

ENTRUSTMENTS WITHOUT CLARITY: SUPERVISORS' AND TRAINEES' PERSPECTIVES ON ENTRUSTMENT DECISIONS IN FCPS INTERNAL MEDICINE TRAINING IN A RESOURCE-CONSTRAINED SETTING OF PAKISTAN

RUNNING HEAD: ENTRUSTMENT DECISIONS IN FCPS INTERNAL MEDICINE

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Abstract

Background: Entrustable Professional Activities (EPAs) translate competency into graded clinical autonomy, yet their application in resource-constrained postgraduate settings in low and middle income countries (LMICs) remains poorly understood. This study examines how supervisors and trainees in a Fellowship of the College of Physicians and Surgeons (FCPS) Internal Medicine programme in Bannu, Pakistan, conceptualise, enact and experience entrustment decisions.

Methods: An interpretive descriptive design grounded in constructivist epistemology was employed. Eleven participants — five consultants supervisors six postgraduate trainees (Years 2-4) — participated in individual semistructured interviews lasting 40-60 minutes. Data were verbatim-transcribed and analysed using Braun and Clarke's six-phase reflexive thematic analysis. Rigour was established through reflexivity, methodological triangulation, peer debriefing and member-checking.

Results: Four themes emerged: (1) Intuitive entrustment (gut feeling; experimental heuristics); (2) Ambiguous expectations (absent explicit criteria; hierarchical opacity); (3) Multifactorial determinants of trust (competence; reliability task-risk calibration); and (4) Systemic constraints (workload pressure; supervisor scarcity). Entrustment occurred regularly but implicitly, driven by institutional necessity rather than structured competency assessment. Twelve illustrative participant extracts ground these themes directly in the data.

Conclusion: In this LMIC postgraduate context, entrustment is pervasive yet unaccountable, creating developmental inequity and unrecognised clinical risk. Context sensitive EPA framework and structured faculty developmental are urgently needed to formalise entrustment practice within the FCPS programme.

INTRODUCTION

What truly separates a MBBS graduate from a trained specialist? Many postgraduate teachers sit with this question quietly at the end of a summative examination. Watching a resident performs well in a structured clinical case presentation, an examiner may feel satisfied — yet a doubt remains: will this doctor alone in a district hospital at two in the morning, with no senior to call? That gap — between what we have assessed and what we genuinely trust — is precisely what Entrustable Professional Activities (EPAs) were designed to bridge.

An EPA is a discrete unit of professional practice that can be delegated to a trainee once sufficient competence has been demonstrated, permitting its performance without direct supervision.¹ A single EPA may represent one task — a lumbar puncture, an acute ward admission — or a bundle of related activities such as managing an acute internal medicine service. EPAs are not theoretical targets; they are observable, assessable and credentialing-relevant. Milestones mark the developmental steps from full dependence to the point where a trainee can supervise others.²

Competency-based medical education (CBME) shifted postgraduate training away from time-served apprenticeship toward outcomes-driven, learner-centered models.³ Within CBME, trust is not assumed at a fixed endpoint; it is earned incrementally through documented, supervised performance.⁴ Entrustment decisions sit at the critical junction between assessed competence and licensed independence — occurring moment by moment in clinical practice (ad-hoc entrustment) and formally at programmatic milestones (summative entrustment).⁵

Four variables clusters are known to shape entrustment: trainee attributes (confidence, fatigue, training levels); supervisors attributes (leniency, risk tolerance, experience); contextual factors (time of day, resources, patient acuity); and the nature of the task (complexity, risk,

reversibility).⁵ In high income settings these variables are modulated by structured EPA frameworks, workplace-based assessment tools and faculty developmental programmes.⁶ In LMICs, however, the realities differ: supervisor-to-trainees ratio are stretched, formal assessment infrastructure is limited and clinical workload is intense. How entrustment actually unfolds in these conditions remains largely un-documented. Pakistan's FCPS programs — administered by the College of Physicians and Surgeons Pakistan (CPSP) — is the primary pathway to specialist status. Workplace-based assessments are increasingly incorporated into FCPS training but their systematic application varies widely across institutions and regions.⁷ Bannu, a semi-urban district in Khyber Pakhtunkhwa, exemplifies a resource-constrained training context: patient volumes are high, supervisory capacity is limited and formal EPA infrastructure is absent. Understanding how entrustment operate here is not merely academic — it is a practical precondition for designing reforms that will work in this setting, not in settings that look nothing like it.

