Domain of Competence: Interpersonal and Communication Skills

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The views expressed in this report are those of the authors and do not necessarily represent those of the Accreditation Council for Graduate Medical Education, the American Board of Pediatrics, the Association of Pediatric Program Directors, or the Academic Pediatric Association. The author declares that he has no conflict of interest.

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INTERPERSONAL AND COMMUNICATION skills are foundational for successful physician practice in the 21st century. Ample evidence links best practices in physician–patient communication with a lower risk of litigation, but the more important truth is that better communication leads to better health outcomes for patients.2,3 The stakes are also high for medical educators and learners because an interdependence exists between interpersonal and communication skills and assessment of the other competency domains. For example, a learner with novice oral presentation skills and an uncomfortable manner may not accurately represent his medical knowledge or patient care skills in a case presentation on rounds. In putting together this supplement, the Pediatrics Milestone Working Group took the opportunity to model the critical need for accuracy and understanding in all forms of communication by rethinking each behavioral narrative described in the milestones and editing as needed to enhance clarity.

REFERENCES


Competency 1. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds

Bradley Benson, MD

BACKGROUND: The ability to communicate effectively with patients, families, and the public is a critical skill for the medical professional and has been directly related to the outcomes of clinical care.1 The importance of this is reflected in the medical education literature in consensus statements on essential elements of communication,2,3 in guidelines for medical school curriculum development,4,5 and through increased emphasis placed on communication skills by professional practice organizations and accrediting bodies.6,7

The task approach is useful in conceptualizing the skills needed for effective physician–patient communication and has been the cornerstone of teaching this domain in medical education. The Kalamazoo Consensus Statement3 clearly summarizes these essential communication tasks. The simplified list is as follows: 1) build the doctor–patient relationship, 2) open the discussion, 3) gather information, 4) understand the patient’s perspective, 5) share information, 6) reach agreement on problems and plans, and 7) provide closure. Multiple other models of effective communication have been proposed; however, the essential elements are similar to those above, and multiple validated tools are available to assess learners’ competence in these
tasks. While the literature on how medical learners develop this competence is limited, there is a large body of literature in other fields (particularly education) that informs the developmental progression proposed below. 8–11

**EARLY PHYSICIAN–PATIENT COMMUNICATION COMPETENCE:** Early communication by the novice learner is predicated on the use of externally provided scripts or templates. During the interactions, the learner is focused as much on remembering the next question as on the responses of the interviewee. The ability to tailor the scripts to patients of different socioeconomic and cultural backgrounds is limited.

**INTERMEDIATE PHYSICIAN–PATIENT COMMUNICATION COMPETENCE:** As the templates become habit, the learner is freed in communication both to be more attentive as a listener and to reflect on barriers (physical, cultural, psychological, and social) to the communication. During this stage of development, however, the learner has little experience to draw from to mitigate these barriers. As experience accrues and is reflected upon, the learner can both identify and mitigate barriers to communication under most normal circumstances. When communication does not go well or a new circumstance is encountered, the competent communicator reflects on the experience and applies lessons learned to future communication.

**ADVANCED PHYSICIAN–PATIENT COMMUNICATION COMPETENCE:** Progression through the proficient and expert stages of communication involves appropriate responsiveness to an ever-expanding set of circumstances that elicits deviations from traditional scripts in order to optimize the encounter and establish/maintain rapport. The master communicator demonstrates continuous assessment of the interaction and intuitively extrapolates from previous experience to meet the needs of the patient, family, or public in the communication. This individual can adjust to any circumstance, even when engaged in crucial or difficult conversations and even when a similar experience has not been encountered in the past.

**DEVELOPMENTAL MILESTONES:**

- Uses standard medical interview template to prompt all questions without varying the approach based on a patient’s unique physical, cultural, socioeconomic, or situational needs. May be tentative or avoid asking personal questions of patients.
- Uses the medical interview to establish rapport and focus on information exchange relevant to a patient’s or family’s primary concerns. Identifies physical, cultural, psychological, and social barriers to communication, but often has difficulty managing them. Begins to use nonjudgmental questioning scripts in response to sensitive situations.
- Uses the interview to effectively establish rapport. Able to mitigate physical, cultural, psychological, and social barriers in most situations. Verbal and nonverbal communication skills promote trust, respect, and understanding. Develops scripts to approach most difficult communication scenarios.
- Uses communication to establish and maintain a therapeutic alliance. Sees beyond stereotypes and works to tailor communication to the individual. Has developed scripts for the gamut of difficult communication scenarios. Able to adjust scripts ad hoc for specific encounters.
- Interacts with patients and families in an authentic manner that fosters a trusting and loyal relationship. Effectively educates patients, families, and the public as part of all communication. Models how to manage the gamut of difficult communication scenarios with grace and humility.

