clinician's practice with her/his requirements for advanced research training. Each participant's interests, learning needs, and career objectives drive the structure and curriculum of the program.

At the beginning of the program, a needs assessment is conducted and individual educational objectives are tailored for research trainees. The general objectives previously listed, along with individually established objectives, form the basis for the interim program evaluation and the progress assessment of the research components of each trainee's program.

Clinical Scholars are expected to organize and carry out all stages of research from planning to dissemination. They are required to present their work-in-progress at the annual Department of Family Practice Research Day. Participants are also encouraged to present at various local and international rounds, workshops, and conferences and publish their research analysis and findings in peer-reviewed journals.

Upon completion of the program, participants are expected to have acquired the knowledge, skills, and attitudes fundamental to embarking on a scholarly career in family practice research. Participants are also given further guidance on securing grants and/or formulating wider research agendas specific to their communities and field of interest.

Although Clinician Scholars are connected to UBC Vancouver as resident researchers, they are not required to attend the Point Grey campus on a daily basis.

Applying for the CSP

The Research Office conducts an annual competition to select participants for July intake into the CSP.

Prior to applying for the program, all potential applicants must identify and secure the consent of a DFP faculty member with sufficient research expertise to act as their research advisor/mentor. This mentorship will be active during both years of the program.

Applicants are asked to submit a research proposal as well as a course of study as part of the application process. Projects are discussed with prospective mentors and/or the Clinician Scholar Program Director before the program begins to ensure that each project meets the CSP's required educational objectives. Successful candidates are chosen by a selection committee comprised of senior members of the Department of Family Practice.

Project themes for the CSP may encompass topics that extend beyond "traditional" areas of clinical and medical research. Subject areas such as medical education, inter-professional practice and care, as well as social and behavioral studies as applied to health and primary care may be considered. Clinician Scholars are encouraged to support the Department's mission of social accountability in their program work, using it to enhance research capacity and engage in research that generates knowledge which can be used to improve the health and livelihood of marginalized, rural and remote populations, and at-risk communities.

Program support

Clinicians entering the CSP receive support and mentorship about research theory, content, and methodology from an appropriate UBC faculty researcher. In addition to faculty mentoring, there is also cross-cohort peer-based mentoring and support provided through monthly teleconferences and interaction with fellow Clinician Scholars and academic researchers. At the monthly meetings, all Clinician Scholars present their work-in-progress for peer mentoring and provide similar support to the other participants.

The CSP is coordinated by the members of the DFP Research Office. The Program Director and Research Coordinators facilitate the administration of the program while the DFP Research Committee oversees the program. To date, the DFP Research Office has provided support for quantitative and qualitative data management, analysis, and ethical compliance guidance to participants during the program. Members of the Research Office also help Clinician Scholars to develop and implement effective knowledge translation and dissemination strategies.

Future directions

Early results indicate that the CSP is well-received in the BC primary care community and that participants are meeting and exceeding expectations. Future plans for the CSP may include activities to facilitate faculty development and further expand the program beyond its present capacity and activities.

Current R3 Clinician Scholars

There are currently eight Clinician Scholars participating in the CSP.These participants, along with CSP Program Director, Dr. Michael Klein, are profiled below:

Dr. Michael Klein (Director, Clinician Scholar Program)

Dr. Michael Klein is a world-renowned physician scientist. He has authored more than 150 peer reviewed articles and received: the Maurice Wood Award for Lifetime Achievement in Primary Care Research from the North American Primary Care Research Group (NAPCRG); the Family Physician of the Year Award from the College of Family Physicians of Canada; and, the Founders Award from DONA International for his work in support of doulas. He has been Listmaster of the Maternity Care Discussion Group MCDG/MATRIX) for more than twenty years, is on the editorial Board of BIRTH—Issues in Perinatal Education and Practice, and is a reviewer for a number of medical journals.

Dr. Patty Belda (2008-2010/Extended to Oct 2010 due to leave of absence from program)

Dr. Patty Belda is a family doctor in Prince George, BC. She entered medicine with a Master's of Science in immunology and international development work in Bosnia and Herzegovina. She completed her medical school at McMaster University and family medicine residency at the University of British Columbia. She is currently working as the medical lead at the Central Interior Native Health Society. Patty also works at the Unattached Patient Clinic, Emergency Department and as clinical faculty at the University of Northern British Columbia and UBC Prince George Family Medicine Residency Program. She is currently completing the R3 Clinician Scholar Program looking at improving HIV care in Northern BC.

Dr. Vanessa Brcic (2009-2011)

Dr. Vanessa Brcic is a graduate of the UBC St. Paul's Hospital Family Practice Residency Program, and is currently practicing as a locum in rural communities, urban community health clinics and teaching practices. Her primary clinical interest is in rural mental health and addictions care. In her second year of the Department's Clinician Scholar Program, her research program includes the development of a poverty case-finding tool for clinical practice, a systematic review of the literature on primary care interventions into poverty, and a BCCFP-funded qualitative study of interventions associated with addressing poverty in primary care. She is further interested in understanding the family physician's role as health advocate within the context of health disparities. She also enjoys spending time in her spiritual and recreational playground in the mountains while ski touring, climbing and cycling.

Dr. David Joyce (2009-2011)

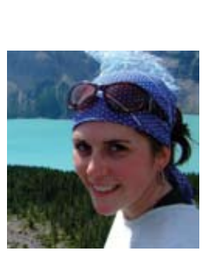
Dr. David Joyce is a family physician at the Pender Community Health Centre and is active in conducting primary care clinical research. Dr. Joyce received his Doctor of Medicine Degree from the University of Toronto and joined UBC Family Practice as an R3 Clinician Scholar. His current area of research focuses on the study of developmental screening in primary care settings. Working in collaboration with Dr. Marjolaine Limbos, a psychologist at Sunny Hill Children's Centre, their research has recruited over 300 children to compare the accuracy of a variety of screening measures that are currently in use or could be used in primary care settings.

Dr. Maureen Mayhew (2009-2011)

Dr. Maureen Mayhew has been providing primary health care in rural and remote locations in Canadian and international settings for two decades. Currently she provides care for refugees in Vancouver, does mixed-methods research on refugee access to primary care and consults in public health both internationally and in northern Canada. She has spent the last ten years helping to revive Afghanistan's battered health system initially through frontline work in maternal and child health, and then later through evaluations and strategy development at a national level. As UBC clinical faculty, she has developed and taught a graduate level course on rural and remote health, in addition to teaching medical students and residents.

Dr. Wendy V. Norman (2009-2011)

Dr. Wendy V. Norman is currently in her second year of the Department's Clinician Scholar Program supporting half-time research. Her research interests include population health, abortion demographics and best practices. Dr. Norman and her interdisciplinary research team are supported within the Women's Health Research Institute of Provincial Health Services Authority (PHSA). Dr. Norman has been a family physician since 1985 and has practiced exclusively in the area of abortion since 1997. As well, she is an active clinical teacher for family physicians and gynecologists in abortion care. She completed an MHSc (UBC 2004), a diploma in Tropical Medicine and International Health (Liverpool 1994) and training as a GP anaesthesiologist (UBC 1988), and has been a Clinical Professor in the Department of Family Practice since 2007.



Dr. Patricia Gabriel (2010-2012)

Dr. Patricia Gabriel has just finished her residency in family medicine through UBC at St. Paul's Hospital. She will be practicing family medicine in Port Moody part-time and doing her Master's of Health Science at SFU part-time. Her research interests are broadly focused on global health, and she has previous research experience in HIV, neglected tropical diseases, and access to essential medicines. With the Clinical Scholar Program she will be looking at the health of refugees in Canada by creating a prospective longitudinal cohort of government assisted refugees in Vancouver.

Dr. Margaret Manville (2010-2012)

Dr. Margaret Manville is a family doctor (CCFP, UBC 1999) and a care of the elderly physician (University of Ottawa, 2002) in Comox, BC. She has practiced family medicine in the Comox Valley since 2002, and since 2007 has provided geriatric medicine consultation for her community. She is Medical Director for 'The Views' extended care unit at St. Joseph's Hospital and is Medical co-Director for the hospital's newly-formed transitional care unit. Her CSP project will examine functional outcomes of ALC patients cohorted on the transitional care unit compared to usual acute hospital care.

Dr. Kara Solmondson (2010-2012)

Dr. Kara Solmundson completed her undergraduate education at the Universities of Manitoba, Calgary and Ottawa, while competing internationally for Canada in the sport of badminton. Following the 2000 Olympics, she completed medical school at the University of Manitoba and family medicine residency through UBC's St. Paul's Hospital program. She was a Lloyd Jones Collins recipient for her joint research project on pregnancy in residency. She recently completed advanced clinical training in sports and exercise medicine, and is currently working towards her Master's degree in sports and exercise medicine. Her research interests are in preventative health, barriers to exercise and medical education.

Dr. Iona Heath

GENERAL PRACTITIONER AND PRESIDENT OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS, GREAT BRITAIN

Dr. Iona Heath worked as an inner-city general practitioner at the Caversham Group Practice in Kentish Town, London from 1975 until 2010. She has been a nationally elected member of the Council of the Royal College of General Practitioners since 1989 and chaired the College's Committee on Medical Ethics from 1998 to 2004 and the International Committee from 2006 to 2009. She is currently President of the Royal College of General Practitioners, having been elected for a three-year term from November 2009.

Great Britain has introduced the Quality and Outcomes Framework (QOF)[1] for general practitioners – can you explain why it was introduced?