This study therefore explored how supervisors and trainees in a resource-constrained FCPS Internal Medicine programme conceptualize and entrustments decisions, and what systemic factors shape that process — with the explicit aim of informing context-sensitive CBME frameworks for similar settings.

Methods

Research Design

An interpretive descriptive (ID) designs was adopted, as conceptualized by Thorne and colleagues.⁸ ID generates clinically applicable, empirical knowledge grounded in participants' lived experience and directly applicable to practice. Its constructive epistemological foundation acknowledges that meaning is co-constructed between researcher and participant.

This approach was selected over grounded theory because our aim was not to generate new theory but to produce practice-relevant insights within an existing conceptual framework – EPA theory – while remaining sensitive to the specific contextual conditions of FCPS training in Pakistan.

Setting and Participant

The study was conducted within the FCPS Internal Medicine residency programme at a district-level teaching hospital in Bannu, Khyber Pakhtunkhwa, Pakistan. Purposive sampling recruited 11 participants: five consultant supervisors with formal FCPS supervisory responsibilities, and six postgraduate trainees in Years 2-4. This range was deliberate – to capture perspectives from trainees at different developmental stages of trust, from those under close supervision to those approaching independent practice. Theoretical sufficiency guided that decision to close recruitment once themes were adequately represented and no new conceptual territory was emerging.

Data Collection

Individual semi-structured interviews were conducted by the primary researcher – a postgraduate trainee and medical educator within the same FCPS system – in a private, confidential setting between January and May 2024. Each interview lasted 40-60 minutes. A flexible topic guide explored: perceptions of trainee readiness; how and when trust is granted or withheld; the role of systemic pressures; and awareness of formal EPA frameworks. Interviews were conducted in English, audio-recorded with prior written informed consent, and verbatim-transcribed by the primary researcher.

Data Analysis

Braun and Clarke⁸ six-phase reflexive thematic analysis (RTA) was applied throughout.⁹Phase one involved immersive, repeated reading for deep data familiarity. Phase two generated initial codes systematically across the full dataset. Phase three codes into candidate themes. Phase four reviewed and refined themes against both coded extracts

and the full dataset, producing a thematic map. Phase five defined and named themes with precision. Phase six produced the analytical narrative. Analysis was iterative; themes were built inductively from the data, not imposed a priori.

Rigour

Four strategies established rigor. A researcher reflexivity journal documented positional assumptions, relationships with participants and evolving interpretive decisions throughout – a critical safeguard given that the primary researcher was a trainee within the same FCPS system under study. Methodological triangulation cross-referenced supervisors and trainee perspective to identify convergence and productive divergences. Peer debriefing with a co-investigator external to the clinical setting provided independent analytical challenge. Member-checking – sharing thematic summaries with four participants – confirmed interpretive accuracy and gave participants the opportunity to contest or refine findings.

Ethical Considerations

Ethical approval was obtained from the Institutional Review Board of Health Services Academy, Islamabad (Approval reference: HAS-IRB_2024_XX). Written informed consent was obtained from all the participants before data collection began. Confidentiality was protected through full anonymization. Participants are identified only by role and, for trainees, training year (e.g., Supervisor 3; Trainee, Year 3). No identifying information appears in the data extracts presented below.

Results

Participant Characteristics

Eleven participants – five consultant supervisors and six postgraduate trainees – were included (Figure 1). Supervisors had between five and 18 years of postgraduate teaching experience. Trainees were distributed across Years 2, 3 and 4 of the FCPS programme. All participants had trained and worked within the same district-level teaching hospital, providing shared contextual grounding for their accounts.

Figure1. Participant Characteristics by Role and Experience

Participant Group	n	Years in Role (range)	Training Year
Consultant Supervisors	5	5 – 18 years	N/A
Postgraduate Trainees	6	FCPS Yrs 2–4	Years 2, 3 and 4
TOTAL	11	—	—

Note. All participants were based at the same district-level teaching hospitals in Bannu, Khyber Pakhtunkhwa, Pakistan. N/A = not applicable.

Overview of Themes

Four interconnected themes emerged from the data (Table 1; Figure 2). Together they describe a

programme in which entrustment is enacted daily yet without explicit criteria – shaped by contextual necessity and interpersonal intuition rather than structured competency assessment. Twelve illustrative participant extracts, selected for conceptual richness and representativeness, ground each theme directly in the data.

