Entrustment

Balancing Supervision & Independence on the Way to Competency

What is Entrustment?

Entrustment is a key decision-making component of competency-based medical education (CBME), addressing the transition from a novice needing extensive direct supervision to an independent physician capable of providing care without supervision[1].. Entrustment decisions seek to do more than assess knowledge or skills in isolation; it is intended to be an informed judgement by faculty about whether a resident can carry out their professional responsibilities as a physician independently.

What are Key Elements of Entrustment?

- Decision oriented-Entrustment is a discrete decision. A resident is either entrusted with the activity under consideration, such that they can perform it in the appropriate context at the designated level of independence or they cannot.[1] As resident become more proficient, they may move through levels of independence, but an informed decision based on robust assessment data should be made at each level.
- Linked to specific outcomes-Entrustment is associated with an explicit outcome. Typically, these outcomes encompass observable, workplace-based skills, knowledge, and attitudes.[2]
- Progressive responsibility-Entrustment occurs along a continuum. Residents will progress from needing direct supervision to indirect supervision to independent practice. The level of independence aligns with development of clinical competency.[2]
- Trust as a core element-Entrustment is more than just an assessment of a clinical skill. It encompasses an informed judgement that a resident can perform a task with discernment, managing potential complications, and recognition of their own limitations. In other words, the resident can be trusted as reliable in performing the task.[2]
- Context dependent-Entrustment decisions are based on a resident's competency and influenced by external factors such as clinical setting and patient complexity. The question becomes not just can a resident perform this task, but can this resident perform this task within a specific clinical context, with the ability to recognize likely complications, manage those complications and ask for help when needed?[2]
- Dynamic and ongoing-Although entrustment decisions are discrete, the continuum of entrustment relies on ongoing, longitudinal assessment of learners. Resident readiness for entrustment for independent practice evolves as they gain experience, confidence, and opportunity for growth.[2]

How Would I Use Entrustment Assessments and Decisions?

- Assessment of competence-Entrustment complements milestone-based assessments and evaluates residents' readiness for independent practice
- Guiding supervision levels-Entrustment can inform decisions on transition from direct supervision to indirect supervision. Entrustment decisions are based on agreed upon outcomes or benchmarks.

As learners demonstrate the required knowledge, skills, and attitudes of a particular benchmark, they can be entrusted to decreased supervision and eventually independent practice.

- Summative decision making-Entrustment is used by CCCs and other decision-making bodies to determine readiness for advancement and promotion, including transition to unsupervised practice.
- Ensuring patient safety-Entrustment helps to balance resident autonomy with patient safety by ensuring that only those who are adequately prepared perform critical tasks independently.

What is an Example of an Entrustment Scale?

Level	Entrustment Description	Supervision Required
1 – Resident able to participate as an observer only	Resident can observe but is **not yet trusted** to perform the activity.	Direct supervision required; faculty must be present.
2 – Resident able to participate with direct supervision	Resident performs the activity **only with direct oversight** and immediate faculty intervention if needed.	Supervisor physically present in the room.
3 – Resident able to participate with indirect supervision	Resident performs the activity **with supervision nearby** and faculty readily available.	Supervisor is in the clinic/hospital but not in the room.
4 – Resident able to participate without supervision	Resident can perform the activity **without direct oversight**, consulting faculty as needed.	Supervisor is off-site but available for questions.
5 –Resident able to supervise others	Resident demonstrates readiness for **unsupervised, independent practice** at the level of a board-certified family physician.	No supervision needed; entrustment level of a practicing physician.

Entrustment shifts from a focus on time as a marker of competency to assessment of the activity under consideration.[2,3] A first-year resident will likely need direct supervision in most clinical contexts. They have not yet had the clinical experience necessary to fully diagnose, treat, or manage complications. We would not say they are entrustable for independent practice. With ongoing clinical experience, accompanied with meaningful feedback, assessment, and reflection, residents begin to demonstrate the ability to diagnose, treat and manage complication in simple cases or less high-stake contexts. We may say they are entrustable for indirect supervision in specific contexts. For some residents, that may occur in the end of first year, but for others that may not happen until second year. It may be more program-specific. For example, if a program provides limited exposure to the emergency department in the first year, entrustment in that context will not happen early in first year because residents will not have had sufficient experience to develop the necessary competence. By the end of training, the goal is for all residents to have had sufficient clinical experiences to be adequately assessed in the demonstration of the expected knowledge, skills, and attitudes and to be found ready to be trusted in the independent care of patients in the relevant clinical contexts.

1. Ten Cate, Olle. “When I Say … Entrustability.” Medical Education, vol. 54, no. 2, Feb. 2020, pp. 103–04. DOI.org (Crossref), https://doi.org/10.1111/medu.14005.
2. Ten Cate, Olle. “Nuts and Bolts of Entrustable Professional Activities.” Journal of Graduate Medical Education, vol. 5, no. 1, Mar. 2013, pp. 157–58. DOI.org (Crossref), https://doi.org/10.4300/JGME-D-12-00380.1.
3. ten Cate, Olle PhD; Schwartz, Alan PhD; Chen, H. Carrie MD, PhD. Assessing Trainees and Making Entrustment Decisions: On the Nature and Use of Entrustment-Supervision Scales. Academic Medicine 95(11):p 1662-1669, November 2020. | DOI: 10.1097/ACM.0000000000003427