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PC3: Provide transfer of care that ensures seamless transitions				
• Demonstrates variability in transfer of information (content, accuracy, efficiency, and synthesis) from one patient to the next. Frequent errors of both omission and commission in the handoff.	• Uses a standard template for the information provided during the handoff. Unable to deviate from that template to adapt to more complex situations. May have errors of omission or commission, particularly when clinical information is not synthesized. Neither anticipates nor attends to the needs of the receiver of information.	• Adapts and applies a standardized template, relevant to individual contexts, reliably and reproducibly, with minimal errors of omission or commission. Allows ample opportunity for clarification and questions. Beginning to anticipate potential issues for the transferee.	• Adapts and applies a standard template to increasingly complex situations in a broad variety of settings and disciplines. Ensures open communication, whether in the receiver- or provider-of-information role through deliberative inquiry, including but not limited to read-backs, repeat-backs (provider), and clarifying questions (receivers).	• Adapts and applies the template without error and regardless of setting or complexity. Internalizes the professional responsibility aspect of handoff communication, as evidenced by formal and explicit sharing of the conditions of transfer (e.g., time and place) and communication of those conditions to patients, families.
• **Provides inconsistent quality handoffs/frequent errors.**	• **Gives regimented handoffs, unable to adapt handoffs in complex situations.** • **May have essential data lacking.** • **Neither anticipates nor adjusts to needs of person receiving handoff.**	• **Adapts and applies a reliable standard template during handoffs.** • **Rarely omits essential data.** • **Starting to adjust to needs of person receiving handoff.**	• **Adapts and applies reliable standard template during handoff, even in complex settings.** • **Ensures discussion and closed loop communication in handoffs.**	• **Adapts and applies reliable standard template during handoff, regardless of complexity.** • **Understands physician's responsibility in effective patient data transfer.**

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PC6: Make informed diagnostic and therapeutic decisions that result in optimal clinical judgment				
• Recalls and presents clinical facts in the history and physical in the order they were elicited **without filtering, reorganization, or synthesis**. **Analytic reasoning** through basic pathophysiology results in a **list of all diagnoses considered** rather than the development of working diagnostic considerations, making it **difficult to develop a therapeutic plan**.	• Focuses on features of the clinical presentation, making a unifying diagnosis elusive and leading to a **continual search for new diagnostic possibilities**. Largely using **analytic reasoning** through basic pathophysiology in diagnostic and therapeutic reasoning; often reorganizes clinical facts in the history and physical examination to help decide on clarifying tests to order rather than to develop and prioritize a differential diagnosis. This often results in **a myriad of tests and therapies** and **unclear management plans**, since there is no unifying diagnosis.	• Abstracts and reorganizes elicited clinical findings in memory, **using semantic qualifiers** (such as paired opposites that are used to describe clinical information [e.g., acute and chronic]) to compare and contrast the diagnoses being considered when presenting or discussing a case. The **emergence of pattern recognition** in diagnostic and therapeutic reasoning often results in a **well-synthesized and organized assessment of the focused differential diagnosis and management plan**.	• Reorganized and stored clinical information (illness and instance scripts) leads to **early directed diagnostic hypothesis testing** with subsequent history, physical examination, and tests used to confirm this initial schema. **Well-established pattern recognition** leads to the ability to **identify discriminating features** between similar patients and to avoid premature closure. **Therapies are focused and based on a unifying diagnosis**, resulting in an effective and efficient diagnostic work-up and management plan tailored to address the individual patient. Adapts and applies a standard template to increasingly complex situations in a broad variety of settings and disciplines. Ensures open communication, whether in the receiver- or provider-of-information role through deliberative inquiry, including but not limited to read-backs, repeat-backs (provider), and clarifying questions (receivers).	•
• **Recalls and presents clinical facts in order elicited without filtering, reorganization or synthesis.** • **Tends to list all diagnoses considered.** • **Generates weak treatment plans.**	• **Focuses on features of clinical presentation.** • **Continues to search for diagnostic possibilities.** • **Uses analytic reasoning to develop myriad of tests and treatments without good prioritization.**	• **Abstracts and reorganizes clinical features using semantic qualifiers (pairing/contrasts) in presentations.** • **Uses pattern recognition to generate organized diagnostic/treatment plans.**	• **Reorganizes information to generate directed diagnostic and hypothesis testing.** • **Uses well established pattern recognition.** • **Treatment plans focused and based on unifying diagnosis and utilizes effective communication strategies with other professionals.**	

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PC7: Develop and carry out management plans				
• Develops and carries out management plans **based on directives from others**, either from the health care organization or the supervising physician. **Unable to adjust plans** based on individual patient differences or preferences. **Communication about the plan is unidirectional** from the practitioner to the patient and family.	• Develops and carries out management plans based on one's **theoretical knowledge and/or directives** from others. Can **adapt plans to the individual patient,** but only within the framework of one's own theoretical knowledge. Unable to focus on key information, so conclusions are often from **arbitrary, poorly prioritized, and time-limited information gathering**. Management plans based on the **framework of one's own assumptions and values.**	• Develops and carries out management plans **based on both theoretical knowledge and some experience**, especially in managing common problems. Follows health care institution directives as a matter of habit and good practice rather than as an externally imposed sanction. Able to more effectively and efficiently **focus on key information**, but still may be limited by time and convenience. **Plans begin to incorporate patients' assumptions and values through more bidirectional communication.**	• Develops and carries out management plans **based most often on experience**. Effectively and **efficiently focuses on key information** to arrive at a plan. **Incorporates patients' assumptions** and values through **bidirectional communication** with **little interference from personal biases.**	• Develops and carries out management plans, even for complicated or rare situations, based primarily on **experience that puts theoretical knowledge into context**. Rapidly **focuses on key information** to arrive at the plan and augments that with available information or seeks new information as needed. Has **insight into one's own assumptions and values** that allow one to filter them out and focus on the patient/family values in a bidirectional conversation about the management plan.
• **Develops/conducts management plans as directed by others.** • **Unable to adjust plans on individual patient characteristics.** • **Communication about plan is unidirectional from practitioner to patient/family.**	• **Develops/conducts management plans based on theory and direction of others.** • **Adapts plans usually based on theory rather than experience.** • **Conclusions often poorly prioritized and reliant on own assumptions and values.**	• **Develops/conducts management plans based on both theory and experience.** • **Follows local directives as matter of habit.** • **Focuses on key information.** • **Begins to generate plans responsive to patient/family needs with more bidirectional communication.**	• **Develops/conducts management plans based more on experience.** • **Efficiently focuses on key information.** • **Generates plans very responsive to patient/family needs with good bidirectional communication.**	• **Develops/conducts management plans based on experience and contextual theory.** • **Rapidly focuses on key information to generate appropriate plans.** • **Has insights into own assumptions and values to allow focus on patient/family needs with good bidirectional communication.**