Table 1. Summary of Themes, Subthemes and Core Interpretations

No.	Theme	Subthemes	Core Interpretation
1	Intuitive Entrustment	Gut feeling; experiential heuristics	Subjective, unarticulated decision-making based on accumulated tacit supervisor knowledge; experienced as unpredictability by trainees
2	Ambiguous Expectations	Absent explicit criteria; hierarchical opacity	Trainee uncertainty about performance standards and progression benchmarks; frustration on both sides of the relationship
3	Multifactorial Determinants of Trust	Competence; reliability; task-risk calibration; relational factors	Trust calibrated across trainee, task, contextual and interpersonal dimensions simultaneously; consistent with Ten Cate's four-variable model ⁵
4	Systemic Constraints	Workload pressure; supervisor scarcity; absent mentorship	Necessity-driven entrustment in the absence of adequate supervisory capacity; the defining contextual feature of this LMIC programme

Note. Themes were identified through Braun and Clarke's six-phase reflexive thematic analysis.⁹ Each theme represents a distinct dimension of the

entrustment experience in this FCPS Internal Medicine programme.

Figure 2. Relative Prominence of Themes Across Participant Interviews

Measure	Theme 1 Intuitive Entrustment	Theme 2 Ambiguous Expectations	Theme 3 Multifactorial Determinants	Theme 4 Systemic Constraints
References across interviews (n)	9	8	10	9
Participants referencing theme (of 11)	10/11	9/11	11/11	10/11
Dominant participant group	Supervisors	Trainees	Both equally	Both equally
Illustrative quotes (n)	3	3	3	3

Note. Theme 3 was the only theme referenced by all 11 participants. Frequency data are illustrative, derived from thematic coding across the full dataset.

Theme 1: Intuitive Entrustment

Supervisors consistently described making entrustment decisions through a felt sense of trainee readiness - a rapid, integrative judgement drawn from years of clinical observation rather than any formal assessment tool. Decisions about unsupervised tasks allocation emerged naturally after extended contact with a trainee. Trainees, however, experienced this same process as unpredictability: they perceived autonomy as granted or withheld according to the supervisor's workload or mood rather than their demonstrable performance. The following extracts illustrates this disconnect from both sides.

"I don't really follow a checklist or form. After working with a resident for a few months, you just develop a feeling - you know whether you can trust them or not. It's experience. You can see it in how they carry themselves on the ward."

-Supervisor 2

"When I see a trainee handling a difficult calmly, asking the right questions, coming back to me with a clear plan - at that point I don't need a form to tell me they are ready. I already know."

-supervisor 4

Trainees, however, experienced this same intuitive process very differently. Rather than feeling their

competence was being recognized, many described the granting of autonomy as unpredictable.

"Sometimes you are given more responsibility, sometimes less - and honestly you cannot always tell why. It depends on the day, on how busy the ward is, on which consultant is on duty. There is no fixed standard that we know about."

-Trainee, Year 3

This disconnect - supervisor intuition versus trainee opacity - is the foundational problem this theme captures. The supervisors experience the decision as natural and well-founded; the trainee experiences the same decision as arbitrary. Without a shared framework, both perceptions coexist indefinitely.

Theme 2: Ambiguous Expectations

Neither supervisors nor trainees could readily articulate what a trainee must demonstrate before being granted independent clinical responsibility. Supervisors described personal expectations that shifted in response to departmental changes rarely communicated formally. Trainees described completing tasks without understanding the intended learning outcome or the progression criteria against which they were being judged.

"To be honest, the expectations are not written anywhere. I tell my trainees what I think they should be doing at each stage, but I am going by my own experience. Another supervisor might have completely different expectations for the same year of training."

-Supervisor 1

"We are supposed to be assessed on certain competencies, but nobody has sat with us and said: this is what Year 3 looks like, this is what you need to achieve by the end of this rotation. We just do the work and hope it is good enough."

-Trainee, Year 2

The frustration this generated was particularly acute among senior trainees approaching independent practice. Having invested years in the programme, they remained uncertain whether they had met benchmarks that had never been made visible to them.

"I am in my fourth year. I should know by now whether I am ready to practise on my own. But nobody has told me where I stand. I pass my exams, I do my work, but the question of whether I am trusted – truly trusted – I don't know the answer."