The Royal College of General Practitioners had long argued for doctors to be paid for the quality of care that they delivered without realizing what they were going to let out of the box. The QOF financial year ends on April 6th and there is always a scramble for points in practices up and down the country. We have to try and discover if people are still smoking, what their weight is, and measure their blood pressure before April 6th of each year. From the patient's point of view, it does not matter whether they have their blood pressure measured on the 1st April or the 30th April. It has nothing to do with the quality of care – it has to do with the points. I went into medicine to use science to care for people who were ill, but what I am being paid to do is coerce people into meeting certain arbitrary criteria, which is the same situation with everybody with blood pressure and the same for everybody with diabetes. There is no individual weighing of what [patients] want from their lives. We have spent a lot of time trying to deal with the paternalism of doctors, but we have replaced that with the idea that the State knows what is best for patients. What we have now is either state or corporate paternalism. A lot of it is also pharmaceutical driven.

Does that mean that the QOF is disease driven as well?

Absolutely – everybody who has an interest in a particular disease, whether it be a patient or a group of doctors, all want their disease in the QOF. I actually think it is the kiss of death for a disease because of the crude imposition of unitary standards. Diabetes is probably the condition for which the QOF is most suited. The major diseases that are in it are coronary artery disease, diabetes, chronic obstructive pulmonary disease, asthma, epilepsy, and hypothyroidism. It will be very significant, the ones I am forgetting, but [they come under the category of] big league diseases and there are criteria that have to be met for each of them. Of course, the problems begin when people have five of them. There is no concession to age because the government does not wish to appear to be ageist, but I think that they should treat a diabetic who has survived to eighty-five differently to how you should treat a diabetic who is forty-five. I think most older people would regard that as flexible, adaptable, and appropriate care.

Do most physicians participate? If so, why?

Yes, and by far, most physicians deliver an extraordinarily high number of points. We all tick boxes. You try very hard to put it in a compartment and then carry on as before. We participate because it brings in a lot of money. It is between twenty and twenty-five percent of our income.

How is the QOF perceived in Great Britain?

There is a lot about it whether it is better now. In the old days, one would measure someone's blood pressure and if it was completely normal one would not necessarily write it down. Now we have to do the weights and heights of everybody. Has that added to the health status of the population? No, it has not. Neither has recording your normal blood pressure or recording that you are not a smoker. I think that the QOF is driven by computers because they give us the capacity to record and analyze this sort of data. We will realize that the contribution that it makes in improving people's health is disproportionate to the amount of data, the amount of reporting, and the number of people who are involved in this huge data collecting and manipulating exercise.

There is also a worry that we are degrading that data for public research. We must be aware of the limitations and remember that you will inevitably set up some "gaming" with the data when you are subject to a financial incentive. It is a very powerful lever, it is a very dangerous lever, and it needs to be used carefully because what people do without the financial incentive, and what they do with financial incentives, is not necessarily a good shift. I am sure a lot of people are subverting the data and there will be a shift in the quality of that data. So what does that do to both the ethics of a profession and the health care service? However, everybody in this strange virtual world is pleased because the profession can say how well it is doing and the government can say how well it is doing with its new system. But, are they actually improving the lives of individual patients? That is the key for me.

How do you improve the quality of life for patients?

Health is such a complicated issue. It [has] to do with a sense of being valued, a sense of being connected, and a sense of having a meaning. People's health status will never be able to be reduced to a data on a computer. I have this feeling that what we do in terms of how we relate to people, how we regard them, how we value them as individual human beings with diseases is what gives the added value. It is not the writing down of the stuff which I feel that there is no understanding of at all in the political structure until of course individuals become ill. David Cameron, the leader of a political party at home [in the UK], his six year-old son died from Cerebral Palsy. It was a terrible tragedy. Cameron was full of praise for the way the family had been looked after all these years. It is clear that people understand only when they are in a position to understand, so in a relatively wealthy country where most people are in good health, the democratic majority is not in a position to understand what is important in healthcare. They are mostly young and well and they want a technical service from their doctor. Their perspective changes completely at the point when they are no longer young or well and then they begin to see that there are other issues that are important.

And what are those issues?

The fact that you want to see some someone you know and not have to tell your story repeatedly. When someone is frightened, it becomes important not to have to tell a painful story again. I had a patient who lost the will to live over a holiday weekend in a hospital. He had to explain his presence to every successive nursing shift – it is exhausting. You want people who know and care for you and understand what is important for you.

What do you see as important for the future of health care?

My ambition for the future is to re-establish the connection between healthcare and suffering. We no longer define disease by suffering. We used to define disease by suffering. Somebody would say 'I feel dreadful. I am ill. I need help." It is not like that anymore. You go to the doctor, you get measured, your number is wrong, you are ill. When we were medical students we were taught that there can be illness without disease. We were also taught that there is disease without illness, but there is very little of it. Now we have an epidemic of disease without illness. Huge numbers of healthcare dollars are going into treating people with disease, but without illness. They feel fine. We are treating some risk for some future that might never happen. We are trying to get them to become a unitary standard of health and to focus more on the sick rather than on the healthy. I think that the improvements in health status have vastly much more to do with increased levels of health, opportunity, and prosperity than any of the technical things that we are doing.

There is a place for a small number of technical measures of quality. It ought to be whether there is clear evidence that the intervention makes a real difference, to real health outcomes that matter to patients.

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Given your knowledge of the QOF in Great Britain, what can physicians in Canada learn?

There is a place for a small number of technical measures of quality. It ought to be whether there is clear evidence that the intervention makes a real difference, to real health outcomes that matter to patients. Not everybody wants to live forever. If you have already lived past the average expectation of life, you know that in the next ten to fifteen years you will die of something. It is about the quality of your life and what is happening to your family. In many senses, the health of your children and grandchildren is much more important to you than your own health.

You have addressed some of the limitations of the QOF. Are there strengths as well?

The best thing that has come out of the QOF is the quality of the software – it has a fantastic prompting software. Family doctors have invested in the software because it is impossible to get the points without it. It is great to have software where you are prompted to think about it, but do not necessarily have to act on it. But, it is the extent to which the financial incentives pervert behaviour. I can see that when I teach with videos with the young doctors. You will see a young doctor interviewing a patient on a video and it is quite clear to me observing that there is something on the computer screen that has come up saying that there is something wrong with this patient's blood pressure. The patient has come in talk about the fact that they cannot sleep because their son has been sent to prison, but the doctor cannot get their blood pressure out of their mind. It is completely inappropriate to talk about the blood pressure on this occasion. This woman has not slept, it is nonsense to even be thinking about it and yet they feel this pressure to deliver on that. High blood pressure may be the only "disease" they have, so from the point of view from the system, that patient's blood pressure is a measure of the quality of their care. Where I am coming from, that patient's blood pressure is irrelevant to her health at that moment. She needs to be listened to, she needs to be understood, and she needs to find a way of incorporating it into the story of her family.

What other ways can you support that patient in a positive way?

The most important thing is to deal with individuals, to deal with the particularity of that person in front of you, and to fit the system to them rather than fit them to the system. If healthcare can deliver that, then people can handle degrees of fear. It is amazing how frightened people are of their cholesterol number or of their blood pressure number. People become obsessed with these numbers and think that they are at bigger risk than they are. It becomes a sort of mystical figure that is very full of fear and yet if somebody is afraid then their blood pressure is going to go higher so it's how you contain that fear and we are using fear a lot to try and coerce behavior.

Is there a way of empowering the patient beyond that fear?

For most people you can definitely work as a partnership – where you are the expert on what your life is all about and I am the expert on the technical medicine. That is the ideal we all aim for. But there are people whose lives are so marked by anxiety and inability that you have to take a greater degree of responsibility. We need to acknowledge that people have different capacities to make those decisions.

What do you see as the most pressing and important issues in healthcare?

I think that it is a way of keeping the individual patient in perspective and in the picture. We are imposing this normative view to health. A healthy person who takes regular exercise, has a nice diet, has the right shape, the right blood pressure, does not smoke, does not use any drugs, drinks maybe half a glass of wine in the evening, has a small square of dark chocolate once a week – some insufferably virtuous person. Imagine a world in which all the people were like the ones I just described. It would be odious. The excess in people is part of what makes life so fascinating, the fact that some people eat too much, some people laugh too much, some people cry too much etc. Great artists are often quite extreme in one form or another. We have to remember that health should be defined by the person whose health it is.

So how does a healthcare professional deal with such diversity and extremes?

I think that we have to learn to love humanity as it is. It is an issue of relishing the diversity and to stop feeling the necessity to control everything.

Endnote

[1] The Quality and Outcomes Framework (QOF) is a payment for performance contractual agreement between GPs and the UK National Health Service which began in 2004. The terms of the contract define 129 quality indicators—the majority on clinical processes and outcomes—and award financial gains to physicians for following those standards.

Source: http://jama.ama-assn.org/cgi/content/extract/302/22/2485 - paraphrased by Dr. Tracy Monk, Clinical Assistant Professor of Family Medicine, UBC.

CENTRE FOR RELATIONSHIP-BASED CARE

EVENT RECAP

(left to right) Dr. Tracy Monk, Dr. Iona Heath, and Dr. Dee Mangin at the "Dessert and Dialogue" event. | Photo by Sharon Mah

In 2009, the UBC Department of Family Practice celebrated the launch of its Centre for Relationship-based Care (CRBC) by inviting UK general practitioner, Dr. Iona Heath, along with New Zealand family doctor and professor, Dr. Dee Mangin, to present at an invitation-only "Dessert and Dialogue" event.

