COMMENTARY

The Importance of Avoiding Entrustment Decisions on Entrustable Professional Activities in the Classroom Setting

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Entrustable Professional Activities (EPAs) are workplace responsibilities that directly impact patient care. The use of EPAs allows learners to be provided with feedback and assessment in the clinical setting. Because they focus assessment on the execution of professional activities with all integrated competencies needed, EPAs help provide a more holistic picture of student performance. Using the EPAs to backwards design classroom learning on those competencies is highly encouraged, but one cannot or should not assess performance and make entrustment decisions using EPAs in the classroom setting for several reasons: classroom performance usually does not predict clinical performance very well, EPAs require direct observations, EPA assessment requires multiple observations of varying patients with varying level of acuity and most importantly, EPA-focused assessment must result in entrustment decisions to perform with limited supervision. By ensuring all entrustment decisions are made in a clinical or experimental setting, students will receive an accurate assessment and benchmark of their performance to lead them one step closer to independent practitioners.

Keywords: entrustable professional activities, EPA, assessment, experiential, didactic

INTRODUCTION

In pharmacy education, an increasing number of programs are beginning to adopt or trial the use of Entrustable Professional Activities or EPAs for assessment. EPAs are workplace tasks or responsibilities that clinicians trust a trainee (eg, student pharmacist) to execute unsupervised once he or she has obtained adequate competence. As such, EPAs have the following characteristics: they are executable within a given time frame (eg, course of a residency); they are general enough to be flexible across different clinical practice settings (eg, perform procedures and implement therapies inpatient and outpatient), they are observable and measurable and therefore suited for entrustment decisions. The difference between an EPA and a more traditional learning objective or competency based outcome is that EPAs are units of work and a method to translate competencies to clinical practice, while competencies themselves are related to a learner ability. Typically, competencies are described as features that include knowledge, professional attitude, communication skill, collaboration skill, etc (Figure 1, Table 1). In essence, EPAs are future objectives as they require a practitioner to integrate multiple competencies from several varying domains including: content expertise, collaboration, communication, and management. Conversely, each competency is relevant to many different EPAs. (Figure 1). EPAs require global performance in units of professional practice in an authentic clinical setting. Assuming EPAs can be performed in the classroom setting neglects the idea that they are contributions to health care. Entrustment decision for EPAs can only happen in professional practice.

Even though EPAs were designed to determine entrustment in an authentic practice setting, it does not mean that EPAs are irrelevant for classroom education. Any curriculum preparing student pharmacists for practice can do so in the didactic setting before they assume these real responsibilities on clinical rotations. Each EPA requires competencies in knowledge, skills, attitudes, and experiences for entrustment of a clinical task. While the classroom setting is needed to acquire many of these competencies, it is important to remember the didactic learning alone is not sufficient. Using a backwards design approach, course instructors of “pre-experiential courses” can use EPAs to inform what competencies should be developed in the classroom setting and are necessary prior to experiential learning. Therefore, the classroom setting is the perfect environment for aligning competencies with subsequent experiential learning EPAs where true entrustment decisions can be made. As such, didactic courses, whether foundational science, clinical or social
While we want to thoroughly prepare our students for the experiential setting, it is important to do so using accurate and evidenced based didactic assessment. Assessing students on EPAs and making entrustment decisions in the didactic setting would be faulty and meaningless. A decision to work without supervision before a student has even entered the clinical arena would be inappropriate. Additionally, classroom performance does not necessarily predict clinical performance. A student may appear to be “competent” in a classroom setting where timelines and available resources are more favorable, but exhibit “dependence” or poor performance in the experiential setting. Most clinical preceptors can provide examples of learners who perform well on written examinations and simulated tests of clinical skills, but are far below “competent” in experiential performance. In order to be trusted to work in the clinical setting without supervision, studies show that both task-specific and general features of learners are needed. These general features include; agency, reliability, integrity, humility, and capability.

