

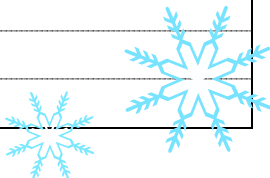


An update for you from the IHC-C office & the Canadian Operating Committee; as always, we invite you to provide any feedback/suggestions that you may have to contribute to this newsletter.

FACULTY DEVELOPMENT

Congratulations to new IHC-C Faculty
October - November, 2007

<p>"TREATING PATIENTS WITH C.A.R.E." Calgary, Alberta - Oct 1 - 3, 2007 Sponsored by: Calgary Health Region - Dept. Support Services</p>	
<p>Course Instructors: Michele Nanchoff-Glatt / Heather Coburn / Maureen Osis</p>	
<p>New Faculty Member</p>	
1.	Naila Bhimani
2.	Richard Cullen
3.	Albert Hale
4.	Shirley Horn
5.	Arlys Juhn
6.	Dave Leggott
7.	Denny Mellott
8.	Jane Morrison
9.	Monika Ramsey
10.	Jeremy Roque
11.	Sid Rosborough
12.	Darryl Sackman
13.	Carol Shelly



<p>"TREATING PATIENTS WITH C.A.R.E." Calgary, Alberta - Oct 15 - 17, 2007 Sponsored by: Health Quality Council Of Alberta</p>	
<p>Course Instructors: Michele Nanchoff-Glatt / Heather Coburn</p>	
<p>New Faculty Member (Organizaton)</p>	
1.	Dyana Bray (Calgary Health Region)
2.	Amie Emilio (Calgary Health Region)
3.	Heather Gallant (Calgary Health Region)
4.	Penny Hammer (East Central Health)
5.	Irene Houghton (Calgary Health Region)
6.	Val Schoonderbeek (Palliser Health Region)
7.	James Stroud (Calgary Health Region)
8.	Peggy Snydmiller (East Central Health)
9.	Linda Walters (Calgary Health Region)

<p>"TREATING PATIENTS WITH C.A.R.E." Edmonton, Alberta - Nov 21-23, 2007 Sponsored by: Health Quality Council Of Alberta</p>	
<p>Course Instructors: Michele Nanchoff-Glatt / Heather Coburn / Maureen Osis</p>	
<p>New Faculty Member (Organizaton)</p>	
1.	Pat Brooks (Capital Health Region)
2.	Doug Buwalda (David Thompson Health Region)
3.	Doris Gudz (Palliser Health Region)
4.	Doug Huber (College of Physicians & Surgeons of AB)
5.	Marnie Johnson (College of Physicians & Surgeons of AB)
6.	Sheila Niven (East Central Health Region)
7.	Troy Pruden (Aspen Regional Health)
8.	Steve Richardson (Aspen Regional Health)
9.	Dianne Robertson (Aspen Regional Health)
10.	Gail Wells (Northern Lights Health Region)
11.	Jennifer Wheaton (City of Edmonton - E.M.S.)

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

FACULTY DEVELOPMENT
 *Continued...*

Please note that Canadian Faculty Development programs are arranged on a "by request" basis. If you are interested in further information, please contact K. Stewart.



The following Faculty Development courses have been tentatively scheduled in Canada ...

- Disclosing Unanticipated Medical Errors**
 Health Quality Council of Alberta
 Dates: February 25-27, 2008
 Vancouver, BC
- Treating Patients with C.A.R.E.**
 Health Quality Council of Alberta
 March 5-7, 2008
 Edmonton, AB
- Disclosing Unanticipated Medical Errors**
 Health Quality Council of Alberta
 Dates: March 17-19, 2008
 Calgary, AB
- Treating Patients with C.A.R.E.**
 Tom Baker Cancer Centre
 Dates: March 24- 26, 2008
 Calgary, AB
- Coaching for Impressive C.A.R.E.**
 Cross Cancer Institute
 Dates: April 1-3, 2008
 Edmonton, AB



The following Faculty Development courses have been planned in the USA in 2008. If you are interested in attending, please contact K. Stewart for more information.

