



# Institute for Healthcare Communication Canada

*Meeting the challenge of providing effective clinician-patient interactions*

IHC-C Faculty Newsletter Volume 5, Issue 2

December, 2010



**Welcome...**



to the **FALL - WINTER 2010** edition  
of the IHC-C Faculty Newsletter

The second half of 2010 has brought an increased awareness and interest in the programs that the IHC-C offers. In fact, November was the busiest month yet for the IHC-C, with 48 **NEW** IHC-C faculty trained within one 3-week time period!

A few "thank you" notes to share with you...

- *Thank you...* to the Executive and Board of Directors of the College of Family Physicians of Canada. The CFPC's generous support and provision of a home for the IHC-C has been essential to the Institute's growth and development over the past 5 years. Their commitment to the IHC-C's vision and the importance of the role that communication plays in health care settings, is vital to the health and longevity of the Institute in Canada!
- *Thank you...* to the IHC for providing the CFPC with the opportunity to oversee these important programs in Canada.
- *Thank you...* to IHC-C Administrative Assistant, Sheila MacDonald, for her many valued contributions and to all of the CFPC staff who assist in the day to day operational affairs of the IHC-C.
- *Thank you...* to the IHC-C Advisory Committee for your ongoing guidance and support.
- *Thank you...* to the many sponsors, clients, partners and collaborators for your commitment to providing educational programming for your staff and colleagues.
- *Thank you...* to senior IHC-C faculty leadership team members for your passion, skills, mentorship and commitment to providing meaningful learning opportunities to course participants and new faculty.
- *Thank you...* to the many active faculty across Canada who promote interest and awareness of the Institute's programming on an ongoing basis, and ultimately contribute significantly to improving the health care experience for patients across Canada. Well done!



**Keep up to date**  
[www.ihcc.ca](http://www.ihcc.ca)

## Coming in 2011 ...



**IHC course offering:**

**"Patient-Centered Medical Home" (PCMH)**

*See details and further information on Page 3.*



### HOLIDAY CLOSURE

The Institute for Healthcare Communication – Canada office will be closed from Thursday, December 23<sup>rd</sup>, 2010, until Tuesday, January 4<sup>th</sup>, 2011.

*Happy Holidays to all!*

### **INSIDE THIS ISSUE**

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## Summary of 2010 IHC-C faculty activity:

### IHC-C FACULTY TRAINED in 2010

Course / Province	<i>Choices &amp; Changes: Clinician Influence and Patient Change</i>	<i>Connected: Communicating &amp; Computing in the Exam Room</i>	<i>"Strangers in Crisis: Communicating with Patients, Families &amp; Your Team in the Emergency Department"</i>	<i>Disclosing Unanticipated Medical Outcomes</i>
Alberta	27	2	-	-
British Columbia	-	-	9	-
Ontario	28	3	-	-
Prince Edward Island	-	-	-	10
<b>TOTALS</b>	<b>55</b>	<b>5</b>	<b>9</b>	<b>10</b>

### 2010 WORKSHOPS (includes internal, external & faculty course context) - ESTIMATES

Course / Province	CARE	C&C	DUMO	CPC	Connected	SIC	CFIC	DCPR	TOTALS
AB	63	55	2	1	2	-	1	1	125
BC	-	-	17	-	-	9	-	-	26
MB	-	-	9	-	-	-	-	-	9
NL	-	-	26	-	-	-	-	-	26
ON	-	5	-	3	1	-	-	-	9
PE	-	-	1	-	-	-	-	-	1
YK	-	-	1	-	-	-	-	-	1
<b>TOTAL # Workshops</b>	<b>63</b>	<b>60</b>	<b>56</b>	<b>4</b>	<b>3</b>	<b>9</b>	<b>1</b>	<b>1</b>	<b>197</b>
<b>Total # participants</b>	<b>688</b>	<b>728</b>	<b>664</b>	<b>31</b>	<b>29</b>	<b>126</b>	<b>30</b>	<b>6</b>	<b>2302</b>

### Workshop Follow-up Survey

Don't forget to assess the impact of your workshop presentation...

