Collective Competence: Adapting our concept of competence to healthcare teams

Lorelei Lingard, PhD
ICRE 2014
Competence is a way of ‘seeing’

Every way of seeing,
is a way of not seeing.

(Kenneth Burke, 1965)
How we ‘see’ competence shapes our attitudes and our actions.

It ‘selects’ and ‘deflects’ our attention.

(Kenneth Burke 1965)
Competence is a ‘god term’

“An expression to which other expressions are ranked as subordinate.”

(Kenneth Burke 1969)
Competence is a rhetorical trump card
Presentation Objectives

• Part One: Our conventional way of seeing
• Part Two: An emergent way of seeing
• Part Three: Are we there yet? CanMEDS 2015
• Part Four: The power of metaphor
IF SOMETHING BUGS THEM, THEY NEVER LET GO OF IT. THEY JUST GO ON AND ON, LONG AFTER ANYONE ELSE IS INTERESTED. IT'S JUST COMPLAIN, COMPLAIN, COMPLAIN! PEOPLE WHO GRIPE ALL THE TIME REALLY DRIVE ME NUTS! YOU'D THINK THEY'D CHANGE THE SUBJECT AFTER A WHILE, BUT THEY NEVER DO. THEY JUST KEEP GRIPING UNTIL YOU START TO WONDER, "WHAT'S WRONG WITH THIS IDIOT?" BUT THEY GO ON COMPLAINING AND REPEATING WHAT THEY'VE ALREADY SAID!
Part One:
Our conventional way of seeing
How to make a competent physician:
Select an appropriate individual
Competent as an individualist phenomenon

Fill them up with knowledge, skills, attitudes
Assess their performance
Document their ‘competence’
If some competence leaks out, refill.
Competence is:

- a quality that individuals acquire and possess
- a state to be achieved
- context-free, untied to time and space
This individualist notion influences

Candidate Selection

Student Assessment

Licensing and Evaluation

Monitoring of Licensed Practitioners

Remediation
The theoretical roots of current learning theories are deeply rooted in the idea of the learner as an active agent. These theories, including adult learning, reflective learning, and experiential learning, emphasize the learner's role at the center of the learning process. Bleakley (2006) highlights this point, stating, "The dominant learning theories (adult learning, reflective learning, experiential learning) take the learner as ‘active agent’ at the center of the activity of learning."
It reflects a particular context

The context has changed

- 24% of all Canadian seniors report having 3 or more chronic conditions
- These seniors report 13.3 million healthcare visits per year

(CIHI, 2011)
``Healthcare is a team sport``
Or a maze of care episodes?
Introduction

Concern about chronic condition care is growing as the prevalence of chronic conditions such as diabetes and high blood pressure increase in Canada. For many chronic conditions, prevalence increases with age, causing a disproportionate health burden on seniors—Canadians age 65 and older. Patients with chronic conditions—in particular, multiple chronic conditions, also called comorbidity—typically have poorer quality of life and require considerable health care resources. Effective prevention and management of chronic conditions is required, especially in the face of Canada’s large boomer generation entering the senior age category.

This study examined the reported experiences of seniors in Canada being treated for chronic conditions in primary health care (PHC) settings. The results of the study can be used to enhance our understanding of patients’ use of health care services and health status, the quality of patient–provider communication, patient self-management, and medication management. This report is focused on seniors because they are more likely than younger people to have chronic conditions, especially comorbidities that can be complex and difficult to manage.

Key Findings

Healthy seniors need less health care. The amount of health care services seniors will use is largely driven by the number of chronic conditions they have, not their age.

- In each of the age groups (65 to 74, 75 to 84, and 85 and older), seniors with three or more reported chronic conditions had nearly three times the number of health care visits than seniors with no reported chronic conditions.
Individual Competence
Individual Competence ≠ Good Healthcare
Part Two:
An emergent way of seeing
‘Truths’ from the study of teams
Competent individuals can form an incompetent team.
A team can be competent even when one member is incompetent.
An incompetent individual can paralyze one team, while another team carries on around her.
A team can be competent one day, and incompetent the next.
Collective Competence

A way to ‘see’ aspects of competence that are not reducible to the individual but emerge instead from social and organizational systems

(Lingard 2009, 2012; Boreham 2000, 2004; Rogalski 2002; Weick & Roberts 1993; Kitto & Grant 2014)
Key premises

Competence is

• a constantly evolving set of multiple, interconnected behaviors

• achieved through participation and enacted in time and space
Theoretical roots

Distributed cognition

Collaborative work as ‘joint cognitive accomplishment not attributable to any individual’.