-Trainee, Year 4

This absence of shared criteria removes the developmental feedback loop on with CBME depends: without visible benchmarks, trainees cannot identify gaps, seek targeted learning opportunities or track their own progress toward independence.

Theme 3: Multifactorial Determinants of Trust

This was the most prominently coded theme, referenced by all eleven participants. Entrustment was not a simple binary decision; it was modulated simultaneously by at least five dimensions: demonstrated clinical competence; consistently and reliability of performance over time; the perceived risk inherent in the specific task; the quality of the supervisor – trainee interpersonal relationship; and immediate contextual pressures including time of day and patient acuity.

"It is not just about whether they know the diagnosis. I think about: have they been reliable? Do they come back and tell me when something changes? Can I trust them to know their own limits? A trainee who knows when to call me is far more trustworthy than one who thinks they know everything."

-Supervisor 3

"For a simple – a stable patient, routine management – I will step back earlier. For something high-risk, a DKA that is not responding, a patient deteriorating overnight – I need to be there. The task itself changes how much I trust, regardless of who the trainee is."

-Supervisor 5

Trainees were equally aware that trust was multidimensional, though they experienced it from the outside, trying to interpret signals they were not directly given.

"I know that what matters is not just clinical knowledge. It is also whether the supervisors likes you, whether you communicate well, whether you have had problems before. Trust is built over time but it is also about the relationship, not just the medicine."

-Trainee, Year 3

This multidimensional structure mirrors the four-variable framework proposed by Ten Cate and colleague⁵ confirming its cross-culture applicability in this LMIC context. The relational dimension – supervisor – trainee relationship quality – emerged with particular prominence here, possibly reflecting the more hierarchical and high-context nature of the clinical culture in this setting.

Theme 4: Systemic Constraints

Structural limitations were pervasive and exerted perhaps the most consequential influence on entrustment decisions in this setting. Heavy patients loads routinely exceeded supervisory capacity, compelling supervisors to grant trainees greater autonomy than their assessed competence alone would justify. Absent protected supervision time, limited faculty numbers and no formal mentorship infrastructure created conditions in which necessity-driven entrustment was the institutional default.

"There are days when I have forty or fifty patients and I am the only consultant. I cannot be everywhere. The trainees have to manage independently – not because I have decided they are ready, but because there is simply no other option. That is the reality here."

-Supervisor 1

"I would like to give proper supervision – sit with the trainee, discuss the case, observe the procedure, give feedback. But with this workload, that is not possibly most of the time. You have to trust them and move on."

-Supervisor 3

Trainees recognised this dynamic clearly, and many described a mixture of professional growth and anxiety about carrying responsibility that was not formally validated.

"We are doing the work of consultants sometimes. Managing complex patients, making decision at night, doing procedures – and this is good experience. But at the same time, nobody has officially said: you are ready for this. It just happens because it has to happen."

-Trainee, Year 4

This form of implicit entrustment under duress – where expended autonomy reflects institutional need rather than demonstrated readiness – is the defining contextual feature of this training environment and the dimension of this study's findings least accounted for by existing EPA frameworks developed in well-resourced settings.

Discussion

Principal Findings and Their Significance

This study set out to understand how entrustment decisions are made in a resource-constrained FCPS Internal Medicine programme in Pakistan. The answer is clear, and it is uncomfortable: entrustment happens constantly, but in the dark. Decisions about what a trainee may be do independently are made daily, yet without explicit criteria, transparent communication are documented accountability. This is not a local management shortcoming. It is a structural inequity that simultaneously compromises trainee development and patient safety.

The dominant pattern – intuitive, supervisor-held, unarticulated entrustment – is consistent with Ten Cate's description of ad-hoc entrustment arising from real-time clinical contact.⁵ What our findings contribute is contextual specificity: in this setting, ad-hoc entrustment does not supplement

structured summative assessment – it replaces it entirely. Trust exists in the supervisor's mind. It is felt, not shared. The Year 4 trainee who, after four years in the programme, did not know whether they were trusted to practise independently makes that inequity vivid in a way that aggregate data alone cannot.

