

# Part II—Essential Skills, Themes, and Observable Behaviours

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## Introduction

Part I of the evaluation objectives document provides a fairly detailed description of the processes used for the development of these evaluation objectives, as well as the rationale for the choices made. It can be found on pages 10-30 of this document (see menu).

Part II of the document, which is the subject of the following pages, is the operational level, containing all the details necessary to assess performances in family medicine, to make objective judgments about competence in specific situations, and to stimulate reflection that can lead to interpretive feedback and suggestions for future learning and changes that will help the trainee or the practitioner to move toward competence. These objectives should also help to concentrate efforts on those elements that are most determinant of competence, both in general and with respect to specific situations. In this way, time spent on evaluation will be both more effective and more efficient. Finally, as these objectives are entirely competency based, their use should drive learning toward competency, rather than toward simply passing examinations at various times.

They are organized according to the six essential skill dimensions of competence. The format varies with the dimension, but in each case it should be sufficient to clearly orient evaluation of the dimension in the context of daily clinical practice and supervision. Each dimension could be considered a menu of useful items to be selected according to the specific needs of the situation. As such it is helpful to be familiar with the whole menu before making the selections that fit the needs. The dimensions are followed by the priority topics and key features: they are not cross-referenced at this time, and so searching for the right combinations may require several steps. The next version of these objectives will be cross-referenced and searchable by various parameters.

These objectives do not contain any test instruments or examinations or scoring scales or performance levels or forms, nor any prescription for developing these tools. This omission is intentional, as was explained in Part I of the objectives. As these tools are developed, these evaluation objectives will provide the primary matter that will direct both the content and the format of the instruments used, and increase the chances that any evaluation will do well according to the five parameters associated with successful evaluations.

Could these evaluation objectives be used as a study guide or a curriculum, and should they be? The answer is mixed. As a curriculum, the evaluation objectives are incomplete. They will represent one set of terminal objectives, but a curriculum must also pay attention to the intermediate and enabling objectives necessary to learning, as well as to other possible end points. As a study guide, these evaluation objectives are more usable, as long as the reader remembers that performances will be assessed in the context of *all* the layers of our definition of competence in family medicine. This means that assessment will concentrate as much on the skills and processes used to deal with problems as it does on the actual answers or solutions to specific problems. With this caveat, it can be said that a physician who can show competence in dealing with an adequate sample of the topics, procedures, and themes on this list, demonstrating the higher levels of competence in each of the six essential skill dimensions, in all phases of the physician-patient encounter, and in the context of the Four Principles of Family Medicine, probably does indeed deserve certification to start independent practice.

## The Patient-Centred Approach

This dimension encompasses the clinical method established by the Centre for Studies in Family Medicine at The University of Western Ontario.

The method sets out to understand a patient’s presenting problem through learning about the disease and how the individual experiences it. One must learn what patients feel in connection to their symptoms, how they explain what they are experiencing, the effect it is having on their lives, and how they hope the physician will be able to help to address the problem.

This is connected to the process of gaining a greater understanding of the whole person—“who the patient is”, his or her “context”. Who the people in their lives are and how they relate to them, who or what their supports are, and what social factors exist all play a role in understanding patients’ context. This context weaves through the patient’s “disease” and how he or she experiences it.

In attempting to address a concern, the patient and the physician work to come to a common understanding of the problem and their roles in addressing it. Understanding a patient and his or her context is also important in effective health promotion and prevention, which are incorporated into this method.

It is a realistic approach and, like care in family medicine, a longitudinal one. The priorities of the patient and physician are respected and balanced. The resources of individuals and the community are considered in the process.

This method is considered an essential tool in building the patient-physician relationship. The working group felt that the details of the method are clearly articulated in *Patient-Centered Medicine: Transforming the Clinical Method* by Stewart, Brown, Weston, McWhinney, McWilliam, and Freeman. We did not attempt to redefine the method, but have instead tried to express the various components of the method as specific actions that can be observed during the clinical encounter. The patient-centred approach permeates all of our clinical encounters, but there are specific instances in which skill in this dimension may be better assessed. Many examples of these instances can be found within the priority topics and key features.

**Observable Behaviours:**

1. Actively explores patients' experience with a problem by inquiring about:
  - what they feel in connection with their problem (feelings)
  - how they explain what they are experiencing (ideas)
  - the effect it is having on their life (impact on function)
  - how they hope the physician will be able to help them address the problem (expectations)
2. In assessing a clinical problem, attempts to gain a greater knowledge and understanding of the whole person by asking about his or her context (i.e., who else is in his or her life [family, partner, children], who or what supports are, other social factors [work, finances, education, etc.])
3. In moving toward developing a management plan for a patient's problem, integrates a patient's context with his or her illness experience in a clear and empathetic way
4. In attempting to address a problem, works with the patient to come to a shared understanding of it and each person's role in addressing it by
  - encouraging discussion
  - providing the patient with opportunities to ask questions
  - encouraging feedback
  - seeking clarification and consensus
  - addressing disagreements
5. In finding common ground around the management of a problem, incorporates relevant health promotion and prevention.
6. Approaches a patient's problems with a realistic and longitudinal view, which respects and appropriately balances the priorities of the patient and physician; considers the resources of individuals and the community.

## Communication Skills

Communication skills were clearly identified as one of the skill dimensions essential for the competent practice of family medicine. There is a large body of literature on communication and the working group did not attempt to redefine communication or develop a theoretical definition. We chose instead to articulate a pragmatic approach focused on skills and behaviours that facilitate communication.

We began by identifying those themes or skill subsets that are essential to good communication. We then used an interactive focus-group approach to define the themes and observable behaviours that should predict competence for entry to the independent practice of family medicine. Other observable behaviours may be added to this list; however, those identified below should be more than sufficient to determine competence.

