WMed Preceptor Guidebook

Updated November 2022

Preface

The WMed Preceptor Guidebook serves to establish standards to assure a comparable experience for all students during each clerkship. Included you will find learner, educator, and staff member expectations as well as helpful references to the Medical Student and Faculty Handbooks. Recommendations are provided to facilitate preparation for the arrival of medical students in both inpatient and ambulatory settings.

Descriptions of the characteristics of excellent teachers are provided to assist faculty in reflecting upon their key roles in medical student education. Guidelines for student assessment are also included to facilitate consistency in observing, assessing, providing feedback, and documenting student performance.

Our goal is to provide a useful guidebook for all teaching physicians. Please direct your feedback regarding this guidebook to Clerkship Directors, the Assistant Dean for Clinical Applications, and/or the Assistant Dean for Clinical Competency and IPE. With our new digital format, we aim to continuously improve this guide to best serve your needs.

Thank you for your commitment to our medical students as you provide outstanding care to the patients you serve.

Sincerely,
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Additional Resources

WMed Faculty Portal

WMed Library

WMed Policies, Handbooks, Manuals, and Statements

Clinical Teaching Etiquette
Detsky AS. The Art of Pimping. *JAMA*. 2009;301:1379-1381.

The learning environment in remediation: a review
Cleland J, Cilliers F, van Schalkwyk S. The learning environment in remediation: a review. Clin Teach. 2018 Feb;15(1):13-18. doi: 10.1111/tct.12739. Epub 2017 Dec 20. PMID: 29266811.

One-minute Preceptor Model
The one-minute preceptor model: A systematic review
Gatewood E, De Gagne J. The one-minute preceptor model: A systematic review. Journal of the American Association of Nurse Practitioners. 2019; 31 (1): 46-57. doi: 10.1097/JXX.0000000000000099.

The One Minute Preceptor: Shaping the Teaching Conversation
Neher JO, Stevens NG. *Family medicine*. 2003;35:391.

Take 5: One Minute Preceptor, Mayo Clinic ***OR*** One Minute Preceptor, Matthew Eberly

Domains of Competency
Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a Common Taxonomy of Competency Domains for the Health Professions and Competencies for Physicians. *Academic Medicine*. 2013; 88:1088-1094.

Family Education Rights & Privacy Act

WMed complies fully with the Family Educational Rights and Privacy Act (FERPA) of 1974, a federal law governing the privacy of students' education records. The medical school takes seriously its commitment to protect the privacy of our students and their education records.

The FERPA definition of education records includes all of the information and records in any format that are used by the medical school in the instruction and evaluation of students. Education records include any information or documentation that is recorded in any way, including records produced by handwriting, computer, email, audio, and video, among others. Education records contain information directly related to a student, and may be maintained by the medical school or any party acting on its behalf.

FERPA protects the privacy of students' education records by setting forth strict instructions and limitations governing the release of information about students. All WMed faculty, residents, and staff are responsible for protecting the educational records in our possession.

For more information regarding FERPA, please review the Student Policy Manual. Specific questions about FERPA should be directed to the registrar.

Verifying a Student's Identity

In maintaining FERPA compliance, when speaking to students on the phone regarding their grades, academic performance, or any part of their educational record, WMed faculty, residents, and staff must verify the students' identity before the conversation begins. Students' identity may be verified by:

- Asking for and verifying their Student Identification number.
- Asking a specific question you can both answer that allows you to identify the student. An example is: "What is the name of the clinic where we last rounded together?"

When in doubt, or if you're unable to verify the student's identity, do not release confidential information. Face to face conversations or email through WMed's secure server are the preferred method of communicating sensitive information to a student.

Clerkship Attendance

Students are expected to be present for all components of each clerkship. You or your office staff should be notified of assigned students 1-2 weeks before the start of each rotation block. Personal activities such as weddings should be conducted during scheduled off days. Requests for scheduled absences (including religious observances and student presentations at professional conferences) are to be submitted at least 2 weeks prior to the first day of the course/clerkship in which the planned absence will occur. If permission for an absence is granted, it is the student's responsibility to notify his or her clinical preceptor.

Illness or other unplanned personal events may necessitate absence. The supervising attending/senior resident, clerkship coordinator, and the clerkship director must be notified immediately. Students who are ill are expected to seek appropriate medical care and provide documentation. While all requests are subject to approval of the clerkship director, examples of acceptable unplanned absences include death of a close family member or serious illness/hospitalization of yourself or a close family member.

Students should maintain personal wellness activities including access to healthcare during clinical rotations. **Students will never be denied an absence for physical or mental health appointments**. Students should submit a planned absence form, which is then managed by the clerkship coordinator and clerkship director to ensure release from clinical responsibilities. On inpatient rotations, afternoons are a better time to schedule appointments when possible.

Students must successfully demonstrate all clerkship objectives. Students must attend all scheduled didactic and assessment activities. If a student misses any mandatory session(s), they must be remediated by the end of that week. Remediation of missed days within allotted limits may or may not require additional clinical experiences. Absences beyond designated limits will typically require additional clinical time. All remediation decisions are at the discretion of the clerkship director. Students will receive a grade of incomplete until all remediation is complete.

Core Clinical

- Students are allowed up to three excused absences in a core clerkship that must be remediated by the end of the rotation.

Advanced Clinical

- In a 2-week rotation, students are allowed one excused absence, which must be remediated by the end of the clerkship.
- In a 4-week rotation, students are allowed up to 4 half-days (2 full days) excused absences, which must be remediated by the end of the clerkship.

Electronic Health Record and Student Documentation

Definitions:

Designated Record Set

"Designated record set" as used in this policy has the meaning as defined in the HIPAA Privacy Rule, 45 C.F.R. & 164.501, as "The medical records and billing records about individuals maintained by or for a covered health care provider… that is used, in whole or in part, by or for the covered entity to make decisions about individuals."

Authorized Attending Physician

An "authorized attending physician" is a licensed physician who is a member of the WMed faculty who has been approved by WMed to supervise the education, training and clinical practice of the medical students and resident physicians enrolled in undergraduate and graduate medical education programs at WMed.

[Note: For the purpose of this policy the term "valid progress note" is synonymous with the term "personal note" as it is used in CMS Manual System Publication 100-04, Medicare Claims Processing; Transmittal 2303; Change Request: 7378 dates September 14, 2011.]

Valid Progress Note

A "valid progress note" is a progress note created in an electronic health record system (EHR) associated with a specific patient encounter that is locked and signed by an authorized attending physician using the electronic signature technology of the EHR and that, in the professional opinion of the attending physician who locked and signed the note, adequately and accurately documents the patient encounter for all relevant medical, legal, and billing purposes.

A valid progress note is presumed to be reviewed and approved as complete and accurate by the attending physician who signs and locks the note. Once he or she signs and locks the note, the attending physician takes ownership of all the information contained in the note and is responsible for any and all errors and omission in the note, regardless of the means by which the information was created in the note, unless the errors and omissions are due to a technical malfunction, data entry error, or other outside process over which the physician has no control AND such errors and omissions could not be detected by careful review by a competent licensed profe4ssional. A progress notes that meets this definition is valid regardless of the specific methodologies, technologies or workflows used to create the note.