We now have a course-specific follow up survey mechanism in place to gather data to assess the impact of workshop techniques and skills on the subsequent clinical interactions of your learners.



Please contact the IHC-C office for more information and / or to get started today!



## **News from IHC in New Haven CT...**

### ***“Enhancing Communication Skills for Patient Aligned Care Teams (PACT)”:***

An exciting new communication program developed by the IHC in 2010. At the request of the Veteran’s Health Administration, the IHC developed this unique program, which was the focus of a successful new faculty course launch in Orlando, Florida, in July 2010.

The IHC plans to introduce this course for the public under a slightly revamped title:

### ***“Patient-Centered Medical Home” (PCMH)***

Plans are underway to complete the development of materials and we hope to be able to train Canadian faculty in the very near future. Stay tuned for more in 2011!



### **Imagine yourself enjoying sunny and warm Atlanta, Georgia, in frosty February!**

The Institute for Healthcare Communication (IHC) is offering an OPEN ENROLMENT 3.5-day Faculty Development (Train-the-Trainer) course to teach IHC’s *“Clinician Patient Communication to Health Enhance Outcomes”* workshop.

**Tuesday February 8 to Friday February 11, 2011**

There are limited spaces available – please contact the IHC-C office if you or someone you know is interested in enrolling in this program.

## **Canadian Faculty Development – 2011**

**ATTENTION:** All those interested in a 3-Day Faculty Development course for

### ***“Treating Patients with C.A.R.E”***

*Health care organizations face the challenge of assuring that all staff who interact with patients use effective communication skills. Patients have better health outcomes when good interactions with staff encourage them to adhere to treatment plans and follow up with care. Treating Patients with C.A.R.E. (Connect, Appreciate, Respond, Empower) provides an interactive model and specific techniques that guide all staff to communicate in ways that will enhance satisfaction and encourage patient partnership.*

### **CONNECT – APPRECIATE – RESPOND – EMPOWER**

There has been a significant amount of interest to run one or two CARE faculty courses in the Calgary area of Alberta.

Plans are being made to host one course in March 2011, and a second course in April, 2011.

Please contact [ks@cfpc.ca](mailto:ks@cfpc.ca) if you would like additional details and to reserve your space today!

### ***“Choices & Changes”***

4-day Faculty Development

January 17<sup>th</sup> to 20<sup>th</sup>, 2011

Ajax, Ontario – COURSE FULL!

## FACULTY DEVELOPMENT



### November 2010 - Ajax, Ontario:

Pictured here, are new "Choices and Changes" (C&C) faculty and the IHC faculty development team.

This is the SECOND successful group Ontario completing the C&C training in 2010, and plans are already underway for a third training in January, 2011!



### **Congratulations to new "Choices & Changes" Faculty** (November 8<sup>th</sup> to 11<sup>th</sup>, 2010)

Faculty leader: Michele Nanchoff-Glatt, PhD, RPsych

Faculty Team: Cecile Carson MD, Heather Coburn MSW

<b>Michelle Bishop</b> MEd, RD	Clinical Dietitian	Ontario Shores Centre for Mental Health Sciences
<b>Tanya Burr</b> , BScN (Hon)	Registered Nurse	Belleville Quinte West Community Health Centre
<b>Pam Cardwell</b> , BA, MA	Self-Management Program Coordinator	Central East CCAC
<b>Nancy Cohen</b> , BScN	Coordinator Cardiac Education Program	North York General Hospital
<b>Reshma Dole</b> , BSc Phm	Management Project Leader Regional Nephrology System	Lakeridge Health Corp
<b>Sherlyn Hu</b> , MSW, RSW	Professional Prog. Development Officer	Carefirst Seniors & Community Services Associat
<b>Phyllis McGee</b> , MN, NP	Nurse practitioner	North York General Hospital
<b>Mary-Lynne Miles</b> , BA, BEd, BNSc, Med	Nurse Practitioner	Belleville Quinte West Community Health Centre
<b>Judy Murray</b> , MScPT	Project Coordinator AAH Stroke Prevention Strategy	York Central Hospital
<b>Christina Vaillancourt</b> , BAsC, RD, CDE	Patient Care Specialist	Lakeridge Health Corp
<b>Mary Walling-Field</b> , BA, BSW, MSW	Social Worker	Kawartha Lakes Community Care Health Team
<b>Deion Weir</b> , BA, MS, RD	Professional Practice Leader, Clinical Dietitian,	Humber River Regional Hospital

