



 **Keep up to date...**
www.ihcc.ca

Welcome to the (almost) winter 2009 edition of the Institute for Healthcare Communication – Canada, Faculty Newsletter.

This year has been an exciting one for the IHC-C. While the number of faculty trained and faculty development programs that were held in 2009 have diminished from the training boom that the IHC-C enjoyed in 2008, the interest in, and awareness of the IHC-C programs has greatly expanded this year. Inquiries have been made on behalf of increasingly diverse professional groups, and interest has spread literally from coast to coast. With a number of programs undergoing major “renovations” this year, those at the helm of the IHC-C feel heartened that 2010 will see a renewed and revitalized IHC-C moving into the future.

Some 2009 highlights include:

- The College of Family Physicians has made a commitment to expand their role in the development and the future of the IHC-C. (see details on page 2)
- The North American debut of the newly revamped “Strangers in Crisis” faculty course and workshop.
- Substantial changes to the IHC flagship program, “Clinician-Patient Communication” and new training materials have been distributed to all active faculty across the country.
- New CEO and Associate Director at the IHC (see details on page 4)

Happy holidays to all!

NEW: Workshop Follow-up Survey

One of the most frequently asked questions from those considering communications training is ...

“What evidence is available to show that IHC workshops have an impact on the communication behaviours of the health care professional?”

We now have a course-specific follow up survey mechanism in place to work towards gathering data to assist in the attempt to answer this question. More details to follow soon; however, for those especially keen, you may also contact the IHC-C office for more information and / or to get started today!

NEW training opportunity: **“Connected: Communicating & Computing”**

As health care organizations, clinics, and hospitals across Canada are preparing to fully embrace the age of the Electronic Medical Record (EMR), the IHC-C plans to be poised to provide expert consultation and guidance to these groups in order to optimize the patient experience once the EMR is introduced to the clinician-patient dynamic. *

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NEW

CFPC | IHC Agreement

As you know, the Institute for Healthcare Communication is a non-profit organization, whose vision is *to optimize the healthcare experience and the quality of patient care through effective communication*. Since January, 2006, the College of Family Physicians of Canada (CFPC), has very generously provided a home to the Canadian arm of the Institute (the Institute for Healthcare Communication – Canada (IHC-C)), as well as providing invaluable in-kind support to ensure smooth running of the organization overall. With the assistance of seed funding from Cancer Care Ontario and the Canadian Cancer Society (Ontario Division), and an educational grant from Merck Frosst, for these past four years, the IHC-C has worked diligently towards becoming a self-sustaining organization; however, in spite of the continuing and growing interest in the Institute's programs, we have yet to achieve this somewhat elusive goal.

At the beginning of this year, the IHC and the CFPC began a series of discussions and negotiations, with a view to the CFPC taking on a greater degree of responsibility in sustaining the Institute as it now exists in Canada. With the time, hard work and collaborative spirit of both the IHC and the CFPC, we are extremely pleased to announce that an agreement has been signed which grants the CFPC an **exclusive** licence for the IHC human health programs in Canada, for a one-year period, beginning in January, 2010.

For the most part, this news will not have a major impact on the Canadian faculty members, business conducted by the Institute, its clients or target groups. The support of the CFPC will allow the continuance of the IHC-C into the foreseeable future, a vital contribution, as we continue our work to become a fully self-sustaining organization.

One significant aspect that this agreement may change is the structure of the governance for the IHC-C. It is proposed at this time that the IHC-C Canadian Operating Committee (COC), with its professionally and geographically diverse membership, continue to provide guidance and strategic direction to the IHC-C, as a Special Advisory Committee. More to come on this, as our plans for the IHC-C future continue to evolve.



Changes to the- IHC-C COC:

The Canadian Operating Committee (COC), in conjunction with the IHC Board of Directors, has provided the governance and strategic direction for the Institute over the past four years. A few significant changes in the committee's constituency have taken place over the past few months, and we share these changes with you, as noted below.