**COMPETENCY 2:** Demonstrate the insight and understanding into emotion and human response to emotion that allow one to appropriately develop and manage human interactions

**BACKGROUND:** The concept of emotional intelligence is a useful construct in elucidating the development of insight and understanding into emotion and human response to emotion that allows one to appropriately develop and manage human interactions. 1 Emotional intelligence is a set of 4 separate but related abilities: perceiving emotions, using emotions, understanding emotions, and managing emotions. 2 Table 1 provides a

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**REFERENCES**


**Bradley Benson, MD**
The issues of patient safety and medical error. Research into the scope of medical practice and is integrally linked with communication is a critical skill that underlies effectiveness across contexts.

### Table 1. Description and Examples of the Abilities of Emotional Intelligence

<table>
<thead>
<tr>
<th>Ability</th>
<th>Narrative Description</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceiving emotions</td>
<td>Accurate identification of emotions in oneself and others.</td>
<td>A senior resident reads fear and anxiety in a mother’s face and body language during a discussion of routine vaccinations.</td>
</tr>
<tr>
<td>Using emotions</td>
<td>Knowledge of and experience with emotions informs and changes behavior.</td>
<td>The above resident acts upon the discovery of the mother’s emotional nonverbal cues and queries for further information about her experiences and fears related to vaccination.</td>
</tr>
<tr>
<td>Understanding emotions</td>
<td>Ability to analyze emotions in oneself and others and describe the connections between those feelings and the resultant behavior.</td>
<td>The above resident learns that the mother’s nephew has been diagnosed with autism and makes the connection between the mother’s anxiety and her fear of the MMR vaccine causing autism in her child.</td>
</tr>
<tr>
<td>Managing emotions</td>
<td>Ability to consciously regulate emotions in oneself and others.</td>
<td>The above resident is able to manage her own strong feelings about the value of vaccinations and counsel the parent in a caring and empathetic manner, allaying her fear.</td>
</tr>
</tbody>
</table>

DEVELOPMENTAL MILESTONES:

- Does not demonstrate anticipation or reading of others’ emotions in verbal and nonverbal communication. Does not demonstrate awareness of one’s own emotional and behavioral cues and may transmit emotions in communication (e.g., anxiety, exuberance, and anger) that can precipitate unintended emotional responses in others. Does not manage strong emotions in oneself or others.
- Begins to demonstrate use of past experiences to anticipate and read (in real time) the emotional responses in herself and others across a limited range of medical communication scenarios, but does not yet demonstrate the ability or insight to moderate behavior to effectively manage the emotions. Strong emotions in oneself and others may interfere with performance.
- Demonstrates anticipation of, reads, and reacts to emotions in real time with professional behavior in nearly all typical medical communication scenarios, including those evoking very strong emotions. Demonstrates use of these abilities to gain and maintain therapeutic alliances with others.

- Demonstrates perception, understanding, use, and management of emotions in a broad range of medical communication scenarios and is able to verbalize lessons learned from new or unexpected emotional experiences. Demonstrates effective management of her own emotions in all situations. Demonstrates effective and consistent use of emotions to gain and maintain therapeutic alliances with others.
- Demonstrates perception, understanding, use, and management of emotions to improve the health and well-being of others and to foster therapeutic relationships in any and all situations.

### REFERENCES


### Competency 3. Communicate effectively with physicians, other health professionals, and health-related agencies

**Bradley Benson, MD**

**BACKGROUND:** Competence in interprofessional communication is a critical skill that underlies effectiveness across the scope of medical practice and is integrally linked with the issues of patient safety and medical error. Research into how competency in this domain develops, however, is scarce and is limited by the complexity of medical communication across different specialties, settings, and contexts.

