

## COMMENTARY

## Beyond “Good Job!”: Using EPAs to Improve Resident Feedback

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“Good job.” This was the extent of the feedback that I received from most of my attending preceptors and supervisors as an internal medicine resident in the late 1990s. If they were feeling especially expansive, I occasionally would get the suggestion, “Read more.” I was reminded of how unsatisfying this feedback was when I recently met with an intern to review her training progress. We were reading her evaluations from her attending physicians when she suddenly burst out, “Why can’t my attendings ever say anything more than ‘good job!’” Her frustration—and mine from more than 15 years ago as a resident myself—has nagged at me; why do we continue to repeat this phrase, which damns with such faint praise?

“Good job” does not give the learner anything to improve upon. Using education-speak, “good job” provides a summative assessment of the past performance of the learner rather than giving formative guidance for future improvement. It comes from a grading—not coaching—perspective. Even the best golfers in the world continue to work with swing coaches since there are always ways to improve their game. Why should learning the much-more-complicated practice of medicine be any different? We obviously need to help those residents who struggle, but the majority of residents who truly are doing a good job—and even those who are “superstars”—deserve the benefit of coaching for improvement.

“Good job” does not require much work from the supervising physician. To be fair, most of us have never received training on how best to deliver meaningful feedback. The phrase “good job” is familiar and

non-threatening. And although we mean this to be reassuring, ultimately it feels dishonest to both the trainee and the supervising physician—surely, not everything went perfectly during the rotation. Providing more constructive substance to trainee feedback requires us to more carefully listen and watch our residents, to identify their strengths and deficits, and to suggest the next steps for improvement; in short, providing meaningful coaching feedback is hard work and requires us to do more than deliver stock phrases.

Postgraduate medical education programs across different specialties have been working for close to two decades to shift to truly competency-based education. While most would agree that graduating residents based not on the number of years in training but instead on their ability to care for patients across the full spectrum of internal medicine clinical contexts is a worthwhile goal, our ability to provide feedback that helps residents attain this has not kept pace. Resident hour restrictions and associated work compression on the wards and in clinics has only made it more difficult to find those quiet moments to give meaningful and substantive feedback and intensifies the need for honest criticism when we finally do sit down with our residents.

For those of us who have struggled to find the right ways to give more meaningful feedback to our medicine residents, entrustable professional activities (EPAs) represent an opportunity to fill this void. EPAs were first described by Olle ten Cate as a way to operationalize the idea of competency-based assessment linked to the authentic real-world activities essential to the practice of

each specialty.<sup>1-3</sup> Attending physicians already assess learners’ skills—often subconsciously integrating multiple dimensions of competence such as medical knowledge, patient care skills, communication, and professionalism—before entrusting trainees to perform clinical activities without supervision. Residency training programs can take this a step further by identifying certain representative activities, or EPAs, for special attention from residents and supervising physicians.

The Education Redesign Committee of the Alliance for Academic Internal Medicine identified 16 of these EPAs from the perspective of a graduating medicine resident ready to enter unsupervised practice.<sup>4</sup> These end-of-training EPAs are easily recognizable as central to the practice of general internal medicine (Table 1) and can help training programs and residents alike as they consider what skills should be in place at the end of three years of training. Alternatively, EPAs can also be identified from the perspective of a trainee within a particular clinic or inpatient rotation. For example, at the University of Washington we have identified EPAs from the perspective of each core rotation and clinic experience (Table 2). Some of these rotation-specific EPAs (also called observable practice activities by other authors)<sup>5</sup> overlap with the end-of-training EPAs, but most are narrower in scope.

The EPAs provide discrete windows through which we can peek into the competence of our residents. Having a list of EPAs helps supervising physicians identify opportunities to directly observe resi-

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**Table 1: End-of-training Internal Medicine EPAs from the Alliance for Academic Internal Medicine<sup>4</sup>**

- Manage care of patients with acute common diseases across multiple care settings.
- Manage care of patients with acute complex diseases across multiple care settings.
- Manage care of patients with chronic diseases across multiple care settings.
- Provide age-appropriate screening and preventive care.
- Resuscitate, stabilize, and care for unstable or critically ill patients.
- Provide perioperative assessment and care.
- Provide general internal medicine consultation to nonmedical specialties.
- Manage transitions of care.
- Facilitate family meetings.
- Lead and work within interprofessional health care teams.
- Facilitate the learning of patients, families, and members of the interdisciplinary team.
- Enhance patient safety.
- Improve the quality of health care at both the individual and systems level.
- Advocate for individual patients.
- Demonstrate personal habits of lifelong learning.
- Demonstrate professional behavior.

**Table 2: Examples of Rotation- and Clinic-specific Internal Medicine EPAs from the University of Washington*****From a General Medicine Ward Rotation***

- Manage a hospitalized patient with decompensated liver disease.
- Recognize clinical deterioration and manage it promptly and efficiently.
- Coordinate discharge for a patient in a way that will reduce his/her chances of readmission.
- Coordinate an admission for an undifferentiated patient from the emergency department.

***From a Medical ICU Rotation***

- Manage a patient with shock.
- Effectively and compassionately guide a patient-centered discussion about goals of care.

***From an Outpatient Geriatrics Elective***

- Diagnose, prevent, and manage cognitive and affective disorders in older adults.
- Prescribe medications appropriately for older patients to minimize harm.

***From an Outpatient Continuity Clinic***

- Coordinate the transition of a recently discharged patient to outpatient care.
- Guide a patient to a decision about screening.
- Manage a patient with chronic joint or musculoskeletal pain.
- Effectively manage care and continuity of patients while not in clinic.

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dents in these pre-defined clinical activities. At the University of Washington, faculty members are encouraged to review this list of rotation-specific EPAs with their residents when attending on the wards or precepting in clinics. When the opportunity arises to watch a resident perform one (e.g. "Safely discharge a patient in a way that reduces his/her chances of readmission"), the attending physician is asked to carefully consider the question of how much trust he/she has that the resident can perform the activity. In the past, this would happen at an intuitive level. The EPAs, however, force attending physicians to be more conscious of this assessment; for each EPA observed, they now must ask themselves, "How closely do I need to supervise this resident in this activity? Would this resident be able to perform this independently?" These questions about supervision help frame the degree of entrustment given to the resident for an EPA; by extension, this reflects the attending physician's perception of the underlying competence of a resident in this specific context.

Assessing residents' competence through these discrete pre-defined windows allows us to ground

our feedback in the context of the real-world essential work of the practicing general internist. Instead of generically offering a "good job" as feedback, we can now provide recommendations for improvement relevant to their rotation (e.g. "I currently feel that when you discharge patients, you require very little supervision. In order for you to be independent in this activity, I would want you to also call the patient's primary care doctor to alert them to pending final culture results.").

Providing feedback more meaningful than "good job" still requires careful observation and hard work by the supervising physician. EPAs provide, however, a framework to structure this hard work in a way that is easily adoptable by faculty physicians since decisions about "entrustment" already happen every day when an attending physician works with a resident. By focusing feedback on how the resident can become independent in these EPAs, we shift from summative backward-looking grading feedback and instead can deliver formative forward-looking coaching feedback. After decades of the same praise, EPAs finally give us a chance to move beyond the tired

phrase to instead be able to say, "Good job.... Now here's what you can do to get even better."

### References

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