The ABCDs of Entrustment

Lindsay A. Taylor, M.D., FACEP

Assistant Clinical Professor, Department of Emergency Medicine

Core Faculty, Emergency Medicine Residency

Clinical Ultrasound Faculty

Virginia Commonwealth University Health System

1250 E Marshall Street

2nd Floor, Suite 500

P.O. Box 980401

Richmond, VA 23298-0401

Lindsay.Taylor@vcuhealth.org

Phone: 804-828-5250

Fax: 804-828-8597

Lauren R. Wingfield, M.D.

Education Fellow

Department of Emergency Medicine

University of Virginia Health

Emergency Department

First Floor

1215 Lee St.

Charlottesville, VA 22903

Lrwingfield10@gmail.com

Margaret Wolff, MD, MHPE

Associate Professor, Department of Emergency Medicine

Associate Professor, Pediatric Emergency Medicine

Author Manuscript

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1002/AET2.10549

This article is protected by copyright. All rights reserved

Associate Program Director, Pediatrics Residency Program
Associate Professor, Department of Pediatrics
Program Director, Medical Education Fellowship
Children's Emergency Services
Department of Emergency Medicine
University of Michigan Medical School
1500 E. Medical Center Drive
Taubman Center B1380P SPC 5303
Ann Arbor, MI 48109-5303
wolffm@med.umich.edu
734-232-6166

Sally A. Santen, M.D., Ph.D.

Professor
Senior Associate Dean, Evaluation, Assessment and Scholarship
Professor Emergency Medicine
Director of the Office of Assessment, Evaluation, and Scholarship
Department of Emergency Medicine
1201 E. Marshall St.
McGlothlin Medical Education Center, 4th Floor, Dean's Office
Box 980565
Richmond, VA 23298
Phone: 804-828-7438
Fax: 804-828-7628
sally.santen@vcuhealth.org

Author Manuscript

No conflict of interest
[LT] reports no conflict of interest.

This article is protected by copyright. All rights reserved

No conflict of interest

[LW] reports no conflict of interest.

No conflict of interest

[MW] reports no conflict of interest.

No conflict of interest

[SS] reports no conflict of interest.

Author Manuscript

This article is protected by copyright. All rights reserved

DR. LINDSAY TAYLOR (Orcid ID : 0000-0001-7397-8665)
DR. MARGARET WOLFF (Orcid ID : 0000-0002-3637-2653)
DR. SALLY SANTEN (Orcid ID : 0000-0002-8327-8002)

Article type : Educational Download

Author Manuscript

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 to 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).[1] The attending EP or supervising senior resident must direct, monitor and observe their residents, while educating and empowering them accordingly. The EP must continually assess and coach their trainees while ensuring patient safety. There are four factors affecting entrustment: the resident, the patient or family, the environment, and the faculty (Table 1).[1] To help attendings and residents navigate this dynamic environment and foster a safe workplace for learners and patients, we developed the ABCDs of entrustment.[1,2]

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

This article is protected by copyright. All rights reserved

29 resident is in their development and will allow for customized feedback and guidance. This is an
30 opportunity to acknowledge variation in practice taught by different attending EP's and
31 supervising senior residents. Highlight evidence-based approaches and acknowledge when there
32 are opportunities for practice variations. As the resident's progress through residency, they will
33 experience graduated responsibility building on the armamentarium of the emergency physician.

34 **Be a silent observer; trust But verify:**

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

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

50 **Communicate and Customize:**

51 Begin each shift with a pre-brief to establish the resident's goals and points of focus. This can
52 help to customize the learning environment and provide an opportunity for specific and direct
53 feedback of a particular micro-skill the resident has identified as an area for improvement. This
54 process encourages the resident to be more receptive to feedback, and more likely to incorporate
55 it into their practice. This pre-brief can also be applied to procedures. For example, before a
56 junior resident begins a procedure, the attending EP can verbally walk through the procedural

Author Manuscript

This article is protected by copyright. All rights reserved

57 steps with them. The attending EP can also recruit a senior resident to assist with customized
58 teaching and communication, such as discussing management of procedural complications and
59 the possibility of alternative procedural approaches. It is important for the resident to be honest
60 about gaps in their knowledge and clinical skills when the supervising physician inquires. The
61 EP should welcome the resident's honesty and encourage self-reflection in an effort to deliver
62 constructive feedback.

63 **Don't micromanage:**

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

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

81 **References:**

82 1. Santen SA, Wolff MS, Saxon K, Juneja N, Bassin B. Factors Affecting Entrustment and
83 Autonomy in Emergency Medicine: "How much rope do I give them?". West J Emerg Med.
84 2019; 20(1):58–63. doi:10.5811/westjem.2018.10.39843

Author Manuscript

This article is protected by copyright. All rights reserved

85 2. Ten Cate O, Hart D, Ankel F, Busari J, Englander R, Glasgow N, Holmboe E, Iobst W, Lovell
86 E, Snell LS, Touchie C, Van Melle E, Wycliffe-Jones K; International Competency-Based
87 Medical Education Collaborators. Entrustment Decision Making in Clinical Training. Acad Med.
88 2016 Feb;91(2):191-8. doi: 10.1097/ACM.0000000000001044. PMID: 26630606.

Author Manuscript

This article is protected by copyright. All rights reserved

Author Manuscript

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 emergency department, 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 micro-manage 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

Table 1: Factors Affecting Entrustment[1]

This article is protected by copyright. All rights reserved

aet2_10549_f1.pdf

The ABCD's of Entrustment

Acknowledge variation in practice

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

Communicate and **C**ustomize

Don't micromanage

Author Manuscript

This article is protected by copyright. All rights reserved