**COMMUNICATIVE COMPETENCE:** A useful construct in understanding the developmental progression of skills in interprofessional communication is that of communicative competence. This model was originally described by Dell Hymes and has been built upon by a legion of subsequent scholars studying how learners acquire a second language. Canale and Swain described the 3 components of communicative competence listed in Table 2, each of which may
**Table 2. Description and Examples of the Components of Communicative Competence**

<table>
<thead>
<tr>
<th>Communicative Competence Component</th>
<th>Narrative Description</th>
<th>Example in Medical Interprofessional Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grammatical competence</td>
<td>Concerned with mastery of the language code itself (ie, the words and the rules).</td>
<td>Medical terminology and jargon, order of presentation (ie, chief complaint before the history of present illness and the physical examination before the labs).</td>
</tr>
<tr>
<td>Sociolinguistic competence</td>
<td>Concerned with appropriateness of the chosen grammar and syntax for the particular situation or context.</td>
<td>Use of jargon may be inappropriate for discussion with nonphysician care team members.</td>
</tr>
<tr>
<td>Strategy competence</td>
<td>Concerned with adoption of the appropriate communication strategy for the situation or context.</td>
<td>Appropriate choice of communication type (eg, alpha text page versus e-mail versus telephone versus face-to-face) or the strategy within a given type (eg, 30-second synopsis versus 5-minute full presentation).</td>
</tr>
</tbody>
</table>

be applied to communication in medicine, as noted in the third column.

**MEDICINE AS A SECOND LANGUAGE:** The literature supports the comparison of learning medicailese and oral presentation skills to the acquisition of a new language. In fact, the observational study by Haber and Lingard using rhetorical analysis to study oral presentation skill development provides great insight into the early milestones.

Competent medical communication requires fluency in the complex language of health care and in the ability to adapt the communication of a message to the context in which it is delivered. This context consists of the audience (eg, supervising resident, consulting attending, pharmacist, nurse), the purpose (ie, to tell a story or make a case), and the occasion (eg, bedside rounds, phone consult request, transfer of care).

**EARLY DEVELOPMENT IN INTERPROFESSIONAL COMMUNICATION:** Using the observations of Haber and Lingard, in the early stages learners describe and conduct presentations as a “rigid, rules based, data storage activity governed by order and structure.” Data are presented in the same order in which the questions were asked and often directly from a written note. The presentation does not change based on context, and the same summary is given to the resident, the attending, and the consultant. The presenter is often not aware of the social purpose of the presentation (eg, to obtain permission from the infectious diseases specialist for use of a restricted antibiotic), but is more focused on clearly stating all of the facts.

**INTERMEDIATE DEVELOPMENT IN INTERPROFESSIONAL COMMUNICATION:** As learners progress, they begin to understand the different audiences and occasions and can tailor their language and corresponding message accordingly. They also begin to see the purpose of the presentation and are able to either tell the story or make the case appropriately. While in some situations they may still err on the side of inclusion of excess details out of fear of causing harm, they begin to shorten presentations to include just the pertinent information. The intermediate developmental stage here also includes the emerging focus on and understanding of communication strategies to adapt to the context of the communication (eg, the use of an e-mail for a quick informational exchange, with face-to-face time reserved for crucial conversations or critical feedback).

**ADVANCED DEVELOPMENT IN INTERPROFESSIONAL COMMUNICATION:** As interprofessional communication skills become advanced, the learner naturally tailors the message and communication strategy to the context to maximize effectiveness and efficiency. The concept of improvisation is helpful in understanding the nature and development of these skills. In the words of Haidet, “Improvisation guides a physician’s process of making moment-to-moment communicative decisions (eg, what to say next, how to structure particular questions, which threads to follow, when to interrupt and when to let the patient keep going).” With regular exposure to new communication scenarios and ongoing reflection, improvisation skills continue to evolve and are a hallmark of the expert communicator.

**DEVELOPMENTAL MILESTONES:**

- Recites facts according to a given set of rules or scripts, often directly from a template or prompt. Does not adjust communication on the basis of context, audience, or situation. Appears unaware of the social purpose of the communication.
- Adapts communication to better fit the context, audience, and situation and can present without templates or prompts, but may still err on the side of inclusion of excess detail.
- Successfully tailors communication strategy and message to the audience, purpose, and context in most situations. Demonstrates awareness of the purpose of the communication; can efficiently tell a story and effectively make an argument. Beginning to improvise in unfamiliar situations.
- Uses the communication strategy that aligns with the situation. Distills complex cases into succinct summaries tailored to audience, purpose, and context. Can improvise and has expanded strategies for dealing with difficult communication scenarios (eg, an interprofessional conflict).
- Improvises in new or difficult communication scenarios. Recognized as a highly effective public speaker and a role model for the management of difficult conversations.