(Hutchins 1991)
Theoretical roots

Situated learning theory

Competence emerges through social interaction, shared experience, development of tacit knowledge, and innovation in response to situated needs.

(Lave 1991; Eraut 2000; Mittendorf 2006)
Socio-material and system theories

Individuals are shaped by social, technological and physical structures – the ‘activity system.’

(Engestrom 1987; 1995; 2002)

Complex systems are inherently unstable; a change anywhere produces a nonlinear ripple effect. Competence is highly context-dependent.

(Sveiby 1997; Zimmerman 2004)
Two ‘ways of seeing’ competence

- Individual possession
  - Stable
  - Context-free
- Distributed capacity
  - Evolving
  - Based in situations

NOT a simple binary opposition.
Collectivist not a ‘solution’ to individualist.
Each ‘selects’ and ‘deflects’.
During a liver resection, the surgeon requests more sponges due to heavy bleeding. She asks the anaesthetist what the CVP is.

“15”, he replies.

She raises her head: “What? 15? No wonder we've got all this bleeding.” Shakes her head, saying to the resident, “It should be kept less than 5 when we’re transecting the liver. We're going to have to try and hurry this up.”
Surgeon asks anaesthetist: “Can you lower the CVP?”

Anaesthetist: “Yes, but he won't tolerate a CVP less than 5. He needs a high preload to maintain output.”

Surgeon: “If you don’t lower it, he’s going to lose a lot of blood and that won’t be pretty either!”
Individualist way of seeing

What do the individuals know?

- Does anaesthetist usually do liver resections?
- Does surgeon understand timing associated with lowering CVP?

What are the individuals’ skills?

- Communication, negotiating conflict
Collectivist way of seeing

What is the access to information across the group?

- Are team members aware of what others know/don’t know?

What are similarities & differences in team members’ perceptions?

- Of patient’s status?
- Of relative advantage of lowered CVP?
- Of the nature of an ‘emergency’?
Part Three:
Are we there yet?
Training & assessing (collective?) competence
Collaborator Role

“As Collaborators, physicians work effectively with other health care professionals to provide safe, high-quality patient-centred care.”
### Key concepts

- Collaboration with community providers: 1.2, 1.3
- Communities of practice: 1.3, 3.2
- Conflict resolution, management, and prevention: 2.2
- Constructive negotiation: 2.2
- Effective consultation and referral: 1.2, 1.3, 3.1, 3.2
- Effective health care teams: all ECs
- Handover: 3.1, 3.2
- Interprofessional: (i.e., among health care professionals) health care: all ECs
- Intraprofessional: (i.e., among physician colleagues) health care: all ECs
- Recognizing one’s own roles and limits: 1.2, 3.1
- Respect for other physicians and members of the health care team: 2.1, 2.2
- Respecting and valuing diversity: 1.2, 2.1, 2.2
- Shared decision-making: 1.2
- Sharing of knowledge and information: 1.3, 3.1, 3.2
- Situational awareness: 1.1, 1.2, 2.2, 3.1, 3.2
- Team dynamics: 1.1, 2.2, 3.1
- Transitions of care: 3.1, 3.2
- Understanding roles and responsibilities of all members of the health care team: 1.2, 3.1
New Handover Competency

3. Effectively and safely transfer care to another health care professional

3.1 Assess when care should be transferred to another physician or health care professional

3.2 Demonstrate safe transfer of care, using both verbal and written communication, during a patient transition to a different health care professional, setting, or stage of care
The Draft CanMEDS 2015 Physician Competency Framework—MEDICAL EXPERT

