



American Board of Surgery

Frequently Asked Questions about General Surgery EPAs

Updated March 2025

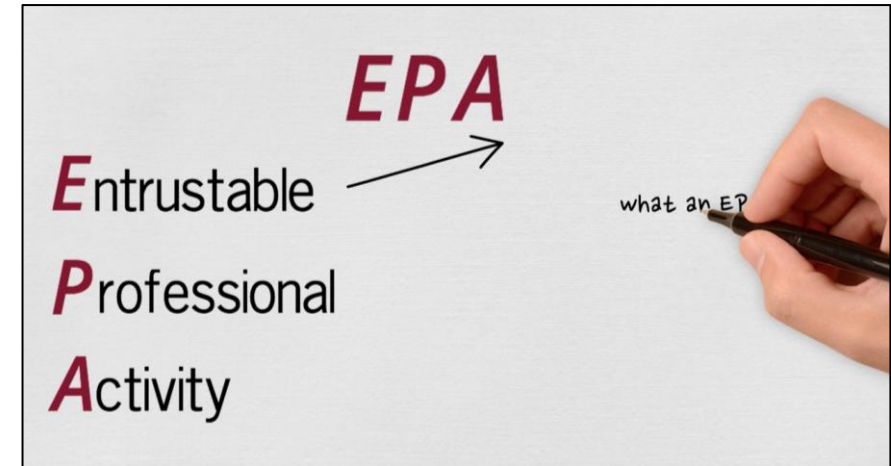
Why are EPAs being implemented? Because EPAs..

- Prioritize demonstrated competence as the outcome of training
- Create an efficient model for frequent formative feedback focused on progressive autonomy
- Establish a clinically relevant and reliable mechanism for assessment of trainee competence
- May help mitigate assessment bias by anchoring assessment on discretely observed behaviors in daily clinical workflow
- Provide a common mental model for trainees and faculty for core training outcomes



What are the characteristics of an EPA? An EPA...

- Facilitates competency-based medical education (CBME)
- Is part of the regular clinical work of a surgeon
- Defines units of professional practice (tasks) that may be entrusted to a learner once they have demonstrated the required competence
- Can be directly observed
- Involves the use of relevant knowledge, skills, and behaviors
- Enables a shift of focus from individual competencies to the work that must be done
- In aggregate can define the core scope of a specialty



- Turns the equation into a partnership between learner and evaluator
 - Empowers learner to seek out the evaluation opportunity
 - Asks evaluator to assess TRUST, changing the frame and conversation
 - Provides clear anchors for evaluator (as part of workflow) that are meaningful and substantial

How are EPAs observed and evaluated?

Entrustment Level	Framework
Limited Participation Knows information, has very basic skills	What a learner should know directly out of medical school. Attending can show and tell.
Direct Supervision Knows the steps of the task/operation but requires direction in executing, does not understand nuances of a basic case	The learner can use the tools but may not know exactly what, where, or how to do it. Attending gives active help through the case to maintain forward progression.
Indirect Supervision Can do straightforward tasks/operations but will not recognize more complex variations, does not understand nuances of an advanced case	The learner can perform the task or operation in straightforward circumstances. Attending gives passive help. This may be while scrubbed for more complex cases or a check-in for more routine cases.
Practice Ready Can manage more complex operations and take care of most cases	Can treat all patients with straightforward disease and has a strong understanding of surgical options and technique for less common scenarios. Attending is available at the request of the learner but not routinely needed for common presentations, though input may be needed for more complex presentations.

Example: Intraoperative/Procedural Phase Generic Behavioral Elements

Intraoperative/Procedural Phase

1

Limited Participation

Can describe basic anatomy pertinent to operation/procedure
Difficulty coordinating hands to accomplish dissection of normal planes
Can identify normal anatomic structures in straightforward setting

2

Direct Supervision

Can articulate but not necessarily identify key anatomic landmarks
Sometimes does not use both hands in a coordinated manner, often tentative
Can do less critical parts of the operation/procedure independently

3

Indirect Supervision

Can perform key steps of operation/procedure in straightforward settings
Smooth instrument handling with effective use of both hands
Can do adjunctive maneuvers when needed in straightforward settings

4

Practice Ready

Can do operation/procedure safely including all steps in essentially all patients
Recognizes when deviation from initial plan indicated
Smooth movements but may lack economy of motion in most difficult cases

