Is It Time for Entrustable Professional Activities for Residency Program Directors?

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Abstract

Residency program directors (PDs) play an important role in establishing and leading high-quality graduate medical education (GME) programs. The PD role has become an essential position within the GME system and one that requires a high level of skill. However, medical educators have failed to codify the PD position on a national level, and PDs are often not recognized for the significant role they play in educational and clinical settings. Currently, no overarching framework informs the design of the PD position. Although previous work has focused on the responsibilities of clerkship directors, limited published literature has focused on the responsibilities of residency PDs. We believe that the core entrustable professional activities (EPAs) framework may be a mechanism to further this work and define the roles and responsibilities of the PD position. The central importance of this role necessitates that we have a clear understanding and codification of the position. Without such an understanding, variability in PDs’ job performance could lead to lower-quality residency education, challenges meeting accreditation requirements, and PD burnout due to a lack of clear job responsibilities.

About the PD Position

The job of the PD can be very rewarding while also being quite demanding. All of us have been or are currently PDs, and we can attest to the gratifying nature and complexity of the position. Two of us (R.G.B., J.L.) also served on Accreditation Council for Graduate Medical Education (ACGME) residency review committees and have observed the educational innovations and successes that result when a strong PD is at the helm. The role is not typically a full-time position, and therefore PDs must balance many competing clinical, teaching, administrative, and personal responsibilities.

Physicians may hold academic leadership positions at different levels and have shared roles and responsibilities (e.g., be a clerkship director and residency associate PD simultaneously). PDs can be junior faculty, and they may be selected for the position based on their interest in medical education (rather than because they demonstrated competence in educational administration). We all came to the PD position through different pathways (K.V. was an associate PD, and R.G.B. was a clerkship director), and our trajectories towards presumed competency also varied (E.H. and R.G.B. participated in the Stanford Faculty Development Program, and K.V. participated in the Harvard Macy Institute Program).

The ACGME Common Program Requirements do not specify the qualifications needed to become a PD; they simply state that the qualifications must include “requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee.” Residency review committees from certain specialties require additional qualifications, but these tend to be general, such as “being a member of the faculty.” These descriptions from the ACGME and the published literature are not comprehensive and for the most part are not written in competency-based language.

The ACGME Common Program Requirements do list at least 14 “must” responsibilities that a PD is expected to carry out. In addition, the recent advent of the Next Accreditation System and the Clinical Learning Environment Review program has further changed the roles and activities of PDs, which require a number of key competencies. For example, a competency-based approach to resident education necessitates a robust review of the curriculum. PDs are also now responsible for Milestones reporting, which necessitates having a strong evaluation system in place and active faculty involvement. In addition, PDs are responsible for developing a group of well-trained faculty so that competency-based education can succeed.
Based on our personal observations and communications with others in the academic medicine community, and given the increased focus on competency-based medical education and outcomes,12–14 we believe that the bar has been raised significantly for PDs regarding their responsibilities and job expectations. For example, heightened public expectations for the addition of newer competencies (e.g., focus on quality, safety, care coordination, interprofessional teamwork) increases the demands on PDs.15 In addition, new leadership challenges for PDs include an increased focus on resident well-being, clinical learning environments, and faculty development. Different stakeholder groups (e.g., residents, department chairs, designated institutional officials [DIOs]) all expect PDs to oversee all aspects of a residency program, including residents’ Milestones attainment. From a certain perspective, these stakeholders entrust the PD to maintain a high-quality residency program with minimal direct supervision. PDs also are expected to grow professionally in this leadership role, but they may be insufficiently prepared or given minimal guidance. As a result, they may feel less competent or confident, leading to declines in job satisfaction and effectiveness.

With the additional ACGME requirements of the Next Accreditation System and the Clinical Learning Environment Review program, a lack of adequate support from superiors, few professional development opportunities, and insufficient promotion opportunities, the PD may become an endangered leadership role. These increased demands give us pause to ask: Is it time to define and develop EPAs for residency PDs to better recognize the importance of what those in this role do and to help guide their professional development?

