Entrustability of professional activities and competency-based training

Olle ten Cate

The idea of competency-based training (CBT) seems to have entered medical education with a speed and impact that has outperformed problem-based learning in the 1980s and 1990s. Within less than 10 years, the CanMEDS competencies in Canada, the ACGME competencies in the United States and similar frameworks in other countries have been introduced for postgraduate medical training countrywide, and examples of competency-based undergraduate medical training have now begun to emerge. The growing number and impact of medical education journals and medical education conferences have helped in the spread of what could almost be called a ‘competencies hype’. It is likely that 2000–10 will be remembered as the decade of CBT in medical education. Competency-based training could remain in our memories as a lasting change that really advanced medical training.

However, if we do not want to end up 10 years from now with the conclusion that a ‘competency’ was essentially nothing but a label, replacing what we conveniently used to call ‘educational objective’, it will now be necessary to specify its definition and translate it into daily practice. Signs of confusion about the concept of competency are already visible in the literature from fields other than medical education. The way in which we succeed in defining competencies, implement competency-based education and – most crucially – assess competencies will be critical.

Competencies can be operationalised and assessed by linking them with professional activities. When this is conducted clearly, disputes about the value of competencies may disappear and trainees, supervisors and the public could begin to know precisely what a competent physician can and cannot perform. Bearing in mind the seven attributes

Correspondence: Professor Olle ten Cate, School of Medical Sciences, University Medical Centre Utrecht, 3508 GA, the Netherlands. Tel: +31 30 2507010; Fax: +31 30 2538200; E-mail: t.j.tencate@umcutrecht.nl
of competencies stated earlier, the daily routine of the medical profession in a speciality can be analysed to identify activities to be entrusted to trainees. These can then be used to infer a threshold competence. Supervisors can match a trainee with EPAs and decide which could and could not be entrusted to them. ‘EPA’ needs some further clarification. Many daily activities do not require particular training, some may not be measurable, others are not linked specifically to the profession. It is therefore valuable to specify the attributes of EPAs. They:

1. are part of essential professional work in a given context;
2. must require adequate knowledge, skill and attitude, generally acquired through training;
3. must lead to recognised output of professional labour;
4. should usually be confined to qualified personnel;
5. should be independently executable;
6. should be executable within a time frame;
7. should be observable and measurable in their process and their outcome, leading to a conclusion (‘well done’ or ‘not well done’); and
8. should reflect one or more of the competencies to be acquired.

It is not difficult to think of examples: performing a vena puncture, performing an appendectomy, giving a morning report after a night call, designing a therapy protocol, chairing a multidisciplinary meeting, requesting an organ donation, and so on. In these examples, a supervisor would not trust un-trained personnel to take responsibility. EPAs have a holistic nature. They include knowledge, attitude and skill. Performing a sternum puncture requires that a resident has the knowledge and skill to perform the procedure, can explain to a patient why it is necessary, collaborate with a nurse and organise all the required conditions to be met. Current competency frameworks such as the CanMEDS roles or ACGME competencies show distinctions between these abilities. EPAs and competency frameworks, therefore, can be viewed as interrelated in a matrix. Performing a sternum puncture requires competence in such roles as medical expert, communicator, collaborator and manager. Conversely, being a skilled communicator can be inferred from observing different EPAs, showing communication with patients, family, colleagues, nursing staff, and so on.

Performing well could be defined as being trusted to carry out critical EPAs.

If programmes really move towards observing and qualifying the competence of individual candidates for critical professional activities, instead of assuming competence at the end of a predetermined training period, a paradigm shift will occur. Medical training could then change from fixed-length variable-outcome programmes to fixed-outcome variable-length programmes.

REFERENCES

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