

Demonstrated Competence Does Not Settle Readiness for Independent Pharmacy Practice: How Task Complexity and Available Supervision Shape the Entrustment of Professional Responsibility

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Abstract

Demonstrated competence is central to pharmacy education and professional progression, yet evidence that a practitioner can perform an activity does not alone determine whether responsibility for that activity should be entrusted under a particular set of practice conditions. This conceptual article develops a Configurational Entrustment Model that distinguishes competence, readiness, entrustment, and independent practice and examines how task complexity and practically available supervision alter the meaning of competence evidence. The model treats task demands and supervisory resources as interacting conditions rather than as additional components of a composite competence score. It proposes that comparable evidence of capability may justify direct entrustment in one setting, conditional or graduated responsibility in another, and continued supervision when consequences, uncertainty, coordination demands, or access to appropriate support change. This approach also makes reassessment theoretically necessary when the practice context changes after an earlier entrustment decision. The model provides a basis for interpreting workplace assessment, transition decisions, and responsibility allocation across heterogeneous pharmacy activities without assuming a universal supervision threshold. Readiness for independent pharmacy responsibility is therefore best understood as a context-conditioned judgment about the safe enactment of demonstrated capability, followed by a distinct decision about what responsibility may be entrusted.

Keywords: Competence, Entrustment, Readiness for practice, Task complexity, Clinical supervision, Pharmacy practice

Introduction

Competency-based education has strengthened efforts to define what pharmacists and pharmacy learners should be able to do, but the pharmacy literature also shows substantial diversity in how competencies are specified, assessed, and translated into educational progression [1]. Entrustable professional activities (EPAs) address part of this problem by shifting attention from isolated attributes

toward meaningful units of professional work. Their implementation in pharmacy education, however, remains heterogeneous in purpose, design, assessment, and interpretation [2]. This creates a consequential distinction: evidence that a learner or practitioner has demonstrated capability may be informative without completely determining what responsibility should be assigned next.

Pharmacy studies have already used EPAs to characterize performance during experiential education [3]. In other health-professions settings, longitudinal workplace evidence can be aggregated to support summative entrustment decisions, yet decision makers may still judge that a learner is progressing, ready, or insufficiently evidenced for a decision [4]. The existence of such uncertainty matters. Entrustment is not simply the

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administrative act of converting an assessment score into permission to practise. It is a judgment about responsibility made in relation to work that has particular demands and consequences.

The problem becomes especially visible when the same practitioner performs in different environments. A capability demonstrated under familiar conditions with immediate expert support may remain genuine when the task becomes less predictable or when help is difficult to obtain, while the responsibility that can safely be assigned may nevertheless change. A competence-only account has difficulty representing this possibility because it locates the decisive information primarily within the person. The configurational question is instead whether demonstrated capability, the demands of the activity, and the supervisory resources actually available together justify the responsibility being considered.

This article develops that question into a Configurational Entrustment Model for pharmacy practice. Its purpose is not to replace competency assessment or established EPA approaches, but to specify what must happen between evidence of capability and a defensible decision to entrust professional responsibility. The central claim is conditional: competence evidence is necessary to many entrustment decisions, but its implication for readiness depends on the task to be undertaken and the support that can realistically be mobilized if performance becomes uncertain, consequential, or difficult to recover.

Competence, readiness and entrustment are not equivalent

A useful starting point is the distinction between characteristics of a person and units of professional work. Competencies and skills describe attributes or capabilities of an individual, whereas EPAs identify professional activities that must be performed [5]. This distinction prevents a common inferential shortcut. Demonstrating a capability answers a question about what the person can do; it does not by itself answer whether a particular activity should now be assigned with less supervision in every environment where that capability might be relevant.

Entrustment-supervision scales reinforce this distinction because their central meaning concerns the amount or

form of supervision considered necessary for the activity, rather than a pure measurement of competence [6]. The decision is consequently relational: evidence about the trainee or practitioner is interpreted alongside characteristics of the supervisor, their relationship, the context, and the task. Medical students themselves have identified these multiple classes of factors when describing how entrustment judgments are made [7]. The practical implication is that an identical assessment record need not compel an identical decision when the surrounding conditions differ.

