THE FUZZY CONCEPT OF

ENTRUSTMENT:

Implications For CBME

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1 Why talking about ENTRUSTMENT?

2 ASSUMPTIONS and REALITY

3 IMPLICATIONS for CBME
Why talking about ENTRUSTMENT?
TRANSITION TO **COMPETENCY-BASED** MEDICAL EDUCATION
WORKPLACE-BASED ASSESSMENTS of Entrustable Professional Activities
This trainee...

... meets expectations.
... performs above average.
... performs according to his level of training.
PROBLEM #2: LENIENCY BIAS
## SOLUTION: Entrustment Scales

### O-SCORE Entrustability Scale

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
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| 1     | “I had to do”  
i.e., requires complete hands on guidance, did not do,  
or was not given the opportunity to do |
| 2     | “I had to talk them through”  
i.e., able to perform tasks but requires constant direction |
| 3     | “I had to prompt them from time to time”  
i.e., demonstrates some independence, but requires intermittent  
direction |
| 4     | “I needed to be in the room just in case”  
i.e., independence but unaware of risks and still requires  
supervision for safe practice |
| 5     | “I did not need to be there”  
i.e., complete independence, understands risks and performs  
safely, practice ready |

ASSUMPTIONS and REALITY
MAIN ASSUMPTION

The process of entrustment in real clinical environments is a good surrogate of trainee’s level of competence.
ENTRUSTMENT \( \equiv \) COMPETENCE

O-SCORE Entrustability Scale

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Definition Entrustment

The **reliance** of a supervisor or medical team on a trainee **to execute** a given professional **task correctly** [because they are competent].

ten Cate et al. Acad Med 2016
ENTRUSTMENT DECISIONS:
RESIDENT TRUSTWORTHINESS

COMPETENCY
(ability)

CONSCIENTIOUSNESS
(reliability)

TRUTHFULNESS
(honesty)

DISCERNMENT OF OWN'S LIMITATIONS
(humility)

Duijin et al. Persp Med Ed 2018
ten Cate et al. Acad Med 2016
BUILDING TRUST as a Process

1. Forming Expectations
2. Confirming Expectations
3. Monitoring Trust

Sagasser et al. Acad Med 2017
Chen et al. Obst Gyn 2017
ENTRUSTMENT DECISIONS: OTHER KEY FACTORS

<table>
<thead>
<tr>
<th>Category</th>
<th>The factors related to the category</th>
</tr>
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<tbody>
<tr>
<td>The trainee</td>
<td>Competence^, Conscientiousness or reliability^, Truthfulness and honesty^, Recognition of limitations and willingness to ask for help^, Empathy, openness, and receptiveness toward patients, Skill in intercollegial and interprofessional communication and collaboration, Self-confidence and feeling safe to act, Habits of ongoing self-evaluation, reflection, and development, Sense of responsibility, Knowing how to deal with mistakes made by one's self and others</td>
</tr>
<tr>
<td>The supervisor</td>
<td>Clinical experience, Experience with supervision and evaluation of trainees, Familiarity with the clinical context, Predispositional willingness to rely on someone, Sense of accountability toward patients, trainees, and institutions, Experience with major trainee-dependent adverse events</td>
</tr>
<tr>
<td>The context or circumstances</td>
<td>Resources, staffing, interaction patterns, and workplace culture, Presence of situational hectic circumstances and competing tasks, Organizational and legal demands and constraints, Time of day, The targeted level of decreased supervision</td>
</tr>
<tr>
<td>The task or activity</td>
<td>Level of complexity, Patient complexity and risk, Level of urgency, Relevance and frequency of occurrence, Interdisciplinary interdependence</td>
</tr>
<tr>
<td>The trainee–supervisor relationship</td>
<td>Duration and intensity of contact, Supervisor role ambiguity as coach, advocate, and evaluator, Shared expectations</td>
</tr>
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</table>

^Ad hoc entrustment decisions by clinical supervisors about trainees are usually based on a mix of estimated trustworthiness of the trainee, estimated risk of the situation, urgency of the job to be performed, and what the supervisor perceives is the right time to entrust this task at this moment for this trainee. They do not necessarily constitute a precedent for similar decisions in the future. See Table 3 for suggested sources of information to help supervisors make such entrustment decisions about the factors related to the first category shown above.