Key concepts

- Agreed-upon goals of care: 2.1, 2.3, 2.4, 3.2, 4.1
- Application of core clinical and biomedical sciences: 1.3
- Clinical decision-making: 1.4, 1.6, 2.2, 5.4
- Clinical reasoning: 1.3, 1.4, 2.1, 3.1
- Compassion: 1.1
- Complexity, uncertainty, and ambiguity in clinical decision-making: 1.6, 2.2, 2.4, 3.2, 3.3, 3.4
- Consent: 3.2
- **Continuity of care: 2.4, 4.1**
- Duty of care: 1.1, 1.5, 2.4
- Integration of CanMEDS Intrinsic Roles: 1.2
- Interpreting diagnostic tests: 2.2

- Medical expertise: all ECs
- Prioritization of professional responsibilities: 1.4, 1.5, 2.1, 3.3, 5.1
- Patient-centred clinical assessment and management: 1.4, 2.2, 2.4, 3.1, 3.3, 3.4, 4.1, 5.1, 5.4, 5.5
- Patient safety: 1.5, 3.4, 5.1, 5.2, 5.3
- Procedural skill proficiency: 3.1, 3.3, 3.4
- Quality improvement: 5.2, 5.3, 5.5
- Self-awareness of limits of expertise: 1.4, 3.4
- **Timely follow-up: 1.4, 2.2, 4.1**
- Working within the health care team: 1.3, 1.4, 2.1, 2.4, 3.3, 4.1, 5.2
The Draft CanMEDS 2015 Physician Competency Framework—COMMUNICATOR

- Accuracy: 2.1, 2.4, 3.1, 4.2, 5.1
- Active listening: 1.1, 1.3, 1.4, 1.5, 2.1, 2.2, 2.3, 2.4, 4.1, 4.3
- Appropriate documentation: 2.1, 5.1, 5.2, 5.3
- Attention to the psychosocial aspects of illness: 1.6, 2.1, 2.2, 4.1
- Breaking bad news: 1.6, 3.1, 3.3
- Concordance of goals and expectations: 1.6, 2.2, 3.1, 4.3
- Disclosure of adverse events: 3.2
- Effective oral and written information for patient care across different media: 5.1, 5.2
- Efficiency: 2.3, 4.2, 5.2
- Eliciting and synthesizing information for patient care: 2.1, 2.2, 2.3, 2.4
- Empathy: 1.1, 1.2, 1.3
- Ethics in the physician–patient encounter: 3.2, 5.1
- Expert verbal and non-verbal communication: 1.4
- Informed consent: 2.2
- Mutual understanding: 1.6, 3.1, 4.1
- Patient-centred approach to communication: 1.1, 1.6, 2.1, 3.1
- Privacy and confidentiality: 1.2, 5.1
- Rapport: 1.4
- Relational competence in interactions: 1.5
- Respect for diversity: 1.1, 1.6, 2.2, 4.1
- Shared decision-making: 1.6, 4.1, 4.3
- Therapeutic relationships with patients and their families: 1.2, 1.3, 1.4, 1.5, 1.6
- Transition in care: 5.1, 5.2
- Trust in the physician–patient relationship: 1.1, 5.2
Key concepts

- Administration: 4.1, 4.2
- Career development: 4.2
- Collaborative leadership and “followership”: 1.1, 3.1, 3.2, 3.3
- Consideration of justice, efficiency, and effectiveness in the allocation of health care resources for optimal patient care: 1.1, 1.2, 1.3, 2.1, 2.2
- Complexity of systems: 1.1
- Effective meetings and committee participation: 1.2
- Health human resources: 2.2, 4.2
- Information technology for health care: 1.3
- Leading change: 1.1, 1.2, 1.3, 2.2, 3.2
- Management of personnel: 4.2
- Negotiation: 1.1, 3.1
- Organizing, structuring, budgeting, and financing: 2.1, 2.2, 4.1, 4.2, 4.3
- Personal leadership skills: 3.1, 4.1, 4.2, 4.3