Welcome new COC members:

- **Kathleen Bonvicini**
CEO, Institute for Healthcare Communication, Inc.
- **Jason Frank**
Associate Director, Specialty Standards, Policy & Development
The Royal College of Physicians and Surgeons of Canada

Farewell and a huge thank you to:

- **Greg Carroll**
CEO, Institute for Healthcare Communication, Inc.
- **Linda Tyre**
Patient Concerns Officer, Cross Cancer Institute
Director of Patient Representative Services,
ACB Northern and Central Sites

CLASS OF 1956



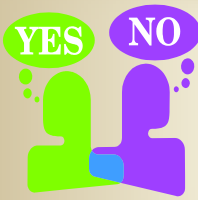
Dr. Donald COWAN, shown here with his wife, Norma, received an Arbor Award in Sept., 2009. During his busy medical career,

he has participated actively in over 60 committees at the Faculty of Medicine (including the MAA), Toronto General Hospital, Princess Margaret Hospital and Sunnybrook Health Sciences Centre, as well as volunteering in a national and international capacity.

**U of T
Medical Alumni
Association
includes two of
the COC
founding
members ...**

CLASS OF 1944

Dr. John LAIDLAW was appointed to the Order of Canada in 2003 for his contributions to medical education, research and patient care. Through his leadership roles, notably with Cancer Care Ontario, he has stressed the importance of good communication in providing quality care to patients. He is currently consultant emeritus at Cancer Care Ontario.



Your opinion matters to us

As all IHC course bibliographies are available at www.ihcc.ca, do you think that it is necessary to include a printed version of the workshop bibliography in the workbook?

To express your opinion, please link to:

<http://www.surveymonkey.com/s/LDDCJMC>



CLINICIAN-PATIENT COMMUNICATION TO ENHANCE HEALTH OUTCOMES

With the newly revamped CPC workshop hot off the press this year, all active CPC facilitators should, by now, have received a copy of the newly revised workbook, a CD with the CPC Powerpoint and other office forms, as well as a cover letter detailing all of the major changes that have been included in this new and improved version. If you requested this material and have not yet received it, please let the IHC-C office know or, if you have not requested the package, but are an active CPC -facilitator, we would be pleased to send out a package to you as well. All CPC workshop presentations should be following the new curriculum.

Reminder!

2009 WORKSHOP SUMMARY

Early in the new year, we will be preparing a review and summary of all workshops held in Canada in 2009. We have worked diligently to keep track of those workshops; however, we realize that sometimes very busy folks forget to let us know. So if you have held an IHC workshop in 2009 that has not been registered, please let us know as soon as possible. Similarly, if we have a workshop registered and have not received the follow up evaluative materials, then you will be contacted soon to verify the event for our records and to request that summative information be submitted as soon as humanly possible!

Don't forget!

WORKSHOP PLANNING and FOLLOW UP

If you have a workshop planned, please let the IHC-C office know who, what, when, and where, so that we are sure to include your event on the listings found at www.ihcc.ca! Also, just a reminder to send along your evaluations or evaluation summary following your workshop. Thanks!

Please!

KEEP US UP TO DATE

If you have already, or plan to change your contact information (especially e-mail), please help us continue to communicate with you effectively, by sending an update note to ks@cfpc.ca. Much appreciated!

Continued from page 1...

NEW training opportunity:

"Connected:

Communicating & Computing"



The IHC-C is anticipating that there will be a significantly increased demand for this workshop, as more and more health care organizations, offices and teams switch to the EMR.

Currently, the IHC-C does not have any Canadian faculty trained to present the CC&C workshop. Therefore, we are planning to run a one-day faculty training for a small group of selected IHC-C faculty.

There will be a very limited number of spaces available and the IHC-C hopes to be able to support at least the tuition portion of this and perhaps, the travel as well, but this has yet to be decided.

The training will occur early in the new year and will most likely be held at the CFPC offices in Mississauga, ON.

If you are interested in attending this one day faculty development session and can say "yes" to the following, then the IHC-C would be very pleased to hear from you:

1. You are currently a trained presenter for "Clinician-Patient Communication" (CPC), and
2. You have time to commit to presenting several (paid) workshops a year, as an IHC-C faculty representative.

Please contact ks@cfpc.ca for more details and to discuss your interest in taking part in this training.

**NEWS from:
IHC, New Haven, CT**



The IHC Announces...

**Appointment of Kathleen Bonvicini, MPH, EdD
as Chief Executive Officer**

Dr. Kathleen Bonvicini has been named the successor to long-term IHC CEO, Greg Carroll, as Chief Executive Officer.

