Entrustable professional activities: addressing confusions and controversies

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Abstract

In this chapter, we address common confusions and controversies with entrustable professional activities (EPAs). With an eye toward practicality, we seek to offer resolutions or advice for these controversies where possible. We detail the differences between competencies and EPAs and discuss how they are complimentary approaches to health professions education that employ different lenses (individuals for competencies, and activities for EPAs). We next detail how EPAs should not be treated as an 'assessment tool' but rather as an approach to education that facilitates a stepwise decrease in supervision within the philosophy of competency-based education. Many terms related to EPAs and entrustment are conflated or poorly understood. This chapter disentangles many of these terms, including entrustment, supervision, trustworthiness, competence, supervision, autonomy, and independent practice. With precise definitions for these terms, it becomes clear how entrustment decisions are a forward-looking decision for the future rather than a report of past performance or supervision provided. Finally, we explore how EPAs and entrustment can support time variability and also how approaches to entrustment vary between contexts and cultures.

This chapter uses cross-references to other chapters of the same book. For those who read this chapter as a standalone publication: all cross-references can be found at: https://doi.org/10.5334/bdc
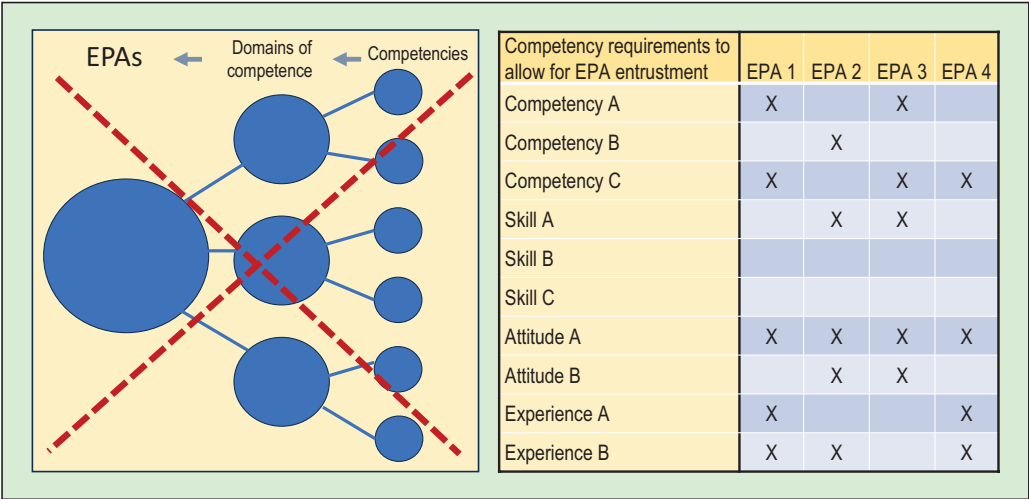
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In this chapter, we address common confusions and controversies with entrustable professional activities (EPAs). With an eye toward practicality, we seek to offer resolutions or advice for these controversies where possible.

Contrasting EPAs and competencies

The prevailing approaches to competency-based education are grounded in defining competencies, entrustable professional activities (EPAs), or both. While some may think competencies and EPAs are similar or alternatives to choose from, this is not the case. Competencies define the abilities of people. A competency integrates knowledge, skills, and attitudes and is specific, durable, focused on performance, and learnable.[1,2] EPAs, however, are activities in a workplace. If a competency is 'the ability to do something successfully' (an Oxford Dictionary definition), then the activity is that 'something.' Execution of an activity requires specific competencies but that activity in and of itself is not a competency.

