DAWSON COLLEGE
IPE SYMPOSIUM

October 17, 2025

FACILITATOR PACKAGE

Building a safe learning environment where the stakes are low, but the learning is high!

Schedule for the Day 2025

Set up at 7:30

8:30-9:00 – Snacks – Lobby of Cineplex theatre

9:00-9:30 – Forum CINEPLEX Theatre

1. Introduction to the disciplines
2. Land acknowledgement.
3. Introduction to the day and guiding principles for the day.
4. Situate the student to the booklet prior to the skit performance.

9:30-10:00- Forum CINEPLEX Theatre

- Performance by Dawson College theatre graduates (Skit 1)
- Review of important aspect of the skit pulling from the Didactic Lecture

10:00-10:10 – Travel to Pepsi Forum Breakout classrooms

10:10-12:00 – Assigned breakout room 1h and 50 mins

- Ice Breaker Activity
- Activity 1 – Conflict resolution workshop

12:00 – 1:00 – Lunch – 1 hour

1:00- 1:45 – Forum CINEPLEX Theatre

- Performance by Dawson College Theatre Graduates (Skit 2)
- Creating link between skit and dysfunctional teams
- Presentation of case study – Jean Louis

1:45-1:55 – Travel to 2P classrooms

1:55- 3:15 – Assigned breakout room

- Activity 2 – Jean Louis case study
- Breaking down one of the incidents as an example for the students.
- Discussion and Teamwork: other incidents
- <u>Key Take aways:</u> Debrief what went wrong in the case and what could have been done differently

3:15- 4:00 – **Assigned Breakout Rooms**

1. Collective competence video Lorelei Lingard (7 minutes)
2. Activity 3 -- Open Discussion on the topic relating back to the cases and skits

- Closing video of thanks
- Feedback questionnaire online? To be completed before leaving

MORNING SESSION IN FORUM CINEPLEX THEATRE

During this time, please sit in the audience to enjoy the skit and presentation. Feel free to take notes to help you facilitate the morning breakout sessions.

Performance by the PhysiAct Troupe* (Dawson Professional Theatre Graduates)

Synopsis:

The long running *Macca's Diner* establishment first made its appearance 30 years ago with the help of the original founders: the Gartinos. Alejandro and Paula started the family-owned diner with the hopes of turning it into a small local franchise. Today, we visit one of the many Macca's branches that have popped up throughout the country. More specifically, we visit AAron M. Anager, owner of the 15-year-old Toronto Macca's branch, alongside his wife and head chef, Richie Quk. However, today is special; after being understaffed for a long time, they welcome a new face to their team: Qasim Gnewman. And who better to train him than their most loyal employee, Billy Beau Bryan.

Characters*:

Richie Quk (*played by Valerie Boisvert)*

Billy Beau Bryan *(played by Jonathan Pariente)*

Qasim Gnewman *(played by Bryan Ku)*

AAron M. Anager *(played by Corbeau Sandoval)*

Reginald/Customer 1: *(played by Alessandro Leone)*

*You will find the actors' bios at the end of this booklet

Conflict Resolution: Key concepts and ideas

Interpersonal conflict issues

Content Conflicts	Relationship Conflicts	Workplace Conflicts	Social Allergen Conflicts
Centers on events, persons, ideologies in the world that are usually external to the people involved in the conflict.	Are numerous and concerned with the relationships between individuals (what to buy, where to hang the picture, who's in charge, who gets the car tonight, intimacy issues, power issues, etc.) .	Personality differences, ineffective leadership, lack of openness, physical and emotional stress, differences in values and resulting clashes	Things that annoy you about other people. Irritants!

Identifying Conflict Triggers

Helps us understand and categorize the root cause of the conflict

1. Hierarchy and Power balance
2. Policies and Procedures
3. Roles
4. Information
5. Goals and values
6. Perceptions and Biases

Non-violent communication steps

1) Observation: What specifically happened?
2) Feeling: What are you feeling?
3) Need: What underlying need do you have?
4) Request: Give clear and specific request

Conflict Resolution Styles

1. Competing: Adversarial; win-lose
2. Avoidant: Deny and withdraw; no outcome
3. Accommodating: Give in; lose-win
4. Compromising: Split difference; lose-lose
5. Collaborating: Cooperative; win-win

5 steps to conflict resolution

Define	**Look beyond**	**Request solutions**	**Identify agreed upon specific solutions**	**Come to an agreement**
What happened? How did this incident begin?	When do you think this problem between us first arose? What are the feelings involved? **Show empathy***.	What are the underlying needs? What do you think would help address those needs?	What are the pros and cons of each solution? Do the solutions meet needs?	How will we prevent a disagreement in the future?