Kathleen has been affiliated with the Institute since 1999 as a consultant, faculty member and, more recently, as the Associate Director for Education and Research since 2003. In her current position, Kathleen has conducted communication workshops and faculty training courses throughout the United States, Canada, and in Europe. She oversees the Institute's national accreditations for continuing education and manages many of the core training programs. In addition, she leads IHC's veterinary communication training, which is sponsored and supported primarily by Bayer Animal Health.

Kathleen has a doctoral degree in Educational Leadership from University of Phoenix, a Masters of Public Health degree from Yale University and a Bachelor of Science in Social Work from Southern Connecticut State University. As a researcher, Kathleen has authored and co-authored a variety of articles in psychiatric genetics and clinician communication, including both human and veterinary medicine. She has recently led the Institute's research initiative and collaboration with the University of California, Riverside, to mine the research data from the IHC-UC Irvine outcomes study, which culminated in her doctoral dissertation and subsequent publications to assess the impact of communication training interventions on physicians' expression of empathy with patients.

**Appointment of David Clarke, DMin, JD, MPH,
as Associate Director**

The IHC is pleased to announce that, as of Oct 1, 2009, Dr. David Clarke will be joining New Haven, Connecticut IHC team as Associate Director, Education and Research.

While new to the position as Associate Director, David is certainly not new to IHC; he has been a valued and active faculty member since 1994 and is certified to conduct 10 of IHC's CE workshops and programs.

David graduated from Wesleyan University (CT) with a BA in psychology and sociology, from Meadville / Lombard Theological School at the University of Chicago with a Doctor of Ministry degree, from McGeorge School of Law in Sacramento and from Harvard School of Public Health. David founded, and for 20 years directed, Massachusetts Health Decisions, a non-profit organization that provides both public and professional education programs on ethical issues in health care. His primary professional interests are improving clinician-patient relationships and patient care through good communication; making health care decisions on behalf of persons with no surrogates; and incorporating ethics into the practical life of health care organizations.

Congratulations Kathleen and David!

**FUNDING
ANNOUNCEMENT**



We are very pleased to report that IHC's medical education grant proposal to Boehringer Ingelheim Pharmaceuticals, Inc. was approved for funding.

This grant proposal was submitted in partnership with two additional organizations (International Society for the Study of Women's Sexual Health (ISSWSH) and Outcomes, Inc.) and a portion of the funding will be assigned to the IHC for professional time, faculty training and pilot testing.

The goal of this program is to provide Communication Training to Improve the Treatment of Female Sexual Disorders and will be conducted from November 2009 to December 2010.

The program objectives are:

- a. Respond to a significant health care problem: Female Sexual Disorders (FSD)
- b. Develop and test a medical education activity (workshop) tailored to assessment and treatment of FSDs
- c. Train physicians as program faculty
- d. Conduct and report outcomes research

This is wonderful news for IHC and provides an exciting opportunity to integrate IHC's structured learning format into a new content area in partnership with two specialty organizations.



**The USA office of the IHC
has recently relocated ...**

**Institute for Healthcare
Communication**

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FACULTY DEVELOPMENT



Congratulations to the **Health Regions of Newfoundland / Labrador** (Eastern, Central, Western and Labrador/Goose Bay), for sponsoring a “Disclosing Unanticipated Medical Outcomes” (DUMO) IHC-C faculty development programs in the second half of 2009.

Congratulations to new “DUMO” FACULTY (October, 2009)

Faculty leader: Dan O’Connell

Faculty Team: Michele Nanchoff-Glatt, Christina Krause, Glenn McRae and Bruce MacLeod

Tina Ackerman	Quality Clinical Safety Leader	Eastern Health
Kofi Amu-Darko	Family Physician, Labrador Grenfell Health	Labrador Health
Judy Budgett	Director Corporate Improvement	Central Health
Joanne Collins	Quality and Clinical Safety Leader	Eastern Health
Deanne Emberley	Quality and Clinical Safety Leader	Eastern Health
Donna Hicks	Regional Director, Quality & Risk Management	Western Health
Elaine Hollett	Regional Risk Manager	Central Health
Rufina O’Dell	Regional Director Community Clinics, Labrador Grenfell Health	Labrador Health
Heather Predham	Assistant Director/Risk Management Consultant Quality and Risk Management	Eastern Health
Sherri Tiller-Park	Regional Manager, Information Access & privacy	Western Health