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PC12: Provide appropriate role modeling				
• Performs routine duties and behaviors of profession **without awareness of the impact** on those around her. **May or may not reflect** on actions as they occur (reflection in action) and does **not share reflections** with others.	• **Inconsistently aware of the impact** of one's behaviors and attitudes on others. **Sometimes teaches by example**. **Occasionally will reflect openly** on events as they occur (reflection in action) and privately on events that have already taken place (reflection on action).	• **Conscious of being a role model** during many interactions. Frequently **teaches by example** and **often reflects in action openly** in the presence of learners. Behavior change implies **frequent private reflection on action.**	• **Conscious of being a role model** during most interactions. Routinely **teaches by example**. Regularly **reflects in action** and frequently **reflects on action,** sharing this analysis of practice with learners	• **Role modeling is a habit.** **Recognizes** that she is a role model in all actions and behaviors at all times. Characteristically **teaches by example**. Routinely **reflects** both **in action** and **on action**. **Examines, analyzes, and explains** actions/behaviors in the presence of learners and colleagues.
• **Performs routine duties without awareness of impact on others.** • **May or may not reflect on present actions (reflection in action) and does not share reflections with others.**	• **Inconsistently aware of impact on others.** • **Sometimes teaches by example.** • **Occasionally reflect openly on present events (reflection in action) and privately on past events (reflection on action).**	• **Conscious of being a role model.** • **Frequently teaches by example.** • **Often reflects in action openly in presence of learners; frequent private reflection on action.**	• **Conscious of being a role model.** • **Routinely teaches by example.** • **Regularly reflects in action and frequently reflects on action, sharing analysis of practice with learners**	• **Role modeling is a habit.** • **Characteristically teaches by example.** • **Routinely reflects both in action and on action, examines and explains actions/behaviors in presence of learners/colleagues.**

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MK2: Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems				
• **Explains basic principles** of EBM, but relevance is limited by lack of clinical exposure. • **Example:** *The senior resident asks each member of the inpatient team to answer a clinical question that he raised during rounds and to be prepared to discuss it the next morning. The learner goes to a more senior colleague for help, since he cannot work through a case or article using the critical appraisal approach, mainly due to lack of clinical context to work from.*	• Recognizes the importance of using current information to care for patients and **responds to external prompts** to do so. Able to **formulate questions with some difficulty,** but **not yet efficient with on-line searching**. Starting to learn critical appraisal skills. • **Example:** *In response to a clinical question raised during rounds and the senior resident's request that everyone answer the question, the learner is able, with some difficulty, to frame the question in a PICO format. He has searching capability, but the search and the steps of analyzing and applying the evidence are time intensive so he is not prepared to discuss his findings on rounds the next morning.*	• **Able to identify knowledge gaps as learning opportunities. Makes an effort** to ask answerable questions on a regular basis and is becoming **increasingly able to do so.** Understands varying levels of evidence and can utilize advanced search methods. **Able to critically appraise a topic** by analyzing the major outcomes; however, may need guidance in understanding the subtleties of the evidence. **Begins to seek and apply evidence when needed**, not just when assigned to do so. • **Example:** *In response to the clinical question raised during rounds, develops an answerable clinical question in PICO format and efficiently searches for best evidence. Volunteers to present on rounds the next day and demonstrates effective analytic skills and the ability to apply his findings to the current patient. Has a bit of difficulty interpreting and applying some of the secondary outcomes and, in the context of this discussion, another question is raised, which he volunteers to search and answer.*	• **Increasingly self-motivated to learn more,** as exhibited by **regularly formulating answerable questions**. Incorporates use of clinical evidence in rounds and **teaches fellow learners.** Quite capable with advanced searching. Able to **critically appraise topics** and does so regularly. Shares findings with others to try to improve their abilities. **Practices EBM** because of the benefit to the patient and the desire to learn more rather than in response to external prompts. • **Example:** *In response to the clinical question raised during rounds, presents a second question that he has already researched in a PICO format as well as a critique of the evidence and its applicability to the current patient. He was motivated to be proactive by his interest in learning as well as the needs of his patient. He shares his tactics with team members by teaching them the steps he engaged in to learn and apply this information.*	• **Teaches critical appraisal of topics to others.** Strives for change at the organizational level as dictated by best current information. **Able to easily formulate answerable clinical questions and does so with majority of patients as a habit**. Able to effectively and efficiently search and access the literature. Seen by others as a **role model** for practicing EBM. • **Example:** *An EBM practitioner, as observed by conversations during rounds, whom others try to emulate. He enjoys teaching colleagues how to become EBM practitioners by role modeling. He helps team members develop and refine their skills using his expertise to make a difficult task practical and doable.*
• **Explains basic principles of EBM, but relevance is limited by lack of clinical exposure.**	• **Recognizes importance of using current information to care for patients.** • **Formulates questions with some difficulty, but not efficient with on-line searching.** • **Learning critical appraisal skills.**	• **Able to identify knowledge gaps as learning opportunities.** • **Tries to ask answerable questions.** • **Understands but still needs guidance in varying levels of evidence and advanced searches.** • **Critically appraises topics by analyzing major outcomes.** • **Begins to seek/apply evidence as needed, not just when assigned.**	• **Increasingly self-motivated to learn more.** • **Regularly formulates answerable questions.** • **Incorporates clinical evidence in rounds and teaches others.** • **Effective at advanced searching, critically appraising topics and sharing findings with others.** • **Practices EBM to benefit patients rather than just when required.**	• **Teaches critical appraisal of topics to others.** • **Strives for change at organizational level based on best current information.** • **Easily formulates answerable questions and regularly does so with majority of patients.** • **Effectively and efficiently searches/accesses literature as EBM role model.**