Example: Evaluate and manage a patient with gallbladder disease

Intra-Operative Phase

1

Limited Participation

Describes anatomic boundaries of hepatocystic triangle
Difficulty coordinating hands to accomplish dissection of normal planes
Can identify normal anatomic structures

2

Direct Supervision

Articulates critical view of safety but cannot reliably obtain it in the OR
Sometimes does not use both hands in a coordinated manner, often tentative
Removes gallbladder from liver bed with minimal assistance

3

Indirect Supervision

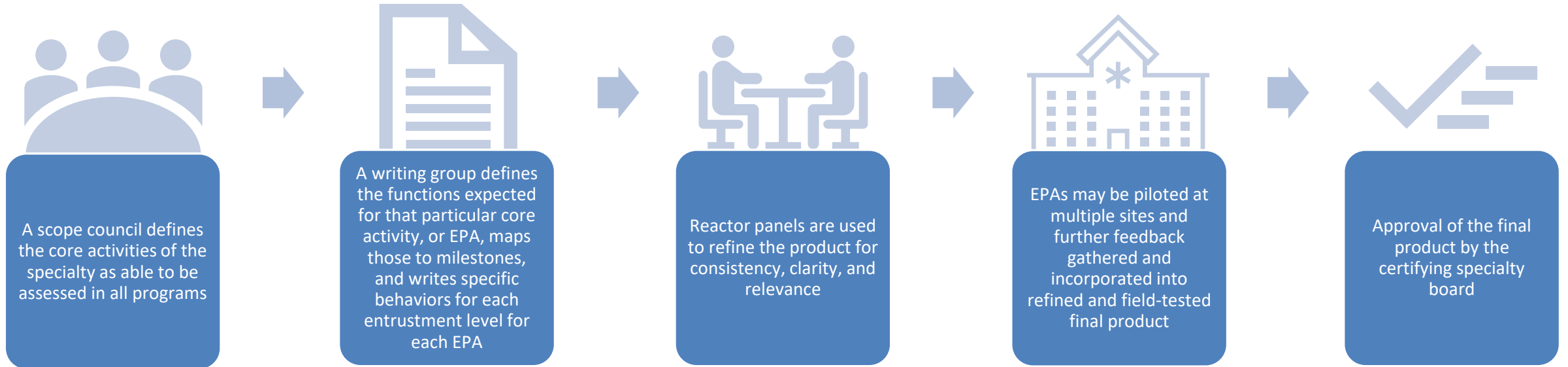
Obtains critical view of safety in routine cases
Smooth instrument handling with effective use of both hands
Performs cholangiography in straightforward cases

4

Practice Ready

Performs cholecystectomy and cholangiography in essentially all patients
Recognizes when deviation from initial operative plan indicated
Smooth movements but may lack economy of motion in difficult cases