Congratulations to new “STRANGERS IN CRISIS” (SIC) Faculty (May, 2009)

Faculty leader: Michele Nanchoff-Glatt

Darin Abbey	Registered Nurse Nanaimo Regional General Hospital	Vancouver Island Health Authority
Jill Breker	Clinical Nurse Educator Nanaimo Regional General Hospital	Vancouver Island Health Authority
Patricia Dianne (Dee) Edworthy	Registered Nurse Nanaimo Regional General Hospital	Vancouver Island Health Authority
Sheri Golia	Registered Nurse Victoria General Hospital	Vancouver Island Health Authority
Sue Munro	Regional Manager – Emergency Services Victoria General Hospital	Vancouver Island Health Authority

Congratulations to new "TREATING PATIENTS WITH C.A.R.E." Faculty (June, 2009)

Faculty leader: Michele Nanchoff-Glatt

Faculty Team: Heather Coburn, Deb Prowse

Jennifer Alexander	Nutritionist, Home Care	Alberta Health Services
Jennette Coates	Clinical Nurse Educator, Seniors Health	Alberta Health Services
Julia Curcio	Community Care Coordinator OT, Calgary Home Care	Alberta Health Services
Carrie Huckerby	Recreation Therapist I, Bassano Health Centre	Alberta Health Services
Miranda Martin	Social Work, Palliative Home Care	Alberta Health Services
Paulette Martin	Transition Coordinator	Alberta Health Services
Kelly McDonald	Clinical Nurse Specialist, Seniors Health	Alberta Health Services
Anne Meier	Home Care RN CCC	Alberta Health Services
Raeann Sharland	Physical Therapist Assistant, Therapy Services	Alberta Health Services
Andrea Storey	Clinical Nurse Educator	Alberta Health Services
Carrie Tsui	APCH	Alberta Health Services

Congratulations ...

to IHC-C faculty who have elected to undergo formal faculty certification in the **second half of 2009** (plus a couple of omissions from the last Newsletter from 2008 – sorry about that!), and thanks to those organization which have supported this initiative, with a view to providing optimal training to their faculty members.



NAME	Organization	IHC-C Course	Date of certification	IHC-C Faculty Mentor / OBSERVER
Colleen Torgunrud	Alberta Health Services, Edmonton, AB	DUMO	Sep. 15 th , 2008	Kristin Atwood
Roxy Thomas	Alberta Health Services, Edmonton, AB	DUMO	Sep. 15 th , 2008	Kristin Atwood
Shirley Gobelle	Winnipeg Regional Health Authority, Winnipeg, MB	DUMO	Sep.19 th , 2009	Bruce Roe
Darin Abbey	Vancouver Island Health Authority, Duncan, BC	SIC	Oct. 2 nd , 2009	Michele Nanchoff-Glatt
Jill Breker	Vancouver Island Health Authority, Duncan, BC	SIC	Oct. 2 nd , 2009	Michele Nanchoff-Glatt
Patricia Dianne (Dee) Edworthy	Vancouver Island Health Authority, Duncan, BC	SIC	Oct. 2 nd , 2009	Michele Nanchoff-Glatt
Sheri Golia	Vancouver Island Health Authority, Duncan, BC	SIC	Oct. 2 nd , 2009	Michele Nanchoff-Glatt
Sue Munro	Vancouver Island Health Authority, Duncan, BC	SIC	Oct. 2 nd , 2009	Michele Nanchoff-Glatt
Debbie Perry	Eastern Health, St. John's, NL	DUMO	Oct. 28 th , 2009	Christina Krause
Lesley Moss	Vancouver Island Health Authority, Victoria, BC	DUMO	Nov 12 th , 2009	Christina Krause

ARTICLES OF NOTE



Overcoming preconceptions and perceived barriers to medical communication using a 'dual role-play' training course.

Lim EC, Oh VM, Seet RC.

Intern Med J. 2008 Sep;38(9):708-13. Epub 2008 Feb 20.

BACKGROUND: Communication is a core component of clinical competence. We introduced a dual role-play (DRP) course, in which participants role-played both the doctor-candidate and the standardized patient. The aim of the study was to assess the usefulness of a DRP communication course for physicians and to identify factors that inhibit effective medical communication.