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PBLI1: Identify strengths, deficiencies and limits in one's knowledge and expertise.				
• The learner acknowledges external assessments, but understanding of his performance is superficial and limited to the overall grade or bottom line; there is little understanding of how the performance measure relates in a meaningful way to their specific level of KSA.	• Assessment of performance is seen as being able to do or not do the task at hand without appreciation for how well it is done and whether there is a need to improve the outcome.	• Prompts for understanding specifics of level of performance are internal and may be identified in response to uncertainty, discomfort, or tension in completing clinical duties. Evidence of this stage demonstrated by active questioning and application of knowledge in developing a rationale for care plans or in teaching activities.	• Prompted by anticipation or contemplation of potential clinical problems, the learner self-identifies gaps in KSA through reflection that assesses current KSA versus understanding of underlying basic science or pathophysiologic principles to generate new questions about limitations or mastery of KSA. Evidence of this stage can be determined by the advanced nature and level of questioning or resource seeking.	• Prompted by a self-directed goal of improving the professional self, the practitioner anticipates hypothetical clinical scenarios that build on current experience and systematically addresses identified gaps to enhance the level of KSA. Elaborate questioning occurs to further explore gaps and strengths.
Example: During a semiannual review a learner is unable to describe in any specific terms how he has performed when asked to do so by his mentor. In response, the mentor reviews and interprets the learner's evaluations and then asks the learner to reflect on the discussion. The learner repeats the language used and recites the overall score/grade without interpretation of further meaning or inference regarding the reported performance assessment.	Example: The learner seeks external assessment of performance as ability "to do" or "not able to do" with little understanding of what the assessment means. "Are these orders written correctly?" "Did I do that correctly?" Seeks feedback approval on whether KSA were "right" or "wrong." Does not seek "How?" or "Why?" as part of request for feedback to assist identification of KSA.	Example: Learner requests elaboration, clarification, or expansion on patient-care related task. "Why would we use this antibiotic for this condition?" or "The patient has underlying condition x. Does that alter therapy y for this patient?" or "I think we should order study w for this patient, since sometimes this disease presents with underlying condition z."	Example: In caring for a patient with an illness not previously encountered, this practitioner says, "I have experience taking care of patients with this acute illness but have never had a patient with this acute illness who also had this particular underlying condition and wonder if the chronic condition might alter his clinical course?"	Example: In caring for a patient a practitioner becomes aware of a gap in KSA, and in response (with or without consultation from a mentor) seeks to understand more about the identified KSA gap. A PICO-formatted question (P = Patient, I = Intervention, C = Comparison, O = Outcome) is constructed, followed by a process of identification of learning needed.
• **Acknowledges assessments but little understanding of how performance measures relate to knowledge/skills/attitudes (KSA)**	• **Assessment of performance is seen as being able to do or not do task at hand without appreciation for how well it is done.**	• **Understands level of performance in response to uncertainty/discomfort with clinical duties.** • **Uses active questioning and applies knowledge in care plans/teaching.**	• **Self-identifies gaps in KSA in clinical settings through reflection.** • **Displays advanced questioning and resource seeking.**	• **Self-directed to improve professional self.** • **Identifies and addresses gaps in own KSA through systematic exploration.**

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PBLI4: Incorporated formative evaluation feedback into daily practice.				
• Has difficulty in considering others' points of view when these differ from his or her own, leading to defensiveness and inability to receive feedback and/or avoidance of feedback; demonstrates a limited incorporation of formative feedback into daily practice	• Is dependent on external sources of feedback for improvement; is beginning to acknowledge other points of view, but reinterprets feedback in a way that serves his or her own need for praise or consequence avoidance, rather than informing a personal quest for improvement; little to no behavioral change occurs in response to feedback (e.g., listens to feedback but takes away only those messages he or she wants to hear)	• Understands others' points of view and changes behavior to improve specific deficiencies that are noted by others (e.g., understands that the perceptions of others are important even when those perceptions are different from his or her own, (such as when a nurse interprets a response as abrupt when it was not intended to be) causing the learner to examine what prompted this perception)	• Internal sources of feedback allow for insight into limitations and engagement in self-regulation; improves daily practice based on both external formative feedback and internal insights (e.g., is able to point out what went well and what did not go well in a given encounter, and makes positive changes in behavior as a result)	• Demonstrates professional maturity and deep emotional commitment that lead to deliberate practice and result in the habits of continuous reflection, self-regulation, and internal feedback and that lead to continuous improvement beyond a focus solely on deficiencies
• **Difficulty considering others points of view.** • **Defensive and unable to receive feedback and/or evaluations.**	• **Beginning to acknowledge others points of view.** • **Reinterprets feedback to suit own need for praise and/or consequence avoidance.** • **Little or no behavioral change in response to feedback.**	• **Understands others points of view.** • **Changes behavior to improve specific issues noted by others.** • **Recognizes that perceptions of other are important, even when different from own.**	• **Internal feedback allows for insight into interactions and self-regulation.** • **Improve daily practice based on both external feedback and internal insights.**	• **Uses regular reflection, self-regulation, external and internal feedback to augment continuous improvement beyond focus solely on deficiencies.**

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PBLI 7. Use information technology to optimize learning and care delivery				
• **Reluctant to utilize information technology.** Generally **does not initiate** attempts to use information technology without **mandatory assignments and direct help**. **Inability to choose between multiple available databases for clinical query** and **inability to filter or prioritize the information retrieved** results in **too much information**, much of which is not useful. Failure to achieve success may worsen perception of information technology ease of use, leading to **resistance to adopting new technologies**.	• Demonstrates a **willingness to try new technology** for patient care assignments or learning. Able to **identify and use several available databases**, search engines, or other appropriate tools, resulting in a **manageable volume of information**, most of which is **relevant to the clinical question**. Basic use of an EHR is improving, as evidenced by **greater efficacy and efficiency in performing needed tasks**. Beginning to **identify shortcuts to getting to the right information quickly**, such as use of filters. Also beginning to **avoid shortcuts that lead one astray** of the correct information or perpetuate incorrect information in the EHR.	• **Efficiently retrieves (from EHR, databases, and other resources), manages, and utilizes biomedical information for solving problems and making decisions that are relevant to the care of patients and for ongoing learning.**	• In addition to the above, the **emotional investment in the outcome** (improved patient care, deeper understanding, or successful resolution of a query) leads to the **habit** of **utilizing familiar information technology resources and seeking new ones to answer clinical questions and remedy knowledge gaps identified in the course of patient care**; utilizes the EHR platform to **improve the care not only for individual patients but populations of patients**; and **utilizes evidence-based (actuarial) decision support tools** to continually supplement clinical experience. .	• Along with the above capabilities and behaviors, the mental energy freed up by comfort level and experience with information technology systems is reinvested to contribute to the **continuous improvement of current systems and the development and implementation of new information technology innovations for patient care and professional learning**
• **Reluctant to utilize information technology (IT).** • **Generally does not initiate use of IT without mandatory assignments and help.** • **Unable to choose between multiple databases for query and unable to prioritize information retrieved results in too much non-useful information.** • **Resistant to adopting new IT.**	• **Demonstrates willingness to try new information technology (IT).** • **Uses several databases/search engines to generate manageable and relevant information.** • **Basic EHR skills improving with greater efficacy/efficiency in tasks.** • **Beginning to identify HER shortcuts to get right information quickly and avoid shortcuts that miss correct information or perpetuate incorrect information.**	• **Efficiently retrieves (from EHR, databases, and other resources), manages, and utilizes biomedical information for solving problems and making decisions that are relevant to care of patients and for ongoing learning.**	• **Efficiently retrieves, manages, and uses information for solving problems and making good clinical and leaning decisions.** • **Regularly uses familiar information technology resources and seeks new ones to answer important questions and remedy knowledge gaps** • **Utilizes EHR to improve care of individual and patient populations; uses decision support tools to improve clinical ability.**	• **Efficiently retrieves, manages, and utilizes information.** • **Regularly uses of information technology (IT) resources well.** • **Utilizes EHR to improve care of individuals and populations of patients; uses EBM decision support tools to continually improve clinical ability.** • **Continuously improves current systems and development/ implementation of new IT innovations for patient care and professional learning.**