After a brief overview of the UK and New Zealand's approaches to the delivery of primary health care, Drs. Heath and Mangin participated in a dialogue with the audience. Several topics were discussed, including:

- the perils of "measuring and missing the point" in research;
- issues of paternalism and control in health care delivery;
- the danger of fitting (and restricting) patient-centered care into pre-set guidelines;
- merits (and disadvantages) of different approaches to measurement for research and performance assessment purposes in primary care; and
- the importance of a relationship-centered approach to healthcare delivery.

Clinicians, academics, members of three Health Authorities, and allied health professionals from across the province engaged in the revealing and occasionally spirited discussion. The evening provided the directors of the CRBC – Drs. Tracy Monk and Robert Woollard – with substantial feedback about the issues the Centre should be investigating and addressing as part of its mandate going forward.

January 1 to June 30, 2010

Granting Agency	Title	Amount	Year	Principal Investigator	Co-Investigators
AstraZeneca	Safe and sound? A documentary film on refugee health and access to primary care in Metro Vancouver	$7,800	2009-2010	**Mayhew, M.**	**Nouch, S.** **Cunes, J.**
Bayer Health Care Pharmaceuticals	Immediate vs. interval insertion of intrauterine contraception after second trimester abortion	$142,500	2010-2011	**Norman, W. V.**	**Kaczorowski, J.** Soon, J. Brant, R. Bryan, S. Dicus, L.
British Columbia College of Family Physicians	Addressing poverty in family practice: Benefits, harms and interventions	$5,000	2010-2011	**Brcic, V.**	**Dharamsi, S.** **Kaczorowski, J.**
British Columbia College of Family Physicians	Are refugees accessing family doctors in BC? –Three years after their arrival how is their health, resiliency and use of the health system?	$5,000	2009-2010	**Mayhew, M.**	Kazanjian, A. **Klein, M. C.** Bath, M. Grant, T. **Corneil, T.**
British Columbia College of Family Physicians	Inspiring health advocacy among residents: Multiple perspectives	$800	2010-2011	**Mu, L.**	**Dharamsi, S.** **Shroff, F.**
Canadian Institutes of Health Research	Educating for equity: Exploring how health professional education can reduce disparities in chronic disease care and improve outcomes for Indigenous populations	$1,234,000	2010-2015	Crowshoe, L. **Calam, B.** Green, M. E. Jacklin, K. M. **Walker, L. M.**	Ho, K. Ly, A. B.
Canadian Institutes of Health Research	Assessing chronic obstructive pulmonary disease (COPD) knowledge, beliefs and health literacy in Chinese immigrant adults with COPD	$200,000	2010	Fitzgerald, M.	Eni, G. Ho, K. Kassam, R. Kazanjian, A. **Mayhew, M.** **McGregor, M. J.** et al.
Canadian Institutes of Health Research: Institute of Gender and Health	Lectureship Program	$2,500	2010	**Janssen, P.A.**	
Canadian Institutes of Health Research	Optimal birth BC	$350,000	2010-2013	**Janssen, P.A.**	Lee, S. Liston, R. **Klein, M.C.** et al.
Canadian Institutes of Health Research		$20,000	2010-2011	**Kornelsen, J.** Bartlett, K.	
Canadian Institutes of Health Research	Using the internet for self-management and monitoring patients with heart failure at a distance	$478,539	2010-2014	Lear, S.	**Bates, J.** **Horvat, D.** Johnson, S. Ignaszewski, A. Kaan, A.
Canadian Institutes of Health Research	Better contraceptive choices: Immediate vs. interval insertion of intrauterine contraception after second trimester abortion	$792,528	2010-2015	**Norman, W.V.**	**Kaczorowski, J.** Soon, J. Brant, R. Bryan, S. Dicus, L.
Canadian Institutes of Health Research	Oral micronized progesterone for perimenopausal vasomotor symptoms	$371,936	2010-2014	Prior, J.	Fung, M. Hitchcock, C. **Janssen, P.A.** Kalyan, S.
Canadian Institutes of Health Research	Home-based newborn screening for biliary atresia using parent completed infant stool colour cards: A pilot feasibility study	$481,274	2010-2013	Schreiber, R.	Ahmed, N. Arockiasamy, V. Bryan, S. Collet, J. P. **Kaczorowski, J.** Morinville, V.
Canadian Institutes of Health Research: Operating Grant, Priority Announcement: Bridge Funding Primary Care	Better contraceptive choices for marginalized women: Immediate vs. interval insertion of intrauterine contraception after second trimester abortion	$100,000	2010-2011	**Norman, W. V.**	Brant, R. Bryan, S. Dicus, L. **Kaczorowski, J.** Soon, J.
Canadian Institutes of Health Research: Catalyst Grant, Primary and Community-Based Healthcare	Effectiveness of an intervention to increase communication and collaboration between solo/small group general practitioners and home health staff	$99,898	2010	Berg, S.	Sheps, S. Barer, M. **McGregor, M. J.** Wong, S.
Canadian Institutes of Health Research: Catalyst Grant, Primary and Community-Based Healthcare	Developing a national electronic network in primary care to advance drug safety and effectiveness (eDSEN)	$96,822	2010-2011	Holbrook, A.	Bernstein, R. Birtwhistle, R. Dolovich, L. Chan, D. **Kaczorowski, J.** et al.
Canadian Institutes of Health Research: Catalyst Grant, Primary and Community-Based Healthcare	Refugee healthcare in BC: What facilitates access to general practitioner care?	$98,380	2009-2010	**Mayhew, M.**	Bath, M. **Corneil, T.** Grant, K.J. Kazanjian, A. **Klein, M. C.**
Canadian Institutes of Health Research: Catalyst Grant, Post Market Drug Safety and Effectiveness program	A national electronic network for rapid assessment of drug safety and effectiveness.	$99,025	2010-2011	Holbrook, A.	Bernstein, R. Birtwhistle, R. Dolovich, L. Chan, D. **Kaczorowski, J.** et al.
Canadian Institutes of Health Research: Partnership for Health System Improvement	Optimal birth BC	$350,000	2010-2012	**Janssen, P. A.**	**Kaczorowski, J.** **Klein, M. C.** Lee, S. Liston, R. Sawchuck, D. Synnes, A.
First Nations and Inuit Health	Addressing the gaps and inequities: Bringing together public health, communities, and prisons. (Workshop – June 8, 2010)	$5,000	2010	**Martin, R. E.** **Buxton, J. A.**	
Medical Council of Canada	Longitudinal assessment in integrated clerkships: More predictive of successful performance than standard clerkship assessment?	$37,473	2009-2010	**Bates, J.**	McLaughlin, K. Konkin, C.
Michael Smith Foundation for Health Research	Optimal birth BC	$61,900	2010-2012	**Janssen, P. A.**	**Kaczorowski, J.** **Klein, M. C.** Lee, S. K. Liston, R. M. Sawchuck, D. J. Synnes, A. R. ▸

January 1 to June 30, 2010 (cont.)

Granting Agency	Title	Amount	Year	Principal Investigator	Co-Investigators
Provincial Health Services Authority	Optimal birth BC	$213,000	2010-2012	**Janssen, P. A.**	**Kaczorowski, J.** **Klein, M. C.** Lee, S. Liston, R. Sawchuck, D. Synnes, A.
Provincial Health Services Authority: Mental Health and Addictions	Addressing the gaps and inequities: Bringing together public health, communities, and prisons. (Workshop – June 8, 2010)	$5,000	2010	**Martin, R. E.** **Buxton, J. A.**	
Social Sciences and Humanities Research Council: Major Collaborative Research Initiatives	Re-imagining residential long-term care	$500,000	2010-2017	Armstrong, P.	Adams, A. M. Armstrong, H. Baines, D. Chivers, S. Choiniere, J. **McGregor, M. J.** et al.
Society of Family Planning	Contraception satisfaction and effectiveness post-abortion: A randomized controlled trial	$99,623	2010-2012	**Norman, W. V.**	Turner, C. Chiles, J.
Sue Harris Research Grant	Development and validation of a survey to assess the health care needs of women in rural British Columbia	$5,000	2010-2011	**Norman, W. V.**	**Malhotra, U.** Guy, M.
Sue Harris Research Grant	Contraception satisfaction and effectiveness after abortion: A prospective cohort analysis	$2,500	2010-2011	Turner, C. Chiles, J.	**Norman, W. V.**
UBC Faculty of Medicine	Exploration of preceptors' experiences in a continuity-based clinical model	$5,000	2010	Cuncic, C.	**Bates, J.** Regehr, G.
UBC Teaching and Learning Enhancement Fund	A Parisian salon: Creating a culture of intellect around the social determinants of health	$5,000	2010-2011	Bainbridge, L.	**Dharamsi, S.** **Frankish, J.** Wood, V.
UBC Teaching and Learning Enhancement Fund	A multi-disciplinary teaching DVD for students, faculty and community education: Providing palliative care in BC hospice/palliative care settings	$123,526	2010-2011	**Boston, P.**	**Nixon, A.** **Hansson, A.** **Siden, H.** **Gallagher, R.** **Black, F.** **Hawley, P.** **Fyles, G.** **Kuhl, D.** **McGregor, D.** **Fonger, M. E.** **Cave, D.** **Dharamsi, S.**
UBC Teaching and Learning Enhancement Fund	Strengthening an ethical platform for international engagement and service-learning at UBC: Filling knowledge and educational resource gaps	$65,000	2010-2011	Foster, K. **Dharamsi, S.**	Baldwin, T. Spiegel, J. Charles, G.