**REFERENCES**

Competency 4. Work effectively as a member or leader of a health care team or other professional group

Bradley Benson, MD

BACKGROUND: The importance of teamwork in medicine is clear from a growing body of literature linking these skills to patient safety, satisfaction, and improved clinical outcomes.\textsuperscript{1–3} The relationship between teamwork and patient safety and outcomes was highlighted in the landmark Institute of Medicine publications To Err Is Human\textsuperscript{4} and Crossing the Quality Chasm,\textsuperscript{5} with specific recommendations for teaching and assessing these knowledge, skills, and attitudes across the continuum of medical education and continuing professional development, with the goal of ingraining this into the culture of our medical institutions. In these publications, however, it is clear that a comprehensive theoretical model of team performance in medical settings has not yet been fully developed and validated, adding to the challenges in assessment, as eloquently stated by Baker et al:\textsuperscript{6}

\textit{For teamwork skills to be assessed and have credibility, team performance measures must be grounded in team theory, account for individual and team-level performance, capture team process and outcomes, adhere to standards for reliability and validity, and address real or perceived barriers to measurement.}

The focus here will be on the individual competencies that a provider brings to a team in order to contribute to effective team function. However, it is important to consider that the development of these competencies is influenced by the individual competencies of other team members, competencies of the team as a unit, and competencies of the organization as a whole.\textsuperscript{7}

Before detailing the proposed milestones for the competency of interprofessional teamwork, we must begin with an accepted definition of a team and a description of the specific knowledge, skills, and attitudes that comprise teamwork. For the purposes of this work, a team will be considered to be a group of 2 or more people with the following characteristics: specific roles, interdependent tasks, adaptability, and a shared common goal.

TEAMWORK-RELATED KNOWLEDGE: Cannon-Bowers and Salas\textsuperscript{8} describe multiple knowledge areas related to effective team performance. Simply stated, to function effectively in a team, a team member must know what team skills are required, what team behaviors are appropriate, and how to perform these skills and behaviors in a team setting. Team members must also know the team’s mission and goals as well as each other’s roles and responsibilities in achieving them. This knowledge is then used to determine the best strategies for interaction and coordination among teammates to best achieve the mission.

TEAMWORK-RELATED SKILLS: The literature in this area is extensive and context specific, leading to a myriad of skill labels and definitions. A review of the teamwork literature in 1995 identified over 130 terms to describe the various teamwork skills.\textsuperscript{9} Much work has been done to distill these into generic skill sets required for effective performance on any team, independent of the context.\textsuperscript{9} The 4 key skills identified by Alonso and colleagues\textsuperscript{10} are leadership, mutual support, situation monitoring, and communication.\textsuperscript{11} These form the basis of the Agency for Healthcare Research and Quality supported team training program, TeamSTEPPSTM, which was released to the public domain in 2006 and has been implemented at health care institutions across the nation and abroad.\textsuperscript{9} The outcomes of this program strengthen the argument that these core skills are teachable and that improved individual performance positively impacts team outcomes. They are clearly interrelated, and improvements in one area may lead to observable improvements in the others. The ontogeny of these 4 teamwork skills is based on developmental models used throughout the milestones work and includes the work of Dreyfus and Dreyfus,\textsuperscript{11} Monrouxe,\textsuperscript{12} and Pangaro.\textsuperscript{13} The developmental progression of these skills is an area ripe for research.

TEAM COMMUNICATION

For the purposes of this competency, team communication is defined as the initiation of a message by the sender, verification of receipt and acknowledgment of the message by the receiver, and verification of the initial message by the sender. The developmental progression for this skill goes from unidirectional communication (ie, with a focus on sending or receiving a message only) to bidirectional information exchange with verification of understanding by both team members and commitment to the greater purpose of the communication. This skill is integral to effective patient handoffs and is discussed in detail in related milestones. Using this example, the early learner would focus on the specific task of providing or receiving the sign-out document. The advanced learner would augment the written
sign-out document with a succinct verbal summary, verify that the covering provider understands the key clinical issues and the tasks that need to be followed up, and ensure that they commit to providing the needed care.

**Mutual Support**

A working definition of mutual support focuses on providing coaching and support to improve performance or, when a lapse is detected, assisting teammates in performing a task or completing a task for the team member when an overload is detected. The proposed developmental progression for this skill moves from a “self”-centered view of one’s work to one that includes the other individual team members and “their” work to a team-focused view of “our” work. Early learners perform their own work but may not seek help when beyond their capabilities or overloaded. With progression, intermediate learners will ask for help with their work as needed and will provide support when other team members ask for it, or passively offer support if it is clear that team members are overwhelmed or unable to complete their work. Finally, advanced learners make certain they get any needed help when overloaded and automatically steps in or arranges for assistance when “our” work is uneven or not adequately completed for any reason. This later stage includes initiation of active assistance as opposed to the passive offering of assistance.

