Reconciling Entrustment and Competence

We read with interest the letter by Sharma entitled "Entrustment Versus Competency—Continued Confusion."[1] As members of the Association of American Medical Colleges Core Entrustable Professional Activities (EPAs) Pilot, we empathize with his struggles in unpacking *trust*, *trustworthiness*, and *entrustment* and how these concepts apply in medical education, assessment, and supervision.[2]

Sharma asks a complex question: *What do we exactly mean by trust?*

The Core EPAs Pilot is exploring trust and entrustment on a variety of levels. Our institutions implicitly make summative entrustment decisions when we entrust our medical school graduates to do the work of an intern, much of which occurs under only indirect supervision. We entrust graduating residents to work unsupervised.

On an individual level, clinical supervisors routinely make informal or ad hoc entrustment decisions.[3] The degree of autonomy we grant a clinical trainee is directly related to judgments of his or her clinical competence and trustworthiness, which the Core EPAs Pilot has defined as demonstrating professional habits such as truthfulness, discernment, and conscientiousness.[2] We can make these judgments explicit with relatively simple and intuitive assessment tools, such as coactivity and supervisory scales.[4] We aim to consider these judgments more carefully as we compile multisource evidence to make formal institutional entrustment decisions.

While our primary goal is to explore how we can safely bestow trust on learners, the Core EPA team is also exploring the trust of all stakeholders in our assessment systems. Our pilot team has developed 1-page schematics for each of the 13 core EPAs to align curriculum development, faculty development, feedback to learners, and assessments.[5] Each schematic describes observable behaviors that might be encountered as a learner progresses along the path to entrustment in an EPA.

We do not see determination of entrustment in opposition to determination of competence. Entrustment requires the integration of multiple competencies to perform an EPA. It also involves an assessment of trustworthiness. In our opinion, trustworthiness and competence are of equal importance to the public's trust in us and our graduates.

Workplace-based assessments of competence are made by humans in real social settings, and thus are inherently subjective. We aim to make subjective workplace entrustment judgments explicit and transparent, simplifying the process of assessment for clinical supervisors. While we would be the first to agree that there is limited evidence *yet* to suggest that incorporating issues of entrustment into these assessments will enhance medical education or clinical outcomes, seeking such evidence is a major aim of our pilot.

Sharma's last question is key: *What are we trying to achieve?* Our team's goal is to ensure that our medical school graduates can be entrusted to perform the basic activities of a physician on the first day of residency. While we believe developing competencies is central to this readiness, trustworthiness in applying competencies should play an equal part. We want to be able to answer the question many program directors ask before they send their new recruits out onto the wards: "What can I entrust this resident to do?"

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