Readiness occupies a related but separate position. Qualitative work with postgraduate nursing preceptors found that decisions about unsupervised care incorporated competence alongside considerations such as risk awareness and reliability [8]. Pharmacy research has likewise used EPA-based instruments to examine practice readiness among students completing advanced practice experiences [9]. These studies do not establish one universal definition of readiness, but they show why the term cannot safely function as a synonym for competence. In this article, readiness refers to a contextual judgment that demonstrated capability can be enacted with an acceptable level of support under the conditions being considered. Entrustment is the subsequent decision about assigning responsibility under those conditions. Independent practice is a possible responsibility state in which routine supervisory involvement is no longer required for that defined activity and context; it is not another name for competence.

These distinctions change the questions that an assessor must ask. Evidence of repeated competent performance may justify confidence that a capability exists while leaving unresolved whether the work is sufficiently predictable, whether consequences are recoverable, whether appropriate help is accessible, or whether a change in setting has altered the conditions under which earlier performance was demonstrated. The four constructs therefore form neither a maturity ladder nor interchangeable labels for increasing proficiency.

The operational separation used throughout the model is shown in **Table 1**.

Table 1. Distinct judgment objects between demonstrated capability and independent pharmacy responsibility

Decision question	Judgment	Principal object of judgment	Evidence that can inform it	Context still relevant?	Practical consequence	Common category error
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What can this person demonstrably do?	Competence	Capability of the learner or practitioner	Observed performance, assessment evidence, knowledge, skills, integrated professional behaviors	Yes for interpretation and generalizability, although capability is the focal object	Establishes evidence of capability	Treating a competence score as permission to practise independently
Can this demonstrated capability be enacted safely under these conditions?	Readiness	Fit between demonstrated capability and the present practice conditions	Competence evidence interpreted with task demands, consequence, uncertainty, setting and accessible support	Intrinsic to the judgment	Supports or weakens the case for assuming greater responsibility	Treating readiness as a fixed personal attribute
What responsibility may be assigned now, and under what supervisory conditions?	Entrustment	Allocation of responsibility for defined professional work	Readiness judgment, task-specific evidence, supervisory resources, escalation arrangements and consequences	Intrinsic to the decision	Direct, conditional, graduated, maintained-supervision or deferred responsibility	Treating entrustment as another proficiency score
What responsibility may be carried without routine supervisory involvement?	Independent practice	Responsibility state for a defined activity and context	Prior entrustment evidence plus continuing fit between capability, task demands and practice conditions	Remains relevant because circumstances can change	Independent performance within a defined scope	Treating independence as permanent proof of unrestricted competence

Table note: The distinctions are analytical, not sequential requirements that every setting must formalize as four separate administrative steps. Readiness and entrustment remain revisable when the activity, setting, consequences, or supervisory resources materially change.

Task complexity as a modifier of entrustment

Supervised workplace learning research indicates that entrustment cannot be understood independently of the contexts in which participation occurs. A realist synthesis of postgraduate clinical training identified mechanisms linking supervision, observation, dialogue, trust, and progressive participation while showing that those mechanisms depend on contextual conditions at several levels [10]. For the present model, this suggests that task complexity should not be treated as a single fixed property labelled “easy” or “difficult.” It is the configuration of demands that determines how much inferential distance exists between prior competence evidence and the responsibility now being considered.

Studies of procedural entrustment illustrate the point. Clinical supervisors have described decisions as depending simultaneously on trainee characteristics and dynamic factors involving the patient, task, available time, and institutional environment [11]. Observational work in general practice likewise demonstrates that early entrustment is enacted through situated supervisory

practice rather than through mechanical application of a context-free competence judgment [12]. The demands of professional work can therefore modify what otherwise similar evidence means at the moment responsibility is allocated.

