

# The ABCDs of Entrustment

The emergency physician (EP) must provide timely diagnosis and care to patients who often have sudden and life-threatening emergencies. Residents must develop into this independent role through graduated responsibility through entrustment. Attending physicians in supervisory roles have the added challenge of overseeing the delivery of emergent clinical care by trainees, while assuring that all patients receive appropriate stabilization and care. The principle of entrustment of diagnostic and management skills is critical in the training and advancement of residents in the emergency department (ED).<sup>1</sup> The attending EP or supervising senior resident must direct, monitor, and observe his or her residents, while educating and empowering them accordingly. The EP must continually assess and coach his or her trainees while ensuring patient safety. There are four factors affecting entrustment: the resident, the patient or family, the environment, and the faculty (Table 1).<sup>1</sup> To help attendings and residents navigate this dynamic environment and foster a safe workplace for learners and patients, we developed the ABCDs of entrustment (Figure 1).<sup>1,2</sup>

## **ACKNOWLEDGE VARIATION IN PRACTICE**

An attending physician should discuss alternative strategies to clinical problems with the resident while encouraging the resident to try different approaches throughout training. This practice serves to facilitate the formulation of the residents own clinical practice. Give autonomy when possible by encouraging the resident to take ownership of their patients. Allow the resident to discuss their complete plan without interruption. This is a crucial step in evaluating where the resident is in their development and will allow for customized feedback and guidance. This is an

opportunity to acknowledge variation in practice taught by different attending EPs and supervising senior residents. Highlight evidence-based approaches and acknowledge when there are opportunities for practice variations. As the residents progress through residency, they will experience graduated responsibility building on the armamentarium of the EP.

## **BE A SILENT OBSERVER; TRUST BUT VERIFY**

The attending EP should assume the role of observer during the history and physical examination. If working with a resident for the first time, before trust has been built, consider joining the resident in the room during the initial patient encounter, standing behind the resident without interrupting or influencing their patient care.


Give autonomy to the residents but consider the “trust but verify” model of monitoring the patient’s encounter. Double-check crucial portions of the history and physical directly with the patient. Monitor the electronic medical record to confirm that laboratory orders, medication dosing, results, etc., are placed and interpreted correctly. The EP and resident must consider the complexity of the patient’s condition and the aptness of the resident to handle this level of patient. Stop and determine if this patient case is suitable for the resident to try a new approach for the first time. The resident should be encouraged to discuss a cohesive plan with backup options. This will allow for better communication and demonstrate a readiness for autonomy. The EP must consider that if the patient was to get harmed, it could cause the learner to feel they have failed and cause them to experience guilt, when the fault was that of the EP. The attending EP should intervene if patient safety could be compromised.


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**Table 1**  
Factors Affecting Entrustment<sup>1</sup>


Resident factors affecting entrustment Prior experience with the resident—did they do well the last time you worked with them? Appropriateness of oral presentation and plan for the patient Familiarity of the resident (worked frequently with resident vs never worked with resident) Level of training/experience (intern vs. senior resident) Resident apparent self-confidence or lack of confidence
Environment factors affecting entrustment Business of the ED, amount of time for supervision Systems factors—e.g., trauma alert may require attending to be present Nursing capability—strong nursing may allow more entrustment Culture of supervision in the department
Faculty factors affecting entrustment Personality—disposition to micromanage or risk averse vs. to entrust Comfort with own skills and level of experience—novice attending may entrust less Attending sense of medical responsibility (to the patient) vs. educational responsibility
Patient/family factors affecting entrustment Acuity/severity of the illness—sicker patients may require more resident supervision Risk to patient (procedures) Socially complex patients and family issues—e.g., informing patient of new cancer diagnosis

### The ABCD's of Entrustment

 **A**cknowledge variation in practice

 **B**e a silent observer, trust **B**ut verify

 **C**ommunicate and **C**ustomize

 **D**on't micromanage

**Figure 1.** Tips and tricks of entrustment.

## COMMUNICATE AND CUSTOMIZE

Begin each shift with a prebrief to establish the resident's goals and points of focus. This can help to customize the learning environment and provide an opportunity for specific and direct feedback of a particular microskill the resident has identified as an area for improvement. This process encourages the resident to be more receptive to feedback, and more likely to incorporate it into their practice. This prebrief can also be applied to procedures. For example, before a junior resident begins a procedure, the attending EP can verbally walk through the procedural steps with them. The attending EP can also recruit a senior resident to assist

with customized teaching and communication, such as discussing management of procedural complications and the possibility of alternative procedural approaches. It is important for the resident to be honest about gaps in their knowledge and clinical skills when the supervising physician inquires. The EP should welcome the resident's honesty and encourage self-reflection in an effort to deliver constructive feedback.

## DON'T MICROMANAGE

The resident should take ownership of his or her patients and be responsible for all patient care tasks, such as placing orders and discussing test results with patients. This allows the resident to take responsibility for medical decision making. If an order is urgent and must be placed before the resident is available, the attending should inform the resident and close the loop of communication. This helps the resident understand that he or she can still continue to manage the patient. Residents tend to feel undermined in their ownership of their patients if the attending EP steps in without addressing it. Having a quick discussion with the resident avoids this issue. If the attending is doing this frequently it could be that they are overstepping, but it could also indicate that the resident requires remediation or additional training to perform at the expected level. Residents who describe their thinking and communicate updates on plans (including during procedures) will typically be entrusted with more responsibility and likely receive less micromanagement.

The ED is a complex teaching and learning environment, making it difficult at times to entrust patient care to residents. The goal of entrustment is to guide the resident to become completely autonomous by the end of training so that they are competent for independent practice. Following the ABCDs of entrustment can help guide the supervising EPs to empower their residents.

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