These are the themes identified:

1. Listening skills
2. Language skills
  - a) Verbal
  - b) Written
  - c) Charting skills
3. Non-verbal skills
  - a) Expressive
  - b) Receptive
4. Cultural and age appropriateness
5. Attitudinal

The working group felt there were tangible differences between communication with health team members and with patients. Physicians may be able to communicate effectively with one group and not with the other; therefore we chose to separate these areas in our definition. For each group we have identified observable behaviours for each type of interaction. Some behaviours appear in both sections. They have been duplicated in order to be comprehensive.

For each subset of skills we have identified behaviours, expressed either positively (✓) or negatively (✗), that reflect competence. Positive behaviours are listed first, followed by negative behaviours. We have not placed the behaviours in any order of priority. For the most part, only the positive or negative expression of the behaviour was described.

## Effective Communication with Patients

### 1. Listening Skills

Uses both general and active listening skills to facilitate communication

#### Observable Behaviours:

- ✓ Appropriately looks at the patient while the patient is talking
- ✓ Allows the time for appropriate silences
- ✓ Feeds back to the patient what he or she has understood from the patient
- ✓ Provides appropriate non-verbal responses to patient's statements
- ✓ At all times responds to verbal cues (e.g., does not go on with regular questioning when the patient reveals major life or situation changes like "I just lost my mother")
- ✓ Clarifies jargon when used by the patient
- ✓ Comprehends what the patient says
- ✓ Lets the patient tell his or her story (does not interrupt the patient inappropriately)
  
- ✗ Does other things while the patient is talking (e.g., looks at computer chart, takes phone calls)

### 2. Language Skills

#### a) Verbal:

Adequate to be understood by the patient; able to converse at an appropriate level for the patient's age and educational level; appropriate tone for the situation—to ensure good communication and patient comfort

#### Observable Behaviours:

- ✓ Asks open- and closed-ended questions appropriately
- ✓ Checks back with the patient to ensure understanding (e.g., "If I say this, am I understanding you correctly?")
- ✓ Facilitates the patient's story (e.g., "Can you clarify that for me?")
- ✓ Provides clear and organized information in a way the patient understands (e.g., test results, pathophysiology, side effects) and checks back to ensure the patient understands
- ✓ Provides explanations to accompany examinations and/or procedures
- ✓ When first meeting a patient, clarifies how the patient would like to be addressed
  
- ✗ Fails to greet the patient
- ✗ Interrupts patients inappropriately
- ✗ Uses inappropriate word choices for the individual's level of understanding (e.g., use of scientific language that the patient cannot understand, overuse of jargon)
- ✗ Displays inappropriate anger
- ✗ Uses inappropriate humour
- ✗ Uses paternalistic language (e.g., use of "dear")
- ✗ Uses offensive language (e.g., swearing)
- ✗ Shouts or uses excessively loud speech

- ✘ Asks multiple questions without awaiting the answers
- ✘ Has language skills that are insufficient to be easily understood by the majority of patients (i.e., patients can't understand what the physician is saying)

**b) Written:**

Clearly articulates and communicates thoughts in a written fashion (e.g., in a letter to a patient, educational materials for the patient, instructions for a patient)

**Observable Behaviours:**

- ✓ Writes legibly
- ✓ Written material is organized so the patient can understand (spelling, grammar, and punctuation must be sufficient to permit understanding)
- ✓ When providing written information, chooses materials that are appropriate to the patient's level of understanding
- ✘ Uses abbreviations that are not understood by the patient

**3. Non-Verbal Skills**

**a) Expressive:**

Being conscious of the impact of body language on communication with the patient and adjusting it appropriately when it inhibits communication

**Observable Behaviours:**

- ✓ Sits while interviewing the patient (in order to convey the feeling of providing the patient with more time and attention)
- ✓ Eye contact is appropriate for the culture and comfort of the patient
- ✓ Is focused on the conversation
- ✓ Adjusts demeanour to be appropriate to the patient's context (e.g., is pleasant, appropriately smiles, is appropriately serious, is attentive, is patient and empathetic)
- ✓ Communicates at eye level (e.g., with children, patients who are bedridden)
- ✓ Physical contact is appropriate for the patient's comfort
- ✘ Fidgets
- ✘ Hygiene or dress that inhibit communication
- ✘ Gets too close (not respectful of other's personal space)

**b) Receptive:**

Aware of and responsive to body language, particularly feelings not well expressed in a verbal manner (e.g., dissatisfaction, anger, guilt)

**Observable Behaviours:**

- ✓ Responds appropriately to the patient’s discomfort ( e.g., gets a tissue for a patient crying, shows appropriate empathy with the patient’s difficulties )
- ✓ Verbally checks the significance of body language (e.g., “You seem nervous/upset/uncertain/in pain; is that right?”)
- ✓ Comments on behaviour/non-verbal actions of the patient when appropriate (e.g., “You seem quiet/unhappy/angry/worried/in pain”)
- ✓ Modifies actions during examination or history-taking in response to the patient’s discomfort (e.g., adjusts angle of exam table when patients are short of breath during an abdominal exam)
- ✗ Misses signs that the patient does not understand what is being said (e.g., blank look, look of astonishment, puzzlement)

#### 4. Culture and Age Appropriateness

Adapts communication to the individual patient for reasons such as culture, age, and disability (e.g., the young child or teenager, or someone with speech deficits, hearing deficits, or language difficulties)

##### Observable Behaviours:

- ✓ Uses appropriate communication skills with adolescents (e.g., offers to see them independently, respects the capacity to make decisions, acknowledges issues of confidentiality, specifically directs questions to the adolescent, is not judgmental)
- ✓ Adapts communication style to the patient’s disability (e.g., writes for deaf patients)
- ✓ Asks about the need for an interpreter and arranges for one
- ✓ Speaks at a volume appropriate for the patient’s hearing
- ✓ Adapts communication style based on the patient’s cultural expectations or norms (e.g., other family members in the room)
- ✓ Uses appropriate words for children and teens (e.g., “pee” vs. “void”)
- ✗ Ignores the patient while exclusively engaging the caregiver, especially with children, the elderly, those with cognitive impairment (e.g., no questions to the patient, patient not involved in management plan)
- ✗ Makes assumptions based on the patient’s appearance or dress (i.e., stereotyping the patient)
- ✗ Uses colloquialisms that the patient does not understand

#### 5. Attitudinal

This permeates all levels of communication. This includes the ability to hear, understand, and discuss an opinion, idea, or value that may be different from your own while maintaining respect for the patient’s right to decide for himself or herself. Communication conveys respect for the patient.