- Physicians as active participant-architects within the health care system: 1.1, 1.2, 1.3, 2.3, 3.2, 3.3
- Physician remuneration: 4.2
- Physician roles and responsibilities in the health care system: 1.1, 1.2, 1.3, 2.2, 3.1, 3.2
- Practice management to maintain a sustainable practice and physician health: 4.1, 4.2, 4.3
- Priority-setting: 2.1, 3.2, 4.1
- Quality improvement: 1.1, 1.2, 1.3, 2.2, 3.2, 3.3
- Stewardship: 2.1, 2.2
- Supervising others: 4.2
- Systems thinking: 1.1, 1.2, 1.3, 2.1, 2.2
- Time management: 4.1
**Key concepts**

- Adapting practice to respond to the needs of patients, communities, or populations served: 2.1, 2.2
- Advocacy in partnership with patients, communities, and populations served: 1.1, 1.2, 2.1, 2.2, 2.3
- Continuous quality improvement: 2.2, 2.3
- Determinants of health, including psychological, biological, social, cultural, environmental, educational, and economic determinants, as well as health care system factors: 1.1, 1.3, 2.2
- Disease prevention: 1.3, 2.1
- Fiduciary duty: 1.1, 2.2, 2.3
- Health equity: 2.2
- Health promotion: 1.1, 1.2, 1.3, 2.1
- Health protection: 1.3
- Mobilizing resources as needed: 1.1, 1.2, 1.3
- Principles of health policy and its implications: 2.2
- Potential for competing health interests of the individuals, communities, or populations served: 2.3
- Responsible use of position and influence: 2.1, 2.3
- Social accountability of physicians: 2.1, 2.3
Now what?

It’s in the framework
We apply it to individual trainees

- Fill them up with these competencies
- Assess their performance of them
<table>
<thead>
<tr>
<th>Objective</th>
<th>Criteria</th>
<th>Applicable</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of community health needs and priorities</td>
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<td>Development of effective communication strategies with community members</td>
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<tr>
<td>Identification and implementation of community health improvement initiatives</td>
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<tr>
<td>Collaboration with community organizations and stakeholders</td>
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<tr>
<td>Health promotion and education for community health</td>
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<tr>
<td>Assessment of community health outcomes and evaluation of interventions</td>
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</tbody>
</table>

*Note: This table is a sample of objectives and criteria for a community health program.*
(Coll. 1.1, 1.2, 1.3, 2.1, 2.2, 3.1, 3.2, 4.1, 5.1, 5.2, 5.3)
+ (Med Exp. 1.3, 1.4, 2.1, 2.2, 2.4, 3.3, 4.1, 5.2, 5.3)
  + (Comm. 2.1, 2.4, 5.1, 5.2, 5.3)
  + (Lead. 1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 3.3)
  + (Adv. 1.1, 1.2, 1.3)

= Collective competence?
Two ‘ways of seeing’ competence

- Individual possession
- Stable
- Context-free

- Distributed capacity
- Evolving
- Based in situations
Two ‘ways of seeing’ competence

- Individual possession
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Two ‘ways of seeing’ competence

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<thead>
<tr>
<th>Procedure</th>
<th>Status</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biopsy</td>
<td></td>
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<tr>
<td>CT Scan</td>
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<tr>
<td>MRI</td>
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</tbody>
</table>

Additional Comments: 

- Patient is allergic to iodine.
- Previous medical history includes hypertension.

Next steps:
- Schedule follow-up appointment in 1 week.

Medical Plan:
- Begin antibiotics if infection is confirmed.
- Refer to specialist for further treatment.

Patient Education:
- Follow a healthy diet and lifestyle.
- Monitor symptoms regularly.

Insurance Information:
- Patient's insurance covers 80% of the procedure costs.
- Co-pay is due at the time of service.

Financial Assistance:
- Apply for financial aid if needed.
- Payment options available online.

