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Supervisors’ approaches to the early entrustment of clinical tasks: an observational study in general practice

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ABSTRACT

Objectives At the very start of medical residency training, entrustment of clinical tasks may be a major challenge, on which current scientific knowledge is scarce. This study therefore aimed to gain insight into the process of supervisors’ decision making underlying the entrustment of clinical tasks at the start of one-on-one supervisor–trainee working relationships.

Setting This study was performed in a general practice (GP) training department in the Netherlands.

Participants For this study, we recruited supervisor–trainee pairs who were just about to start the first year of GP residency training. Of 10 eligible supervisor–trainee pairs, 4 participated.

Design We used a qualitative, social-constructivist research approach. Data from naturalistic non-participant observations and semistructured interviews with supervisors in four GP practices were triangulated and analysed using a thematic analysis approach.

Results Supervisors’ early entrustment decisions were based on generic trainee qualities such as self-reflexivity, knowing one’s limitations and asking for help in time, rather than on task-specific performance. At the start of residency training, supervisors’ primary concern was to create a safe working and learning environment in which trainees could and would ask for timely supervision while being entrusted with challenging tasks. Supervisors used idiosyncratic entrustment strategies that were influenced by their propensity to trust, previous experiences with trainees, and their perspective on learning and teaching.

Conclusion Entrustment decisions require high levels of safety for all stakeholders involved. Especially at the beginning of supervisor–trainee relationships, establishing an educational alliance in which entrustment is the subject of ongoing trainee–supervisor conversations is essential to achieve and maintain optimal balance between trainee learning and patient safety. Additional research may further our understanding of early entrustment decision making and the role of generic trainee qualities in different settings.

INTRODUCTION

Over the past few decades, residency programmes increasingly implemented competency-based models for education and assessment. Although translation of competency-based education into practice is difficult and repeatedly met with resistance or critique,1–3 its primary goal is to ensure trainees are able to provide safe, unsupervised, professional care on graduation. In order to optimally prepare trainees for independent clinical practice, they should be entrusted with challenging clinical tasks that offer learning opportunities appropriate to their level of competence development.4 Guiding trainees towards readiness for independent practice is therefore a balancing act for supervisors, as they must continuously make entrustment decisions to foster trainee learning, while also ensuring patient safety.5–7

These entrustment decisions are influenced by a range of interrelated factors, such as the clinical task, trainee trustworthiness, as well as the relationship between supervisor and trainee.7–10 In their study on the influence of trust on supervision and learning in the clinical workplace, for example, Hauer et al10 clearly showed how entrustment decisions are affected by supervisor familiarity with a trainee and a responsive interpersonal dynamic in which mutual expectations and goals are shared and aligned.10

Recent studies on entrustment decision making in residency training have mainly been conducted in hospital settings where multiple and frequently changing healthcare workers and supervisors are involved.

STRENGTHS AND LIMITATIONS OF THIS STUDY

We used a qualitative, social-constructivist approach to explore processes involved in early entrustment.

We gathered data using non-participant observations in daily practice that were triangulated with semistructured interviews.

The study is a single-centre study, which may limit the generalisability of our findings.

Participants included in the study were only involved in long-term, one-on-one educational relationships, which may limit the transferability to other educational relationships.

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in entrusting trainees with tasks in patient care and in settings where a supervisory relationship has already been established.\(^6\)\(^9\)\(^11\)\(^12\) However, supervisors start making entrustment decisions from the very beginning of residency training, when little information about the trainee is available yet. In this phase, supervisors’ initial trust typically reflects ad hoc entrustment decision making—more than summative decision making based on grounded trust over a longer training period.\(^13\) In one-on-one supervisor–trainee relationships, such as general practice (GP), where individual supervisors are solely responsible for assessing trainee trustworthiness, supervisors need to make entrustment decisions under great uncertainty from the very start of the training programme.

Yet, very little is known about how supervisors make entrustment decisions when supervisory relationships in residency-training are just starting to develop. The purpose of this study was to gain insight into the process of supervisors’ decision making underlying the entrustment of clinical tasks in the earliest stages of one-on-one working relationships. These insights may add to existing knowledge about the early entrustment decision-making process in medical residency training and help us to further optimise supervisory practices when balancing trainees’ learning needs with the need to provide safe patient care.

