THE FUTURE OF MEDICAL EDUCATION IN CANADA

CONTINUING PROFESSIONAL DEVELOPMENT

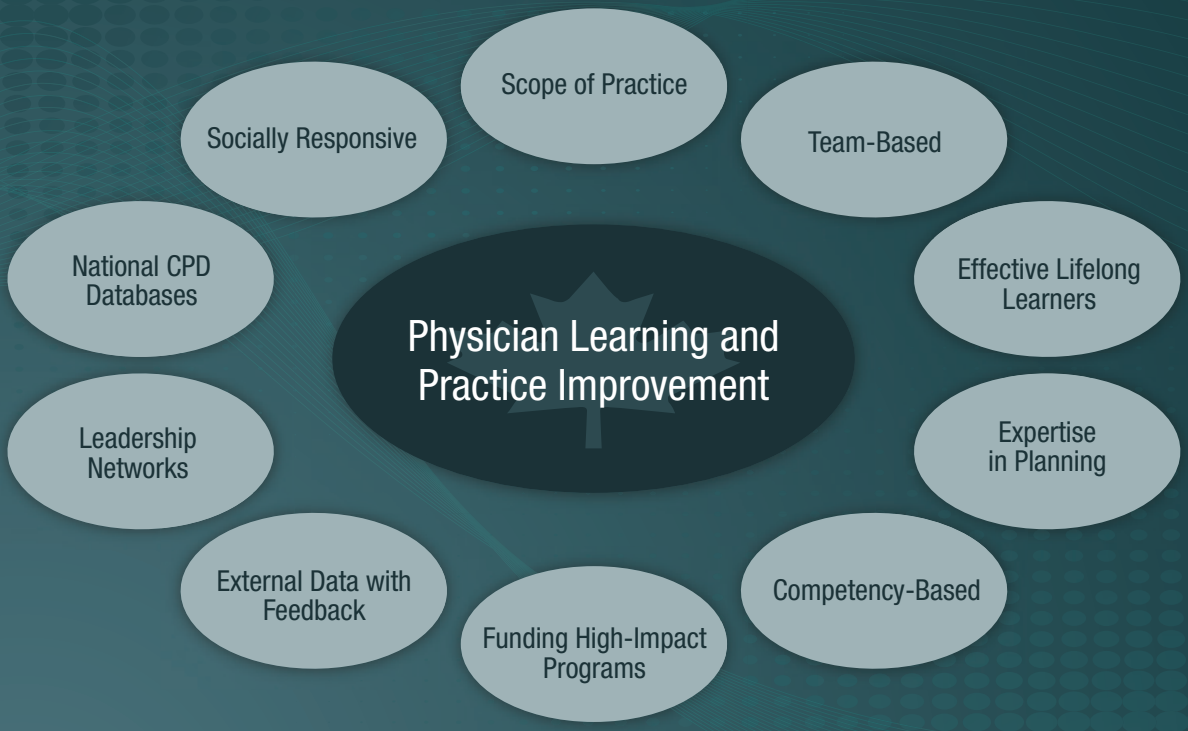
L'AVENIR DE L'ÉDUCATION MÉDICALE AU CANADA

DÉVELOPPEMENT PROFESSIONNEL CONTINU

FMEC CPD WORKING GROUP REPORT

**THEME 3**

# Scope of practice as a tool to describe practice, identify learning needs, and plan CPD




*A Collective Vision for CPD in Canada*

# THE FMEC CPD INITIATIVE

The Future of Medical Education in Canada (FMEC) initiative is a collaborative effort to re-evaluate and rigorously improve the Canadian medical education system. The first two phases of the project resulted in recommendations to guide reforms in undergraduate and residency education. The third phase of the initiative – FMEC CPD – seeks to define policies, structures, and mechanisms for the development of a pan-Canadian system for continuing professional development that sustains innovation and ongoing quality improvement for the health of Canadians.

