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When can You Trust a Medical Trainee with a Clinical Responsibility? How Entrustment Thinking is Affecting Clinical Training and Assessment

Abstract:

In the 1990s, Competency-based medical education was embraced in several countries and early 21st century the frameworks to describe the breadth of the medical profession in competency terms became common on national levels in many countries, known as *CanMEDS* or *ACGME* competency frameworks. Particularly for postgraduate training, professional bodies like Royal Colleges became uneasy with the model in which a fixed time in training would automatically lead to a license to practice, rather than a rigorous evaluation of the competence of the trainee. A need was felt to move from time-based to competency-based medical education. The authoritative 2010 Carnegie Report on reform in medical school and residency proposed fixed standards and flexible pathways.
While national regulators of medical training and registration of practitioners began to enforce the requirements of schools and trainees to meet these new standards, not everyone was excited. Some clinician educators and some educational scholars voiced criticism in the literature. There was a reason to translate connect competencies better to the practice of every day work in health care.

The wish to bridge this gap between well-elaborated competency frameworks and clinical practice in patient care led to the creation of *entrustable professional activities* (EPAs). EPAs are the units of professional practice that constitute the work clinicians do in daily practice. They can be conceived of the responsibilities or tasks that must be done in patient care. What is critical in medical education at the completion of training is that these activities can be executed safely. This means that the assessment of learners should be focused on the ability to carry these out. General competencies, such as adequate communication skills, professionalism and collaboration skills remain critically important and must be evaluated, but they serve to inform the key objectives of training: these professional activities.

EPAs call for a process of *entrustment of clinical tasks* related to the level of supervision that goes with is: the less supervision, the more risks there are and the higher level of competence should be required. The decision to transfer a responsibility to a learner has been called an *entrustment decision* and can have an ad-hoc or a summative nature. In a workplace curriculum built on EPAs, summative entrustment decisions constitute the permission to generally carry out an EPA when there is sufficient grounding of trust among the staff, that the learner can bear this responsibility from that moment on. Research shows that ad-hoc entrustment decisions, afforded by the here-and-now of the

situation, are influenced by many factors, to be summarized as the trust propensity of a clinical supervisor, the trustworthiness of the learner, the benefits of the decision and the risks of the decision. Multipe ad-hoc entrustment decisions with satisfactory results must eventually lead to summative entrustment decisions. Using this model, individualized EPA- and competency-based workplace curricula serve to better guarantee the graduation of learners meeting the required standards of unsupervised practice.

This plenary presentation will provide backgrounds of this thinking and will put the use of EPAs in the wider perspective of the continuum of medical education.