Intuitive Entrustment Honest but Insufficient

The reliance on supervisor intuition documented here is not unique to Pakistan or to LMIC settings. Hauer and colleagues, studying general internal medicine programmes in the United States, found that supervisor entrustment decisions were substantially shaped by trainee affect, perceived trustworthiness and interpersonal familiarity, even when formal EPA instruments were actively in use.¹⁰ Intuition, in the other words, does not disappear when structured frameworks are introduced – it becomes one callibrated input among many rather than the only input. That distinction matters enormously. The supervisors in our study were not making poor decisions; they were making reasonable, experience-grounded judgements that remained invisible to the trainees being judged. Van Enk and Ten Cate have argued that the tacit knowledge underlying such judgements must be 'language' – made articulable and documentable – if it is to function as genuine assessment.¹¹ That language has not yet happened in this setting.

This interpretation aligns with Ten Cate and Taylor's argument that the primary value of EPAs lies not in their psychometric properties but in the conversations they generate: structured occasions for supervisors and trainees to speak explicitly about what readiness looks like and how close the trainee is to it.⁶ Those conversations are not happening in Bannu. They need to be.

Ambiguous Expectations: A Solvable Problem

The theme of ambiguous expectations closely mirrors findings from Rafiq and Sethi's study of entrustment for bedside clinical teachers in Pakistan, where absent explicit performance criteria generated trainee confusion and undermined developmental feedback.⁷ It resonates equally with Holmboe and colleagues'

observation that without explicit milestones framework, trainees default to institutional custom and informal peer modeling as proxies for competency targets – introducing large variability into trainee development.¹²

This is among the most tractable problems identified in the data. Younas and colleagues demonstrated that a modified-Delphi consensus process can generate locally valid, contextually grounded EPA descriptors for physicians-patient communication within Pakistan's postgraduate system.¹³ If that is achievable for communication, it is achievable for Internal Medicine clinical practice. The preconditions already exist in this institution: supervisor with experience, trainees with motivation, and a shared clinical context. What is absent is the organised, institutional sanctioned process for making implicit knowledge explicit.

Necessity Driven Entrustment: The Distinctive LMIC Contribution

The fourth theme – systemic constraints producing necessity-driven entrustment – is where this study makes its most original contribution to the EPA literature. That literature was developed and tested predominantly in the North American and European settings, where adequate supervisory infrastructure is assumed. In Bannu, that assumption does not hold. The trainee who said 'we are doing the work of consultants sometimes' and the supervisors who said 'there is simply no other option' are not describing exceptional circumstances – they are describing Tuesday.

This finding carries three distinct concerns. First, patient safety: necessity-driven entrustment allocates clinical tasks by institutional need rather than by the match between trainee capability task complexity, bypassing the risk-calibration that is the moral core of the EPA model.⁵ Second, a false developmental narrative: trainees who regularly perform advanced procedure under conditions of supervisor scarcity may internalise a sense of competence that has not been validated – a particular danger as they approach independent practice. Third, hidden labour: trainees carry real clinical risk without institutional

acknowledgement or educational credit, which overtime erodes professional identity and contributes to moral distress. Norcini and Bruch established that the educational value of clinical work depends critically on feedback and supervisory presence; without these, exposure may reinforce error as readily as competence.¹⁴ Schumacher and colleagues' realist synthesis of entrustment committee decision-making similarly found that default entrustment decisions – those driven by necessity rather than deliberate assessment – constitute a significant and underaddressed risk in postgraduate programmes.¹⁸ Our findings bring both observations into sharp contextual relief.

Implications for Practice and Policy

Three implications follow directly. First, the CPSP should commission the development of a locally validated EPA framework for FCPS Internal Medicine through a structured consensus process involving supervisors, trainees, programme directors and patient representatives. The 28-EPA framework validated by Poudeh and colleagues for Iranian Internal Medicine residents¹⁶ and the 13 AAMC Core EPAs¹⁷ offer validated starting architectures that can be adapted – not imported wholesale – through local Delphi or consensus processes. Contextualising EPA descriptors to the specific procedural case mix and supervisory structures of district-level hospitals in Pakistan will be essential.

Second, faculty development is not an odd-on; it is the enabling condition. The supervisors in this study were entrustment-capable but entrustment-unstructured. Targeted faculty development programmes that translate tacit clinical wisdom into articulable, documentable decisions frameworks have shown consistent benefits for entrustment consistency and trainee developmental outcomes in comparable settings.¹⁸

Third, supervisory workload is an educational quality variable, not merely an administrative one. The systemic constraints in this study are institutional design failures, not individual supervisors shortcomings. Addressing them requires health-system-level decisions about staffing ratios, protected supervision time and

consultant appointment processes – decisions within the reach of CPSP and provincial health authorities.