##### Observable Behaviours:

- ✓ Shows interest in the patient’s opinion
- ✓ Is empathetic
- ✓ Maintains an appropriate attitude in response to inappropriate/offensive language or comments made by the patient

- ✘ Appears rude
- ✘ Appears impatient
- ✘ Displays irritation or anger
- ✘ Belittles the patient
- ✘ Trivializes or dismisses the patient's ideas or concerns
- ✘ Is sarcastic
- ✘ Appears intimidating
- ✘ Appears arrogant (e.g., ignores the patient's concerns or opinions about the management plan)

## Effective Communication with Colleagues

(“Colleague”, for our purposes, means all members of the health care team.)

### 1. Listening Skills

Many specific listening skills are better assessed in the context of communication with patients. Some are well assessed in the context of communication with colleagues.

#### Observable Behaviours that Can Be Assessed with Colleagues:

- ✓ Is attentive
- ✓ Stops and takes the time to listen respectfully to colleagues
- ✓ Appropriately maintains eye contact while discussing issues with all members of the health care team
- ✓ Allows sufficient time for colleagues to articulate their concerns
  
- ✗ Does other tasks that interfere with listening

### 2. Language Skills

#### a) Verbal:

Adequate to be understood in face-to-face communication, and with all other commonly used methods (e.g., phone, video conferencing, etc.); adequate to understand complex profession-specific conversation; appropriate for colleagues with different backgrounds, professions, and education; appropriate tone for the situation, to ensure good communication and colleague comfort

#### Observable Behaviours:

- ✓ Introduces self when meeting a colleague for the first time
- ✓ When asking colleagues to do something, makes a clear request and ensures that it is understood
- ✓ Offers rationale for a plan or an approach to improve understanding
- ✓ Adjusts tone to be appropriate to circumstances
- ✓ Asks rather than demands
- ✓ Uses non-blaming, appropriate, and specific observations when addressing difficult circumstances
  
- ✗ Case presentations are poorly organized or incomplete
- ✗ Is not specific with requests
- ✗ Interrupts colleagues
- ✗ Asks multiple questions without awaiting the answers
- ✗ Does not target language to the individual’s professional background and level of understanding
- ✗ Displays inappropriate anger
- ✗ Uses inappropriate humour
- ✗ Uses condescending language
- ✗ Shouts or uses excessively loud speech
- ✗ Swears or uses offensive language

**b) Written:**

(e.g., hospital and office charting, consultant letter, lawyer letter)

- Clearly articulates and communicates thoughts in a written fashion
- Has spelling, grammar, legibility, and punctuation that are adequate to facilitate understanding

**Observable Behaviours:**

- ✓ Writes legibly
- ✓ Written material is organized
- ✓ When writing to request consultation, is specific about questions/reasons and provides relevant information
- ✓ Patient-care plans (e.g., test requests, follow-up orders) are:
  - a) clearly written and
  - b) securely transmitted to the appropriate recipient
- ✗ Uses abbreviations that are not universally known or are prone to misinterpretation

**c) Charting Skills**

Assessment should concentrate mainly on the charting of individual encounters. Overall organization and structure of the ongoing clinical record are important, but these are often predetermined and outside the control of the individual—they can be assessed, but in a different context. Note that these charting skills are formatted as a set of key features.

- a) A clinical note must
  - a) be legible.
  - b) avoid using acronyms or abbreviations that may be misunderstood or confusing (e.g., “U” for “units”).
  - c) be organized so as to facilitate reading and understanding.
  - d) follow an agreed-upon structure within a practice setting.
- b) Charting must be done in a timely fashion, so as to minimize inaccuracies and lost information, and to ensure that the information is available for others involved in care. It should usually be done immediately after the encounter; if delayed, notes must be made to direct the later charting.
- c) Corrections or changes to the note must be clearly visible as such, and dated if not made at the time of the original entry.
- d) Should not write anything in the chart that you would not want the patient to read (e.g., disparaging remarks)
- e) Must not falsify data (e.g., don’t include data in the note that has not been gathered)
- f) The clinical note must
  - a) reflect all the phases of the clinical encounter that are relevant to the presenting situation.

- b) show an obvious and logical link between the data recorded and the conclusions and plan.
  - c) include the relevant negative findings, as well as the relevant positive findings.
  - d) avoid inappropriate verbatim reporting of the encounter (it should synthesize the data gathered).
- g) As part of ongoing care, acknowledge additional received data (e.g., test results, consultation reports) and document follow-up action when appropriate.
- h) As new information is gathered during an encounter, maintain the chart according to the expectations of the work milieu (e.g., flow sheets, summary page).
- i) Structure and use the clinical record as a tool to try to improve comprehensiveness and continuity of care.

