

Comparing the scopes of practice of geriatric-focused physicians in Canada: a qualitative study of core competencies

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Abstract

Background: Given long-standing deficits of medical expertise to care for a growing population of older adults, it is important to understand the geriatric medical workforce. We aimed to describe and compare the scopes of practice of the 3 geriatric-focused physician providers in Canada (i.e., family physicians with certification in Care of the Elderly [FM-COE], geriatricians and geriatric psychiatrists).

Methods: We conducted a qualitative study to compare competencies across geriatric-focused physician provider types in Canada, using a directed content analysis approach. We identified and obtained relevant publicly available documents that described the competencies required for certification by searching the websites of The College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada between June 2 and July 31, 2020. An inductive content analysis was used to compare content within each CanMEDS Role according to the CanMEDS Framework.

Results: We identified and obtained 4 relevant publicly available documents describing the competencies required for geriatric-focused certification for the 3 geriatric-focused physician provider types. We found substantial overlaps in the expected medical expertise of FM-COE and geriatricians. The few substantive differences across providers may result from different priorities about which competencies were made explicit for providers. The focused nature of mental health care is apparent in several competencies unique to geriatric psychiatry.

Interpretation: This work highlights substantial overlaps in the scopes of practice for FM-COE and geriatricians. Our findings may encourage efforts to develop more robust delineations between the scopes of practice of these related professionals to facilitate inter-specialty collaboration to lead to more equitable and accessible medical care for older adults.

Older adults (≥ 65 yr) are among the fastest-growing cohorts in the developed world; they are living longer but with high rates of multimorbidity and medical complexity.¹ Long-standing deficits of medical expertise in the care of older adults are recognized and threaten equitable access to geriatric-focused medical care.²⁻⁴ Although some physicians report a lack of confidence and competence to manage the complexity of care for older adults,^{5,6} 3 Canadian medical specialties receive specialized training to care for older Canadians: family physicians with certification in Care of the Elderly (FM-COE), geriatricians and geriatric psychiatrists. Although there is evidence to support decision-making within individual specialties about systems of care,⁷⁻¹⁰ there is scant information available on the differences or overlaps across these geriatric specialists, which is important to facilitate efficient and equitable care coordination for older adults.

Competencies outline fundamental expectations of trainees and provide foundational knowledge required to practise in a particular domain of medicine.¹¹⁻¹³ Although competencies do not represent firm boundaries of knowledge or skills, they provide a foundation for identifying scopes of practice.

Previous research has described the processes of identifying and establishing competencies for geriatric-focused medical disciplines,^{11,12,14,15} but much remains unknown about their convergence. Therefore, to identify areas of overlap and differences in scopes of practice across the 3 geriatric-focused specialties in Canada, we compared the competencies for FM-COE physicians, geriatricians and geriatric psychiatrists. We aimed to stimulate critical thinking about the opportunities for collaborative care of a shared patient population, in ways that recognize providers' unique perspectives and professional identities.

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Methods

Study design and setting

We followed the Standards for Reporting Qualitative Research (SRQR) guideline¹⁶ to report this study and used a comparative approach to document analysis to identify overlap across the competencies of Canadian FM-COE physicians, geriatricians and geriatric psychiatrists, as defined by The College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC), respectively.¹⁷ The FM-COE comprises a heterogeneous group of family physicians who practise in inpatient and outpatient settings, and dedicate different proportions of their medical practice to focused care of older adults.² Most geriatricians practise within academic health sciences centres and community hospitals, and engage in hospital-based practice.⁴ Similar to geriatricians, geriatric psychiatrists provide care across inpatient and outpatient settings.¹¹

Data sources

The CFPC and the RCPSC provide publicly available documentation of the competencies required to be a certified practitioner of each geriatric-focused specialty. We searched the CFPC and RCPSC websites for the terms “competenc* AND Canada AND care of the elderly OR geriatric psychiatry OR geriatric medicine.” The search was conducted between June 2 and July 31, 2020.

We consulted clinical education leaders in each geriatric-focused specialty to confirm the completeness and relevance of these documents. We consulted FM-COE program directors to obtain applicant and match data for the 2019 (July 1, 2019, to June 30, 2020) and 2020 (July 1, 2020, to June 30, 2021) academic years, because the Canadian Resident Matching Service was not nationwide for those 2 years. We consulted 15 FM-COE program directors across Canada (none of whom were members of our author group). We selected them from the current list of program directors at Canadian medical schools and solicited their input by email in May 2021. We asked each director to share the number of COE spots

(6 or 12 mo in length) their program had and the number of COE spots that had been filled, for each of those 2 academic years. One of the authors (H.S.) is a practising FM-COE physician and another is a geriatrician (A.J.), and both confirmed the relevance of the search results.