***Empathy**: "The capacity to understand and respond to another person's subjective experience" (Ives et al. 2020 p.421)

*Empathy is often confused with **Sympathy.** "Sympathy is I feel bad FOR you. Empathy is I feel WITH you. Sympathy can make us feel more alone. Empathy helps us feel connected" (Brown, 2020).*

Collective Care

- The notion that we can "...**collectivize our struggles and care for each other** in ways that are congruent with our visions and values." (Profitt, 2011, p. 288).
- Understanding how **systemic factors** (ex: unrealistic work demands, insufficient resources) impact our individual and collective wellbeing in the healthcare system and how this can in turn impact the quality of care we provide to the patient/client.
- There is only so much one person can do, but when groups of people (practitioners) come together for a **common purpose** (the patient/client's wellbeing), a great deal more can be accomplished.

Examples of Collective Care Practices in the workplace:

- Cultivating a sense of belonging
- Team-building practices
- Solution-focused work
- Nonviolent communication
- Learning from each other
- Acknowledging and appreciating each team member's contribution
- Practicing Cultural Safety

BREAK OUT ROOM FACILITOR SCRIPT

Morning activity

TIME: 10:10-12:00

LOCATION: Pepsi Forum Classrooms

SET UP: Small group pods of about 7-8 students (3 groups)

TOTAL NUMBER OF STUDENTS: 20-22 per room

All *italics* are notes for the facilitator. No need to read them aloud. The rest is designed for you to **read aloud.** Use accompanying power point as a guide ☺

TIME	PLAN
10:10 – 10:30	1. Welcome the group to the breakout session and introduce yourself as their facilitator for the day. Mention your 1. Name 2. Discipline 3. How you will help to guide their experience throughout the day. 2. Explain how there will be lots of opportunities to learn "with, from and about each other" throughout the day. 3. Challenge the students to keep an open mind and contribute to the conversations. 4. Remind the students of the pre-symposium presentation on conflict and communication and remind them that there are summaries listed in their student booklets. 5. Encourage them to lean on their experiences, whether positive or negative, when discussing communication and conflict resolution throughout the day.

1.1 10:10 – 10:30	**ICE BREAKER** As a team, spend the first 20 minutes <u>getting to know each other.</u> 1. Introduce yourself and your discipline 2. What are 3 words that come to mind when you think of conflict and why? 3. What is the conflict resolution style that you most relate to and why? 4. Were there commonalities found across the IPE group in relation to question 2 and 3? *** students will be given these questions in advance as part of a reflection on the pre-packaged video they must watch prior to the symposium.

1.2 10:30 - 10:50	**Discuss typical conflicts in small and large groups** **Small group Discussion (10 mins)** - Spend the next 10 minutes discussing the types of conflicts that you have seen (or will see) within your field/discipline. - See if you can make links to the conflicts you saw in the skit. - Pay attention to the commonalities and differences between the conflicts. - Are there any that are similar? Are they any that are unique to one profession? **Large group Discussion (10 mins)** - Open up the floor to a shared discussion across the class. *Guiding Questions if needed.* What did you find interesting about the conflicts that we brough up? Are you surprised that the conflict occurred? What was your initial reaction to the conflict as it played out? ***** Don't get too much into the solutions yet…will be discussed in 1.4**
1.3 11:50 – 11:15	**Design a typical conflict scenario (to be completed in small groups)** Using this previous conversation, Work with your team to design a typical conflict scenario observed within the health care sector. (it could be one previously mentioned in the group discussion) *Direct them to their student booklets to help guide/organize their thoughts.* *Guiding Questions if needed* What category of conflict does it fall into? What triggered this conflict? Who is involved? Where did the communication breakdown?
1.4 11:15 – 11:30	**Design solutions for the conflict (to be completed in small groups)** - Using the table found in their student booklets, encourage them to discuss ways to solve the conflict. - Encourage the use of the information provided in the communication and conflict resolution presentation to help guide their answers. - Let them know that we will ask 2 groups to present their findings. (option to perform a skit) Guiding Questions if needed Was it resolved? What steps were taken for resolution.

