The College of Physicians and Surgeons of Ontario

EXPECTATIONS OF PHYSICIANS WHO HAVE CHANGED OR PLAN TO CHANGE THEIR SCOPE OF PRACTICE TO INCLUDE ENDO-COLONOSCOPY

BACKGROUND

The College is gradually moving toward a system of performance measurement by focusing on a physician's competence in a field of practice rather than simply relying on paper credentials (e.g., specialty certification). The Changing Scope of Practice policy is based on these principles. It states that "a physician's ability to perform competently in his or her scope of practice is determined by the physician's knowledge, skills and judgment, which are developed through training and experience in that scope of practice." The Changing Scope of Practice policy is available at www.cpso.on.ca under Policies and Publications.

The policy indicates a physician's scope of practice is determined by the:

→ patients the physician cares for,
→ procedures performed,
→ treatments provided, and
→ practice environment.

In addition, the CPSO policy on Changing Scope of Practice states:

"All physicians who have undergone a significant change in scope of practice or who will be changing their scope of practice significantly and who do not have the training and/or experience to practise competently in the new area of practice, will have to participate in a process to ensure that they have the necessary competence to practise in that area. This process will be individualized for each physician but, in general, the core activities involved are training; supervision; and assessment."

Ontario's aging population and aggressive cancer screening programs have led to a need for skilled endoscopists in the province. Upper endoscopy and colonoscopy are usually performed by gastroenterologists and general surgeons. These skills are taught and learned in Royal College of Physicians and Surgeons of Canada-accredited residency programs and according to Objectives of Training. It is the expectation that graduates of Canadian residency programs in these areas have proficient endoscopic skills.

Occasionally, physicians from other disciplines may want to develop competence in upper endoscopy and/or screening colonoscopy. This clearly represents a change in scope of practice and such physicians are bound by College policy to undergo a change

in scope of practice process to ensure that they have the requisite knowledge and experience to work in a new area.

Increasingly, some general surgeons have not been formally trained in endo-colonoscopy or have not performed endo-colonoscopy for a number of years. In these circumstances, general surgeons who wish to begin to incorporate endo-colonoscopy into their practice may need to go through a change of scope process despite their Royal College certification in general surgery.

It must be emphasized that if a physician plans to practice endo-colonoscopy in an Out-of-Hospital Premises (OHP) they must meet the qualifications set out in the OHP Standards. As such, a physician who is not certified by the Royal College as a relevant specialist AND is not recognized by the CPSO under the "Recognition of Non-Family Medicine Specialists" policy MUST satisfactorily complete all CPSO requirements for Changing Scope of Practice AND have active privileges to support similar procedures at a local hospital. **This is true irrespective of when the physician changed their scope of practice**.

This document has two purposes. The first is to outline minimal training requirements for the above two groups of physicians wishing to incorporate endo-colonoscopy into their practice. The second is to outline the expectations for data that should be collected from every patient encounter during training that can be used to assess ongoing competence or educational needs for physicians.

This document draws heavily from two resources. The first is entitled *Cancer Care Ontario Colonoscopy Standards: Standards and Evidentiary Base*, dated October 15, 2007. The second document is entitled *Quality Assurance Guidelines for Colonoscopy*, publication of the UK's National Health Service (NHS BCSP Publication No 6), dated March 2010. Other references utilized are listed where appropriate.

SECTION I MINIMUM TRAINING REQUIREMENTS FOR ENDO-COLONOSCOPY

A. Physicians with no prior experience or training in endo-colonoscopy

Physicians with no prior experience or training in endo-colonoscopy must go through a rigorous change of scope of practice process in order to be considered by the Quality Assurance Committee as having completed necessary components to allow them to start working independently in this new area. The change in scope of practice process involves education, supervised practice and assessment by the College.

Physicians who go through a change of scope process for endo-colonoscopy must complete an acceptable training program to provide them with the knowledge and skills needed to provide safe care in this area. It has been demonstrated in the literature that non-gastroenterologists have a greater risk of missed cancer diagnosis and as such the importance of the rigor of the programs cannot be understated.[1] Supervisors must be acceptable to the College and, in general, should be experienced gastroenterologists or general surgeons who are actively involved in endo-colonoscopy procedures as a significant part of their current clinical practice.

It is desirable for a physician to gain experience using an endoscopy or colonoscopy simulator in order to acquire basic skills in endoscopy before beginning their "in vivo" training. The College recognizes, however, that access to simulation facilities may be limited and, as such, while this is desirable it is not currently viewed as imperative.

It is desirable to indicate a minimum number of procedures to be performed as a guideline to physicians contemplating this change of scope. [2,3] Determining exactly what that minimum number should be is a significant challenge. Unfortunately the medical education literature does not resolve this issue for us. One study suggested that for physicians who are already competent in flexible sigmoidoscopy, 50 supervised colonoscopies are likely sufficient to ensure competence in that procedure.[4] The program outlined below indicates a greater number than this on the assumption that these physicians would NOT have prior competence in flexible sigmoidoscopy. Additionally, as an added measure to reduce patient risk, the recommended number of scopes completed under high supervision has been increased. This is consistent with

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[1] Pierzchajlo RPJ, Ackermann RJ, Vogel RL. Colonoscopy performed by a family physician. A case series of 751 procedures. J *Fam Pract*. 1997;44(5):473-80.