Creation of a progress note in the EHR:

A valid progress note can be created by the attending physician in the EHR using a variety of methodologies, technologies, and workflows, including, but not limited to: typing directly into the note; adding pre-built templates; structured data, or macro-generated text into the note; electronically pasting or merging text or data from other relevant documents generated by the attending physician or other clinician; and merging or downloading data from devices such as blood pressure cuffs, EKGs, and spirometers.

Sections of the note may also be created by medical students, residents, nurses, physician assistants, therapists, social workers, and other authorized individuals provide the contribution of each individual can be clearly identified as to content and time of entry.

The progress note becomes a valid progress note when, after performing the necessary review, and completing any required modifications or revisions, and after adding the appropriate attestation language for services rendered by a resident, the attending physician locks and signs the note.

Medical student documentation in the progress note:

Learning how to document patient care in the medical record is an essential part of the education of medical students. Medical students should learn to provide complete and comprehensive patient documentation that includes all relevant aspects of the medical history, physical examination, laboratory findings, medical decision making and treatment plan in the patient's medical record. Medical students should learn and refine their documentation skills in a clinic environment using all available health information technology tool, wherever and whenever possible.

Medical students may enter information directly in an unlocked and unsigned attending physician's note provide appropriate audit, logging, and tracking tools are in place to identify the author of each entry as well as the date and time of the entry.

Medical students may participate in different parts of a patient encounter and document in the appropriate section of the note as follows:

- Medical students may take and document past family and social history (PFSH) without teaching physician being present.
- Medical students may conduct and document a review of systems (ROS) without the teaching physician being present.
- Medical students may conduct and document an HPI. The teaching physician must verify the HPI, review any student documentation of the HPI, and correct, edit, or revise the documentation as needed to reflect the findings of the teaching physician.
- Medical students may perform and document an examination. The teaching physician must also perform the examination and correct, edit or revise the documentation as needed to reflect the findings of the teaching physician.

Medical students may also create a separate medical student note to document patient encounters.

Use of medical student note by attending physicians in the creation of a progress note:

Text and other information created by the medical student in a separate medical student note is not part of the designated record set of the patient medical record. The text and other information created by the medical student only becomes part of the designated record set of the medical record when it is actively selected for inclusion in a valid progress note by an authorized provider and subsequently reviewed, edited, or modified as needed and then locked by the authorized attending physician.

With the exception of a review of systems (ROS) and the recording of the past, family, and/or social history (PFSH) of the patient, any contribution and participation of a medical student to the performance of a billable service must be performed in the physical presence of an attending physician. Any documentation of such service by a medical student in a medical student note may then be used by an attending physician in the creation of a progress note. The attending physician may document the relevant information from the medical student note into the valid progress note. Documentation can be performed using all available documentation tools of the EHR, including copy forward, and copy/paste features, provided that the EHR has the capability to log all actions that went into constructing the note and that the log clearly identifies the author of each entry, modification, edit, or other activity.

A review of systems (ROS) and the recording of the past, family, and/or social history (PFSH) of the patient may be performed by a medical student without an attending physician being physically present. Any documentation of these services created by a medical student may also be used in the creation of a progress note.

General Guidelines for Medical Student Use of Electronic Health Record Systems During Clerkship:

Purpose of these Guidelines:

Learning how to use an electronic health record (EHR) is an important part of the education and training of medical students. Medical students should be trained to use an EHR early in their medical school education and should make full use of the EHR during clerkship.

The Alliance for Clinical Education (ACE) has developed best practices recommendations for medical student use of EHR. These best practices specify that the medical student should learn to:

- Search for data within the EHR
- Review patient care protocols
- Find and use disease specific templates, reminders and decision support tools
- Enter data into the appropriate fields in the EHR
- Review screening and prevention recommendations for a given patient, bringing these to the attention of the supervising physician if needed
- Become familiar with and use associated EHR functionality for:
    - Selection of diagnoses, CPT/ICD-10 codes, and how these are linked to billing
    - Order entry, including linked diagnoses to tests
    - E-prescribing
    - Capturing Patient Centered Medical Home and other quality metrics
    - Capturing "Meaningful Use" metrics
    - Running queries that practices use for population management

Workflow required for complying with CMS rules regarding student documentation in the medical record:

CMS permits medical students to document in the medical record of a patient. CMS rules specify the following:

- Med students may take and document past family and social history (PFSH) without teaching physician being present.
- Med students may conduct and document a review of systems (ROS) without the teaching physician being present.
- Med students may take and document an HPI. The teaching physician must verify the PHI, review any student documentation of the HPI, and correct, edit, or revise the documentation as needed to reflect the findings of the teaching physician.
- Medical students may perform and document an examination. The teaching physician must also perform the examination and correct, edit or revise the documentation as needed to reflect the findings of the teaching physician.

Roles and Responsibilities

Medical Students:

- Understand and comply with the policy "MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD".
- Understand his or her role on the team
- Use his or her log-in when entering information in the EHR
- Enter documentation as required on a timely basis
- Proactively seek guidance/assistance if unsure about how to use the EHR
- Alert the teaching physician to any documentation needing review by the teaching physician
- Report any mistakes, missteps or other errors made in using EHR

Teaching Physician:

- Understand and comply with the policy "MEDICAL STUDENT DOCUMENTATION IN THE ELECTRONIC HEALTH RECORD"
- Explain to the medical student his or her role on the treatment team
- Verify, re-perform, review, edit, correct, confirm, and otherwise validate all work performed by the medical student, as well as the associated documentation created by the medical student when such documentation is included as part of the patient record
- Provide meaningful feedback to the medical student that helps him or her improve their use of the HER

Technology Requirements

In order to implement workflows and processes that support medical students' full use of an EHR, the EHR technology should have features that:

- Provide a clear audit trail or tracking mechanism so that it can be determined who authored/edited all entries in a note or other documentation and what each user did
- Prevent medical students from performing actions that are not within their permitted scope of practice (e.g. locking and signing a progress note, sending an electronic prescription to a pharmacy, authorizing an order for a diagnostic test, etc.)
- Alert teaching physician when something is pending that needs to be reviewed, signed or authorized

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Frequently Asked Questions – Medical Student Documentation Guidance

On February 2, 2018, the Centers for Medicare and Medicaid Services (CMS) released new guidance relaxing Evaluation and Management (E/M) documentation requirements for documentation created by medical students participating in a billable service. This policy change was identified by the CMS Documentation Requirement Simplification workgroup and is part of a broader goal to reduce administrative burden on practitioners.

1. **Question:** What is the definition of a medical student?

   Answer: A medical student is an individual who participates in an accredited program that is not an approved Graduate Medical Education (GME) program. A medical student is never considered to be an intern or a resident.

2. **Question:** What changed with the latest CMS update?

   Answer: *A teaching physician may now verify in the medical record any student documentation of components of E/M services, rather than re-documenting the work.* Prior to this change, the teaching physician could only refer to the medical student's documentation related to review of systems and/or past/family /social history, which are not separately billable, but are taken as part of an E/M service. The teaching physician was required to re-document history of present illness, physical examination and medical decision-making activities of the service.

