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Um...EPAs?

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In November 2013, the AAMC unveiled the Core Entrustable Professional Activities for Entering Residency (CEPAER). These are skills and activities that individuals should be able to perform on day 1 of residency *without direct supervision*. While these are not yet ready for prime time, the CEPAER items are felt to be an improvement over a competency-based system in that they are intended to be more definable and granular (but judge for yourself). The initial document is available for review on the AAMC's MedEdPortal/iCollaborative website, and one interesting thing that the authors have done is to provide vignettes that sketch out what pre-entrustable and entrustable learners might look like.

Recently, I encountered a student who was having difficulty in the spoken case presentation. The nuts and bolts of the presentation were mostly present. The problem was "um's," used every third word. In thinking about how to provide constructive feedback to this student, I decided to peruse the CEPAER document. Two of the 13 EPAs seemed most promising:[1] gather a history and perform a physical examination (EPA 1), and provide an oral presentation/summary of the patient encounter (EPA 6).

EPA 1 seems to concern primarily verbal and non-verbal data gathering, and my student did not really have large deficiencies in this area. EPA 6 looked more encouraging. The document maps each EPA to the familiar Accreditation Council for Graduate Medical Education (ACGME) competency domains (i.e. patient care, knowledge, systems-based practice, etc.) and identifies critical sub-competencies within each domain, providing examples of behaviors that are deemed "pre-entrustable" as opposed to "entrustable."[1] Within EPA 6, there are eight sub-competencies: two interpersonal & communication skills, two professionalism, one patient care, one practice-based learning and improvement, and two personal & professional development.

Of these, only two approached the area in which my student was having difficulty. Interpersonal & communication skill #2 involves communicating effectively with colleagues and health professionals. However, the examples of these that are deemed pre-entrustable really concern failures in appropriate communication strategies (i.e. not maintaining open dialogue among team members, not encouraging idea exchange). It does include being able to "efficiently tell a story and make an argument," but again, the problem was not the storytelling, but the "um's."

Personal & professional development (PPD) #7 is another area that might have fit my student as it describes speaking in a confident manner—although this is seen as pre-entrustable. Rather, the document states that the desirable trait is knowing when to be confident and when to express uncertainty with situations. On further reflection, however, PPD #7 hints at impending confidence-knowledge/skill disparity. My student's "um's" certainly did not imply an overabundance of confidence, and I sensed no such disparity.

While still not quite appropriate, PPD #7 did raise a question: What was the root cause of the "um's"? I set up a feedback session after rounds, and I asked him what he wanted to get out of the rotation, mostly because I just wanted to hear him talk. Much to my surprise, in five minutes of simple chatting—not a single "um."

Um, uh, like, you know, okay—linguists refer to these as "filler words," most commonly occurring at the beginning of a sentence or in between ideas.[2,3] Some reasons why people introduce filler words include:

- Confidence or nervousness issue,
- Verbal pause, for no particular reason,
- Verbal pause, to plan what to say next and
- Verbal pause, to answer a question.

For the first reason, there is no magic recipe whereby one simply becomes more confident in the oral presentation. Reassurance and practicing, I think, may provide the most consistently helpful answer. Practice with a friend or significant other, in front of the mirror, or into a recording device (and listen to it). For the remaining three, if a learner needs time to think, encourage him/her to just pause; no verbalizations are needed. Pause, think, and then provide the next idea. My student and I discussed these, and we agreed that he would read his written note or H&P verbatim (only for the next two days), and if an "um" threatened, he would pause. Initially, the presentations were a little choppy and fraught with awkward pauses, but they became much smoother by the third day, with only three "um's" in an eight-minute presentation.

As educators, we try to make a call as to whether a given individual is on track to becoming a good physician, provide feedback to prioritize changes, and guide designers of curricula. Benchmarks, competencies, milestones, and EPAs are frameworks that educators use to help make this judgment and to do

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so with granularity and some measure of objectivity. I recognize that the CEPAER document is still evolving. I am not sure if the way I used it was what the authors had in mind, but I did identify a deficiency in a student's oral case presentation and found that the CEPAER format only somewhat fit with the issue I sought to remediate. I do like the way the CEPAER format is laid out, and I am willing to give it at try. But lest we wholly become a profession of checkboxes, there is still, I believe, a role for the intangibles—the gestalt assessment.

References

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