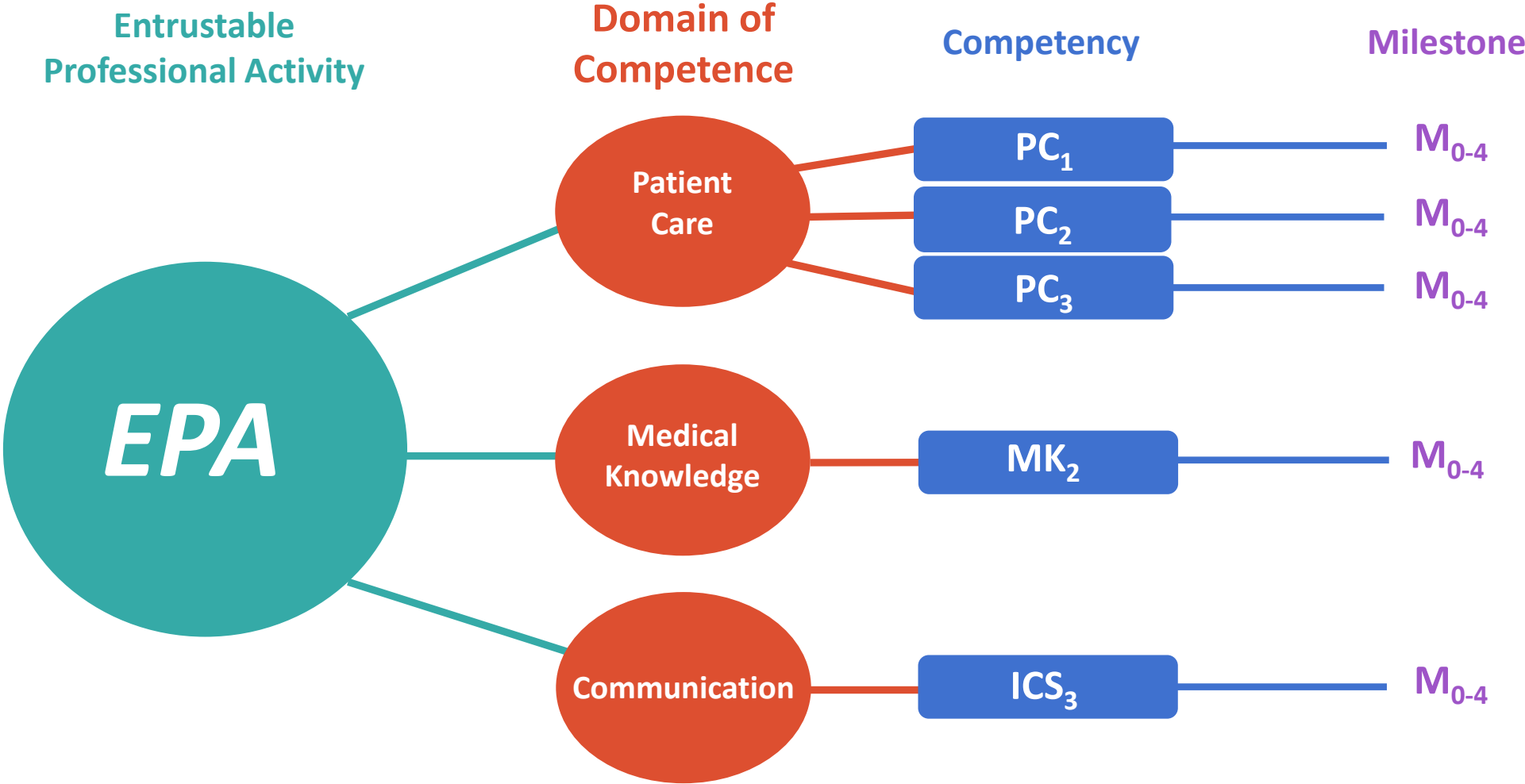
How are EPAs developed?



Do EPAs replace milestones and competencies?

- No, EPAs provide a means of assessing a trainee's progress towards autonomy and full entrustment in relevant clinical workflow contexts that reflect competence
- EPAs are mapped to sub-competencies to inform milestones assessments by CCCs
- Programs should continue to use other assessments, particularly for sub-competencies that aren't easily observed in clinical workflow and in line with RRC requirements

