There has been a growing interest in the development of Entrustable Professional Activities (EPAs) for entry-level health professional education, as demonstrated by Bramley et al’s scoping review on this issue. EPAs are a specific type of competency-based education (CBE), which describe discrete activities that can be entrusted to early health professionals, are essential to the profession, and encapsulate one or more core competencies. The purpose of EPAs are to formalise decisions of entrustment or responsibility and to allow supervisors to justify the safe delegation of an activity to a learner.

EPAs must be supported by evidence that they constitute meaningful descriptions of the activities performed by the early health professional.

First and foremost, EPAs must be supported by evidence that they constitute meaningful descriptions of the activities performed by the early health professional. Unfortunately, this has been identified as a weakness for some EPAs despite there being a wide variety of

...
methods reported for doing so (eg surveys to assess whether the EPAs are an accurate reflection of work activities,\textsuperscript{4,5} review of entry-level job descriptions\textsuperscript{10}). At their heart, EPAs provide a stimulus for work analysis that can help identify and define the tasks performed by early health professionals.\textsuperscript{3} Human factors engineering, occupational psychology or systems engineering might, therefore, provide important guidance regarding the most appropriate strategy for performing job analysis that is properly work-oriented and breaks trainees’ roles down into its constituent parts (eg through cognitive task analysis, hierarchical task analysis, or other strategies that are well-established in these disciplines).\textsuperscript{5}

There is much more we need to understand regarding how EPAs should be implemented in relation to assessment processes and the curriculum more generally.

Second, it is important to note that descriptions of the use of EPAs for assessment show substantial variability in terms of quality.\textsuperscript{5} Approaches to the assessment of EPAs that have been identified to have particular potential include the use of simulation and portfolios with their constituent opportunities to improve reliability relative to workplace-based tools and to offer a longitudinal and developmentally appropriate strategy.\textsuperscript{6,11,12} However, there is a need for much more research to provide guidance regarding how such tools can be used effectively as a means of addressing whether the appropriate level of entrustability has been achieved for each EPA. Doing so will include a consideration of the feasibility of these assessments being carried out by busy clinical supervisors. Effective assessment of EPAs is likely to require a suitable information technology infrastructure to store longitudinal performance data, but how to incorporate that into busy professional lives has yet to be determined.\textsuperscript{11}

For all the benefits that EPAs might bring, they are unlikely to be widely adopted or implemented as intended if the costs, to busy clinicians in terms of time and to programmes in terms of dollars, outweigh their benefits.

Once an appropriate focus and method for EPA assessment have been established, there is a need for a better understanding of EPA implementation issues more broadly. We would advocate the utilisation of the APEASE criteria to assess any implementation: affordability, practicability, effectiveness and cost-effectiveness, acceptability, side-effects/safety and equity.\textsuperscript{13} Affordability is also a key consideration. For all the benefits that EPAs might bring, they are unlikely to be widely adopted or implemented as intended if the costs, to busy clinicians in terms of time and to programmes in terms of dollars, outweigh their benefits.

Future research is now needed to consider how to move from developing EPAs to their optimal implementation for training and assessment.

In sum, while the growing research on EPAs is evidence of the desire in medical education to improve the training of early health professionals, changes to working conditions such as the European Working Time Directive indicate that training programmes must become more efficient. Whether EPAs help or hinder in this regard, relative to what has been done in the past remains to be seen. EPAs have great potential to improve the efficiency of training of early health care professionals and ensure that they perform only the activities they have been deemed safe to perform. Future research is now needed to consider how to move from developing EPAs to their optimal implementation for training and assessment.

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Many participants also described feelings of isolation, loneliness, doubt and, initially, incompetence. Interestingly, none had reported having had an opportunity to debrief from their experiences.¹

The paper on ‘contextual competence’ by Teunissen and colleagues, in this issue, illuminates some dark corners of residents’ experience adapting to new practice contexts. The authors are explicit about the emotional connection co-author Dr Joanna Bates felt when participants described their difficulties and named the model in honour of her work in distributed medical education and its scholarly contributions to understanding the role of context. The model describes different trajectories residents follow to adapt and develop competency in new learning situations and highlights the limits of productive struggle. The authors discuss the need for educators to engage in reflective practice and to make orientation and debriefing opportunities available to learners. These teaching responsibilities may seem obvious but can be overlooked. There are important takeaways for distance educators from this study.

As we reflect on the import of this research, however, we ask what more it can teach us about the role educators should play in the development of competence in all contexts. How is contextual competence a matter of collective responsibility? This question reflects our positionality as researchers of learner experience in medical education and as teachers in other disciplines. In this commentary, we aim to extend ‘Bates’ Hierarchy of Contextual Competence’ by putting the findings that led to it into conversation with theories of situated learning, self-determination and capability. These theories tell us more about creating the conditions for contextual competence.

How is contextual competence a matter of collective responsibility?

1 | SITUATED LEARNING THEORY: COLLECTIVE COMPETENCE

Lave and Wenger’s situated learning theory is based on extensive ethnographic studies in practice-based learning.² One of the lessons this work produced is that competency in a community of practice...