### 3. Non-Verbal Skills

#### a) Expressive:

Appropriate eye contact, respectful of others' personal space, appropriate demeanour (e.g., pleasant, smiles appropriately, appropriately serious, attentive, patient and empathetic), and conscious of the impact of body language on the colleague

#### Observable Behaviours:

- ✓ Is focused on the conversation
- ✓ Eye contact is appropriate for the culture and comfort of the colleague
- ✓ Adjusts demeanour to be appropriate to the colleague's context
- ✓ Physical contact is appropriate for the colleague's comfort

#### b) Receptive:

Aware of and responsive to body language, especially as seen with dissatisfaction; correctly interprets signs of feelings not expressed, such as anger and frustration

#### Observable Behaviours:

- ✓ When a colleague is manifesting signs of distress, demonstrates awareness by actions such as modifying demands, exploring concerns, seeking resolution

### 4. Culture and Age Appropriateness

There may be instances where communication with colleagues and other team members from different cultural backgrounds can be problematic. Awareness of these potential problems and subsequent adjustments to communication are elements of competence. This, however, is better assessed in the context of communication with patients and in professionalism.

### 5. Attitudinal

This permeates all levels of communication. Competent family physicians possess an attitude that allows them to respectfully hear, understand, and discuss an opinion, idea, or value that may be different from their own.

**Observable Behaviours:**

- ✓ Seeks to understand rather than judge
- ✓ Returns the focus to effective patient care when interprofessional conflicts occur
- ✓ Attempts to resolve difficulties before ending the discussion or walking away
- ✓ Apologizes when appropriate
  
- ✗ Appears rude
- ✗ Appears impatient
- ✗ Belittles colleagues or their field of work
- ✗ Trivializes or dismisses ideas or concerns of colleagues
- ✗ Appears arrogant
- ✗ Displays anger or irritation
- ✗ Uses derogatory language when describing a patient's circumstances or case
- ✗ Appears threatening or intimidating

## Professionalism

The key feature analysis of the priority topics for evaluation did not lead to the required detailed operational definition of competence in the dimension of professionalism. It was therefore necessary to use a different process to define this dimension. The working group used a process analogous to the priority topic–key feature approach, more or less simply inverting it. We went from the general behaviours characteristic of professionalism to specific behaviours in certain situations, rather than the other way round.

Twelve general behaviours or themes were identified following analysis of the terms used to describe professionalism by the practicing family physicians who replied to our initial survey. We then used small groups and multiple iterations to generate lists of behaviours in certain situations that reflect on competence in each of the 12 general behaviours and so on the dimension of professionalism as a whole. These 12 themes and examples of behaviours under each theme make up most of the content of this section.

We do not think that it will be pertinent to assess the 12 themes individually as they are rather interdependent, and any separation risks becoming artificial. For example, from the point of view of competence, how can we draw a clear line between ethics and professionalism? For the same reason, even though there is considerable overlap between the behaviours listed under the 12 themes, we made little effort to eliminate this overlap: better to have too many concrete examples from which to develop assessment tools and programs than not enough. Any necessary conciliation can be done when this next step (assessment tools and programs) is reached.

There was one other major difference in our approach to the definition of competence in professionalism. Throughout the process of developing evaluation objectives we had intentionally stayed away from test instruments and specific examination scenarios, not wishing to bias the evaluation objectives toward that which is testable by existing instruments or examinations. The process of developing test instruments and examinations has been intentionally left to a second independent step. We soon realized that this was not entirely possible for professionalism, as the nature and structure of our detailed evaluation objectives for this dimension must make some assumptions about the context of the ultimate assessments. Before giving these assumptions, we will first list the observations that justify this slight deviation from our usual approach:

1. Professionalism is perhaps the most multi-faceted dimension of competence; it is essentially subjective, determined by all those working around the individual (e.g., patients, colleagues, employees, employers, occasional contacts) and the cultural environment in which we find ourselves.
2. Although there is a considerable body of knowledge on “professionalism”, the demonstration of the possession of this knowledge itself is not sufficient for competence, as it does not seem to predict, in any way, adequate professional behaviour. We are, therefore, more interested in specific behaviours that are indicative of acting professionally than in knowledge about professionalism.
3. Examples of professional behaviour may be quite context specific, and may depend on local expectations. Expectations in any evaluation situation should, therefore, be quite explicit, and any apparently unprofessional behaviour should first be discussed and explored before any final judgment is made.

4. There are many circumstances during practice and training that may demonstrate, to a greater or lesser degree, whether an individual is acting in a professional manner. Professional behaviour is the sum of an appropriate mix of all these. In this sense, there is no one set of key features for professionalism.
5. No one is expected to be perfect all the time, but we expect certification of competence to imply that the individual acts in a professional manner. Competence in this domain is absent when there is a pattern of repeated unprofessional behaviour that cannot be readily justified or explained. There may also be a single incident of behaviour that is fundamentally incompatible with certification of competence in this dimension.

Professionalism can be defined in theoretical terms or in a pragmatic fashion. We have opted again for the pragmatic fashion, starting with input from practicing family physicians, then using a focus group to identify common themes, and then listing specific examples of behaviours (positive or negative) that reflect on professionalism.

For these reasons we feel that our working definition of competence in professionalism requires the assessment to have certain characteristics:

- a) It must be done on real-life performances, either immediately or at a distance. It would appear to be easiest to do this during residency training; it is just as important, however, to be able to do the equivalent for those already in practice.
- b) Many performances, in many situations, over an extended period of time, must be included in the evaluation. This also implies the involvement of many different assessors or judges of the different performances.
- c) All judgments will be based on certain criteria specific to the situation at hand, but the judgment will still be subjective, made by the observer-assessor most appropriate for the situation and performance.
- d) All initial judgments of unprofessional behaviour must be subject to discussion, and possible resolution, before being maintained. Staff or preceptors may not always behave professionally.
- e) The criteria for certification remain to be established, but it is unlikely that certification of professionalism will be based on scores or averages. Competence is essentially the absence of unprofessional behaviour over a period of sufficient exposure and observation.

## **Twelve Themes that Define Professionalism in Family Medicine**

(Examples of observable behaviours related to each theme can be found on the following pages.)