3. **Question:** How can a teaching physician "verify" student documentation?

   Answer: WMed's Clinical Enterprise Integrity and Legal departments have approved the following attestation that may be added to the E/M documentation by the teaching physician verifying the student's documentation: *"A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the student and made modifications to such information, when appropriate."*

4. **Question:** Can I create a dot phrase for this attestation?

   Answer: Yes, you may create a dot phrase.

5. **Question:** Can a resident "verify" the student documentation?

   Answer: The resident may not verify the student documentation on behalf of the teaching physician, but the resident may edit the student's documentation and provide additional documentation related to the service. Ultimately, the verification is the responsibility of the teaching physician.

6. **Question:** Can I combine attestations/verification in one statement when the service involves both a medical student AND a resident?

   Answer: Yes, you can combine attestations. WMED's Clinical Enterprise Integrity and Legal departments have approved the following attestation that may be added to the E/M documentation by the teaching physician verifying both the resident's and student's documentation:

   "A student assisted with documenting this service. I saw the patient and reviewed and verified all information documented by the medical student and resident, and made modifications to such information, when appropriate."

7. **Question:** The guidance states that any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or physical presence of a resident. Is that a new requirement?

   Answer: This is not new. CMS has always required physical presence with the student participating in patient care other than the review of systems and/or past/family/social history. If your student workflow does not currently abide by this physical presence requirement, you should contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

8. **Question:** The guidance states that the teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed. Is that a new requirement?

   Answer: This is not new. CMS has always required that the teaching physician perform the physical examination and medical decision-making activities of the service. If your student workflow does not currently abide by this personal performance requirement, you should contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

9. **Question:** What about procedures? Does this guidance apply to procedures with student participation?

   Answer: This guidance is for E/M only, not procedures. WMED's Clinical Enterprise Integrity department is currently drafting internal guidance on how to compliantly involve medical students in procedures and how to document procedures for billable services. Guidance will be forthcoming in the next couple of months. If you require advice on procedures and student involvement, you may contact the Clinical Enterprise Integrity department for a compliance assessment.

10. **Question:** Can we apply the new student guidelines and attestation to other students (i.e. NP student or PA student)?

    Answer: Yes, this may be applicable to other types of students who are involved in E/M services using the approved attestation. Please contact the Clinical Enterprise Integrity department to evaluate the workflow for compliance.

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Assessment of Medical Students

Introduction for Completing Clinical Assessments

WMed uses Entrustable Professional Activities for Entering Residency (EPAs) as the guiding principle for assessing student performance in clerkships. The 13 EPAs represent the fundamental knowledge graduating medical students should have and the skills they should be able to perform without direct supervision on Day One of their residency education. The EPAs are further broken down into **Key Functions**, which are critical to the performance of the skill set.

The **13 EPAs** are:

1. Gather history, perform physical examination
2. Prioritize differential diagnosis from clinical encounter
3. Recommend and interpret common diagnostic and screening tests
4. Enter and discuss orders and prescriptions
5. Document a clinical encounter in the patient record
6. Provide oral presentation of a clinical encounter
7. Form clinical questions and retrieve evidence to advance patient care
8. Give or Receive a patient handover to responsibly transition care
9. Collaborate as a team member of an inter-professional team
10. Recognize a patient requiring urgent/emergent care and initiate evaluation & management.
11. Obtain informed consent for tests/procedure
12. Perform general procedures of a physician
13. Identify system failures and contribute to a culture of safety and improvement

Schematics for each EPA and key function may be found as part of the AAMC EPA Project website, https://www.aamc.org/initiatives/coreepas/publicationsandpresentations. To view the PDFs of each EPA, you may also go to Appendix 1.

Your clerkship director can review the specific form that you will be using in your department.

The responsibility of the preceptor during **core clerkships** (year 3) is to assess the developmental progression toward entrustment for the students on their service. Faculty ratings should be based on your observation of the student's level of performance at the end of their time with you. The scale is developmental, with the far right column ready for independent performance as an intern. Core clerkships target reporter and interpreter skills that are observable by the preceptors in that particular clinical setting. It is important you become familiar with the key functions that are to be assessed for your students.

In addition to rating the performance of EPAs, preceptors are asked to rate the frequency with which you consistently observed students practice the foundational competencies required for entrustment: truthfulness, conscientiousness and discernment. Finally, and most importantly, preceptors are asked to provide narrative feedback to students on their clinical performance and next steps for future growth and development.

Advanced Required Clerkships (year 4) will be assessed on a broader number of key functions as students begin to take more responsibility and ownership of patient management and education. While our goal is to have as many EPAs assessed in the clinical setting as possible, we recognize there will be some that will require simulation or other forms of assessment.

Elective Clinical Clerkship assessments will focus on Foundational Competencies and narrative feedback. Elective Non-Clinical Clerkships will include additional questions regarding the attainment of learning objectives that were defined at the beginning of the elective.

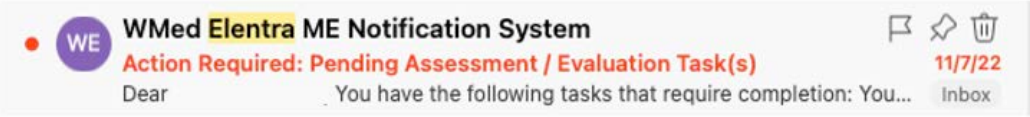
Narrative feedback is vital to student learning and development as a physician. Your comments regarding both what the student has done well and areas to target for growth are critical to student understanding of their their current level of performance, as well as providing suggestions for future improvement (feedback "for learning").

There are multiple options that faculty can use to organize their narrative comments:

1. EPA developmental schema and their performance narratives
2. Supervision that was required by you to ensure safe, effective, appropriate medical care was provided to your patient.
   Modified Ottawa scale: (Rekman et al 2016)
   In supervising this student, how much did you participate in the task?
   a. "**I did it.**" - Student required complete guidance or was unprepared; I had to do most of the work myself.
   b. **"I talked them through it."** - Student was able to perform some tasks but required repeated directions.
   c. **"I directed them from time to time."** – Student demonstrated some independence and only required intermittent prompting.
   d. **"I was available just in case."** - Student functioned fairly independently and only needed assistance with nuances or complex situations.
3. RIME - Reporter, Interpreter, Manager, Educator - See Appendix 2

Assessment Completion – Elentra

You will receive an email from WMED when you have an assessment that is due. Alternately, you may use your WMED login information to directly access the Elentra system. If you are ha having any difficulty finding or completing an assessment, please contact your clerkship coordinator. Our goal is for faculty to complete their student assessments within one week after you or the the student leaves the service.



Faculty Appointment & Benefits

Appointment to WMed Faculty

Clinical faculty are an integral part of the medical school. The appellation "doctor" – from the Latin *docere*, meaning "to teach" – includes the responsibility of all physicians to share knowledge and information with colleagues, trainees, and patients. Physicians have the opportunity to give back to their profession by teaching the science, art, and ethics of medicine to medical students, residents, and fellows. The medical school provides the opportunity for clinical faculty to participate in training the next generation of physicians for tomorrow's patients, and ultimately, improving the health of the communities we serve.