1.5 11:30--11:45	**2 Groups present their conflict/solutions with the option of performing a SKIT** 1) Types of questions to ask after the interventions if not covered by the groups a. What was the conflict about? b. What strategies were attempted? Which strategies did you recognize from the presentation? c. What was the group successful at? d. Has anyone been in this type of conflict before? e. What were the key reasons the conflict was resolved?
1.6 11:45-12:00	**Consolidation and Morning Debrief** What are THREE (3) **key takeaways** from the morning's session? **Instruct them to Please meet back in the main CINEPLEX theatre room at 12:50 as the afternoon session will start at 1 pm <u>sharp.</u>**

AFTERNOON SESSION IN FORUM CINEPLEX THEATRE

During this time, please sit in the audience to watch the second skit and the Jean Louis case.

Feel free to take notes to help you facilitate the afternoon breakout sessions. We will be doing a debrief of the skit and case in the Theatre before sending the students back to their breakout rooms.

SKIT # 2: Conflict Resolution

NOTES

What steps were taken to discuss and resolve conflict? Were conflicts resolved? What stood out to you?

DEBRIEF NOTES

What conflict resolution strategies were displayed in the skit?

_____

_____

_____

_____

_____

List 3 words that describe the communication between the skit characters?

_____

_____

_____

_____

_____

Jean Louis case study

During the case study video, please jot down what you believe are the **FOUR (4) triggers/conflicts** that occurred while learning about Jean Louis' care. Briefly outline the type of conflict seen and potential triggers that brought on this conflict.

CONFLICT 1:

_____

_____

What type of conflict: (circle): Content. Relationship. Workplace. Social Allergen

What was the trigger? _____

CONFLICT 2:

_____

_____

What type of conflict: (circle): Content. Relationship. Workplace. Social Allergen

What was the trigger? _____

CONFLICT 3:

_____

_____

What type of conflict: (circle): Content. Relationship. Workplace. Social Allergen

What was the trigger? _____

CONFLICT 4:

_____

_____

What type of conflict: (circle): Content. Relationship. Workplace. Social Allergen

What was the trigger? _____

NOTES

BREAK OUT ROOM FACILITOR SCRIPT

Afternoon activity 2.

TIME: 1:55pm – 4:00 pm

LOCATION: Pepsi Forum Classrooms

Use accompanying power point as a guide.

TIME	PLAN
Activity 2.1 1:55 – 2:20	The main objective of the afternoon breakout session is for you to work in interprofessional groups to a) Outline the conflicts and triggers found in the 4 incident reports related to Jean Louis' case. b) Determine recommendations to address the issues identified in the incident reports Hand out the incident report forms: Students have 10 minutes to read the forms and then start the activity. **FIRST COLUMN: Conflict and triggers** Your job as an interprofessional team is to work through the guiding questions found in the tables on pages 16-19 of your student booklets. - List who was involved in the conflict - Describe the conflict - Discuss its triggers - Discuss why you think this would happen *** Complete this for each incident report
Activity 2.2 2:20 – 2:45	**SECOND COLUMN: Resolution/better understanding of the conflict** Your job as an interprofessional team is to work through the guiding questions found in the tables on pages 16-19 of your student booklets. - What steps can be taken to resolve this conflict? - What are your recommendations to prevent this conflict in the future. *** Complete this for each incident report
Activity 2.3 2:45 - 3:15	**Consolidation in large group:** Review the tables in a larger group. Can move through the smaller groups in the classroom to share their answers. **Lead them to answer:** was patient care affected? YES/NO….HOW? Finish with Key Take aways of this activity

Extra information on incidents for Teachers.
The students will receive their incident report packages.

Incident report 1
Lab lost the sample
"Objective and detailed description of the event"
Nursing made the report (Procedure not followed correctly, transportation, Lost sample in the lab)

Date: November 5th 2023
The patient was called in for a blood test in the outpatient oncology unit. 2 gold tubes and 1 lavender tube were drawn for ca-125, SMA-10 and a CBC at 12:30. The tubes were labelled and were placed by writer in the porter's basket to be sent to the lab at 12:45. At 15:00 the writer checked OASIS to verify the laboratory results, and no results were found. At 15:10 the writer called the laboratory and spoke with a Laboratory technologist about this event, and they stated they never received the blood tubes for this patient and the blood would need to be re-drawn. The patient was notified that the blood test samples were lost at this time would need to be re-drawn within the next 2 days. Writer notified Nurse manager and Laboratory manager at 15:30.