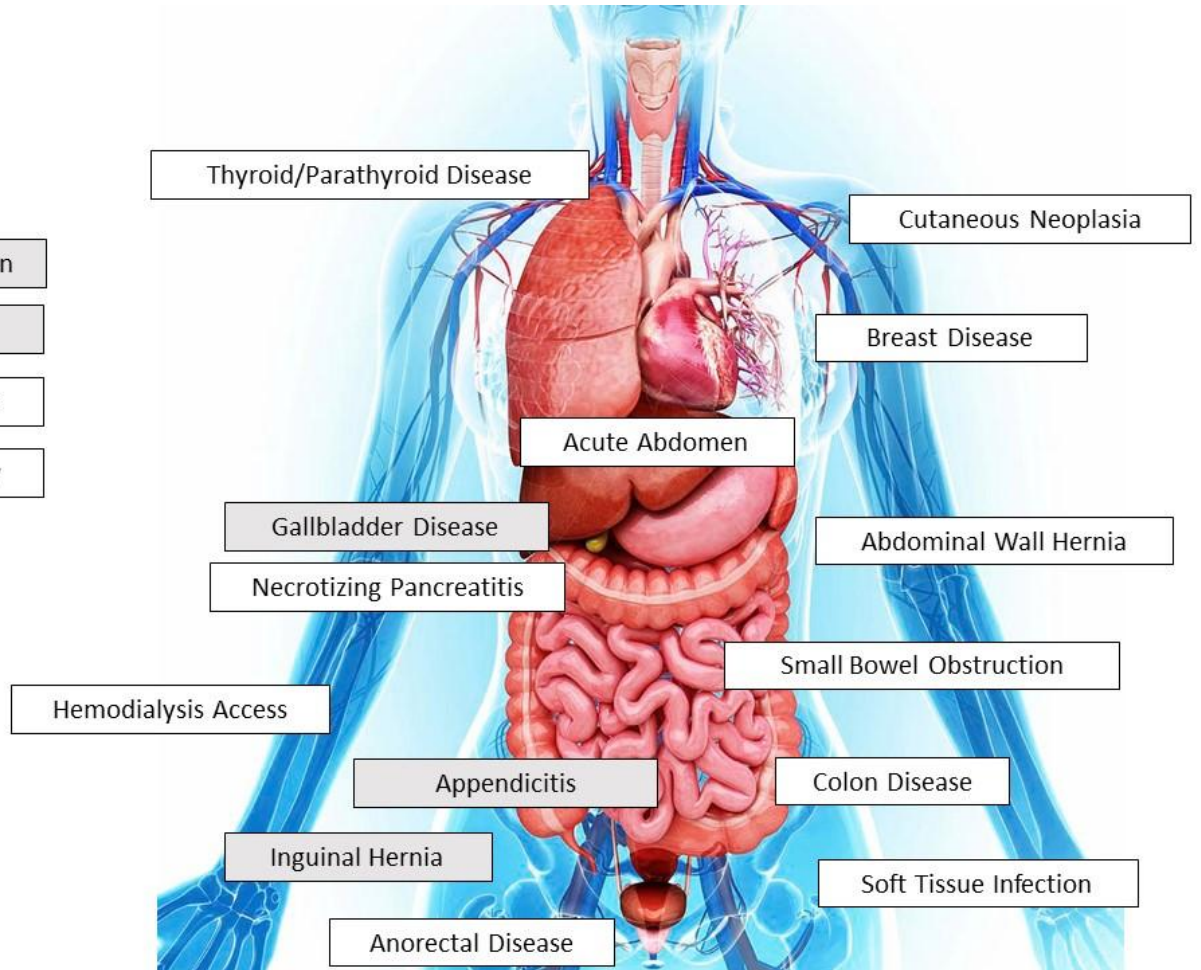
EPA's incorporate and reflect competencies and milestones



What are the general surgery EPAs?

- Collectively, these are meant to define the core of the specialty as able to be assessed in all training programs
- Those in gray background were evaluated in pilot study 2018-20

- Surgical Consultation
- Trauma
- Critically Ill Patient
- Flexible Endoscopy



ABS Specialty Board EPA Timeline

- All specialty EPAs expected to launch in 2025-2026 academic year
- **Vascular Surgery Board: 15 EPAs**
- **Pediatric Surgery Board: 20 EPAs (19 required, 1 optional)**
- **Trauma, Burns, and Surgical Critical Care Board: 13 EPAs (9 required, 4 optional)**
- **Complex General Surgical Oncology Board: 12 EPAs**

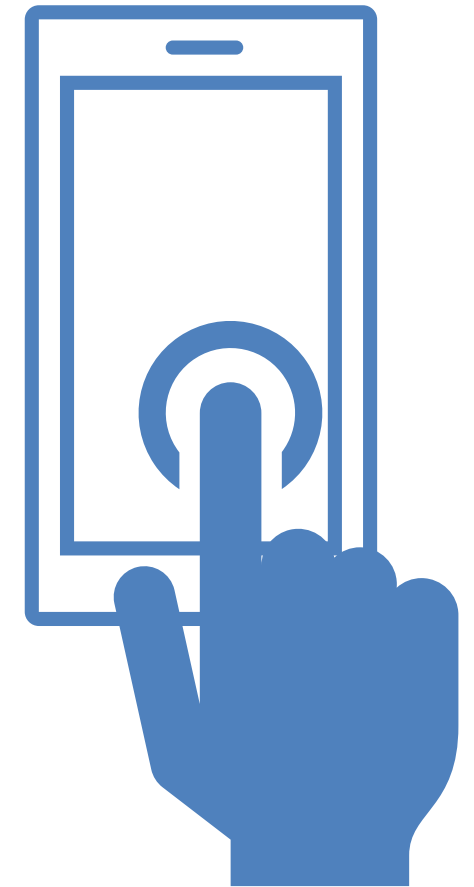
What about the mobile app?

How will trainees be assessed on EPAs?

- A mobile app is available to programs free of charge (sponsored by the ABS)
- Involves 4 possible entrustment levels, defined as the level of entrustment which would be granted to the trainee the next time based on what was just witnessed
- Involves multiple phases of care (e.g., preop, intraop, postop)

What does the app do?