**METHODS**

**Methodology and reflexivity**

We used a qualitative, social constructivist approach to explore the social processes involved in entrustment decisions during the first phase of one-on-one supervisor–trainee relationships in medical residency training. We collected and analysed data in iterative cycles, and used memo writing in order to produce an audit trail from data to interpretation. We recognised that the phenomenon under scrutiny is subject to multiple interpretations, depending on the position of the researcher, the participants and the research context.\(^14\)\(^15\)

Our research team consisted of individuals with varying expertise and perspectives on processes related to entrustment and supervision: a family physician and educator (LdJ), a psychologist working at a GP training institute (MG), two family physicians with clinical supervisory experience (AK, JM) and an educational psychologist (CvdV). Furthermore, all investigators have track records in medical education research, in particular in programmatic and workplace-based learning and assessment. Researchers’ knowledge of the study topic and setting enabled them to provide depth of reflection and interpretation. However, this knowledge and experience may also have led to confirming and supporting prior experiences, beliefs and values for example, about entrustment decision making. In order to address this, the heterogeneous research team acknowledged their individual perspectives and stances throughout data collection and analysis. They did so by discussing their findings from individual data analysis within the research team and exploring how their personal interpretations contributed to making meaning of the data.

**Setting and participants**

This study was conducted in the 3-year GP residency-training programme at Maastricht University, the Netherlands. In the first and third years of this programme, trainees receive one-on-one supervision when providing patient care in GP practice. A few months before the start of the training programme, supervisors receive application letters and curricula vitae from 10 to 12 prospective trainees. Supervisors do not receive information on previous trainee performance (eg, scores on knowledge tests or clerkship grades). All supervisors alternately hold one-on-one interviews with prospective trainees and establish a ranking, after which they are being assigned a trainee for the full training year by the educational institute. For this study, we recruited supervisor-trainee pairs who were just about to start the first year of GP residency-training. Of 10 eligible supervisor-trainee pairs, four participated. All supervisors were male and three trainees were female. Supervisors and trainees’ mean age was 46 (range: 42–53) and 26 years (range: 25–27), respectively; the mean number of years’ experience as a supervisor was 6 years (range: 2–10).

**Data collection**

Data were obtained in two phases (table 1), following iterative cycles of collection, analysis and refinement, in order to further develop emerging themes. We gathered naturalistic data using non-participant observations in clinical practice. In non-participant or passive observation, participants and the research context.\(^14\)\(^15\)

| Table 1 | Schedule of observations and interviews in four general practice practices* |
|---------|-------------------------------------------------|
| **Week** | 1 2 3 4 5 6 7 8 9 10 |
| Practice 1 | Obs (8) | Obs (7) | | | | | Int | |
| Practice 2 | Obs (7) | Obs (8) | | | | | Int | |
| Practice 3 | Obs (7) | Obs (4) | Obs (3) | | | | Int | |
| Practice 4 | Obs (6) | Obs (6) | | | | | | |

*Obs=Observations (number: hours of observation); Int=End-of-observation interviews. LdJ carried out the observations and interviews in practice 1–3; AT in practice 4.
the investigator acts as an observer, without interacting directly with the participants in the setting.\textsuperscript{16,17} As this did not enable us to explore participants’ reasoning and their underlying beliefs or conceptions regarding entrustment decision making, we complemented our data by conducting semi-structured end-of-observation interviews with supervisors, thereby allowing for data triangulation and data sufficiency.\textsuperscript{16,18} We described all themes that emerged during data collection and analysis. From a content perspective, the resulting rich data set seemed appropriate to answer our research questions.\textsuperscript{18} To enhance the credibility of our data interpretation, we conducted member checks by sending narrative summaries of our analysis to the supervisors, asking them to review our reflections and interpretations and give feedback, if necessary.\textsuperscript{17} All supervisors agreed with our interpretation of the data.

**Phase 1: non-participant observations**

The first round of observations took place in the first or second week of residency (table 1). The focus during the observation was on the entrustment of clinical tasks. For each supervisor–trainee pair, we observed the daily activities in GP practice such as medical coworkers’ triaging activities, trainees’ and supervisors’ patient encounters and house calls, levels of supervision in trainees’ task performance,\textsuperscript{19} as well as daily debriefing sessions and learning conversations (see online supplemental appendix A: Phase 1: Protocol non-participant observations of entrustment in clinical practice). Trainees and supervisors were encouraged to act as they normally would. We collected data by writing field notes of all observed activities and by audiotaping debriefing sessions and learning conversations. Our notes included information about the setting (date, time and location), actors and activities as well as a separate section containing the observer’s reflections on the observation.\textsuperscript{20} The second round of observations took place in the third to fifth week of residency and offered us the opportunity to compare our findings with the previous observations and to reflect on the development of entrustment of clinical tasks in the first weeks of training.