1. Day-to-day behaviour reassures one that the physician is responsible, reliable, and trustworthy.
2. The physician knows his or her limits of clinical competence and seeks help appropriately.
3. The physician demonstrates a flexible, open-minded approach that is resourceful and deals with uncertainty.
4. The physician evokes confidence without arrogance, and does so even when needing to obtain further information or assistance.
5. The physician demonstrates a caring and compassionate manner.

6. The physician demonstrates respect for patients in all ways, maintains appropriate boundaries, and is committed to patient well-being. This includes time management, availability, and a willingness to assess performance.
7. The physician demonstrates respect for colleagues and team members.
8. Day-to-day behaviour and discussion reassure one that the physician is ethical and honest.
9. The physician practices evidence-based medicine skillfully. This implies not only critical appraisal and information-management capabilities, but incorporates appropriate learning from colleagues and patients.
10. The physician displays a commitment to societal and community well-being.
11. The physician displays a commitment to personal health and seeks balance between personal life and professional responsibilities.
12. The physician demonstrates a mindful approach to practice by maintaining composure/equanimity, even in difficult situations, and by engaging in thoughtful dialogue about values and motives.

***A few remarks on the organization and wording of the behaviours listed under each theme:***

Although the behaviours are listed under 12 different themes, they could be considered as one list, to be used in the most general sense as a menu from which to draw concrete examples that can be used when giving feedback on professional or unprofessional behaviour, or when assessing the same in a more structured fashion.

We have not placed the behaviours under each theme in any order of priority. For each theme, positive behaviours are listed first, with negative behaviours second. The choice of positivity or negativity in the formulation was spontaneous—it might be advantageous to generate the opposite formulation when using a particular behaviour in an assessment, but that can be done at the appropriate moment. Some behaviours are quite similar to others, some are opposites, but no conscious effort was made to determine the latter. In general, only the positive or the negative manifestation of the behaviour was described. At the moment, in this list, there are about 80 behaviours expressed positively, and about 50 behaviours expressed negatively.

No standard structure or formulation was used. Some are quite general and others very specific. Taken together, however, we do feel that they provide a sufficient and clear operational definition that can serve as the basis for the development of a structured evaluation of professionalism in most of the contexts applicable to family medicine. The user will make both the selection and the refinements appropriate to the situation.

**1. Day-to-day behaviour reassures one that the physician is responsible, reliable, and trustworthy.**

**Observable Behaviours:**

- ✓ Comes to clinic when expected
- ✓ Answers pages when on call
- ✓ Notifies attending colleague if he or she is going away and has a maternity patient due or is following an in-patient
- ✓ Notifies others when away for illness or emergencies as soon as possible
- ✓ Sets up systems for follow-up of patients
- ✓ Does not lie
  
- ✗ Does not look up questions after specific requests
- ✗ Leaves early, arrives late, without advising

- ✗ Inappropriately double schedules activities
- ✗ Switches schedules to personal advantage
- ✗ Does not do patient rounds appropriately i.e., too infrequent, too cursory
- ✗ Is unavailable for clinical responsibilities for personal reasons, without consideration of the needs of the patient or team
- ✗ Allows chart completion to back up unreasonably
- ✗ Does not document lab results as normal or abnormal; does not document follow-up
- ✗ Does not do letters, summaries
- ✗ Cheats on exams or quizzes (e.g., ALSO, NRP)
- ✗ Goes into SOOs with foreknowledge of cases (i.e., cheats on exams)
- ✗ Does not check allergies or interactions when prescribing
- ✗ Fails to follow up in a timely fashion with patients when investigations are pending (e.g., a skin biopsy), or in potentially serious clinical situations (e.g., a depressed adolescent who does not show up for an appointment)
- ✗ Lies about prior experience with a procedure to get to do it
- ✗ Signs in for others when attendance is taken at academic events
- ✗ Plagiarizes on projects

**2. The physician knows his or her limits of clinical competence and seeks help appropriately.**

**Observable Behaviours:**

- ✓ Seeks opportunities to address limitations to improve knowledge and skills (electives/continuing education)
- ✓ Does not use the excuse of limited clinical competence to avoid challenging clinical problems
- ✗ Argues about deficiencies in clinical competence in spite of examples to illustrate concerns
- ✗ Ignores clinical problems to mask clinical limitations
- ✗ Refers cases even when he or she has the skills and resources to perform the tasks (does not take the time to do appropriate medical procedures)
- ✗ Does not initiate the management of complex/difficult problems when a patient presents— defers to an attending physician or a consultant
- ✗ Does not prepare adequately for a procedure

**3. The physician demonstrates a flexible, open-minded approach that is resourceful and deals with uncertainty.**

**Observable Behaviours:**

- ✓ In patient encounters, consistently demonstrates a willingness to explore the patient's ideas of cause and take steps to include or exclude these from the ensuing differential diagnosis
- ✓ Is willing to adapt diagnosis/plan when provided with an alternative view/information/perspective (willing to change his or her mind)
- ✓ Provides time to deal with the emotion related to an uncertain diagnosis
- ✓ Does not unnecessarily limit patient options (i.e., does not display paternalism)
- ✓ Is satisfied with "symptom diagnosis" (e.g., says "dyspepsia", not "peptic ulcer disease") when information is limited or diagnosis is not confirmable

- ✓ Formulates a patient-centred stepwise plan to deal with a situation even when he or she doesn't know the answer
- ✗ Cuts patients off
- ✗ Refuses to deal with a major problem during an office visit because of time
- ✗ Refuses to see a patient who arrives slightly late for an appointment
- ✗ Shows anger/rigidity when patients don't follow a prescribed course of action
- ✗ Becomes dismissive of patient ideas when they don't fit his or her own
- ✗ Uses manipulative techniques to influence patient behaviour ("I won't be able to take care of you if you choose to do...")