Data analysis

Two researchers (A.J. and R.C.) reviewed the documents in full and used a data extraction template to examine and code the documents independently using a directed (deductive) content analysis approach to organize and compare data across specialties.^{17,18} The CanMEDS and CanMEDS–Family Medicine (FM) Frameworks were used to examine the relevance of competencies to the 7 CanMEDS Roles: medical expert/family medicine expert, communicator, collaborator, leader, health advocate, scholar and professional.^{19,20} The CanMEDS–FM is the CFPC-adapted version of the CanMEDS Framework, wherein “medical expert” is replaced with “family medicine expert.”²⁰

Two authors (A.J. and R.C.) compared the presence of competencies within each CanMEDS Role across each of the specialties and documented memos to identify patterns. All of the authors reviewed and resolved areas of disagreement through discussion. Concordance and discordance within each CanMEDS Role were identified through inductive content analysis.

Ethics approval

Data were publicly available, and ethics approval for this project was thus not required.

Results

We analyzed 4 documents on the CFPC and RCPSC websites that described the educational competencies and priority topics required to be a certified practitioner of FM-COE, geriatric medicine or geriatric psychiatry (Table 1).

Table 2 displays the results of our analysis for both unique and shared competencies, grouped by CanMEDS Roles. In each category, concordance is described before difference.

Table 1: The College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada competency documents pertaining to geriatric-focused providers

Specialty	Competency document	
	The College of Family Physicians of Canada	The Royal College of Physicians and Surgeons of Canada
FM-COE	Residency training profile for family medicine and enhanced skills programs leading to certificates of added competence ²¹	
	Priority topics and key features for the assessment of competence in Care of the Elderly ²²	
Geriatric medicine		Objectives of training in the subspecialty of geriatric medicine ²³
Geriatric psychiatry		Objectives of training in the subspecialty of geriatric psychiatry ²⁴

Note: FM-COE = family physicians with certification in Care of the Elderly.

Table 2 (part 1 of 2): Summary of the core competencies of geriatric psychiatrists, geriatricians and family physicians with certification in Care of the Elderly, by CanMEDS Roles

CanMEDS role	Competency	Geriatric psychiatrist	Geriatrician	Family medicine, Care of the Elderly
Medical expert/family medicine expert	Differentiates normal and abnormal aging	X	X	X
	Considers a patient's comorbidities, frailty and functional status to prognosis	X	X	X
	Prevents, diagnoses and manages delirium	X	X	X
	Examines, diagnoses and manages neurocognitive disorders (i.e., dementia) and associated behavioural changes or disturbances	X	X	X
	Appropriately prescribes pharmaceuticals	X	X	X
	Elicits patient histories	X	X	X
	Tailors interventions for health promotion and disease prevention	X	X	X
	Assesses issues related to capacity and competency (i.e., personal decision-making, driving)	X	X	X
	Enquire about caregiver stress and capacity	X	X	X
	Knowledgeable about end-of-life care	X	X	X
	Applies best practices for falls prevention and screening		X	X
	Diagnoses and manages osteoporosis and fracture risk		X	X
	Develops rehabilitative approaches		X	X
	Performs detailed medication reviews		X	X
	Assesses for urinary incontinence		X	X
	Diagnoses and manages pain		X	X
	Manages palliative and end-of-life care issues		X	X
	Knowledgeable about psychotherapeutic constructs, psychopharmacology and therapeutic approaches	X		
	Exhibits extensive knowledge about mental illnesses and psychiatric disorders	X		
	Communicator	Performs a comprehensive geriatrics assessment		X
Diagnoses and manages bowel dysfunction			X	
Elicits and synthesizes information from patients, families and care providers		X	X	X
Recognizes and mitigates communication barriers		X	X	X
Considers the merits of a second opinion		X	X	X
Ensures communication during transfers or handover		X	X	X
Collaborator	Prioritizes issues for patient encounters with a recognition that the role is that of a specialist (not a primary care provider)	X	X	
	Proficient in the use of telepsychiatry	X		
	Performs timely consults	X	X	X
	Exhibits respect for team members	X	X	X
	Collaborates on assessments and care management	X	X	X
	Respects the scopes of practice, differences and overlapping or shared responsibilities of providers	X	X	X
	Engages in shared decision-making with families and caregivers	X	X	X
	Identifies opportunities for learning and improvement	X	X	X
	Plans and delivers learning activities	X	X	X
	Describes the roles and responsibilities of geriatric mental health care teams and show leadership in teams	X		
Acts as an expert resource on issues such as mental health legislation	X			

