Entrustment as Assessment: Recognizing the Ability, the Right, and the Duty to Act

Olle ten Cate, PhD

The Challenge

Competency- and milestone-based frameworks are designed to improve assessment of learners on broad domains, such as professionalism, communication, or medical knowledge. In practice, marking trainees on competency scales has been found to be difficult.[1] In addition, these assignments often do not directly translate to judgments to trust trainees to work effectively in an unsupervised fashion. By the end of training, programs must ensure that residents can provide high-quality, safe patient care without supervision.

What Is Known

The concept of entrustable professional activities (EPAs) has recently emerged. It connects competencies with practice[2,3] via assessment focused on specific clinical activities rather than on general competencies. The primary question in EPA-based assessment is "Can we trust the trainee to execute EPA X without supervision?" followed by "*Why or why not?*" often involving 1 or more competencies. Examples of EPAs with the predominant relevant competencies are (1) providing anesthesia in an ASA-4 patient (medical knowledge, collaboration); (2) lumbar puncture in a child (technical skill, collaboration, communication); and (3) chairing a family meeting in rehabilitation medicine (communication, health advocacy, professionalism, leadership).

Entrustment: More Than Evaluating Ability

Since Aristotle, philosophers and researchers have identified conditions that must be met before someone trusts another person and is willing to be vulnerable for the associated risks,[4,5] which can be summarized in 4 words: *Ability, Integrity, Reliability,* and *Humility* (TABLE 1).

Entrustment decisions combine traditional assessment of ability with the right to execute an EPA without supervision (or with indirect supervision only). EPA-based entrustment decisions thus reflect the stepwise acceptance of a trainee to become part of the medical or specialty community. However, distinctions between *ad hoc* and *summative entrustment decisions* must be made (TABLE 2).

Levels of Supervision Instead of Traditional Rating Scales

Being evaluated on an EPA means that the learner is being judged on his or her readiness to provide care under a specified level of supervision that decreases, as trainees increase in their competence and skills. A 5-level rating scale has been proposed: at Level 1, the trainee is ready to be present and observe; at Level 3, the trainee is ready to act under indirect supervision; and at Level 5, the trainee is ready to provide supervision to junior learners.[2] Each of the 5 levels has direct consequences for the trainee and for patient care. EPA decisions imply the acceptance of risks related to patient safety. Balancing thoughtful challenges for learners and adequate supervision is necessary.

Rip Out Action Items

Program directors should:

1. Ensure that faculty, residents, and staff understand EPA concepts and how EPAs are established in your program.
2. Emphasize the "E" for entrustable within the EPA concept: supervisors make ad hoc entrustment decisions every day when working with residents.
3. Incorporate both ability and trust conditions—*integrity, reliability, humility*—in summative entrustment decisions.
4. Start small with a few EPAs; link these EPAs to your speciality's competencies and milestones; build from the literature; collaborate with faculty and trainees.

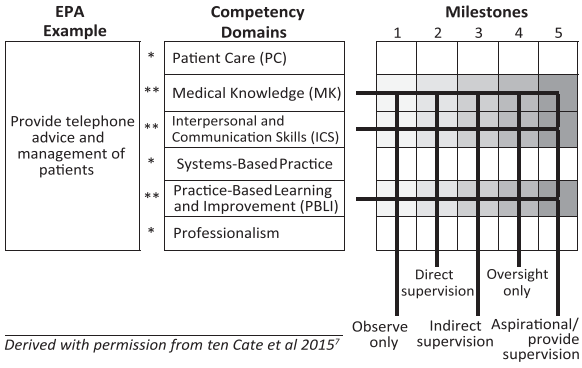
Combining Milestones, EPAs, and Supervision Levels

All residents must be evaluated using each specialty's competency specific milestones. Using an EPA rating scale of supervision is not in conflict, but can be aligned with milestones which also usually have 5 anchor levels. The FIGURE illustrates how competencies and milestones can be combined into an EPA in actual practice.[6] In this example, the key competencies for an EPA decision are MK, ICS, and PBLI.

