THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

Expectations of General Practitioners and Family Physicians Intending to Include Skin Disorders as Part of Their Practice
Changing Scope of Practice Process

BACKGROUND

The CPSO's *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 & Publications.

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

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

In addition, the policy states:

> All physicians who wish to change their scope of practice and/or re-enter practice must participate in a College review process to demonstrate their competence in the area in which they intend to practise. The process for re-entry and change in scope of practice will be individualized for each physician but, in general, includes a needs assessment, training, supervision, and a final assessment.

PURPOSE OF THIS DOCUMENT

This document clarifies the CPSO's expectations of General Practitioners (GPs)/family physicians[1] intending to include skin disorders as part of their practice. Prior to changing their scope of practice, physicians must ensure they have the appropriate education, training, and experience to competently assess and manage those conditions they plan to include in their practice, and that they are meeting the standard of practice.

While the changing scope of practice process generally involves a needs assessment, training, supervision, and assessment, not all of these components apply in every case. To determine what components are necessary to facilitate a changing scope of practice, the CPSO will review each physician's individual circumstances.

[1] Other specialists who intend to include skin disorders as part of their practice who have never had prior education, training, and/or experience are subject to the overarching CPSO policy *Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice*

Document Development Process

A Working Group comprised of dermatologists and family physicians developed this framework to assist the CPSO in a developing a plan for GPs/family physicians to safely transition into including skin disorders as part of their practice.

GUIDELINES ON CHANGING SCOPE OF PRACTICE TO INCLUDE SKIN DISORDERS

Needs Assessment: The College will consider a physician's specialty background, prior training and/or experience, as well as their intended practice, when determining their overall training needs. Moreover, GPs/family physicians who have received formal training, and/or who have previously included skin disorders as part of their practice, but have not practised in this area in more than 2 years would likely need to go through a change of scope process despite their related training/background. Each situation is assessed on an individual basis and generally physicians who want to include skin disorders as part of their practice would be required to fulfill the training requirements as described further below.

Training/Supervision: Training and supervision often occur at the same time. The College expects a physician with no prior training and/or experience in skin disorders to complete the *minimum* number of months of training/supervision defined in this document, which is 12 months. If a physician has had prior training and/or experience in skin disorders, then the College may exercise flexibility on the number of months of training/supervision required. The duration of training will also depend on recommendations made by the physician's Clinical Supervisor(s). Regardless of number of months, the goal of training/supervision is to ensure that the physician has achieved competence.

GPs/family physicians applying for a change in scope of practice to include skin disorders as part of their practice will complete a personalized training program[2] that must include:

i. All components of the "Core Competencies" contained within this document (this can inform the content of Individualized Education Plan).
ii. Supervision with Clinical Supervisor(s) approved by the CPSO, who agree to report on the content of the training/supervision as directed.
iii. Written objectives of training identified through an Individualized Education Plan (IEP).
iv. A comprehensive course in skin disorders (online or in-person) as a foundation to the changing scope of practice process which may be completed prior to, or concurrently with the changing scope of practice process.

The table below summarizes the College's general expectations about training/supervision. However, each physician's situation is unique, hence, the level and duration of supervision is discretionary. Likewise, a change in level of supervision depends on the Clinical Supervisor's feedback.

[2] A personalized training program relies on the physician finding a suitable Clinical Supervisor who will help develop an individualized education plan (IEP), and supervise the physician for its duration. Both the proposed Clinical Supervisor and the content of the IEP must be acceptable to the College. Refer to the "Guidelines for College-Directed Clinical Supervision" for more information about the responsibilities and characteristics necessary for a Clinical Supervisor which are available here: http://www.cpso.on.ca/Policies-Publications/CPGs-Other-Guidelines/Other-Guidelines/Guidelines-for-College-Directed-Supervision/Guidelines-for-College-Directed-Supervision-(1)

