



RESIDENT PORTFOLIO

Establishing Entrustment of Residents and Autonomy

Abstract

As residents, we constantly strive to independently manage our patients and develop care plans, while the role of the attending faculty varies between complete supervision and control, to allowing complete autonomy. This concept of attending physicians allowing appropriate autonomy so that residents can develop independence in their practice has been termed entrustment. Patients' and instructors' entrustment of responsibility reflects upon one's preparedness to assume professional responsibility after graduation. Over the past several months, we have been reflecting on our experiences working in the emergency department and how different faculty members entrust residents during each shift. Some experiences have been incredible as we develop our styles of practice, while others have been incredibly frustrating and soured the learning environment. As third-year residents, we studied the factors that allow faculty to foster an appropriate amount of entrustment and conducted discussions with multiple residents on this topic. We have found several themes of how this can be done well and share these ideas with a goal of improving autonomy for emergency medicine residents.

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PORTFOLIO

In January of my third year of residency, I received sign-out from my coresident and started a busy night shift. I was examining my first patient of the night, when I heard overhead "Doctor needed in CT scanner, stat." Overhead pages to the CT scanner are rare. I rushed over to the scanner to find a 60-year-old woman in extremis and realized I had just taken over her care in sign-out. She was audibly wheezing, flushed, and speaking in only one-word phrases. I called for the crash cart and epinephrine, as it appeared she was experiencing anaphylaxis from the intravenous (IV) contrast. Still tenuous, we moved her into a resuscitation bay. Over the next 20 minutes, I managed the distressed patient, ordering more epinephrine, nebulizer treatments, IV steroids, additional IV access, and close monitoring. The support staff rapidly completed the tasks while I debated the need for intubation. Fortunately, the patient clinically improved. Later, I realized two attendings were standing quietly behind me; one had just finished his shift and knew the patient, and the other was the oncoming attending for the night shift. Neither had said a word during the resuscitation and the nurses and techs looked to me for each order and next step. Afterward, I realized that this was my patient and my resuscitation, and the attendings had stood back silently allowing me to fill that role.

On another shift, a critical patient arrived and I was called to the bedside. The patient was transferred from an outside hospital, and as I rushed to the room, the attending was right behind me. He had taken the transfer call and already knew most of the details of the case. I knew none, so I started with the report from EMS and then turned to the patient to fill in more of the history.

He appeared stable, but I was not quite sure of all the details of the case. My attending already knew the patient had a gastrointestinal bleed and was anticoagulated due to his left ventricular assist device. He started barking out orders, including "Can you put the patient on the monitor?" "I need a second IV," "Type and cross for two units of RBCs," and "Call cardiac surgery." I stood there stunned for a minute, realizing that he had entirely taken over the care of the patient and I would just be doing the documentation of the case.

Another night, I was called to the bedside of a critical patient who arrived just after a motor vehicle crash. I prepared to intubate and arranged to have the GlideScope video laryngoscope available for backup. My first attempt with direct laryngoscopy bought me a grade three view, and I decided to retry with the GlideScope. As I prepared for the next step, I looked up and realized there was a mass of people surrounding me: my attending, the trauma attending, the trauma chief resident, other residents, and medical students, as well as the anesthesiologist, respiratory therapist, nurses, techs, and the new trauma research team. Suddenly I felt my heart begin to race. My attending looked at me, "You ready?" I directed in the GlideScope with a beautiful view, smiled, and advanced my tube, but could not get it through the cords. I panicked inside; this had never happened to me with a GlideScope. We bagged the patient. All eyes were on me. My attending turned to me, "You can do this. Try the GlideScope again, you've got plenty of time." Another attempt, another defeat. I wanted to hide in the corner. The trauma attending spoke up, "Don't you think it's time for anesthesia to take a look?" The anesthesia attending walked up calmly, "So what did you see?" We talked and as I tried

to move away to let her take over, she stopped me. "You can do this," and she handed me a bougie. With my attending on one side and anesthesia on the other, I tried one more time, with direct laryngoscopy and a bougie, and the tube slid right in.

