

the  
**BEAR  
BONES**

UBC Department of Family Practice Research Office



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**Publications, Grants,  
Awards & Presentations**

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**Burdened Whispers**

*Dr. Amritpal Arora's creative narrative  
explores the effects of domestic violence in the  
South Asian community*

**One-On-One Colleague Interviews**

*The Bear Bones sits down with Community-  
Based Clinician Investigators Dr. Ruth Elwood  
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**Health Research and the Arts**

*Seeing Anew—Discovering Art in Research  
By Debra Hanberg*



from the editors

Eight years ago in the spring of 2001 the Family Practice Research Office published the first edition of *The Bear Bones*. Then Research Director, Dr. Stefan Grzybowski, dedicated the publication “to chronicling the challenges and the achievements of the Department as we organize and build our research capacity and successes.” Naming the publication in honour of the mythic Bear Mother of Haida Gwaii, Grzybowski saw her story as emblematic of the journey he believed family practice research would take over the next years. As well as being the inspiration for the Department’s logo designed by Haida artist Clayton Gladstone, the story of the Bear Mother according to Grzybowski, “speaks to the transformation of a curious and willful young woman into one of the wise elders of the people. The myth resonates with the joys and hardships of growth and transformation.”

Over the past years we have seen research within Family Practice grow and transform by... well not quite mythic proportions but in ways that inspire and bode well for the future. In that first edition, Grzybowski indicated how the Department graduated 45 new family physicians every year with each of them having to com-

plete and present a scholarly research project. That number has since grown to 95 with over 60 presentations (some of them by multiple authors) scheduled for this year’s Research Day (June 19, 2009).



A “nascent” Clinical Investigator (CI) program directed at supporting junior researchers was only two years old in 2001 when it had just “enrolled its fifth and sixth candidates.” Since then 26 physicians have successfully gone through the program with most of the participants working with marginalized and vulnerable populations.

The Department has also witnessed the birth and growth of a unique initiative in Canada—the Community Based Clinician Investigator (CBCI) program—dedicated to supporting mid-to-advanced level clinical researchers. Currently, a CBCI+ program is in development with the intention of creating a continuous stream of research support from residents to senior scholars.

That first edition also spoke to the 500 faculty within the Department as “a huge reserve of untapped potential...with a wealth of clinical experience and a vibrant curiosity.” Now up-

wards of more than 1,400 members, our clinical faculty continue to be a vital source of innovation and wisdom. Their participation will contribute to a new era in primary care research within the province and beyond.

The transformations that have taken place have inspired us to redesign *The Bear Bones* to better embody the current vibrancy, potential, and relevance of Family Practice research. Along with crafting a more contemporary format, graphic designer Michael Nomura has utilized the Bear Mother logo as source material in designing unique elements for the publication. The section tags as well as other abstract shapes are all derived from the Bear logo. In some cases Nomura linked specific aspects thematically to certain sections. For example the mouth of the Mother Bear is tied to “Colleagues,” which comprises personal interviews with related researchers.

We hope you enjoy this edition of *The Bear Bones* as it reawakens with a fresh identity.

#### Cover Image

Electric Company Theatre's *THE SCORE*  
Commissioned by Dr. Michael Hayden and Genome Canada  
Later adapted to film by Screen Siren Pictures and the CBC  
[www.electriccompanytheatre.com](http://www.electriccompanytheatre.com)  
Photo by Tim Matheson

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Debra Hanberg

## Seeing Anew

### DISCOVERING ART IN RESEARCH

When one envisions research, one rarely considers a poem, a play, or a short story—art is not often thought of relevant to the research process. A growing number of health researchers, academics, and scientists from multiple disciplines are however, starting to see the value of blending the arts with traditional forms of research. Departments at major universities such as UBC's Family Practice have implemented Interdisciplinary Art projects into resident curriculum and key stakeholders, such as the Canadian Institutes of Health Research (CIHR) and Health Canada, have begun to fund groundbreaking research that utilizes the arts in health policy development. According to Dr. Susan Cox, health researcher and Assistant Professor at UBC's W. Maurice Young Centre for Applied Ethics, the arts can be integrated "right across the spectrum of research activities" from the development of research questions, to data collection, analysis, public engagement, and policy development. By integrating arts and research, Cox is convinced "you think differently, you think bigger, and you see new things if you employ all of your senses."

Cox offers a concrete example of the benefits of integrating art into research. After conducting a "found poetry" workshop, Cox said a colleague contacted her to say "she tried using found poetry with her research team when they had hit a bit of a jam in knowing how to proceed with their data. It had created a whole new starting point for them and it had sort of freed many of them from feeling stuck in the way that they were trying to analyze their data—it gave them a new insight into some of the things that were most meaningful in the transcripts and really refreshed them and gave them a new starting point."

Dr. Michael Hayden, winner of the CIHR's 2008 Health Researcher of the Year award, affirms the value of combining the arts with research. "If we provide opportunities for researchers and artists to interact the results can be surprising. When artists look down a microscope and tell me what they see...they give me 'new' eyes to re-look at the same picture. I start seeing the beauty of nature, the

patterns of disruption, and start thinking about it differently because an artist has brought their eyes to a particular slide. And so, it's a matter of taking a few steps back and realizing how art can enrich our very scientific activity," says Hayden.

As Director and Senior Scientist at the Centre for Molecular Medicine and Therapeutics (CMMT) in Vancouver, Hayden insisted art be an integral part of the Centre's recently constructed state-of-the-art building, for which Hayden helped raise support. Hayden feels that an art-filled space enriches daily life and provides a nurturing environment that is essential to research activity. He explains that with scientific research there is often failure and the way to resolve that failure is to develop new ways to look at a problem. The presence of art helps Hayden to re-think the way he approaches his research. "Art works in subtle ways," explains Hayden, "it shifts perspectives and it allows you to see and experience the world differently."

First Nations artwork and local photography now hang throughout the halls, offices, and lounges at the CMMT. Hayden draws parallels between First Nations culture and genome research in that they both embrace our relationship to nature and history. "Our DNA is a reflection of the past and a portrayal of the future. We are living fossils, in that we carry the DNA for billions of years." This is why First Nations artwork was a nature choice to complement the Centre's research. It did not, however, come about without "a lot of effort," says Hayden, "people saw art as a luxury and they didn't realize that it can be a critical contribution to successful research."

Hayden also used art to engage Vancouverites in cutting-edge research from the Human Genome Project. In 2000, he collaborated with Kim Collier, Artistic Producer of Vancouver's Electric Theatre Company, to create an award-winning play called *The Score*. The production communicated findings from a fifteen-year, three-billion dollar initiative that produced the first draft of the human genome sequence. The Genome Project is a "big deal," says



DNA—Artist rendering by Osuleo | iStockphoto.com

Hayden, "it is the blueprint of our past and our future."

The play, along with post-performance discussions, allowed the audience to share in the excitement of this momentous achievement. They were transported to a scientific lab to learn about—and engage with—research and results that would normally be limited to scientific journals or academic conferences. "The actors, the storytellers, my students and post-docs, and occasionally me...we were all together on stage. It was terrific—lots of absolutely fascinating discussion that went back and forth," Hayden adds.

Over the past several years, UBC's Department of Family Practice has encouraged medical residents to combine the arts with research in the form of Interdisciplinary Art projects. Creative writing, theatre, film, and the visual arts have been integrated into projects, which often start as qualitative research studies. Dr. Ruth Elwood Martin, Lead Faculty for UBC's Family Practice Postgraduate Residency Program, was instrumental in integrating the arts into resident curriculum. After reading *Developing the Knowledge Base of Family Practice* Elwood Martin became excited about exploring research from alternative perspectives. According to Stange and colleagues, there are four types of knowledge and each one represents a different—but equally "valid and always present"—way of perceiving the world: subjective self-knowledge, collective knowledge based on relationships between people and the community, objective knowledge based on the traditional biomedical paradigm, and systems knowledge.<sup>1</sup> Knowledge generated by research often focuses only a single aspect rather than integrating multiple ways of knowing.

For Elwood Martin, this multiplicity opens the door to alternative forms of inquiry, such as the arts, and knowledge translation. She sees Interdisciplinary Art projects as a valid, albeit different, way of engaging with research, understanding the world, and knowing a subject. In *Knowledge and Art*, Elliot Eisner writes that "works of art enable us to know something about feeling that cannot be revealed in literal scientific statements."<sup>2</sup> Elwood Martin describes the response of one of her colleagues after he saw Yvette Lu's resident production, *Stories from the Closet: A Play about Living with Chronic Illness*. "When he came out of the play he had tears in his eyes and said 'Ruth, now I get it. Now I understand why this kind of work is important.'" The arts allow audience members to connect to the "often invisible and intangible aspects of social life" that are difficult to express in an academic paper, but are present in everyday life and the data gathering experience.<sup>3</sup>

In his resident project and short story *Burdened Whispers*, recent graduate Dr. Amritpal Arora, "garnered a deeper understanding" of the issue of domestic violence through the creative writing process that could not have been captured through traditional research methods alone. Using information collected in both one-on-one and group interviews, Arora crafted the character Simran, a fictional synthesis of his eleven interviewees. *Burdened Whispers* conveys Simran's struggles to provide a caring environment for her son while enduring both emotional and physical abuse. Arora hopes his fiction will help family physicians understand the complex issues facing South Asian women and why it is so difficult for them to leave abusive relationships.

Recognizing the significant role the arts could play in knowledge translation, agencies such as CIHR and Health Canada have moved to fund projects such as the play *Orchids*, as a means to engage public participation and to “move research into policy, programs and practice.”

*Burdened Whispers* was well received when presented at the 2008 UBC Department of Family Practice Research Days and later went on to win the 2008 CFPC Family Medicine Residency Research Award. It was also recently published in *Canadian Family Physician*, which is distributed to all licensed family physicians in Canada, as well as eight hundred individuals, libraries, clinics, and institutions [editor's note: *Burdened Whispers* is re-published on page 14 of this edition of *The Bear Bones*].