Minimum Expectations for High, Moderate, and Low Level Clinical Supervision			
Clinical Supervisor	Level of Supervision		
	High (6 months)	Moderate (3 months)	Low (3 months)
Tools	• Chart reviews (including photos) • Daily observation with Clinical Supervisor • Discussions with physician • Repeated image exposure and pattern recognition • Additional tools as indicated	• Chart reviews (including photos) • Occasional direct observation with Clinical Supervisor • Discussions with physician • Repeated image exposure and pattern recognition • Additional tools as indicated	• Chart reviews (including photos) • Occasional direct observation with Clinical Supervisor • Discussions with physician • Repeated image exposure and pattern recognition • Additional tools as indicated
Identification of MRP (Most Responsible Physician)	**Clinical Supervisor is the MRP**	Supervised Physician is the MRP	Supervised Physician is the MRP
Availability and Frequency of Clinical Supervisor visits	Must be available to review and sign off on treatment plans[3] daily	Weekly to bi-weekly meetings (at minimum) to review practice	Bi-weekly to Monthly visits (at minimum) to review practice
Frequency of Reporting to the College	Monthly, or as directed by the CPSO	Bi-Monthly, or as directed by the CPSO	Quarterly, or as directed by the CPSO

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

Once the training/supervision phase is complete, the physician is generally required to undergo a College-directed assessment prior to being approved to practise independently in the desired area of practice, i.e. skin disorders. 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 a needs assessment, 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.

[3] While high level supervision is ideally performed in person, circumstances may exist where high quality telemedicine imaging may be satisfactory; see CPSO Telemedicine Policy https://www.cpso.on.ca/Policies-Publications/Policy/Telemedicine

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 discussions with the physician, chart reviews, direct observation of patient management and/or procedures performed, interviewing colleagues/referring physicians, etc.

Core Competencies

Physicians will be expected to demonstrate the ability to diagnose and manage patients with skin disorders, which may vary by disease category (see "Specific Disorders of the Skin" section). If a physician intends on treating special populations (neonates, infants, pregnant patients, elderly populations, immuno-compromised, patients requiring immunosuppressive or immunomodulating medication for their dermatologic illness, etc.), then he or she must also be able to demonstrate additional competencies to diagnose, treat, and manage these types of patients.

Note: It is essential that the candidate be able to recognize when a skin disorder is beyond their scope of training, and when they need to refer a patient for assistance with diagnosis and management. This would apply not only to rare or undifferentiated skin disorders, but also common disorders that are severe or not responding to treatment.

Competency will be determined by the physician's ability to demonstrate the following:

1) General medical skills including history taking and physical examination skills relevant to dermatology.
2) Appropriate documentation including diagnosis, differential diagnosis, dermatologic history, medical history, medications, allergies, relevant occupational/other exposures, family history, dermatologic findings, diagnosis, management, and follow up plan.
3) Provision of appropriate consultation/follow up notes that are both timely and complete.
4) Morphology
    a. Comprehensive knowledge of all terms and definitions
    b. Demonstration of appropriate use of morphologic terms
5) Fitzpatrick phototypes
6) Mastery of common dermatologic procedures, (patient characteristics, comorbidities, site selection, rationale for each type of biopsy or procedure, managing complications, and obtaining informed consent).
    a. Skin biopsy: punch, superficial shave
    b. Excision: deep shave, full thickness
    c. Immunofluorescence biopsy
    d. Biopsies for tissue culture
    e. Utilization of dermatopathologist vs general pathologist
    f. Equipment and facilities
    g. Relevant surgical anatomy
    h. Local anesthetics
    i. Wound healing
    j. Surgical complications
    k. Cryotherapy

l. Hemostasis
m. Intralesional steroid injection
n. Fungal, bacterial, and viral culture collection techniques
o. Principles of infection prevention and control

7) Basic principles of sun protection/sunscreen and demonstrates ability to counsel patients.
8) Therapeutics
    a. General considerations involving compliance, costs and properly educate patients about the proposed agent
    b. Familiarity with agents implies dispensing appropriate quantity, indications, contraindications, adverse effects, as well as appropriate monitoring and screening tests
    c. Familiarity with all commonly used topical therapeutics in dermatology; anti-inflammatory, anti-infective, topical chemotherapeutic, emollients
        i. Appropriate counseling for patients prescribed topical steroids
        ii. Appropriate therapeutic history
        iii. Appropriate counseling for the correct application of all topical therapeutics
        iv. In particular, the use of field therapy for the management of actinic keratoses
    d. Familiarity with short and long-term use of systemic corticosteroids
    e. Familiarity with all non-immunomodulating systemic medications
        i. Medications may include, but are not limited to: antibiotics, terbinafine, itraconazole, fluconazole, alitretinoin, spironolactone, OCPs, antivirals
        ii. In particular, competency in prescribing isotretinoin
    f. Familiarity with systemic immunomodulating agents. This class of medication should be prescribed only if the physician has additional competencies to diagnose, treat, and manage dermatologic illness in patients that require these medications.
        i. Medications include: azathioprine, acitretin, all biologics, cyclosporine, colchicine, dapsone, mycophenolic acid, mycophenolate mofetil, methotrexate, hydroxychloroquine, chloroquine, and others.
9) Investigations
    a. Appropriate use of diagnostic imaging and laboratories in the management of patients with skin disorders