EPAs are sometimes depicted as large domains of competence, which in turn are composed of select competencies from those domains, in turn composed of milestone stages of development for each of those competencies (Figure 7.1, left). However, the relationship between EPAs and competencies depicted this way can lead to confusions, as EPAs thus seem to represent (large) competencies. EPAs are just the work-units trainees must be prepared to take on. The dimension of health care requirements and the dimension of competencies that professionals bring with them may be better viewed as perpendicular. In addition, EPAs do not need to be large. The contributions of a junior medical student to patient care can be relevant but small, and will, at later stages, be nested with the much broader EPAs of senior students and residents. Thus, EPAs related to competencies can better be visualized two axes or dimensions—one focused on features of individuals and the other focused on features of work, i.e., the activities that those individuals could do (Figure 7.1, right). EPAs are context-specific by definition. The reason that 'interprofessional collaboration,' as an example, can be a desired competency or skill but not an EPA is that it is not a concrete activity with a beginning and end that can be assigned at a specific time to a health professional or trainee.[3] However, it is a required skill for most EPAs. However, if a contextual specification (e.g., chairing an interprofessional session or committee) can be provided, it might be an activity that meets EPA criteria.[4] Finally, Figure 7.1 (right) also shows that the requirements to allow a trainee to be entrusted with the responsibility for an EPA can be specified to include not only specific competencies but also other skills, attitudes, and experiences.

Competency requirements to allow for EPA entrustment	EPA 1	EPA 2	EPA 3	EPA 4
Competency A	X		X	
Competency B		X		
Competency C	X		X	X
Skill A		X	X	
Skill B				
Skill C				
Attitude A	X	X	X	X
Attitude B		X	X	
Experience A	X			X
Experience B	X	X		X

Figure 7.1: Not recommended (left) and recommended (right) representations of competencies, skill, and abilities versus EPAs.

The term 'EPA'

As units of professional practice, EPAs were introduced to facilitate a stepwise decrease in supervision for trainees executing activities that are germane to their profession. Because entrustment with these activities requires assessment of trainees, EPAs are often presented as an assessment method or framework. However, they are not an approach to assessment but rather a philosophical approach to health professions education, encompassing curriculum and assessment. Viewing EPAs simply as an approach to assessment fails to recognize their importance in defining the work of a profession and thus the requisite curriculum to be able to prepare individuals to execute the EPAs as well as develop their professional identity over time. When trainees are asked to secure supervisor observations of the performance on an EPA, they may say things like: 'if we don't have enough EPAs, we're going to fail.'[5] When they say this, trainees may actually be referring to observations rather than EPAs, expressing sentiments that reflect the experience of seeking a quantity of assessments rather than feelings about the EPAs themselves.

What is 'competent'?

The word 'competent' is often interpreted in multiple ways. For some, the word defines a comfortably acceptable level for physicians who no longer require supervision. However, for others, 'competent' is considered a level barely meeting standards ('all our graduates should be excellent, not competent'). Still others would regard a medical student as 'competent' in an area *for their stage of training*, while a resident with identical skills would be deemed not competent. The Dreyfus developmental model (novice–advanced beginner–competent–proficient–expert),[6] extensively applied in health professions training, places 'competent' in the middle of the trajectory. To escape such confusions, most of the EPA literature defines 'competent' as the threshold level in the development of a trainee when they are entrusted to act unsupervised.[7] That is not a moving target but rather fixed and defined for EPAs. It includes the primary meaning of competent, that is, '[p]ossessing the requisite qualifications for, or to [something]; properly qualified' (Oxford Dictionary), thus being entitled to act. This also implies that an individual cannot be competent in general but only in relation to particular EPAs.

Entrustable, trustworthiness, and trust

Scholars and educators have spoken of trainees being 'entrustable' and even 'pre-entrustable.'[8] However, entrustable was never intended to refer to individuals but rather to activities. Thus, an activity is entrustable when it can be entrusted to someone.