- Intensive Communication Skills**
 Jan 27-Feb 1, 2008
 New Haven, Connecticut
- "Difficult" Clinician-Patient Relationships**
 Feb 19-22, 2008
 New Haven, Connecticut
- Choices and Changes**
 Apr 14-18, 2008
 New Haven, Connecticut
- Clinician-Patient Communication**
 May 4-9, 2008
 New Haven, Connecticut

2007 Faculty Development			
Sponsor	Course	Date	# trained
Fraser Health Authority	CPC	Jan	16
Winnipeg Regional Health Authority	DUMO	Jan	20
Cross Cancer Institute	CFIC	Mar	4
Health Quality Council of Alberta	DUMO	Apr	12
Calgary Health Region: Dept. Home Care	CARE	May	10
Calgary Health Region: Dept. Support Services	CARE	Oct	13
Health Quality Council of Alberta Calgary	CARE	Oct	9
Health Quality Council of Alberta Edmonton	CARE	Nov	11
TOTALS			95

CFPC MAINPRO -1 Accreditation

A national application for Mainpro-1 credits has been submitted to The College of Family Physicians of Canada, by the IHC-C office. The application covers the **workshop** versions of the following courses:

- Clinician-Patient Communication
- "Difficult" Clinician-Patient Relationships
- Choices & Changes
- Care not Cure
- Disclosing Unanticipated Medical Outcomes
- Strangers in Crisis

The submitted documents are currently under review. Once accreditation is approved, to receive credits for a *specific* workshop, a brief application (providing details of the venue, presenters and costs) must also be submitted to the provincial organization of the CFPC; the cost for the provincial application is \$100.



2007 COURSE SUMMARY:

FACULTY COURSES

Number of Faculty Courses held = 8

Number of New Faculty trained = 95

WORKSHOPS (reported)

TOTAL Number of IHC-C-associated presentations = 157

- Full **INTERNAL** workshop presentations = 124
- Full **EXTERNAL** workshop presentations = 4
- Promotional / Demo presentations = 9
- Non-workshop use of IHC material = 10
- Medical school licensed presentations = 10

Estimated number of workshop participants = 2200

WORKSHOP DEMOGRAPHICS

Course	Total # workshops	Summary by Province				
		AB	BC	MB	ON	PQ
Treating Patients with C.A.R.E.	58	57	-	-	-	1
Disclosing Unanticipated Medical Outcomes	46	30	-	16	-	-
Clinician-Patient Communication	30	12	5	1	5	7
Choices & Changes	13	8	-	1	4	-
"Difficult" Clinician-Patient Relationships	5	2	-	-	3	-
Care not Cure	3	-	3	-	-	-
Coaching for Impressive C.A.R.E.	2	2	-	-	-	-
TOTALS	157	111	8	18	12	8

ARTICLES OF NOTE



The effect of professional skills training on patient-centredness and confidence in communicating with patients

Authors: Noble, L M; Kubacki, A; Martin, J; Lloyd, M
Source: [Medical Education](#), Vol 41, No 5, May 2007, pp. 432-440(9)

Objectives: The effect of introducing professional skills training on students' patient-centred attitudes and perceptions of ability to communicate was examined. Professional skills included weekly training in communication skills, ethics and law, and clinical skills.

Methods: Consecutive cohorts of medical students receiving a traditional pre-clinical curriculum (n=199) and a new curriculum including professional skills training (n=255) were compared. Students completed the Doctor-Patient Scale to assess patient-centred attitudes and an 11-item scale to assess confidence in their ability to communicate with patients. Students completed the measures at the start of Yr 1 and end of Yr 2.

Results: Students receiving professional skills training showed increased confidence in communicating with patients and increases in 2 dimensions of patient-centredness ('holistic care' & 'patient decision making'). Students receiving the traditional curriculum showed increased nervousness in talking to patients. Gender and ethnic differences were found in patient-centredness and confidence in communicating, which were maintained over time.

Conclusions: The introduction of professional skills training was successful in improving students' confidence in their ability to perform specific communicative behaviours and increasing patient-centredness relative to a traditional curriculum.

Coming of age as communicators: differences in the implementation of common communications skills training in four residency programmes

Authors: Razack, S; Meterissian, S; Morin, L; Snell, L; Steinert, Y; Tabatabai, D; MacLellan, A-M
Source: [Medical Education](#), Volume 41, Number 5, May 2007, pp. 441-449(9)

Objectives: To determine thematic similarities and differences in the implementation of common-content communications skills training (CST) in medicine, surgery, paediatrics, and obstetrics and gynaecology residency programmes.


