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Crossing the threshold: Seizing the *kairos* moment as postgraduate medicine adopts workplace-based assessment

After years of committee work, pilot testing, and quiet persuasion, workplace-based assessment built around entrustable professional activities (EPAs) is poised to be rolled out across six postgraduate medical disciplines - Clinical Pharmacology, Emergency Medicine, General Surgery, Nuclear Medicine, Obstetrics and Gynaecology, and Otorhinolaryngology (Ear, Nose, and Throat) - in South Africa (SA). This formative-assessment rollout involves entrustment decisions that will count towards progression and exit eligibility over time. This is not a minor administrative adjustment to the assessment process in specialist medical education; it is a *kairos* moment, a bounded, opportune window in which the underlying pedagogy of postgraduate training, not only its paperwork, can be reshaped. The ancient Greeks distinguished *kairos*, the right or opportune moment, from *chronos*, the mere passage of time. *Chronos* has brought us to this point through years of curriculum committees and accreditation cycles; *kairos* determines whether that time was well spent. EPAs translate the abstract language of competency frameworks into observable units of professional work that can be entrusted to a trainee with graduated independence,[1] closing the long-lamented gap between what such frameworks promise and what happens at the bedside. Holmboe *et al*.[2] made a related point that assessment is not the endpoint of curriculum reform, but its engine room, and where assessment does not change, teaching rarely does either. These disciplines, now moving to implementation, hold something more consequential than a new form to complete after each patient encounter. They hold the chance to ensure that this procedural shift becomes a genuine pedagogical one.

The first, and perhaps most difficult, opportunity lies in the culture of medical hierarchy itself. Postgraduate training in SA, as elsewhere, has long been organised around steep gradients of power between consultant and registrar, a structure that discourages trainees from questioning, disagreeing, or admitting uncertainty in front of those who will ultimately sign off on their competence.[3] Properly implemented, workplace-based assessment can quietly but persistently disrupt this. Because EPAs require frequent, low-stakes, direct observation rather than a single high-stakes terminal examination, they force supervisor and trainee into repeated, structured conversation about performance—conversation that, conducted well, is dialogic not merely evaluative. This creates a systematised channel through which the trainee's own voice becomes part of the record, as opposed to being something offered tentatively and often unheard. Watling and Ginsburg[4] described assessment and feedback as inseparable from the relational and emotional context in which they occur; it follows that a hierarchical culture that silences trainees will produce assessment data that are thin, defensive, and unreliable, however sophisticated the instrument. If these disciplines use this rollout to insist on regular, documented, two-way engagement instead of assessment that is done to the trainee, workplace-based assessment becomes an instrument of fairness as much as one of measurement.

The second opportunity is curricular, and it has been a long time coming. Medical disciplines rarely work in isolation in real clinical practice: A patient with a gynaecological malignancy may move between the gynaecologist, general surgeon, nuclear medicine colleagues, and clinical pharmacologist advising on regimen toxicity, often within the same week. Yet postgraduate curricula have historically been designed as separate silos, each discipline assessing its own trainees against its own criteria, with interdisciplinary contact left to chance. The simultaneous introduction of EPAs across multiple programmes is, finally, an invitation to design shared or overlapping entrustable activities where disciplines and professions intersect. Although these are disciplines within a single profession but separate from one another, the evidence from interprofessional education is instructive. A major best evidence in medical education (BEME) systematic review found that learning together was generally well received and associated with improvements in collaborative attitudes, knowledge, and skills, although evidence of change in clinical practice and patient outcomes was more limited.[5] Curriculum renewal through this lens would, in the training years, model the multidisciplinary practice already expected of consultants.

None of this will matter, however, if feedback remains what it has too often been: an unstructured word offered in a corridor after something has gone wrong or withheld until the annual progress report. Workplace-based assessment delivers on its formative promise only if feedback is built into its architecture as a deliberate, scheduled activity instead of as an incident-triggered afterthought. Norcini and Burch[6] were explicit on this point, namely, that the educational value of workplace-based assessment lies largely in the feedback conversation that follows observation, not in the score itself, and that conversation requires training, protected time, and institutional expectation to happen reliably. Programmes in which feedback is dispensed only after a critical incident or a failed rotation teach trainees, however unintentionally, that assessment is surveillance rather than support. These disciplines now have the opportunity, before habits harden, to build fixed points of structured, criterion-referenced feedback into each EPA, with feedback delivered regardless of whether anything has gone wrong, so that it becomes a rhythm of training rather than being a symptom of its failure. This resonates with a distinctly SA image. Writing on African notions of time, the SA theologian Cilliers[7] speaks of the *kairos* of the *karos* (a traditional animal-skin blanket used for warmth and protection, and a word probably of Khoekhoe origin) to evoke time experienced as communal sharing and caring. We hope that these learning conversations will transform cold, abstract, and often adversarial encounters into a communal blanket of collective responsibility.

Finally, if hierarchy softens, disciplines converge, and feedback becomes routine, the conditions are set for something Vygotsky[8] and, later, Lave and Wenger[9] described from different directions: learning as a social, situated process as opposed to a private accumulation of facts. Vygotsky's zone of proximal development reminds us that trainees achieve with skilled guidance what they cannot yet achieve alone. Lave and Wenger's account of legitimate peripheral participation reminds us that becoming a specialist is, more than the passing of tests, a matter of holding gradually fuller membership in a community of practice. Regular, entrustment-based observation that is embedded in genuine mentorship rather than gatekeeping is the mechanism by which trainees on the periphery move towards full participation. Hodges[10] has warned that assessment reform too easily collapses back into

a narrower, checklist-driven psychometric evaluation in which the collective and developmental nature of clinical learning is forgotten. The task now is to resist that collapse and to build mentorship, community, and genuine belonging into the scaffolding of EPAs so that what is assessed is not merely competence but the trainee's growing membership in the profession itself. The threshold has been reached; whether it is crossed well, in this narrow *kairos* moment, is now a matter of pedagogical will as much as policy.

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