Eight working groups were established to collaboratively address the following priority themes established by the FMEC CPD steering committee:

1. Amplify and operationalize Physician Practice Improvement principles and roles.
2. Demonstrate how CPD can help to address emerging and unmet issues of importance to the health of Canadians.
3. **Amplify the meaning and implications of scope of practice for physicians.**
4. Contribute to understanding and rationalizing funding for the creation and dissemination of CPD activities.
5. Address CPD as an important part of the lifelong learning continuum for physicians.
6. Advance competency-based CPD tools, assessment strategies, and data.
7. Address the knowledge and skills needed by those participating in the development and delivery of CPD.
8. Address interprofessional teams as an important audience for CPD.

***This report presents the deliberations and resulting recommendations for priority theme 3.***

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# BACKGROUND

Scope of practice (SOP) has become an increasingly important focus of discussion in the Canadian health care system.[1–3] Typically, this discussion has focused on interprofessional issues such as collaboration,[4] SOP reviews,[5] and inconsistencies between legislated and regulated scopes of practice.[6] Yet SOP issues also arise within individual professions. It is essential to examine SOP within medicine, which has the broadest SOP of the health professions[7] along with the highest degree of clinical independence and professional autonomy.[8] Despite intraprofessional discussion about SOP[9–13] and emphasis on SOP in the academic medical literature,[14–21] its meaning and implications for physicians and their continuing professional development (CPD) bear further examination.

The complexity of SOP discussions poses a challenge for the medical profession. Even the term "scope of practice" is subject to multiple and inconsistent definitions, interpretations, and uses.[2] In their reviews of health professional scopes of practice, Baranek[1 (p. 7)] and the Health Professions Regulatory Advisory Council[22 (p. 2–3)] identified six "layers" of SOP: (1) how professionals are defined; (2) what professionals are trained to do; (3) what professionals are authorized to do by legislation; (4) what professionals actually do; (5) how professionals do what they do; and (6) what others expect professionals to do. O'Neill and colleagues[16 (p. 228)] identify various "dimensions" of medical SOP: legal SOP (broadly defined by the laws of a jurisdiction in which anyone holding a medical license can perform "any aspect of medicine covered by those laws"; specialty SOP (a narrower SOP defined by the parameters of education and training established by certification bodies and specialty associations); and individual SOP (a description of what physicians actually do in practice). Therefore, the multiple lenses through which SOP may be viewed include legislation, regulation, accreditation, certification, education, employment,[1] liability, and advocacy. Accordingly, there is no universally agreed definition of SOP.[3]

In 2015, a Royal College working group proposed the following definition of SOP:

> "Scope of practice" is a term used to describe clinical and non-clinical professional roles, responsibilities, activities, abilities, interests, and demonstrated competencies of a health care practitioner. Scope of practice is initially established by the successful completion of formal medical education training requirements and guided and sustained through the continual acquisition and assessment of new knowledge, skills, and abilities through engagement in formal and informal continuing professional development and assessment activities. Scope of practice serves as the basis of professional accountability for processes and regulations related to professional licensure and privileging practices and is influenced by multiple internal and external factors, including changing patient population needs. Scope of practice is foundational to the development and implementation of lifelong learning plans and how competence, performance, and enhanced expertise will be demonstrated within professional practice (C. Campbell, Office of Specialty Education, RCPSC, personal communication, 22 February 2018).

For practical purposes, our application of this comprehensive definition should reflect that SOP is unique to the individual practitioner; changes throughout his or her career; refers to what he or she currently does in practice; includes self-limitations on practice (i.e., choices of what to do or not do); is contextually specific; and includes the team or teams with which the practitioner works and how these teams provide care.

## METHODS

As part of the Future of Medical Education in Canada–Continuing Professional Development (FMEC CPD) project, we formed a working group to "amplify the meaning and implications of SOP for physicians." Members included academics, physicians (with clinical, academic, education, administration, and research backgrounds), and representatives from the College of Family Physicians of Canada and the provincial medical regulatory

authority in Ontario. All had expertise in SOP either in medicine or from an interprofessional perspective, and in CPD through their education and careers.