Not only do the Interdisciplinary projects draw participants into a subject in ways that traditional research methods do not or cannot do, they provide a means to connect research with audiences beyond scientific communities, health professionals, and academia. Consider *Centering Ourselves as Patients*, a quilt installation project created by former resident Dr. Suzanne Watters and artist Lindsay Zier-Vogel. Their Interdisciplinary Art project explored the dynamics of physician as patient and was featured in a full-page article in *The Vancouver Sun* (May 1, 2008) and later travelled to various hospitals across Canada. Elwood Martin believes that projects such as these have “enormous implications for the health of our patients because they are going to be able to respond to these projects in a way that they cannot with more traditional research.”

For eminent funding agencies such as CIHR, knowledge translation and exchange has become a key focus as the creation of new knowledge from research “often does not on its own lead to widespread implementation or impacts on health. With the increased focus on research governance and accountability from the federal and provincial governments, as well as from the public, it becomes increasingly important to demonstrate the benefits of investment



Photo by Jean-Marie Maillet | Fotolia.com

of taxpayer dollars in health research by moving research into policy, programs and practice.”<sup>4</sup>

Recognizing the significant role the arts could play in knowledge translation, agencies such as CIHR and Health Canada have moved to fund projects such as the play *Orchids*, as a means to engage public participation and to “move research into policy, programs and practice.” Through performances and post-presentation discussions, *Orchids* encouraged audience members and participants to critically examine the ethical, social, and political issues surrounding the use of reproductive genetic technologies. Dr. Jeff Nisker, Professor of Obstetrics-Gynaecology and Oncology at the University of Western Ontario, and Dr. Susan Cox collaborated on *Orchids* to specifically address *preimplantation genetic diagnosis* (PGD), “a controversial method for selecting the genetic characteristics of embryos created through in vitro fertilization.”<sup>5</sup> One of the strengths of *Orchids*, and of theatre in general, is its ability to “provide information and engage ordinary citizens and stakeholders in a stimulating and policy relevant dialogue.”<sup>6</sup> Seven hundred forty-one people attended the play, which was performed sixteen times in Vancouver, Toronto, and Montreal.

*Orchids* offered benefits in terms of knowledge translation as it provided a forum for communication between communities, policy-makers, and researchers. “This is possible because socially aware theatre, when successful, stimulates participatory, critical, and empathic forms of engagement wherein audience members are not passive recipients of in-

formation. They are equipped to reframe as well as respond to the problems presented, to challenge as well as digest various interpretations of what is right or just, and to formulate as well as choose between exiting options for policy development.”<sup>7</sup>

Beyond being just a stage for dissemination, *Orchids* was integrated into a full circle of research activities, including the development and exploration of ethical issues, collection of research data, engagement of the public in dialogue, and reintegration of findings back into health policy development.

Certainly the success of arts-based research projects speaks to their potential, but it also calls to the need for the development of more formalized knowledge translation strategies and evaluation processes. Cox acknowledges there are a “great many unknowns” as much of what is being explored is uncharted territory. Some of the ‘big picture’ questions that are central to assessing the arts in health research include what are the benefits of using arts-based methods? What is unique about using them in a research context? And, how can arts-based methods help make better policy or improve the health of Canadians?

Growing recognition of the place for arts in health research does bode well for its acceptance and integration into mainstream research despite the reluctance of more conservative elements. Hayden insists that if the arts are going to become an accepted part of the research milieu, “we need to elect or appoint people that are willing to stand up for it and we need enough people like me saying this is important—in the end, we will be better scientists and better physicians for it.”

## References

1. Stange KC, Miller WL, McWhinney I. *Developing the Knowledge Base of Family Practice*. Family Medicine; 2001, 33(4), 288.
2. Eisner E. “Knowledge and Art,” *Handbook of the Arts in Qualitative Research: Perspectives, Methodologies, Examples and Issues*. Eds. J. Gary Knowles and Ardra L. Cole. Los Angeles: Sage; 2008, 8.
3. Leavy P. *Method Meets Art: Arts-based Research Practice*. New York: Guilford Press; 2009, viii.
4. April 23, 2009 <<http://www.cihr-irsc.gc.ca>>
5. Cox SM, Kazubowski-Houston M, Nisker J. Genetics on stage: Public engagement in health policy development on preimplantation genetic diagnosis. *Social Science & Medicine*; 2009, 68(8), 1472.
6. Cox et al, 1477.
7. Cox et al, 1479.

## HEALTH RESEARCH & THE ARTS RESOURCES

### Upcoming Events

An “arts-based methods in health research exploratory workshop” will be held at the Peter Wall Institute of Advanced Studies (UBC) from November 20 to 22, 2009. It will be preceded by an arts-based event that will display and/or perform found poetry, drama, visual arts and song all arising from a pilot project utilizing data from interviews with human subjects in health research. There will also be a public component to this event.

*For further information contact:* Dr. Susan Cox  
suecox@interchange.ubc.ca | 604.822.0536.

### Books

- Knowles, G.J., Cole, Ardra L. (Eds.). (2008). *Handbook of the Arts in Qualitative Research. Perspectives, Methodologies, Examples and Issues*. Los Angeles: Sages Publications.
- Cahnmann-Taylor, M., Siegesmund, R. (2008). *Arts-Based Research in Education. Foundations for Practice*. New York and London: Routledge.

### Journals

- The Canadian Creative Arts in Health Training and Education Journal (CCAHTe) [www.cmclean.com](http://www.cmclean.com)
- Arts & Health  
[www.thesah.org/template/page.cfm?page\\_id=445#Issues](http://www.thesah.org/template/page.cfm?page_id=445#Issues)

### Websites

- History and Narrative in Family Medicine  
[www.cfpcstories.sydneyplus.com/CLFM/Portal.aspx?lang=en-US](http://www.cfpcstories.sydneyplus.com/CLFM/Portal.aspx?lang=en-US)
- National Network of Arts in Health Canada (NNAHC)  
[www.artsinhealth.ca/](http://www.artsinhealth.ca/)



## Dr. Ruth Elwood Martin

**FAMILY PHYSICIAN & COMMUNITY-BASED CLINICIAN INVESTIGATOR (CBCI)**

Ruth Elwood Martin is a family physician with an interest in community-based participatory research, which originated from her part-time medical practice in BC prisons. She is the Inaugural Director of the Collaborating Centre for Prison Health and Education, which seeks to nurture university-community-prison engagement. Ruth is the lead research faculty for UBC Department of Family Practice postgraduate program, in which family practice residents create scholarly projects that further the knowledge base of family medicine. Ruth is also a co-investigator on the CIHR funded HPV-FOCAL study (a randomized controlled trial to evaluate HPV-testing as a primary screening tool) and the College of Family Physicians of Canada project, “Giving voice to the stories of family medicine.”

**TBB:** Can you tell us a bit about the research that you are doing for the Community-Based Clinician Investigator (CBCI) Program?

**REM:** The main work that I am doing is community-based participatory research, focusing on women’s health in prison. It’s part of a continuum. I started work in prison in 1994 as a family physician, just going into one or two clinics a week, either in the women’s prison or the men’s prison. I found the work as a prison family physician generated a ton of questions, along the lines of, “How on earth can we improve health in prison?” Over the years, I started to look at some clearly defined things, such as cervical cancer and cervical dysplasia and how to improve pap smear screening in prison. But in 2005 I took a course on action research, and realized that participatory research (PR) was an

effective way to engage people who are otherwise disadvantaged in the research process. So I embarked on the process of PR in prison back in 2005 and then, subsequently, was awarded the CBCI award, which enabled me to spend more time on the project.

**TBB:** What are you hoping to accomplish?

**REM:** That is a very interesting question. Participatory research is unlike a regular research project where you have a defined question at the beginning and you have a longitudinal linear track and you come out at the end with your questions answered. This process, for me, has been much more circular or iterative so even the question, “What am I hoping to accomplish?” has many layers and many complexities to it. At a personal level, I hope that my role in this would be

## colleagues

This process, for me, has been much more circular or iterative so even the question, “What am I hoping to accomplish?” has many layers and many complexities to it.



(left to right) Dr. Patti Janssen, Dr. Ruth Elwood Martin, Jennifer McMillan, Mo Korchinski, Carrie Smith, Kelly Murphy / (opposite page) Photograph by Martin Dee

to facilitate others in the process of PR. My long-term vision is, as a result of all of these processes, that there would be more opportunities in prison settings to engage in this kind of participatory approach to health promotion so that there would be more hope amongst prisoners. I am realizing how powerful PR is as a mode of engagement in research and so I see myself a little bit as a pioneer in this mode of engagement. I would hope then I am opening doors for people to see what is possible.

**TBB:** What is possible?

**REM:** Well it has blown me away to see how excited people get by being involved in this process. People who would normally be considered as subjects of research projects, when you invite them to be co-researchers and co-participants, have phenomenal expertise and wisdom to contribute to the process, so by doing that then they are af-

firmed in their expertise. What becomes possible is knowledge exchange: I find I am learning everyday in the process, as they are learning a bit from the academics. The process of collaborating and sharing that knowledge is win-win all round. So when you say “What is possible?” I think that all those kind of things are possible but you have to believe that they are possible, that there is a sense of a leap of faith or hope, that it is actually possible. It takes time.