**Phase 2: end-of-observation interviews**

After the second round of observations, we continued data collection by means of semistructured interviews with supervisors, building on themes we identified and discussed in the research team after the observation rounds. The first part of the interview guide contained general questions about trust, entrustment decisions and strategies used (see online supplemental appendix B. Phase 2: Semistructured interview about the early entrustment of clinical tasks). The second part comprised probing questions about entrustment decisions in specific situations observed during phase 1, aimed to gain a better understanding of supervisors’ reasoning and their underlying beliefs or conceptions regarding entrustment decision making. Audio recordings of all interviews were transcribed verbatim and anonymised prior to analysis.

**Data analysis**

We used NVivo software, V.12, for data management to facilitate qualitative coding.\textsuperscript{21} Our a priori coding framework (online supplemental appendix C) was based on the literature on entrustment decision making in medical training programmes.\textsuperscript{5,7,8,10–13,22–24} Throughout data analysis, we combined a deductive and inductive approach by complementing and refining the a priori coding framework with salient themes that were identified in our observations and interviews. After the first observation round in all practices, AT and LdJ read each other’s field notes and the transcripts of the audiotaped learning conversations and discussed the authenticity, comprehensibility, completeness and usability of these data. The outcome of these discussions informed the second round of observations, which was again followed by a discussion of findings within the team and the further collection of data by means of semistructured interviews. After that, field notes and learning conversation were coded by LdJ and AT, and three investigators (LdJ, AT and MG) independently conducted line-by-line coding of interview transcripts. An audit trail of the developing themes and their interrelationships was maintained. Discrepancies in the coding framework were compared and discussed within the research team in order to achieve unanimous consensus. Frequent discussions were held to test and enrich our conceptualisations and to refine existing theory about the early entrustment process in medical training.

**Patient and public involvement**

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

**RESULTS**

We collected data from September to November 2018, and conducted 56 hours of observations and four 1-hour interviews in total. The distribution of observation hours across time periods and participant pairs is shared in table 1. Overall, supervisors acknowledged the need to entrust trainees with tasks in patient care to foster competence development. Our data furthermore suggest that in the earliest phase of training, supervisors based their entrustment decisions more on generic trainee qualities than on perceived clinical competence. In order to make these decisions, supervisors’ primary concern was to create a safe working and learning environment in which trainees could and would ask for timely supervision. Supervisors used different strategies to offer trainees a challenging learning climate, while at the same time minimising the risks for patients and themselves. These strategies were influenced by interrelated factors, such as supervisors’ propensity to trust, their previous experiences with trainees and their perspective on learning and...
teaching. In the next sections, we will describe our findings in more detail and include representative observational and interview quotes to illustrate them.

**Early entrustment decisions are based on generic trainee qualities**

Within a few days at most, we observed that all trainees were allowed to perform clinical tasks independently. Examples of clinical tasks that were entrusted to the trainee were the diagnosis and treatment of minor ailments and/or common, low-complexity patient problems as well as house calls that did not require extensive evaluation of trainee performance. At the start of the training programme, when supervisors knew little about the trainee, these entrustment decisions were specifically based on generic trainee attributes:

Of course it’s important what a person knows and what he’s able to do. […] But is it someone who self-reflects, dares to ask questions or is it someone who thinks: “I know it all”? That makes the difference for me when entrusting tasks. (S2)

Generic trainee qualities, such as eagerness to learn, self-reflexivity, or asking for help when necessary, were considered to be of more importance than a trainee’s task-specific performance. As another supervisor explained after his trainee had asked for help in a consultation where she had not been able to take a complete history: ‘I consider that even to be a positive quality, that she runs into a problem and then specifically asks for help’ (S3). By doing so, even challenging tasks that are possibly beyond trainees’ capability can be entrusted, as this supervisor explained:

So in general, yes, I think that simply to start doing something new can be very instructive, at least when I have the feeling that a trainee will discuss her uncertainties or dilemmas without a feeling of being judged. (S1)

**Entrustment calls for a safe working and learning environment**

All supervisors in our study acknowledged the tension between providing the opportunity to learn from mistakes versus the risk of harming patients:

She tries to do her very best and told me she feels like she’s walking a tightrope sometimes. Then I told her that she is still learning and that this involves making mistakes. (S4)

Supervisors also clearly acknowledged the need to create a safe learning environment for entrustment decisions to support trainee learning as well as ensure patient safety. Illustrating the reciprocity of the entrustment relation, supervisors unanimously emphasised that trainees must feel safe in that they trust their supervisors not to take too big a risk. When trainees make a mistake, they must feel reassured that their supervisors have oversight and will provide a safety net:

I want to give her [the trainee] a certain degree of independence, but I also want to give her the confidence that if anything weird happens, we will notice. If she misses something, that it will be noticed, and that we will discuss it together. I want to give her confidence, that I can check the electronic medical records myself, even if we don’t discuss that. (S2)

In addition to ensuring a safety net, supervisors considered it at least as important that trainees always felt safe to ask for supervision:

In the first days, I tell the trainee that there is no such thing as a stupid question. And then later on, there are days that she hardly asks for supervision, and on other days she may ask ten times. That is no problem. Then I will ask her if she stills feels comfortable to ask for supervision every time. Even if I’m running behind schedule, for example, and she notices that too and then she thinks: “Oh, can I ask this for the sixth time?” I verify if she then still experiences the safety to ask for supervision. I think that is the most important thing. (S1)

**Supervisors use various strategies in entrustment decision making**

All supervisors in our study adopted similar approaches to create the right preconditions for the gradual involvement of trainees in clinical practice. At the start of training, trainees observed several consultations of their supervisor but the tables were quickly turned. However, before allowing trainees to perform tasks independently, we observed that supervisors set boundaries by explicitly sharing their expectations about, for example, when and how to ask for supervision (eg, always ask for help when handling medical emergencies), and by providing guidelines or procedures for ordering diagnostic tests and referring patients.

Observed examples of common supervisor strategies to entrust were: limiting supervisory activities to the discussion of consultations only on the trainee’s initiative, randomly checking electronic medical records, or asking medical coworkers or patients about their experiences with the trainee:

[…] What patients say, whether or not they are satisfied. They just make straightforward comments, often not very nuanced. Then I want to know what is going on, especially if I hear those comments more often. (S4)

On further scrutiny, however, we also found differences in supervisors’ strategies to ensure safe entrustment. Supervisors indicated that previous experiences with supervising trainees were likely to influence their entrustment strategies. In general, positive past experiences made supervisors entrust more easily, while negative
experiences, as another supervisor explained, could ‘make you more alert, taking a wait-and-see approach’ (S4).

This is our third trainee and up to now we’ve actually only had well-performing trainees that gave me a good feeling, because I know that they will alert me, if necessary. So then I am not at all compulsive about supervising them in a way that I say: Oh, I must have seen everything myself. (S3)

All supervisors in our study acknowledged that, apart from their supervisory experiences with previous trainees, their propensity to trust influenced their entrustment approaches at the very start of the training programme. One supervisor described this propensity in relation to his personal tendency to control:

Naturally, I tend to be in control. So, at first I find it difficult to trust, but when I realize that it is fine, if I have a good feeling about it, then I can also let go, although I always want to hear what happened to a certain patient in the learning conversation afterwards. […] I protect the patient, the trainee, and myself a bit by doing so. (S3)

This supervisor believed that a high level of control was necessary and supervised his trainee accordingly, by consistently discussing and giving consent for all clinical tasks that the trainee would perform autonomously. By doing so, he felt he was minimising the risks for his patients and providing safety for all stakeholders in the entrustment process, including himself. In contrast, another supervisor with a self-reported high propensity to trust explained:

I trust easily if it turns out that my confidence is not betrayed. The first time, I check the trainee. After that, I think: “fine, this trainee keeps to his agreements” and then I trust that this will also happen in the future. (S1)

This supervisor very quickly decreased his level of control and supervised in a more backstage way, as long as he perceived that the trainee was aware of her limitations and would ask for supervision in time.

DISCUSSION
Our findings provide insight into supervisors’ approaches to entrusting trainees with clinical tasks in one-on-one supervisory relationships at the very start of residency training, when little information about the trainee is available. We found that supervisors’ early entrustment decisions were primarily based on their assessment of generic trainee qualities, rather than on judgements about task-specific performance. Influenced by interrelated factors such as their propensity to trust, previous experiences supervising trainees and their perspective on how to best create a safe learning and working environment, learning and teaching, supervisors would use different strategies to comfortably, safely and responsibly start entrusting clinical tasks to their trainee.

