deviants if they presented any one or more of the following: non-adherence to antihypertensive therapy; recent history of hospitalisation for HBP, and use of tobacco. Home visits identified potential PD individuals, for whom data characterising their family and social inter-relationships were obtained by interviews. Thus, criteria that characterised positive deviants were identified and all such individuals were invited to participate in the intervention.

What lessons were learned? Of the 218 patients diagnosed with hypertension, only 85 (39.0%) presented with controlled BP and 31 (14.2%) were characterised as potential PD individuals. Nine (4.1%) individuals fulfilled the criteria and were considered highly motivated and therefore were selected as positive deviants. Despite living in resource-poor settings, these individuals presented significant leadership qualities, were motivated and were able to take an active role in maintaining control of their BP. We believe that the small number of patients selected partially reflects the complexity of hypertension control. Future studies should involve positive deviants in groups with other hypertensive patients in order to encourage improved new behaviours and practices. It is possible to work with PD within the FHS. Our future goal is to insert the PD model into the routine work of health professionals. Furthermore, PHC offers a positive environment in which skills and knowledge relevant to specific population needs can be improved, which is valuable in graduate medical education.

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Photovoice: medical residents reflecting on poverty

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What problem was addressed? Both the public and academic sectors recognise the importance of addressing social inequities in health care. However, health professionals, particularly family physicians, may misunderstand poverty and its impacts on self-management among disadvantaged patients. Hence, there is a need to strengthen family medicine residents' training and better prepare them to consider the impacts of poverty on health and health care.[1]

What was tried? We conducted a photovoice study in a primary care teaching unit in Quebec, Canada. This study aimed to: (i) explore residents' perceptions of their training needs in relation to providing care for socio-economically disadvantaged persons, and (ii) examine how their participation in a photovoice study helped them uncover their prejudices and assumptions about poverty.

Photovoice is a participatory action research method that uses photography to enable participants to share experiences and develop critical consciousness of a variety of topics. Participants were four family medicine residents, two medical supervisors and two researchers. Residents attended six photovoice meetings at which they discussed photographs they had taken. In collaboration with the researchers, the participants defined the research questions, took photographs, and participated in data analysis and the dissemination of results.

What lessons were learned? Photovoice appears to be a promising and innovative teaching approach in medical education, especially for medical residents. Participating in a photovoice study helped future physicians uncover and examine some of their prejudices and assumptions about poverty. They reported feeling unprepared to provide care to socio-economically disadvantaged patients. Supported by medical supervisors and researchers, the residents underwent a three-phase reflexive process of: (i) engaging reflexively; (ii) making breakthroughs, and (iii) taking action. One unexpected outcome was that students felt encouraged to adopt a different care approach and enabled to overcome the barriers and social distance between themselves and their socio-economically disadvantaged patients. Some residents reported that discussing issues of poverty with the other participants empowered them to ask patients questions they would not have dared to ask before, which opened up the possibility of exploring the resources available instead of avoiding the patient's problem. The residents directly attributed their new professional behaviour to the reflexive process fostered by the photovoice project. They now felt better equipped to serve patients with health problems caused in part by poverty. In addition, after medical residents had presented their

data to faculty members, a 'social competence' component was incorporated into the spectrum of competencies that medical residents should acquire during their training and a course on poverty was developed and given to medical residents.

In conclusion, we believe that the photovoice project represented a learning process for all participants. Residents' concrete actions in direct response to the project can be seen as evidence that the photovoice method can be an effective tool for raising health professionals' awareness of socio-economic realities that differ from their own and have direct consequences on their patients' health.

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Feedback fairs: low-tech, high-impact knowledge to action

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What problems were addressed? An ethnographic study examining the experiences of hip fracture patients, their family members and health care professionals (HCPs) in acute care settings was conducted. Upon completion of our study, we wanted to share the findings with HCPs. World Café events are a popular participatory method of encouraging knowledge transfer and exchange (KTE).[1] World Cafés feature rounds of collaborative conversation in which small groups spend time at various stations discussing specified topics such as research findings, future interventions and implementation strategies. However, these valuable KTE events are often underutilised as a result of resource constraints. Accordingly, there was a need to develop a KTE event that extended the benefits of the World Café approach, but better met the context within which HCPs work (e.g. in multiple shifts and under the demands of an acute care unit) and would not be experienced as onerous or resource-intensive by the unit leaders, staff or researchers.

What was tried? We adapted the World Café approach to create a low-cost, low-resource method of engaging HCPs; we call this revised approach the 'feedback fair'. We hosted feedback fairs in two acute orthopaedic units at two hospitals in British Columbia, Canada. The feedback fairs used a 'drop-in' style format (HCPs could come at any time during the day) and consisted of six stations arranged in a circular layout. At the first station, a researcher explained the study and handed out a summary in plain language. Attendees were given stickers for a voting station and index cards on which to provide written feedback. The next four stations exhibited boards containing findings from the study, including participant quotes, care strategies, images illustrative of study themes and questions to spark discussion, and snacks. The sixth station (the voting station) exhibited a board with a list of five recommendations for improving care. Participants voted on the recommendations they would most like to see implemented. Two or three researchers were present to answer questions, encourage dialogue and record observational field notes.

What lessons were learned? Based on an analysis of observational field notes and the feedback provided through index cards, feedback fairs were found to generate three main outcomes. Firstly, they established a feedback loop: attendees considered that opportunities to hear and discuss patient and family concerns were extremely valuable, and reported increased awareness of patient and family experiences of care transitions. Secondly, they fostered interdisciplinary dialogue on interventions to improve patient care. These events provided a forum for HCPs to share experiences, discuss research findings and identify strategies to improve care. A need for more opportunities to strengthen interdisciplinary communication and collaboration was identified. The 'science fair' approach, with snacks and flexible timing, was perceived as unique and appropriate to the context. Thirdly, the feedback fairs created a forum in which researchers could interact with clinicians and gain an understanding of HCPs' reflections on the experiences of patients and family members. The fairs created an opportunity for two-way dialogue between researchers and HCPs.

Our findings illustrate that World Café principles can be adapted for the purposes of smaller-scale KTE interventions tailored to resource-limited settings in which a flexible drop-in style approach is required.