For pharmacy, relevant complexity may arise from several different sources. A familiar technical procedure may become consequential when an error is difficult to reverse. A clinical review may involve uncertain or conflicting information rather than procedural difficulty. Counselling may become demanding because of communication barriers or rapidly changing patient circumstances. Medicines optimization or prescribing-related work can involve interprofessional dependence and delayed consequences. These dimensions should not be added into a universal complexity score; they identify different reasons why previously demonstrated capability may require more support in one episode than another. Supervisory roles also shape how these demands are interpreted. Senior residents making entrustment decisions incorporate patient safety, the learning needs of

junior colleagues, and their own intermediary supervisory responsibilities [13]. Entrustment may further involve networks of team members whose willingness to engage with a learner affects opportunities and responsibility [14]. These findings make coordination itself relevant to complexity. Some professional work is difficult because the individual action is technically demanding; other work becomes difficult because safe completion depends on obtaining, integrating, or escalating information across people and roles.

Task complexity therefore modifies entrustment by changing the conditions under which capability must be enacted. It does not erase competence and should not be used to reinterpret every difficult outcome as incompetence. Instead, it changes the evidentiary question from “Has this person performed competently before?” to “How closely do the demands of the present responsibility resemble the conditions under which that competence evidence remains informative?”

Available supervision as a contextual resource

The second contextual component concerns whether appropriate support can actually be used when needed. Residents describe supervisor trust and support as influencing their responsibilities, learning opportunities, and experiences of patient care [15]. This suggests that supervision is more than a formal assignment of one professional to oversee another. For entrustment purposes, its important properties include whether support is accessible, sufficiently prompt, appropriately expert, and capable of enabling escalation before a developing problem becomes difficult to recover.

Supervisory practice is also fluid. Clinical supervisors shift between more and less hands-on approaches in response to situational demands rather than maintaining a stable supervisory style across every encounter [16]. Available supervision should therefore be distinguished from nominal supervision. A named supervisor who is remote, occupied, unfamiliar with the activity, unable to intervene promptly, or embedded in an unclear escalation pathway may provide less usable support than the organizational chart implies. Conversely, physical proximity is not always necessary when knowledgeable assistance is reliably reachable and the task allows time for escalation.

The relationship between assessment and supervision introduces an additional complication. Workplace-based assessment is shaped by trust and power, which can

influence whether trainees expose authentic uncertainty or strategically present performance to assessors [17]. These effects should not be absorbed into the Configurational Entrustment Model as if every rater preference were a legitimate component of readiness. They instead identify a rival source of variation: two supervisors can reach different judgments because the task-support configuration differs, but they can also differ because their tolerance of uncertainty, relationship with the learner, or interpretation of evidence differs.

Accordingly, the model treats available supervision as a contextual resource whose practical usefulness is conditional. Accessibility without suitable expertise may be insufficient. Expertise that arrives too late may be insufficient. Immediate support may matter less when the activity is predictable and recoverable. What matters is the relationship between the support that can be mobilized and the demands and consequences of the responsibility being considered.

Conceptual development of the entrustment model

Entrustment scholarship has already conceptualized decision making as an integration of information about the trainee, supervisor, and situation [18]. The distinctive task here is to reorganize those insights around the specific inferential transition that pharmacy progression decisions require: demonstrated capability must be interpreted for a defined responsibility under a defined configuration of task demands and usable supervision. The resulting model does not create another global competence score. It separates three analytical operations: establishing capability evidence, interpreting whether that capability is ready for enactment in context, and assigning responsibility with a specified form of supervision.

Workplace assessment records can contain information relevant to this interpretation. Analysis of thousands of direct-observation narratives has shown that feedback characteristics and task type contain information associated with entrustment judgments [19]. Professional activities can also be formulated at a sufficiently specific level to connect assessment with meaningful work; Delphi development of communication EPAs illustrates how complex professional interactions can be translated into entrustable tasks [20]. Yet greater task specificity does not eliminate measurement concerns. Generalizability work demonstrates that entrustment assessments remain sensitive to assessment conditions and assessor familiarity [21].

The model therefore treats competence evidence as an input whose applicability must be examined rather than as a verdict whose consequences are predetermined. Task demands and available supervision condition the interpretation of that evidence. The readiness judgment asks whether the demonstrated capability appears enactable under those conditions. Entrustment then specifies the responsibility that should follow. When the activity or support environment changes materially, the

model permits reassessment without implying that previously established competence has disappeared. This reasoning produces a distinctive configuration field. Evidence-supported relationships establish that entrustment is context-sensitive and supervision-responsive; the specific integration of competence, task demands, supervisory resources, and reassessment is the proposed synthesis advanced here.