When appraising trainee trustworthiness, supervisors seemed to take different trainee characteristics into account, a finding that is consistent with Mayer et al’s model of trust. According to this model, individuals determine the trustworthiness of others based on their beliefs about the trustee’s ability (ie, knowledge, skills and competencies), benevolence (ie, the extent to which a trustee would act in the best interest of the trustee) and integrity (ie, the extent to which the trustee would act in accord with a set of principles that the trustee finds acceptable). A key finding of our study is that, when entrusting clinical tasks in the earliest phases of residency, supervisors considered generic qualities such as self-reflexivity, knowing one’s limitations and asking for help in time far more important than the trainee’s clinical performance.

This focus on generic qualities echoes recent research on entrustment in clinical education settings. For instance, Bonnie et al found that supervisors in GP training evaluate their trainees’ openness about their task performance and learning process before entrusting challenging tasks, such as emergency care. Similarly, in a study on entrustment in an internal medicine residency setting, Melvin et al found that, despite being deemed competent to complete a specific task, a trainee may not be allowed to do so independently if he or she did not display adequate professional behaviour, such as being on time. In contrast, in settings where entrustment of procedural skills is at the heart of competence assessment (eg, surgery), the evaluation of specifically task-specific performance may be of decisive importance for the construction of trust. A study by van Loon et al in addition, suggests that generic competencies are hardly taken into account when supervisors make decisions about entrustment of clinical tasks in obstetrician-gynaecologist residency training. Entrustment decision making may, therefore, be context-specific and depend on educational or workplace culture.

Concordant with sociocultural views of learning, all supervisors in our study recognised the importance of allowing trainees to make mistakes and learn from them. Hence, supervisors considered it essential that their trainees trusted them not to take too big a risk in patient care. Supervisors, in their turn, should be able to trust that their trainees would ask for their help in a timely manner. This finding highlights the importance of the reciprocity required in entrustment-based supervision. Although entrustment is typically framed as a unidirectional transactional process, our findings clearly illustrate the importance of supervisors being trustworthy in the eyes of their trainees, when providing suitable training opportunities. These findings also resonate with a recent review by Jackson et al who identified agreement on the supervisory goals and roles of both supervisor and trainee as well as clarity on mutual expectations as important ingredients of effective supervision in GP supervisory settings. Findings furthermore tie in with recent research

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on workplace-based learning, which emphasises the importance of establishing an educational alliance in which both trainee and supervisor demonstrate their commitment to the learning process by discussing and reflecting on mutual intentions and agendas very early on.\textsuperscript{30} Being self-aware, reflective and open to feedback, as well as being clear about assumptions and principles underlying entrustment approaches can therefore be considered preconditions for making trustworthy and defensible entrustment decisions that foster learning in a supportive educational relationship, while at the same time ensuring high-quality patient care.\textsuperscript{29}

Findings from our study showed that supervisors started entrusting clinical tasks to their trainees within a few days of the start of the training programme. In line with previous research findings,\textsuperscript{13,21} previous experience with trainee trustworthiness appeared to be a key factor in shaping supervisors’ strategies and approaches to creating and maintaining a safe learning and working environment for themselves as well as their trainees. We found that positive past experiences made supervisors entrust tasks more easily to their current trainee, while negative experiences could lead to a more controlling approach. Consistent with the literature, moreover, we found that supervisors’ propensity to trust had a significant effect on their trustworthiness perceptions and resulting entrustment strategies.\textsuperscript{22,23,31} This finding is particularly relevant when little information about an individual’s trustworthiness is available, such as at the start of a supervisory relationship.\textsuperscript{23,32} Especially at the start of residency-training, supervisors’ propensity to trust, experiences and their resulting supervisory strategies may thus impact on the extent to which trainees are allowed control over their own learning and supervision processes, and, consequently, on the supervisory relationship, effectiveness of supervision and learning outcomes.\textsuperscript{19} Our findings thus show that entrustment is not a ‘data-driven process’. Rather, emotions and feelings about trustworthiness and entrustment (related to holistic impressions of a trainee’s professional behaviour and balancing feelings of safety and vulnerability) play an important role in when and how supervisors make decisions about trust and entrustment of clinical tasks.