Let us look at an extreme example considering a PhD trained pharmacokineticist with 20 years of experience in research and teaching in the discipline. Despite their long history and extensive drug knowledge base and their ability to perform well didactically in drug dosing, they cannot (or should not) be entrusted with properly dosing a medication for a patient in a clinical practice setting. This is a hallmark example of the difference between didactic and experiential learning and how examination of ability to execute clinical tasks should be done in the clinical environment. Making entrustment decisions differs from standard assessment as standard assessment in the classroom does not have the direct consequences of patient care and as such serves as a proxy measure rather than an authentic workplace measure.

Since EPAs are solely workplace practices or tasks, there is an additional concern with using EPAs to assess in the didactic setting. In the classroom, we attempt to simulate the workplace or experiential environment with patient cases, simulated electronic health records or even standardized patients. However, these are not authentic workplace activities and as such do not fit within the EPA philosophy. In order for EPAs to be correctly and accurately assessed they must reflect an actual contribution on health care. One may argue that assessment using standardized patients or OSCEs is closer to experiential learning and therefore, may serve to assess readiness for EPAs. However, these simulated environments are still not completely appropriate for EPA assessment unless the required skill is rare. For example, a basic life support class can prepare the student for performing clinical tasks on emergency care when needed. The entrustment on the student's ability to perform these tasks can happen in a simulated environment as these emergency clinical situations are so rare and within the authentic environment may risk patient health. A simulated environment may be the only place to allow assessment of a proxy of the EPA of a actual resuscitation, which otherwise would not be able to be assessed. In contrast, using a simulated environment or written patient cases to provide student entrustment around counseling patients, providing recommendations or determining a pharmacotherapy assessment and plan would not be appropriate as these are all clinical tasks that can be well observed and assessed repeatedly in the live experiential setting.

Lastly, in the classroom setting, students are tasked with reading about one patient case at a time and providing an assessment and plan for this patient with static context, acuity and complexity. As a result, entrustment decisions cannot be used in this classroom setting. Entrustment decisions should instead be made after EPAs have been observed multiple times in multiple settings with varying context, acuity, and complexity and with varying patient characteristics. To further explain the implications of providing entrustment decision in varying environment consider the following scenarios:

Abbie is a fourth year student-pharmacist who recently completed her general medicine experience. During the month she was responsible for the assessment and management of 4 to 8 patients a day. Over the course of the month, the preceptor directly observed Abbie provide appropriate medication counseling to patients, provide appropriate treatment interventions to the team and appropriately document a variety of clinical encounters. For each of the above observations, Abbie has provided accurate, patient-centered and evidence-based information without unnecessary details or repetitions. She was able to accurately interpret laboratory values and key problems while communicating bidirectionally to develop the plan. Abbie’s documentation and tasks were completed in a timely fashion and contained the required elements of the practice site. The clinical documentation provided contained the problem list and plan and reflected a combination of critical thinking processes.

Billy is a third-year student pharmacist who recently completed the pharmacotherapy course. Within the course, Billy was required to provide management of approximately one patient a week. To do so, he was provided an online patient encounter that was set up in the simulated electronic health record of patients in a general medicine practice. Using this information, Billy was expected to provide patient counseling points, appropriate treatment recommendations and document all relevant information over a weeks time. During the week, and under no direct observation, Billy interacts with classmates and the instructor to help decipher the patient case and determine the appropriate recommendations while using endless online resources. For the clinical case, Billie provided accurate, patient-centered and evidence-based
information without unnecessary details or repetitions. He was able to accurately interpret laboratory values and key problems while communicating bidirectionally to develop the plan. His documentation and tasks were completed in a timely fashion and contained the required elements of the practice site. The clinical documentation provided contained the problem list and plan and reflected a combination of critical thinking processes.