NOTES

Incident report 2
Pain medication
RO Tech made the report (Delay in treatment, pain medication wore off)
Date: November 11th 2023

Patient transport was booked at 7:10 am using the *Logitrans* reservation system. Transport was booked for 1:30 pm with a scheduled treatment time of 2:00 pm. Patient chart indicates he was in pain during his planning CT scan last week and has Fentanyl prescribed. Called the nursing desk at 14W to ensure patient would be pre medicated prior to transport for this afternoon's treatment.

Treatment machine had an MLC breakdown around 1 pm and it took ~1h30m to replace the motor, causing us to run behind schedule. Patient treatment only started at 3:42 pm by which point his pain medication seemingly wore off. Patient was in a great deal of pain during the transfer to the treatment table and had difficulty staying still during the treatment, causing further delays.

NOTES

Incident report 3
Black spots
"Objective and detailed description of the event"
Porter made the report (Misdiagnosis, confidentiality breach)

Date: November 15th 2023
Patient on out-patient oncology unit had a CT scan of his abdomen and pelvis on November 25th at 10:00. While waiting for the patient in the full waiting room to be transported back to unit, writer asked Diagnostic Imaging technologist "How did his scans go?" to which the technologist responded "Oh, it went okay, but we saw some black spots and stuff". Patient overheard the described conversation and became noticeably anxious and frustrated by this news. The patient requested more information from the technologist at this time and the technologist responded "The doctor will give you more information about it when your scan is ready, I can't give you any information". The patient looked upset during the transport back to the out-patient oncology unit and arrived to his room at 11:15. Writer notified transportation manager about this situation at 11:45.

NOTES

Incident report 4
PT and SW arguing
"Objective and detailed description of the event"
Unit agent made the report (unprofessional behaviour in the workplace, confidentiality)

Date: December 16th 2023
Outpatient at Montreal Oncology Rehab center, unit 5W was sitting in the waiting room for treatment at 11:30. Writer witnessed the Physio Technologist and the Social Service worker arguing loudly about patient's case beside to the waiting room at 11:35. The writer asked the PT and SW to "stop arguing and please resolve this issue in a professional manner" but they continued to raise their voices and the PT stated "If you cared more about the team we wouldn't be in this situation with Mr. Jean Louis! Now he is going to file a complaint against us" The SW responded with "You don't know what you're talking about, stay in your lane, you have no idea what my job is". The patient approached the writer and stated he "felt uncomfortable with this public argument regarding his care and asked for a report of this incident to be documented and filed immediately". Writer notified Nurse manager of this situation at 12:00.

NOTES

Answers for the tables found on the following pages.

Incident Report 1: Lost Blood Sample.

Conflicts and Triggers Describe the conflict. What were the triggers that led to conflict? Why do you think this happened?	**Resolution/better understanding of the Conflict** What steps can we take to resolve this conflict? What are your recommendations to prevent this conflict in the future?	**Which professionals are involved?**	
<u>Conflict/incident:</u> Workplace conflict Blood sample was lost, results were therefore not prepared, and blood had to be redrawn. The patient was not happy. <u>Trigger:</u> Policies and procedures Roles (not knowing what each other does) Lost sample. This could have happened during extraction, transport or in the lab. <u>What do you think happened? Possible reasons</u> - Mislabelled bloods - Lost in transport - Label put on incorrectly therefore the lab can't read it properly. - not following procedures/protocols on the floors and in the lab - Miscommunication with the nursing team from the Floor and the biomed lab technicians. <u>Other factors that could contribute to the conflict.</u> Inadequate working conditions (overtime, staff shortage, equipment malfunction, etc.). Also: quantity of blood not sufficient, mislabeled specimen, delayed results, etc.	Frustration and Blame could be a big barrier to resolving conflict. Need to reach a "don't blame" mindset. Open discussion on what happened, where did things break down etc. Both disciplines need to be open-minded, be transparent, have humility and be motivated to work towards improving the situation. Both disciplines need to be aware that they are fighting against the same strained working conditions, and they should strive to work as a team and confront any policy and procedural errors in a straightforward manner.	Social Service	
		Physiotherapy Tech	
		Biomedical Laboratory Tech	**x**
		Radiation Oncology	
		Diagnostic Imaging	
		Medical Ultrasound Tech	
		Nursing	**x**
		Other (indicate here)	
		Was patient care affected? YES NO **How?** Patient was negatively impacted, both physically (ex: having to go through the discomfort of getting more blood tests done) and emotionally (ex: increased anxiety, confusion and uncertainty about his medical status, frustration, distress around having to go back for more blood tests)	