WMU Homer Stryker M.D. School of Medicine faculty have a primary appointment in a department of the medical school whether or not they are directly employed by WMed. Clinical faculty are physicians and other healthcare providers who participate in teaching, clinical research, and administration of medical school programs.

There are three principles on which the faculty appointment is based: teaching activities, sustained efforts to improve personal teaching abilities, and service to the medical school. Clinical faculty participate directly in teaching or service to the medical school for a minimum of 50 hours in each year of the appointment period to continue to qualify for faculty appointment.

Benefits

- Recognition: Framed certificate for office posting
- Inclusion in faculty meetings, activities, CME events
- Opportunity to participate in WMed research
- Opportunities to serve on WMed committees
- Purchase computer equipment at discount
- Faculty development/education
- CME for teaching
- Full access to eLibrary

EPA 1: Gather a History and Perform a Physical Examination

An EPA: A unit of observable, measurable professional practice requiring integration of competencies

EPA 1

Gather a history and perform a physical exam

Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.

This schematic depicts development of proficiency in the Core EPAs. It is *not* intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.

Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Obtain a complete and accurate history in an organized fashion **PC2**	Does not collect accurate historical data Relies exclusively on secondary sources or documentation of others	Gathers excessive or incomplete data Does not deviate from a template	Uses a logical progression of questioning Questions are prioritized and not excessive	Obtains a complete and accurate history in an organized fashion Seeks secondary sources of information when appropriate (e.g. family, primary care physician, living facility, pharmacy) Adapts to different care settings and encounters
Demonstrate patient-centered interview skills **ICS1 ICS7 P1 P3 P5**	Is disrespectful in interactions with patients Disregards patient privacy and autonomy	Communicates unidirectionally Does not respond to patient verbal and nonverbal cues May generalize based on age, gender, culture, race, religion, disabilities, and/or sexual orientation Does not consistently consider patient privacy and autonomy	Demonstrates effective communication skills, including silence, open-ended questions, body language, listening, and avoids jargon Anticipates and interprets patient's emotions Incorporates responses appropriate to age, gender, culture, race, religion, disabilities and/or sexual orientation	Adapts communication skills to the individual patient's needs and characteristics Responds effectively to patient's verbal and nonverbal cues and emotions
Demonstrate clinical reasoning in gathering focused information relevant to a patient's care **KP1**	Fails to recognize patient's central problem	Questions are not guided by the evidence and data collected Does not prioritize or filter information Questions reflect a narrow differential diagnosis	Questions are purposefully used to clarify patient's issues Is able to filter signs and symptoms into pertinent positives and negatives	Demonstrates astute clinical reasoning through targeted hypothesis-driven questioning Incorporates secondary data into medical reasoning
Perform a clinically relevant, appropriately thorough physical exam pertinent to the setting and purpose of the patient visit **PC2**	Does not consider patient's privacy and comfort during exams Incorrectly performs basic physical exam maneuvers	Performs basic exam maneuvers correctly Does not perform exam in an organized fashion Relies on head-to-toe examination Misses key findings	Targets the exam to areas necessary for the encounter Identifies and describes normal findings Explains exam maneuvers to patient	Performs an accurate exam in a logical and fluid sequence Uses the exam to explore and prioritize the working differential diagnosis Can identify and describe normal and abnormal findings

Barron, B, Orlander, P, Schwartz, ML. Obeso V, Brown D, Phillipi C, eds.; for Core EPAs for Entering Residency Pilot Program
Adapted from the Association of American Medical Colleges (AAMC). Core entrustable professional activities for entering residency. 2014.

EPA 2: Prioritize a Differential Diagnosis Following a Clinical Encounter

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EPA 2

Prioritize a differential diagnosis

Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.

This schematic depicts development of proficiency in the Core EPAs. It is *not* intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.

Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Synthesize essential information from previous records, history, physical exam, and initial diagnostic evaluations to propose a scientifically supported differential diagnosis **PC2 KP3 KP4 KP2**	Cannot gather or synthesize data to inform an acceptable diagnosis Lacks basic medical knowledge to reason effectively	Approaches assessment from a rigid template Struggles to filter, prioritize, and make connections between sources of information Proposes a differential diagnosis that is too narrow, is too broad, or contains inaccuracies Demonstrates difficulty retrieving knowledge for effective reasoning	Gathers pertinent data based on initial diagnostic hypotheses Proposes a reasonable differential diagnosis but may neglect important diagnostic information Is beginning to organize knowledge by illness scripts (patterns) to generate and support a diagnosis	Gathers pertinent information from many sources in a hypothesis-driven fashion Filters, prioritizes, and makes connections between sources of information Proposes a relevant differential diagnosis that is neither too broad nor too narrow Organizes knowledge into illness scripts (patterns) that generate and support a diagnosis
Prioritize and continue to integrate information as it emerges to update differential diagnosis, while managing ambiguity **PC4 KP3 KP4 PPD8 PBL1**	Disregards emerging diagnostic information Becomes defensive and/or belligerent when questioned on differential diagnosis	Does not integrate emerging information to update the differential diagnosis Displays discomfort with ambiguity	Considers emerging information but does not completely integrate to update the differential diagnosis Acknowledges ambiguity and is open to questions and challenges	Seeks and integrates emerging information to update the differential diagnosis Encourages questions and challenges from patients and team
Engage and communicate with team members for endorsement and verification of the working diagnosis that will inform management plans **KP3 KP4 ICS2**	Ignores team's recommendations Develops and acts on a management plan before receiving team's endorsement Cannot explain or document clinical reasoning	Recommends a broad range of untailored diagnostic evaluations Depends on team for all management plans Does not completely explain and document reasoning	Recommends diagnostic evaluations tailored to the evolving differential diagnosis after having consulted with team Explains and documents clinical reasoning	Proposes diagnostic and management plans reflecting team's input Seeks assistance from team members Provides complete and succinct documentation explaining clinical reasoning

EPA 3: Recommend and Interpret Common Diagnostic and Screening Tests

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EPA 3

Diagnostic and screening tests

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Recommend first-line cost-effective screening and diagnostic tests for routine health maintenance and common disorders **PC5 PC9 SBP3 PBLI9 KP1 KP4**	Unable to recommend a standard set of screening or diagnostic tests Demonstrates frustration at cost-containment efforts	Recommends tests for common conditions Does not consider harm, costs, guidelines, or patient resources Does not consider patient-specific screening unless instructed	Considers costs Identifies guidelines for standard tests Repeats diagnostic tests at intervals that are too frequent or too lengthy	Recommends key, reliable, cost-effective screening and diagnostic tests Applies patient-specific guidelines
Provide rationale for decision to order tests, taking into account pre- and posttest probability and patient preference **PC5 PC7 KP1 KP4 SBP3 PBLI9**	Cannot provide a rationale for ordering tests	Recommends unnecessary tests or tests with low pretest probability Neglects patient's preferences	Understands pre- and posttest probability Neglects impact of false positive or negative results Aware of patient's preferences	Provides individual rationale based on patient's preferences, demographics, and risk factors Incorporates sensitivity, specificity, and prevalence in recommending and interpreting tests Explains how results will influence diagnosis and evaluation
Interpret results of basic studies and understand the implication and urgency of the results **PC4 PC5 PC7 KP1**	Can only interpret results based on normal values from the lab Does not discern urgent from nonurgent results	Misinterprets insignificant or explainable abnormalities Does not know how to respond to urgent test results Requires supervisor to discuss results with patient	Recognizes need for assistance to evaluate urgency of results and communicate these to patient	Distinguishes common, insignificant abnormalities from clinically important findings Discerns urgent from nonurgent results and responds correctly Seeks help for interpretation of tests beyond scope of knowledge

