THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

EXPECTATIONS OF PHYSICIANS NOT CERTIFIED IN EMERGENCY MEDICINE INTENDING TO INCLUDE EMERGENCY MEDICINE AS PART OF THEIR RURAL PRACTICE
CHANGING SCOPE OF PRACTICE PROCESS

BACKGROUND

The CPSO "Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice" policy states that "physicians must only practice in the areas of medicine in which they are educated and experienced." The policy is available at **www.cpso.on.ca** under Policies and Publications.

The policy indicates a physician's scope of practice is determined by a number of factors, including:

- → education, training and certification;
- → patients the physician cares for;
- → procedures performed;
- → treatments provided;
- → practice environment.

Traditionally many patient visits in Ontario's Emergency Departments have been managed by physicians who have no formal certification in Emergency Medicine (EM). These physicians have gained knowledge and experience in Emergency Medicine through their internship, residency and/or through practice experience. At the same time, the practice of EM has evolved. Certification in EM through the Royal College or the College of Family Physicians of Canada (CFPC) has been available for about 30 years and is becoming increasingly more prevalent. Most Emergency Departments (EDs) in larger centres are staffed by physicians with certification from one of these bodies.

<u>Emergency Departments in Smaller Centres and Rural Communities</u>

The College has always expected and continues to expect that patients will receive care that meets the standard of practice irrespective of where that patient is seen. The College also recognizes that an ED in an urban centre is a much different place from an ED in a rural centre. There are many differences in the patient populations, the availability of resources and the approach to management of patient problems between these two types of practice locations. For example, a rural ED may differ from an urban ED with regard to its approach to the management of an acute myocardial infarction due to differences in the availability of human and facility resources.

EDs in smaller centres and particularly in rural communities are more likely to be staffed by physicians without EM certification. Access to resources (e.g. personnel and health care services) is typically limited and the need for critical patient transport resources can pose

additional challenges. Still, these communities often have well-established supports in place that can offset the complexities associated with this type of environment. These supports include: mentoring networks, telemedicine and other technology, credentialing committees which can map physician competencies to community needs, as well as relationships with larger centres. The CPSO recognizes the informal support system and other supports available to physicians practising in EDs in smaller centres or rural communities.

While recognizing the particular challenges of working in an ED in a rural setting, the CPSO seeks to ensure the competence of all physicians. To work in an ED safely in any setting (urban or rural), a physician must have competence in the set of critical skills needed in that practice setting.

Purpose of this document

This document serves as a guide for physicians without certification in EM who wish to work in the ED in a rural environment[1]. The goal of this process is to ensure that physicians who plan to include ED work as part of their rural practice are equipped to meet the standard of practice of the profession, in the context of the particular challenges associated with their proposed practice location.

This document DOES NOT apply to:

- **Physicians who already include Emergency Medicine as part of their practice prior to the establishment of this document.**
- **Family Medicine residents graduating from accredited Canadian Residency Programs.**

Document Development Process

A Working Group comprised of family physicians and emergency physicians from both rural and urban settings developed this framework to assist physicians, hospitals, and the College in developing a plan for physicians to safely transition to including working in the ED as part of their practice.

The main reason for developing this framework is to ensure consistency in how such requests to change scope of practice are managed by the CPSO.

1 A 'rural' community in Ontario has a population of less than 30,000 that is greater than 30 minutes away in travel time from a community with a population of more than 30,000: Rural and Northern Health Care Framework/Plan Stage 1 Report – Final Report by the Rural and Northern Health Care Panel, Ministry of Health and Long-Term Care.

GUIDELINES ON CHANGING SCOPE OF PRACTICE TO INCLUDE EM

Physicians without formal certification in EM who are contemplating including working in the ED as part of their rural practice are expected to undergo a period of **low-level** clinical supervision. This low-level supervision is similar to the informal mentorship relationships that already exist in many communities and is intended to tap into those existing relationships.

Generally, the physician is required to retain a Clinical Supervisor[2] who is expected to provide supervision reports to the CPSO on a quarterly basis for a period of six to 12 months. **Each case is considered on an individual basis** and therefore the length and frequency of supervision will be determined by the CPSO based on consideration of:

- A physician's prior training and/or practice experience in EM[3];
- A description of the physician's **proposed practice** location, in particular, acuity of cases, volume of patients, staffing needs of location, proximity to and relationships with larger centres etc.