Next appointment: 

- Date: [Date]
- Time: [Time]

Contact Information:
- Office: [Phone]
- Email: [Email]
<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room #</td>
<td>5</td>
</tr>
<tr>
<td>Device Manager</td>
<td>N/A</td>
</tr>
<tr>
<td>Physicist/Engineer</td>
<td>N/A</td>
</tr>
<tr>
<td>Nurse/Staff NURSE 1</td>
<td>N/A</td>
</tr>
<tr>
<td>Nurse/Staff NURSE 2</td>
<td>N/A</td>
</tr>
<tr>
<td>Nurse/Staff NURSE 3</td>
<td>N/A</td>
</tr>
<tr>
<td>Other Staff Members</td>
<td>N/A</td>
</tr>
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</table>

**Room Information**

- **Room**: 5
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  + (Adv. 1.1, 1.2, 1.3)

X all team members

_____________________________

= Collective competence?
X all team members

= Collective competence?
Competent individuals can form an incompetent team.
Part Four:
The power of metaphors, or...

Why we’re stuck
Elements & their connections are equally important. Simple algorithms produce simple & predictable responses. Components response is fully determined. = Complicated.

Elements & their connections are equally important. Simple algorithms produce simple & predictable responses. Components response is fully determined. = Complicated

Connections are critical; individual agents much less so. Simple rules result in complex & adaptive responses. Agents have latitude of response within the rules. = Complex

Does individual competence matter? 
Yes

Is collective competence a whole lot harder to teach & assess? 
Yes
Is this our problem? Yes
Because...
Individual Competence ≠ Good Healthcare
I’m not saying this exactly...
I am saying that we should incorporate both ‘ways of seeing’ competence into training & assessment efforts.
How?

• Be aware and wary of mechanistic metaphors
• Evaluate in situ, authentic activity
• Evaluate interactions, not just individuals
• Consider interactions among elements of the system, not just among people
• Capture ‘the cracks between’ care episodes
Evaluate in situ

• Observe and evaluate actual practices

• Broaden focus beyond individual actions, to include inter-actions among individuals

• Consonant with shift to milestones in CanMEDS 2015
<table>
<thead>
<tr>
<th>COLLABORATOR MILESTONES: RESIDENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Work effectively with other physicians and other health care professionals</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Transition to discipline</th>
<th>Foundations of discipline</th>
<th>Core of discipline</th>
<th>Transition to practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Establish and maintain healthy inter- and intraprofessional working relationships for collaborative care</td>
<td>Identify regular inter- and intraprofessional collaborators in their discipline</td>
<td>Compare and contrast enablers of and barriers to collaboration between colocated teams and in other health care situations</td>
<td>Analyze interactions among health care providers</td>
<td>Establish and maintain healthy working relationships to support relationship-centred collaborative care</td>
</tr>
<tr>
<td></td>
<td>Differentiate between task and relationship issues after observing interactions between health care providers</td>
<td>Demonstrate respect for established rules of team function (team norms)</td>
<td>Consistently scan for patient safety concerns relating to team function, anticipate issues that could degrade situational awareness, and respond to mitigate potential harm to patients</td>
<td>Institute strategies (tools and approaches) in daily practice to enhance relationship-centred collaborative care</td>
</tr>
<tr>
<td></td>
<td>List ground rules for collaboration</td>
<td>Demonstrate receptivity to input from other health care providers</td>
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</tr>
<tr>
<td>1.2 Negotiate overlapping and shared responsibilities with inter- and intraprofessional health care providers for episodic or ongoing patient care</td>
<td>Discuss the role and responsibilities of a specialist in their discipline</td>
<td>After case discussion, identify other health care providers, including other physicians or surgeons, required for consultation</td>
<td>Appropriately consult with other health care providers, including other physicians or surgeons</td>
<td>Negotiate role overlap and shared responsibilities with inter- and intraprofessional health care providers for episodic or ongoing care of patients</td>
</tr>
<tr>
<td></td>
<td>Describe the roles and scopes of practice of other health care providers related to the discipline</td>
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<tr>
<td>1.3 Engage in effective and respectful shared decision-making with inter- and intraprofessional care providers</td>
<td>Describe strategies to promote engagement of inter- and intraprofessional colleagues in shared decision-making</td>
<td>Discuss the aspects or components of referrals and consultation reports that support collaborative or shared decision-making processes</td>
<td>Partner with inter- and intraprofessional colleagues in addition to the patient and his or her family to integrate the patient’s perspective and context into the care plan</td>
<td>Respectfully engage in shared decision-making with inter- and intraprofessional care providers in addition to the patient and his or her family</td>
</tr>
<tr>
<td></td>
<td>Identify referral and consultation as opportunities to improve quality of care and patient safety by sharing expertise</td>
<td></td>
<td>Consistently discuss with patients and their families any plan for involving other health care professionals, including other physicians, in their care and their expectations of such involvement</td>
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</tbody>
</table>
Evaluate interactions