TABLE 1
General Conditions for Trust

Conditions	Features
Ability	Competence, including specific competencies and associated milestones
Integrity	Benevolence: having favorable intentions, honesty, and truthfulness
Reliability	Working conscientiously and showing predictable behavior
Humility	Discernment of own limitations and willingness to ask for help when needed

DOI: http://dx.doi.org/10.4300/JGME-D-16-00097.1



Derived with permission from ten Cate et al 2015[7]

FIGURE
Connecting EPAs, Competencies, Milestones, and Supervision Levels

How You Can Start TODAY

1. Determine if your specialty has defined EPAs for practice. If specialty-specific EPAs are not available, begin discussions about the most relevant EPAs for your program.
2. Reframe existing evaluations for key entrustment decisions and deliberately assign levels of required supervision. Readiness for indirect supervision or unsupervised practice should include the specific EPA-related ability and the 3 other trust conditions: integrity, reliability, and humility.
3. Clinical competency committees can include these features in discussions of residents' readiness for promotion and graduation.
4. Make residents aware of the EPAs, as these are defined, and that supervisors will judge them regarding levels of supervision, first ad hoc and later in a summative sense. Residents should also know that the general qualities of integrity, reliability, and humility will be considered in these entrustment decisions.

What You Can Do LONG TERM

1. Use guidelines to assist the process[7] of defining and elaborating EPAs for curriculum development and to integrate entrustment as a core approach to assessment.
2. Implement faculty development starting with the clinical competency committee. EPAs and levels of supervision often feel more natural to clinicians compared to competency-based rating scales. However, clinicians' frames of reference may differ when judging residents' readiness for unsupervised practice.
3. Build high-stakes summative entrustment decisions based on information from multiple sources (eg, short practice observations, multisource feedback, knowledge/skills tests).

TABLE 2
Ad Hoc and Summmative Entrustment Decisions

	Ad Hoc Entrustment Decisions	Summative Entrustment Decisions
When	Daily: on every ward or clinic in every clinical training institution	One-off recognition of ability, supplemented with permission to act unsupervised and a duty to contribute to care, for 1 unit of professional practice, at graduation standards level
Condition	Situation dependent—based on supervisor's judgment re: case, context, trainee's readiness	Trainee has passed the threshold of competence and trustworthiness for an EPA at the level of licensing; clinical oversight remains in place for trainees

4. True summative entrustment decisions for EPAs require that the public (regulators, insurers, and patients) understand that physicians-in-training can be ready to bear full responsibility for specific tasks. Be an advocate for a new view on certification and licensing.

Resources

1. Hawkins RE, Welcher CM, Holmboe ES, Kirk LM, Norcini JJ, Simons KB, et al. Implementation of competency-based medical education: are we addressing the concerns and challenges? *Med Educ*. 2015;49(11):1086–1102.
2. ten Cate O. Nuts and bolts of entrustable professional activities. *J Grad Med Educ*. 2013;5(1):157–158.
3. ten Cate O. AM last page: what entrustable professional activities add to a competency-based curriculum. *Acad Med*. 2014;89(4):691.
4. ten Cate O, Hart D, Ankel F, Busari J, Englander R, Glasgow N, et al. Entrustment decision-making in clinical training. *Acad Med*. 2016;91(2):191–198.
5. Kennedy TJT, Regehr G, Baker GR, Lingard L. Point-of-care assessment of medical trainee competence for independent clinical work. *Acad Med*. 2008;83(suppl 10):89–92.
6. Warm EJ, Mathis BR, Held JD, Pai S, Tolentino J, Ashbrook L, et al. Entrustment and mapping of observable practice activities for resident assessment. *J Gen Intern Med*. 2014;29(8):1177–1182.
7. ten Cate O, Chen HC, Hoff RG, Peters H, Bok H, van der Schaaf M. Curriculum development for the workplace using entrustable professional activities (EPAs): AMEE Guide No. 99. *Med Teach*. 2015;37(11):983–1002.

Olle ten Cate, PhD, is Professor of Medical Education and Director of the Center for Research & Development of Education, University Medical Center Utrecht, the Netherlands.

Corresponding author: Olle ten Cate, PhD, University Medical Center Utrecht, PO Box 85500, 3508 GA Utrecht, the Netherlands, t.j.tencate@umcutrecht.nl