**TBB:** You mentioned that you are learning from each other, what are you learning?

**REM:** I think there is something about being a family doctor where you feel that you have learned an awesome amount because you are listening to people’s stories all day long. As a family physician if you have seen twenty people in an office—say, three otitis medias and five pharyngitis and some plantar warts—you may think at the end

of the day that you are not learning very much. But, in fact, if you actually listen to the narratives of the people that come with those conditions, you are learning a lot about the human condition, about resilience, about how to cope with adversity and you become changed by those encounters. Participatory research for a family physician researcher is almost a natural extension of what you are doing in a family practice office. I am learning so much more about health and what health means and so much more about the potential for healthcare practitioners to be involved in a different role. For example, today I was giving grand rounds at BC Centre for Disease Control (BC CDC) on blood-borne infections in prison. In the past, I would have just given that presentation myself. This time I invited one of our community-based participatory researchers from Women in2 Healing to come along with me. So we gave the grand rounds together. We purposefully left a lot



Image sourced from Stock Exchange

of time open for questions. The answers that Jen gave from her lived experience were far more profound than my perspective as a family doctor. In fact, people from the audience would ask Jen the questions more than me.

Every time I listen to a woman who has come through the process and is now engaged in this PR project I find myself in awe about where they have come to and the things that they share and the expertise that they have. The things I am learning are probably more at an interpersonal level or a personal level than at an academic level but it has also impacted my academic work as well.

**TBB:** How so?

**REM:** Well I do not think I will ever be content with doing traditional research again. There is always that element of me that wants to engage the participants. And I think it has also impacted the way I approach many things in life now. Even department meetings, I see things that should be more circular instead of hierarchical. And, my approach to family medicine would embody more a health promotional kind of engagement of the community rather than a hierarchical doctor-patient kind of relationship.

**TBB:** You mention expertise. Can you expand on the expertise of the community researchers?

**REM:** I think a lot of the writing talks about lived expertise or lived experience. Coming back to the BCCDC Grand Rounds last week, if the audience wants to understand what it is like for somebody living in a prison situation, what it is like for prisoners trying to access health care or trying to get treatment for their Hepatitis C or their HIV, what it is like to be released from prison with nothing, we can only imagine it because we have not been through it. But, the people who have actually lived through that themselves, they are the experts. But not only that, they have also become experts in advising us on how to approach people in prison. They have the expertise to be able to tell us “In your educational campaigns you should be doing it this way” or “In your research projects you should be doing it this way”. I remember when we were pulling together our CIHR grant, the third time we were applying to CIHR – just before the deadline for the proposal – we realized there was a certain glitch and we were not going to get the permission from the Corrections to continue PR inside prison. And I remember that Patti Janssen and I were just horrified that all

this would come to naught. I said, “You know we should go and consult with the women in the Women in2 Healing office because there are women now who have been released from prison who actually know”... so we went down and said to the women, “Look, how can we modify this design so that it will actually work now?” We spent about an hour brainstorming through the details of the CIHR design and we re-wrote the grant application based on their input and that was the one that went on to be successfully funded.

**TBB:** I am going to step back a bit. Could you define what Participatory Research is, how it works, and the context in which you are working?

**REM:** There are various different names in the literature for PR. Sometimes it’s just called participatory research (PR), sometimes community-based participatory research (CBPR), sometimes participatory action research (PAR). CBPR was the name that, I think, Anne McCauley at McGill coined and the name CBPR has actually been used a lot in the States. People, I think, mistakenly think that PR is the same as qualitative research, but it’s not. PR can involve mixed methodology, so it can involve quantitative and/or qualitative methodology. The key is that PR engages community members in the processes of asking the question, designing the methods, gathering the data, analyzing the data, interpreting the data, and disseminating the results. The community participants are engaged, as equal but different members, in all aspects of the process. In practice it’s actually very difficult to ensure that that happens, but at the table, all members are considered equal. We acknowledge that people bring different gifts— diverse gifts, to that table.

**TBB:** And how is it manifesting in your own context? Can you talk about your own projects?

**REM:** Yeah, so the project inside the prison... I guess I will backtrack. The definition of ‘community’ is varied so as you look at PR across different countries, and different areas. ‘Community’ could be

people brought together with a single purpose, or people brought together by a single ethnicity, or people brought together because of location. PR has not really been done in prison before, but you could look at prison as a community, in some way. Ideally, when we started doing that project I had this ideal notion that the academics, the prison staff, the inmates, the administrators, and the policy-makers would all be at this table, on an equal footing. As it rolled out that became less practical I guess. But I think what continued was the sense that the women in prison were themselves driving that research and that they were equal players with the academics. That project went on for two years and so we are now publishing, finally. We have got one article coming out this June and one in December looking at that data and we are still writing stuff up from that data. The women are co-authors of those publications.

**TBB:** What are the benefits of PR –with prison populations and in general?

**REM:** PR benefits the whole process. Ultimately when you are asking a research question, and you are collecting the data, and you are doing the analysis, and you are getting the results, then you actually want to feed the results back to somewhere in order to improve health. However that is often where the breakage happens in traditional research. You do not get the feedback and you do not get the uptake, so you do not get the knowledge translation and the knowledge uptake by the people who are researched in the first place. With PR that process is built into the system. The ‘subjects’ of the research are actually participating in the research so they are learning about the results as they are going along. In the process, they are changing so you are getting action that is happening in the process. That is one of the big things. For the prison population itself, if you have got people engaged in this then they themselves are being changed by the process just through that engagement. The other women in prison who are, perhaps more peripheral to it, are being given hope because they can see their peers are engaged. You have, almost like an onion,

different layers of engagement. You then have vicarious involvement of the community agencies because they are also being impacted. They are there to serve this population in various capacities, whether or not it’s on the Downtown Eastside or in various parts of the province. They see that women in prison are being engaged in this work and then they are encouraged, seeing that it is beneficial. Ultimately, what we would love to show is that it has an economic benefit to society and then it will influence policy in the long run.

**TBB:** Are there other areas of health care that you see the participatory approach being helpful to or is it all of the above?

**REM:** I think all of the above. Ideally, the process of PR does three things: it builds new knowledge that is relevant to the community engaged in the research; it builds capacity (skills, education) amongst all members engaged in the research; and, it results in action, change and, ideally, improvement. For example, colleagues across the country involved in PR talk about how PR resulted in designing health centres and healthcare units. There is an example –I am not sure if they call it PR but it would certainly be a community development endeavour– of starting up a health centre in Abbotsford for street workers and it’s completely designed on the advice they have got from their clients. In Saskatoon a PR project among homeless people has helped to shape the nature of their healthcare centre. In Mount St. Joseph’s Hospital at McGill they are looking at PR involving adolescents and street youth and getting them engaged in developing the survey.

Interestingly, I was reading *The Audacity of Hope* by Barack Obama and he writes two pages on how he engaged with troubled youth in Chicago when he was a Senator. There is a lot of distrust amongst the youth, so he sent staff there to engage the teens in developing their own survey, with which they then surveyed the other youth, their peers. When Obama came to visit they talked with him about the survey results and about ways that they

could more forward. There are all sorts of areas in which PR could be used.

**TBB:** Do you see this as having impact on other aspects of clinical practice?

**REM:** Yes, I do because there is a real sense that...okay I am being really frank here, ...I think the model of fee-for-service primary care is really obsolete and that actually what we should be looking at is a community-oriented primary care (COPC) structure where we, as healthcare providers in an interdisciplinary setting, are actually providing care to a defined population or community. And you can actually engage the members of that community or population, because you know who they are, you can engage them in helping to shape what their health care or health provision should look like. I am really excited when I see examples of that working in the world –community-oriented primary care– because I think that is the model that we should be aiming for. So I guess people might tend to slot PR into the prison medicine world but actually I see the lessons of PR being really applicable to primary care delivery.

**TBB:** And where are these successes?

**REM:** There are various publications that describe it (COPC) in other countries, but I see, for example, the Mid-Main Clinic (Vancouver) and the Fraser Lake (BC) Community as working in a small way towards that. So we have examples around our province that give us an inkling of what is possible.



## Dr. David Tu

### FAMILY PHYSICIAN & COMMUNITY-BASED CLINICIAN INVESTIGATOR (CBCI)

Dr. David Tu is a family physician and current Clinic Coordinator for the Vancouver Native Health Clinic. He is the current recipient of a Vancouver Foundation (BCMSF) Community-based Clinician Investigator Award; Co-Program Director for the UBC R3 Enhanced Skills Residency Program in International Health; Clinical Assistant Professor in the UBC Department of Family Practice; and Clinical Associate at St. Paul's Hospital's HIV ward. His research interests include HIV care in conflict affected regions and HIV care for urban Aboriginal People.

**TBB:** Can you take a moment to introduce yourself and tell me about your research with the Community-Based Clinician Investigator (CBCI) program.

**DT:** The project that has been the focus of support from the CBCI program is called CHCNUP, which is an Ojibway word meaning “to look at more closely.” But it is also an acronym that stands for “Complete HIV Care for Native Urban People.” CHCNUP is focused around people living with HIV in the Downtown Eastside about half of whom, who we see at our clinic, are Aboriginal. Each year we have been seeing between five and ten percent of the people we were following with HIV dying, which is the same rate of people dying as I was experiencing when I worked in the Congo... So something is clearly wrong when you have a resource rich country having levels of mortality equivalent to the Third World. Something, in our approach was clearly off.

Part of what I saw going on was that the system was top down—a very classic medical model of physician directing care towards a patient and treating HIV like other infectious diseases. And infectious diseases are really things you look to treat and cure with antibiotics. However, HIV is unique somewhat amongst infectious diseases in that it is a chronic infection—it's not curable, it's manageable. And just intuition and knowledge of this community and how we were approaching things said that we needed a new model.

I think the project is unique in that we went about finding a new model in a slightly different way. Certainly there was a look at the literature and the move towards chronic disease management... what was different was that, right from the start, we actually had a Community Advisory Committee made up of about fifteen people all living with HIV who had been long-time clients of ours. So right from the beginning, we were

able to bring them on board and say, “What makes sense? How do we need to change things?” ... we meet every six months as an official committee, with a lots of ad hoc things along the way, but in terms of formulating the initial proposal for this project, we had a lot of community input and that has really shaped what the project is like today.