A configurational model of entrustment in professional practice

Integrating demonstrated competence, situational demands, and available supervision

Multiple inputs.
Contextual judgment.
Flexible responsibility.

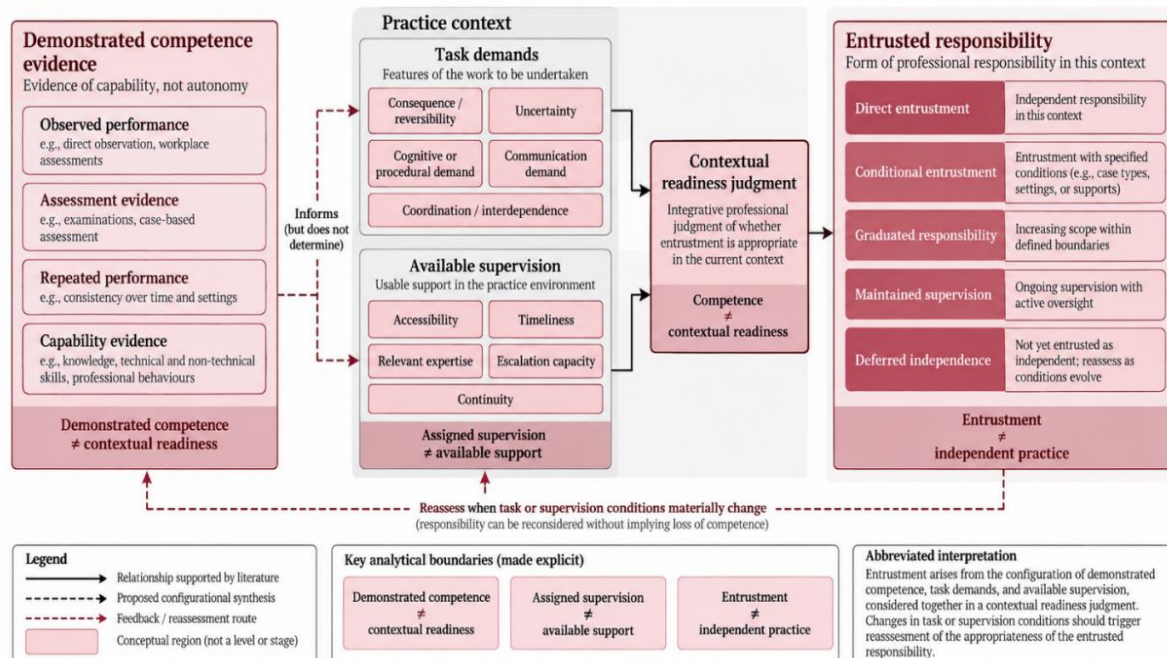


Figure 1. Demonstrated capability becomes entrusted responsibility through task- and supervision-conditioned interpretation

The task complexity × supervision configuration

Pharmacy-specific assessment research shows that entrustment can be operationalized through supervision-oriented rating systems rather than through competency labels alone [22]. This provides a useful measurement bridge but does not itself resolve which supervision level is appropriate for every activity. Indeed, preceptors evaluating readiness for advanced pharmacy practice experiences have shown substantial variation in the level of entrustment they expect across EPAs, alongside the broader problem that practice readiness lacks one consistently applied definition [23]. Such disagreement cautions against deriving a universal cut point from the existence of an entrustment scale.

Contextual calibration offers a different approach. In ambulatory-care experiential education, setting-specific expectations have been used to describe progression over the course of an APPE, while implementation work also exposed difficulties in obtaining consistent grading [24]. The important theoretical point is not the particular weekly schedule used in that setting. It is that an entrustment expectation can be meaningful only in relation to the professional activity, practice environment, supervisory arrangement, and point in progression for which it was designed. The Configurational Entrustment Model therefore treats task demands and available supervision as interacting conditions. When task demands are familiar,

consequences are readily recoverable, and appropriate support can be mobilized promptly, established competence may justify comparatively direct responsibility. When demands become less predictable or more consequential, the same practitioner may require conditional responsibility even if expert help remains readily accessible. Conversely, a task that is usually manageable can require greater caution when supervisory support becomes delayed, fragmented, or poorly matched to the problem that might arise.

