Article ID: 2021-0193

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

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Reviewer: 1
Dr. Lesley Charles, University of Alberta

Thanks for this good summary in an area with little research.

1. The CFPC priority topics and key features are not educational competencies. Refer to Charles L, Frank C, Allen T, Lozanovska T, Arcand M, Feldman S, Lam R, Mehta P, Mangal N. Identifying the Priority Topics for the Assessment of Competence in Care of the Elderly. C Geriatr J 2018; 21(1):6-13. doi:10.5770/cgj.21.289. eCollecton 2018 Mar. PubMed PMID: 29581816; PubMed Central PMCID: PMC5864573. "In summary the approach we used differs from existing publications about core competencies in COE in that it focused on the practitioner and the patient population, rather than educational programs and curricula. The primary goal was to determine the priorities for the assessment and determination of competence, as opposed to the educational approaches and objectives that may be used to help to achieve competence. The number of topics produced using this approach is smaller than list of competencies developed using educators as the primary input for development.

Thanks for this comment. We used the CFPC priority topics and key features as the basis for our analysis because, to our knowledge, it is the most reputable document that aligns with the expected knowledge and skills of FM-COE providers. However, we recognize that we need to explicitly state that these are not educational competencies (i.e., use the language "priority topics"), as conveyed in this reviewer comment and the reference provided.

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

Page 11: ***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.***

2. Maybe some further discussion of limitations in comparing between CFPC and RCPSC.

We agree these limitations are important to discuss. In response to other editor and reviewer comments, we incorporated this suggestion in our "Limitations" section.

Page 11: ***Comparisons across the three 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.

3. They are also not divided into the Can MEDS roles

We agree this is important to highlight and have done so under "Limitations".

Page 11: ***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.***

4. As you identify, COE is directed by the CFPC in terms of CanMEDS roles, PT and KFs as well as CPAs with the latter addressing "a lack of competencies related to scholarship, advocacy, leadership, and professionalism was apparent for COE family physicians". This should be added or the statement removed from abstract. Each individual program translates the CanMEDs roles, PTs/KFs, CPAs into their own competencies/goals and objectives. This is due to the CFPC philosophy of being less prescriptive on the educational competencies while still mandating the overall practice competence.

Thanks for this suggestion. We agree that removing this statement from the Abstract is necessary, as it undermines how the CPAs elaborate on the expected competencies for these roles. We also added a statement to clarify that individual programs translate the available information into their own competencies/goals and objectives.

Removed from Abstract: ***A lack of competencies related to scholarship, advocacy, leadership, and professionalism was apparent for COE family physicians.***

Page 11: ***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.***

5. I agree a study looking at actual practice patterns and remuneration would be interesting. I believe one has been done by Dr Borrie et al but not yet published.

Thanks for this comment pertaining to the "Future directions" sub-section of our "Interpretation" section. We appreciate that you agree a study examining these aspects of FM-COE practice would be interesting. We scanned the literature and were unable to find a study by Dr. Borrie et al in this regard.

Reviewer: 2
Dr. Faizan Amin, McMaster University

Intriguing study with important message that has broad based implications for providers looking after geriatric population. Well presented information, clear messaging, reads well.

Thanks for your service as a reviewer and the encouraging feedback.