Specific Disorders of the Skin

As a guide to what should form the basis of the competencies for a trainee physician, an extensive list of dermatological conditions[4] has been classified below. Category I diseases are deemed to be conditions which a GP/family physician should be able to expertly manage at the completion of their individualized education plan. Categories II and III represent more advanced dermatologic illness that is either more complex or rare, and would fall outside of the scope of practice of a GP/family physician unless that physician had additional training under supervision and had demonstrated competency in managing those conditions.

[4] Bolgonia – Dermatology, 3rd ed.

Disease Categorizations

Skin disorders will be classified into 3 categories. The level of expectation for the candidate is indicated in the table below (Table 1). The table after that will list conditions and their assigned category.

For Category I diseases, the physician is expected (except in exceptional circumstances) to comprehensively manage the patient. This would encompass:

- Generating a reasonable differential diagnosis
- Arriving at the correct diagnosis
- Appropriate use of investigations
- Having an understanding of the pathophysiology
- Distinguishing varying levels of disease severity
- In relevant conditions, having an understanding of specific severity indices
- When relevant, consider comorbidities
- Considering all potential contributing factors to a disease presentation including; lifestyle, risk factors, concomitant medications, occupational and or other exposures may play
- Mastery of the treatment options for the condition in question
- Appropriate follow-up to document treatment response and ongoing safety
- Critical analysis of patients that do not respond to therapy
- Recognizing the need for the involvement of other health care professionals in the management of the disease in question

For Category II diseases, the expectation would be an ability to make a diagnosis, investigate the patient appropriately and initiate management. Ongoing management of patients in this disease category would be determined by the particular areas of competence achieved by the physician during their training program and as assessed by the College.

Category III diseases represent skin conditions that would usually fall outside the scope of practice of a non-dermatologist. For Category III diseases, the expectation would be that the GP/family physician generates an appropriate differential diagnosis, initiate investigations based on that differential and, in most cases, would refer the patient to a dermatologist for further management. Frequently, the GP/family physician and the dermatologist may co-manage these patients.

	• Comprehensive management	• Diagnosis • Investigations • Management • Referral*; if necessary	• Differential diagnosis • Investigations • Referral *
Category I	X		
Category II		X	
Category III			X

Level of Management Expectations By Disease Category

*Once disposition of the patient is determined and course stabilized, ongoing management could be transferred back to the family physician.

*those requiring immunomodulating systemic agents would be Category III

Disease	Category
Pruritus, normal skin exam	I/II
Prurigo Nodularis/Lichen Simplex Chronicus	II
Notalgia parasthetica	I
Aquagenic pruritus	II
Brachioradial pruritus	II
Pruritus Ani	I
Renal Pruritus	II
Cholestatic Pruritus	II
Burning mouth syndrome	II
Burning scalp syndrome	II
Reflex Sympathetic Dystrophy	I/II
Delusions of Parasitosis	I/II
Body dysmorphic disorder	I/II
Dermatitis artefacta	I/II
Neurotic excoriations	I/II
Trichotillomania	I/II
Acne excoriee	I/II
Psoriasis, topical treatment	I
Psoriasis (requiring more than topical treatment)	II/III
Pustular psoriasis	III
Erythroderma	III
Guttate psoriasis	II
Palmoplantar pustulosis	II
Palmoplantar psoriasis	II
Inverse psoriasis	II
Nail psoriasis	I/II
Sneddon Wilkinson Disease	III
Psoriatic arthritis	III
Small plaque parapsoriasis	II/III
Large plaque parapsoriasis	II/III
Cutaneous T-cell Lymphoma	II/III
Pityriasis lichenoides	II
Pityriasis rubra pilaris	II/III
Lymphomatoid papulosis	III