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PBLI 9. Participate in the education of patients, families, students, residents, and other health professionals				
• **The learner has gaps in knowledge and experience that result in a rigid, scripted** type of patient education and counseling that may not meet the needs of the patient. **Doctor-centered interaction.**	• **The learner is closing gaps in knowledge**, allowing him to educate patients and families in a **somewhat flexible** way that begins to meet the needs of the patients. Education varies between **doctor-centered and patient-centered depending upon the circumstances and the family dynamics**. Responsive to patient's educational needs. Learning the importance of the concept of checking for patient understanding.	• **The learner has** a **solid breadth of both knowledge and experience**, resulting in the ability to **modify teaching** to meet the needs of the individual patient. Educational efforts are typically **patient centered** and the learner is **able to modify strategies** to adapt to complex patient characteristics. **Checks for patient understanding** inconsistently.	• Broad **knowledge base and significant experience** with a variety of disease processes and patient characteristics. Facilitates the participation of patients in all discussions about their health. Able to be quite **flexible** with strategies of educating patients. **Patient-centeredness** is clearly a priority and a conscious effort. Consistently checks for patient understanding. **Empowers and motivates patients**.	• Similar to level four in terms of knowledge and flexibility. **Patient-centeredness is a habit**. Seamlessly, skillfully, and comfortably educates and interacts with patients in a way that satisfies the patients. Uncanny ability to **motivate and empower patients** to make healthy changes and choices. Does not leave the patient encounter without knowing that the **patient understands the counseling.**
• **Gaps in knowledge/experience result in rigid, scripted patient education and counseling that may not meet the needs of the patient.** • **Doctor-centered interaction.**	• **Closing gaps in knowledge/ experience to better educate patients/families in flexible ways to meet patient needs.** • **Education varies between doctor-centered/patient-centered based on patient needs..** • **Responsive to patient's educational needs and begins to check for patient understanding.**	• **Solid knowledge and experience result in ability to modify teaching to meet patient needs.** • **Educational efforts are typically patient centered** • **Able to modify strategies to adapt to patient characteristics and checks for patient understanding inconsistently.**	• **Broad knowledge base and experience with variety of disease processes and patients.** • **Engages patients in all discussions about their health.** • **Flexible in educating patients.** • **Patient-centeredness is priority and conscious effort to check for patient understanding evident.** • **Empowers/motivates patients.**	• **Knowledgeable and flexible in patient education.** • **Patient-centeredness is a habit.** • **Skillfully educates patients in way that satisfies patients and always checks for patient understanding.** • **Easily motivate and empower patients to make healthy changes and choices.**

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ICS 3. Communicate effectively with physicians, other health professionals, and health related agencies				
• **Rigid rules-based** recitation of facts. Often communicates from a **template** or prompt. Communication does not change based on context, audience, or situation. **Not aware of the social purpose of the communication.**	• Begins to **understand the purpose of the communication** and at times adjusts length to context, as appropriate. However, will often still **err on the side of inclusion of excess details.**	• Successfully **tailors communication strategy** and message to the audience, purpose, and context in most situations. **Fully aware of the purpose of the communication**; can efficiently tell a story and effectively make an argument. **Beginning to improvise** in unfamiliar situations	• Uses the **appropriate strategy for communication**. Distills complex cases into succinct summaries tailored to audience, purpose, and context. **Can improvise** and has expanded strategies for dealing with difficult communication scenarios (e.g., an interprofessional conflict).	• **Master of improvisation** in any new or difficult communication scenario. Recognized as a highly **effective public speaker**. Intuitively develops strategies for **tailoring message** to context to gain maximum effect. Is sought out as a **role model** for difficult conversations and mediator of disagreement.

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ICS 4. Work effectively as a member or leader of a health care team or professional group				
• Limited participation in team discussion; **passively follows** the lead of others on the team. Little **initiative** to interact with team members. More **self-centered** in approach to work with a focus on one's own performance. Little awareness of one's own needs and abilities. Limited 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. In general, works towards achieving team goals, but may put **personal goals related to professional identity development (e.g., 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. Will **adapt and shift roles and responsibilities as needed to adjust to changes to achieve team goals**. **Communication is bi-directional** 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 **takes 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 to ensure that the correct message is understood by all. **Seeks out and takes on leadership roles** in areas of expertise and makes sure the job gets done.	• Goals of the team supersede any personal goals, resulting in the ability to seamlessly assume the role of leader or follower, as needed. **Creates a high-functioning team de novo or joins a poorly functioning team and facilitates improvement,** such that team goals are met.