METHODS: We conducted four medical communication skills courses from 2004 to 2006. A questionnaire was administered before and after completion of each course. We assessed respondents' confidence levels before and after the course and sought to identify perceived barriers to effective communication among medical trainees in Singapore. Finally, we asked if they found participation in the course and its DRP nature to be useful.

RESULTS: Twenty-six participants, 20 men, 6 women, of mean age 30.2 years (standard deviation (SD) 2.01) completed the survey. The pre-course confidence levels (rated on a scale of 1-10) of 6.23 (SD 1.18) rose significantly to 7.58 (SD 0.95) on completion of the course ($P = 0.001$, Wilcoxon signed rank test). All respondents felt that they had benefited from participation in the medical communication skills course. 24 (92.3%) respondents deemed it useful to have role-played both the doctor and standardized patient in the exercise. We identified respondents with language difficulties to have benefited the most from the course ($P = 0.031$, odds ratio 2.906 (95%CI 0.292-5.519), linear regression analysis).

CONCLUSION: DRP is an effective way to train doctors in medical communication.

Adverse symptom event reporting by patients vs clinicians: relationships with clinical outcomes.

Basch E, Jia X, Heller G, Barz A, Sit L, Fruscione M, Appawu M, Iasonos A, Atkinson T, Goldfarb S, Culkin A, Kris MG, Schrag D.

J Natl Cancer Inst. 2009 Dec 2;101(23):1624-32. Epub 2009 Nov 17.

BACKGROUND: In cancer treatment trials, the standard source of adverse symptom data is clinician reporting by use of items from the National Cancer Institute's Common Terminology Criteria for Adverse Events (CTCAE). Patient self-reporting has been proposed as an additional data source, but the implications of such a shift are not understood.

METHODS: Patients with lung cancer receiving chemotherapy and their clinicians independently reported six CTCAE symptoms and Karnofsky Performance Status longitudinally at sequential office visits. To compare how patient's vs clinician's reports relate to sentinel clinical events, a time-dependent Cox regression model was used to measure associations between reaching particular CTCAE grade severity thresholds with the risk of death and emergency room visits. To measure concordance of CTCAE reports with indices of daily health status, Kendall tau rank correlation coefficients were calculated for each symptom with EuroQoL EQ-5D questionnaire and global question scores. Statistical tests were two-sided.

RESULTS: A total of 163 patients were enrolled for an average of 12 months (range = 1-28 months), with a mean of 11 visits and 67 (41%) deaths. CTCAE reports were submitted by clinicians at 95% of visits and by patients at 80% of visits. Patients generally reported symptoms earlier and more frequently than clinicians. Statistically significant associations with death and emergency room admissions were seen for clinician reports of fatigue ($P < .001$), nausea ($P = .01$), constipation ($P = .038$), and Karnofsky Performance Status ($P < .001$) but not for patient reports of these items. Higher concordance with EuroQoL EQ-5D questionnaire and global question scores was observed for patient-reported symptoms than for clinician-reported symptoms.

CONCLUSIONS: Longitudinally collected clinician CTCAE assessments better predict unfavorable clinical events, whereas patient reports better reflect daily health status. These perspectives are complementary, each providing clinically meaningful information. Inclusion of both types of data in treatment trial results and drug labels appears to be warranted.



From Reuters Health Information

Patients Happier When Doctors Discuss What Went Wrong

NEW YORK (Reuters Health) Nov 19th, 2009

Hospital patients who suffer a side effect from treatment are more likely to give high ratings to their quality of care when hospital staff are up front about what went wrong, a new study suggests.

In a survey of nearly 2,300 patients treated at 16 Massachusetts hospitals, researchers found that 603 had some sort of "adverse event" -- most often side effects from a newly prescribed drug or complications from surgery -- during their hospitalization.

When asked whether hospital staff had explained the problem to them, only 40% of patients said they had.

Yet, when staff did discuss the problem, patients were more likely to be happy with their care -- even when the adverse effect was a preventable one, the study found.

"Our findings show that disclosure is associated with patients' perception of higher-quality care, even when they were harmed by an adverse event," lead researcher Dr. Lenny Lopez, of Massachusetts General Hospital in Boston, said in a statement.