Congratulations to the **Fraser Health Authority (FHA) & Vancouver Island Health Authority (VIHA)** for sponsoring a *“Strangers in Crisis: Communicating with Patients, Families and Your Team in the Emergency Department” (SIC)* IHC-C faculty development program in November 2010.

**Congratulations to new “SIC FACULTY** (November 15<sup>th</sup> to 18<sup>th</sup>, 2010)

Faculty Leader & Team: Michele Nanchoff-Glatt PhD, RPsych, Heather Coburn MSW

<b>Julie Dufton, BSN</b>	Registered Nurse Emergency Department	<b>FHA</b>
<b>Lynn Gifford, BTEch, MA (in progress), RN</b>	Coordinator Forensic Nursing Services	<b>FHA</b>
<b>Alison Koropatniski, BScN, RN</b>	Registered Nurse	<b>VIHA</b>
<b>Kristina Ledger, BSc, DipNurs</b>	Clinical Nurse Educator Royal Jubilee Hospital	<b>VIHA</b>
<b>Christopher MacGregor, RN</b>	Emergency Clinical Nurse Educator Royal Columbia Hospital	<b>FHA</b>
<b>Rick Odell, BSW, MSW, RSW</b>	Manager Eagle Ridge Hospital	<b>FHA</b>
<b>Lauren Rose, RN, ENC</b>	Patient Care Coordinator, Emergency Room Chilliwack General Hospital	<b>FHA</b>
<b>Norman Sim, BSN, RN, DipTCM</b>	Registered Nurse Emergency Department	<b>VIHA</b>
<b>Bev Stone, BHA, RN</b>	RN, Patient Care Coordinator Ridge Meadow Hospital	<b>FHA</b>



**Congratulations to ALBERTA HEALTH SERVICES for sponsoring the  
development of new “Choices & Changes” Faculty**

**November 23<sup>rd</sup> to 26<sup>th</sup>, 2010**

IHC-C Faculty leader: Michele Nanchoff-Glatt, PhD, RPsych

IHC Faculty Team members: Cecile Carson MD, Heather Coburn MSW

AHS Faculty Team members: Laura Brule, RN, BN / Peggy Clarke, RDH / Loreen Foster, RPN /  
Carole Harnack, RN BN CCP CDE / Doris Listoe, BSChEc, RD