EPA 4: Enter and Discuss Orders and Prescriptions

An EPA: A unit of observable, measurable professional practice requiring integration of competencies

EPA 4

Enter and discuss orders and prescriptions

Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Compose orders efficiently and effectively verbally, on paper, and electronically **PC6 PBLI1**	Unable to compose or enter electronic orders or write prescriptions (or does so for the wrong patient or using an incorrect order set) Does not follow established protocols for placing orders	Does not recognize when to tailor or deviate from the standard order set Orders tests excessively (uses shotgun approach) May be overconfident, does not seek review of orders	Recognizes when to tailor or deviate from the standard order set Completes simple orders Demonstrates working knowledge of how orders are processed in the workplace Asks questions, accepts feedback	Routinely recognizes when to tailor or deviate from the standard order set Able to complete complex orders requiring changes in dose or frequency over time (e.g., a taper) Undertakes a reasoned approach to placing orders (e.g., waits for contingent results before ordering more tests) Recognizes limitations and seeks helps
Demonstrate an understanding of the patient's condition that underpins the provided orders **PC5 PC2**	Lacks basic knowledge needed to guide orders Demonstrates defensiveness when questioned	Has difficulty filtering and synthesizing information to prioritize diagnostics and therapies Unable to articulate the rationale behind orders	Articulates rationale behind orders May not take into account subtle signs or exam findings guiding orders	Recognizes patterns, takes into account the patient's condition when ordering diagnostics and/or therapeutics Explains how test results influence clinical decision making
Recognize and avoid errors by attending to patient-specific factors, using resources, and appropriately responding to safety alerts **PBLI7**	Discounts information obtained from resources designed to avoid drug–drug interactions Fails to adjust doses when advised to do so by others Ignores alerts	Underuses information that could help avoid errors Relies excessively on technology to highlight drug–drug interactions and/or risks (e.g., smartphone or EHR suggests an interaction, but learner cannot explain relevance)	May inconsistently apply safe prescription-writing habits such as double-check of patient's weight, age, renal function, comorbidities, dose and/or interval, and pharmacogenetics when applicable	Routinely practices safe habits when writing or entering prescriptions or orders Responds to EHR's safety alerts and understands rationale for them Uses electronic resources to fill in gaps in knowledge to inform safe order writing (e.g., drug–drug interactions, treatment guidelines)
Discuss planned orders and prescriptions with team, patients, and families **ICS1 SBP3**	Places orders and/or prescriptions that directly conflict with patient's and family's health or cultural beliefs	Places orders without communicating with others; uses unidirectional style ("Here is what we are doing...") Does not consider cost of orders or patient's preferences	Modifies plan based on patient's preferences May describe cost-containment efforts as externally mandated and interfering with the doctor–patient relationship	Enters orders that reflect bidirectional communication with patients, families, and team Considers the costs of orders and the patient's ability and willingness to proceed with the plan

EPA 5: Document a Clinical Encounter in the Patient Record

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EPA 5

Document a clinical encounter

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Prioritize and synthesize information into a cogent narrative for a variety of clinical encounters (e.g., admission, progress, pre- and post-op, and procedure notes; informed consent; discharge summary) **P4 ICS1**	Provides incoherent documentation	Misses key information Uses a template with limited ability to adjust or adapt based on audience, context, or purpose	Provides key information but may include unnecessary details or redundancies Demonstrates ability to adjust or adapt to audience, context, or purpose	Provides a verifiable cogent narrative without unnecessary details or redundancies Adjusts and adapts documentation based on audience, context, or purpose (e.g., admission, progress, pre- and post-op, and procedure notes; informed consent; discharge summary)
Follow documentation requirements to meet regulations and professional expectations **ICS5 P4 SBP1**	Copies and pastes information without verification or attribution Does not provide documentation when required Provides illegible documentation	Produces documentation that has errors or does not fulfill institutional requirements (e.g., date, time, signature, avoidance of prohibited abbreviations) Has difficulty meeting turnaround expectations, resulting in team members' lack of access to documentation	Recognizes and corrects errors related to required elements of documentation Meets needed turnaround time for standard documentation May not document the pursuit of primary or secondary sources important to the encounter	Provides accurate, legible, timely documentation that includes institutionally required elements Documents in the patient's record role in team-care activities Documents use of primary and secondary sources necessary to fill in gaps
Document a problem list, differential diagnosis, and plan supported through clinical reasoning that reflects patient's preferences **PC4 PC6 ICS1 ICS2**	Includes inappropriate judgmental language Documents potentially damaging information without attribution	Does not document a problem list, differential diagnosis, plan, clinical reasoning, or patient's preferences Interprets laboratories by relying on norms rather than context Does not include a rationale for ordering studies or treatment plans Demonstrates limited help-seeking behavior to fill gaps in knowledge, skill, and experience	Documents a problem list, differential diagnosis, plan, and clinical reasoning Is inconsistent in interpreting basic tests accurately Engages in help-seeking behavior resulting in improved ability to develop and document management plans Solicits patient's preferences and records them in a note	Documents a problem list, differential diagnosis, and plan, reflecting a combination of thought processes and input from other providers Interprets laboratory values accurately Identifies key problems, documenting engagement of those who can help resolve them Communicates bidirectionally to develop and record management plans aligned with patient's preferences

EPA 6: Provide an Oral Presentation of a Clinical Encounter

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EPA 6

Provide an oral presentation of a clinical encounter

Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Present personally gathered and verified information, acknowledging areas of uncertainty **PC2 PBL1 PPD4 P1**	Fabricates information when unable to respond to questions Reacts defensively when queried	Gathers evidence incompletely or exhaustively Fails to verify information Does not obtain sensitive information	Acknowledges gaps in knowledge, adjusts to feedback, and then obtains additional information	Presents personally verified and accurate information, even when sensitive Acknowledges gaps in knowledge, reflects on areas of uncertainty, and seeks additional information to clarify or refine presentation
Provide an accurate, concise, well-organized oral presentation **ICS2 PC6**	Presents in a disorganized and incoherent fashion	Delivers a presentation that is not concise or that wanders Presents a story that is imprecise because of omitted or extraneous information	Delivers a presentation organized around the chief concern When asked, can identify pertinent positives and negatives that support hypothesis Supports management plans with limited information	Filters, synthesizes, and prioritizes information into a concise and well-organized presentation Integrates pertinent positives and negatives to support hypothesis Provides sound arguments to support the plan
Adjust the oral presentation to meet the needs of the receiver **ICS1 ICS2 PBL1 PPD7**	Presents information in a manner that frightens family	Follows a template Uses acronyms and medical jargon Projects too much or too little confidence	When prompted, can adjust presentation in length and complexity to match situation and receiver of information	Tailors length and complexity of presentation to situation and receiver of information Conveys appropriate self-assurance to put patient and family at ease
Demonstrate respect for patient's privacy and autonomy **P3 P1 PPD4**	Disregards patient's privacy and autonomy	Lacks situational awareness when presenting sensitive patient information Does not engage patients and families in discussions of care	Incorporates patient's preferences and privacy needs	Respects patients' privacy and confidentiality by demonstrating situational awareness when discussing patients Engages in shared decision making by actively soliciting patient's preferences