Granting Agency	Title	Amount	Year	Principal Investigator	Co-Investigators
UBC Teaching and Learning Enhancement Fund	Enhancing undergraduate medical education by creating learning opportunities and clinical electives in prison communities; Phase 2, evaluation.	$19,000	2010	**Martin, R. E.**	**Smith, M.** Koehn, J. Malebranche, D.
UBC Vice Provost Office	UBC CARES: Computer assisted reproductive health education for students	$35,128	2010-2011	**Norman, W. V.**	**Malhotra, U.** Fitzsimmons, B. **Vedam, S.** Garrett, B.
Vancouver Foundation – BC Medical Services Foundation Community Engagement Grant	Book proposal: Prisons That Heal	$3,000	2010	**Martin, R. E.**	Fels, L. Leggo, C. **Smith, M.**
Vancouver Foundation – Community-based Clinician Investigator Dissemination Grant	Addressing the gaps and inequities: Bringing together public health, communities, and prisons. (Workshop – June 8, 2010)	$4,000	2010	**Martin, R. E.** **Buxton, J. A.**	
Vancouver Island Health Authority	Addressing the gaps and inequities: Bringing together public health, communities, and prisons. (Workshop – June 8, 2010)	$1,000	2010	**Martin, R. E.** **Buxton, J. A.**	
WorkSafe BC	Health and work productivity web-portal: Knowledge to action for disability prevention and management – a pilot study	$68,000	2010-2011	**White, M.**	**Kaczorowski, J.** Schultz, I. Iverson, R. Samri, J. Wagner, S.

January 1 to June 30, 2010

Awardee	Name of Award	Foundation	Year
Joanna Bates	**Honorary Doctorate**	University of Sherbrooke	2010
Shafik Dharamsi	**Honorable Mention** for Tips for teaching in the UBC Distributed Medical Educational Program	Office for Faculty Development, Faculty of Medicine, UBC	2010
Martha Donnelly	**Primus Inter Pares**	Vancouver Medical Association	2010
Martha Donnelly	**Killam Teaching Prize**	University of British Columbia	2010
Patricia Janssen	**Killam Teaching Prize**	University of British Columbia	2010
Janusz Kaczorowski et al.	**Top Breakthroughs, Co-Chairs Award** for Impact for improving cardiovascular health at the population level: A 39 community cluster-randomised trial of the Cardiovascular Health Awareness Program (CHAP)	1st Canadian Stroke Congress	2010
Paul Whitehead	**Excellence in Education Award**	BC Children's and Women's Hospital	2010

publications

January 1 to June 30, 2010

Book Chapters

> **Kaczorowski, J.,** M. Shubair and M. Kaczorowski (2010). "Fast food and the global epidemic of Type 2 diabetes: Are we doomed to become obese and develop diabetes?" Chocolate, Fast Foods and Sweeteners: Consumption and Health. M. R. Bishop, Nova Science Publishers: 293-299.

Refereed Publications

> Bancej, C. M., N. Campbell, D. W. McKay, M. Nichol, R. L. Walker and **J. Kaczorowski** (2010). "Home blood pressure monitoring among Canadian adults with hypertension: Results from the 2009 Survey on Living with Chronic Diseases in Canada." Can J Cardiol **26**(5): e152-157.

> **Beever, R.** (2010). "Do far-infrared saunas have cardiovascular benefits in people with Type 2 diabetes?" Canadian Journal of Diabetes **34**(2): 113-118.

> **Beever, R.** (2010). "The effects of repeated thermal therapy on quality of life in patients with Type II diabetes mellitus." The Journal of Alternative and Complementary Medicine **16**(6): 677-681.

> Bollegala, N., H. Garfield, **I. Scott**, B. Wright, F. Brenneis, E. Atenafu, M. Feldman (2010). "The clerkship pediatric rotation: Does setting matter?" Canadian Medical Education Journal **1**(1): e51-e55.

> Campbell, N. R., **J. Kaczorowski**, R. Z. Lewanczuk, R. Feldman, L. Poirier, M. M. Kwong, M. Lebel, F. A. McAlister and S. W. Tobe (2010). "2010 Canadian Hypertension Education Program (CHEP) recommendations: The scientific summary – An update of the 2010 theme and the science behind new CHEP recommendations." Can J Cardiol **26**(5): 236-240.

> Cameron, I. D., S. Robinovitch, S. Birge, P. Kannus, **K. M. Khan**, J. Lauritzen, J. Howland, S. Evans, J. Minns, A. Laing, P. Cripton, S. Derler, D. Plant and D. P. Kiel (2010). "Hip protectors: Recommendations for conducting clinical trials – An international consensus statement (part II)." Osteoporos Int **21**(1): 1-10.

> Chalmers, B., **J. Kaczorowski**, E. Darling, M. Heaman, D. B. Fell, **B. O'Briain** and L. Lee (2010). "Caesarean and vaginal birth in Canadian women: A comparison of experiences." Birth **37**(1): 44-49.

> **Choi, J., S. Chan** and **E. R. Wiebe** (2010). "Natural family planning: Physicians' knowledge, attitudes and practice related to four evidence-based natural family planning methods: Standard days, cervical mucus, basal body temperature, and lactational amenorrhea methods." J Obstet Gynaecol Can **32**: 673-667.

> Davis, J. C., C. A. Marra, M. C. Robertson, **K. M. Khan**, M. Najafzadeh, **M. C. Ashe** and T. Liu-Ambrose (2010). "Economic evaluation of dose-response resistance training in older women: a cost-effectiveness and cost-utility analysis." Osteoporos Int. **21**(8): 1295-1306

> Davis, J. C., M. C. Robertson, **M. C. Ashe**, T. Liu-Ambrose, **K. M. Khan** and C. A. Marra (2010). "Does a home-based strength and balance programme in people aged > or = 80 years provide the best value for money to prevent falls? A systematic review of economic evaluations of falls prevention interventions." Br J Sports Med **44**(2): 80-89.

> Davis, J. C., M. C. Robertson, **M. C. Ashe**, T. Liu-Ambrose, **K. M. Khan** and C. A. Marra (2010). "International comparison of cost of falls in older adults living in the community: A systematic review." Osteoporos Int **21**(8): 1295-1306.

> Dawes, M. G., **J. Kaczorowski**, G. Swanson, J. Hickey and T. Karwalajtys (2010). "The effect of a patient education booklet and BP 'tracker' on knowledge about hypertension. A randomized controlled trial." Family Practice, Jul 14 [Epub ahead of print]

> Eftekhary, S., **M. C. Klein** and S. Xu (2010). "The life of a Canadian doula: Successes, confusion, and conflict." J Obstet Gynaecol Canada **32**(7): 642-649.

> Hanley, G. E., **P. A. Janssen** and D. Greyson (2010). "Regional variation in the cesarean delivery and assisted vaginal delivery rates." Obstet Gynecol **115**(6): 1201-1208.

> Hearns, G., **M. C. Klein**, W. Trousdale, C. Ulrich, D. Butcher, C. Miewald, R. Lindstrom, S. Eftekhary, **J. Rosinski**, O. Gomez-Ramirez and A. Procyk (2010). "Development of a support tool for complex decision-making in the provision of rural maternity care." Health Care Policy **5**(3): 83-95.

> **Jamieson, J. L.**, E. M. Webber and **K. S. Sivertz** (2010). "Re-entry residency training: Opportunities and obstacles." Can Fam Physician **56**(6): e226-232.

> **Janssen, P. A.** and **M. C. Klein** (2010). "Time for improved standards for studies of home birth." Am J Obstet Gynecol. June 24 [Epub ahead of print]

> Jimenez, V., **M. C. Klein**, M. Hivon and C. Mason (2010). "A mirage of change: Family-centred-maternity care in practice." Birth **37**(2): 160-167.

> Kaida, A., F. Laher, S. A. Strathdee, **P. A. Janssen**, D. Money, R. S. Hogg and G. Gray (2010). "Childbearing intentions of HIV-positive women of reproductive age in Soweto, South Africa: The influence of expanding access to HAART in an HIV hyperendemic setting." Am J Public Health. April [Epub ahead of print]

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> **Khan, K. M.** and J. C. Davis (2010). "A week of physical inactivity has similar health costs to smoking a packet of cigarettes." Br J Sports Med **44**(6): 395.

> **Klein, M. C.** (2010). "What do episiotomy and Caesarean have to do with Copernicus, Galileo, and Newton?" Birth **37**(1).

> **Kornelsen, J.** and **S. Grzybowski** (2010). "Rural maternity practice: How can we encourage family physicians to stay involved?" Can J Rural Med **15**(1): 33-35.

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> Lisonkova, S., **P. A. Janssen**, S. B. Sheps, S. K. Lee and L. Dahlgren (2010). "The effect of maternal age on adverse birth outcomes: Does parity matter?" J Obstet Gynaecol Can **32**(6): 541-548.

> Liu-Ambrose, T., J. C. Davis, L. S. Nagamatsu, C. L. Hsu, L. A. Katarynych and **K. M. Khan** (2010). "Changes in executive functions and self-efficacy are independently associated with improved usual gait speed in older women." BMC Geriatr **10**: 25.

> Madden, K. M., C. Lockhart and **K. M. Khan** (2010). "Arterial stiffness and the response to carotid sinus massage in older adults." Aging Clin Exp Res **22**(1): 36-41.