Table 2 (part 2 of 2): Summary of the core competencies of geriatric psychiatrists, geriatricians and family physicians with certification in Care of the Elderly, by CanMEDS Roles

CanMEDS role	Competency	Geriatric psychiatrist	Geriatrician	Family medicine, Care of the Elderly
Leader	Knowledgeable about community resources	X	X	X
	Mediates and resolves conflicts within interprofessional teams	X	X	X
	Applies quality improvement principles to evaluate and improve health care systems and cost-appropriate care	X	X	X
	Understands the health care system relevant to caring for older patients	X	X	
	Competent in the use of health informatics to improve care quality and optimize safety		X	
	Engages in stewardship of health care resources	X	X	X
Health advocate	Adapts to meet patient needs and preferences	X	X	X
	Recognizes and manages abuse, neglect and mistreatment of older adults	X	X	X
	Advocates for essential hospital and community resources and services	X	X	X
	Identifies and responds to policies affecting health	X	X	X
	Identifies vulnerable and marginalized populations and responds to cultural issues	X	X	
	Identifies patient vulnerabilities		X	
	Advocates for evidence-based health promotion		X	
	Determines the need for immediate intervention, such as home visits			X
Scholar	Recognizes knowledge limitations or gaps in literature specific to the medical care of geriatric populations	X	X	X
	Critically appraises evidence, research and literature	X	X	
	Poses scholarly questions, selects and applies methods to address questions, and communicates and disseminates findings	X	X	
	Participates in research, program development, medical education and other activities that improve the delivery of services	X	X	X
	Recognizes the influence of role modelling and the effect of the formal, informal and hidden curricula on learners		X	
Professional	Identifies the capacity for decision-making	X	X	X
	Obtains and documents informed consent	X	X	X
	Respects confidentiality, privacy and ethical codes	X	X	X
	Adheres to substitute decision-making policies	X	X	X
	Exhibits appropriate professional boundaries	X	X	
	Shows a commitment to high-quality care and excellence	X	X	
	Prioritizes personal and professional duties	X	X	

Medical expert/family medicine expert

All 3 provider competency lists indicate proficiency is required in eliciting patient histories and tailoring health promotion and interventions for disease prevention. All are expected to differentiate normal and abnormal aging, and to consider the contributions of a patient’s comorbidities, frailty and functional status, when determining patient prognosis. Appropriately prescribing pharmaceuticals and

preventing, diagnosing and managing delirium are recognized as core competencies. Providers should be able to assess issues related to capacity and competency. All providers should diagnose and manage neurocognitive disorders (i.e., dementia) and associated behavioural changes or disturbances. Each should be able to enquire about caregiver stress and capacity and be prepared to facilitate end-of-life discussions.

Geriatricians and FM-COE physicians are expected to be competent in best practices for fall prevention, including the diagnosis and management of osteoporosis. Geriatricians and FM-COE physicians are also expected to perform detailed medication reviews, assess urinary incontinence, diagnose and manage pain, and manage end-of-life care issues.

Uniquely, geriatric psychiatrists must be knowledgeable about psychotherapeutic constructs, psychopharmacology and therapeutic approaches. They are expected to exhibit extensive knowledge about mental illnesses and psychiatric disorders. Geriatricians are responsible for performing comprehensive geriatric assessments.

Communicator

All providers are expected to elicit and synthesize information from patients, families and care providers, and consult with colleagues as required. They should be able to mitigate communication barriers by providing assistive devices and ensure adequate communication during transfers of care.

Geriatric psychiatrists and geriatricians should prioritize issues for patient encounters by recognizing their roles as specialists. Exclusively, geriatric psychiatrists must be proficient in the use of telepsychiatry.