EPA 7: Form Clinical Questions and Retrieve Evidence to Advance Patient Care

An EPA: A unit of observable, measurable professional practice requiring integration of competencies

EPA 7

Clinical questions to advance patient care

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Combine curiosity, objectivity, and scientific reasoning to develop a well-formed, focused, pertinent clinical question (ASK) **KP3 PBLI6 PBLI1 PBLI3**	Does not reconsider approach to a problem, ask for help, or seek new information	With prompting, translates information needs into clinical questions	Seeks assistance to translate information needs into well-formed clinical questions	Identifies limitations and gaps in personal knowledge Develops knowledge guided by well-formed clinical questions
Demonstrate awareness and skill in using information technology to access accurate and reliable medical information (ACQUIRE) **PBLI6 PBLI7**	Declines to use new information technologies	Uses vague or inappropriate search strategies, leading to an unmanageable volume of information	Employs different search engines and refines search strategies to improve efficiency of evidence retrieval	Identifies and uses available databases, search engines, and refined search strategies to acquire relevant information
Demonstrate skill in appraising sources, content, and applicability of evidence (APPRAISE) **PBLI6 KP3 KP4**	Refuses to consider gaps and limitations in the literature or apply published evidence to specific patient care	Accepts findings from clinical studies without critical appraisal With assistance, applies evidence to common medical conditions	Judges evidence quality from clinical studies Applies published evidence to common medical conditions	Uses levels of evidence to appraise literature and determines applicability of evidence Seeks guidance in understanding subtleties of evidence
Apply findings to individuals and/or patient panels; communicate findings to the patient and team, reflecting on process and outcomes (ADVISE) **ICS1 ICS2 PBLI1 PBLI8 PBLI9 PC7**	Does not discuss findings with team Does not determine or discuss outcomes and/or process, even with prompting	Communicates with rigid recitation of findings, using medical jargon or displaying personal biases Shows limited ability to connect outcomes to the process by which questions were identified and answered and findings were applied	Applies findings based on audience needs Acknowledges ambiguity of findings and manages personal bias Connects outcomes to process by which questions were identified and answered	Applies nuanced findings by communicating the level and consistency of evidence with appropriate citation Reflects on ambiguity, outcomes, and the process by which questions were identified and answered and findings were applied

EPA 8: Give or Receive a Patient Handover to Transition Care Responsibility

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EPA 8

Give or receive a patient handover

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**** Functions are designated as "transmitter" or "transmitter and receiver."***

Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Document and update an electronic handover tool and apply this to deliver a structured verbal handover **PBLI7 ICS2 ICS3 P3** ***Transmitter**	Inconsistently uses standardized format or uses alternative tool Provides information that is incomplete and/or includes multiple errors in patient information	Uses electronic handover tool Inconsistently updates tool Requires clarification and additional relevant information from others to prioritize information Provides patient information that is disorganized, too detailed, and/or too brief	Consistently updates electronic handover tool with mostly relevant information, applying a standardized template Adjusts patient information for context and audience May omit relevant information or present irrelevant information	Consistently updates electronic handover tool with clear, relevant, and succinct documentation Adapts and applies all elements of a standardized template Presents a verbal handover that is prioritized, relevant, and succinct
Conduct handover using communication strategies known to minimize threats to transition of care **ICS2 ICS3** ***Transmitter**	Is frequently distracted Carries out handover with inappropriate timing and context	Requires assistance to minimize interruptions and distractions Demonstrates minimal situational awareness	Requires assistance with time management Focuses on own handover tasks with some awareness of other's needs	Avoids interruptions and distractions Manages time effectively Demonstrates situational awareness
Provide succinct verbal communication conveying illness severity, situational awareness, action planning, and contingency planning **ICS2 PC8** ***Transmitter**	Communication lacks all key components of standardized handover	Inconsistently communicates key components of the standardized tool Does not provide action plan and contingency plan	Identifies illness severity Provides incomplete action list and contingency planning Creates a contingency plan that lacks clarity	Highlights illness severity accurately Provides complete action plans and appropriate contingency plans
Give or elicit feedback about handover communication and ensure closed-loop communication **PBLI5 ICS2 ICS3** ***Transmitter and Receiver**	Withholds or is defensive with feedback Displays lack of insight on the role of feedback Does not summarize (or repeat) key points for effective closed-loop communication	Delivers incomplete feedback; accepts feedback when given Does not encourage other team members to express their ideas or opinions Inconsistently uses summary statements and/or asks clarifying questions	Accepts feedback and adjusts Summary statements are too elaborate Inconsistently uses repeat-back technique	Provides and solicits feedback regularly, listens actively, and engages in reflection Identifies areas of improvement Asks mutually clarifying questions, provides succinct summaries, and uses repeat-back techniques
Demonstrate respect for patient's privacy and confidentiality **P3** ***Transmitter and Receiver**	Is unaware of HIPAA policies Breaches patient confidentiality and privacy	Is aware of HIPAA policies	Is cognizant of and attempts to minimize breaches in privacy and confidentiality	Consistently considers patient privacy and confidentiality Highlights and respects patient's preferences

EPA 9: Collaborate as a Member of an Interprofessional Team

An EPA: A unit of observable, measurable professional practice requiring integration of competencies

EPA 9

Collaborate as a member of an interprofessional team

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Identify team members' roles and responsibilities and seek help from other members of the team to optimize health care delivery **IPC2 SBP2 ICS3**	Does not acknowledge other members of the interdisciplinary team as important Displays little initiative to interact with team members	Identifies roles of other team members but does not know how or when to use them Acts independently of input from team members, patients, and families	Interacts with other team members, seeks their counsel, actively listens to their recommendations, and incorporates these recommendations into practice	Effectively partners as an integrated member of the team Articulates the unique contributions and roles of other health care professionals Actively engages with the patient and other team members to coordinate care and provide for seamless care transition
Include team members, listen attentively, and adjust communication content and style to align with team-member needs **ICS2/IPC3 IPC1 ICS7 P1**	Dismisses input from professionals other than physicians	Communication is largely unidirectional, in response to prompts, or template driven Has limited participation in team discussion	Listens actively and elicits ideas and opinions from other team members	Communicates bidirectionally; keeps team members informed and up to date Tailors communication strategy to the situation
Establish and maintain a climate of mutual respect, dignity, integrity, and trust **Prioritize team needs over personal needs to optimize delivery of care** **Help team members in need** **P1 ICS7 IPC1 SBP2**	Has disrespectful interactions or does not tell the truth Is unable to modify behavior Puts others in position of reminding, enforcing, and resolving interprofessional conflicts	Is typically a more passive member of the team Prioritizes own goals over those of the team	Integrates into team function, prioritizing team goals Demonstrates respectful interactions and tells the truth Remains professional and anticipates and manages emotional triggers	Supports other team members and communicates their value to the patient and family Anticipates, reads, and reacts to emotions to gain and maintain therapeutic alliances with others Prioritizes team's needs over personal needs