> Myers, M. G., M. Godwin, M. Dawes, A. Kiss, S. W. Tobe and **J. Kaczorowski** (2010). "Measurement of blood pressure in the office: Recognizing the problem and proposing the solution." Hypertension **55**(2): 195-200.

> Neufeld, E., N. O'Rourke and **M. L. Donnelly** (2010). "Enhanced measurement sensitivity of hopeless ideation among older adults at risk of self-harm: Reliability and validity of Likert-type responses to the Beck Hopelessness Scale." Aging and Mental Health **14**: 757-761.

> **Ogilvie, G. S.**, D. J. v. Niekerk, M. Krajden, **R. E. Martin** et. al. (2010). "A randomized controlled trial of human papilloma virus (HPV) testing for cervical cancer screening: Trial design and preliminary results (HPV FOCAL Trial)." BMC Cancer **10**:111.

> Ploeg, J., K. Brazil, B. Hutchison, **J. Kaczorowski**, D. M. Dalby, C. H. Goldsmith and W. Furlong (2010). "Effect of preventive primary care outreach on health related quality of life among older adults at risk of functional decline: Randomised controlled trial." BMJ **340**: c1480.

> Spiegel, J., **S. Dharamsi**, K. Wasan, A. Yassi, S. Burton, P. J. Hotez, C. Hanson and D. A. P. Bundy (2010). "Which new approaches to tackling neglected tropical diseases show promise?" PLoS Med **7** (5): e1000255.

> Szabo, S. M., **P. A. Janssen, K. M. Khan**, S. R. Lord and M. J. Potter (2010). "Neovascular AMD: An overlooked risk factor for injurious falls." Osteoporos Int **21**(5): 855-862.

> Trudeau, J., K. Wynn, K. Taunton, and **I. Scott** (2010). "The role of nutrition in primary care: Current practices, attitudes, and barriers." Can Fam Physician **56**: e109-16.

> Westwood, M. J., H. B. McLean, **D. G. Cave**, W. A. Borgen, and P. Slakov (2010). "Coming home: A group-based approach for assisting Canadian military veterans in transition." Journal for Specialists in Group Work **March**: 44-68.

> **Wiebe, E. R., K. J. Trouton** and J. Dicus (2010). "Motivation and experience of nulliparous women using IUDs (intrauterine contraceptive devices)." J Obstet Gynaecol Can **32**: 335-338.

> Yassi, A., **S. Dharamsi** and J. Spiegel (2010). "Industry in academia: Ethical frameworks would clarify links." Nature **464**: 486.

> Yassi, A., **S. Dharamsi**, J. Spiegel, A. Rojas, E. Dean and **R. Woollard** (2010). "The good, the bad and the ugly of partnered research: Revisiting the sequestration thesis and the role of universities in promoting social justice." International Journal of Health Services **40**: 485-505.

Abstracts

> **Adams, D. J., J. Kaczorowski** and **K. M. Khan** (2010). "The extended Community-based Clinician Investigator (CBCI) program." Family Medicine **42** (Suppl 2).

> Agarwal, G., **J. Kaczorowski**, H. Gerstien and S. Hanna (2010). "Effectiveness of a community-based diabetes program to increase awareness and detection of diabetes." Family Medicine **42** (Suppl 2).

> Ao, P., B. Narayan, W. G. Cannon, J. P. Collet, R. Goldman, **J. Kaczorowski**, J. Druker and R. Cadelina (2010). "Enhancing research skills for post-graduate pediatric trainees: Implementation of a pediatric research curriculum." Paediatr Child Health **15** (Supp A): 57a.

> **Collins, M. B.**, R. Holehouse and **J. Kaczorowski** (2010). "Expanded access to Chlamydia screening in an international resort community – an outreach pilot project." Family Medicine **42** (Suppl 2). ▸

January 1 to June 30, 2010 (cont.)

> Dolovich, L., M. C. Rodriguez, A. McKibbon, **J. Kaczorowski**, L. McCarthy, T. L. Cheung, T. Karwalajtys and D. Chan (2010). "The effectiveness of web-based patient self-management programs for hypertension: A systematic overview." Family Medicine **42** (Suppl 2).

> **Kaczorowski, J.**, L. W. Chambers, L. Dolovich, B. Farrell, B. McDonough, R. Sebaldt, L. Thabane, K. Tu, B. Zagorski, R. Goeree, J. M. Paterson and T. Karwalajtys (2010). "Improving cardiovascular health at the population level: A 39 community cluster-randomised trial of the Cardiovascular Health Awareness Program (C-CHAP)." Stroke **41**(7): e474.

> **Kaczorowski, J.**, S. Liu, M. Heaman, B. Chalmers, S. Dzakpasu, L. Lee and D. Young (2010). "Prevalence and correlates of planned Caesarean births in a random sample of Canadian women: Results from the maternity experiences survey." Family Medicine **42** (Suppl 2).

> Levitt, C., L. Hanvey, **J. Kaczorowski**, B. Chalmers, S. Bartholomew and M. Heaman (2010). "The Canadian hospital maternity policies and practices survey: Comparison of infant feeding policies and practices between 1993 and 2007." Family Medicine **42** (Suppl 2).

> Liu, S., **J. Kaczorowski**, D. Young, M. Heaman, B. Chalmers, L. Lee and S. Dzakpasu (2010). "Effect of maternal characteristics and conditions on primary Caesarean delivery performed on health care provider advice." JOGC **32**(6) Suppl: S34-35.

> Myers, M. G., M. Godwin, M. Dawes, A. Kiss, S. W. Tobe and **J. Kaczorowski** (2010). "Use of automated office blood pressure measurement in routine clinical practice." Journal of Hypertension **28** (June): e14-e15.

Editorials and Letters

> Chalmers, B. and **J. Kaczorowski** (2010, 8 April). "A disappointing study (Al-Sahab B, Lanes A, Feldman M, Tamim H. "Prevalence and predictors of 6-month exclusive breastfeeding among Canadian women: A national survey")." BMC Pediatrics 2010 **10**: 20.

> **Kaczorowski, J.** (2010). "Chronic health conditions and obesity among children and youth." JAMA **303**(19): 1915; author reply 1915-1916.

> **Kaczorowski, J.** (2010, May 29). "1 in 4 adults in Scotland are toothless?" BMJ .

> Keshavjee, K., A. Holbrook, M. Levine, **J. Kaczorowski**, M. Maclure, D. Chan, R. Bernstein, L. Dolovich, M. Green, F. Lau and M. Shepherd (2010, April 6). "Patient safety needs more than e-health." CMAJ.

> **White M. I.** and J. P. Holland (2010, April). Guest editorial: "Approaching neck pain from in a multidisciplinary perspective: A comprehensive approach to an important public health and societal issue." J Occup Environ Med. **52**(4): 421-3.

Reports

> **Bates, J.** and A. Towle (2010, April). "Dean's Task Force on Curriculum Renewal." Final Report to University of British Columbia (UBC). Vancouver, BC.

> Bluman, B., B. Lynn, T. Olatunbosun, C. Wu, **R. E. Martin**, L. Kan and L. Sware (2010). "Primary care physician education and engagement in the promotion of recommended cancer screening in BC: Final report of province wide cancer screening needs assessment." UBC Division of Continuing Professional Development, Faculty of Medicine. Vancouver, BC.

> Bryan, S., J. Murphy, M. Doyle-Waters, L. Kuramoto, N. Ayas, J. Baumbusch, E. Balka, C. Mitton, J. Gray, C. Harrington, J. Globerman and **M. J. McGregor** (2010, July). "A systematic review of research evidence on: (a) 24-hour registered nurse availability in long-term care, and the relationship between nurse staffing and quality in long-term care."The Expedited Knowledge Synthesis Program of the Canadian Institutes for Health Research (CIHR) Commissioning province: Saskatchewan.

> Lee, L., L. Dahlgren, **P. A. Janssen**, **J. Kaczorowski**, R. Liston, A. Synnes, C. Enns, B. Wagner, K. Der, R. McMaster, C. Johnson and T. Pacheco (2010). "Perinatal health report 2008." British Columbia Perinatal Health Program 2010 (member of the BCPHP Surveillance Committee). Vancouver, BC.

> **Martin, R. E.** (2010, March). "Research report."Women's Health Research Institute Board of Directors Meeting. Vancouver, BC.

> McGrail, K., M. Lilly, **M. J. McGregor**, A. M. Broemeling, K. Salomons, S. Peterson, R. McKendry and M. Barer (2010, July). "Who uses assisted living in British Columbia? An initial exploration prepared on behalf of Home and Community Care and Performance Accountability Branch." Health Authorities Division BC Ministry of Health Services. Vancouver, BC.

> Wong, S. T., M. MacDonald, R. K. Valaitis, **J. Kaczorowski**, V. Munroe and J. Blatherwick (2010). "An environmental scan of primary care and public health in the province of British Columbia." Centre for Health Services and Policy Research, UBC. Vancouver, BC. http://chspr.ubc.ca or http://www-fhs.mcmaster.ca/nursing/research_reports.html.

January 1 to June 30, 2010

Presentations

> **Anderson, E.** and C. Lowen (2010, June 18). Evaluation of a youth clinic with a waiver of consent process involving peer researchers. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Belda, P.** (2010, June 18). Improving HIV care in Prince George, BC. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Brcic, V.** and **M. J. McGregor** (2010, June 18). Practice and payment preferences of new residency graduates. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Brcic, V.** (2010, June 18). Addressing poverty in family practice: Benefits, harms, and interventions. UBC Department of Family Practice Research Day. Vancouver, BC.