The most restrictive configuration occurs when high uncertainty or consequence coincides with thin usable supervision. Here, continued supervision or deferred independence can be justified without declaring the practitioner globally incompetent. The converse error also matters. Extensive supervision for work that is well

within established capability, predictable in its demands, and supported by clear escalation routes can constitute under-entrustment, limiting development and unnecessarily retaining decisions at a supervisory level. A configuration is therefore a qualitative pattern of conditions, not a score. The model does not claim that one combination invariably produces one decision, because organizational policy, legal scope, assessor judgment, practitioner familiarity, and patient-specific circumstances can independently constrain responsibility. Its contribution is to make explicit which comparison should be made before competence evidence is translated into permission to act.

The resulting responsibility conditions are summarized in **Table 2**.

Table 2. How task demands and usable supervision alter the responsibility that demonstrated competence can justify

Task-demand signature	Practically available supervision	Entrustment condition	Responsibility form that may be justified	Safeguard emphasis	Reassessment trigger	Principal error if context is ignored
Familiar, predictable activity with consequences that are readily detected or recoverable	Appropriate support is reliably accessible if an exception occurs	Capability evidence closely matches current conditions	Direct entrustment within the defined activity and scope	Clear exception and escalation criteria	Material change in task, setting, consequence or performance pattern	Under-entrustment through unnecessary routine oversight
Activity contains meaningful uncertainty, coordination demands or greater consequence, but appropriate support is readily mobilizable	Timely, relevant expertise and escalation are available	Capability can be enacted with a protective support structure	Conditional entrustment with defined consultation or escalation expectations	Trigger points for consultation; explicit availability of expert support	Repeated exceptions, changed patient/task profile, or support becoming less accessible	Over-entrustment if support is assumed rather than verified
Familiar activity performed where support is delayed, fragmented or poorly matched to likely problems	Nominal supervision exists but usable assistance is thin	Technical familiarity is offset by reduced recoverability if difficulty develops	Graduated responsibility or maintained supervision depending on consequences	Contingency planning and narrower scope of independent action	Restoration or further erosion of usable supervisory capacity	Mistaking nominal supervision for practically available supervision
Activity has substantial uncertainty, potentially serious consequences, difficult reversibility or strong interdependence while usable support is limited	Escalation is delayed, unavailable or lacks relevant expertise	Context creates a weak basis for independent responsibility despite demonstrated capability	Maintained supervision or deferred independence for the defined activity	Direct oversight, transfer of responsibility or explicit deferral	Improved support, stronger task-specific evidence or reduced demand profile	Over-entrustment by treating prior competence as context-free permission

Previously entrusted activity after a material change in setting, task characteristics, technology, patient population or supervisory resources	Availability differs from the conditions under which prior entrustment was established	Prior entrustment remains evidence but no longer settles the present decision	Continued, expanded, narrowed or temporarily reconditioned responsibility	Targeted reassessment focused on what changed	Evidence that the new configuration is stable and adequately supported	Treating independence as permanent and context-insensitive
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Table note: These are proposed qualitative configurations derived from the reviewed evidence and the article's synthesis. They are not numerical categories, do not imply universal thresholds, and should not be interpreted as a fixed progression ladder.

Applying the model across pharmacy responsibilities

The configurational logic becomes more useful when applied to pharmacy responsibilities that differ materially in their demands. Prescription verification provides one example. Pharmacy students have been assessed on entrustable prescription-verification activities within skills-based laboratory courses, showing that a recognizable professional responsibility can be decomposed and assessed before independent workplace performance [25]. Yet successful performance in a laboratory cannot by itself settle responsibility in a practice environment where workload, atypical prescriptions, incomplete information, interruptions, or delayed access to an experienced pharmacist may alter the task-support configuration.