EPA 10: Recognize a Patient Requiring Urgent or Emergent Care and Initiate Evaluation and Management

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EPA 10

Recognize urgent or emergent situation

- Chest pain
- Mental status change
- Shortness of breath and hypoxemia
- Fever
- Hypotension or hypertension
- Tachycardia or arrhythmia
- Oliguria, anuria, or urinary retention
- Electrolyte abnormalities
- Hypoglycemia or hyperglycemia

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Recognize normal and abnormal vital signs as they relate to patient- and disease-specific factors as potential etiologies of a patient's decompensation **PC2 PC4 PC5**	Fails to recognize trends or variations of vital signs in a decompensating patient	Demonstrates limited ability to gather, filter, prioritize, and connect pieces of information to form a patient-specific differential diagnosis in an urgent or emergent setting	Recognizes outliers or unexpected results or data and seeks out an explanation	Recognizes variations of patient's vital signs based on patient- and disease-specific factors Gathers, filters, and prioritizes information related to a patient's decompensation in an urgent or emergent setting
Recognize severity of a patient's illness and indications for escalating care and initiate interventions and management **PC4 PC3 PC2 PC5 PC6 PPD1**	Does not recognize change in patient's clinical status or seek help when a patient requires urgent or emergent care	Misses abnormalities in patient's clinical status or does not anticipate next steps May be distracted by multiple problems or have difficulty prioritizing Accepts help	Recognizes concerning clinical symptoms or unexpected results or data Asks for help	Responds to early clinical deterioration and seeks timely help Prioritizes patients who need immediate care and initiates critical interventions
Initiate and participate in a code response and apply basic and advanced life support **PC1 PPD1 SBP2 IPC4**	Responds to a decompensated patient in a manner that detracts from or harms team's ability to intervene	Requires prompting to perform basic procedural or life support skills correctly Does not engage with other team members	Demonstrates appropriate airway and basic life support (BLS) skills Initiates basic management plans Seeks input or guidance from other members of the health care team	Initiates and applies effective airway management, BLS, and advanced cardiovascular life support (ACLS) skills Monitors response to initial interventions and adjusts plan accordingly Adheres to institutional procedures and protocols for escalation of patient care Uses the health care team members according to their roles and responsibilities to increase task efficiency in an emergent patient condition
Upon recognition of a patient's deterioration, communicate situation, clarify patient's goals of care, and update family members **ICS2 ICS6 PPD1**	Dismisses concerns of team members (nurses, family members, etc.) about patient deterioration Disregards patient's goals of care or code status	Communicates in a unidirectional manner with family and health care team Provides superfluous or incomplete information to health care team members Does not consider patient's wishes if they differ from those of the provider	Tailors communication and message to the audience, purpose, and context in most situations Actively listens and encourages idea sharing from the team (including patient and family) Confirms goals of care	Communicates bidirectionally with the health care team and family about goals of care and treatment plan while keeping them up to date Actively listens to and elicits feedback from team members (e.g., patient, nurses, family members) regarding concerns about patient deterioration to determine next steps

EPA 11: Obtain Informed Consent for Tests and/or Procedures

From day 1, residents may be in a position to obtain informed consent for interactions, tests, or procedures they order and perform, including immunizations, medications, central lines, contrast and radiation exposures, and blood transfusions.

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EPA 11

Obtain informed consent

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Describe the key elements of informed consent: indications, contraindications, risks, benefits, alternatives, and potential complications of the intervention **PC6 KP3 KP4 KP5 P6**	Lacks basic knowledge of the intervention Provides inaccurate or misleading information Hands the patient a form and requests a signature	Is complacent with informed consent due to limited understanding of importance of informed consent Allows personal biases with intervention to influence consent process Obtains informed consent only on the directive of others	Lacks specifics when providing key elements of informed consent Lacks specifics or requires prompting	Understands and explains the key elements of informed consent Provides complete and accurate information Recognizes when informed consent is needed and describes it as a matter of good practice rather than as an externally imposed sanction
Communicate with the patient and family to ensure that they understand the intervention **PC7 ICS1 ICS7 PC5**	Uses language that frightens patient and family Disregards emotional cues Regards interpreters as unhelpful or inefficient	Uses medical jargon Uses unidirectional communication; does not elicit patient's preferences Has difficulty in attending to emotional cues Does not consider the use of an interpreter when needed	Notices use of jargon and self-corrects Elicits patient's preferences by asking questions Recognizes emotional cues Enlists interpreters	Avoids medical jargon Uses bidirectional communication to build rapport Practices shared decision making, eliciting patient and family preferences Responds to emotional cues in real time Enlists interpreters collaboratively
Display an appropriate balance of confidence and skill to put the patient and family at ease, seeking help when needed **PPD1 PPD7 PPD8**	Displays overconfidence and takes actions that can have a negative effect on outcomes	Displays a lack of confidence that increases patient stress or discomfort, or overconfidence that erodes trust Asks questions Accepts help	Has difficulty articulating personal limitations such that patient and family will need reassurance from a senior colleague Asks for help	Demonstrates confidence commensurate with knowledge and skill so that patient and family are at ease Seeks timely help

EPA 12: Perform General Procedures of a Physician

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EPA 12

Perform general procedures of a physician

- Basic cardiopulmonary resuscitation (CPR)
- Bag-mask ventilation (BMC)
- Sterile technique
- Venipuncture
- Insertion of an intravenous line
- Placement of a Foley catheter

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Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Demonstrate technical skills required for the procedure **PC1**	Lacks required technical skills Fails to follow sterile technique when indicated	Technical skills are variably applied Completes the procedure unreliably Uses universal precautions and aseptic technique inconsistently	Approaches procedures as mechanical tasks to be performed and often initiated at the request of others Struggles to adapt approach when indicated	Demonstrates necessary preparation for performance of procedures Correctly performs procedure on multiple occasions over time Uses universal precautions and aseptic technique consistently
Understand and explain the anatomy, physiology, indications, contraindications, risks, benefits, alternatives, and potential complications of the procedure **PC1**	Displays lack of awareness of knowledge gaps	Does not understand key issues in performing procedures, such as indications, contraindications, risks, benefits, and alternatives Demonstrates limited knowledge of procedural complications or how to minimize them	Describes most of these key issues in performing procedures: indications, contraindications, risks, benefits, and alternatives Demonstrates knowledge of common procedural complications but struggles to mitigate them	Demonstrates and applies working knowledge of essential anatomy, physiology, indications, contraindications, risks, benefits, and alternatives for each procedure Knows and takes steps to mitigate complications of procedures
Communicate with the patient and family to ensure they understand pre- and post-procedural activities **PC7 ICS6 P6**	Uses inaccurate language or presents information distorted by personal biases Disregards patient's and family's wishes Fails to obtain appropriate consent before performing a procedure	Uses jargon or other ineffective communication techniques Does not read emotional response from the patient Does not engage patient in shared decision making	Conversations are respectful and generally free of jargon and elicit patient's and family's wishes When focused on the task during the procedure, may struggle to read emotional response from the patient	Demonstrates patient-centered skills while performing procedures (avoids jargon, participates in shared decision making, considers patient's emotional response) Having accounted for the patient's and family's wishes, obtains appropriate informed consent
Demonstrate confidence that puts patients and families at ease **PPD7 PPD1**	Displays overconfidence and takes actions that could endanger patients or providers	Displays a lack of confidence that increases patient's stress or discomfort, or overconfidence that erodes patient's trust if the learner struggles to perform the procedure Accepts help when offered	Asks for help with complications	Seeks timely help Has confidence commensurate with level of knowledge and skill that puts patients and families at ease