<b>Patricia Acheson, BSc</b>	<b>Edmonton (PCN)</b>	Registered Dietitian, Edmonton N Primary Care Network
<b>Barb Bell, RN, BN, GNC(C)</b>	<b>Calgary (Home Care)</b>	Education Consultant
<b>Nancy Becker Hallford, RDH</b>	<b>Edmonton</b>	Health Literacy Consultant/Health Educator Chronic Disease Management
<b>Kathryn Brandt, RN, BN, MN (in progress)</b>	<b>South (Home Care)</b>	Lead, Integrated Case Management
<b>Tricia Chambers, RN, DC, BHsCN</b>	<b>Calgary</b>	Clinical Coordinator, CDM Nursing
<b>Susan Cormack, RSW</b>	<b>Calgary (Tob. Reduction)</b>	Program Coordinator
<b>Wayne Enders, RN</b>	<b>Edmonton (CA Care)</b>	Clinical Educator, Cancer Care
<b>Bahigi Fyith, RD, BSc</b>	<b>Calgary</b>	Chronic Disease Management Coordinator
<b>Lisa Gall, BSc</b>	<b>North</b>	Self Management Facilitator
<b>Leslie Gareau, BHE, RD</b>	<b>Calgary</b>	Registered Dietitian, Living Well With a Chronic Condition
<b>Kelly Gormley, BSW, BEd</b>	<b>Calgary</b>	Social Worker, Living Well With a Chronic Condition
<b>Leanne Kiss, BN</b>	<b>Calgary</b>	Education Consultant Diabetes Hypertension & Cholesterol Centre
<b>Charlene Knudsen, BScN, MEd</b>	<b>Edmonton (Home Care)</b>	Manager, Home Living Program
<b>Norma Love, RN, GNC(C)</b>	<b>North (Home Care)</b>	Clinical Educator
<b>Allison MacGregor, RN</b>	<b>Calgary</b>	CDM Nursing, Southern AP HIV Program
<b>Vanya McGaffey, BScN, RD</b>	<b>South</b>	Clinical Coordinator, Building Healthy Lifestyles
<b>Louise Morrin, MBA, BSc</b>	<b>Calgary</b>	Director, Integration, Resource and Team Development Primary Care & Chronic Disease Management
<b>Isabel Nordquist, BN, RN</b>	<b>South (Home Care)</b>	Manager of Access Centre & Placement
<b>Linda Phalen, RN</b>	<b>Calgary (CA Care)</b>	CCN Nursing Educator / Liaison Nurse Cancer Care
<b>Rheta Prill, BScN</b>	<b>Central (Home Care)</b>	Area Manager, Seniors Health
<b>Rose (Ruth) Pugh, BScN</b>	<b>North</b>	Chronic Disease Management, Nurse Educator
<b>Darline Reid, BN</b>	<b>North (Home Care)</b>	Area Manager, Seniors Health
<b>Robin Schwartz, BPE</b>	<b>Central (PCN)</b>	Wellness Coordinator, Big Country PCN
<b>Christina Sirman-Hundt, MPH, BSc</b>	<b>Edmonton</b>	Program Coordinator, Chronic Disease Management
<b>Sherri Sterling, MEd, CEP</b>	<b>South</b>	Improvement Facilitator, Chinook Primary Care Network
<b>Shelly Storozuk, RN</b>	<b>Calgary (PCN)</b>	Program Manager, South Calgary Primary Care Network
<b>Kendall Taylor, BA</b>	<b>North</b>	Area Supervisor, Addiction

## You may be interested in reading...



### *Web-enabled video-feedback: A method to reflect on the communication skills of experienced physicians.*

Noordman J, Verhaak P, van Dulmen S.

*Patient Educ Couns.* 2010 Dec 9. [Epub ahead of print]

Netherlands Institute for Health Services Research (NIVEL)

#### **OBJECTIVE:**

To describe our web-enabled video-feedback method designed to reflect on the communication skills of experienced physicians.

#### **METHODS:**

Participating physicians (n=28) received a 'personal web link' to two of their video-recorded consultations. After watching the consultations physicians received feedback by telephone or in a face-to-face meeting, structured around an individualized feedback report. This report contained scores on the communication behavior of the physician in comparison with colleagues and their own communication behavior observed in a previous study, as well as patients' opinions about their physician's communication behavior. The physicians were asked to reflect on their communication skills and to comment on the usefulness and efficiency of the feedback method.

#### **RESULTS:**

Almost all physicians were satisfied with the feedback method and in particular valued the web-enabled link to the video-recorded consultations and the structured written report. Feedback by telephone or face-to-face feedback was considered equally appropriate.

#### **CONCLUSION:**

This web-enabled video-feedback method is a useful and structured design to reflect on the communication skills of physicians.

#### **PRACTICE IMPLICATIONS:**

As part of continuing medical education, feedback on communication skills should become a recurrent activity for experienced physicians. This method can also be used to reflect on the communication skills of medical students.

### *The value of training in communication skills for continuing medical education.*

Rotthoff T, Baehring T, David DM, Bartnick C, Linde F, Willers R, Schäfer RD, Scherbaum WA.

*Patient Educ Couns.* 2010 Sep 30.

Duesseldorf University Hospital

#### **OBJECTIVE:**

Question arises as to what extent communication skills are considered in continuing medical education (CME).