- Utilizes drop-down menus and behavioral anchors to allow efficient assessment
- Allows for additional narrative feedback via dictation or typing function
- Includes analytics for trainees, faculty, CCCs, and program leadership to review



Can my program use an alternative collection method?

- Yes, programs may use whatever collection method they choose
 - Programs will need to collect data via locally available electronic or other methods
 - Alternate tools must be approved by and developed in conjunction with the ABS
- Trainees from programs so affected will still be required to turn in a composite EPA performance profile when they apply to take any written ABS initial certification examination

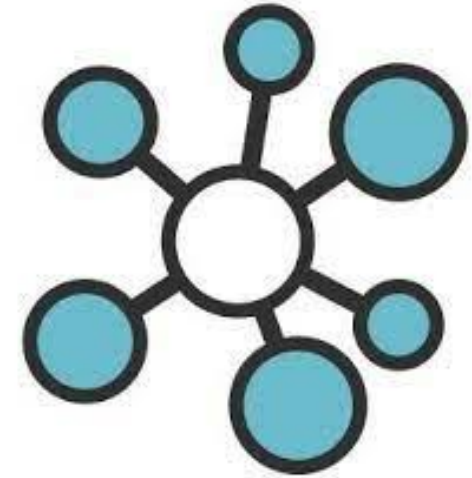
How will data be housed and processed?

- The SIMPL Collaborative, as the app developer, provides secure data storage stakeholder-specific dashboards for trainees, program directors, faculty, and residency administrators
- The ABS does not have identified data until trainees turn in their composite EPA profile as a requirement for application to any written ABS initial certification examination

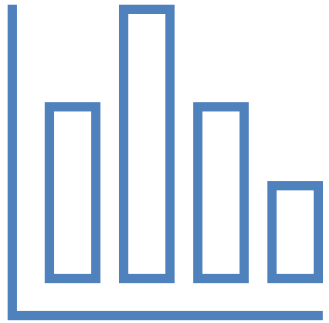


How will the ABS EPA app relate to the SIMPL OR operative assessment tool some programs are already using on a subscription model?

- The ABS EPA app can be accessed on a mobile device via the SIMPL app
- The ABS EPA app is being provided to all programs at the ABS's expense
 - This does not include the subscription service offered by the SIMPL Collaborative for the SIMPL OR operative assessment or any other subscription model products
 - Programs can choose to subscribe to these offerings separately with the SIMPL Collaborative



How will the data be useful to programs, trainees, and faculty?



Trainees will receive frequent formative feedback and behaviorally anchored data defining specific ways they can progress toward autonomous capability

Faculty will be able to see the entrustment profile of trainees they have not worked with recently to inform decisions on real-time entrustment



CCCs will have multiple data points based on direct observation, in temporal proximity to the performance observed, across nearly all milestones to factor into summative CCC decision-making

Program directors will have compiled data over the entire course of training on which to base attestations required at the completion of training



How will the ABS evaluate the adoption, impact and quality of this initiative?

- The ABS will monitor de-identified overall usage and engagement data by program
- The ABS will identify best practice models and provide resources to programs struggling with implementation
- The ABS Research Committee has developed a research agenda
 - This committee will also review proposals to allow substantiation, refinement, and critical review of the EPA model to guide future improvements and modifications

What does the ABS expect of programs regarding use of the EPA model?

- **ABS Exam Application:** All applicants to written ABS initial certification examinations **will be required** to turn in a composite profile across all EPAs when they apply for the exam beginning with the:
 - **General Surgery:** 2028 GSQE
 - **Vascular Surgery:** 2029 VSQE
 - **Pediatric Surgery:** 2028 PSQE
 - **Complex General Surgical Oncology:** 2028 CGSO QE
 - **Surgical Critical Care:** 2027 SCC CE
- **Every trainee should be assessed on every EPA in every phase**
- **All faculty should be trained to function as assessors** to promote reliability and validity of the assessment

How does the rollout of EPAs affect trainees other than those who will be applying to take the ABS GSQE in 2028?