### *Guiding questions*

The following questions were used to guide our initial discussions and literature search:

1. What tools and strategies can be used to enable physicians to describe their SOP (what they do today in practice)?
2. What role does a description of, and the process of describing, SOP have in identifying learning needs for physicians?
3. How does SOP contribute to the development of an individual and/or group learning plan?
4. What level of competence does a physician need to demonstrate before expanding his or her scope of practice?
5. How does a description of SOP contribute to improving competence in performance and health outcomes experienced by patients?
6. How can an aggregate understanding of scope of practice information contribute to identifying learning needs across groups of physicians or interprofessional teams?

After scanning the literature, we concluded that we could not adequately address questions 4 and 5. Although literature searches yielded results for question 1, the working group decided to focus this narrative review on questions 2, 3, and 6.

We used a consensus decision-making approach informed by expert opinion to search for and select literature to include in our narrative review; determine key themes and findings of the literature reviewed; identify challenges and opportunities for medicine and CPD; and make recommendations for the structure of a new national CPD system that would support the implementation of our recommendations for this theme, promote innovation, and sustain the quality of the national CPD system. Our search encompassed academic and grey literature published in English between 2005 and 2017 that focused on physicians, other health professions, and interprofessionalism. Using these parameters and the above questions, individual searches were conducted and the results presented to the group for a discussion and vote. Databases and search engines used included PubMed, Google Scholar, and Google. Keyword search terms included "physician," "scope of practice," "health professional," "interprofessional," "team-based care," "description," "definition," "competence," "performance," "learning needs," "continuing professional development," "measurement," "reflection," and "tools."

The searches yielded 32 articles, including 3 duplicates (29 unique articles), of which 19 were selected for review. These were divided among the group members (3 per person, with some overlap) to read in depth and summarize. The working group then reconvened to discuss the main themes and findings and to identify challenges and opportunities on which to base our recommendations. A draft report was produced and distributed to the working group for feedback and revisions.

## RESULTS

A number of the articles reviewed addressed the concepts of education and training[15,17–19,21] Directly or indirectly, education and training were pervasive topics in the literature on SOP, insofar as SOP effectively becomes the curriculum for CPD. For medical trainees (e.g., undergraduate, residency, fellowship), criteria and guidelines for education, training, and examination are well established and prescriptive. In independent practice, on the other hand, these parameters are removed. SOP, and therefore CPD, become moving targets according to environment, people, and changes over time. It is difficult to set a curriculum on this basis. Thus, an overarching finding from our review is that SOP is fundamental to CPD. Specifically, SOP is integral to determining CPD needs and the content and delivery of CPD. In other words, CPD should be practice-based, and

CPD programming needs to consider SOP in order not to "miss the mark"– even within specialty areas, as has been observed in rural practice.[23] Education and training is the thread that ties SOP and CPD together; below we discuss issues identified in the literature that are relevant to this theme.

### *Measurement and assessment of SOP*

Various questionnaires, inventories, and scales have been produced to decipher, measure, or predict the SOP of physicians.[14,16,20] Elements covered by these instruments include available professional supports in the practice setting;[14,15] areas of clinical care and non-clinical practice;[15,16] patient referrals[20] or patients seen;[12,16] physician demographic characteristics;[14,15] practice environment;[12–16,21] practice type and structure;[14,15] and descriptions of clinical practice, including range of diagnoses, disease consults, and services, procedures and treatments provided.[12–16,20,21]

*How this issue addresses the questions.* Any tool created to capture SOP must carefully target and match the purpose for which it is created. For instance, if the objective of the tool is to determine appropriate CPD for one's SOP, it needs to be reflective in nature. When creating such instruments and interpreting the results, it is crucial to consider what questions are asked, how questions are asked, to whom questions are asked, the "fit" of responses, and the conclusions one may draw about SOP. For example, family physicians are more likely to provide care to patients across the lifespan and to serve a broader spectrum of patients than other specialists. Similarly, practice information may be missed, depending on how response options are structured and how respondents understand or choose to answer questions.[16] (Question 1.)