[2] Rabeneck L, Paszat LF, Hilsden RJ, et al. Bleeding and Perforation after Outpatient Colonoscopy and Their Risk Factors in Usual Clinical Practice. *Gastroenterology* 2008; 135(6): 1899-1906

[3] Experience acquired through simulation labs does *not* count towards the minimum number of procedures required for training.

[4] Romagnuolo J, Enns R, Ponich T, Springer J, Armstrong D, Barkun AN. Canadian credentialing guidelines for colonoscopy. *Can J Gastroenterol* 2008;22(1):17-22.

other work in the area, where numbers ranging from 140 to 500 colonoscopies have been recommended.[3, 5] *While the minimum number of scopes to be performed is listed below, it should be recognized that on the recommendation of the supervisor(s), the College may require the physician to complete more than the minimum number of procedures at any stage during the training program. The goal is to ensure that the physician has achieved competence in the procedure, rather than simply relying on a number of procedures performed.*

Features of an acceptable minimal training program in endo-colonoscopy include:

1) Training must be completed within two years of commencement of the program[6]
2) More than one supervisor[7] should be involved in the training.
3) A MINIMUM of 100 upper endoscopies performed under HIGH supervision (learner is NOT the Most Responsible Physician – MRP)
4) A MINIMUM of 200 colonoscopies under HIGH supervision
5) A CPSO-interim assessment (including chart review and observation of technique) following completion of the above requirements in order to allow for progress to practice under MODERATE supervision (learner is the MRP, but scopes are ALWAYS performed with a supervisor IMMEDIATELY available)
6) A MINIMUM of 100 upper endoscopies under MODERATE supervision
7) A MINIMUM of 100 colonoscopies under MODERATE supervision
8) During the period of MODERATE supervision the learner will keep track of all indicators as outlined in SECTION II.
9) A final CPSO assessment (including chart review and observation of technique) for review by the Quality Assurance Committee for consideration of approval of the change of scope of practice.

B. Physicians with remote experience or training in endo-colonoscopy

Circumstances may arise where a physician (gastroenterologist or surgeon) has not been practicing endo-colonoscopy for some time and chooses to return to this focus for their practice. While this scenario is not described in College's Changing Scope of Practice policy, the principles behind the College's Re-Entering Practice policy would apply: that is, if a physician has been away from endo-colonoscopy for three years OR has practised endo-colonoscopy for less than the equivalent of six months in the previous five years,

[5] Spier BJ, Benson M, Pfau PR, Nelligan G, Lucey MR, Gaumnitz EA. Colonoscopy training in gastroenterology fellowships: determining competence. *Gastrointest Endosc* 2010;71(2):319-24.

[6] The College may exercise flexibility with regard to duration depending on the physician's individual circumstances.

[7] Please refer to the "Guidelines for College-Directed Supervision" for more information about the responsibilities and characteristics necessary for a Clinical Preceptor, as well as the College's expectations for supervision.

the physician should go through a re-entry process. An educational process should be followed, albeit the supervision requirements should be less.

The details of the educational process will be individualized, however should contain the following elements:

1. Training must be completed within two years of commencement of the program
2. More than one supervisor should be involved in the training.
3. A MINIMUM of 25 upper endoscopies performed under HIGH supervision (learner is NOT the Most Responsible Physician – MRP)
4. A MINIMUM of 25 colonoscopies under HIGH supervision
5. Once the supervisor(s) are content and report to the College, the physician may transfer to MODERATE supervision.
6. A MINIMUM of 25 upper endoscopies under MODERATE supervision
7. A MINIMUM of 25 colonoscopies under MODERATE supervision
8. During the period of MODERATE supervision the learner will keep track of all indicators as outlined in SECTION II.
9. A final CPSO assessment (including chart review and observation of technique) for review by the Quality Assurance Committee for consideration of approval of the Re-Entry to Practice.

C. General surgeons with no prior training or experience in endo-colonoscopy

While unlikely, it is conceivable that a general surgeon could practice throughout their career without any endo-colonoscopy experience. In these cases, despite being certified by the Royal College in general surgery, the addition of endo-colonoscopy would be considered a significant change of scope of practice.

Where the surgeon has no prior training or experience in endo-colonoscopy, the Change of Scope of Practice process should be the same as in Section A for non-surgeons.

SECTION II QUALITY ASSURANCE ACTIVITIES REQUIRED FOR PHYSICIANS-IN-TRAINING IN ENDO-COLONOSCOPY

A number of quality assurance indicators are available for colonoscopy. These indicators are internationally accepted and should be collected by all endo-colonoscopists in training in order to gauge proficiency and allow individuals to focus on areas that are in need of improvement.

The following information should be collected by all physicians training in colonoscopy procedures. Where physicians are involved in a change of scope of practice or re-entry process, these indicators may be reviewed as part of the process to objectively decide whether or not a physician is ready for independent practice in colonoscopy. The

achievement of the given indicator should be comparable to internationally recognized expectations.

1. Caecal intubation rate
2. Adenoma detection rate

Additionally, all complications associated with colonoscopy should be recorded including perforation and bleeding. Complication rates will be reviewed at the time of physician assessment.