- Although the requirement for an EPA profile as part of the ABS QE application process will not occur until 2028 for general surgery, **use of EPAs for trainees at all PGY-levels is strongly encouraged as a best-practice strategy** to promote consistent habits of meaningful assessment and feedback and to provide other assessment economies
- To decrease administrative burden and in recognition of the changing educational environment in those programs that have already adopted EPAs:
 - PGY-5 residents who have been assessed using EPAs are not required to have completed the 6 operative and 6 clinical assessments that are required as part of the GSQE application
 - Current residents from U.S. programs who are actively engaged in EPAs (actively collecting assessments) are not required to complete the GME section of the application
 - Residents from programs that are not actively engaged in EPAs (have not collected any assessments), residents from Canadian programs, and residents who completed training prior to 2024 but did not apply to their qualifying exam previously will still be required to complete the GME section of the application

Specifically, are there requirements or recommendations for the number and distribution of assessments?

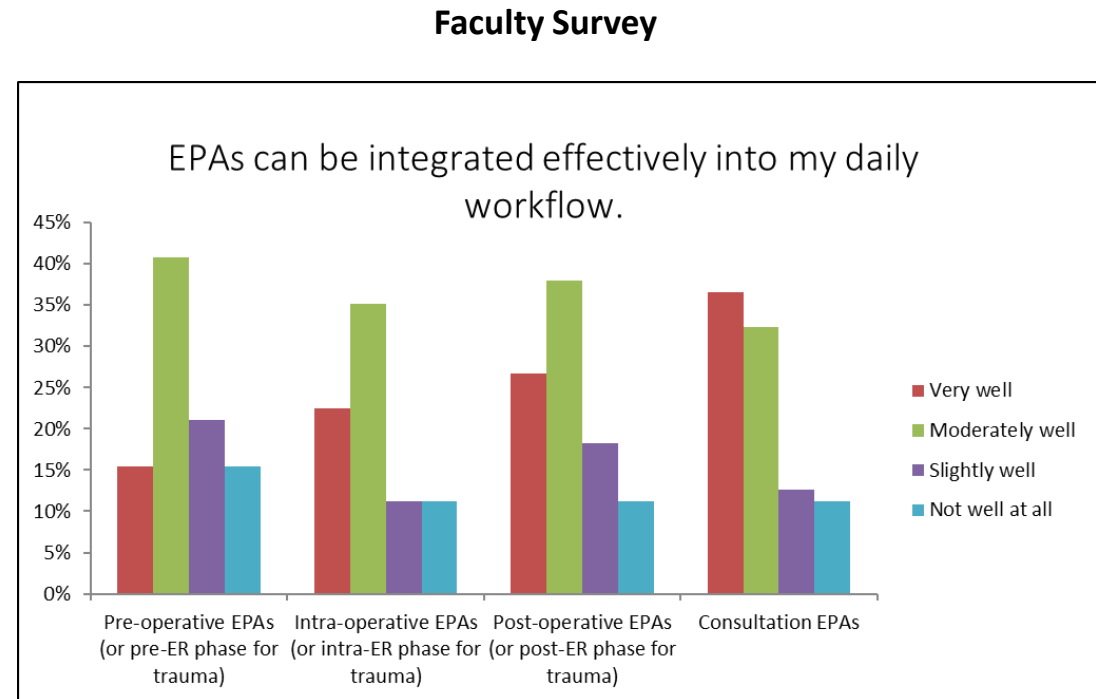
- Early data suggests 5-10 EPA microassessments may provide a foundation for CCC decision-making regarding entrustability for a given subcompetency domain
- A minimum of at least 2 EPA evaluations per week for each trainee would provide approximately 50 evaluations/resident over 6 months to inform CCC meetings
- The overall number of EPA evaluations may vary in relation to the number of EPAs in a given specialty

Will trainees be required to achieve practice-ready entrustment in all of their specialty's EPAs?

- Yes, that is the goal for the core elements of the specialty in a competency-based model
- The EPA model should be seen as a continuous quality improvement strategy for the developing trainee; it charts a journey with frequent waypoints and doesn't just define the endpoint
 - A single assessment of competency will not be sufficient
- The specialty boards of the ABS will monitor progress and collective performance with EPAs over the next several years to further inform acceptable performance endpoints

Faculty are busy; what do EPAs accomplish to relieve rather than impose faculty and program burden?

- EPA use will allow elimination or attenuation of other assessment structures that are not based on immediate assessment of directly observed performance
- By engaging with EPAs, programs will readily accomplish a number of RRC and ACGME program requirements, including those related to meaningful trainee assessment and faculty development
- EPAs will make CCC discussions more efficient and grounded
- EPAs can be completed in 1-2 minutes or less on a mobile device and are efficient for faculty workflow



What are specific examples of faculty assessment burden that EPAs could help improve?