> Cox, M. B., K. Salomons and **M. J. McGregor** (2010, May). Variation in potential facility determinants of Emergency Department (ED) transfers – A survey of residential care facilities (RCFs) in one large health authority in British Columbia. Canadian Association of Health Policy Research (CAHSPR) Conference. Toronto, ON.

> Desmarais, S., **P. A. Janssen**, **R. E. Martin**, **K. Murphy**, **M. Korchinski** and M. Fairbarn (2010, May). Women's trajectories after release from prison. International Association of Forensic Mental Health 10th Annual Convention. Vancouver, BC.

> Desmarais, S., **P. A. Janssen**, **R. E. Martin**, **K. Murphy**, **M. Korchinski**, A. Granger-Brown, A. Christie, C. Yablonski, **J. Buxton**, A. Macaulay, L. Condello, M. Buchanan and A. Elliott (2010, May). From doing time to doing research: a community-based participatory study of community reintegration among formerly incarcerated women. International Association of Forensic Mental Health 10th Annual Convention. Vancouver, BC.

> **Dharamsi, S.** (2010, April 28-29). International service-learning and ethical conduct: An appreciative inquiry. Dalhousie Conference on University Teaching and Learning: Learning Outside the Classroom. Halifax, NS.

> **Dharamsi, S.**, **J. Osei-Twum**, **R. Tabata**, L. Bainbridge, V. Verlaan and **R. Woollard** (2010, May 1-5). Toward socially responsive medical education and practice: The Community Liaison for Integrating Study and Service (CLISS) initiative at the University of British Columbia. Canadian Conference on Medical Education. St. John's, NL.

> **Dharamsi, S.**, **J. Osei-Twum** and **R. Woollard** (2010, June 10-11). Socially responsible approaches to global health: Some ethical issues that medical students and residents should consider before participating in international service. Medical Education Days for Health Professionals. Vancouver, BC.

> **Donnelly, M. L.** (2010, March 1). Seniors mental health, illness, services and mental health promotion. Health Promotion Class, Faculty of Health Sciences, SFU. Vancouver, BC.

> **Donnelly, M. L.** (2010, March 17). Care of elders incapacity assessment interdisciplinary educational module. VGH Geriatric Medicine Rounds. Vancouver, BC.

> **Donnelly, M. L.** (2010, April 17). Consent and theoretical and practical issues. Physiotherapy Association of BC – Physiotherapy Practice Forum. Vancouver, BC.

> **Donnelly, M. L.** (2010, April 23). Risky choices – Risky behavior. Providence Health Care Annual Health Ethics Conference. Vancouver, BC.

> **Donnelly, M. L.** (2010, April 30). Continuing medical education effectiveness: Small group facilitated case-based learning on dementia. BC Psychogeriatric Association. Nanaimo, BC.

> **Donnelly, M. L.** (2010, April 30). Incapacity assessments. 13th Annual Conference BC Psychogeriatric Association – Updates in Older Adult Mental Health…Meeting the Clinical Challenges. Nanaimo, BC.

> **Grzybowski, S.** (2010, May 21). Measuring rural women's experiences of stress in pregnancy. 19th WONCA World Conference of Family Doctors. Cancun, Mexico.

> **Grzybowski, S.** (2010, May 22). Level of maternity service and population birth outcomes for rural British Columbia, 2000-2004. 19th WONCA World Conference of Family Doctors. Cancun, Mexico.

> **Janssen, P. A.**, A. Henderson and K. MacKay (2010, June). Family violence and maternal mortality in the South Asian community: The role of Obstetrical Care Providers. Canadian Public Health Association Centenary Conference. Ottawa, ON.

> **Janssen, P.** and **M. C. Klein** (2010, February 27). Is home birth safe? A five year study of home births in British Columbia. Mother-Friendly Childbirth Forum and Annual Meeting CIMS (Coalition for Improving Maternity Services). Austin, TX.

> **Janssen, P. A.**, **R. E. Martin**, S. Desmarais, **K. Murphy**, **M. Korchinski** and M. Fairbarn (2010, May). Doing Time: A time for incarcerated women to develop an action health strategy. International Association of Forensic Mental Health 10th Annual Convention. Vancouver, BC.

> **Joyce, D.** (2010, June 18). Screening for developmental delays in primary care using the Nipissing District Developmental Screen (NDDS). UBC Department of Family Practice Research Day. Vancouver, BC. ▸

January 1 to June 30, 2010 (cont.)

> Kaida, A., F. Laher, S. Kanters, D. Money, **P. A. Janssen**, R. Hogg and G. Gray (2010, May). Trends in the incidence of livebirth among HIV-positive and HIV-negative women in Soweto, South Africa: The influence of expanding access to Highly Active Antiretroviral Therapy (HAART). 19th Annual Canadian Conference on HIV/AIDS Research. Saskatoon, SK.

> Keegan, D., M. Sylvester, **I. Scott**, W. Weston, L. Graves, C. Dyck and C. Bernier (2010, May). SHARC-FM: The shared Canadian curriculum in Family Medicine. AFMC-CAME-CFPC-MCC-RCPSC Medical Education Conference. St John's, NL.

> **Klein, M. C.** (2010, February 27). Confusion on the maternity floor! How do attitudes and beliefs of obstetricians, family physicians, maternity care nurses, licensed midwives and doulas differ about little old childbirth? Mother-Friendly Childbirth Forum and Annual Meeting CIMS (Coalition for Improving Maternity Services). Austin, TX.

> **Kuhl, D. R.** (2010, March 26). Difficult and awkward conversations in practice. British Columbia Nurse Practitioners Annual Conference. Richmond, BC.

> Lipsky, N., N. Fairbrother, A. Young, M. Lau, **P. A. Janssen**, M. Antony and P. v. Dadelszen (2010, April). Perinatal Anxiety Disorder screening study. Innovations in Treatments of Anxiety Disorders Conference. Vancouver, BC.

> Lipsky, N., N. Fairbrother, A. Young, M. Lau, **P. A. Janssen**, M. Antony and P. v. Dadelszen (2010, February). Screening for anxiety and depression among new mothers: Implications for care in BC. 10th Annual Western Perinatal Research Meeting. Banff, AB.

> **MacKay, F.** (2010, June 18). Family Practice Well Women's Group medical appointments: The office assistant role. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Mayhew, M.** (2010, June 18). Refugee health care in BC: What facilitates access to general practictioner care? UBC Department of Family Practice Research Day. Vancouver, BC.

> **McGregor, M. J.** (2010, January). Staffing, hospitalization, and consumer complaints in BC's long-term care facilities – Does ownership matter? UBC Division of Geriatric Annual Meeting. Vancouver, BC.

> **McGregor, M. J.** (2010, May). Public, non-profit or for-profit residential care facilities in long-term residential care: Does it matter? International Council For Canadian Studies. Montreal, QC.

> **McGregor, M. J.** (2010, June 18). Complaints in Ontario's for-profit, non-profit and public long-term care homes – a cross-sectional study. UBC Department of Family Practice Research Day. Vancouver, BC.

> Mcintosh, K., **P. A. Janssen** and A. Klein (2010, April). Women with epilepsy and folic acid supplementation prior to pregnancy. American Academy of Neurology 62nd Annual Meeting. Toronto, ON.

> Mehrabadi, A. and **P. A. Janssen** (2010, May). Early hospital admission associated with increased Caesarian section among low risk pregnant women in British Columbia, Canada. International Association of Forensic Mental Health 10th Annual Convention. Vancouver, BC.

> Mehrabadi, A. and **P. A. Janssen** (2010, May). Early hospital admission associated with increased Caesarian section among low risk pregnant women in British Columbia, Canada. Canadian Association for Health Services and Policy Research. Toronto, ON.

> **Norman, W. V.** and B. Fitzsimmons (2010, January 19). Abortion in BC: Trends, services, gaps, opportunities. Women's Health: Practice & Policy Series jointly sponsored by BC Women's Hospital & Health Centre and the British Columbia Centre of Excellence for Women's Health. Vancouver, BC.

> **Norman, W. V.** (2010, June 18). Abortion in BC: Trends, gaps, and opportunities. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Patrick, L.** (2009, May). Is the past present? An international, interprofessional course on health impacts of colonization for indigenous peoples: Report on development of the pilot course at the University of British Columbia. Canadian Conference on Medical Education. Edmonton, AB.

> **Patrick, L.** and N. Miriahi (2009, June). Is the past present? An example of digital humanities. Canadian E-Learning Conference. Vancouver, BC.

> **Scott, I.** (2010, May). Report from the Undergraduate College of Family Physicians of Canada Undergraduate Medical Education Committee—Presented to the National Undergraduate Dean's Meeting. AFMC-CAME-CFPC-MCC-RCPSC Medical Education Conference. St John's, NL.

> **Singh, S.** (2010, June 18). Can a Mobile Falls Prevention Clinic reduce falls and risk of falls in community dwelling seniors? UBC Department of Family Practice Research Day. Vancouver, BC.

> **Tu, D.** (2010, June 18). A chronic care model approach to inner-city HIV care increases care engagement and antiretroviral treatment success. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Tu, D.** (2010, June 18). HIV self-management support for Aboriginal and non-Aboriginal peoples living in Vancouver's Downtown Eastside –The impact on antiretroviral adherance and uptake. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Wiebe, E. R.** (2010, April). The experience of delaying motherhood after age 33 by having an abortion. National Abortion Federation. Philadelphia, PA.