Gingerich et al. Med Ed 2018
*ten Cate et al. Acad Med 2016*
Educational Context
Clinical Context
Cultural Context

Trust as a **PERSONAL RELATIONSHIP**

Trust as a **GIVEN UNLESS PROVEN OTHERWISE**
ENTRUSTMENT \neq\ COMPETENCY
COMPETENCY \neq\ TRUST
TRUST \neq\ ENTRUSTMENT
MAIN ASSUMPTION

The process of entrustment in real clinical environments is a good surrogate of trainee’s level of competence.

ENTRUSTMENT in real clinical environments is partially based on trainee’s level of competence...

BUT ALSO ON OTHER VARIABLES THAT HAVE LITTLE TO DO WITH TRAINEE’S COMPETENCE!
IN REALITY...

Entrustment decisions depend on a global judgment (incorporating MANY competencies) of trainee’s competence AND many factors unrelated to trainee performance.

Entrustment decisions change with “longitudinal” exposure.
COROLLARY ASSUMPTIONS

TRUSTWORTHINESS

ENTRUSTMENT

SUPERVISION

AUTONOMY

RISK
<table>
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<th>Table 2. Supervision scale for entrustment decisions as an assessment\textsuperscript{11,15}</th>
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<tr>
<td><strong>→ Undergraduate medical education</strong></td>
</tr>
<tr>
<td><strong>1a</strong></td>
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<td><strong>2a</strong></td>
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<tr>
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</tr>
<tr>
<td><strong>3c</strong></td>
</tr>
<tr>
<td><strong>4b</strong></td>
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EPA, entrustable professional activity.
TRAINEE LEVEL OF AUTONOMY

1. Be present and observe
2. Act with direct supervision
3. Act with indirect supervision
4. Act without supervision
5. Provide supervision
Autonomy Gap

Never reaching **FULL** autonomy

Sense of **UNPREPAREDNESS**
Full Entrustment...

Not a reality
[Internal Medicine]

Not perceived as a reality
[General Surgery]
Coupling

**Interdependence** of trainee and supervisor performance

Assessment of independent performance often one of coupled performance

Seybok-Seyer *et al.* Med Educ 2018
needed.” Trust requires interdependence between truster and trustee, and creates supervisor vulnerability, as mistakes made by a trainee may affect the supervisor personally. Trust thus entails an acceptance of being vulnerable to the actions of a trustee—an acceptance based on the expectation that the trustee will probably perform in a predictable way. The first time a clinical supervisor asks a trainee to care for a patient or to perform a procedure without his or her direct supervision implies a willingness to take some risk of adverse events.
Increased trust in trainee’s ability does not necessarily lead to lower level of supervision and greater trainee autonomy.

Risks for the patient and for the supervisor are taking into account when entrusting trainee with high level of autonomy.
IMPLICATIONS for CBME
Assessment Based On Entrustment

AD HOC
Past level of supervision

SUMMATIVE
Future level of supervision

Gomez-Garibello et al. Med Ed 2018
ten Cate et al. Clin Teach 2017
Ad Hoc Entrustment-Based Assessment
Assessment Based On Entrustment

AD HOC
Past level of supervision

SUMMATIVE
Future level of supervision

Gomez-Garibello 2018
TenCate 2017 Clin Teach
Summative Entrustment-Based Assessment

TRANSITION TO DISCIPLINE
THREATS TO VALIDITY
of Assessments Based on Entrustment

1. Content
2. Response process
3. Internal structure
4. Relationship to other variable
5. Consequences
REFLECTIONS

Workplace-Based Assessment are not necessarily AUTHENTIC.

Role for NON-WORKPLACE BASED ASSESSMENTS beyond capturing rare EPAs.

Need for ONGOING STUDIES on Entrustment-Based Assessments.

I am not quite ready for AUTONOMOUS cars.
THANK YOU
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