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ICS 5. Act in a consultative role to other physicians and health professionals				
• Actively participates as a member of the consultation team and **can accurately gather and present the patients' history and physical findings, scribe recommendations, and document them in the medical record**. Lack of discipline-specific knowledge **limits 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**. Can accurately gather and present the patient's history and physical findings with a **focus on those details pertinent to the question asked**. Increased discipline-specific knowledge and ability to filter and prioritize information lead to a **more focused (although not comprehensive), differential, realistic working diagnosis; more specific recommendations; and more succinct documentation**. Takes more **ownership" of the patients' outcomes** during follow-up of initial recommendations.	• Identifies self as an **integral member** of the consultation team based on **advanced knowledge and skills in specific areas** tempered by **recognition of limitations** in others, leading to pursuit of new knowledge. **Independently assesses and confirms data**. Combination of past experience and ability to use information technology to seek new knowledge allows for **recommendations that are consistent with best practice**. Develops **good relationships** with referring providers, but may not encourage the bidirectional feedback that makes the relationship truly collaborative.	• Identifies self as an **expert** in her discipline based on advanced knowledge and **vast experience** that manifest as **intuitive clinical reasoning that is succinctly communicated to answer the specific questions asked**. • This **drives life-long learning behavior** and clear communication of the strength of the evidence on which recommendations are based. • Develops and maintains a **collaborative relationship with the referring providers** that **maximizes adherence to recommendations** and supports continuous bidirectional feedback.	• 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**.

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P2: A sense of duty and accountability to patients, society and the profession.				
• Appears to be interested in learning pediatrics but not fully engaged and involved as a professional, which results in an observational or passive role.	• Although he appreciates the role in providing care and being a professional, at times has difficulty in seeing self as a professional, which may result in not taking appropriate primary responsibility.	• Demonstrates understanding and appreciation of the professional role and the gravity of being the "doctor" by becoming fully engaged in patient care activities. Has a sense of duty. Rare lapses into behaviors that do not reflect a professional self-view.	• Has internalized and accepts full responsibility of the professional role and develops fluency with patient care and professional relationships in caring for a broad range of patients and team members.	• Extends professional role beyond the care of patients and sees self as a professional who is contributing to something larger (e.g., a community, a specialty, or the medical profession.
• **Interested in learning pediatrics but not fully engaged; taking more of passive role.**	• **Appreciates role in providing care and being a professional.** • **Sometimes has difficulty seeing self as professional.** • **Sometimes does not take appropriate primary responsibility.**	• **Understands gravity of being the "doctor" and sense of duty.** • **Rare lapses into behaviors that do not reflect professional values.**	• **Understands and accepts full responsibility of professional role.** • **Easily applies skills to work with wide range of patients and team members.**	• **Has deep appreciation for professional role beyond care or patients, contributing as to greater good.**

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SBP1: Coordinate patient care within the health system relevant to their clinical specialty.				
• Performs the role of medical decision-maker, developing care plans and setting goals of care independently. The patient/family is informed of the plan. No written care plan is provided. Makes referrals, requests consultations and testing with little or no communication with team members or consultants. Not involved in the transition of care between settings (e.g., outpatient and inpatient, pediatric and adult); little or no recognition of social/educational/cultural issues affecting the patient/family.	• Begins to involve the patient/family in setting care goals and some of the decisions involved in the care plan. A written care plan is occasionally made available to the patient/family. The care plan does not address key issues. Variable communication with team members and consultants regarding referrals, consultations, and testing. Patient/family questions are answered regarding results and recommendations. May inconsistently be involved in the transition of care between settings (e.g., outpatient and inpatient, pediatric and adult). Makes some assessment of social/educational/cultural issues affecting the patient/family and applies this in his interactions.	• Recognizes the responsibility to assist families in navigation of the complex healthcare system. The patient/family is frequently involved in decisions at all levels of care, setting goals, and defining care plans. A written care plan is frequently made available to the patient/family and to appropriately authorized members of the care team. The care plan omits few key issues. There is good communication with team members and consultants. Results and recommendations are consistently discussed with the patient/family. Routinely involved in the transition of care between settings (e.g., outpatient and inpatient, pediatric and adult). Social, educational and cultural issues are considered in most care interactions.	• Actively assists families in navigating the complex healthcare system. Communication is open, facilitating trust in the patient-physician interaction. Goals are developed and decisions are made jointly with the patient/family (shared-decision-making). A written care plan is routinely made available to the patient/family and to appropriately authorized members of the care team. The care plan is thorough, addressing all key issues. Facilitates care through consultation, referral, testing, monitoring and follow-up, helping the family to interpret and act on results/recommendations. Coordinates seamless transitions of care between settings (e.g., outpatient and inpatient, pediatric and adult; mental and dental health; education; housing; food security; family-to-family support). Builds partnerships that foster family-centered, culturally effective care, ensuring effective communication and collaboration along the continuum of care.	
• Communicates care plan with family but does not give a written care plan. **• Does not communicate with team/consultants.** **• Not involved in transition of care between settings.** **• Poor recognition of social/cultural issues affecting patient.**	**• Involves patient/family in setting care goals and occasionally gives them a written but incomplete care plan.** **• Variable communication with team/consultants.** **• Inconsistently involved in transition of care.** **• Some assessment of social/culture issues affecting patient.**	**• Frequently involves patient/family in decisions & setting goals, and provides a written mostly complete care plan.** **• Good communication with team/consultants.** **• Routinely involved in transition of care between settings.** **• Considers social/cultural issues in most interactions.**	**• Open communication with families. Makes decisions jointly with the patient/family. Routinely provides effective written care plan.** **• Facilitates care through consultation, testing, and follow up.** **• Coordinates seamless transitions of care.** **• Provides family-centered, culturally effective care.**	

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SBP2: Advocate for quality patient care and optimal patient care systems.				
• Attends to medical needs of individual patient(s). Wants to take good care of patients and takes action for the individual patient's health care needs.	• Demonstrates recognition that an individual patient's issues are shared by other patients, that there are systems at play, and that there is a need for quality improvement of those systems. Acts on the observed need to assess and improve quality of care.	• Acts within the defined medical role to address an issue or problem that is confronting a cohort of patients. May enlists colleagues to help with this problem.	• Actively participates in hospital-initiated quality improvement and safety actions. Demonstrates a desire to have an impact beyond the hospital walls.	• Identifies and acts to begin the process of improvement projects both inside the hospital and within one's practice community.
Example: Sees a child with a firearm injury and provides good care.	Example: A physician notes on rounds, "We have sent home four-to-five firearm-injury patients and one has come back with repeated injury. We need to do something about that."	Example: The physician works with colleagues to develop an approach, protocol, or procedure for improving care for penetrating trauma injury in children and measures the outcomes of system changes**.**	Example: The physician attends a hospital symposium on gun-related trauma and what can be done about it and then arranges to speak on gun safety at the local meeting of the parent-teachers association.	Example: Upon completion of quality improvement project, the physician works on new proposed legislation and testifies in City Council.
• **Attends to medical needs of individual patients.**	• **Recognizes that individual patient needs are shared by other patients.** • **Recognizes systems at play and need for QI.**	• **Acts within defined medical role to address an issue or problem that confronts a cohort of patients.**	• **Actively participates in hospital-initiated QI and safety actions.** • **Desire to have impact beyond hospital.**	• **Identifies and acts to begin process of improvement projects both inside the hospital and within one's practice community.**