Rather than 'entrustable,' individuals should be described in terms of their trustworthiness. Trustworthiness itself is a complex construct that has been explored in medical education. ten Cate and Chen have summarized varying components of trainee trustworthiness with regard to entrustment decision-making: agency (proactive toward work, team, safety, personal development), reliability (conscientious, predictable, accountable, responsible), integrity (truthful, benevolent, patient-centered), capability (specific knowledge, skills, experience, situational awareness), and humility (recognizes limits, asks for help, receptive to feedback).[9] Although entrustment decisions are context-dependent (dependent on the assessor, context, task, etc.), trainee trustworthiness is a central component of all entrustment decisions.[10,11]

In common parlance, trustworthiness is spoken of as a moral character trait ('we can always rely on that person's word'). However, in connection with EPAs, it should be applied to specific entrustment decisions. To draw a parallel: a parent may deem their 15-year-old daughter more

trustworthy than their 19-year-old son, yet would allow him but not her to drive their car because he has a driver's license and she does not.

Trustworthiness is different from trust. Trust has been defined in medical education as 'the willingness of a party to be vulnerable to the actions of another party on the basis of the expectation that the other will perform a particular action, irrespective of the trustor's ability to monitor or control that other party.'[12] Trust is the expected response from a person when they determine another individual to be trustworthy. However, trustors vary in their baseline propensity to trust.[13] Thus, trust is situationally determined based on: (a) the trainee's trustworthiness, (b) the trustor's trust propensity, and (c) the context and risk for the task at hand.[14]

Because entrustment does not follow solely from the trustworthiness of an individual, we believe it is best to avoid using potentially harmful phrasing such as 'not trusting' trainees. Rather, we suggest using language such as 'not yet ready' to practice a task at a given level of supervision in a particular context. This phrasing not only avoids language that could be harmful but also anchors conversations with trainees in the task at hand. A trustworthy trainee may simply not be ready for a particular task. The use of the word 'yet' also implies that they can be determined ready in the future.

Entrustment decisions versus entrustment determinations

Trust is future-facing. One individual can only entrust another with tasks that will occur in the (uncertain) future (e.g., whichever patient comes through the door next). Past experiences with the trainee matter, as predictions for what will happen in the future are often based on past events.[15] Trust, however, focuses on what might happen next. Entrustment is, therefore, a prospective *decision* about a future task.

In practice, entrustment in health professions education programs is often framed only as a score on a retrospective-oriented scale. That score is informed by a completed activity performance and assigning an entrustment–supervision level score reflecting what the supervisor in fact chose to allow at that time. This summary of past performance can be called an entrustment *determination*[16] but should not be confused with an entrustment *decision*.[17] In the context of entrustment, decisions are determinations that have real-world consequences in terms of advancement or granting of more responsibilities for trainees. Entrustment decisions operationalize the stepwise, graduated autonomy and responsibility to move trainees from legitimate peripheral participation[18] in patient care toward the center of the professional team. Failure to decrease supervision when warranted deprives trainees of the opportunity to execute work with full responsibility, including the psychological weight of being the individual ultimately responsible, during training. This blunts trainee growth and development and may risk patient safety once a trainee graduates.[19]

Disentangling supervision, autonomy, and independent practice

The decision to entrust another individual with unsupervised practice requires further consideration as it pertains to what being unsupervised means in terms of autonomy. Supervision and autonomy are often presented as opposite ends of the same spectrum with an inverse relationship—an individual can either have full autonomy or require full supervision. However, we prefer the definition of autonomy that Ryan and Deci present in self-determination theory: the ability to 'self-regulate one's experiences and actions.'[20] Framed this way, autonomy is more than just unfettered agency. Even an individual requiring full supervision can be allowed to self-regulate. For example, a medical student on the first day of a new clinical rotation can be allowed to choose which patients to care for or which clinic to attend.

'Unsupervised' and 'independent' practice are also often conflated. True independent practice is exceedingly rare in modern health care, and 'unsupervised' practice should therefore be the preferred term. Independent practice connotes that an individual works without any support from others. This is simply not consistent with the realities of working in nearly all health systems, where individual health professionals are a part of a team and where help is always available in person, over the phone, or over email.