> **Wiebe, E. R.** (2010, June 4). Sex, mood and the pill. Department of Family Practice and Midwifery, BC Women's Hospital (BCWH). Vancouver, BC.

> **Wiebe, E. R.** (2010, June 4). Sex, mood and the pill. Centre for Clinical Epidemiology and Evaluation (C2E2). Vancouver, BC.

Abstracts

> Baradaran, N., S. Hearps, **M. C. Klein, J. Tomkinson** and **J. Kaczorowski** (2010, June 18). The attitudes of family physicians providing intrapartum care vs. those that do not: Does it matter? UBC Department of Family Practice Research Day. Vancouver, BC.

> **Brcic, V., M. J. McGregor, J. Kaczorowski** and S. Verman (2010, June 18). A survey of practice models and payment preferences of recent family medicine residency graduates in BC. UBC Department of Family Practice Research Day. Vancouver, BC.

> Eckland-Jetzer, S., P. Sahota and **J. Kaczorowski** (2010, June 18). A-TIP (After-hours telephone instructions to patients) survey. UBC Department of Family Practice Research Day. Vancouver, BC.

> Heaman, M., P. O'Campo, M. Urquia, **P. A. Janssen** and K. Thiessen (2010, June). Correlates of abuse around the time of pregnancy: Results from the Canadian Maternity Experiences Survey. Society for Pediatric and Perinatal Epidemiologic Research (SPER) 23rd Annual Meeting. Seattle, WA.

> Hearpes, S., **J. Tomkinson**, N. Baradaran, W. Hall, R. Brant, **L. Saxell, J. Kaczorowski** and **M. C. Klein** (2010, June 18). Beliefs and attitudes of Canadain women approaching their first birth: A national sample. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Janssen, P. A.**, M. Urquia, M. Heaman, P. O'Campo and K. Thiessen (2010, June). Postpartum depression after pregnancy: Who is at risk? . Society for Pediatric and Perinatal Epidemiologic Research (SPER) 23rd Annual Meeting. Seattle, WA.

> **Kaczorowski, J.**, L. W. Chambers, L. Dolovich, B. Farrell, B. McDonough, R. Sebaldt, L. Thabane, K. Tu, B. Zagorski, R. Goeree, J. M. Paterson and T. Karwalajtys (2010, June 7-8). Improving cardiovascular health at the population level: A 39 community cluster-randomised trial of the Cardiovascular Health Awareness Program (CHAP). 1st Canadian Stroke Congress. Quebec City, QC.

> **Kaczorowski, J.**, L. W. Chambers, L. Dolovich, J. M. Paterson, T. Karwalajtys, T. Gierman, B. Farrell, B. McDonough, L. Thabane, K. Tu, B. Zagorski, R. Goeree, C. Levitt, W. Hogg, S. Laryea, M. Carter and D. Cross (2010, June 18-21). Improving cardiovascular health at the population level: A 39 community cluster-randomised trial of the Cardiovascular Health Awareness Program (CHAP). 20th European Meeting on Hypertension (ESH 2010). Oslo, Norway.

> Myers, M. G., M. Godwin, M. Dawes, A. Kiss, S. W. Tobe and **J. Kaczorowski** (2010, June 18-21). Use of automated office blood pressure measurement in routine clinical practice. 20th European Meeting on Hypertension (ESH 2010). Oslo, Norway.

> O'Campo, P., M. Heaman, M. Urquia, **P. A. Janssen** and K. Thiessen (2010, June). Prevalence of abuse and violence before, during and after pregnancy in a random sample of Canadian women participating in the Maternity Experiences Survey. Society for Pediatric and Perinatal Epidemiologic Research (SPER) 23rd Annual Meeting. Seattle, WA.

> **Tomkinson, J.**, R. Brant, **J. Kaczorowski**, S. Hearpes, R. Liston, N. Baradaran, W. Fraser and **M. C. Klein** (2010, June 18). The attitudes of the new generation of Canadian obstetricians: How do they differ from their predecessors? UBC Department of Family Practice Research Day. Vancouver, BC.

> Urquia, M., P. O'Campo, M. Heaman, **P. A. Janssen** and K. Thiessen (2010, June). Experiences of violence during pregnancy and adverse pregnancy outcomes. Society for Pediatric and Perinatal Epidemiologic Research (SPER) 23rd Annual Meeting. Seattle, WA.

> Yeung, C., A. Brown and **J. Kaczorowski** (2010, June 18). Defining walk-in clinics vs family practice clinics: A cross-sectional survey of urban family physicians. UBC Department of Family Practice Research Day. Vancouver, BC.

Posters

> Agarwal, G., **J. Kaczorowski**, H. Gerstein and S. Hanna (2010, January 18-19). Effectiveness of a community-based program to increase awareness and detection of diabetes. CIHR Primary Healthcare Summit. Toronto, ON.

> Dolovich, L., **J. Kaczorowski**, L. W. Chambers, A. Miville and S. Laryea (2010, January 18-19). Community-led program integrated with primary care to prevent and control chronic disease. CIHR Primary Healthcare Summit. Toronto, ON.

> Dueck R., B. Hestrin, **W. V. Norman** (2010, April 24). Provincial Pregnancy Options Telephone Referral Service: Ten-year retrospective review. National Abortion Federation Annual Meeting. Philadelphia, PA.

> **Kozak, J. F., A. Mithani** and E. Alzona (2010, May 19-23). Adverse medication events in LTC: Who is screening what? 19th WONCA World Conference of Family Doctors. Cancun, Mexico. ▸

January 1 to June 30, 2010 (cont.)

> Liu, S., **J. Kaczorowski**, D. Young, M. Heaman, B. Chalmers, L. Lee and S. Dzakpasu (2010, June 2-6). Effect of maternal characteristics and conditions on primary Caesarean delivery performed on health care provider advice. 66th Annual Clinical Meeting of the Society of Obstetricians and Gynaecologists of Canada (SOGC). Montreal, QC.

> **Martin, R. E.**, T. G. Hislop, **G. Grams**, **B. Calam**, E. Jones and V. Moravan (2010, February). The evaluation of a cervical cancer screening intervention pilot program for women in prison. Canadian Partnership Against Cancer, Canadian Cervical Screening Collaboration: Sharing Strategies to Maximize Participation in Cervical Screening in Canada Workshop. Montreal, QC.

> **Mithani, A.**, **J. F. Kozak**, E. Alzona and S. Rahim-Jamal (2010, May 19-23). The development of a standardized protocol for medication review in long-term care facilities. 19th WONCA World Conference of Family Doctors. Cancun, Mexico.

> **Norman W. V.**, L. Dicus, M. Lam and B. Gurm (2010, April 24). A multi-culturally validated contraception satisfaction survey for use in studies of women following abortion. National Abortion Federation Annual Meeting. Philadelphia, PA.

> **Ogilvie, G. S.**, M. Krajden, J. Maginley, J. Isaac-Renton, T. G. Hislop, **R. E. Martin**, C. Sherlock, D. Taylor and M. Rekart (2010, February). Feasibility of self-collection of specimens for human papillomavirus testing in hard-to-reach women. Canadian Partnership Against Cancer, Canadian Cervical Screening Collaboration: Sharing Strategies to Maximize Participation in Cervical Screening in Canada Workshop. Montreal, QC.

> **Ogilvie, G. S.**, D. V. Niekerk, M. Krajden, **R. E. Martin**, T. G. Ehlen, K. Ceballos, S. Peacock, L. Smith, L. Kan, D. A. Cook, W. Mei, G. C. E. Stuart, E. L. Franco and A. J. Coldman (2010, February). HPV FOCAL study: Will primary HPV testing change cervical cancer screening participation in British Columbia? Canadian Partnership Against Cancer, Canadian Cervical Screening Collaboration: Sharing Strategies to Maximize Participation in Cervical Screening in Canada Workshop. Montreal, QC.

> Teng F., **W. V. Norman**, U. Malhotra, B. Fitzsimmons, J. Soon, **S. Vedam**, B. Garrett and T. Cessford (2010, June 10). UBC CARES: Computer-Assisted Reproductive Health Education for students: A community needs-based, inter-professional, student-driven collaboration to enhance family planning medical education. 2010 Medical Education Days for Health Professionals. Vancouver, BC.

> **Wiebe, E. R.** (2010, April). Mood and sexual side effects from hormonal contraceptives. National Abortion Federation. Philadelphia, PA.

> **Wiebe, E. R.** (2010, May 20). The experience of delaying motherhood after age 33 by having an abortion. European Society of Contraception. The Hague, Netherlands.

> **Wiebe, E. R.** (2010, May 20). Sexual and mood side effects of hormonal contraception: What do the women tell us? European Society of Contraception. The Hague, Netherlands.

> **Wiebe, E. R.** (2010, June). Mood and sexual side effects from hormonal contraceptives: Comparing Caucasian and Asian women. Asia Pacific Congress on Contraception (APCOC). Beijing, China.

> **Wiebe, E. R.** (2010, June). Asian and Caucasian women delaying motherhood by having abortions. Asia Pacific Congress on Contraception (APCOC). Beijing, China.

Invited Presentations

> **Bates, J.** (2010, May). Lenses for leadership (Invited plenary) Association of Faculties of Medicine of Canada, Medical Education Conference. St. John's, NL.

> **Cave, D. G.** (2010, June 11). Know yourself: Engaging our hearts in health care. Inter-professional HIV Course, University of British Columbia. Vancouver, BC.