Hence, our findings not only highlight the importance of creating a safe working and learning climate for the sake of patient safety and competence development, they also underline the need for faculty development programmes that engage supervisors to reflect on their individual entrustment strategies and on how these might influence trainee learning and the supervisor–trainee relationship. More specifically, supervisors need to be aware that their individual experiences, conceptions and beliefs influence their approaches to entrustment and, consequently, foster or limit trainees’ learning opportunities. Therefore, to ensure that entrustment strategies are well aligned with the needs of all stakeholders, it seems especially important that supervisor and trainee regularly discuss and explicate mutual expectations and responsibilities regarding the supervision initiative in workplace learning.

Our findings clearly show the role of generic qualities rather than task-specific performance, in the assessment of trainee trustworthiness. To further support the robustness of entrustment decisions and trainee learning, careful monitoring and provision of feedback on generic trainee qualities may be needed, especially at—but not limited to—the start of competency-based residency training. In fact, our findings seem to support and justify a more critical stance on behaviourist approaches to competence-based assessment, and emphasise the need to include and value more holistic professional judgements on trainee capabilities.\textsuperscript{33} Therefore, assessment programmes may need to ensure incorporation of instruments that capture generic trainee trustworthiness qualities as a starting point for a meaningful feedback dialogue on trust, entrustment and the trainee’s development towards autonomous and self-regulated professional practice.

**Strengths and limitations**

In this longitudinal, in-depth study, naturalistic data from observations in clinical practice were completed by semistructured interviews with supervisors to explore the underlying reasoning in entrustment decision making. The study is a single-centre study, which may limit the generalisability of our findings. Our study sample was self-selected; all participating GP supervisors were male, and three out of four trainees were female. In terms of ethnic background of supervisors and trainees, the study sample was representative for our study setting. Since we were not able to include participants with different (ethnic) backgrounds nor different gender dyads in our study sample, we could not study the phenomena of differential attainment or supervisor-assessor bias in the entrustment dynamic. We did not notice any impact of years of experience as a supervisor, neither were issues related to gender raised during our observations or interviews. Future research in different settings may elucidate on these and other parameters that may affect entrustment decision making in real life clinical contexts. As participation was voluntary, self-selected supervisor–trainee pairs might have been more interested in the study’s topics than others. However, as we were able to observe both differences as well as similarities in supervisors’ approaches to entrustment in this study sample, self-selection did not seem to have an important effect on our results. Participants included in the study were only involved in long-term, one-on-one educational relationships. This setting allowed us to gain knowledge on the development of the entrustment-based relationship but may limit the transferability to other educational relationships, such as the episodic and dynamic and multi-professional hospital setting. Our sample size was small. However, triangulation of observed behaviours with GP supervisors’ perspectives and experiences as elicited during semistructured interviews generated a rich and practice-based data set, which enabled us to gain in-depth
insights into early entrustment decision making in GP practices. By observing unselected daily activities directly, non-participant observation allowed us to observe actual behaviour instead of relying on reported behaviour. Yet, the he researchers’ presence may have influenced the results as participants may have acted differently than they otherwise would have. During the individual interviews, supervisors were invited to reflect on their cognitions and feelings when making entrustment decisions while being observed. Based on supervisors’ reflections and our observations in daily practice we did not have the impression that supervisors acted differently as they would normally do. We noticed, for instance, supervisors did not always stick to clinical guidelines when supervising their trainee.

Future research
Future research on the perspectives and strategies of GP trainees regarding entrustment decisions may complement our work. In GP residency training, where supervisor-trainee relationships are typically long-term and one-on-one, individual supervisor and trainee interactions may have a stronger influence on entrustment decisions than they likely have in short-term relationships with multiple supervisors in hospital-based settings. Additional research in other clinical settings may, therefore, further our understanding of interrelationships between characteristics of the supervisory setting and (early) entrustment decision making.

In conclusion, our study underscores that supervisors may use various strategies to establish and maintain a safe working and learning climate for all stakeholders, conditional for trustworthy entrustment decisions. Explicit attention to cultivating trainees’ generic trustworthiness qualities in meaningful feedback dialogues as well as mutually agreed on expectations and discussions about preconditions for entrustment are key, especially at the beginning of residency training. Establishing an educational alliance in which entrustment is the subject of ongoing trainee-supervisor conversations is essential to achieve and maintain and optimal balance between trainee learning and patient safety.

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