When reading these two scenarios it is evident that one follows the necessary environment for EPA assessment while the other does not as EPAs are more than completing a clinical task, they must demonstrate contribution to healthcare. Using Table 1, we can see that in the experiential setting we have the opportunity for direct observation of clinical tasks and we can assess entrustment of the student in varying contexts. However, in the classroom, we have indirect observations (usually) and minimal variety, especially while the student is completing the “task” or recommendations. Additionally, it is evident that the student in the experiential setting interacts with many patients daily of varying complexity and acuity while the student in the classroom usually focuses on one patient with much less variability. While it could be argued that these classroom situations are “simulations” the evidence is clear regarding the role of simulated assessments in that these are saved for impractical or rare clinical experiences.

Ultimately, an entrustment decision means the supervising clinician is putting their license on the line in stating a student is ready for unsupervised practice and there is no way this could (or should) occur in a pure classroom setting. The decision to endorse the highest level of entrustment happens after repeated daily observation of the student or learner in the practice setting. This repeated observation is what allows the supervising clinician to feel as though they can confidently leave the learner in the practice site under supervision without putting patients or other practitioners at risk. While there are varying scales for clinical supervisors to determine how much help or supervision a student needs for a specific activity, none of them involve providing this entrustment decision in the classroom.

CONCLUSION

Entrustable professional activities are contributions to health care and entrustment decisions which serve to allow learners to start making these contributions. A decision to entrust a trainee with an EPA therefore only happens in a clinical setting after multiple observations. As a result, there are a few exceptions to the rule that entrustment decisions can only be made in a live clinical setting. However, a decision that the learner is ready for indirect supervision to execute will rarely happen outside the workplace.

The use of EPAs allows students and learners to be provided with feedback and assessment in the workplace or clinical setting. EPAs help provide a more holistic picture of student performance. While using the EPAs to backwards design classroom competencies is highly encouraged, one cannot or should not assess performance using EPAs in the classroom setting as: classroom performance does not predict clinical performance, EPAs require direct observations, and EPA assessment requires multiple observations of varying patients with varying level of acuity. By ensuring all entrustment decisions are made in a clinical or experimental setting students will receive an accurate assessment and benchmark of their performance to lead them one step closer to independent practitioners.
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Table 1. Summary of EPA Assessment in Experiential Environment vs Classroom Environment. 17

| Entrustment decisions based on... | Abbie (Experiential) | Billy (Classroom) | Explanation |
|----------------------------------|----------------------|-------------------|-------------|
| Direct observation               | Yes                  | No                | A preceptor can observe the process of Abbie interacting with the patient and treatment team with subsequent assessment of written or verbal recommendation. However, in the classroom, Billy will not be observed while he completes his pharmacotherapy consult note over the course of a week and he may have done so with additional help or resources. |
| Observed in multiple clinical settings | Yes                  | No                | Abbie completed her Advanced Pharmacy Practice Experiences in a variety of settings including the intensive care unit and ambulatory care clinic and therefore was able to be observed in multiple settings. However, Billy was only observed in the classroom setting while completing case notes around different pharmacotherapy topics |
| Varying Context, acuity, complexity and varying patient characteristics | Yes                  | Maybe             | During her Internal Medicine rotation, Abbie worked with multiple patients of different complexities and acuities and subsequently modified her treatment plans based on varying patient characteristics. However, Billy read about one patient characteristic with one level of acuity which lacked varying context. |
Independence/Unsupervised

Yes  No

During rotations Abbie can demonstrate independence in the experiential setting as she is able to be left alone while she educates a patient or provides a recommendation to the treatment team. However, Billy cannot demonstrate independence as there was no direct observation confirming the level of entrustment and it is unknown what resources were used to make his clinical decision.
Figure 1. Comparison of EPA and learning objectives.  

| Competency / Learning Objective | EPA       |
|---------------------------------|-----------|
| Context                         | Classroom |
| Represents                      | Workplace |
| Assessment                      | Traditional (exams, etc) |
| History                         | Supervision of activities |
|                                  | New and intended for residency-to-practice transition |