During the period of low-level supervision the following elements are required, subject to individualization as noted above:

1. There must be a formal system of back-up for the first three months of practice. Experienced physician colleagues must be available to assist with all patients who are seriously ill or injured.
2. In the first three months there will be a review of 10 charts per month to comment on the quality of documentation and care. Additionally, this review must include a review of all patients cared for by the supervised physician who:
    a. Were triaged as a CTAS level 1
    b. Required a life-saving intervention (emergency intubation or other invasive airway management, emergency non-invasive ventilation, cardiopulmonary resuscitation, central line placement, inotropic support, cardioversion, placement of thoracostomy tubes)
    c. Required transfer to another centre for higher level care.
3. The Clinical Supervisor will submit a report to the College after three months, summarizing his/her review of the above cases.
4. Subsequently, and on approval from the College, chart reviews and reports based on the above parameters may occur quarterly (every three months).
5. During this phase of supervision it is expected that the hospital's normal system of back-up continue to be in place.

The Working Group also identified a set of Mandatory Courses and Desired Clinical Experiences

2 Two physicians are recommended as this takes the burden of responsibility off a sole physician. The Clinical Supervisors are not meant to be working with the physician at the same time.

3 If a physician has had previous training and/or practice experience, then letters from Program Directors and/or Chiefs of Staff attesting to the training and/or practice experience, etc. would be required.

(see ‘Appendix A’) for EM practice; this includes courses that a physician must complete prior to practicing independently in EDs, as well as a guideline for physicians and Clinical Supervisors with respect to the types of procedures in which the physician should try to obtain experience during the course of supervision.

Evidence of Competence

The College relies on demonstration of competence through regular narrative reports from Clinical Supervisor(s). These reports will also be utilized by the CPSO as a basis for determining the physician’s readiness for practice assessment (if applicable).

Once the supervision is complete, the physician may have to undergo an assessment of practice prior to approval of the change in scope of practice. The determination for a need for an assessment is made by the Quality Assurance Committee (QAC). While the changing scope of practice process generally involves training, supervision and assessment, all of these components *may not* apply in every case. In arriving at a decision, the QAC will review each physician’s individual circumstances.

In some cases, where the supervision reports have been of high quality and uniformly positive, the QAC *may* be content to approve the change in scope without requiring a formal practice assessment. Where a formal practice assessment is required, College staff seeks to retain an assessor who has a background and/or practice experience with similarities to that of the physician being assessed. The assessment will generally involve a review of charts, interviews with the physician, as well as colleagues and coworkers, and some time spent on direct observation in the Emergency Department.

Appendix A -
MANDATORY COURSES AND DESIRED CLINICAL EXPERIENCES TO PRACTICE EMERGENCY MEDICINE

Mandatory Courses

In order for a physician to move from a supervised program to independent practice, he or she **must** have completed the following:

1) Current ACLS and ATLS or equivalent
2) Advanced pediatric resuscitation course (Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS)

Alternatively, the College may consider completion of comprehensive rural-focused critical care courses such as the CARE (Comprehensive Approach to Rural Emergencies) Course or the CALS (Comprehensive Advanced Life Support) program as equivalent to the above courses. Each physician will be considered independently.

While it is desirable to have these courses completed before beginning supervised work, that determination should be informed by the local hospital's credentialing process.

Desired Clinical Experiences

Physicians and Clinical Supervisors should refer to the list of clinical experiences (below) to inform them on the types of clinical encounters in which physicians should either have direct clinical experience or to which they should gain exposure during the period of supervision. These experiences need not take place exclusively in the ED setting. For example, if a physician is experienced in the use of non-invasive ventilation for in-patients, these skills and experiences are transferable to the Emergency Department. Similarly, there are helpful online resources for radiographic and cardiogram interpretation.

a) Critical Care resuscitation with significantly abnormal vital signs (e.g. cardiac arrest, sepsis, shock, acute respiratory distress)
b) Trauma Resuscitation (multisystem with abnormal vital signs and/or GCS)
c) Acute airway management, including Emergency intubations
d) Use of Non-Invasive Ventilation
e) Emergency Vascular Access, including central line and intraosseous placement
f) Insertion of chest tubes/percutaneous thoracostomy
g) Fracture/dislocation management, e.g. Colles fracture, shoulder dislocation
h) ECG interpretation
i) Interaction with Poison control
j) CritiCall and Transport
k) Slit lamp