Incident Report 2: Pain Medication Delays

Conflicts and Triggers Describe the conflict. What were the triggers that led to conflict? Why do you think this happened?	**Resolution/better understanding of the Conflict** What steps can we take to resolve this conflict? What are your recommendations to prevent this conflict in the future?	**Which professionals are involved?**	
<u>Conflict: Workplace,</u> There was a delay between the medication given and the time of the treatment. This is a common issue as the oncology department could get backed up in their scheduled appointments. The conflict is due to a lack of communication, planning and awareness between the two professions. <u>Trigger</u> Policies and Procedures Roles Information or lack thereof Patient's increased level of pain. Delays in one department affecting the care given by another dept. <u>Why did it happen?</u> Machinery breaks down from time to time and unforeseen issues come up throughout a day that causes delays. Unfortunately, there was no safeguard for the patient when it came to pain medications, and he had to perform the scan while experiencing high levels of pain. <u>Other factors that could contribute to the conflict.</u> Information lacking in the patient's file. Scheduling issue (too many patients in one day).	Proper communication between the RO dept and floors to know when a delay is occurring so that the patient can be sent for tests with an adequate amount of pain medications. If a delay was noted only while in the RO department, then steps could have been made to make sure the patient is adequately medicated for the transfer and the procedure. It seems there was more focus on the shortcomings of other staff members and not enough on the patient's needs.	Social Service	
		Physiotherapy Tech	
		Biomedical Laboratory Tech	
		Radiation Oncology	X
		Diagnostic Imaging	
		Medical Ultrasound Tech	
		Nursing	X
		Other (indicate here) Porter	X
		Was patient care affected? YES NO **How?** Direct impact on the patient's physical wellbeing (pain due to omission of medication and rushed transfer) and emotional wellbeing (feeling disregarded, neglected; becoming fearful of tests; loss of trust in the medical team; loss of hope; etc.)	

Incident Report 3: Confidentiality Breach (Technologist talking about findings in the open)

Conflicts and Triggers Describe the conflict. What were the triggers that led to conflict? Why do you think this happened?	**Resolution/better understanding of the Conflict** What steps can we take to resolve this conflict? What are your recommendations to prevent this conflict in the future?	**Which professionals are involved?**	
<u>Conflict</u> Patient upset that information was shared without his consent and knowledge and when he confronted the technologist, he was told that he couldn't give any information until the doctor read the results. <u>Trigger</u> Policies and procedures Goals and values Perceptions and Biases - Overhearing a confidentiality breach. - Possible negative findings on his report. - Not following policies and procedures related to confidentiality. <u>Why did it happen?</u> - Lack of awareness or training with respect to patient confidentiality. - Professional boundaries: Stepping out of one's role/expertise. - Lack of empathy for the patient? - Not discussing findings in a confidential environment instead of in the open.	This incident could lead to conflict with other staff members who respect the rules of confidentiality and overheard the discussion in the hallway (clash in terms of professional values) or with the patient who heard the professionals talking about his ultrasound/scan in the "public" spaces of the hospital and drawing conclusions about his medical status without having the credentials to do so. - Keeping conversations about the patient private (closed room). - Keeping clinical discussions within the limits of the team (ex: clinical meetings). - Not making assumptions about the patient's status without having the qualifications to assess results. - Treating information about the patient with as much care as you would like your own personal information to be treated. If this is a recurrent issue, is it important for health care workers to complete online courses on patient confidentiality.	Social Service	
		Physiotherapy Tech	
		Biomedical Laboratory Tech	
		Radiation Oncology	
		Diagnostic Imaging	X
		Medical Ultrasound Tech	
		Nursing	
		Other (indicate here) PAB or transporter	X
		Was patient care affected? YES NO **How?** This could cause a breach to the trust the patient has in the medical team (his right to privacy was disregarded and he felt exposed)	

Incident Report 4: Unprofessional behavior in the workplace + patient confidentiality.