#### **METHODS:**

Analysis for CME-courses in communication skills in the area of the Chamber of Physicians North Rhine (ÄkNo), Germany. Supply Arm (A): CME events (n=19,320) certified in 2007 were evaluated. Demand Arm (B): course participation of 850 family physicians in the period 2002-2007 was analyzed (n=37,724). Tests were calculated to the level 0.05 using Mann-Whitney U-test.

#### **RESULTS:**

(A) 388 (2.0%) events were concerned with the topic communications. 59.3% involved active cooperation of the participants. 0.5% events devoted more than 50% of their duration to the topic communication. Proportions in the subjects of internal medicine, general medicine and pediatrics amounted to 0.2%. (B) 803 (2.1%) events with a focus on communication were identified. Women took part in significantly more events than men ( $p < 0.002$ ) and selected more interactive courses.

#### **CONCLUSION:**

Content on communication training was small. Increasing experience does not automatically improve communication skills but an extent of deliberate praxis seems to be necessary and must be sought and developed.

#### **PRACTICE IMPLICATIONS:**

Communication skills are still insufficiently provided in CME-courses and should be more directed to focus as treatment strategies and scientifically investigated for outcome improvements.



**You may be interested in reading (continued) ...**

### ***The Use of Electronic Medical Records: Communication Patterns in Outpatient Encounters***

GREGORY MAKOUL, PHD, RAYMOND H. CURRY, MD, PAUL C. TANG, MD

**J Am Med Inform Assoc.** 2001;8:610–615.

#### **Abstract**

##### **Objective:**

To assess physician–patient communication patterns associated with use of an electronic medical record (EMR) system in an outpatient setting and provide an empirical foundation for larger studies.

##### **Design:**

An exploratory, observational study involving analysis of videotaped physician–patient encounters, questionnaires, and medical-record reviews.

##### **Setting:**

General internal medicine practice at an academic medical center.

##### **Participants:**

Three physicians who used an EMR system (EMR physicians) and three who used solely a paper record (control physicians). A total of 204 patient visits were included in the analysis (mean, 34 for each physician).

##### **Main Outcome Measures:**

Content analysis of whether physicians accomplished communication tasks during encounters; qualitative analysis of how EMR physicians used the EMR and how control physicians used the paper chart.

##### **Results:**

Compared with the control physicians, EMR physicians adopted a more active role in clarifying information, encouraging questions, and ensuring completeness at the end of a visit. A trend suggested that EMR physicians might be less active than control physicians in three somewhat more patient-centered areas

(outlining the patient’s agenda, exploring psychosocial/emotional issues, discussing how health problems affect a patient’s life). Physicians in both groups tended to direct their attention to the patient record during the initial portion of the encounter. The relatively fixed position of the computer limited the extent to which EMR physicians could physically orient themselves toward the patient. Although there was no statistically significant difference between the EMR and control physicians in terms of mean time across all visits, a difference did emerge for initial visits: Initial visits with EMR physicians took an average of 37.5 percent longer than those with control physicians.

##### **Summary:**

An EMR system may enhance the ability of physicians to complete information intensive tasks but can make it more difficult to focus attention on other aspects of patient communication. Further study involving a controlled, pre-/post-intervention design is justified.

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of Canada

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médecins de famille  
du Canada



## You may be interested in reading (continued) ...

### *Consulting room computers and their effect on general practitioner–patient communication*

J Noordman, PVerhaak, I van Beljouw, S van Dulmen

*Family Practice* 2010; 27:644–651

Netherlands Institute for Health Services Research

**Background:** In the western medical world, computers form part of the standard equipment in the consulting rooms of most GPs. As the use of a computer requires time and attention from GPs, this may well interfere with the communication process. Yet, the information accessed on the computer may also enhance communication.

**Objectives:** The present study affords insight into the relationship between computer use and GP–patient communication recorded by the same GPs over two periods.

**Method:** Videotaped GP consultations collected in 2001 and 2008 were used to observe computer use and GP–patient communication. In addition, patients' questionnaires about their experiences with communication by the GP were analysed using multilevel models with patients (Level 1) nested within GPs (Level 2).