**TBB:** You were with Doctors Without Borders and now you are a physician with the Native Health Society, what made you decide to go down the research path?

**DT:** “Why research?”—the kind of research I'm interested in is quality improvement research, which has a lot to do with program evaluation and interventions to

make things better. So when I started to work here and took over as the Director I wanted to know okay, so how many people are we treating? What are our retention rates? What's our level of uptake of anti-retroviral? What's our satisfaction amongst our users? And none of those questions could be answered. There just was not that infrastructure in place. And these are just things that, I think, should be done as part of managing the healthcare system. And to make those things happen I really had to do it under the guise of research. So a lot of the research I do is just really good program management, but with the added step that once you actually assess the quality you see deficiencies.

I also want to make things better and, actually, that's what quality improvement

## colleagues

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research is all about. There is a cycle of evaluating, reflecting upon where you are at, making an intervention to see if it makes sense, implementing it, and then going back to evaluating it. So that cycle of research, if you like, just seems like common sense.

**TBB:** I know that self-management is an important aspect of your research and HIV care; can you define it for me and tell me how it works with a person who comes into the clinic?

**DT:** Our intervention is a modified version of the Chronic Disease Model adapted to HIV as a disease and for a population of marginalized people, many of whom are Aboriginal. There are really four pillars to the Chronic Disease Model as it is traditionally applied. One, is having an information system where you can track... For HIV there are things such as uptake of antiretroviral, rate of virologic suppression with treatment, but also things such as engagement with monitoring, screening for other infections, not to mention social things such as housing, drug use, mental health. Those are all things that are part and parcel.

Second is having a set of clinical guidelines that clinicians can use that are embedded in the system of monitoring. Like a flow sheet model that actually gives people guidelines as to what should be done so you can standardize the care and bring it up to standards of evidence.

The third part is actually getting the whole team organized in such a way that there are common goals being sought after... The fourth part is self-management... From



Original artwork by T. Jones



Dr. David Tu with community-based peer coaches at the Vancouver Native Health Society. Photo by Sharon Mah

the very start we have had peers involved in defining all of those things, as well as peers involved in sort of intensive case management.

So the first year we spent just getting our house in order. We recognized that the biggest challenge was going to be how to create a system of self-management support. Again, from my experience of working overseas where human resources are probably the biggest limiting factor, I realized the power and importance of peers, especially peers living with a stigmatized chronic disease.

As well a lot of marginalized people suffer from lack of voice—particularly because of isolation, lack of ability to articulate those needs, or the inability of people to listen to those needs. Particularly true amongst Aboriginal people, historically as well as today, a lot of people suffer from voicelessness. And that's from distrust of the system, an unsympathetic system perhaps. One of the other things from a social

justice perspective, was to give people a greater voice in their healthcare—not only because of the intrinsic value of that but also to actually improve the quality of the health system. We really wanted to have a peer-involved patient self-management program. There has been no real precedent for that in the world of HIV, specifically in marginalized populations.

**TBB: Can you give me a difference between the two systems? Maybe how it might contrast with regular management?**

**DT:** It's been a long process actually to come up with a system of self-management that we think is appropriate. Now we are engaged in a randomized controlled trial comparing the impact of a peer-led system of self-management support against a medical professional coached self-management support to a control group. Again our main outcome we are looking at initially is uptake and adherence to antiretroviral, which is something

that is relatively easy to measure. We are hoping that there will be value in having a self-management program and we are looking at it also from an ethnographic perspective.

Most HIV care is centered on their healthcare provider, usually their doctor but often a nurse. It is very much a traditional medical model: you have a problem, you try to solve that problem; this is what your blood work shows, you need treatment, okay let's try to provide you treatment. Self-management is a completely different paradigm. It embraces the notion of patient-centric care and takes it to the next level, where really the encounter is based around coaching as opposed to healthcare provision. Actually it's much more in keeping with the traditional Aboriginal model of a health provider, who walks along the path of someone's life, as opposed to someone who is providing direction and telling another where they should go.

So a coaching session begins by asking someone to identify what the major problems and the major issues are that they feel they need to address and they may be something completely different from the agenda of the healthcare provider. When you ask people what the greatest problems are, even if you frame it around being related to the HIV infection, the most common responses have to do with homelessness, lack of employment, depression, anxiety, addictions, and past history of trauma. We did focus group work on this previously to try and identify what people's major issues were. But then self-care management says that okay, this is your problem and then clearly tries to help people to define that problem and makes sure that it is something that they are passionate or really motivated to work on. And then it just takes them through a process of "What small step can you take?" or "What change would you like to make to improve that problem?" You are just asking questions and it's the person that you are coaching who is providing all the answers... it's amazing how fast things can change when someone is supported and motivated, but eventually their HIV infection does become an issue and there are steps that start to get taken.

**TBB: Are there peer coaches as well? Can you describe their role?**

**DT:** We actually had training sessions over the fall where we mixed thirteen HIV positive peers—all people we knew well that had a lot of experience of living with their illness and were at a stage in their life where they wanted to help others—with fifteen physicians and nurses. We actually did a set of workshops on self-management and it was sort of a bi-directional coaching, where the health professional was being coached by the peer and the peer was being coached by the medical professional. It was a great social experiment. And so these same thirteen people who were trained in the fall are now our team of peer coaches.

Next we start enrolling participants. The participants have been randomized to one of the three groups. The actual coaching

is to start over the next couple of weeks. The research side is also run by community research assistants who are five individuals who are also peer coaches and who have worked to help us to develop the survey we are using to measure knowledge, confidence, and social circumstances related to their HIV, but as well are primarily responsible for the informed consent process. So there's community involvement on the research side and peer involvement on the coaching side.

**TBB: You speak about the two-way learning process, can you talk about what the physicians learned, what they gained from the process?**

**DT:** So it was the training workshops in the fall; we got very positive feedback and it was testament to the group of physicians, nurses, social workers and counselors that are here at the Native Health Society that they embraced it and they were willing to switch roles. It's hard for me to speak for everyone. I can speak from my own experience of being coached. Personally it was very useful. My coach has a lot of life experience and is nothing if not a true survivor and was attuned to recognizing and identifying some of the problems in my life. One of the things he honed in on was the inability to say no to requests, to be involved in things and take things on and what kind of impact that was having on my life in terms of how stressed and how run ragged I had been at the time and it was just a process of myself actually turning to an action plan to try to limit that behaviour. Again, the first action plan we did, I was going to say no to all requests between November and early January, anything new I either had to say I would take on later or just say no to outright. Again very helpful.

**TBB: Was it successful?**

**DT:** Relatively. Change takes time. Baby steps. But it was very interesting being accountable to my community coach. But, again, you can see how the model of change actually works, knowing that someone is invested—that someone else is involved in the change you are going

through—and that's very powerful. The experience of someone who has lived and survived on the street, through drug addiction, through a stigmatizing disease, through the prison system, there's a lot that people who've lived through that process can offer society as a whole. He certainly had something to offer me. Again part of this is creating opportunities for these people who want desperately to give back and to help others. More so, the whole structure of the program is to centre it on the participant and to give voice to that participant.

**TBB: What do you hope comes of the research?**

**DT:** What I want to happen, just from a program level, is that the research shows that peers are effective in terms of coaching—justifying people investing in peer coaching for HIV. And that, in turn, leads to a sustainably fundable program, supporting peers to coach those that are most in need of coaching and most vulnerable. From a research perspective I'm really hoping that this team of researchers that we have invested in is really going to be able to serve the Vancouver Native Health Society and this community by actually being involved in the next and the next and the next research project. That they actually become co-investigators on projects and ideas and initiation of new things are coming from this group. Again we have created a structure where people can have the skills and have a voice to be in a position to be heard, to make something happen. I do not exactly know what is going to happen next, what the next project's going to be, but I'm hoping more and more that the ideas for new projects are going to come from the individuals that we are working with now. And that they will be hired to help actualize these projects, to put them into reality.





In the past few years, there have been numerous high-profile cases of domestic violence in the South Asian community of British Columbia. These cases have led to an increased focus on an oft-neglected subject. Research in this area, although scarce, has shown a complex interplay between patriarchy, cultural expectations, and a desire for autonomy.

As a part of my residency in family medicine, I decided to explore the effects of domestic abuse on South Asian women in British Columbia. The intent of this exploration was to develop a better understanding of their experiences, coping strategies, and possible barriers to seeking support. Eleven South Asian women who identified themselves as victims of domestic abuse were interviewed in a combination of one-to-one and group interviews. Circumstances around the

abuse, their methods of coping, and the effects it has had on their lives were discussed. They were also asked about the support available to them and possible barriers they faced in accessing this support.

Common themes from the interviews were analyzed and used as inspiration to produce a work of fiction. I hope that this piece will provide family physicians with insight into the unique struggles faced by South Asian victims of abuse and serve as an impetus to identifying and supporting women at risk.

I would like to extend my sincere gratitude to the women who participated in this study. Their immeasurable courage and strength made such work possible.

# Burdened      W   H   I   S   P   E   R   S

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Amritpal Singh Arora MD CCFP

Simran's head is heavy, like she is 5 again, wearing Papa Ji's starched blue turban; the first and last wraps form a perfect point resting on the bridge of her nose. She sits by her son, Karan, who sleeps to her left, his lips dry from allergies that have rendered him a mouth breather. Simran's hand continues to move up and down her son's back slowly, even though he has been asleep for hours. Each stroke slow and deliberate like that of a painter putting the final touches on her greatest work. She reaches with her free hand to untie Karan's patka. She begins by unravelling the head covering's strings from his top knot and then untying the knot at the back of his head. She removes his patka and softly rubs his forehead along a line defining the patka's end seam, tanned skin below, smooth and milky white above. The line, like her life she thinks, varies greatly with the season. At times it is sharp and clearly in focus. At times it is blurred, barely distinguishable from its surroundings.

