Entrustable Professional Activities (EPAs) for clerks in Surgery.

These summaries describing the various EPAs can be used to formulate entrustability decisions and feedback comments on the clinic card. A student can be assessed on an entire EPA or one bullet only as long as associated written feedback linked to that EPA/bullet is given. Each student will receive numerous clinic cards on each EPA as they progress through clerkship.

EPA 1 - Gather a history (H) and perform a physical examination (P)

Pre-Entrustable

- H: errors of omission
- H: limited ability to systematically filter/prioritize/connect information
- H: limited integration of knowledge/pattern recognition results in slow/linear reasoning
- H/P: Decisions based on intuition, not evidence/understanding
- H/P: Patient-centered method inconsistent, may generalize
- P: skills – technique poor/ key findings missed

Entrustable

- H: Accurate focused /complete hx from patient/collateral when required
- H/P: Can activate prior foundational knowledge
- H/P: Uses analytical reasoning and/or prior clinical experiences as guide
- H/P: Consistently patient-centered /listens and talks
- H/P: Professional (even under conditions of stress or fatigue)
- P: Accurately identifies/documents/describes abnormal findings
- P: Knows limitations and when to ask for help

EPA 2 – Prioritize a differential diagnosis (DD) following a clinical encounter

Pre-Entrustable

- Largely rigid template approach associating symptoms and signs with diagnosis
- DD too broad/narrow or inaccurate
- Integration of new information/evidence with basic medical knowledge to update DD limited
- Overly reliant on supervisors/team for DD and Mx plan
- May create /carry out a Mx plan without verifying with supervisor
- Not able to recognize own limitations or seek help in Mx or communicating ambiguity and uncertainty

Entrustable

- Regularly gathers, updates and links current findings to prior clinical encounters to develop DD
- Is able to avoid most errors of clinical reasoning eg. premature closure.
- Management plan usually cohesive and tailored to prioritized DD
- Has understanding of own limitations, knowing when to ask for help/verification
- Comfortable with some ambiguity, able to respond to questions from team (including pt/family) professionally even when answer is uncertain
- Documentation demonstrates evidence of clinical reasoning
EPA 3 - Recommend and interpret common diagnostic and screening tests

Pre-Entrustable

- Recommends standard set of investigations but not prioritize to specific pt
- Rationale for recommendations not always explained
- Engagement of the health team in shared decision making limited
- Misinterprets minor abnormal test results
- Misses important/urgent abnormal results

Entrustable

- Recommends initial investigations targeted to working diagnosis
- Gives rationale if asked eg. pre test/post test probabilities for each investigation
- Engages healthcare team in shared decision making
- Methodically reviews and interprets each test result
- Correctly interprets cause and urgency of abnormal results
- Asks for help interpreting results when needed
- Notices and attempts to interpret unexpected results

EPA 6 – Provide an oral presentation of an encounter

Pre-Entrustable

- Follows rigid template not tailored to audience/specific pt
- Not concise/organized around primary problem
- Unable to present uncertainty – becomes defensive or confabulates
- Fails to retrieve requested information
- Over/under confident – fails to incorporate teams recommendations in real time
- Does not conclude by summarizing agreed upon plan to all team members

Entrustable

- Skilled communicator, adjusts for receiver and context
- Involves healthcare team
- Difficult, stressful or uncertain issues not shied away from
- Assistance/additional information sought when appropriate
- Communicates bidirectionally, ensures shared understanding, avoids unnecessary medical jargon
- Accurate, concise, prioritized and organized
- Sensitive to privacy and confidentiality concerns

EPA 7 – Form clinical questions and retrieve evidence to advance patient care

Pre-Entrustable

- Uses linear thinking focused on one patient, less aware of population trends
- Jumps to conclusions too early
- Less aware of own knowledge limitations
- Unable to advance beyond knowledge to higher level questions/problem solving
- Retrieval/appraisal of evidence skills limited
- Communication of new findings/ translating them into specific pt care limited
Entrustable