- Tools for evaluating interactions between individuals
  - D Roter’s RIAS for patient/provider interactions
  - R Pianta’s instruments for parent-child and teacher student interactions
Evaluate interactions

• Beyond the dyad, among the collective

  – Tools for evaluating teamwork on criteria such as shared mental models, adaptive behavior, situational assessment (McIntyre 2005; Salas 2007)

  – Struggles to move from research application to widespread use in practice (C Burke, 2009)
Attend to more than just the ‘people’

• Our current language directs our attention to interactions among ‘people’ and deflects it from other system elements

• E.g., Collaborator role
<table>
<thead>
<tr>
<th>Key competencies</th>
<th>Enabling competencies</th>
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<td>Physicians are able to:</td>
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<td>1.3 Engage in effective and respectful shared decision-making with inter- and intraprofessional health care providers</td>
</tr>
<tr>
<td>2. Work with inter- and intraprofessional colleagues to prevent misunderstandings, manage differences, and resolve conflicts</td>
<td>2.1 Demonstrate a respectful attitude toward collaborators, including inter- and intraprofessional health care providers</td>
</tr>
<tr>
<td></td>
<td>2.2 Work with others to prevent misunderstandings, manage differences, and resolve conflicts</td>
</tr>
<tr>
<td>3. Effectively and safely hand over care to an appropriate health care professional</td>
<td>3.1 Recognize when care should be transferred to another physician or health care provider</td>
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<td>3.2 Demonstrate effective and safe handover, both verbal and written, during a patient transition to a different setting or stage of care</td>
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<td></td>
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</table>
Beyond people

- Other socio-material elements in the system play a role in (in)effective collaboration
  - Technology, tools (EMR: Varpio 2006)
  - Structure (of schedules, of teaching teams: Kennedy 2007, 2008; Goldszmidt 2013)
  - Policies (Privacy legislation: Ng Forthcoming)
The cracks between care episodes

• Experts cultivating collective competence:
  
  “Know how the system usually fails in this situation, and plan accordingly”

  “Use relationships, history, backup plans to make sure the patient gets safely from A-Z”

• Situational assessment & adaptive behavior (Salas)
• How can we see this? What can we ask or do to make it visible for feedback & assessment?
In summary
Competence is a way of ‘seeing’, that both *directs & deflects* our attention
Our attention is directed towards individual competence
And deflected from collective competence
We need both.
Key concepts

- Collaboration with community providers: 1.2, 1.3
- Communities of practice: 1.3, 3.2
- Conflict resolution, management, and prevention: 2.2
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- Effective consultation and referral: 1.2, 1.3, 3.1, 3.2
- Effective health care teams: all ECs
- Handover: 3.1, 3.2
- Interprofessional: (i.e., among health care professionals) health care: all ECs
- Intraprofessional: (i.e., among physician colleagues) health care: all ECs
- Recognizing one’s own roles and limits: 1.2, 2.3
- Respect for other physicians and healthcare providers: all ECs
- Respecting and valuing: all ECs
- Sharing knowledge and information: 1.3, 3.1, 3.2
- Cultural awareness: 1.1, 1.2, 2.2, 3.1, 3.2
- Team dynamics: 1.1, 2.2, 3.1
- Transitions of care: 3.1, 3.2
- Understanding roles and responsibilities of all members of the health care team: 1.2, 3
But our metaphors are holding us back
And our conventional assessment approaches are limiting.
Treating competence as both individual & collective will be a challenge.

But it is absolutely necessary.
Thank You
Selected image attributions

- Camera and hands scene. Douglas Buller.
- Stick man team. Douglas Buller.
- Glowing book. Re-worship blogspot.com