**Situation Monitoring**

Situation monitoring is defined here as tracking fellow team members’ performance to ensure that the work is running as expected and that proper procedures are followed. In the early stages, the proposed developmental progression for this skill begins with the self-awareness of one’s needs, abilities, and contributions, and progresses to include awareness of the needs, abilities, and contributions of the other team members. The more advanced stages are characterized by a global view of team performance as it relates to achieving team goals.

**Team Leadership**

For our purposes, team leadership is defined as the ability to direct/coordinate team members, assess team performance, allocate tasks, motivate subordinates, plan/organize, and maintain a positive team environment. When translated into behaviors, these may be observed and assessed in any member of a health care team, not just the designated leader. The proposed developmental progression for this skill involves moving from behaving as a passive bystander on the team, to taking an active ownership role, to ensuring that the overall team goals are met.

**Teamwork-Related Attitudes:** Teamwork-related attitudes are internal states that affect a team member’s choices and behavior. Examples include shared vision, mutual trust, collective orientation, and a belief in the importance of teamwork as the best approach to achieve a goal. Studies demonstrating better performance of individuals who view success as more a function of cooperation than competition as compared to those with the opposite view suggest the importance of attitudes in team outcomes. It is upon this foundation of team theory that developmental milestones in this competency are proposed. As with other milestones, there is significant overlap, particularly with systems-based practice and professionalism. The development of a team-based systems approach to health care provision is well described in the systems-based practice milestones, and similar overlap is noted in the discussion of leadership related to personal and professional development.

While the teamwork-related knowledge, skills, and attitudes could be further parsed by the various elements that comprise this competency, we will not attempt that here. We propose rather to unify them into developmental stages informed by the work of Dreyfus and Dreyfus, Zabarenko and Zabarenko, and Brent.

**Developmental Milestones:**

- Demonstrates limited initiative to interact with team members with minimal participation in team discussion. Passively follows the lead of others on the team. Focuses more on her own than the team’s performance. Demonstrates limited awareness of her own needs and abilities with minimal recognition and acknowledgment of the contributions of others.
- Demonstrates an understanding of the roles of various team members by interacting with appropriate team members to accomplish assignments. Actively works to integrate herself into team function and meet or exceed the expectations of her given role. Works toward achieving team goals, but may put personal goals related to professional identity development (eg, recognition) above pursuit of team goals.
- Identifies herself and is seen by others as an integral part of the team. Seeks to learn the individual capabilities of each fellow team member and will offer coaching and performance improvement as needed. Adapts and shifts roles and responsibilities as needed to achieve team goals. Communication is bidirectional, with verification of understanding of the message sent and the message received in all cases.
- Initiates problem solving, frequently provides feedback to other team members, and appears to take personal responsibility for the outcomes of the team’s work. Actively seeks feedback and initiates adaptations to help the team function more effectively in changing environments. Engages in closed loop communication in all cases, ensuring that all understand the correct message. Seeks out and takes on leadership roles in areas of expertise and makes sure the job gets done.
- Assumes the role of leader or follower, seamlessly, as needed. Goals of the team appear to supersede any personal goals. Creates a high-functioning team de novo or joins a poorly functioning team and facilitates improvement, such that team goals are met.

**References**

Competency 5. Act in a consultative role to other physicians and health professionals

Bradley Benson, MD

**BACKGROUND:** The medical consultation is not a straightforward procedure, and the effectiveness of such consultations is not easily studied in a randomized controlled trial. It is, however, a common intervention in patient care, and nearly all medical professionals request or provide consultative services as part of their clinical work. As with many other competencies and subcompetencies, there is significant overlap in the skill sets that are required. For consultation skills in particular, specific expertise is required in the domains of medical knowledge and patient care. Certain specific aspects of professionalism are also critical and have been the subject of much ethical and medicolegal debate as they relate to consultation. The American Medical Association noted 9 ethical principles directly pertaining to physician consultation, 3 of which apply to the referring physician; the remaining 6 focus on the consultant. These serve to clarify the responsibilities and role of the consultant and are summarized briefly as follows: 1) one physician should direct the patient’s care and treatment, and the consultant should not take on primary management without the consent of that primary provider; 2) the consultation should be done in a timely manner, the results should be communicated directly to the referring provider, and the results should be shared with the patient only by prior consent of that provider; and 3) differences of opinion need to be resolved with a second consultation or withdrawal of the consultation, although the consultant has the right to discuss her opinion with the patient in the presence of the referring physician.