How an EPA-based model aligns with flexibility and time variability in training

A basic tenet of competency-based education is the idea of time variability,[21] that is, moving from a fixed training time with variable trainee outcomes to fixed outcomes (i.e., minimum competence standards) and variable training time.[22–24] Yet time-variable training has proven challenging to implement. Many health profession educators acknowledge that some trainees complete training while not meeting all critical objectives; however, the provision of more time, or conversely graduating others earlier, frequently leads to practical problems. One cause of the concern is a fixed transition point in the year. The annual North American selection or match procedure (resulting in a start date of July 1 for all residents) differs significantly from other countries, where graduation from medical school and entry into residency programs is more flexible in terms of timing.[25] Importantly, time variability should not lead to unexpected surprises at the end of training. Extensions and reductions in training time should be foreseen by programs, and communicated to trainees, months or semesters ahead.

In theory, EPAs could facilitate more granular time variability, as the EPAs for which one is not ready to practice should be definable at any point of time in training. Owing to logistical or other challenges, if time variability is not a potential option, entrustment decisions run a substantial risk of remaining a theoretical construct, relying on the presumption that a PGY-4 (postgraduate year four) can be entrusted with an activity just because they are a PGY-4.

International and cultural differences in entrustment

How trainees and educators think and behave with respect to particular tasks and environments is socially, culturally, and historically contingent.[26] Controversy and confusion can arise during international discussions about entrustment and consequent responsibilities for trainees in health care. Differences in entrustment practices are affected by the nature of the educational continuum (for an overview, see Chapter 16), by regulatory and legislative differences, by differences in resources for health care and training in countries in the Global North and Global South, and by historically rooted differences in culture and hierarchy. We could not locate useful references, even though we felt these differences exist. In preparation for this chapter, a subset of authors convened a discussion group of medical educators with backgrounds in India, the Philippines, Taiwan, China, Malaysia, Ireland, the Netherlands, and Canada to obtain an impression of differences. In some countries (e.g., India, Malaysia), interns are entrusted with a wide range of responsibilities (e.g., lumbar puncture, chest tube insertion, pericardiocentesis, uncomplicated deliveries) in public medical colleges that predominantly supply graduates for rural areas. In this scenario, supervision is formalized as countersigning histories and procedures done by trainees in task-oriented logbooks. In contrast, in private medical colleges, where high numbers of supervisory teaching faculty are employed, trainee responsibilities are much more restricted and supervised. Paradoxically, although graduates from private medical colleges receive more teaching, they may be far less prepared for practical patient care responsibilities than graduates from government-sponsored public academic hospitals that frequently rely on interns to meet the health care needs of large rural populations.

Timelines for licensure can also differ vastly. For example, the Philippines allows some unsupervised practice prior to licensure, while China delays that fully until after licensure. Politico-historical developments within a country can also affect hierarchical permissions of autonomy. Until 1945, during the period of Japanese rule, a strong Prussian-styled hierarchy (originally derived from German medical education culture) determined the roles of professors, attendings, and trainees in Taiwan. Physicians had significant autonomy to perform procedures owing to an elevated societal respect for the profession. The SARS epidemic in 2003 became a turning point, with an emphasis on patient safety outweighing the cultural respect for physicians. As a result, direct supervision increased and North American influence became more dominant in medical education.

Conclusion

In this chapter, we have attempted to resolve confusion and debate around EPAs and entrustment decision-making, addressing both conceptual and practical issues. Undoubtedly, such debates will continue; however, this book may serve as a supportive resource to provide reference for the implementation of educational innovations. Educational improvement is a continuous endeavor, with the path to inventive and productive progress often charged/infused with dialogue, debate, clarification, and argumentation aiming for a shared mental model and common terminology.

Acknowledgments

Competing interests

The authors declare that they have no competing interests.

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