The pain from the beating begins to subside. The sounds of Mohan's snoring filter in from the adjoining room and throw salt on Simran's wounds. He sleeps peacefully. She will not share his bed tonight, nor will she tomorrow. He will ignore her, carry on not as if she had never existed but as if he had suppressed her like an unpleasant thought brewing in the deep recesses of one's mind. By the third night, guilt will compel her to return to him. She will adjust to fit his curves, put her hand on his shoulder and whisper apologies in his ear. He will acknowledge them with a pat on her head, roll over to his side and fall asleep. Such is the game they play, she thinks as she rubs the bruises on her forearm.

Simran looks to her son, his thin chest rising and falling with every breath. One leg protrudes from underneath his covers, his body not fully convinced of the departure of fall, the beginning of winter. "What began with your conception," Simran whispers, "did not end with your birth." She thinks back to the pregnancy and the first time Mohan beat her. It was 4 months into their marriage, 2 months into the pregnancy. Nausea had prevented Simran from having a hot meal ready on Mohan's arrival from work. He beat her with his belt, then with his shoe. She remembers being on her knees and against a wall, covering her belly with her hands, accepting blows on her face so as to protect the child that grew inside her. She remembers the apologies that followed and their convincing sincerity. Most of all, she remembers the feeling of guilt that plagued her: she did not have dinner ready in time. If one looks closely, one can still see the scars from that beating. They serve as small, measurable reminders that greet her every morning. What one cannot see, however, are the far larger scars Simran carries within her. They stem from more penetrating wounds, such as having to beg for rides to prenatal appointments, giving birth without a hand to hold, and the realization of continued beatings despite producing a son.

A thick fog declares itself as it moves in from the Pacific and blankets Vancouver. Moonlight navigates through and



Photo by Ronnie | Fotolia.com / (previous page) Photo by T. F. Miracle | iStockphoto.com

shines tepidly in Karan's open window. A slight breeze drifts in and dilutes the stale air. Simran closes her eyes and travels inward, wading through her own fog as she escapes to a place of solitude. She journeys to that temple within her, seeking shelter from the harsh realities of her life. Here, there are no prospects of midnight beatings, no need for sunglasses when there is no sun. There are no monitored phone calls and finances, no mixture of sweat and cheap cologne assailing her nostrils. This sanctuary, whose foundations were laid before Simran's wedding henna had faded, is far from public humiliation and the silent tension that follows. She does not have to worry about walking 2 steps behind Mohan when she is here.

Yet her escape is often fleeting. Long enough to perhaps catch a glimpse of Papa Ji reading the paper with his cloth thata tied so that his beard remains in shape. Smells of Mata Ji's mesi parathay may drift into her room and whisper for her to wake up. She may hear the night chaunkidar's stick scrape across the concrete as she lies with Mata Ji on the terrace to take advantage of a slight summer's breeze. On the rare occasion, she can get away long enough to allow a conversation. She may be able to squeeze in a hymn at the Golden Temple or even enjoy a plate of Blue Fox's famous chilli chicken.

Tonight her mind is in Dharamsala, and she remembers skipping down Temple Road with her new pashmina-type

shawl on her shoulders. Papa Ji and Mata Ji walk behind her, cautioning her to slow down, worried about her tripping and ruining her salwar kameez. The aroma of steamed momos fills the air. Tibetan women sit roadside selling jewelry to free-spirited Europeans who have come for the cheap drugs, to find themselves, or a bit of both. Monks in their maroon robes chat as they sip butter tea at roadside cafes. Tibetan elders out for their morning walk greet Simran with toothless smiles, folded hands, and an enthusiastic "Tashi Dele."

Simran yearns to be there again with her parents. She imagines Papa Ji lifting her so she may spin a Tibetan prayer wheel. She hears Mata Ji recite "Waheguru" as she spins each wheel, combining the blessings of both Buddha and Nanak. She tastes the laichee in the chai from the self-proclaimed "best tea stall in Asia" on Jogibara Road. She laughs as Papa Ji strokes his mustache after each sip. Most of all she remembers a sense of contentment, the ability to breathe freely without the heaviness in her chest.

Sounds of Karan stirring bring Simran back. The night has grown much colder. Simran moves to close the window. She adjusts the blanket to cover Karan's outstretched leg and smiles at how his top knot has loosened and now lies limp and off centre. She gets a second blanket from his closet, rolls up a towel from his bathroom for a pillow and settles in beside Karan, moving carefully so as not to wake him. She

She closes her eyes but the mental images do not stop. Her mind is restless, and her thoughts travel from the mountains of Himachal to the fields of Punjab. Images of her wedding day begin to traverse her mental screen...

closes her eyes, knowing full well that she will not sleep. She closes her eyes but the mental images do not stop. Her mind is restless, and her thoughts travel from the mountains of Himachal to the fields of Punjab. Images of her wedding day begin to traverse her mental screen...

She sits cross-legged on the floor of the Gurudwara. Extravagant patterns of henna cover her hands and feet. Her heavily embroidered red duppatta is pinned so as to keep her hair covered. Panjeban delicately caress her ankles and match the numerous bracelets that cover her forearms. Large gold earrings hang carefree from her ears, almost brushing her shoulders. Mohan sits to her right, dressed in a cream-coloured kurta with a Chinese collar and resham embroidery. Close friends and family sit in quiet anticipation and watch as Papa Ji takes one end of the cloth hanging from Mohan's shoulders and moves to place it in Simran's hands. In doing so, he prepares to absolve himself of his responsibilities and place Simran's well-being on Mohan's undeserving shoulders. To mark this transfer, the Ragis, musicians with matching turbans and long flowing beards, sit on a stage and sing the appropriate hymn:

I have discarded praise and slander, O Nanak; I have abandoned everything. I have seen that all relationships are false, and so I have grasped hold of the hem of your robe, Lord.

Simran takes the end of the cloth from Papa Ji and lowers her eyes...

As she thinks back to that day, she recalls the happiness in Papa Ji's eyes. His eldest daughter was moving to Canada and marrying a successful man from a reputable family. "A father could ask for nothing else," he would repeat as he greeted well-wishers. The burden of having 3 daughters had clearly aged Papa Ji beyond his years. Three daughters meant 3 characters to keep pure, 3 sets of in-laws to please, and 3 dowries to assemble. Papa Ji carried this burden with his head high, Simran proudly remembers. He acquiesced to all of Mohan's parents' demands and went out of his way to



Photo by Nimbus | Fotolia.com

please their guests; all in order to maintain the family's izzat. Now, so much of that family honour rests with Simran and the life she builds in Canada. Simran, acutely aware of this fact, has kept her problems with Mohan from her parents. She has had thoughts of confiding in them, hoping they may intervene, but she cannot bring herself to inflict such disappointment on them. What can they possibly do? They are not going to change his behaviour from thousands of miles away. No, Simran knows that if anything, they will ask her to change her behaviour. They will encourage her to anticipate his needs, adapt to his moods. They will warn her not to trigger his anger. "A man's blood can boil," she can hear Mata Ji saying. "A woman must cool it with her patience, obedience, and the softness of her touch."

Above all, they will implore her for her silence. If the community back home ever got wind of her situation, her family's izzat would suffer greatly. Women sitting on woven beds sifting through uncooked lentils would speculate on her virtue. Cleaning women would pass stories from house to house, taking great delight in educating the housewives on the latest gossip. Men, tending to their fields, would openly cast doubt on the marriageability of Simran's younger sisters. Vendors at the local sabji mandi would quietly whisper

among themselves as Papa Ji shopped for fresh vegetables. Sharma Ji would warn of the dangers of allowing girls too much education and freedom as his customers purchased glucose biscuits at his general goods shop. For all these reasons, Simran will have to suffer in silence. She cannot bear the thought of Papa Ji, overcome with shame, lowering his eyes when addressing the other villagers. She cannot imagine ruining the lives of her younger sisters, Manjit and Raman. No one in the community will marry them if their family izzat is not maintained. Papa Ji will be forced to seek matches from different villages, arrange for larger dowries, and hope that stories of his eldest daughter don't reach the ears of potential in-laws.

Like the hands of a Kathak dancer in her standing that pose while narrating tales of Krishna-Leela, the hands of the clock strike 3; the constant ticking of the second hand provides Simran some respite from the night's deafening silence. Her headache continues. She gets out of bed, reaches for her purse at the bedside, and walks toward Karan's bathroom. His Transformers night light provides enough illumination for her to navigate his collection of toys, colouring books, and half-completed puzzles. In his bathroom, she turns on the light and looks in the mirror. Dark bags underneath her eyes weigh down their already pained expression. Strands of white mingle with her coarse and thinning black hair like unwelcome guests at a funeral. A look around the neck of her kameez reveals that Mohan's hands have left their mark. She reaches into her purse and pulls out an assortment of medicine bottles. Some are for her sleep, others for her pain, and some to help with her mood. According to her family doctor, Dr Roberts, she has insomnia, chronic pain, and depression. "A chemical imbalance" Simran recalls Dr Roberts saying as he handed her the latest prescription. He is like the medicine-walla that used to come to our village, Simran thinks; listening to your story briefly and offering the latest magic potion. "Bhenji, drink this and it will help all tension-vension, all aches and pains, money-back guarantee," he would say.