**4. The physician evokes confidence without arrogance, and does so even when needing to obtain further information or assistance.**

**Observable Behaviours:**

- ✓ Says, "I don't know but I know how I am going to find out"
- ✓ Management discussions with patients are clearly helpful to the patient with "value added", even without a certain diagnosis or final opinion about available treatment
- ✓ Projects appropriate confidence in non-verbal communication: looks patients in the eye when he or she says, "I don't know"
- ✗ Uses own experience to devalue the patient's experience (e.g., "I didn't have to have an epidural")
- ✗ Tells patients what to do without understanding their circumstances (displays arrogance, paternalism)

**5. The physician demonstrates a caring and compassionate manner.**

**Observable Behaviours:**

- ✓ Allows patients time to verbalize their concerns without cutting them off; listens for a while before talking—actively listens before talking
- ✓ Does not belittle the patient's losses/fears
- ✓ Asks patients about their feelings, worries, hopes
- ✓ Sits down with patients whenever possible while communicating
- ✓ Addresses issues or behaviours with patients rather than confronting them personally or judgmentally
- ✓ Expands on healthy options or choices with patients
- ✓ Keeps patients' needs foremost when faced with own personal concerns about medical errors/disasters/accusations
- ✓ Is willing to acknowledge the patient's emotions within the encounter
- ✓ Does not blame patients for difficult situations they encounter
- ✓ When dealing with a difficult patient, recognizes his or her own feelings and avoids expressing anger inappropriately
- ✓ Despite time and workload pressure, maintains a pleasant, compassionate approach

**6. The physician demonstrates respect for patients in all ways, maintains appropriate boundaries, and is committed to patient well-being. This includes time management, availability, and a willingness to assess performance.**

**Observable Behaviours:**

- ✓ Respects the patient's time as if it were his or her own: does his or her best to be on time; acknowledges when he or she is not
- ✓ Does not impose personal religious, moral, or political beliefs on a patient
- ✓ Does not ask for or accept offers of dates from patients
- ✓ Does not ask patients for favours
- ✓ Does not accept inappropriate gifts
- ✓ Does not make jokes at a patient's expense
- ✓ Respects a patient's lifestyle choices as his or hers to make
- ✓ Appreciates the power differential in the physician-patient interaction
- ✓ Maintains personal appearance to facilitate patient comfort and confidence for individual patients, or for specific patient populations
- ✓ Comments and behaviours reinforce and enhance the patient's abilities and capabilities
- ✓ Does not lend patients money (or borrow money from patients)
- ✓ Recognizes the difference between maintaining confidentiality and seeking appropriate professional advice when needed in difficult situations
- ✓ Actively looks at his or her practice with assessment tools, and implements appropriate changes
- ✓ Thinks and speaks about patients in a positive manner
- ✓ Attempts to understand the patient's issues that precipitate difficult behaviour or non-compliance, and adapts his or her response accordingly
  
- ✗ Always seems rushed or burdened by too many demands
- ✗ Complains about other team members in front of patients
- ✗ Blames others for a personal lack of organization or harried approach ("Who took my stethoscope this time?", "Where's my pen?", "I'm late because there are no parking spots", "The secretary didn't remind me I had to be there", "My charts weren't out")
- ✗ Is reluctant or refuses to see some patients

**7. The physician demonstrates respect for colleagues and team members.**

**Observable Behaviours:**

- ✓ Does not undermine and avoids making negative comments about other providers, especially those who may have seen patients in different settings or contexts
- ✓ When consulted or asked for help, listens to concerns and tries to respond positively and to be available ("How can I help?" vs. "I don't need to see this patient")
- ✓ When needing to talk to someone unexpectedly, waits and picks the right moment; does not interrupt unduly
- ✓ Thinks and speaks about colleagues in a positive manner; respects their time as if it were his or her own
- ✓ Arrives on time

- ✓ Pays attention when others are speaking
- ✓ Lets others speak/continue; hears them out and stays respectful even if he or she may not agree with topics or points of view
  
- ✗ Provides inappropriate feedback in an insensitive manner (non-specific, wrong place, wrong time)
- ✗ Leaves early, picks the easy tasks, leaves tasks unfinished, etc., such that others have more work
- ✗ Discusses contentious issues in public, or gossips
- ✗ Avoids the discussion of contentious issues that are having or may have a major impact on team dynamics and outcomes
- ✗ Argues with other team members
- ✗ Does not make personal adjustments in spite of repeated messages from others about performance in the workplace
- ✗ A male trainee does not accept feedback from a female colleague or faculty
- ✗ Does other things (i.e., does not pay attention) while a colleague is speaking (e.g., text messages, reads paper, does charts)

**8. Day-to-day behaviour and discussion reassure that the physician is ethical and honest.**

**Observable Behaviours:**

- ✓ When an error has been made, acknowledges his or her own contribution, discusses it with the appropriate parties, tries to clarify why the error was made and apply corrective action for the future
- ✓ Obtains informed consent, asks about privacy/communication/confidentiality
- ✓ Respects patient autonomy, and assesses whether patient decision making is impaired
- ✓ Provides honest estimates concerning time, services, and billing
  
- ✗ Discloses patient information against his or her expressed wishes, especially with respect to adolescents, the elderly, and patients with different cultural issues
- ✗ Discusses patients in “public” places
- ✗ Provides medical treatment inappropriately to colleagues, including writing prescriptions
- ✗ Claims (to colleagues, patients, others) to have done something that has not been done (e.g., history, physical exam, lab tests, phone calls, follow-up)
- ✗ Takes credit for work done by others (for monetary reasons, for prestige, for any reason)
- ✗ Has inappropriate prescribing practices:
  - Puts in the name of someone with a drug plan instead of the patient
  - Prescribes inappropriately for self-gain
  - Prescribes without sufficient assessment
- ✗ Makes unjustifiable claims on insurance or other forms