Collaborator

All providers must be competent in performing timely consultation in a respectful and collaborative manner. They are expected to respect the scopes of practice, differences and overlapping responsibilities of other providers. They should aim to engage in shared decision-making with families and caregivers during team discussions and case conferences. All providers should identify learning and improvement opportunities, and plan and deliver learning activities.

Geriatric psychiatrists must be able to describe other geriatric mental health care team members' roles and responsibilities. They are also expected to show leadership and act as an expert resource on issues such as mental health legislation.

Leader

All providers must be familiar with available community resources (e.g., local social support services) to facilitate equitable patient access and use. Providers are expected to mediate and resolve conflicts that may arise. All providers should also be able to employ quality improvement methods within their respective health care systems, allocate resources efficiently and manage cost-appropriate care. They must also understand the structure and function of the health care system relevant to caring for older patients.

Geriatricians must be competent in the use of health informatics to improve the quality of care and optimize patient safety.

Health advocate

All providers should be flexible to meet patient needs and preferences for care management. They must recognize and manage abuse, neglect and mistreatment of older adults. All providers must be competent in advocating for essential hospital and community resources and services, as well as systems-level change.

Geriatricians and geriatric psychiatrists are expected to identify and respond to health policies, identify vulnerable or marginalized populations and respond to cultural issues. Geriatricians must be competent in identifying patient vulnerabilities that increase their risk of poor health and advocating for evidence-based primary care. The FM-COE physicians should be able to determine the need for immediate interventions to mitigate harm.

Scholar

All providers are expected to recognize knowledge limitations and gaps in the literature specific to the medical care of older adults. They must also be competent and engaged in research by posing scholarly questions, applying scientific methods, and communicating and disseminating findings. They are encouraged to participate in research, program development, medical education and other activities that improve health care of older adults.

Geriatricians and geriatric psychiatrists should be able to appraise evidence, research and literature critically. Exclusively, geriatricians should be able to recognize the influence of role modelling and its effect on learners.

Professional

All providers should identify decision-making capacities among patients and obtain informed consent. They must be competent in respecting patient privacy and confidentiality while recognizing, fulfilling and adhering to professional and ethical codes. They are required to conform to legal obligations, policies and procedures relevant to substitute decision-making.

Geriatricians and geriatric psychiatrists are expected to exhibit appropriate professional boundaries with patients and families. They must be competent in showing a commitment to high-quality care and excellence, while prioritizing personal and professional duties.

Comparison across specialties

As presented in Table 2, there are substantial overlaps in the competencies expected of geriatric-focused providers across the CanMEDS roles. Although there are few points of distinction between the expected competencies of geriatricians and FM-COE physicians regarding medical expertise, the focused nature of mental health care is apparent in several competencies unique to geriatric psychiatry.

Many of the similarities across the 3 provider types pertain to communicator, collaborator and health advocate roles. In addition, there are many similarities among geriatricians and geriatric psychiatrists for competencies related to leader and scholar roles. Competencies related to the professional role likely apply to all providers but were not always made explicit in the FM-COE documents.

Interpretation

We analyzed practice competencies and priority topics across geriatric-focused providers in Canada as outlined by their respective colleges. We identified substantial overlaps in the

expected medical expertise of FM-COE physicians and geriatricians, which blurs the scopes of practice between disciplines. Although there were a few substantive differences, such as the expectation that geriatric psychiatrists be conversant with psychotherapeutic techniques and medications, some of the distinctions we identified are likely the result of different priorities about implicit and explicit competencies. Although collaboration is expected among all geriatric-focused providers, the absence of published literature concerning their shared areas of practice and individual competencies may inhibit opportunities for collaboration.

When examining the priority clinical domains set out by the CFPC, it is not initially apparent where the CanMEDS-FM Roles of scholarship, advocacy, leadership and professionalism are addressed in training. This may reflect that FM-COE training is scaffolded on top of generalist competencies within family medicine. For example, although this is not an explicit competency in the documents we reviewed, FM-COE physicians are expected to maintain appropriate professional boundaries with patients and families. The CFPC uses multiple guideline documents to detail the professional activities and clinical competencies for FM-COE physicians. The college recently published its national standards for “Core Professional Activities” (CPAs); there is a CPA list specific for PGY-3 residents pursuing an extra year of training in COE.²⁵ The CPAs list indicates that scholarship, advocacy, leadership and professionalism are expected for FM-COE physicians. Given that FM-COE physicians are family physicians first, the documents we reviewed serve to augment, not replace, the core clinical and professional competencies expected of all family physicians.