Simran has never been entirely comfortable with Dr Roberts. He is a slight, unimposing man with a predilection for print ties and wing-tipped shoes. When talking to her, he rubs his eyes and temples, making Simran wonder why his own doctor hasn't offered him any pills. He is always running late, and Simran has often waited an hour to see him for 10 minutes. Chronic headaches and trouble with sleep have plagued Simran for years. Dr Roberts always seems to have a new answer: an increase in dose, a trial of new medicine, a sample in his cupboard. What frustrates Simran is that he doesn't ask the right questions. Why does her head constantly hurt? What causes her to lie awake for hours? Why does she have no desire to attend Gurudwara on Sunday or no energy to fix Karan's school lunch? She feels Dr Roberts has been handing her bandages without inspecting her wounds; quick fixes that are amenable to a 10-minute appointment and sufficient until the next visit.

Simran once summoned the courage to discuss her marital problems with Dr Roberts. It was when Karan was

about 1 year old; she had taken him in for his scheduled immunizations. Dr Roberts noticed and inquired about a bruise on Simran's face. She alluded to her problems with Mohan hoping he would be able to provide some advice. She thought that maybe he would tell her what to say to Mohan to make him stop or that he might reassure her, tell her that Mohan would change and that she needed to be patient. Perhaps he would send her to talk to someone who could give her some ideas on how to be better, how to keep Mohan happy. What she had not been prepared for, however, was Dr Roberts' suggestion: divorce. Simran remembers the chill that came over her body upon hearing this. Was he joking? Did he not realize the absurdity of his suggestion? She could never bring such shame upon her family. Leaving Mohan would ruin Mata Ji and Papa Ji. How would they ever overcome such a burden? What would they tell potential suitors for her sisters? They would be the talk of the village; she could not do that to them. What of Karan? A boy needs his father. He would blame Simran his whole life for taking his father away. She could not care for him alone. She could not provide for the both of them with no skills and a limited grasp of English. The government would certainly take Karan away and give him to Mohan. How could she live without him—her very breath, her reason for being, and the one source of joy in her life? Didn't Dr Roberts understand that divorce is not an option for an Indian woman? No man would marry her; she would be forced to spend the rest of her life alone and in shame.

Simran cowers as she thinks of the possibility of being alone. She swallows a sleeping pill and returns to Karan's room. She stands at the foot of the bed and watches her son. He sleeps in peace, unaware the woman in front of him is but a mere shadow of her former self. He has kicked off most of his covers and the moonlight shines off his Kara, a metal bracelet on his right arm symbolizing the infiniteness of the Divine. She lifts his blanket off the floor and places it over him gently. Simran sits by his head and strokes her fingers through his long, uncut hair. "To suffer is my karma, son," she whispers. "I will not let it be yours." She settles in beside her son, closes her eyes, and waits for sleep to come.

Dr Arora is a family physician in Burnaby, BC. Competing interests none declared.

Details of the research study can be obtained by contacting Dr Arora, PO Box 59026, 5962 Sperling Ave, Burnaby, BC, V5E 0A3  
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the BEAR BONES

## DOMESTIC ABUSE RESOURCES

### Vancouver and Lower Mainland Multicultural Family Support Services and Society

Phone: 604.436.1025

Email: [againstviolence@vlmfss.ca](mailto:againstviolence@vlmfss.ca)

VLMFSS provides services in a safe and non-judgmental environment for immigrant and visible minority women in their own language and culture.

### Battered Women's Support Services

Phone: 604.687.1868 (Business)

Phone: 604.687.1867 (Crisis Line and Intake)

BWSS provides a wide array of services such as crisis support, counseling, legal advocacy, an Aboriginal women's program, a Latin American women's program, and violence intervention training.

Visit: [www.bwss.org](http://www.bwss.org)

### YWCA

Phone: 604.895.5800

Phone: Munroe House (transitional housing) 604.734.5722

The YWCA provides a wide range of programs and services to support women who have experienced abuse.

For the YWCA 'Stopping the Violence' resource list visit: [www.ywcan.org/content/Information\\_for\\_Women\\_Leaving\\_Abuse/703/31/266](http://www.ywcan.org/content/Information_for_Women_Leaving_Abuse/703/31/266)

### Vancouver Coastal Health— Domestic Abuse Program

Phone: 604.875.4924

Email: [dvclinic@vch.ca](mailto:dvclinic@vch.ca)

The Domestic Violence Program offers services for persons who are abused and come to the hospital for assistance.

For the VCH—Domestic Violence Resource Card visit: [www.vch.ca/programs/doc/dv\\_resource\\_card.pdf](http://www.vch.ca/programs/doc/dv_resource_card.pdf)

### THE YWCA 'STOPPING THE VIOLENCE' BROCHURE AND THE VCH—DOMESTIC VIOLENCE RESOURCE CARD

both provide a comprehensive list of services and resources:

- emergency numbers
- crisis lines
- transition housing
- counseling for women
- counseling for children who have witnessed abuse
- legal assistance
- street youth
- victim assistance
- services for seniors, First Nations, multicultural, lesbian, or bisexual women

Dr. Michael C. Klein

## A Book That Changed My Life

THOMAS KUHN: “THE STRUCTURE OF SCIENTIFIC REVOLUTIONS”<sup>1</sup>



What does episiotomy have to do with Copernicus, Galileo and Newton? Like those who thought the world was flat and the sun revolved around the earth, believers in routine episiotomy considered its use as based on “normal science”<sup>1</sup> and fully accepted within the obstetrical/gynecological community, a discipline that saw birth as inherently abnormal, and whose scientific questions accepted this reality as the only framework for legitimate inquiry.

Kuhn defined “revolutionary science,” as opposed to “normal science,” as the study of “anomalies,” or the failure of the accepted paradigm to explain or take into account observed phenomena. In the 1970s and 80s, beliefs about childbirth were coming under intense scrutiny. Worldwide, many people had come to believe that routine episiotomy did not make sense, was anomalous and in need of formal study. In the early 1980s, I pondered how to get funded for a randomized controlled trial of an accepted procedure that I thought was inappropriate when applied routinely. Later I struggled to get the episiotomy trial published when the dominant culture wanted the results buried. In this context, I thought about how strongly held beliefs came about and the critical importance of timing. And then I discovered “paradigms” and “paradigm shift,” the latter term coined by Kuhn.

I had been reading the seminal work of Joseph B. DeLee and was struck by the way that he put together, both the need for a new way of providing protection for the mother and the fetus, and the need of his professional discipline. DeLee was in the process of developing the field of Gynecology into a new discipline to be called “Obstetrics and Gynecology.” His presidential address to the then American Gynecological Society in Chicago was a masterpiece that proposed a new way to save babies and the perineum and pelvic floor, by his combination of outlet forceps and episiotomy – this while simultaneously creating a new professional discipline and wrestling the territory away from “incompetent general practitioners and midwives.”<sup>2</sup> DeLee exhorted his audience to take up this new

approach, claiming that since GPs and midwives would not have the tools [forceps] nor the inclination to use a surgical technique [episiotomy], the new discipline of Obstetrics and Gynecology would gain hegemony. DeLee’s timing was impeccable. Mothers and babies were indeed in trouble in the 1920s – especially in the slums of Chicago. Society needed a new way of looking at birth and gynecologists needed a strengthened discipline. To accomplish this, they had to situate themselves as scientifically providing the solution to a problem, a new way of viewing birth – from a natural phenomenon to a process fraught with danger, a danger that would be mitigated by the new discipline. And society was ready for this way of seeing birth. Kuhn would say that the old paradigm was about to be shifted.

When I proposed an RCT of a procedure that was considered established, the initial response from funding agencies was negative. The reviewers from the Medical Research Council of Canada were dismissive. When the RCT was finally funded by Health Canada, it was because women inside the agency wanted it to be funded. Later we had great trouble getting the study published. The reviewers made misogynistic comments and were harsh in their desire to see the research disappeared. I wrote about this fascinating process,<sup>3</sup> using the actual words of the reviewers as substrate, but before gaining the insight required to write, I turned again to the Kuhn. Through his powerful little book I had come to realize that I must not take these rejections personally. What do you expect when you are contesting the current paradigm or orthodoxy? When the research was finally published,<sup>4,5</sup> it was because the discipline of obstetrics and gynecology itself had within their leadership (and a key editor), significant players who were also skeptical of the old paradigm and believed that, routinely applied, episiotomy did more harm than good. My colleague, Janusz Kaczorowski, and I found that belief structures about episiotomy were firmly grounded in a strongly held paradigm of birth. If you knew how practitioners saw episiotomy, you knew how they

I had been reading the seminal work of Joseph B. DeLee and was struck by the way that he put together, both the need for a new way of providing protection for the mother and the fetus, and the need of his professional discipline.

viewed birth itself.<sup>6</sup> So our timing was on, and so was a scientific revolution.

Today, there remain only a few holdouts who still believe that routine episiotomy is beneficial and deny the improvements in perineal and pelvic floor damage that accrued from abandonment of routine episiotomy.<sup>7/8-10</sup> Kuhn: “A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents die, and a new generation grows up that is familiar with it.”

I turn to Kuhn once again to explain a new and evolving paradigm. As an old obstetrician friend told me, “You know Michael, it hurts me to have to admit that episiotomy does not do what we thought that it did. But you know what the real problem is? Its vaginal childbirth itself!” So we are on the cusp of a new potential paradigm, but it is in fact a return to an old one. This time the tool is cesarean section rather than prophylactic forceps with episiotomy, but the problem to be solved is the same, damage to the mother (pelvic floor and perineum) and the baby (preventing brain damage). And the language and justification sound so familiar. Never mind that the evidence for cesarean section as the technique to prevent both is not there. However, fear-based practice and the desire to control the uncontrollable are present for both the maternity care professions and society as well.