At the heart of effective consultation is the communication with the referring provider. There is a body of literature on factors that improve compliance with consultant recommendations, and these findings support the importance of advanced communication skills for an effective consultant. This literature has formed the basis of most subsequent writing on the knowledge, skills, and attitudes required for effective consultation. The cardinal article by Goldman et al. pragmatically summarizes this work. This work has been updated to reflect current practice, but the key principles remain the same. Review of Goldman’s 10 key skills is provided in Table 3; however, the developmental process of becoming an expert consultant is much more complex and involves not only the acquisition of specific knowledge and skills but also attitudes and behaviors related to professional identity, which are addressed in other milestones.

The skills noted in Table 3 are relatively straightforward and amenable to assessment by chart audits and multisource assessments. More difficult to conceptualize and assess is the development of the professional identity of a consultant. Much has been written about the development of professional expertise. Refer to Bereiter and Scardemalia, Ermut, and Dreyfus and Dreyfus for a deeper understanding of the foundation on which this framework is developed.

**DEVELOPMENTAL MILESTONES:**

- Participates as a member of the consultation team; gathers and presents the patients’ histories and physical findings, and scribes recommendations in the medical record. Demonstrates limited discipline-specific knowledge, which impacts ability to focus the data gathering and presentation to those details relevant to the question asked.
- Identifies self as a member of the consultation team. Demonstrates the ability to accurately gather and present the patient’s history and physical findings with a focus on those details pertinent to the question asked. Demonstrates increased discipline-specific knowledge and ability to filter and prioritize information, presents a focused differential, realistic working diagnosis, and more specific recommendations with more succinct documentation. Takes ownership of the patients’ outcomes during follow-up of initial recommendations.
- Identifies self as an integral member of the consultation team and demonstrates advanced knowledge and skills in the specific area. Independently assesses and confirms data. Consistently provides recommendations that align with best practice. Develops relationships with referring providers, but may not encourage the bidirectional feedback that makes the relationship truly collaborative.

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<table>
<thead>
<tr>
<th>Skill</th>
<th>Narrative</th>
<th>Novice</th>
<th>Anchor</th>
<th>Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarify the question</td>
<td>Communicate with the referring provider to determine whether a specific question is to be answered, a procedure requested, or if co-management is the goal.</td>
<td>Does not attempt to clarify clinical questions where needed.</td>
<td>Negotiates (and, if needed, renegotiates) most appropriate role and question on the basis of the needs of provider and patient.</td>
<td></td>
</tr>
<tr>
<td>Determine the urgency</td>
<td>Understanding the question and the patient’s situation allows determination of how quickly an opinion needs to be given to provide optimal patient care.</td>
<td>Not able to determine urgency; own time constraints trump patient/provider needs.</td>
<td>Determines urgency and conveys this to the requestor of the consultation, mobilizing the team as needed in acute situations.</td>
<td></td>
</tr>
<tr>
<td>Independently assess the patient</td>
<td>Independent assessment of the patient is necessary.</td>
<td>Relies primarily on others’ assessments in the medical record.</td>
<td>Approaches each patient independently and verifies all important data while seeking out missing information to obtain a complete and accurate clinical picture.</td>
<td></td>
</tr>
<tr>
<td>Be as brief as appropriate</td>
<td>Succinct medical documentation and communication improve compliance.</td>
<td>Lengthy documentation often includes unnecessary detail and irrelevant information.</td>
<td>Brief documentation synthesizes clinical picture with just the right amount of detail.</td>
<td>Makes specific recommendations that could be transcribed as orders.</td>
</tr>
<tr>
<td>Be specific</td>
<td>Treatment recommendations should be as specific as possible (eg, medication doses, routes of administration, duration of therapy).</td>
<td>Makes vague general recommendations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide contingency plans</td>
<td>Communication of the anticipated clinical course with clear recommendations to help manage potential complications that may arise is ideal.</td>
<td>Does not anticipate clinical course or provide contingency plans.</td>
<td>Clearly communicates predictable complications and clinical course plans for monitoring, prevention, and treatment, as appropriate.</td>
<td></td>
</tr>
<tr>
<td>Stay within your expected/negotiated role</td>
<td>Writing orders on patients may be inappropriate; in other cases, comanagement is what the referring provider wants. This must be tactfully negotiated up front.</td>
<td>Does not determine what role is expected/desired by the requesting physician.</td>
<td>Tactfully negotiates the most appropriate role up front with the requesting physician.</td>
<td></td>
</tr>
<tr>
<td>Carry out teaching role</td>
<td>Discipline-specific teaching is an important role of the consultant and must be tailored to the individual needs/expectations of the requesting physician. A pejorative style must be avoided.</td>
<td>Does not teach or is condescending in communicating recommendations.</td>
<td>Effectively tailors education to meet the needs and expectations of the requesting physician in a respectful manner.</td>
<td></td>
</tr>
<tr>
<td>Make direct contact with referring provider</td>
<td>Direct communication allows questioning, specific teaching, and feedback regarding satisfaction with the consultation.</td>
<td>Does not directly communicate with the referring provider; may simply use the medical record.</td>
<td>Determines and practices the preferred mode of communication with each requesting physician and makes sure that two-way communication is clear and effective.</td>
<td></td>
</tr>
<tr>
<td>Provide adequate follow-up</td>
<td>Appropriate interval and level of follow-up required to assess outcomes and patient and referring provider needs and to adjust recommendations accordingly.</td>
<td>Timing and level of follow-up not appropriate to the clinical picture.</td>
<td>Timing and level of follow-up optimally tailored to the patient’s and the requesting physician’s needs and expectations; makes conscientious use of resources.</td>
<td></td>
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</table>