- Some programs have **significantly shortened their end of rotation evaluations to 2-5 focused questions**, given the breadth of data EPAs will have already covered
- Some programs noted **CCC meetings were shortened by 50-75%** when the discussions were informed by EPA frequent micro-assessment data

Milestone mapping gaps in EPAs

- Because EPAs are based on directly observed performance in daily clinical work contexts, they cover most, but not all, milestone subcompetency domains
 - Examples of areas not covered may include themes such as self-maintenance, performance of administrative tasks, and longitudinal learning or project management

Who else besides surgical faculty can complete an EPA assessment?

- Some programs have recruited non-surgical specialists to complete EPAs for performances they are more likely to witness than a surgical faculty member
 - Such faculty should be developed to perform the assessments similar to the surgical faculty
- APPs can complete EPAs if they have participated in EPA faculty development programs and are assessing behaviors they are entrusted to perform independently themselves

Can trainees complete EPAs on more junior trainees?

- *Trainees may not function as a substitute for faculty in completing EPAs*
- Chief residents and senior fellows who have participated in EPA training and faculty development and have themselves been entrusted at the highest levels may complete EPAs on more junior trainees to provide feedback **IN ADDITION** to that provided by the faculty member

How will programs develop faculty and trainees for use of the EPAs?

- Engagement opportunities already available include recorded and ongoing webinars and townhalls and participation in the ABS EPA Program Champions initiative
 - [Become an ABS EPA Program Champion](#)
 - [Upcoming & Past ABS EPA Events](#)
- The ABS has developed additional materials to prepare programs, faculty, and residents for implementation, including checklists, timelines, videos, train-the-trainer courses, and more
 - [ABS EPA Resources](#)

EPA Resources
Faculty development materials and key guides and videos about Entrustable Professional Activities (EPAs) for programs and trainees.

[View Resources](#) [All EPA Videos](#)

FREQUENTLY ASKED QUESTIONS
Your most commonly asked questions about EPAs

Browse our EPA FAQs, where we answer the most commonly asked questions about EPAs. This document is updated regularly to reflect where we currently are in the implementation phase.

[Review the FAQs](#)

ESSENTIAL GUIDES AND VIDEOS
Key faculty development materials

These resources will be the most useful when introducing program faculty to EPAs and the ABS EPA App.

- Frequently Asked Questions About EPAs
- EPA Grand Rounds Videos
- "Train the Trainer" Essential Videos for Faculty
- Additional EPA Videos
- Implementation Checklists

GET CERTIFIED

Entrustable Professional Activities (EPAs)

In February 2022, the ABS announced the move to competency-based assessment of surgical trainees with the introduction of the ABS Entrustable Professional Activities (EPA) Project, which launched in July 2023 for general surgery residency programs and will expand to all ABS specialties by 2026.



WHAT IS AN EPA?

EPAs are units of work a physician performs that can be directly observed

Entrustable Professional Activities (EPAs) were developed to provide the opportunity for frequent, time-efficient, feedback-oriented and workplace-based assessment in the course of daily clinical workflow. EPAs are an important clinical assessment component of competency-based resident education (CBRE). They offer the opportunity to operationalize competency evaluation and related entrustment decisions in the course of regular patient care, and address some of the challenges educators and trainees have faced in bridging core competency theory into clinical practice and performance assessment.

It is important to note that EPAs are NOT competencies, but rather a complement to competencies, and serve as a way to translate the broad concept of competency into everyday practice.

- EPAs are units of work a physician performs that can be directly observed - things people do, such as evaluating and managing a patient experiencing a specific medical concern.
- Competencies are broad and foundational domains of ability, such as medical knowledge or interpersonal skills.
- Milestones are capabilities that describe progress at advancing levels of competence along the sequence from novice to expertise.

A suite of EPAs for a specialty can define the core clinical activities that a resident should exhibit to be deemed competent and worthy of autonomy and entrustment in patient care. Because EPAs are anchored in clinical practice, they allow a way to capture the in-the-moment decisions that attending physicians are already making about how much supervision or autonomy they will give a trainee in a real-world setting and can inform the trainee's progress towards entrustment for a patient's care.

Questions?

Contact us at epas@absurgery.org



Don't forget to check out the new EPA section of the [ABS website](https://www.absurgery.org)!