But just as the new paradigm is emerging, new evidence is arising in both Canada and the USA: indicators of maternal and newborn health are going in the wrong direction – as they have done in high cesarean environments in Latin America.<sup>11</sup> Kuhn would say that a new “normal science” is not yet established. The new candidate for paradigm status, cesarean section as just another way of having a baby – in fact a better way, struggles with the old “conservative” notion that cesarean section is major, risky surgery to be reserved only for specific indications. This debate is far from over. We are in a period of conflicting paradigms, as the adherents

of each, design new studies to prove their view is the right one. And some studies will be seriously biased, going from what Phil Hall has called “evidence-based decision-making to decision-based evidence making.”<sup>12</sup>

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the BEAR BONES

Debra Hanberg & David Adams

## Reflections From the Symposium

### ON SOCIAL RESPONSIBILITY IN THE HEALTH PROFESSIONS

“When the dust settled on the roadside of a rural town in Kenya, all that remained were young children squatting on the ground sifting through the loose, dry soil to find the remaining kernels of white rice. Aid workers regularly distribute food rations to the most affected areas of the drought stricken region, but this time as the crowd rushed forward, their fingers pierced the loosely woven sac, and grains of rice were sent cascading to the ground. The children knew the value of each kernel.”

~Dr. Shafik Dharamsi, in his opening remarks at a Symposium on Social Responsibility in the Health Professions funded by the Social Sciences and Humanities Research Council of Canada and held at UBC on February 23 and 24, 2009.

What images come to mind when you hear the term “social responsibility”? For Dr. Shafik Dharamsi, Assistant Professor in UBC’s Department of Family Practice, such experiences as having witnessed despair measured in grains of rice embody the essence of social accountability. As witness, researcher, and educator, Dharamsi believes that family physicians, as with all healthcare professionals, have an intrinsic responsibility to address the disparities and inequities within our healthcare system, our communities, and beyond. Dharamsi focuses his research on social accountability in medical education, specifically looking at how best to educate the next generation of physicians to be community and socially responsive: what do these terms mean, what do they look like in teaching, and what are the implications for health care practice?

In order to answer these and other related questions, several scholars from across Canada and the United States, representing various health and human service disciplines, gathered to explore the meaning of social responsibility among diverse health professions, with a particular focus on implications for the education of health professionals. The symposium, co-hosted by Dr. Dharamsi from UBC’s Department of Family Practice and Professor Tara Fenwick from the Faculty of Education, brought together scholars from a spectrum of fields including community health, gerontology, clinical practice, law, philosophy, bioethics, and professional education. Each scholar presented a paper for critical discussion, with participants being encouraged to explore the contested implications of social responsibility. Professor Fenwick described the meeting as a “place of openings rather than closure”

—a space to critically explore the ideas of social responsibility rather than develop a set of neat conclusions.

The general aim of the symposium was to stimulate a coordinated and integrated effort across the health professions to support effective educational strategies for nurturing socially responsible healthcare practitioners. Despite considerable public investment in health professions education nationally and internationally, there is yet little robust research that supports evidence-based development of social responsibility in the education of health professionals and that measures its impact on healthcare provision. Much needs to be learned about how different stakeholders within the healthcare system think about and act on the concept of social responsibility.

Dharamsi and Fenwick are developing a web site that will connect symposium participants, build a collaborative research network, as well as highlight themes and questions from the symposium itself. The symposium will also be the basis for a special journal edition that will disseminate information about social responsibility to researchers, educators and students in the health professions; Dharamsi hopes that the outcomes of the symposium “will provide insights into how health practitioners experience and practice their role as promoters and educators of social responsibility, and the related implications for curricular development, pedagogy, student evaluation, and faculty development.”

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- > **Wang P, Koehle MS, Rupert JL.** Genotype at the Missense G894T Polymorphism (Glu298Asp) in the NOS3 Gene is Associated with the Susceptibility to Acute Mountain Sickness. *High Altitude Medicine and Biology*. (In press)
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## January to April 2009

Granting Agency	Title	Amount	Year	Principal Investigator	Co-Investigators
Women's Health Research Institute	Screening young adults in Whistler BC for Chlamydia trachomatis infection, using non-traditional and non-clinic settings – a pilot program	23,902	2009-2010	<b>M. Collins</b>	<b>J. Kaczorowski</b> R. Holehouse
University of British Columbia	Teaching and Learning Enhancement Fund	118,567	2009-2010	<b>S. Dharamsi</b>	J. Spiegel K. Beaumont T. Baldwin C. Angeles G. Charles D. Currie S. Dahinten, M. Fee A. Ho, L. Lai C. Larson J. McLean <b>M. Parkes</b> <b>R. Tabata</b> <b>R. Woollard</b> <i>et al</i>
SSHRC & PWIAS	Social Responsibility in the Health Professions: Critical Explorations	8,500 & 1,000	2009-2010	<b>S. Dharamsi</b>	T. Fenwick
Canadian Institute of Health Research	Choosing, using and losing medications in older adults: A research training program bridging biosciences, clinical, population health, and health policy research	1,781,941	2009-2015	L. Dolovich P. Raina A. Holbrook MA. Levine L. Thabane	<b>J. Kaczorowski</b> A. Papaioannou R. Goeree J-E Tarride S. Kaasalainen E. Pullenayegum M. Oremus, <i>et al</i>
University of British Columbia	Teaching and Learning Enhancement Fund	23,000	2009-2010	L. Eccott	V. Wood <b>C. Newton</b> W. Hall, M. Lee A. Grieg
University of British Columbia	Teaching and Learning Enhancement Fund	42,000	2009	<b>R. Elwood</b> <b>Martin</b>	M. Smith, J. Koehn AD Malebranche
Coast Capital Savings Project	Postpartum mood disorders	25,000	2009	N. Fairbrother	<b>P. Janssen</b> , M. Lau
Cedar Foundation	A partnership between the UBC Internal Medicine Residency Training Program & The Donald Fraser Hospital, Limpopo Province, South Africa	325,000	2009-2014	A. Hill	<b>S. Dharamsi</b> M. Roberts G. Meneilly K. Plewes
Metropolis BC	Assessment for Intimate Partner Violence	13,793	2009	<b>P. Janssen</b>	S. Desmarais
University of British Columbia	Teaching and Learning Enhancement Fund	106,084	2009	<b>P. Janssen</b>	C. Richardson, B. Sobelov, K. Craib J. Sandu, P. Tang
University of British Columbia	Teaching and Learning Enhancement Fund	41,000	2009-2010	<b>C. Newton</b>	V. Wood, T. Flavell <b>L. Nasmith</b> L. Sawchenko, <i>et al</i> ▶



Granting Agency	Title	Amount	Year	Principal Investigator	Co-Investigators
Women's Health Research Institute	CART: Clinical Abortion Research Team	25,000	2009-2010	<b>W. Norman</b>	B. Fitzsimmons L. Dicus J. Burgunder L. Eccles, B. Sieker
Child and Youth Health Research Network (a Michael Smith Funded Network)	CART: Clinical Abortion Research Team	4,900	2009	<b>W. Norman</b>	B. Fitzsimmons L. Dicus J. Burgunder L. Eccles, B. Sieker
Vancouver Foundation	Enabling Multilingual Input to Survey Development for Better Contraceptive Choices after Second Trimester Abortion	3,000	2009	<b>W. Norman</b>	M Doyle-Waters L. Dicus
Canadian Institute of Health Research	The Cedar Project: Exploring HIV and hepatitis C vulnerabilities among young aboriginal drug users in three Canadian cities	1,900,000	2009-2012	P. Spittal	M. Schechter BW. Baylis C. Callaghan <b>P. Janssen</b>
Vancouver Foundation	Complete HIV Care for Native Urban People/Self Management Support	73,513	2009-2010	<b>D. Tu</b>	M. Tyndall D. Littlejohn D. Elliott
Canadian Institute of Health Research	A mixed-methods study of the experiences of Canadian maternity care providers and key informants with planned home birth	298,277	2009-2011	<b>S. Vedam</b>	<b>S. Dharamsi</b> N. Fairbrother <b>J. Kaczorowski</b> <b>MC. Klein</b> <b>J. Kornelsen</b> R. Liston
Vancouver General Hospital/Department of Family Practice		5,000	2009	<b>ER. Wiebe</b>	R. Basson, L. Brotto

## January to April 2009

Awardee	Name of Award	Foundation	Year
Shafik Dharamsi	Sustainability Education Intensive	UBC SEI	2009
Shafik Dharamsi	2009 CASTL Scholar - Carnegie Academy for the Scholarship of Teaching and Learning Institute Scholar	The Carnegie Foundation for the Advancement of Teaching	2009
Cathryn Ellis	William Webber Award	William Webber Foundation	2009
Faye MacKay	Distinguished Leadership in the Improvement of Primary Care in BC	GP Services Commission/BCMA	2009