*Based on the work of Goldman et al.*
• Identifies self as an expert in her discipline and demonstrates advanced knowledge and vast experience. Clinical reasoning is succinctly communicated to answer the specific questions asked. Communication includes the strength of the evidence on which recommendations are based. Consistently develops and maintains collaborative relationships with the referring providers that maximizes adherence to recommendations and supports continuous bidirectional feedback.

• Is identified by self and others as a master clinician who effectively and efficiently lends a practical wisdom to consultation. Answers to all but the most difficult diagnostic dilemmas are intuitive, leaving most mental energy available for reinvestment in ongoing clinical, educational, and/or research contributions to the field.

REFERENCES

Competency 6. Maintain comprehensive, timely, and legible medical records, if applicable

 Bradley Benson, MD

BACKGROUND: Medical documentation serves many purposes in our health care system,1 including the following:

• Communication and clinical care planning among caregivers.
• Providing a basis for assessing quality of care.2
• Legal recording for protection of patients, providers, and facilities.
• Providing a clinical database for research and education.3,4
• Documentation for billing of the services provided.

The quality and accuracy of medical documentation are closely linked with competence in all of the other domains, with special emphasis on medical knowledge and patient care. For this discussion of the development of competence in the specific area of medical documentation, however, we will focus on those aspects that are relatively independent of the specific medical content of the documentation. For example, an expert history and physical for a patient with developmental delay might include a thorough developmental assessment and discussion of how the findings suggest a unifying genetic diagnosis with a detailed plan for testing and follow-up. This, however, requires advanced medical knowledge and patient care skills that are evidenced in the content of the documentation, which reflects clinical assessment and decision-making abilities. This competency, while inextricably linked to the other competencies that target content, will focus primarily on the structure and timing of the medical documentation, as these aspects are also independently linked to the quality of patient care. The widespread adoption of electronic health records has dramatically changed documentation practices and has eliminated some problems (legibility), but it has created others.5,6 For example, the practice of cutting and pasting, or “copying forward,” parts of a medical record from one encounter to another may contribute significantly to medical error.7

To adequately address this competency, we must define the key terms, specifically comprehensive, timely, and legible. In the assessment of comprehensiveness, we ask 2 key questions: first, is the record complete (ie, does it contain all of the appropriate information)? Second, is the record accurate (ie, does it reflect what was actually said and done)? The concepts of complete and accurate documentation also refer not only to the records for an individual patient encounter (ie, an admission history and physical examination) but to a patient’s medical record as a whole. For the individual physician–patient encounter, the documentation standards are setting and context specific. For example, a complete interval note for a continuity panel patient seen for follow-up of eczema would differ considerably from that of a new patient seen in consultation for developmental delay. Chart audit and video review of encounters are most often used to assess the completeness and accuracy of documentation and interventions; use of these methods has been demonstrated to improve physician compliance with set standards.8,9 There are also generally accepted standards for comprehensive medical records as a whole.10,11 The specific requirements vary with the patient setting (eg, inpatient versus ambulatory) and the specific disease state (eg, diabetes versus cystic fibrosis), but there are similarities to all. As an example, the Joint Commission for Accreditation of Healthcare Organizations requires accredited hospitals to perform chart audits for 19 data items (eg, identification data, medical history, physical examinations, progress notes, consultation reports, reports of diagnostic and therapeutic procedures) and to document their presence, timeliness, legibility, and
authentication to ensure that the medical records are comprehensive.