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SBP3: Incorporate considerations of cost awareness and risk-benefit analysis in patient and / or population-based care as appropriate				
• Unaware of cost issues in evaluation and management of patients; has difficulty processing cost and risk-benefit information in a way that results in cost-containment actions or appropriate risk-benefit analysis; frustrated by cost containment efforts that are viewed as primarily externally mandated.	• Uses externally provided information (eg. prescribing information, test ordering patterns, research around a treatment) to inform cost-containing action and/or preliminary risk-benefit analysis; demonstrates inadequate skills in critical appraisal that may result in inappropriate cost containment activities and/or risk-benefit counseling	• Critically appraises information available on an evaluation test or treatment to allow optimization of cost issues and risk-benefit for an individual patient; adopts strategies that decrease cost and risk and optimize benefits for individuals, with less attention to those outcomes for populations	• Critically appraises information in the context of not only the individual patient, but also the broader population / system; ascribes value to cost and risk-benefit decisions based on this broad understanding of the information	• Consistently integrates cost analysis into one's practice while immunizing risk and optimizing benefits for whole systems or populations
• **Unaware of cost issues in evaluation and treatment** • **Poor at processing cost/risk-benefit information** • **Frustrated by cost containment efforts viewed as primarily externally mandated.**	• **Uses externally provided information to inform cost-containing action and/or preliminary risk-benefit analysis** • **Demonstrates poor critical appraisal skills in cost containment and risk-benefits.**	• **Able to critically appraise information to allow optimizing cost issues and risk-benefit for an individual patient** • **Adopts strategies to decrease cost /risk to optimize benefits for individuals more than populations.**	• **Critically appraises information for individual patient and population** • **Ascribes value to cost and risk-benefit decisions based on broad understanding of the information**	• **Consistently integrates cost analysis into one's practice while immunizing risk and optimizing benefits for whole systems or populations**

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SBP5: Work in inter-professional teams to enhance patient safety and improve patient care quality.				
• Seeks answers and responds to authority from only intra-professional colleagues. Does not recognize other members of the interdisciplinary team as being important or making significant contributions to the team. Tends to dismiss input from other professionals aside from other physicians.	• Beginning to have an understanding of the other professionals on the team, especially their unique knowledge base, and is open to their input. However, still acquiesces to physician authorities to resolve conflict and provide answers in the face of ambiguity. This individual is not dismissive of other health care professionals, but she is unlikely to seek out those individuals when confronted with ambiguous situations.	• Aware of the unique contributions (knowledge, skills, and attitudes) of other health care professionals. Seeks their input for appropriate issues. As a result, is an excellent team player.	• In addition to the above features, individuals at this stage understand the broader connectivity of the professions and their complementary nature. Recognizes that quality patient care only occurs in the context of the interprofessional team. Serves as a role model for others in interdisciplinary work and is thus an excellent team leader.	
• **Does not recognize other professionals aside from physicians as being an important part of team and tends to dismiss others' input.**	• **Beginning to understand that other professionals on team have a unique knowledge base.** • **Still defers to physician authorities to resolve conflict or ambiguity.** • **Unlikely to see out those individuals for new concerns.**	• **Aware of unique contributions (knowledge, skills, and attitudes) of other health care professionals.** • **Seeks their input for appropriate issues.**	• **Understands the broader connectivity of the professions and their complementary nature.** • **Recognizes that interprofessional team is necessary for quality patient care.** • **Serves as a role model for others in interdisciplinary work.**	

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SBP 6. Participate in identifying system errors and implementing potential systems solutions				
• **Defensive or blaming** when encountering medical error. **No perception of personal responsibility** for individual or systems error correction. **Not open to discussion of error or identification of the type of error**. Approaches error prevention from an **individual case perspective only**.	• **Occasionally open to discussion** of error **without a defensive or blaming approach**. **Some awareness of personal responsibility** for individual or systems error correction. **Identifies medical error events**, but **cannot identify the type** (active versus latent) of error**. Begins to perceive that error may be more than the mistake of an individual**.	• **Usually open to a discussion** of error. **Actively identifies medical error events** and **seeks to determine the type of error**. Occasionally identifies the element of **personal responsibility** for individual or systems error correction. **Sees examination and analysis of error as an important part** of the preventive process.	• **Usually encourages open and safe discussion of error**. **Actively identifies medical error events. Accepts personal responsibility** for individual or systems error correction, regularly **determining the type of error** and beginning to **seek system causes of error**.	• **Consistently encourages open and safe discussion of error**. **Characteristically identifies and analyzes error events**, habitually approaching medical error with a **system solution methodology**. **Actively and routinely engaged with teams and processes through which systems are modified to prevent medical error.**
• **Defensive or blaming when encountering medical error.** • **No personal responsibility for individual/systems error correction.** • **Not open to discussion of error or identification of type of error.** • **Approaches error prevention only from individual case perspective.**	• **Sometimes addresses errors without defensiveness/blaming.** • **Sometimes aware of personal responsibility for individual or systems error correction.** • **Identifies medical error events, but cannot identify type (active versus latent) of error.** • **Begins to see that error may be more than mistake of individual.**	• **Usually open to error discussion.** • **Actively identifies medical error events and seeks to determine the type of error.** • **Sometimes identifies personal responsibility for individual or systems error correction.** • **Sees examination and analysis of error as important to prevention.**	• **Usually encourages open and safe discussion of error.** • **Actively identifies medical error events.** • **Accepts personal responsibility for individual or systems error correction, regularly determining type of error and beginning to seek system causes of error.**	• **Consistently encourages open and safe discussion of error.** • **Always identifies and analyzes error events with system solution methodology.** • **Actively engaged with teams and processes through which systems are modified to prevent medical error.**