**9. The physician practices evidence-based medicine skillfully. This implies not only critical appraisal and information-management capabilities, but incorporates appropriate learning from colleagues and patients.**

**Observable Behaviours:**

- ✓ Does not give undue weight to evidence-based medicine: incorporates the patient's and family's expertise about the uniqueness of their situation; incorporates the experience and expertise of colleagues and team members, as well as his or her own
- ✓ When a patient questions care or makes suggestions, is open to respectful discussion; responds positively to patients who bring materials from the Internet
- ✓ When using guidelines or the results of clinical trials (on large populations), customizes and adapts them to ensure applicability to the individual patient in question
- ✓ Does not change a current treatment plan when temporarily dealing with someone else's patient; if thinks changes are desirable, discusses them first with the regular provider
- ✓ Checks as to whether practice is consistent with recent evidence, and makes changes consistent with this evidence
- ✓ Identifies knowledge gaps in own clinical practice, and develops a strategy to fill it; frames clinical questions that will facilitate the search for "answers" to these gaps
  
- ✗ Does not use resources to acquire up-to-date information about specific cases
- ✗ Following a group discussion and decision, does not incorporate agreed-upon changes into clinical practice
- ✗ Relies too much on a limited set of inappropriate information resources (e.g., drug company representatives, unselected Internet material, The Medical Post, "expert" opinion)
- ✗ Does not critically question information

**10. The physician displays a commitment to societal and community well-being.**

**Observable Behaviours: \*\***

- ✓ Does not dismiss concerns raised by patients on local issues that have an impact on their health (e.g., safe walking areas, pollution)
- ✓ Tries to empower the patient who raises concerns about community issues; acts in a confidential manner
- ✓ Responds positively to community requests for participation: will dedicate some time and experience, some resources (e.g., put a poster up)
  
- ✗ Does not respect the duty to report in situations where there is a clear danger to others (e.g., meningococcal disease, capacity to drive, child abuse)
- ✗ Does not report inappropriate behaviour (e.g., substance abuse) of professional colleagues to the appropriate supervisor or authority

\*\* Although many examples around this theme may be found later in practice, we do not think it practical or fair to assess this theme in great detail at the time of certification, namely during training or at the very beginning of independent practice. The other themes of professionalism provide better opportunities for the appropriate assessment of this dimension.

**11. The physician displays a commitment to personal health and seeks balance between personal life and professional responsibilities.**

**Observable Behaviours:**

- ✓ Takes appropriate time to fulfill personal needs
- ✓ Is willing to discuss observations from colleagues or team members when behaviour suggests difficulty because of stress
- ✓ When a conflict between professional and personal activities is brought to his or her attention, discusses it, makes an appropriate adjustment or not
- ✓ Sometimes puts the patient first, ahead of personal need, and demonstrates satisfaction and appreciation of the value of this action
- ✓ Has a healthy lifestyle: does not smoke, does not drink to excess, drives reasonably
- ✗ Takes frustration, etc., out on colleagues/staff (e.g., is rude and inappropriate)
- ✗ Fails or refuses to recognize or deal with significant illness or a condition that may have an impact on professional activities, especially when concerns are identified by others
- ✗ Stays overtime inappropriately, comes to work sick, is unwilling to take time off
- ✗ Burdens co-workers when taking care of own needs (i.e., leaves many things undone without communicating with colleagues)
- ✗ Transfers tasks to colleagues without clear justification, without adequate communication; changes availability for professional tasks “frequently”, “at the last minute”
- ✗ Seeks medical care from friends or colleagues outside of a normal physician-patient relationship; acts as own physician

**12. The physician demonstrates a mindful approach to practice by maintaining composure/equanimity, even in difficult situations, and by engaging in thoughtful dialogue about values and motives.**

**Observable Behaviours:**

- ✓ Given a difficult situation, maintains composure and is able to act appropriately (e.g., with angry patients, an unexpected clinical turn of events, an overwhelming demand, examinations)
- ✓ Is consistently attentive to a patient or colleague throughout any interaction
- ✓ Tries to understand the behaviour of others without getting mad or being hurt
- ✓ Does not display anger, inappropriate humour, or other emotions when this could undermine constructive work with patients or colleagues
- ✓ When emotions are intense or visible, can nevertheless explain or suggest a constructive plan of action
- ✓ Does not lose his or her cool—even when the other person in the room loses it
- ✓ Can allow for multiple perspectives from various participants in complex situations; entertains or solicits other viewpoints
- ✓ Is willing to engage in dialogue, in order to learn from experience and others, when
  - a bad/unexpected outcome occurs
  - there are conflicting ideas

- he or she is asked questions (does not perceive these as a threat; makes time to discuss them vs. being “too busy to talk about it”)
- ✓ When a mistake appears to have been made, acknowledges it and looks first for personal responsibility rather than directing blame elsewhere

## Clinical Reasoning Skills

This dimension of competence is one of two that are currently almost entirely defined by and within the key features of the priority topics.

Each key feature suggests, explicitly or implicitly, the dimensions of competence as well as the phase of the clinical encounter, and, hence, the specific cognitive skills, that are characteristic of competence when dealing with the problem in question. All the key features have been individually coded as to the skills and phases assessed, but these codes are not yet visible in this version of the evaluation objectives document—the majority of the key features (60%), however, involve clinical reasoning skills, so using them in an unselected fashion will certainly touch on this dimension.

Clinical reasoning is a more familiar territory and the framework used is that of clinical problem solving using the hypothetico-deductive model, with particular emphasis, however, on using it in an expert fashion. The skilled physician will use this model efficiently, in a manner adapted to the patient's needs, as well as to those of the problem at hand and the context of the encounter, to deal with a patient's problems.