The definition of *timely* is more straightforward. In this context, timely documentation refers to the availability of the written communication regarding a medical encounter within an accepted time frame that allows others involved in the care of the patient to use it in understanding the course of medical events that have occurred during a hospitalization, a clinical encounter (eg, an outpatient visit), or an interval between visits. The most common example would be the availability of a discharge summary for the primary pediatrician to review prior to the scheduled follow-up visit with the child.

Last, the definition of *legible* is similarly straightforward. Handwritten documentation or an order is either easily readable or not. This aspect of medical communication is critical, and a learner who persists in illegible documentation would not ever be judged competent. As we shift to universal use of electronic health records, however, we must move beyond the concept of legibility and focus on the comprehensibility of medical documentation. This construct addresses grammar and syntax, culturally competent communication, use of jargon, and other critical issues, such as flow and cohesiveness. In other words, does it tell the story of the patient’s care? Handwritten documentation may be illegible, abbreviations are often used, and date/time/signature may be omitted.

Little literature exists on the development of this specific competency, but the following progression is proposed on the basis of work focusing on the development of expertise. 12–15

**EARLY DEVELOPMENT IN MEDICAL DOCUMENTATION:**
Early learners focus on the individual encounter and, with progression of competence, gain the larger view of the importance of the comprehensive medical record. In their documentation of the individual encounter, early learners lack the ability to filter and prioritize and therefore commit both errors of omission (leaving out important information) and commission (including unimportant information). With progression, the errors of omission decrease and errors of commission increase, as evidenced by more lengthy documentation with more extraneous information.

**INTERMEDIATE DEVELOPMENT IN MEDICAL DOCUMENTATION:**
As the learner progresses to competence and beyond, the documentation becomes succinct, containing just the right amount of information. At this level, care must be taken to balance the brevity with the need for thoroughness and to accurately document the key aspects of what was said and done during a specific encounter.

**ADVANCED DEVELOPMENT IN MEDICAL DOCUMENTATION:**
As further development occurs, more focus is placed on management of the medical record as a whole. Maintaining a problem list, medication list, immunization status (including those administered elsewhere), growth curves, and communicating with specialists are examples of items the advanced learner focuses on.

**DEVELOPMENTAL MILESTONES:**
- Commits both errors of omission and errors of commission in documentation. In the former case, documentation is often incomplete; critical data sections (eg, medical history) and critical data (eg, specific diagnoses in the medical history) may be missing and may not document what was actually said and done. In the latter case, documentation is subject to errors of inclusion of unnecessary information or detail. Documentation is often not available for other providers to review in time for their use in the patient’s care. Handwritten documentation may be illegible, abbreviations are often used, and date/time/signature may be omitted.
- Includes all appropriate data sections in documentation, though some information may be missing from some sections or presented in a sequence that confuses the reader (eg, evolution of symptoms is not documented chronologically). Documentation may be overly lengthy and detailed. It may contain erroneous information carried forward from review of the medical record. However, the practitioner at this stage begins to go beyond documentation of specific encounters and may update the patient-specific databases (eg, problem list and diabetes care flow sheet) where applicable. Documentation is often in the medical record in a timely manner but may need subsequent amendment to be considered complete. Handwritten documentation is usually legible, timed, dated, and signed.
- Accurately documents the patient’s story and the service provided, yet is not overly long and detailed. Begins to tailor the documentation to the specific situation. All important data are verified or the source is stated. Identified errors in the medical record are reported and appropriate measures initiated to correct them. Key patient-specific databases are maintained and updated where applicable. Documentation is completed and available for others to review within an appropriate time frame for it to aid in their care of the patient. Handwritten documentation is always legible, prohibited abbreviations are avoided, and all documentation has a time, date, and signature.
- Tailors documentation to the specific care situation without loss of comprehensiveness. Synthesizes key information in a succinct manner. Begins to develop standard templates or tools for ensuring that documentation includes all appropriate quality markers, supports accurate billing and coding, meets legal and community care standards, enables identification of patients for disease registries, and supports chart audits. Regularly participates in chart audits for quality of documentation and acts on the results for self-improvement.
- Demonstrates behaviors in milestone immediately above. In addition, uses her expertise to improve documentation systems to drive better patient care outcomes and works to disseminate best practices.

**REFERENCES**