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PPD 5. Demonstrate trustworthiness that makes colleagues feel secure when one is responsible for the care of patients				
• Has significant knowledge gaps or is unaware of knowledge gaps and demonstrates lapses in data gathering or in follow-through of assigned tasks. May misrepresent data (for a number of reasons) or omit important data, leaving others uncertain as to the nature of the individual's truthfulness or awareness of the importance of attention to detail and accuracy. (overt lack of truth-telling is assessed in a professionalism competency) • **Example:** *An individual calls her supervisor at home to present a patient that she admitted. Key laboratory results are missing in the presentation and the supervisor requests that she seek this critical information and report back. Several hours later on rounds, the individual is again questioned about the laboratory values and reports that the results are normal but she is unable to locate those results in her paperwork.* D-2, C-1, T-2	• Has a solid foundation in knowledge and skill but is not always aware of or seeks help when confronted with limitations. Demonstrates lapses in follow-up or follow-through with tasks, despite awareness of the importance of these tasks. Follow-through can be partial, but limited due to inconsistency or yielding to barriers. When such barriers are experienced, no escalation occurs (such as notifying others or pursuing alternative solutions). • **Example:** *On hand-over of patients from the day team to the night team, several tasks are identified as needing follow-up or completion during the next shift. The following day, when the service is handed back over to the original individual, several of these tasks were either incomplete or not completed as specified in the signed-out. When questioned about these tasks, the night-float individual indicated that things were busy, she forgot, or she gives another excuse indicating that she was aware of the expectation but failed to complete the tasks.* KSA-3, D-2, C-3	• Solid foundation in knowledge and skill with realistic insight into limits with responsive help seeking. Data-gathering is complete with consideration of anticipated patient care needs, careful consideration of high risk conditions first and foremost. Little prompting is required for follow-up. • **Example:** *Presentation of a patient consultation is done in a comprehensive manner, without the need for prompting. Questions posed by the individual allow the consultant to appreciate the individual's understanding of the disease process and the individual's awareness of gaps in her knowledge. Careful attention to detail and accuracy are evident in the history and physical examination that is presented. The next day, the service is busy and the individual needs reminding to re-check the send-out labs.* KSA-3, D-3, C-3	• Has a broad scope of knowledge and skill and assumes full responsibility for all aspects of patient care, anticipating problems and demonstrating vigilance in all aspects of management. Pursues answers to questions and communications include open, transparent expression of uncertainty and limits of knowledge. • **Example:** *An individual possesses the KSA to lead the team on rounds, asking for pertinent data not presented by other team members (assertive inquiry). Constant review and vigilance of patient status uncovers unexplained findings on laboratory or physical examination. Findings are reported to supervisors as change with un-identified meaning (and potential concern).* KSA-4, D-4, T-4	• As above, but any uncertainty brings about rigorous search for answers and conscientious and ongoing review of information to address the evolution of change. May seek the help of a master in addition to primary source literature. • **Example:** *This is the practitioner who leaves no stone unturned. Colleagues are confident when handing-off a patient that he will receive exemplary care. In fact, when there is a complex patient colleagues are relieved when this practitioner is on call because she typically invests much time and energy in searching for needed answers and meticulously reports back on all important developments.* KSA-4, D-4, C-4, T-4
• **Significant knowledge gaps and lapses in data gathering or in follow-through of assigned tasks.** • **May misrepresent and/or omit important data (raising concerns about truthfulness/attention to detail/accuracy (overt lack of truth-telling is professionalism concern).**	• **Solid knowledge and skills but not always aware or willing to seek help when appropriate.** • **Demonstrates lapses in follow-up/through with tasks, despite awareness of importance of tasks.** • **Follow-through can be partial, but limited due to inconsistency or yielding to barriers.**	• **Solid knowledge and skills with realistic insight into limits and appropriate help seeking.** • **Data-gathering complete with anticipated patient care needs and high risk conditions realized.** • **Little prompting required for follow-up.**	• **Broad scope of knowledge and skills** • **Assumes full responsibility for patient care and anticipates problems and variability.** • **Pursues answers to questions and displays open, transparent expression of uncertainty and limits of knowledge.**	• **Broad scope of knowledge and skills; responsible and appropriately vigilant.** • **Pursues answers to questions and displays transparent expression of uncertainty and knowledge limits.** • **Pursues answers for concerns.** • **May seek help of master in addition to primary useful literature.**

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The clinical scenarios described below use the following abbreviations to identify the elements observed: KSA = Knowledge, skills and attitudes; D = discernment; C = conscientiousness; T = truthfulness. The milestone (level of performance) is indicated by the number from 1-4. Thus the scoring would be a combination of the observed element and their milestone – example KSA-1 would be knowledge, skills and attitudes as described in Milestone 1 in **Table 1.**

PPD 6. Provide leadership skills that enhance team function, the learning environment, and/or the health care delivery system/environment with the ultimate intent of improving care of patients.				
• **Does not define/clarify roles and expectations** for team members. Team management is **disorganized and inefficient**. Interacts with supervisor(s) in an **unfocused and indecisive manner**. **Open communication is not encouraged** within the team. **Team members are not given ownership or engaged in decision-making**. **Manages by mandate. Unable to advocate effectively for the team** with faculty, staff, families, patients, and others.	• Interactions suggest that **there are roles and expectations for team members, but these are not explicitly defined.** Manages the team in a **somewhat organized** manner. Interacts with supervisor(s) in a **somewhat focused but poorly decisive manner**. **Begins to encourage open communication** within the team. **Sometimes engages team members in decision-making** processes. **Manages most often through direction,** with some effort towards consensus building. **Attempts to advocate for the team** with faculty, staff, families, patients, and others.	• Provides **some explicit definition to roles and expectations for team members**. Manages the team in an **organized** manner. Interactions with supervisor(s) **are focused and decisive in most cases.** **Open communication within the team is routinely encouraged**. **Team members are routinely engaged in decision-making and are given some ownership** in care. Usually **manages through consensus-building** and **empowerment** of others, but sometimes reverts to being directive. **Advocates somewhat effectively for the team** with faculty, staff, families, patients, and others.	• **Routinely clarifies roles and expectations** for team members. Manages the team in an **organized and fairly efficient** manner. Interactions with supervisor(s) are **focused and decisive**. **Creates a foundation of open communication within the team**. **Team members are expected to engage in decision-making and are encouraged to take ownership** in care. **Utilizes a consensus-building** process and **empowerment** of others, only in rare instances becoming directive. **Advocates effectively for the team** with faculty, staff, families, patients, and others.	• **Routinely clarifies roles and expectations for team members**. Team management is **organized and efficient**. Interacts with supervisor(s) in a **focused and decisive** manner. **Creates a strong sense of open communication within the team**. **Team members routinely engage in decision making and are expected to take ownership** in care. **Consensus-building and empowerment** are the norm. **Proactively and effectively advocates for the team** with faculty, staff, families, patients, and others. **Inspires** others to perform.
• **Does not define/clarify roles and expectations for team members.** • **Team management disorganized/ inefficient; interaction with supervisor unfocused/indecisive.** • **Open communication not encouraged. Team members not given ownership or engaged in decision-making.** • **Manages by mandate.** • **Unable to advocate effectively for team with faculty/staff/patients.**	• **Evident roles and expectations for team but not explicitly defined.** • **Team management somewhat organized/ inefficient; interaction with supervisor somewhat focused but not decisive.** • **Encourages open communication in team. Sometimes engages team in decision-making.** • **Manages most often through direction but some use of consensus.** • **Attempts to advocate for team with faculty/staff/patients.**	• **Provides some explicit definition for team members.** • **Manages team in organized manner; interaction with supervisor focused and decisive.** • **Open communication in team encouraged. Team members routinely engaged in decision-making.** • **Manages most often through direction but some use of consensus.** • **Attempts to advocate for team with faculty/staff/patients.**	• **Routinely clarifies roles and expectations for team members.** • **Manages team in organized and efficient manner; interactions with supervisor focused/decisive.** • **Creates open communication. Team expected to engage in decision-making and take ownership in care.** • **Utilizes consensus-building and empowerment of others, only in rare instances becoming directive.** • **Advocates effectively for the team with faculty/staff/ patients.**	• **Routinely clarifies roles and expectations for team members.** • **Team management organized and efficient. Interactions with supervisor focused/decisive.** • **Creates a strong sense of open communication within the team. Team members routinely engage in decision making and expected to take ownership in care.** • **Consensus-building and empowerment are norm.** • **Effectively advocates for team with faculty/staff/patients.**