A second responsibility family involves evidence appraisal and collective decision making. A mock pharmacy and therapeutics committee activity has been used to integrate drug-information retrieval, evidence evaluation, written work, and verbal communication within an EPA-supporting educational task [26]. Such work illustrates why complexity cannot be represented only by procedural difficulty. The technical act may be manageable while uncertainty, communication requirements, coordination, or consequences of an incorrect recommendation make independent responsibility more demanding. Confidence developed through the exercise can inform learning but should remain distinct from a context-specific entrustment judgment.

Broader pharmacy EPA validation provides another perspective. Experienced pharmacists have judged a set of EPAs to be pertinent to the work expected of new graduates [27]. That finding supports the professional relevance of activity-based assessment while leaving room for different supervision requirements across activities and environments. A medication-history activity, a dispensing decision, patient counselling, evidence evaluation, or collaborative therapeutic recommendation may all be legitimate professional responsibilities, yet they differ in reversibility, uncertainty, patient contact, interprofessional dependence, and opportunities for timely escalation.

The model therefore predicts portability of entrustment logic without uniformity of entrustment outcomes. A pharmacist may be entrusted directly with a familiar responsibility in a well-supported setting and receive conditional responsibility for a superficially similar activity when consequences, ambiguity, or interdependence increase. The distinction is especially important during transition to practice because responsibility does not expand uniformly across all professional activities. Entrustment can be responsibility-specific and context-specific while still recognizing genuine competence.

Figure 2 represents this application as a field of heterogeneous pharmacy responsibilities rather than as a single progression sequence.

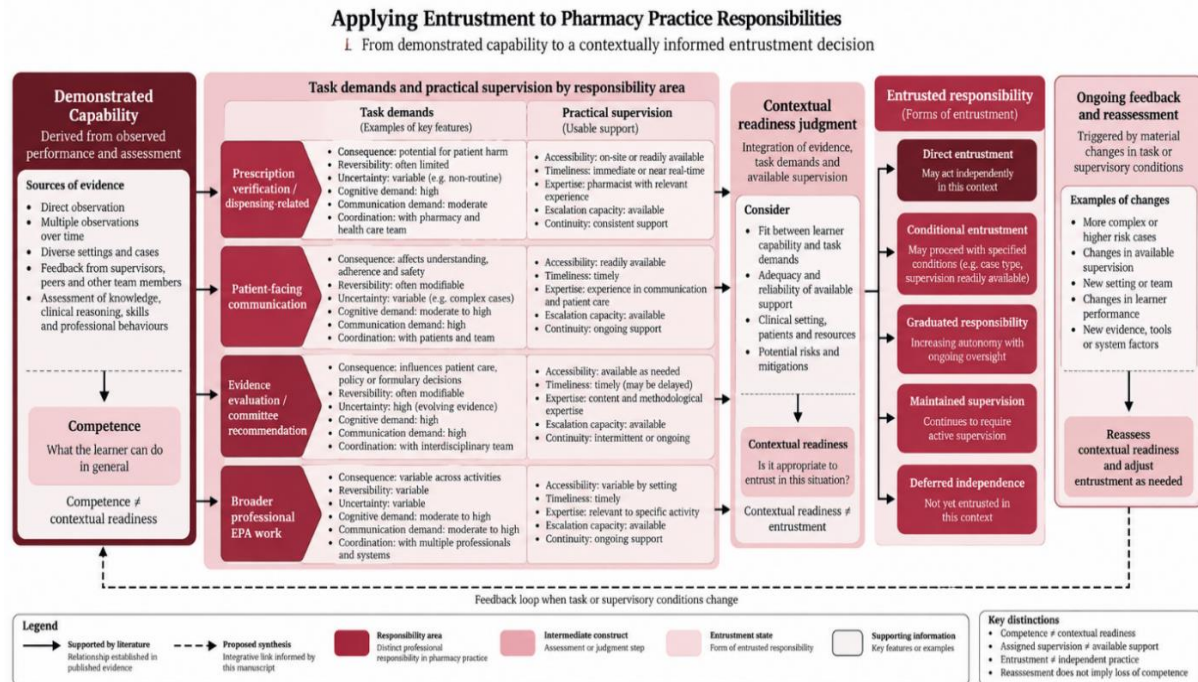


Figure 2. The same entrustment logic yields different responsibility states across heterogeneous pharmacy work