Methods: Communications skills training based upon the Kalamazoo consensus statement of communication skills in the clinical encounter was implemented in 4 residency programmes. Field notes of the CST sessions in each programme were analysed and coded for themes, considering the domains of Context, Input, Process and Product ('CIPP' methodology). Immediate learning outcomes were quantitatively assessed using retrospective pre/post methodology.

Results: Important differences were noted in the implementation of CST in the 4 disciplines. The 2 surgical disciplines showed relatively less reflective language and greater concentration on straight skill acquisition, whereas the 2 medical disciplines concentrated on the residents' role as teachers of communication skills for buy-in. Thematic similarities between disciplines included similar challenges to being good communicators in practice, as identified by residents (e.g. inadequate time and space), as well as lack of formal training. Quantitative learning outcome data from the educational intervention were significant in all groups ($P < 0.05$).

Conclusions: Common material in CST can be adapted to different disciplines. By analysing for thematic similarities and differences in implementation in the 4 disciplines, a picture of different pedagogic 'subcultures' emerged, with different behavioural norms and values related to the doctor's role as communicator. In shared core competency training, it may be useful to consider these differences in planning, so that the training may be both sensitive to the behavioural norms of different disciplines, and effective.

ARTICLES *continued ...*



 **Poor communication may impair optimal asthma care: a qualitative study**

Authors: Moffat, M; Cleland, J; van der Molen, T; Price, D
Source: Family Practice, Feb 2007, V 24, no.1, Pg: 65-70(6)

Background: Despite asthma being primarily managed in general practice and primary care, there is little research into the issues and tools which may impact on managing poorly controlled asthma in this setting.

Objective: To explore the views of health care professionals (HCPs) towards asthma guidelines and self-management plans (SMPs) to identify why these are not used routinely in general practice.

Methods: Data from 54 HCPs [GPs and practice nurses (PNs)] in north-east Scotland were collected via qualitative interviews and focus groups. Participant views and experience of asthma guidelines and SMPs were explored.

Results: Participants had mainly positive attitudes towards guidelines and SMPs, although both were used only when deemed suitable by the individual. Suitability depended on individual patient issues (e.g. psychosocial factors, level of control) and/or professional issues (e.g. ease of use, time available, job roles). Patient issues were viewed as impacting on asthma control directly and, indirectly, as the main reason for not using guidelines or SMPs with a patient. HCPs reported lacking necessary communication skills for dealing with patient asthma control issues, particularly where these were non-medical. Professional and organizational issues such as training and communication were also perceived as impairing asthma management.

Conclusion: Our findings indicate that guidelines are seen as providing the 'why' of helping asthma patients' self-manage but not

the 'what to...' or 'how to...' communicate. Poor professional-patient communication seems largely to explain the poor uptake of SMPs and guideline use in general practice and primary care. This limitation is more obvious to professionals when they are working with patients with poorly controlled asthma. There is a need to identify key communication skills for effective professional-patient partnership in adult asthma management, and to develop robust strategies for effectively training GPs and PNs in enhancing these skills.

USA Today Examines Push to Improve Patient-Provider Communication (Jul 25, 2007)

The federal government, nonprofit organizations and patient advocates are working to strengthen patient-provider communication in hospitals in light of evidence from the Joint Commission on the Accreditation of Healthcare Organizations and the Institute of Medicine that poor communication practices may increase the risk of preventable medical errors, USA Today reports. As it considers whether to hold facilities accountable for the quality of patient-provider communication, the Centers for Medicare and Medicaid Services (CMS) is requiring hospitals to begin collecting patient satisfaction data this month through the Hospital Consumer Assessment of Health Providers and Systems survey, which includes questions addressing providers' listening skills and the accessibility of medical explanations. USA Today notes, meanwhile, that some hospitals are already taking steps to improve patient-provider communication. For example, Sacred Heart Hospital in Eau Claire, Wis., which ranks in the top 1 percent nationally in Press Ganey patient satisfaction scores, has sought to enhance patient-provider communication by adopting physician behavioral standards, making post-discharge follow-up calls and implementing hourly nursing rounds. To complement hospital-based efforts, a retired physician in Boston launched Bedside Advocates, an organization that recruits volunteers to serve as patient guides during medical encounters. The guides translate medical jargon into laymen's terms and help patients with limited English proficiency understand care recommendations, according to the program's founder (Donaghue, USA Today, 7/25/07).

