EDITORIAL

My Personal "Entrustment": A Pathway of Ongoing Discovery

Over the past 20 years, graduate medical education in North America has evolved from simple procedural counting (eg, numbering procedures of each type) to developing milestones of progressive or stepwise entrustment based on demonstration of the knowledge, skills, and self-awareness of the clinical learner's limitations. One of the more surprising aspects for clinical learners is the permission to say "I don't know" and therefore provide space for a conversation with the attending provider. This self-awareness process is so important to the attending because it is a clear message when the learner wants to do more but they are at the edge of their experience, knowledge, and skills. And that's okay.

The idea of progressive entrustment works through a four-stage process of demonstration. The first stage is *ability*, which covers one's knowledge, skills, and attitude. The second is *conscientiousness* and is defined as one's hard work and reliability, which is always needed. The third is *truthfulness*; for example, when a student says "Yes, Dr Stanford, I checked the blood pressure before the procedure," when in fact it is clear they copied and pasted the notes from a prior visit. Such actions raise doubts as to how entrustable the learner is at that moment in time. Lastly, the fourth concept is *discernment*. In this case, does the learner really understand their limits now? These four concepts of entrustment are based on the work of Dr Tara Kennedy and others,[1] and a key aspect to all four steps is direct observation.

In the dental world, at least at the university level, I'm always impressed by how experienced and skilled the staff nurses and chairside support personnel are when assessing the abilities of students, residents, and faculty. What this tells me is that I'm being watched and (to a degree) assessed by those who help me on a day-to-day basis. Knowing this also tells me that often it is not the attending or faculty on the floor that really knows what is going on, but it is other students, support staff, and colleagues that do. Thus, when considering the concepts of entrustment, it is often best to collect direct observations from many perspectives as we consider how much "freedom" the residents and junior faculty (or senior faculty for that matter) should have when taking on complex patient situations.

So how does this apply to implant dentistry? For one, this area of tooth replacement therapy is rapidly evolving in the workflows deployed to provide care. As applications of technologies continue to escalate, clinical learners often want to do the next sophisticated step. Secondly, a learner who is at a university clinic or a private office for a short time may not see the long-term outcome(s) of care and the implications that assumptions made in planning and deployment have on it. Third, implant systems keep changing, and the advent/application of what I call *advanced approaches* (eg, zygoma devices or printed plate-style devices) are often advocated to be used by the generalist when many specialists have limited experience.

As a teacher in the clinic, entrustment is observing and watching the development of each area of the learner's development, including ability, conscientiousness, truthfulness, and discernment. As an administrator, I use the same approach in evaluating faculty career progression as well as promotion and tenure decisions. As a clinician, I wonder how do other faculty and staff see me? Am I entrustable in the clinic now? As we know, all experts decline with time, so don't I also need to evaluate myself (as others already are) to see if I still have the ability and the conscientiousness to do the hard work of making diagnoses, creating treatment plans, and deploying solutions while being truthful to myself? In the end, one must recognize that the fourth stage of entrustment (discernment) may need to be evaluated when one's limits are reached or when it is time for reflection. Reflection and inputs from trusted colleagues and staff (called 360 evaluations) are a wonderful way I continue to try to improve day by day.

Thank you,

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Editor-in-Chief

REFERENCE

1. Gingerich A, Daniels V, Farrell L, Olsen SR, Kennedy T, Hatala R. Beyond hands-on and hands-off: Supervisory approaches and entrustment on the inpatient ward. Med Educ 2018:52;1028–1040.