Implications for assessment and transition to independent practice

The model changes what progression assessment should attempt to document. Faculty evaluating readiness for advanced pharmacy practice experiences have demonstrated strong agreement about the importance of many professional activities while showing less agreement about the precise entrustment levels expected for them [28]. Importance and entrustment are consequently different questions. Assessment systems should preserve information about the responsibility being judged and the conditions under which performance was observed instead of allowing a global readiness label to erase those distinctions.

EPA-based assessment tools can support this work when their intended interpretation is explicit. An EPA assessment implemented in pharmacy practice experiences demonstrated strong internal reliability and close agreement between calculated and preceptor-assigned grades in its local setting [29]. Such measurement evidence is valuable, but reliability within one implementation does not establish that the resulting score predicts safe independent responsibility across different activities, supervisors, or practice environments. The entrustment interpretation still requires attention to task and supervision conditions.

Simulation provides another source of structured performance evidence. A dispensing-skills assessment framework has been supported through a validity argument linking simulation tasks to pharmacy competencies [30]. Redesigned EPA tools have also been viewed positively by pharmacy preceptors with respect to usability, accuracy, and feedback [31]. These developments can strengthen the evidence entering progression judgments. They do not eliminate the need to ask whether assessment conditions resemble the responsibility conditions for which independence is being considered.

For transition decisions, the practical implication is to record the conditions attached to an entrustment judgment. A learner may have accumulated convincing evidence of capability while entering a site where supervisory accessibility is different, the patient population is less familiar, or the responsibility involves greater uncertainty. A targeted reassessment of the changed component can be more defensible than either restarting competence assessment from zero or treating prior entrustment as permanently portable.

The same logic can inform credentialing, re-entry, expanded scope, and role transition. It supports calibrated responsibility without requiring a universal formula. Assessment evidence remains central, but its decision

meaning depends on the work to be performed and the resources available when difficulty arises.

Testable propositions and research agenda

The Configurational Entrustment Model can be tested against simpler explanations rather than accepted because it appears intuitively plausible.

Proposition 1. When demonstrated competence is held approximately constant, entrustment decisions will vary systematically with task demands and practically available supervision. Studies could present supervisors with standardized competence histories while experimentally or factorially varying task uncertainty, consequence, and supervisory availability. A competence-only account predicts limited change once capability is established; the configurational account predicts structured changes in assigned responsibility. Context-sensitive supervision findings provide a basis for such contrasts [10]. Procedural entrustment research likewise indicates that situational factors enter supervisors' judgments [11].

Proposition 2. The effect of reduced supervision availability on entrustment will be greater when tasks are difficult to reverse or escalate safely than when comparable capability is applied to predictable, recoverable work. This could be examined through vignette experiments, simulation-linked entrustment studies, or prospective workplace assessments in which accessibility and response time are recorded. Supervisor trust should be measured separately because trust can influence responsibility allocation independently of the configuration under study [15].

Proposition 3. Changes in task or supervisory conditions will explain some reversals or restrictions in responsibility even when competence evidence remains stable. Longitudinal studies could examine whether responsibility changes after rotation, site, workload, technology, or supervision changes. Demonstrating this pattern would distinguish the model from an experience-only explanation in which accumulated time or prior independence should make entrustment increasingly resistant to contextual change. Assessment generalizability across conditions should be measured explicitly [21].

Proposition 4. Confidence, assessor familiarity, and relationship quality will explain additional variance but will not fully account for the effects of task-demand and supervision configurations. Learner perspectives already indicate that entrustment incorporates supervisor, trainee,

relationship, context, and task factors [7]. Supervisory approaches also change dynamically in workplace practice [16], while trust and power can affect what becomes visible in assessment [17]. Multilevel studies separating practitioner, supervisor, task, and site effects could therefore test whether configurational variables retain explanatory value after these rival influences are modeled.