**Results:** Both in 2008 and in 2001, GPs used their computer in almost every consultation. Still, our study showed a change in computer use by the GPs over time. In addition, the results indicate that computer use is negatively related to some communication aspects: the patient-directed gaze of the GP and the amount of information given by GPs. There is also a negative association between computer use and the body posture of the GP. Computer use by GPs is not associated with other (analysed) non-verbal and verbal behaviour of GPs and patients. Moreover, computer use is scarcely related to patients' experiences with the communication behaviour of the GP.

**Conclusions:** GPs show greater reluctance to use computers in 2008 compared to 2001. Computer use can indeed affect the communication between GPs and patients. Therefore, GPs ought to remain aware of their computer use during consultations and at the same time keep the interaction with the patient alive.

### *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*

A Kachalia; SR Kaufma; R Boothma; S Anderson; K Welch; S Saint; and M Rogers

*Ann Intern Med.* 2010;153:213-221.

**Background:** Since 2001, the University of Michigan Health System (UMHS) has fully disclosed and offered compensation to patients for medical errors.

**Objective:** To compare liability claims and costs before and after implementation of the UMHS disclosure-with-offer program.

**Design:** Retrospective before–after analysis from 1995 to 2007.

**Setting:** Public academic medical center & health system.

**Patients:** Inpatients/outpatients involved in claims made to UMHS.

**Measurements:** Number of new claims for compensation, number of claims compensated, time to claim resolution, and claims-related costs.

**Results:** After full implementation of a disclosure-with-offer program, the average monthly rate of new claims decreased from 7.03 to 4.52 per 100 000 patient encounters (rate ratio [RR], 0.64 [95% CI, 0.44 to 0.95]). The average monthly rate of lawsuits decreased from 2.13 to 0.75 per 100 000 patient encounters (RR, 0.35 [CI, 0.22 to 0.58]). Median time from claim reporting to resolution decreased from 1.36 to 0.95 years. Average monthly cost rates decreased for total liability (RR, 0.41 [CI, 0.26 to 0.66]), patient compensation (RR, 0.41 [CI, 0.26 to 0.67]), and non–compensation-related legal costs (RR, 0.39 [CI, 0.22 to 0.67]).

**Limitations:** The study design cannot establish causality. Malpractice claims generally declined in Michigan during the latter part of the study period. The findings might not apply to other health systems, given that UMHS has a closed staff model covered by a captive insurance company and often assumes legal responsibility.

**Conclusion:** The UMHS implemented a program of full disclosure of medical errors with offers of compensation without increasing its total claims and liability costs.

# Stories that inspire...

## **MAKING A DIFFERENCE... ONE HAND WASH AT A TIME**

From ....

Alberta RN February 22 2009  
Volume 65 No 2 [www.nurses.ab.ca](http://www.nurses.ab.ca)

BY SUE RIDEWOOD



*RN Laura Brule performs a hand washing skit to overcome the language barrier and to educate Nepalese women on the importance of hygiene in illness prevention.*

Whether here at home, or halfway around the world, sometimes it's the smallest things that make the biggest difference.

In March 2008, to commemorate her 50th birthday, Calgary RN Laura Brule, along with nine other women, took part in a 10-day Women's Trek for Peace and Development in Nepal, an experience that changed her life.

"I love to hike. It's my greatest passion," says Brule.

The trek was designed around themes important to the promotion of peace, health and economic development. Brule's nursing background made her a perfect fit for the health team. The group hiked for four-to-six "hard hours" each day, except for one.

"One of the objectives of the trek was to empower women to participate fully in their communities," says Brule. The health team worked toward that objective by providing sanitation and hygiene awareness sessions at several locations along the trek.

When they arrived in a community, they met people dressed in their best. Their Nepalese hosts provided dancing, singing and celebration to welcome their guests. Community women were invited to share their knowledge and practice of indigenous medicinal plants and healing methods. Brule's team responded by offering health and nutrition information in the form of skits to overcome the language barrier. Brule's particular contribution proved to be her acting ability.

"When you can't speak the language, you have to get your message across somehow," says Brule. "In the mountains, everyone 'goes' everywhere. So, I mimed squatting and 'going' and then hand washing." It brought down the house.