Strength and Limitations

To our knowledge, this is the first qualitative study of entrustment decisions in FCPS Internal Medicine in Pakistan. It fills a specific gap in the LMIC CBME literature. The interpretive descriptive designs, combined with reflexivity, triangulation, peer debriefing and member-checking, strengthens credibility and transferability. Including both supervisors and trainees enable a genuinely a dialogic account of an inherently relational process. Twelve participant extracts allow readers to evaluate interpretive claims directly against the data.

Limitations must be acknowledged. Eleven participants from one institution limit generalisability; multi-site replication across different FCPS centers and specialties is the clear new step. The primary researcher was a trainee in the same system, introducing potential social desirability effects despite confidentiality assurances – an influence the reflexivity strategy sought to identify and minimise. Finally, the data do not link entrustment practices to patient outcomes; future mixed-methods studies connecting entrustment process quality to clinical safety indicators would substantially strengthen the evidence base the reforms recommended here.

Conclusion

In this resource-constrained FCPS Internal Medicine programme, entrustment decisions are

made every day – but implicitly, inconsistently and without the transparency that trainees and patients deserve. A Year 4 resident who does not know whether they are trusted to practise independently is not an edge case; they are the product of a system without a structure to answer that question. The absence of a formal EPA framework does not stop entrustment from happening; it stops it from being fair, educational or safe.

The path forward is not to import frameworks designed for Boston or Amsterdam. It is to build something here, from the ground up, with the supervisors and trainees who carry this programme every day. They hold the knowledge. What they need is the institutional structure to make that knowledge visible, the CPSP policy mandate to require it, and the faculty development investment to sustain it.

Safe, equitable specialist training is not a privilege of well-resourced systems. It is a baseline obligation to every trainee who walks onto ward – and to every patient who depends on what they find there.

Supplementary Material

Table 2. Internal Medicine Residency EPAs and Entrustability Levels by Training Year

The 28 EPAs below, with entrustability levels by training year, were validated by Poudeh and colleagues in an Iranian programme¹⁶ and are cited in the Discussion as a potential adaption framework for the FCPS programme in Pakistan.

Table 2. Internal Medicine Residency EPAs and Entrustability Levels (Adapted from Poudeh et al., BMC Med Educ, 2021)

No.	Entrustable Professional Activity	Yr 1	Yr 2	Yr 3	Yr 4
1	Managing internal medicine emergency cases (e.g., diabetic ketoacidosis, GI bleeding)	2	3	4	5
2	Managing cardiac emergency cases	2	3	4	5
3	Leadership of Internal Medicine emergency wards during crises	2	3	4	5
4	Leadership of the healthcare team	2	3	4	5

No.	Entrustable Professional Activity	Yr 1	Yr 2	Yr 3	Yr 4
5	Cardiopulmonary resuscitation	3	4	5	5
6	Internal medicine history-taking and physical examination	4	5	5	5
7	Clinical judgement and differential diagnosis	2	3	4	5
8	Interpreting para-clinical findings	2	3	4	5
9	Developing therapeutic protocols	2	3	4	5
10	Drug administration	2	3	4	5
11	Patient discharge	1	2	3	4
12	Admitting patients from other medical services	1	2	3	4
13	Referring patients to other services	1	2	3	4
14	Admitting patients to other services	1	2	3	4
15	Consultation to other services	1	2	3	4
16	Pre-operative consultation	1	2	3	4
17	Requesting consultation from other services	1	2	3	4
18	Appropriate patient education	2	3	4	5
19	Teamwork and collaboration with other services	2	3	4	5
20	Continuous professional competence improvement	2	3	4	5
21	Education of junior-level trainees	2	3	4	5
22	Managing common Internal Medicine outpatient cases	2	2	3	4
23	Care of patients in intensive care wards	2	3	4	5
24	Requesting appropriate diagnostic investigations	3	4	5	5
25	Administering and requesting appropriate rehabilitation	2	3	4	5
26	Team leadership in the specialty field	2	3	4	5
27	Performing primary procedures (e.g., NGT insertion, urine microscopy)	3	4	5	5
28	Performing advanced procedures (e.g., lumbar puncture, pleural/ascitic tap)	2	3	4	4

Note. Entrustability levels: 1 = Be present and observe; 2 = Act with direct supervision; 3 = Act with indirect supervision; 4 = Act without supervision; 5 = Provide

supervision to others. Adapted from Poudeh et al. (2021).¹⁶

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