Why EPAs for PDs

EPAs are those tasks or responsibilities that are entrusted to an individual to complete with limited supervision16 and are units of work grounded in an individual’s day-to-day professional activities. EPAs are not substitutes for competencies (i.e., knowledge, skills, abilities, attitudes), but they help translate competencies into descriptions of the essential parts of an individual’s professional practice.17 EPAs have garnered much interest in recent years, but the literature has focused on the supervision needed when residents complete specific tasks18 and the factors that influence a supervisor’s trust in a trainee19,20 rather than on the other roles involved in GME.

To our knowledge, no one has described EPAs for PDs, though EPAs and competencies have been described for DIOs.21,22 We believe that PDs should be empowered to function without close or direct supervision by their department chairs or DIOs, who may have variable medical education expertise and be unable to supervise PDs. That said, we believe there should be a strong, trusting relationship between PDs and their department chairs, with the latter providing support and resources to the former. PDs also might benefit from mentorship from other senior PDs and/or medical education leaders at their institution.

To help catalyze a national conversation about the roles and responsibilities of PDs, we propose a list of EPAs that describe the core work of PDs (see List 1). These EPAs are based on our collective professional experiences and what we honestly believe is required to run a competency-based residency program. The ideal number of EPAs for PDs is not well defined, and part of the challenge in identifying these EPAs is the lack of well-defined or agreed-on competencies for PDs.

Developing Competencies for PDs

Certainly the aforementioned list of PD responsibilities from the ACGME may be viewed as a list of competencies (e.g., evaluate program faculty); however, most are not written using competency-based language. Competencies have been described for medical faculty,23 medical teachers,24–26 and clinician–educators,27 and although some of these competencies do apply to PDs (e.g., provide feedback to learners), this literature does not address the administrative and leadership aspects of the PD role. We believe that PDs are both “managers” and “leaders”28 and part of their work is focused on performing tasks efficiently and proficiently as well as driving improvement and transformation. In addition to the management skills needed, PDs also must possess leadership skills—to manage and lead up and down the structure of the program.

To develop competencies for PDs, first domains of competence must be established. Based again on our collective professional experience, we suggest that these domains include medical education knowledge; resident/fellow education; organizational development and practice; communication; residency administration and improvement; professionalism and self-development; and scholarship and innovation. Additional domains of competence and/or specific competencies may be identified from the literature focused on physicians and administrators in management positions.29–31

Benefits of EPAs for PDs

As we indicated earlier, we believe that establishing EPAs for PDs will highlight the increasingly important role that these individuals play in maintaining high-quality GME programs. Such EPAs can help guide PD performance evaluation, determination of PD competence, and design of PD remediation efforts as needed.

In addition, we believe that there are additional benefits to describing such EPAs. First, using backward design,32 EPAs for PDs can be deconstructed to describe competency domains; required knowledge, skills, or attitudes;
and methods to observe and assess PD performance. We outline one such example in Table 1. Alternatively, medical educators could use a forward design approach, starting with the agreed-on competencies. However, we believe that starting with a list of EPAs provides a broader perspective regarding the scope of the PD role. Second, using a parallel equation aligning EPAs for residents and high-quality care (i.e., trainee performance × appropriate supervision = safe, effective patient-centered care), we propose that PD performance and appropriate oversight will result in superior, effective resident-centered learning. We believe that EPAs for PDs allow these individuals to focus their professional development efforts on the most important areas for their work.

Feedback related to these EPAs may be more effective when PDs are working with coaches (e.g., DIOs) or mentors. Finally, having clearly defined EPAs can help guide the PD recruitment and selection processes to match applicant qualifications with desired outcomes.