### *The importance of context*

Practice context is a key driver of SOP.[12–14,20,21,23,24] Contextual factors identified in the literature pertain to practice environment (e.g., location) and organizational structure (e.g., solo practice, interprofessional team). Practice environment factors that affect SOP include transfer or referral of patients from small rural communities to larger urban centres for specialty consult and case management, as well as patient populations with varying health histories and social determinants of health.[24]

Organizational structures that influence SOP include practice supports and workplace stresses (i.e., collegial behaviour in taking call or offering assistance), employer supports and constraints, available practice options, and professional mentorship and role modelling in the post-training work environment.[15,19] Some practice environments have specific curricular, training, competency, and skill-set requirements. For example, rural practice requires family physicians to have broad clinical expertise and to receive additional training (e.g., in surgical and procedural skills, emergency medicine, and community-oriented primary care.[21,24] Within a given practice setting, the composition, availability, and skill sets of other health professionals (i.e., who else is there and what they do), how care is funded, financed, and delivered, and how new and existing health professionals are remunerated all have the potential to impact the SOP of individual physicians, specialties, and medicine more generally.[2] Physicians may have a more focused SOP in environments where there are more physicians. In environments with a lower concentration of health professionals, who is most appropriate to deliver certain aspects of care, rather than who wants to deliver those services, is more likely to influence practice and SOP.

*How this issue addresses the questions.* The fact that practice context can push SOP outside the "typical" breadth of a specialty area suggests that looking at specialty alone to determine CPD needs is insufficient.[23] It is important to understand that SOP is context specific, and to be aware of how and why contextual factors influence SOP.[14] SOP is a key driver of CPD needs for individual physicians and can inform contextually relevant content and delivery mechanisms for CPD programming.[23] (Questions 2 and 3.)

### *Interprofessional collaboration*

The regulatory and legal context in which health professionals work can promote or impede collaboration among health professionals.[25,26] Some regulatory and medico-legal barriers can arise from perceptions that liability within a team automatically flows to physicians. However, recent analysis suggests that courts and negligence law do not presume "the existence of a pyramidal model" of legal responsibility.[26] When these barriers, whether real or perceived, are overcome, interprofessional collaboration requires teams to reach consensus regarding the workload of each team member and the workflow of the team as a whole. Bearing in mind that team members are not necessarily interchangeable, decisions can be made regarding patient assignments (i.e., patients and problems seen), and expected roles, responsibilities, and task delegation.[18] This interaction between professions can affect the scopes of practice of all professionals involved.

*How this issue addresses the questions.* For physicians, working with other professions can result in a narrowing of typical practice activities. As a result, there may be areas of practice that are seldom encountered and that require CPD to maintain competence, or areas of focus that require constant attention.[27] In either case, reflecting on how team interactions affect SOP is an important part of understanding practice learning needs. (Question 6.)

### *Competence, performance, and continuous assessment of SOP*

A physician's ability to perform competently is determined by knowledge, skill, and judgement, all of which are developed through training and experience in a particular clinical practice area.[12] Yet competence is not a fixed trait. Physician migration, re-entry to practice, career interruptions, significant changes in SOP, and career stage warrant periodic reassessment and reaffirmation of competence.[12,28] Assessment of competence must extend beyond training and credentials to capture what physicians currently do in practice.[28] It cannot be assumed that the acquisition of additional knowledge, advanced clinical competencies, and correspondingly larger SOPs will in and of themselves ensure competence.[29] In their assessment of factors associated with physician performance on competence assessment, Grace and colleagues[30] identified several predictive factors associated with the individual (e.g., age and certification status), practice-to-training match (i.e., practising within the SOP of one's speciality), and solo practice. Practising outside of one's SOP may be a risk factor for poor performance and competency issues.[30]

*How this issue addresses the questions.* It is important to help physicians understand that practising beyond their scope may present a risk to their patients and their practice. Helping physicians to reflect on potential gaps between their training and practice, or to otherwise raise awareness of issues related to SOP, may significantly reduce this risk. Understanding risk factors more broadly can support the development of proactive CPD, particularly for those with "high risk" practices. (Question 5.)

## CHALLENGES AND OPPORTUNITIES

Our discussions identified the following challenges and opportunities for the medical profession to address in relation to SOP and CPD.