EPA 13: Identify System Failures and Contribute to a Culture of Safety

An EPA: A unit of observable, measurable professional practice requiring integration of competencies

EPA 13

System failures and culture of safety

Underlying entrustability for all EPAs are trustworthy habits, including truthfulness, conscientiousness, and discernment.

This schematic depicts development of proficiency in the Core EPAs. It is *not* intended for use as an assessment instrument. Entrustment decisions should be made after EPAs have been observed in multiple settings with varying context, acuity, and complexity and with varying patient characteristics.

Key Functions with Related Competencies	Behaviors Requiring Corrective Response	→ Developing Behaviors → (Learner may be at different levels within a row.)		Expected Behaviors for an Entrustable Learner
Identify and report actual and potential ("near miss") errors in care using system reporting structure (e.g., event reporting systems, chain of command policies) KP1 ICS2 P4 PPD5	Reports errors in a disrespectful or misleading manner	Superficial understanding prevents recognition of real or potential errors	Identifies and reports actual and potential errors Demonstrates structured approach to describing key elements of patient safety concerns	Identifies and reports patient safety concerns in a timely manner using existing system reporting structures (e.g., event reporting systems, chain of command policies) Speaks up to identify actual and potential errors, even against hierarchy
Participate in system improvement activities in the context of rotations or learning experiences (e.g., rapid-cycle change using plan–do–study–act cycles, root cause analyses, morbidity and mortality conference, failure modes and effects analyses, improvement projects) PBLI4 PBLI10	Displays frustration at system improvement efforts	Passively observes system improvement activities in the context of rotations or learning experiences	Participates in system improvement activities when prompted but may require others to point out system failures	Actively engages in efforts to identify systems issues and their solutions
Engage in daily safety habits (e.g., accurate and complete documentation, including allergies and adverse reactions, medicine reconciliation, patient education, universal precautions, hand washing, isolation protocols, falls and other risk assessments, standard prophylaxis, time-outs) SBP4	Places self or others at risk of injury or adverse event	Requires prompts for common safety behaviors	Demonstrates common safety behaviors	Engages in daily safety habits with only rare lapses
Admit one's own errors, reflect on one's contribution, and develop an individual improvement plan P4 SBP5	Avoids discussing or reporting errors; attempts to cover up errors Demonstrates defensiveness or places blame	Requires prompts to reflect on own errors and their underlying factors May not recognize own fatigue or may be afraid to tell supervisor when fatigued	Identifies and reflects on own contribution to errors but needs help developing an improvement plan	Identifies and reflects on the element of personal responsibility for errors Recognizes causes of lapses, such as fatigue, and modifies behavior or seeks help

APPENDIX

The RIME (Reporter–Interpreter–Manager–Educator) Feedback Tool, with examples of feedback in 'Next Steps'

Skill area	Needs improvement	Competent	Strength	Next Steps (examples)
Reporting	Data gathering and reporting are incomplete or disorganised. Rarely incorporates test results or other data (e.g. nursing information). Incomplete or incompetent physical examination.	Gathers pertinent data, reports in an organised fashion. Utilises lab results and information from colleagues. Competent physical examination skills, occasionally misses findings.	Data complete and concise, presentations and write-ups are organised. Always uses test results and data from colleagues. Physical examination thorough, focused when appropriate, and reliable.	*You develop good rapport with your patients and ask good questions. Now I'd like you to organise your history for each problem by symptom description, systems review for the involved system, past history of the problem, risk factors, etc.*
Interpretation	Rarely/occasionally able to generate a differential diagnosis including most likely and do-not-miss. Difficulty justifying or demonstrating clinical reasoning.	Usually generates a good differential including most likely and do-not-miss diagnoses. Justifies and demonstrates clinical reasoning when prompted.	Consistently generates a good differential diagnosis including most likely and do-not-miss. Justifies and demonstrates clinical reasoning without prompting.	*You do a good job of suggesting a diagnosis for each problem. Now, for each problem please list, in order, three most likely diagnoses and one 'do-not-miss' diagnosis.*
Management	Rarely able to suggest appropriate tests or therapy. Relies on preceptor almost exclusively.	Almost always able to suggest appropriate tests or therapy. Looks up questions.	Consistently orders appropriate tests and therapy. Incorporates outside reading.	*You seem to enjoy managing patients and when we get your presentations more organised, you'll be able to ask yourself better questions that will let you choose tests and treatments.*
Education	Rarely does outside reading or incorporates information into patient care. Knowledge base concerns. Relies on preceptor for learning. Rarely self-directed.	Almost always reads specialty texts when needed. Teaches preceptors something occasionally. Mostly self-directed. Understands and applies evidence-based medicine concepts.	Practises evidence-based medicine independently using primary and secondary sources. Summarises information for colleagues. Teaches preceptor something frequently.	*You are doing a good job of reading from the syllabus when I ask you to look something up and you do a good job of answering questions. Now I'd like you to try to look up a question on each patient, e.g. differential diagnosis before you present (or before you do your write-up). I'd also like you to look up medications.*

Skill area	Needs improvement	Competent	Strength	Next Steps (examples)
Interpersonal skills	Often poor rapport with patients and colleagues, disorganised, disrespectful. Does not demonstrate empathy.	Respectful, good rapport with patients and colleagues. Able to demonstrate empathy.	Always respectful. Excellent rapport with patients and colleagues. Regularly demonstrates empathy.	*You have outstanding interpersonal skills. The next time you have a very upset patient, I'd like to watch you as you specifically work on expressing empathy to establish rapport with the patient.*
Professionalism	Sometimes unprofessional, leaves work undone. Sometimes unprepared. Does the minimum.	Prompt, appropriate. Follows through on patient care and educational issues as asked.	Always prompt, well prepared, professional. Does patient care follow-up without prompting. Self-directed.	*As you like to manage patients, let's start having you check the labs the day after the visit and make a plan on each patient. Then we'll talk about it and you can call your patients with results.*

The teacher circles or checks the level attained by the student. The Next Steps column is filled in by the teacher. Examples of feedback are provided here. This method differs from RIME evaluation in that in RIME evaluation a student is expected to consistently perform appropriately at a level before proceeding to the next level, but the form can be used for cross-level feedback. For example, a student might do well at interpretation but be disorganised despite this and still need feedback on his or her organisation (reporting) skills

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