- Identifies knowledge or information gaps in patient care/needs routinely
- Clinical questions based on real time clinical scenarios.
- Identifies appropriate evidence to answer questions
- Appraises information and assesses applicability to pt care
- Uses information technology appropriately
- Communicates information and “closes the loop” to improve patient care

EPA 10 – Recognize a patient requiring urgent or emergent care and initiate evaluation and management

Pre-Entrustable

- Dismissal of other team members’ concerns/delay in asking for help due to minimal insight into personal limitations
- Difficulty gathering, filtering, prioritizing and communicating critical data
- Gaps in knowledge or application thereof make anticipating next steps difficult
- Fails to note variations in vital signs that may occur with age or disease states
- Inconsistently orders tests/interprets results delaying reassessment/further mx
- Difficulty initiating a code within a particular health care system
- Communicates unidirectionally as opposed to seeking health care team input.
- Documentation of urgent interventions my not be accurate

Entrustable

- Has insight into personal limitations and seeks help appropriately
- Uses information from credible sources to aid in decision making
- Gathers, filters, prioritizes information eg. vitals, focused H/P, recent tests, meds.
- Forms focused differential diagnosis
- Initiates interventions and drives early testing decisions to stabilize patient
- Anticipates next steps in care
- Communicates to and interacts effectively with team (including pt and family)
- Seeks guidance and feedback from the team to improve future patient care

EPA 11 – Obtain informed consent for tests and/or procedures

Pre-Entrustable

- Waits for others to direct them to obtain consent
- Documentation often not fully completed
- Indications/contraindications/risks/benefits/alternatives not understood
- Discussion one sided using medical jargon poorly understood by pt
- Opportunity for pt to voice preferences or questions not given
- Lacks understanding to answer questions or recognize emotional cues of pt

Entrustable

- Importance of this process in the pt –physician trust relationship understood
- Indications/contraindications/risks/benefits/alternatives understood
- Bidirectional interaction with pt/family including shared decision making.
- Medical jargon not used
- Patients’ level of understanding and preferences explored and respected.
- Emotional cues from pt/family appreciated and addressed.
EPA 12 – Perform general procedures of a physician

Pre-Entrustable

- Mechanical approach, no understanding of anatomy/physiology/context
- Medical jargon use limits pts understanding of why/what is being done
- Confidence in answering questions/doing procedure lacking
- Overly confident = potential harm to patient
- Inconsistent skills = unable to reliably complete procedure.
- Intense focus does not allow for awareness of pt responses eg. pain/fear
- Documentation may be incomplete

Entrustable

- Good understanding of anatomy/physiology/context
- Medical jargon avoided and allows pt to verbalize understanding
- Complications and how to mitigate them recognized
- Level of confidence in knowledge and skills appropriate
- Skills consistent and reliable most of the time, knows how/when to get help
- Attention to procedure and patients emotional responses simultaneous
- Documentation complete and timely

EPA 13 – Identify systems failures and contribute to a culture of safety and improvement

Pre-Entrustable

- Systems that prevent/recognize errors (real/potential) not recognized
- Common safety behaviors eg. hand washing still need prompting
- Systems level consequences of lack of common safety behaviors/single error not understood.
- Passive team member, no self ID of safety risks/errors (real/potential)
- Defensive/blames others or system when asked re role in error (real/potential)
- Workarounds used to ease personal burden/ avoid disclosing errors (real/potential) with no system improvement for others
- Fatigue not always recognized/consequences of disclosure feared thus increasing risk

Entrustable

- Systems understood enough to identify and understand implications of errors
- Performs common safety behaviours eg. handwashing with rare lapses
- Actively reflects/takes responsibility for his/her role in errors (real or potential)
- Works with team members to identify causes and implement solutions.
- Almost always reports errors (real or potential) when identified
- Fatigue recognized and behavior modified/ help sought prn limiting risk