A pharmacy-specific research program should also test whether the model discriminates among responsibility families. Existing disagreement about expected EPA entrustment levels provides an empirical setting in which to examine whether variation that appears to be assessor inconsistency becomes more interpretable once activity demands and usable supervision are measured [23]. The goal is not to prove one universal entrustment algorithm, but to determine whether explicit contextual variables improve explanation and reproducibility beyond competence, experience, or supervisor preference alone.

Results and Discussion

The central contribution of this article is a separation of judgments that are often compressed into a single progression decision. Competence concerns demonstrated capability; readiness concerns whether that capability appears enactable under specified conditions; entrustment allocates responsibility; and independent practice describes a responsibility state for a defined activity and context. The distinction is consistent with the conceptual separation of competencies from professional activities [5]. It also aligns with evidence that supervised workplace learning is context-sensitive [10], that trust affects responsibility and learning opportunities [15], and that pharmacy education can operationalize entrustment through activity-based assessment [22]. Pharmacy EPA validation further supports the legitimacy of defining professional work as the object of entrustment [27].

The model adds task complexity and available supervision as interacting contextual conditions between competence evidence and responsibility allocation. This addition should not be interpreted as a claim that supervisors consciously compute these variables or that every observed variation in entrustment is desirable. Supervisors differ in how they conceptualize procedural entrustment [11], adjust their supervisory approach dynamically [16], and exercise power within assessment relationships [17]. Faculty also differ in expected

entrustment levels for pharmacy activities [28]. These findings establish important rival explanations. Some apparent contextual calibration may instead reflect assessor preference, institutional culture, risk tolerance, or uneven opportunities to observe performance.

Task complexity also requires careful use. The article deliberately avoids a generic complexity score because pharmacy responsibilities vary along non-equivalent dimensions. Uncertainty, consequence, reversibility, communication demand, and interprofessional dependence may matter differently across activities. Likewise, “available supervision” should not become a proxy for organizational prestige or staffing intensity. Its relevant meaning is narrower: whether appropriate support can be mobilized with sufficient expertise and timeliness for the responsibility at issue.

Several boundary conditions follow. Entrustment can be constrained by regulation, scope-of-practice rules, credentialing requirements, or organizational policy even when competence, task demands, and supervision would otherwise support greater responsibility. Experience and familiarity may alter performance independently of competence assessments. Confidence may influence willingness to act without demonstrating actual readiness. Trust can facilitate responsibility allocation while also creating the possibility that relational familiarity substitutes for task-specific evidence. The model therefore does not treat every contextual influence as part of the same mechanism.

Its strongest use is interpretive. Pharmacy education has adopted EPAs while continuing to confront variability in implementation and assessment [2]. Other health-professions research shows that entrustment emerges through supervision, participation, and workplace conditions [8]. Supervised learning itself is responsive to context [10]. Pharmacy validation work supports activity-based definitions of professional responsibility [27], while simulation-based assessment can strengthen evidence about performance without reproducing every condition of independent practice [30]. The synthesis developed here connects these findings without claiming that the proposed configuration has already been prospectively validated in pharmacy workplaces.

This interpretation also changes the meaning of inconsistency. Different responsibility decisions for practitioners with similar competence evidence are not automatically evidence of defective assessment. Some may reflect legitimate differences in task demands or available supervision; others may represent bias, local

convention, or unreliable judgment. Making the configuration explicit allows these possibilities to be separated empirically. That distinction is essential if entrustment is to support both development and safe transition without converting contextual judgment into unexamined discretion.

Conclusion

Demonstrated competence is necessary evidence for many decisions about professional responsibility, but it cannot determine readiness for independent pharmacy practice by itself. Readiness depends on whether that capability can be enacted under the demands of the specific responsibility and with the supervisory resources actually available. Entrustment is the decision that follows from that contextual interpretation, while independence is one possible responsibility state rather than the inevitable endpoint of a competence score.

The same evidence of capability can consequently support different responsibility decisions when task uncertainty, consequences, reversibility, coordination demands, or access to appropriate support change. The defensible conclusion is conditional: demonstrated competence can justify independent responsibility when the demands of the work and the available supervisory environment make that competence sufficient for the responsibility being entrusted.

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