1. SOP and/or necessary CPD remain unclear for: (1) distinct and not-so-distinct disciplines in medicine; (2) specialties for which training programs have yet to be fully established in Canada, such as Sleep Medicine; and (3) practices for which the SOP is entirely non-clinical (e.g., physicians who have certified in Public Health and Preventative Medicine and have moved away from clinical practice, or those who are occupied full time in teaching, research, administration, consulting/advisory, or public service roles. Future inquiries could examine what, or the extent to which, CPD exists for intrinsic skills, or aspects of practice that are not clinically driven.

2. The breadth of training at the undergraduate and postgraduate levels (at the time of certification) is finite and well defined. In independent practice, context interacts with that base knowledge and training and may necessitate the acquisition of additional competencies. Over time, the interaction between what one knows, and what one needs to do, in a specific practice can evolve and may even cross specialty lines. Thus, being able to determine CPD needs in a changing landscape is difficult. This is an area where physicians require assistance and guidance, and this should be considered in CPD planning and delivery. The profession may even need to move toward a more fluid concept of what constitutes a specialty.
3. Links between SOP, learning needs, and CPD have been identified in the literature and by the profession.[31,32] What is lacking in these discussions is specific guidance as to what form this CPD to address SOP and learning needs should take.
4. To some extent, CPD offerings are influenced by revenue generation rather than defined needs. CPD offerings tend to be repetitive, and even core topics can be overlooked. Also, it can be difficult for physicians to find or access CPD they identify and require, especially in rural and remote locations. Additionally, programs for specific specializations can be limited, requiring physicians to travel to obtain CPD in their area of practice. That being said, in identifying distance as a potential obstacle, it is assumed that most physicians still use in-person learning forums (e.g., conferences, meetings) as the major contributor to their CPD. However, online medical education can also contribute to physicians' learning, and perhaps distance is not as isolating as it once was.
5. There may be a social accountability gap between the SOP assumed by physicians and the SOP required of them by the populations, communities, and patients they serve (e.g., by not adequately addressing care of the elderly in an aging population). Ideally, in a patient-centred system, SOP and resulting CPD should be patient-driven to meet current and emerging needs. In family medicine, this is an important driver of evolving scopes of practice (e.g., a family medicine group wanting to provide primary care dermatology because of long wait times for this specialty in their area). However, a physician's SOP can change for a number of reasons, such as personal strengths, professional interest, or the emergence of health or personal issues that preclude continued practice in one's original SOP. Physicians should be encouraged to exercise their discretion and autonomy in shaping their SOP and responding to patient needs. Physician interests and community needs need not be mutually exclusive.
6. Research is needed to examine the extent to which physicians lean toward CPD they are comfortable with or that plays to their strengths – that is, catering to their "scope of interest" rather than their SOP. The current credit system potentially reinforces this by permitting physicians to do all of their CPD in one area. Physicians are responsible for assessing their practice, determining their learning needs, and making the right CPD choices for their SOP. This includes searching for and selecting topics that meet their CPD requirements. However, it is possible that CPD choices and requirements are not always appropriate for one's SOP.

## RATIONALE FOR RECOMMENDATIONS

Our recommendations are based on the literature reviewed, the challenges and opportunities described above, and the expert consensus opinion of our working group. The working group was intentionally not prescriptive with respect to how these challenges and opportunities might be addressed, or how our recommendations might be implemented by stakeholders, who are best positioned to effect change in a way that is consistent with their institutional programs, frameworks, and mandates. Here, we offer some general conclusions to support our recommendations.

A strong evidence base, both in the articles included in our review and the CPD literature more broadly, indicates that the impact of CPD is strongest when it is based on learners' immediate practice environment and the needs that arise from their daily practice activities. Thinking about what those activities are and the context or contexts in which they occur – that is, reflecting on SOP – is a logical and important step in planning effective ongoing learning.

Post-certification SOP is the basis for CPD curricula throughout a physician's career. For individuals and groups of physicians, practice (and SOP) can shift over time, sometimes without the individual or group's explicit awareness. Having a consistent way to track these changes throughout CPD cycles is important. For CPD provider organizations, SOP is important for the determination of assessment needs and the development of context-specific learning activities. CPD planners can also use SOP information to inform program development more broadly. Ensuring that the focus of CPD for medicine and other professions is geared toward achieving competence for specific scopes of practice throughout a career will contribute to the quality, sustainability, and safety of the national CPD system.