Near the end of a busy shift, and one of my first in the fourth-year role in which we supervise patients with the new interns, I staffed my last patient of the night with the intern. He was a 36-year-old male with atypical chest pain that developed after pulling weeds all day. The pain was reproducible and worse with movement. At the time of my evaluation, the pain had completely resolved and the patient had no identifiable cardiac risk factors. My intern had ordered ibuprofen and chose to avoid further work-up. I went through my usual spiel regarding how cardiac chest pain cannot be ruled out entirely, but agreed that my clinical suspicion for acute coronary syndrome was low. I presented to the attending that the best option would be a 4-hour cardiac rule-out. He remained quiet during my presentation and afterward stated, "Four hour rule-out, huh?" as his only response. Five minutes later, he returned. "How could you even think of sending that patient home? I know you are all confident now as a fourth year, but come on ... is this what you are teaching the interns? Just wait 'til next year and your style will change."

REFLECTION

These experiences working in the emergency department have ranged from incredible to incredibly frustrating. As residents, we constantly strive to independently manage our patients and develop care plans, while the role of the attending faculty has varied between complete supervision and control of the plan, to allowing complete autonomy. This concept of attendings allowing appropriate autonomy so that residents can develop independence in their practice has been termed entrustment.¹ Patients' and instructors' entrustment of responsibility to us demonstrates our preparedness to assume professional responsibility after graduation.² Over the past several months, we have been reflecting on these experiences working in the emergency department and how different faculty members entrust us during each shift. We have been studying the factors that allow faculty to foster an appropriate amount of entrustment and we have found several themes of how this can be done well.

As we strive toward a final goal of being independent practitioners after leaving residency, during training we want to be the primary clinician, develop the plan of care, and make the clinical decisions. However, the attending is the safety net and will step in to change plans when needed and appropriate.

Amidst the frenzy of the patient who had developed anaphylaxis, it took a minute before I realized that the attendings were standing back and letting me run the show. This was a thrilling confirmation of my ability to lead the team, and we prefer attendings who have the self-control to stand back during critical moments and allow us to step forward.

Attendings who are micromanagers are much more difficult to work with and learn from. The attending

who took over resuscitation of the patient with gastrointestinal bleed dictated the plan of care by calling out every order and discussing the case with the appropriate consultant, without allowing me a chance to obtain a story from EMS or to interview or examine the patient. I was playing catch-up the entire time and my learning in the case was minimized. However, the responsibility of all the documentation on the case fell to me without question. We prefer meaningful work, including assessment and developing an appropriate care plan for the patient.

As frustrating as it was in the trauma intubation case, being allowed to try to intubate again allowed me success in that situation and provided tools that I can use to approach the many anticipated difficult airways in my future. The attendings realized this was an invaluable teaching moment and provided me that opportunity.

We have also noticed that when presenting our plan for the patient's work-up to micromanagement-style faculty, we try to deduce the attendings' practice patterns to avoid conflict and fear for loss of reputation. For example, it would not be uncommon for an attending with this style to look at you as if you had two heads if you decided not to perform a lumbar puncture on a patient with "a terrible headache," but who had multiple findings pointing away from a diagnosis of subarachnoid hemorrhage. To avoid this disdain and conflict, we would just obtain a head CT and lumbar puncture on any patient with this complaint, regardless of our clinical acumen.

It is difficult when attendings significantly modify the care plans on patients to suit their personal preferences, but do not acknowledge that "there are many ways to skin a cat" when caring for this patient. For example, in the case of the patient with chest pain, I felt my plan for this patient was appropriate. The attending forced me to question my judgment, when I had thought this was well within the standard of care. I wondered if this was only because he would not do that in his own practice, and therefore it was unacceptable. The way he voiced his criticisms made me feel crushed, as he considered my plan entirely unreasonable, and my interns and the patient's family heard his loud response. I was embarrassed to ask questions about his decision with this case and to address the educational aspects that I really need to know. This is why I am a resident, right?

It is very frustrating when we are told "You are wrong" after developing a care plan we have used previously in a similar clinical situation with another attending. We realize that we are not "wrong," but the attending just has a different practice style. If the attending in the chest pain case had approached the situation by acknowledging variations in practice patterns in managing low-risk chest pain, it would have made a world of difference in the learning environment and my understanding of the case.

In the end, residency has been an enlightening and, at times, frustrating experience as we work out our growing pains and develop our clinical practice. Attendings can promote autonomy by letting the residents lead the care team and stepping in when appropriate

for patient safety, and help prepare us for independent practice. Alternatively, they can dominate the care, make all the clinical decisions, and leave the resident with unanswered questions and piles of unrewarding documentation. We hope that our dive into resident autonomy and examination of entrustment will allow improved resident experiences throughout the field of emergency medicine.

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