Canada has long acknowledged severe shortages in geriatric medicine and services.^{2,4} Although field experts and leaders encourage medical trainees to pursue a geriatric medicine specialty,^{26,27} many suggest that training through the FM-COE pathway may be more efficient.^{12,28,29} Since 1989, family physicians have had opportunities to receive additional certification in an enhanced area of family medicine practice.³⁰ The eligibility criteria to earn the FM-COE certification vary as some physicians have earned certification through completion of their medical residency, whereas others have been certified given their previous clinical or leadership experience.³⁰ Some family physicians use their additional training to practise in several care settings and take on specialized roles — similar to their counterparts practising in similar medicine areas that have undergone different pathways into a specialty.^{30,31} Despite similar competency profiles, geriatricians and FM-COE physicians are hired, compensated and deployed within the health care system in different ways.^{8,10,31}

Patient care is a shared responsibility of all physicians. However, there is a need to determine how best to assign responsibility for specialized care of older adults, given physicians' overlapping scopes of practice.³² Research is needed to characterize the degree to which geriatric-focused providers exemplify these competencies in daily practice and negotiate the scopes of their shared competencies, especially as medical complexity increases in patients. At present, literature describing the characteristics and practice patterns of FM-COE physicians is sparse,^{8,33,34}

despite the need to understand better how their medical practice differs from that of geriatricians. In addition, more research is needed to characterize the effects of geriatric-focused providers on practice patterns, patient outcomes and satisfaction, and use of health services.

Future work to identify geriatric-focused practice locations may offer insights about access to care. For instance, in remote regions of Canada, community hospitals may not have access to staff geriatric psychiatrists. However, given the overlap in medical expertise, hospitals may be able to leverage the services of either FM-COE physicians or geriatricians. This highlights an opportunity to build capacity in geriatric care among generalist physicians, who already provide much of the care for older patients. For example, collaboration between an FM-COE physician and generalist psychiatrist may help meet the psychiatric care needs of older adults in the community.

The degree of detail used to define the expected level of competence varied across disciplines, hindering our comparisons. Geriatric psychiatry framed competencies by specifying the degree of knowledge depth to which trainees and subspecialists were expected to attain, although definitions surrounding the evaluation of competence were not provided. Establishing and standardizing whether geriatric-focused providers should acquire knowledge at the “advanced” or “expert” level is essential to tailor and standardize evaluations across specialties.

Limitations

Comparisons across the 3 physician types were limited by the organization and degree of detail specified in each competency list. The RCPSC organized geriatric medicine and geriatric psychiatry competencies according to CanMEDS Roles, whereas the CFPC framed FM-COE competencies around 18 priority areas of knowledge, leaving programs to operationalize these lists into specific learning goals and outcomes. The CFPC priority topics intend to list key features for assessment and determination of competence focused on the practitioner and the patient population, which contrasts with the more exhaustive list for educational programs and curricula published by the RCPSC.

In addition, our analysis was limited to document review. However, collaboration with clinical and academic co-authors helped discern whether the competencies not explicitly stated in some lists were implied or relevant to other groups. Finally, the CFPC competency list reflects the expectations of family physicians who complete COE training through medical residency and may not represent those who earned the COE designation through clinical practice or leadership routes.

Conclusion

We compared the scopes of practice and competencies among geriatric-focused physicians in Canada. We identified substantial overlaps in the required medical expertise of FM-COE and geriatricians, and some unique discipline-specific competencies, particularly for geriatric psychiatrists. However, some competencies are not explicitly documented, and the degree of required knowledge was inadequately defined in some regulatory documents. Therefore, our findings should

encourage efforts to develop more robust definitions of medical practice and delineations of scopes of practice for these providers, which may ultimately facilitate more equitable and accessible medical care for older adults.

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Contributors: Rebecca Correia and Amina Jabbar conceived the study design and conducted the qualitative analysis. Rebecca Correia, Amina Jabbar and Henry Yu-Hin Siu collected the competency documents from the respective colleges. Meredith Vanstone verified the qualitative methods. Sophie Hogeveen, Darly Dash, Fabrice Mowbray and Henry Yu-Hin Siu verified the results. Rebecca Correia and Amina Jabbar prepared the original draft of the manuscript. All of the authors discussed the results, revised the manuscript critically for important intellectual content, gave final approval of the version to be published and agreed to be accountable for all aspects of the work.

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