A Nepalese nurse explained to crowds, sometimes numbering 100 or more, the details of the skit. The team would then hand out soap and nail clippers to their assembled hosts. "We told the women that for seven rupees (about a penny) they could buy a bar of soap instead of buying tobacco or gambling with the money," says Brule. "We would explain 'Now that you know what causes many of the illnesses you see, would you rather buy the soap now or pay for hospitalization later?'"

"A defining moment for me was near the end of our trek," says Brule. "After we'd done our hand-washing skit, one lady washed her hands and then her baby's hands. That made my trip. "It wasn't exactly traditional nursing as we think of it," says Brule..... *continued on next page*

## MAKING A DIFFERENCE ONE HAND

### WASH AT A TIME ... continued

"It was more helping the people there, especially the women, to empower themselves. That's not much different than what I do here at home, supporting nurses to empower and advocate for their clients."

Brule became a nurse at 37, after two earlier careers that also had a focus on giving and nurturing. "It's all about helping people," she says. Currently, Brule's role is in chronic disease management.

Brule says the experience has helped her grow personally as well as professionally. "I see a shift in me. The trip has given me a different perspective. I think back to the Nepalese women and the limited resources they have to use wisely and realize that we have so much abundance. They have a great community spirit and are really there for each other.

"Sharing information and helping is rewarding. Although I'm not on the front line with clients anymore, I try to have fun, be supportive and encouraging with everyone I interact with in my work and in my day-to-day life. Sharing information and helping is rewarding."

There were no "aha moments" for Brule in Nepal. She explains it as a process that she is still going through. "It reinforced for me that women don't need much to be resourceful and resilient – they just need a little bit of information."

#### HEALTH CARE IN NEPAL

Total population	27,641,000
Life expectancy at birth (years)	62/63*
Healthy life expectancy at birth (years)	52/51*
Probability of dying under age five (per 1,000 live births)	59
Probability of dying between 15 and 60 yrs old (per 1,000 population)	292/280*
Total expenditure on health per capita	78
Total expenditure on health as per cent of GDP	5.7

\*Source: World Health Organization

*Laura Brule has been an active IHC-C faculty member since taking part in the Choices & Changes Faculty Development course in May, 2008, in Lake Louise. Having recently completed her BN, Laura successfully took on the role of small group facilitator for the Choices & Changes Faculty Development program held in Calgary, AB in November. Well done and thank you for sharing one of your many wonderful stories!*

## Institute for Healthcare Communication - Canada

The College of Family Physicians of Canada  
2630 Skymark Avenue  
Mississauga ON L4W 5A4

T: 905-629-0900

T: 1-800-387-6197 x251

F: 905-629-0893

 [ks@cfpc.ca](mailto:ks@cfpc.ca)



#### The IHC-C Team:

Manager: **Katheryne Stewart (x 251)**

Admin. Assistant: **Sheila MacDonald (x 212)**

#### IHC-C Advisory Committee:

**W. Wayne Weston, MD, CCFP, FCFP**

Chair, IHC-C Advisory Committee

Professor Emeritus,

Schulich School of Medicine & Dentistry

University of Western Ontario

**Kathleen Bonvicini, MPH, EdD**

CEO, Institute for Healthcare Communication, Inc.

**Don Cowan, MD**

Consultant Emeritus, Cancer Care Ontario

**Greta Cummings, PhD**

Associate Professor, Faculty of Nursing

University of Alberta

**Joan Evans, PhD, RN**

Associate Professor, Division of Medical Education

Director, Communication Skills Program

Dalhousie University

**Jack Laidlaw, MD**

Consultant Emeritus, Cancer Care Ontario

**Bernard Marlow, MD CCFP FCFP FACME**

Director, Continuing Professional Development

The College of Family Physicians of Canada

**Dale Wright, BSP, MSc, MDE**

Quality and Safety Initiatives Lead,

Health Quality Council of Alberta

Welcome new committee member...

**Cynthia Abbott**

Manager, CanMEDS and Faculty Development

Royal College of Physicians & Surgeons of Canada