**Next Steps**

We are not arguing that the approach we have proposed here is necessarily the best one to define the roles and responsibilities of the PD position. Instead, we are arguing for applying the entrustment element of EPAs to the PD position, as society has placed significant trust in PDs to graduate competent physicians from their residency programs. By using this novel approach applying EPAs to PDs, we hope to strengthen the relationship between PDs and their supervisors (i.e., department chairs, division directors, DIOs) who should be more directly involved in entrustment decisions related to this important professional activity.

We recommend taking advantage of the national movement toward competency-based medical education to develop EPAs for PDs. As part of this work, we also must define competencies for PDs. Input from multiple stakeholders nationwide is needed (e.g., PDs, DIOs, residents, department chairs, specialty PD organizations, ACGME leadership) and could be gathered through various iterative methods (e.g., focus groups, Delphi procedure, surveys). Possible unanswered questions include the following: Are EPAs for PDs similar across disciplines? Should these EPAs differ based on the size of the training program? How will PD performance evaluation improve? What professional development opportunities can be created for PDs based on well-defined EPAs? Further work to identify the ideal professional development trajectory for novice PDs is needed as well. Although our list of proposed EPAs for PDs is not ready for implementation, we hope to spur a national dialogue in the academic medicine community, with these EPAs acting as a strong foundation for future conversations and work.

**Table 1**

<table>
<thead>
<tr>
<th>EPA part</th>
<th>Example</th>
</tr>
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<tbody>
<tr>
<td>Title</td>
<td>Conduct a resident evaluation program</td>
</tr>
<tr>
<td>Description</td>
<td>The program director is responsible for ensuring that all residents are evaluated in an effective and efficient manner, based on the Accreditation Council for Graduate Medical Education Milestones. Program directors cannot conduct a resident evaluation program in isolation and must coordinate the involvement of trained faculty and the buy-in of educated residents and collaborate with the residency coordinator.</td>
</tr>
<tr>
<td>Expiration date</td>
<td>Three years after transitioning out of program director position</td>
</tr>
<tr>
<td>Required knowledge, skills, and attitudes</td>
<td>Be able to:</td>
</tr>
<tr>
<td>- Describe specialty-specific Milestones</td>
<td></td>
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<tr>
<td>- Discuss the competency expectations for residents and the residency program</td>
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<tr>
<td>- Organize Clinical Competency Committee meetings</td>
<td></td>
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<tr>
<td>- Recruit and select faculty for the Clinical Competency Committee</td>
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<tr>
<td>- Train residents and faculty in Milestones theory and language</td>
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<tr>
<td>- Implement evaluation tools geared toward Milestones assessment</td>
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<tr>
<td>- Review evaluation data with residents and faculty in a timely and comprehensive fashion</td>
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<tr>
<td>- Determine mechanisms for organizing evaluation data and communicating with required data management systems</td>
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<tr>
<td>- Manage group meetings</td>
<td></td>
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<tr>
<td>- Use aggregate Milestones data to effect programmatic changes</td>
<td></td>
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<tr>
<td>Assessment information sources</td>
<td>• Review of evaluation tools used in residency</td>
</tr>
<tr>
<td>- Observation of Clinical Competency Committee meetings (e.g., group process checklist)</td>
<td></td>
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<tr>
<td>- Resident survey of evaluation program</td>
<td></td>
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<tr>
<td>- Annual program evaluation (e.g., self-evaluation reviewed to the Graduate Medical Education Committee)</td>
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<tr>
<td>- Review of remediation and probation plans (e.g., file-stimulated recall exercise)</td>
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<tr>
<td>When entrustment is likely to be reached</td>
<td>One to two years after appointment as program director; evaluation by department chair, designated institutional official, and peers</td>
</tr>
<tr>
<td>Expiration date</td>
<td>Three years after transitioning out of program director position</td>
</tr>
</tbody>
</table>

**References**

Invited Commentary


Riesenberg LA, Rosenbaum PF, Stick SL. Competencies, essential training, and resources viewed by designated institutional officials as important to the position in graduate medical education. Acad Med. 2006;81:426–431.