Our recommendations focus on the themes described below.

1. **The need for adaptability and specificity (recommendation 1)**. For physicians, SOP is a primary consideration in devising CPD plans over the course of their careers. CPD is necessary to expand or further specialize SOP, and must fill the gaps between the scope of the disciplines in which physicians are certified and the actual scope of individual physicians' practice. The profession needs to better assist its memberships when making the transition from the broader competencies specific to medical disciplines to the more specific competencies that must be maintained (and potentially learned) for individual practices. It is also important for SOP to be adaptable to meet community needs. Recognizing this need for adaptability will allow for meaningful CPD to take place. CPD activities should be derived from what physicians need and choose to do in practice within their specific contexts.
2. **The need for a common terminology (recommendations 2 and 3)**. There is a mismatch between the scope of specialties or disciplines as understood by certification bodies, and the regulatory meaning of SOP, which is unique to individual physicians. Put another way, there is conceptual slippage between the SOP for medical specialties and the SOP of the specialist. Although SOP is to a certain extent determined by the discipline in which one is certified, it is not necessarily tied to, and potentially extends beyond, the education and credentials that reflect the medical specialty/discipline in which one was trained.
3. **The need for self-reflection on SOP and learning needs (recommendation 4)**. It is important for physicians to demonstrate how their learning and improvement are anchored in a description of their SOP. Given that self-identification of one's learning needs is subjective, part of this self-reflection needs to consider the impact of practice context on SOP. The creation of personal education plans and individual practice profiles should be included as part of CPD planning, and reviewed every 5 years, to identify issues relevant to maintaining competence within one's SOP.
4. **The need to facilitate awareness of and access to meaningful CPD (recommendations 5, 6, and 7)**. Physician feedback to certification bodies and medical regulatory authorities indicates much uncertainty regarding what physicians need to know, and where and how to access meaningful CPD for their SOP. Specialty societies, certifica-

tion bodies, and CPD providers could institute offerings over and above the guidance of Triple C and Competence by Design to account for differences between individual physicians within and across specialties, and for SOP changes experienced by individual physicians over time.

5. **The need to emphasize teamwork and collaboration (recommendations 8, 9, and 10)**. An individual clinician's competence depends to a great extent on others. Reflecting on how patient, collegial, educational (in person or through distance learning), team, and other professional interactions affect SOP is an important part of understanding learning needs across groups of physicians and interprofessional teams. Likewise, CPD programming needs to account for how care is actually provided – that is, often in teams rather than by individual practitioners or specialties. Although health professional scopes of practice are defined by provincial regulators, they are taught by educators who follow national "scope of discipline" standards. If the SOP or entrustable professional activities within a certain context were agreed upon by all disciplines responsible for carrying them out at the provincial level and were shared with those with educational responsibilities at the national level, this might influence how health professionals are taught, certified, and credentialed in the future.

# RECOMMENDATIONS

1. Anchor CPD programming and offerings for individuals and groups of practitioners in SOP rather than solely in medical disciplines.
2. Address issues of terminology between stakeholders instrumental to determining, implementing, and deploying SOP to determine the CPD needed throughout professional lives.
3. Generate an agreed upon, consistent terminology to make clear the distinction between scope of discipline as outlined by certification bodies and national specialty societies, and what physicians actually do (SOP).
4. Enable individual physicians or groups of physicians to describe their own SOP for their own reflective purposes using tools to measure or approximate SOP. Create, and periodically review and revise, tools such as personal education plans and individual practice profiles.
5. Encourage greater access to meaningful CPD offerings for SOP.
6. Categorize and present CPD activities in a clear way, particularly for those physicians who have changed their SOP and for whom choosing appropriate CPD that reflects their new SOP is not intuitive.
7. Provide a centralized, online resource for physicians to access information, such as location, about available CPD activities.
8. Acknowledge teamwork and account for team-based care delivery in CPD.
9. Make CPD more interprofessional in nature to maximize the safety and quality of care across all professions who perform collaboratively in the same activity areas.
10. Work to remove barriers to collaborative CPD. Develop specialty-specific tools, and identify needs, for collaboration.

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