Conflicts and Triggers Describe the conflict. What were the triggers that led to conflict? Why do you think this happened?	**Resolution/better understanding of the Conflict** What steps can we take to resolve this conflict? What are your recommendations to prevent this conflict in the future?	**Which professionals are involved?**	
<u>Conflict (Workplace)</u> - Workplace conflict relating to roles and responsibilities, and possibly professional values. - unprofessional behavior due to a misunderstanding of each other's professional roles. - The Physiotech confronted the social service worker in an open environment. <u>Trigger</u> Physiotech (PT) being unaware of social service's role in helping the patient advocate for himself. PT feels like they are speaking on behalf of the medical team and find that the social service worker is not "looking out for the best interest of the medical team". <u>Why do you think this happened?</u> - Lack of understanding of each professional's role and duty to the patient. - Lack of timely communication between team members as to issues brought forth by the patient. - Lack of cohesiveness in the team (lack of collective competence); people working in silos. If not resolved, it could lead to ongoing resentment and power struggles. <u>Additional Factors that could contribute to the conflict.</u> - Heavy caseloads/schedules, - Staff turnover - Team feeling burnt out - Fear of consequences of patient's complaint	If there was a difference of opinions and a conflict between the two approaches, a heated argument was not the answer. It would have been important for the parties involved to use their conflict management techniques to handle the situation more constructively. Timely, transparent communication between team members, along with clarification of the context and purpose of the interventions carried out would have been helpful. Time reserved for the team to connect and problem-solve around issues encountered. Respect for each professional's role and responsibilities when it comes to patient care. The type of mindset that is needed to prevent this incident is to remember that every health professional has their role with the client. In silos, these roles do help the client in their journey. However, it is when these roles can overlap, collectively, that the quality of patient/client care is truly at its highest. To achieve that high level of care, the team needs to be aware of the power of the collective and how effective collaboration with the team is critical to successful care.	Social Service	**X**
		Physiotherapy Tech	**X**
		Biomedical Laboratory Tech	
		Radiation Oncology	
		Diagnostic Imaging	
		Medical Ultrasound Tech	
		Nursing	
		Other (indicate here) ***** could have been any member of the team.**	
		Was patient care affected? YES NO **How? Not directly…but confidence in the team YES** Patient was exposed to the conflict between professionals, which could cause distress and diminish the trust he has in the team. It could make him question his decision to advocate for his rights as a patient and undermine the challenges he has faced up until now.	

Activity 3. 3:15 to 3:50pm
The Concept of Collective Competence

"The healthcare system is full of competent professionals...
The challenge is forming a competent team" (Lingard, 2012)

Watch the 7-minute video of Lorelei Linguard linked on the powerpoint. Instruct student to take notes in their booklets.

Discussion Points

What makes a collectively competent team?

What steps can we take to move towards collective competence?

If an interprofessional team is collectively competent, does the patient care improve?

Activity 4. 3:50 to 4:00 pm

Closing video of thanks and online feedback form to complete.

Show the video of Thanks linked on the PowerPoint

Have student click on the QR Code to fill out the feedback Questionnaire

Special Thanks to our IPE Symposium Sponsors and Contributors

This Dawson IPE Symposium would not have been possible without the financial, logistical, creative, and pedagogical support, knowledge, and wisdom provided by the following partners:

Forum Cineplex Theatre

Dawson Foundation – Student Academic Enrichment Fund

Dawson Student Success Action Plan (SSAP)

Science, Medical Studies, and Engineering (SMSE) Dean's Office

Dawson Student Union (DSU)

Office of Sustainability

Campus Life

Dawson College Campus Recreation

Social Service Faculty member Rosemary Barrett: Pre-Symposium Video

Dawson Professional Theatre Graduates (Corbeau Sandoval, Valerie Boisvert, Bryan Ku, and Jonathan Pariente)

Dawson Professional Theatre Department

Nursing Department

Social Service Department

Physiotherapy Technology Department

Biomedical Laboratory Technology Department

Radiation Oncology Department

Diagnostic Imaging Department

Medical Ultrasound Department

Interprofessional Education Team

Greatly appreciated food donation of bananas and fried donuts from Marché Korea www.marchekorea.com

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