ARTICLES *continued ...*



The role of empathy in establishing rapport in the consultation: a new model

Authors: Norfolk, T; Birdi, K; Walsh, D

Source: [Medical Education](#), Volume 41, Number 7, July 2007, pp. 690-697(8)

Objectives: Considerable research has been conducted recently into the notion of patient-centred consulting. The primary goal of this approach is to establish a clear understanding of the patient's perspective on his or her problem, and to allow this understanding to inform both the explanation and planning stages of the consultation. The quality of this understanding is largely determined by the empathic accuracy achieved by the doctor; the primary benefit is a therapeutic rapport between doctor and patient.

Methods: To highlight the role of empathy and communication skills in establishing rapport, we initially developed a model which seeks to draw the various motivational and skill elements identified in separate research papers into a comprehensive model of the journey towards shared understanding between doctor and patient. We then conducted an initial validation of the model via qualitative analysis involving general practitioners (GPs) and clinical psychologists.

Results: The validation offered encouraging support for the principal elements of the model. Specific suggestions for clarification and extension were then incorporated in a revised model.

Conclusions: The model appears to capture the dynamic process of establishing a therapeutic relationship (rapport) between doctor and patient, defined by the quality of the doctor's understanding of the patient's perspective on his or her problem. Arguably, the most important contribution of the model is to highlight the fact that 'empathy' and consequent 'rapport' are not mystical or exclusive concepts but, rather, involve the use of specific skills accessible at some level by all.

Perceptions of and attitudes towards medical errors among medical trainees

Authors: Muller, David; Ornstein, Katherine

Source: [Medical Education](#), Volume 41, Number 7, July 2007, pp. 645-652(8)

Objectives: The purpose of this study was to develop a better understanding of how medical trainees define medical errors and what factors influence medical trainees' perceptions of medical errors.

Methods: We surveyed 423 medical students and house staff at an urban academic medical centre to learn about how they defined medical errors, their experiences with medical errors, their beliefs about when a patient should be informed of an error, and their attitudes towards medical errors with differing severity of outcomes.

Results: Trainees stated that an event could be considered an error regardless of outcome, negligence, intention or consent. Definitions did not vary according to gender or level of training. Trainees had increasing feelings of guilt and fear as the outcomes related to errors worsened. Respondents were more likely to feel guilty and angry at themselves, and be afraid of accusations of malpractice, losing their licence, damaging their reputation, or losing confidence when errors were made while working individually versus in a team setting. Female trainees were more likely than male trainees to feel guilty and angry at themselves, and were afraid of losing confidence if they made an error.

Conclusions: Trainees' perceptions and attitudes towards errors vary depending on whether they are in their clinical years, the severity of outcome, and whether the error is attributable to an individual or a team. These factors will have to be explored in greater depth if we are adequately to prepare young doctors for the errors they will inevitably make.

IHC-C Governance

Governance for the IHC-C is achieved through a Canadian Operating Committee (COC). This committee was originally comprised of representatives from the three "parent" organizations - Cancer Care Ontario (CCO), the Canadian Cancer Society - Ontario Division (CCS-OD) and the College of Family Physicians of Canada (CFPC), plus ex officio participation of the current IHC CEO. In 2006, the COC membership was expanded to broaden the base of expertise and now includes faculty members and representation from additional healthcare sectors. The COC is currently reviewing candidates and recruiting to its membership in order to more fully represent and reflect the diversity of professional groups and geographical regions across the country.

Stay tuned for member announcements in the new year...



Please feel welcome to contact our Canadian office if you have any questions, concerns, or comments.

If you wish to be removed from the newsletter e-mail list, please let us know.



PRIOR TO A WORKSHOP:

For **INTERNAL** workshops ...

As soon as a date is set, please submit the Workshop Scheduling / Material Request FORM to the IHC-C office, even if you are not ordering materials.

For **EXTERNAL** workshops ...

Please inform the IHC-C office right away if you are negotiating a presentation of this sort, so that that we can work with you to develop budgets and any necessary materials that are within the IHC-C guidelines.

FOLLOWING A WORKSHOP:

For all workshops, please submit all evaluations, or an evaluation summary, along with number of participants and participant demographics (if available). THANKS!

IHC-C forms may be accessed via ...

<http://www.ihcc.ca/work.asp>

Seasons Greetings

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