"We believe this is the first study to address how disclosure affects the quality-of-care impression in patients who actually were harmed during the course of their treatment and may reassure physicians and others who worry about the consequences of disclosure," he added.

Using hospital records and patient interviews, the researchers found that almost one-third of adverse events in the study were preventable -- being related to errors such as giving the wrong dose of medication.

Hospital staff were less likely to discuss preventable adverse events with patients compared with ones that could not be avoided -- such as an unforeseeable reaction to a new drug. When patients suffered a preventable adverse event, staff explained the problem to them only 30% of the time, Lopez's team found.

Yet, patients tended to give their care higher quality ratings when a problem was explained to them, even when the complication was preventable.

On average, study patients rated their hospital care as "very good." But patients who'd discussed their adverse event with hospital staff were twice as likely to give high ratings as those who been given no explanation.

"It's quite notable that high-quality ratings continued to be associated with disclosure even when the event was determined to be preventable," Dr. Lopez said.

The findings, according to Lopez, suggest that hospitals should not be afraid to disclose the reasons for patients' adverse events, even if they did arise from error.

"Although rates of disclosure remain disappointingly low," he said, "our findings should encourage more disclosure and allay fears of malpractice lawsuits."

"Patients want to be told the truth," Dr. Lopez added, "and they perceive disclosure as integral to high-quality medical care."

Dr. Lopez and his colleagues report their findings in the Archives of Internal Medicine.

In a separate study published in the same journal, researchers focused on diagnostic errors by physicians. They found that among 300 doctors at 22 U.S. hospitals, the most commonly missed or delayed diagnoses were pulmonary embolism, drug reactions and overdoses, heart attacks and lung, colon and breast cancers.

On average, the doctors described committing or witnessing two such errors in their careers. "Actively soliciting such cases represents an opportunity for tapping into a hidden cache of medical errors that are not generally collected by existing error surveillance and reporting systems," the authors write.

Arch Intern Med 2009.

Reuters Health Information © 2009

Connected: Communicating & Computing in the Exam Room



INTRODUCTION

Computers have brought great advances to the practice of medicine. With the information a clinician needs instantly available through the electronic medical record, many health care organizations have literally done away with paper patient charts. This technological advance comes at the cost of adding another element that clinicians and office staff must juggle when caring for patients in their clinics and hospitals. In an effort to prepare clinicians and staff for the challenges of communicating and computing in the exam room, the Institute has developed the "Connected" workshop.

THE CHALLENGE

The exam room computer offers new avenues for inviting patients to become active partners in their health care. It also can become a barrier to effective communication. Busy clinicians, whose tasks are now accomplished through the computer, are sometimes drawn immediately to the screen, omitting a critical opportunity to start with a personal connection with the patient. As clinicians have a wealth of data at their fingertips, patients may experience them as distracted by the computer. When it is not introduced, patients have told researchers that they believed that clinicians were doing computer work unrelated to their visit. For those patients who see the clinician with a friend or family member, the on-screen display can pose a threat to confidentiality. Often, the patient first experiences the computer with the medical assistant. When the medical assistant and clinician are not working in concert, patients can be alienated by computer use. The challenge is to provide clinicians and office staff with tools to help them communicate effectively with patients while using exam room computers. With effective communication, patients will experience computers as a valuable medical tool that enhances their confidence in care, encourages adherence to medical regimens, and invites their active participation in maintaining their health.

THE PROGRAM

Connected is a 3-hour program for clinicians and medical office staff who use computers while interacting with patients. The workshop is highly interactive and engages participants in considering both the challenges and opportunities that the exam room computer presents to the patient's relationship with clinicians and staff. "Connected" builds on the Institute's 4E Model (Engage, Empathize, Educate, and Enlist) to address the unique aspects of communicating and computing in the exam room.

OBJECTIVES

- By the end of the workshop, participants will:
- Develop increased skills and greater confidence in their ability to communicate effectively while using exam room computers
 - Identify techniques that communicate to patients, "We know you"
 - Identify techniques that enhance shared decision-making and patient satisfaction through the use of exam room computing

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HOLIDAY CLOSURE

The IHC-C office will be closed
December 23rd, 2009, until Jan. 4th, 2010.