> **Dharamsi, S.** (2010, June 17). Global health outreach. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Donnelly, M. L.** (2010, January 29). Integration of services. Vancouver Island Health Authority. Parksville, BC.

> **Donnelly, M. L.** (2010, March 1). Seniors mental health, illness, services and mental health promotion. Health Promotion Class, Faculty of Health Sciences, SFU. Vancouver, BC.

> **Donnelly, M. L.** (2010, April 27). Mental health strategy: Roundtable on seniors. Mental Health Commission of Canada. Ottawa, ON.

> **Donnelly, M. L.** (2010, April 29). International symposium on exercise to promote cognitive health and functional independence. Centre for Hip Health and Mobility Vancouver General Hospital. Vancouver, BC.

> **Horvat, D.**, **W. Clifford**, **E. Anderson** and S. Wong (2010, June 17). Supporting family practice and improving patient care – The roles of Divisions of Family Practice, the Attachment Initiative, developments in practice-based research and the use of EMRs and data. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Janssen, P. A.** (2010, January). Generating new knowledge for best care practices in obstetrics/gynecology. BC Women's Hospital Multidisciplinary Rounds. Vancouver, BC.

> **Janssen, P. A.** (2010, June). Home births, new evidence, new strategies? American College of Nurse Midwives 55th Annual Meeting. Washington, DC.

> **Janssen, P. A.** (2010, May). Maternal child health in the UBC School of Population and Public Health. Child and Family Research Institute Town Hall. Vancouver, BC.

> **Kaczorowski, J.** (2010, January 15). Practice-based research networks: An introduction. Education, Research and Informatics Postgraduate Retreat, Department of Family Practice, University of British Columbia. Vancouver, BC.

> **Kaczorowski, J.** (2010, January 18-19). Canadian cardiovascular harmonized guidelines endeavour (C-CHANGE): An innovative knowledge transfer platform. CIHR Primary Healthcare Summit. Toronto, ON.

> **Kaczorowski, J.** (2010, February 1). Systematic reviews and meta-analysis: An introduction. Academic Half Day, Department of Pediatrics, University of British Columbia. Vancouver, BC.

> **Kaczorowski, J.** (2010, March 4). Abstract writing clinic. UBC Department of Family Practice. Vancouver, BC.

> **Kaczorowski, J.** (2010, March 18-20). Different ways maternity providers and women see normal childbirth. Canadian Society of Obstetrics and Gynecology. Update in obstetrics and gynecology. Banff, AB.

> **Kaczorowski, J.** (2010, April 29-30). Introduction to epidemiology and study designs. Drug Safety and Effectiveness Cross-Disciplinary Training (DSECT) Program. Burlington, ON.

> **Kaczorowski, J.** and **M. B. Collins** (2010, June 17). Diagnostic and screening tests: Yes, no and maybe. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Klein, M. C.** and **J. Kaczorowski** (2010, March 18-20). Different ways maternity care providers see normal childbirth. West/Central CME Program: Update in obstetrics and gynecology, Society of Obstetricians and Gynecologist of Canada. Banff, AB.

> **Klein, M. C.** (2010, May 14). Birth in balance. Midwives Association of Washington State 2010 Spring Conference. Seattle, WA.

> **Klein, M. C.** (2010, May 14). How do attitudes and beliefs govern how we practice? Midwives Association of Washington State 2010 Spring Conference. Seattle, WA.

> **Kuhl, D. R.** (2010, January 11). What dying people want. Social Work Department, Providence Health Care. Vancouver, BC.

> **Kuhl, D. R.** (2010, January 18). Decision making process for complex patient and family issues. Social Work Department, Providence Health Care. Vancouver, BC.

> **Kuhl, D. R.** (2010, January 29). Veterans Transition Program: Therapeutic enactment as an intervention for PTSD. Schofield Barracks, Pacific Command, US Military. Honolulu, HI.

> **Kuhl, D. R.** (2010, March 5). Team care in residential care. Residential Care Services, Vancouver Coastal Health. Vancouver, BC.

> **Kuhl, D. R.** (2010, March 10). Therapeutic enactment as an intervention for trauma. Chicago School of Psychology. Los Angeles, CA.

> **Kuhl, D. R.** (2010, March 15). Guidelines for decision making: Ethical principles and group process. Palliative Care: Medical Intensive Course, Victoria Hospice. Victoria, BC.

> **Kuhl, D. R.** (2010, May 6). Dreams and spiritual autonomy, spirituality: The invisible ingredient in health care. Providence Health Care. Vancouver, BC.

> **Kuhl, D. R.** (2010, May 8). Caring… Manitoba Palliative Care Nurses Association (full day workshop). Winnipeg, MB.

> **Kuhl, D. R.** (2010, June 11). Decision making at the end of life. Roswell Park Cancer Institute. Buffalo, NY.

> **Kuhl, D. R.** (2010, June 11). Facing death, embracing life. Roswell Park Cancer Institute. Buffalo, NY.

> **Kuhl, D. R.** (2010, June 11). Family matters. Roswell Park Cancer Institute. Buffalo, NY.

> **Martin, R. E.** (2010, March). Federal corrections: Mental health and addictions. Standing Committee on Public Safety and National Security. Ottawa, ON.

> **Martin, R. E.** (2010, April). Confines of health. Positive Women's Network 6th Spring Board Conference. Vancouver, BC.

> **Martin, R. E.** (2010, April). Primary HPV testing in a Canadian organized cervical cancer screening program: A randomized controlled trial. Richmond General Hospital Grand Rounds. Richmond, BC.

> **Newton, C.** and L. Bainbridge (2010, June 17). Interdisciplinary research in primary health care. UBC Department of Family Practice Research Day. Vancouver, BC.

> **Solmundson, K.** (2010, April). The role of exercise in the prevention and treatment of metabolic syndrome and Type 2 diabetes. Guest Lecturer UBC Human Kinetics 471. Vancouver, BC.

the BACK BONES

The Bear Bones is published twice a year by the Department of Family Practice Research Office.

This publication is printed by Bond Repro using 50% recycled and 25% post-consumer waste paper.

Spotlight on UBC Family Practice Researchers

Dr. Shafik Dharamsi recently issued *The Health Advocate Role: Preparing Future Physicians for Socially Responsive Practice*, an e-booklet for medical educators, physicians, physicians-in-training and other healthcare professionals. This resource identifies tangible ways in which health advocacy can be integrated into clinical practice as well as medical curriculum.

This document discusses the social determinants of health – providing case examples of health advocacy in practice – and highlights the work of six inspirational health advocate 'champions', including Department members Drs. Vanessa Brcic and Tracy Monk. It also lists relevant literature, teaching approaches and existing programs for clinicians and health professionals interested in learning more about health advocacy.

The research of Dr. Dharamsi and his team – consisting of DFP members Jo-Ann Osei-Twum, Dr. Farah Shroff, Dr. Lisa Mu and Dr. Robert Woollard – was supported by a Faculty Development Initiatives Grant (UBC Faculty of Medicine), UBC Teaching and Academic Growth (TAG), and The Royal College of Physicians and Surgeons of Canada.

For more information about the e-booklet, contact Dr. Shafik Dharamsi:
email shafik.dharamsi@familymed.ubc.ca
website www.familymed.ubc.ca/__shared/assets/HA_ebooklet17625.pdf

Dr. Marc White was part of a collaborative team of rheumatologists and researchers whose paper "Treatment of Very Early Rheumatoid Arthritis with Symptomatic Therapy, Disease-Modifying Antirheumatic Drugs, or Biologic Agents: A Cost-Effectiveness Analysis" was cited as one of "The Top Ten Advances in Arthritis Research for 2009." The publication appeared in Volume 151 of the *Annals of Internal Medicine* and was identified as an important conceptual advancement in arthritis research.

The Arthritis Foundation conferred the honour on Dr. White and his colleagues for definitively establishing that very early intervention with disease-modifying antirheumatic drugs (DMARDs) is a very cost-effective treatment that can improve the quality of life for people with rheumatoid arthritis. The study also provided a strong case for both physicians and insurers that early intervention in RA is essential to mitigate the progression of this disease.

Take part in FMF!

Department members attending the CFPC's Family Medicine Forum are invited to participate in two events on ***Saturday, October 16, 2010:***

6th Annual CFPC Walk for the Docs of Tomorrow | 7:00 am – 8:00 am

The proceeds of this fundraising 5k walk/8k run support CFPC Medical Student Scholarships. Start a team, join an existing team, or sign up as an individual participant. Family and friends are welcome to join.

For more information, contact the CFPC's Research and Education Foundation:
phone 1.800.387.6197 ext. 244
website www.gifttool.com/athon/AthonDetails?ID=1280&AID=1219

History & Narrative: Stories in family medicine | 10:15 am – 12:20 pm

Narrative adds a powerful dimension to many aspects of family medicine. It can help physicians understand their patients' experience of illness, act as a guide to ethical decision-making and be a tool for teaching.

Join a guest speaker and the winners of the 2010 AMS-Mimi Divinsky Awards as they share their experiences of illness and care-giving through stories. A presentation for 2010 award recipients will conclude this event.

The History and Narrative in Family Medicine Program is supported by a donation by Associated Medical Services Inc. (AMS)

the BEAR BONES

Feedback / Suggestions

Is there a topic, profile, or notice you would like to see in an upcoming issue of the Bear Bones? Would you like to receive our Writer's Guidelines to contribute or write an article? Please contact us.

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