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PPD 8. Recognize that ambiguity is part of clinical medicine and respond by utilizing appropriate resources in dealing with uncertainty				
• Feels **overwhelmed** and **inadequat**e when **faced with uncertainty** or ambiguity. **Communications** with patients/families and development of therapeutic plan are **rigid and authoritarian**, with assumption that the patient can manage information and participate in decision-making; **patient/family numeracy presumed**. Seeks only self or self-available resources to manage response to this uncertainty, resulting in a **response characterized by their (individual) preexisting state of risk aversion or risk taking**. Does not regard patient need for hope; feels compelled to make sure that patients understand full potential for negative outcome (defensive/protective of physician).	• Recognizes uncertainty and feels tension/pressure from not knowing or knowing with limited control of outcomes. **Explains** situation **to the patient in framework most familiar to the physician,** rather than framing it with terms, graphics, or analogies familiar to the patient. Seeks rules and statistics and feels **compelled to transfer all information to the patient immediately**, **regardless of** patient readiness, patient goals, and **patient ability to manage information**. .	• **Anticipates** and focuses on **uncertainty**, looking for resolution by **seeking additional information**. Aims to inform the patient of the more optimal outcome(s), framed by physician goals. Does not manage overall balance of patient/family uncertainty with quality of life, need for hope, and ability to adhere to therapeutic plan. **Focuses on own risk management position for a given problem** and does not suggest that more or less risk taking (different from physician's position) could be chosen. Still seeks patient/parent recitation of uncertainty/morbidity as proof that patient/family understands the uncertainty. **Unresolved balance of expectations with physician expectations taking precedence**.	• Anticipates that uncertainty at the time of diagnostic deliberation will be likely. Uses such uncertainty or larger ambiguity as a prompt/motivation to seek information or understanding of unknown (to self or world). **Balances delivery of diagnosis with hope, information, and exploration of individual patient goals**. Concepts of risk versus hope are worked through **using conceptual framework** that **includes cost** (e.g., suffering, lifestyle changes, financial) **versus benefit; framed by patient health care goals**. Expresses openness to patient position and patient uncertainty about his/her position and response.	• Is **aware of and keeps own risk aversion** or risk-taking position in check. Seeks to **understand patient/family goals for health** and their capacity to achieve those goals, given the uncertain treatment options. Engages in discussion with **high sensitivity towards numeracy**, emphasizing patient/family control of choices with initial plan development and ongoing information sharing through changes as knowledge and patient health status evolve. Remains flexible and committed to engagement with the patient/family throughout the patient's illness, serving as a **resource to gather information so that degree of uncertainty is minimized.** Openly and comfortably discusses strategies and outcomes anticipated with the patient/family, emphasizing that all plans are subject to the imperfect knowledge and state of uncertainty. **Constant revisiting of knowledge, uncertainty, and developed plans is balanced with acceptance of what is unknown**; transparent communication of limits of treatment plan outcomes

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• Feels overwhelmed/inadequate with uncertainty or ambiguity. • Communications with patients/families rigid and authoritarian; numeracy presumed. • Seeks only self-available resources to manage uncertainty, leading to risk aversion/unnecessary risks. • Does not regard patient need for hope; feels compelled to make sure patients understand full negative outcome potential (defensive/protective of MD).	• Recognizes uncertainty and feels tension/pressure from not knowing or knowing with limited control of outcomes. • Explains situation to patient in framework most familiar to the physician, rather than in terms familiar to patient. • Seeks rules/statistics and feels compelled to transfer all information to patient, regardless of patient readiness, goals and ability to manage information. .	• Anticipates/focuses on uncertainty, looks for resolution by seeking additional information. • Aims to inform patient of more optimal outcome(s), framed by physician goals. • Does not manage overall balance of patient uncertainty with quality of life, need for hope, adherence. • Focuses on own risk management; does not suggest more or less risk taking could be chosen. • Unresolved balance of expectations with physician expectations taking precedence.	• Anticipates uncertainty at time of diagnostic deliberation. • Uses uncertainty/ambiguity as prompt/motivation to seek better understanding of unknown. • Balances delivery of diagnosis with hope, information, and exploration of patient goals. • Concepts of risk versus hope are worked through framework that includes cost (e.g., suffering, lifestyle changes, financial) versus benefit; framed by patient goals. • Expresses openness to patient position/uncertainty about his/her position and response.	• Aware of and keeps own risk aversion or risk-taking in check. • Seeks to understand patient goals for health and capacity to achieve goals. Sensitive to patient numeracy, control of choices and ongoing information sharing. • Remains flexible and committed to engagement with patient. • Discusses strategies and outcomes with patient, emphasizing that all plans are subject to imperfect knowledge and uncertainty. • Revisits knowledge, uncertainty, and plans with acceptance and clear communication of limits.