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- > **Bainbridge L, Drynan D, Eccott L, Newton C, Wood V.** UBC College of Health Disciplines Workshop: Preparing Now For IPE Accreditation Standards, Vancouver BC, February 2009.
- > **Collins M, Kaczorowski J, Dharamsi S.** Resident (R2) Research Project Planning. UBC Department of Family Practice. Vancouver BC, April 2009.
- > **Desmarais S, Janssen P.** Emergency Department visits by Victims of Partner Violence in Vancouver. Population Data BC. Vancouver BC, March 2009.
- > **Dharamsi S, Tabata R, Baldwin T.** Going Global: Ethical Implications of Volunteering in Under-resourced Countries. UBC Student Leadership Conference. Vancouver BC, January 2009.
- > **Dharamsi S, Hill A.** Socially responsible approaches to global health. UBC Department of Medicine, Division of General Internal Medicine. Vancouver BC, January 2009. (Invited)
- > **Dharamsi S.** What is social responsibility? Paper presented at the International Symposium on Social Responsibility in the Health Professions: Critical Explorations. Vancouver BC, February 2009.
- > **Dharamsi S, Spiegel J.** Partnerships for Ethical Global Health Engagement. Second Clinton Global Initiative University (CGI U). Austin TX, February 2009.
- > **Dharamsi S.** Professionalism and Ethics. The College of Dental Surgeons of British Columbia, Professional Development Workshop. Vancouver BC, January/February 2009.
- > **Dharamsi S.** Keynote speaker: Oxfam UBC's Hungry4Change Banquet. Vancouver BC, February 2009.
- > **Dharamsi S.** The Ethics of International Service Learning. Centre for International Event: Integrating Research, Service & Learning in Global Health - Case Studies & Student Research Posters, UBC Celebrate Research Week. Liu Institute for Global Issues, Vancouver BC, March 2009.
- > **Dharamsi S.** Opening Speech to the Canadian Association of Public Health Dentistry Annual General Meeting as Chair of the Research Advisory Committee of the Canadian Dental Hygienists Association. Vancouver BC, March 2009.
- > **Dharamsi S.** Ethical considerations when engaging in global health and development projects. INSPIRE | Global Health Conference: Challenges and Opportunities of the 21st Century. UBC Integrated Sciences Student Association. Vancouver BC, March 2009. (Invited)
- > **Dharamsi S, Sidhu R.** Social Accountability. UBC Department of Surgery: Post Graduate Education & Core Surgery. Vancouver BC, April 2009. (Invited)
- > **Donnelly ML.** Incapacity Assessments 2009. Geriatric Medicine Whistler Retreat. Whistler BC, February 2009.
- > **Donnelly ML.** Suicide Prevention Toolkit (workshop). BC Association of Geriatric Care Physicians Conference. Vancouver BC, March 2009.
- > **Donnelly ML.** Seniors and depression: assessment and management. Mood Disorders Association of BC – Education Evening. Vancouver BC, April 2009.
- > **Donnelly ML.** Seniors and depression: assessment and management. BC Psychogeriatric Association 12th Annual Conference. Richmond BC, April 2009.
- > **Donnelly ML.** Incapacity Assessments 2009. Neuropsychiatry Video Rounds. BC Neuropsychiatry Program. Vancouver BC, April 2009.
- > **Fenwick T, Dharamsi S.** Organized a SSHRC Funded International Symposium entitled: Social Responsibility in the Health Professions: Critical Explorations. Vancouver BC, February 2009.
- > **Fleming B, Hoube J, Dharamsi S.** How to be a Health Advocate? UBC Associate Dean's Office, Postgraduate Medical Education. Vancouver BC, April 2009. (Invited)
- > **Janssen P.** Mothering at the Margins. Interdisciplinary Women's Reproductive Health Research Training Program and Reproductive Health Sciences Program, Child and Family Research Institute. Vancouver BC, March 2009. (Invited)
- > **Janssen P.** Finding Opportunities for Hope and Healing in the Health Care System. Richmond Family Violence Prevention Network (Workshop). Richmond BC, March 2009. (Invited)
- > **Janssen P.** Searching for Truth with Numbers: Epidemiology and biostatistics in Public Health: Celebrate Research Week, UBC Robson Square. Vancouver BC, March 2009. (Invited)
- > **Janssen P.** Optimal Birth BC. Women's Health Research Institute Board of Directors Meeting. Vancouver BC, January 2009. (Invited)
- > **Janssen P.** Measurement in Fetal/Newborn Parameters of Well-being. Inaugural presentation of Methodology rounds, Child and Family Research Institute. Vancouver BC, December 2008. (Invited)
- > **Janssen P.** Optimal Birth BC, Collaborative Maternal and Newborn Health Group. Vancouver BC, December 2008. (Invited)
- > **Klein MC.** How epidural analgesia has transformed birth, sometimes for the better and sometimes not. POGO—Pediatrics, Obstetrics and Gynecology. Saskatoon SK, February 2009. (Invited)
- > **Klein MC.** Do you really believe that midwives attending home births are harming babies and mothers?—How to integrate midwifery into mainstream maternity care in a safe collaborative environment. POGO—Pediatrics, Obstetrics and Gynecology. Saskatoon SK, February 2009. (Invited plenary speaker)
- > **Koehle MS, Giles LV, Walsh M, White MD.** The Effects Of Lower Body Positive And Negative Pressure On Hypoxic Ventilatory Decline. International Hypoxia Symposia. Lake Louise AB, March 2009.
- > **Kornelsen J.** Tri-Council grant writing: Content, context and strategy. Workshop at Family Practice Research Day. Vancouver BC, June 2008.
- > **Kornelsen J.** Sustainable maternity care: Midwifery's contribution. Ministry of Health Services Planning Joint Committee on Midwifery. Victoria BC, June 2008.
- > **Kornelsen J.** Maternal health in a rural environment using clinical outcomes to inform policy. Canadian Institutes of Health Research. Victoria BC, April 2008. (Invited)
- > **Kornelsen J, Grzybowski S.** Rural Birth Index: Planning allocation and level of maternity service for rural British Columbia. Kootenay Boundary Regional Hospital Meternal/ Child Integrated Network of Care. Rossland BC, January 2008. (Invited)
- > **Lisonkova S, Janssen P, Sheps S, Lee S, Dahlgren L.** The effect of maternal age on adverse birth outcomes: Does parity matter? Society of Maternal Fetal Medicine. San Diego CA, January 2009.
- > **MacKay F, Parent S.** Advanced Access. Practice Support Program. Cranbrook BC, February 2009.
- > **MacKay F, Parent S.** Change in BC's Rural Interior. Institute for Healthcare Improvement Conference. Vancouver BC, April 2009.
- > **MacKay F, Parent S.** Steps for Better Access: A Rural Perspective. Poster Presentation, Institute for Healthcare Improvement Conference. Vancouver BC, April 2009.
- > **MacKay F, Parent S.** Group Medical Appointments. Practice Support Program Regional Support Team Learning Session. Vancouver BC, Oct 2008.
- > **Nasmith L, Scott I.** Leadership for the National Award Winners (3-hours workshop) for the medical student and resident award winners of the years of the year –co facilitated with the president of the college of family physicians– College of Family Physicians of Canada Annual General Meeting (Family Medicine Forum), Toronto ON, December 2008.
- > **Newton C, Moran M, Di Loreto L.** The Health Care Team Challenge. IPE Ontario Conference. Toronto ON, January 2009.
- > **Newton C, Copeman-Stewart K.** IHA Integrated Health Networks Regional Learning Session 1: Collaborative Care Teams. Kelowna BC, March 2009.
- > **Norman W, Bergunder J, Eccles L.** Women Seeking Abortion Underreport Gestational Age by an Average of One Week Based on Last Menstrual Period Compared to Ultrasound Dating, National Abortion Federation meeting. Portland OR, April 2009.
- > **Scott I, Wilson R.** Leadership Skills Workshop for Family Medicine Interest Group Leaders, College of Family Physicians of Canada. Toronto ON, February 2008.
- > **Scott I, Wright B, Gowans M, Brenneis F, Banner S, Boone J.** Predictors of a Career in Family Medicine. College of Family Physicians of Canada Annual General Meeting (Family Medicine Forum). Toronto ON, December 2008.
- > **Parnell TA, Stanford J, Boyle P.** Perinatal Outcome for Infertile Women Treated With Natural Procreative Technology (NPT) North American Primary Care Research Group (NAPCRG) 2007 Annual Meeting, Vancouver BC.
- > **Wiebe ER.** Sex and mood and the pill. Vancouver General Hospital Family Practice Rounds. Vancouver BC, March 2009.





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## The UBC School of Population & Public Health Offers A New Master of Public Health Degree

The UBC School of Population and Public Health offers a new Master of Public Health degree that allows family physicians to extend their knowledge in the field of public health. The distributed learning format, which consists of weekend courses and on-line curriculum, will be of particular interest for those maintaining clinical practices or pursuing a research career.

### What does an MPH offer?

The UBC Master of Public Health Degree integrates learning in epidemiology, biostatistics, the social, biological and environmental determinants of health, population health, global health, disease prevention and health systems management with skill-based learning in a practicum setting. Public health is the science and art of health surveillance, disease prevention, and health promotion through the organized efforts of society.

### MPH Learning Formats

**1. Traditional classroom-based curriculum** with on-campus classes scheduled on a Monday to Friday timetable.

**2. Distributed learning format.** Each course consists of three full days, one day per month. An additional 15 hours of curriculum is online for each course. Courses will be scheduled so that a full course load

(four classes) can take place over three extended weekends (Thurs, Fri, Sat, Sun) in a term.

In both formats the program will consist of 21 core course credits, 15 elective credits and a six credit practicum. In most circumstances, three academic terms will be required to complete course requirements and one term for the practicum. Some students may be able to undertake their practicum on a part time basis concurrently with their course work over a period of two terms and finish in three terms. Students may take up to three electives from other Departments.

### How to Apply

Applications are accepted December 1<sup>st</sup>-February 1<sup>st</sup> for admission in September. An online application, is available at [www.grad.ubc.ca/apply/online](http://www.grad.ubc.ca/apply/online)

### Inquiries

Visit the website at [www.mph.spph.ca](http://www.mph.spph.ca)

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### 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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## Join Us For The Department of Family Practice's Research Day

*Friday, June 19, 2009*

Research Day celebrates the research work of Department faculty, midwives, clinical investigators, community-based clinical investigators, and residents. This event will be an excellent opportunity to engage with investigators from all over the province.

### Friday, June 19, 2009: Daytime presentations, 8:30 am-5:00 pm

Concurrent presentations will cover a wide range of topics that will inform the dialogue at the event's networking sessions.

### Thursday, June 18, 2009: Research Skills Workshops, 1:30 pm-5:00 pm

Concurrent workshops will be offered to Department members who wish to learn about "using EMR medical data to answer primary care research questions;" abstract and paper writing, submitting to journals and dealing with rejection; participatory research; and, systematic reviews.

### RSVP to Monica Glaboff

[monica.glaboff@familymed.ubc.ca](mailto:monica.glaboff@familymed.ubc.ca)  
604.822.6811