What are some of the characteristics of expert clinical reasoning, as opposed to the not-yet-expert? Repeated studies have shown that the history is the most important part of the clinical encounter and that it is usually sufficient to suggest the correct diagnoses. We use the term “diagnosis” in its widest sense, including problem identification at all levels, not just medical diagnoses. The experienced clinician often generates the diagnostic possibilities or hypotheses within the first minute of the clinical encounter. The expert then uses these hypotheses to direct the subsequent data gathering: he may collect less information than a non-expert, but the information selected is often much more detailed around the important points—he or she gathers the data necessary to deal with the problem, and does not lose time gathering non-contributory information for the problem at hand. The data is interpreted as it is obtained, to finish with a second round of diagnostic hypotheses—this step certainly requires expertise, but it is often self-evident if the initial diagnostic hypotheses and the data gathering have been done in a skilled fashion. The physical examination and investigation phase often play minor roles—indeed it is often a question of confirming or eliminating diagnostic possibilities generated by the history.

Is it reasonable to almost equate clinical reasoning skills (and medical problem solving) with skill in arriving at an accurate diagnosis? Most would agree with this assumption, for two reasons. First, management and treatment certainly require skill, but they are heavily knowledge dependent, so they are situated closer to the lower cognitive levels of clinical competence, as well as being particularly dependent on an accurate set of diagnoses. Second, with a few domain-specific exceptions, the various cognitive and non-cognitive skills required in the later phases of the clinical encounter are all required to a higher degree in making an accurate and pertinent diagnosis.

Of course, although skill at making accurate diagnoses is a necessary element of competence in clinical reasoning skills, it is probably not sufficient by itself. A well-planned assessment of competence in clinical reasoning skills will put great emphasis on taking the history and making diagnoses, but it will also include some tasks situated in the later parts of the clinical encounter. It will not do this in a random fashion, however. This brings us back to the concept of the interaction between the patient, the physician, and the problem. Each interaction will itself determine which steps are most critical: for some it may well be the treatment or the physical examination, and, if this is so, then this is where competence lies for this interaction, and this is what should be assessed. The challenge, for valid assessment, is to match the evaluation with the interaction. The key feature analysis did this, so the best definition of competence in clinical reasoning skills can be found in the Priority Topics and Key Features List.

## Selectivity

This dimension has not, to our knowledge, been previously described with respect to physician competence, although it is surely not an original idea. It is the term that was chosen by the initial focus group to describe a set of skills that was frequently cited in the survey as characterizing the competent family physician: such a physician does not do things in a routine or stereotypical fashion but is very adaptable and selective in approach, modifying it to suit both the situation and the patient. Some of the ways in which a physician demonstrates competence in this dimension are as follows:

- Sets priorities and focuses on the most important
- Knows when to say something and when not to
- Gathers the most useful information without losing time on less contributory data
- Does something extra when it will likely be helpful
- Distinguishes the emergent from the elective and intervenes in a timely fashion
- Acts when necessary, even though information may be incomplete
- Determines the likelihoods, pertinence, and priorities in his or her differential diagnoses
- Distinguishes the sick from the not sick
- Selects and modifies a treatment to fit the particular needs of a patient and a situation

Selectivity could perhaps be considered a subset of all the other dimensions, but it was used frequently enough in the descriptions of competence to merit its own dimension. As we saw earlier, selectivity is found at the higher levels of competence, and it could be an extremely robust indicator of overall competence when used for assessment purposes. It could also be considered to be one of the operational levels that go to make up clinical judgment, and provides a way to assess this important concept.

This dimension of competence is one of two that are currently almost entirely defined by and within the key features of the priority topics. Each key feature suggests, explicitly or implicitly, the dimensions of competence, as well as the phase of the clinical encounter, and, hence, the specific cognitive skills that are characteristic of competence when dealing with the problem in question. Sixteen percent of the key features involve selectivity as an essential skill, most often (although not exclusively) associated with clinical reasoning skills. It may be sufficient to assess selectivity only in this context, but we could also envisage its assessment in other dimensions, if necessary. The concept surely applies. It would simply remain to develop a further operational definition of selectivity as it is expressed in the other dimensions.

## Procedure Skills

Certification for independent practice requires a certain level of experiential competence: this includes the technical skills to perform a certain number of procedures. Sixty-five core procedures are listed below, and these are the procedures upon which the assessment of competence will be based<sup>19</sup>. It should be remembered that it is not only the technical aspects of the individual procedures that are important. The higher levels of competence must also be assessed, as always, in the context of family medicine—the key features describe this aspect.

### The General Key Features of Procedure Skills\*

1. In order to decide whether or not you are going to do a procedure, consider the following:
  - a) The indications and contraindications to the procedure
  - b) Your own skills and readiness to do the procedure (e.g., your level of fatigue and any personal distractions)
  - c) The context of the procedure, including the patient involved, the complexity of the task, the time needed, the need for assistance, and location
2. Before deciding to go ahead with the procedure:
  - a) Discuss the procedure with the patient, including a description of the procedure and possible outcomes, both positive and negative, as part of obtaining their consent.
  - b) Prepare for the procedure by ensuring the appropriate equipment is ready.
  - c) Mentally rehearse the following:
    - The anatomic landmarks necessary for procedure performance.
    - The technical steps necessary in sequential fashion, including any preliminary examination.
    - The potential complications and their management.
3. During performance of the procedure:
  - Keep the patient informed to reduce anxiety.
  - Ensure patient comfort and safety always.
4. When the procedure is not going as expected, re-evaluate the situation, and stop and/or seek assistance as required.
5. Develop a plan with your patient for after care and follow-up after completion of a procedure.

\* Apply to all procedures. These can be used to guide the development of specific evaluation tools for specific procedures.

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<sup>19</sup> Wetmore SW, Rivet C, Tepper J, Tatemichi S, Donoff M, Rainsberry P. Defining core procedure skills for Canadian family medicine training. *Can Fam Physician*. 2005; 51(10): 1364-5.