Pityriasis rosea	I
Lichen planus	I/II
Lichen striatus	I
Lichen nitidus	II
Lichenoid drug eruption	II
Lichen planopilaris	II
Oral lichen planus	II
Atopic dermatitis	I/II
Pityriasis alba	I
Seborrheic dermatitis	I
Asteatotic eczema	I
Stasis dermatitis	I
Disseminated eczema/autosensitization	II
Nummular dermatitis	I
Dyshidrotic eczema	I/II
Juvenile plantar dermatosis	I
Diaper dermatitis	I
Allergic contact dermatitis	I/II
Irritant contact dermatitis	I/II
Hand dermatitis	I/II
Cheilitis	I
Phytophotodermatitis	I
Allergic contact dermatitis to plants	I
Urticaria	I/II
Angioedema	II/III
Urticarial vasculitis	II
Erythema annulare centrifugum	I
Erythema migrans	II
Erythema multiforme	I/II
Steven-Johnson Syndrome	III
Toxic Epidermal Necrolysis	III
Exanthematous drug eruption	II
DRESS	III
Fixed drug eruption	I
Sweet Syndrome	III
Linear IgA Bullous Dermatosis	III
Purpura NYD	III
Batemans Purpura	I
Pigmented purpuric dermatosis	I
Livedo reticularis	III
Embolic phenomena	III
Arterial insufficiency	I/II

Lipodermatosclerosis	II
Vasculitis	II
Granuloma faciale	III
Well's syndrome	III
Insect bite reaction	I
Pyoderma gangrenosum	III
Behcets Disease	III
Pemphigoid gestationis	III
Polymorphic eruption of pregnancy (PUPPP)	I/II
Cholestasis of pregnancy	II
Atopic eruption of pregnancy	II
Pemphigus (all variants)	III
Bullous pemphigoid	II/III
Mucous membrane (cicatricial) pemphigoid	III
Epidermolysis bullosa aquisita	III
Dermatitis herpetiformis	II/III
Epidermolysis bullosa	III
Acne	I/II
Solid facial edema/Morbihan syndrome	III
Rosacea	I/II
Perioral dermatitis	I
Folliculitis	I
Pseudofolliculitis barbae	I
Acne keloidalis nuchae	I
Hidradenitis suppurativa	II
Generalized hyperhidrosis	II
Localized hyperhidrosis	I/II
Hypo and anhidrosis	III
Miliaria	I
Transient acantholytic dermatosis (Grover's disease)	I/II
Acute cutaneous lupus erythematosus (ACLE)	II/III
Discoid lupus erythematosis (DLE)	II
Subacute cutaneous lupus erythematosus (SCLE)	II
Panniculitis	II/III
Dermatomyositis	III
Systemic sclerosis	III
CREST syndrome	II/III
Sclerosing disorders,NOS	III
Raynaud's phenomenon	II/III
Morphea	II
Lichen sclerosis (et atrophicus)	III
Periodic fever syndromes	III

Relapsing polychondritis	III
Sjogren's syndrome	III
Macular amyloidosis	I
Lichen amyloidosis	I/II
Amyloidosis, all other forms	III
Porphyria cutanea tarda	II/III
Photosensitivity, NOS	III
Polymorphous light eruption	II
Acanthosis nigricans	I/II
Paget's disease	II
Extramammary pagets	III
Sarcoidosis	II/III
Ichthyosis vulgaris	I
Ichthyoses, NOS	II/III
Keratodermas NOS	II/III
Darier disease	II/III
Hailey-Hailey disease	II/III
Primary immunodeficiencies NOS	III
Neurofibromatosis	II/III
Tuberous sclerosis	III
Cutaneous mosaicism NOS	III
Ectodermal dysplasia NOS	III
Aplasia cutis congenita	III
Midline congenital lesion NOS	III
Vitiligo	I/II
Post-inflammatory pigmentary alteration	I
Hereditary hypomelanosis NOS	III
Tinea versicolor	I
Idiopathic guttate hypomelanosis	I
Melasma	I
Drug induced pigmentation NOS	II
Pigmentary demarcation lines	II
Dyschromatosis NOS	III
Confluent reticulated papillomatosis	I/II
Male pattern hair loss	I
Female pattern hair loss	I
Telogen effluvium	I
Alopecia areata	I/II
Scarring alopecia NOS	II
Hair shaft abnormalities	II
Hirsutism	II/III
Hypertrichosis	III

Beau's lines	I
Onychomadesis	I
Nail pitting	I
Onychorrhexis	I
Trachyonychia	II
Leukonychia	I
Splinter hemorrhages	I
Onycholysis	I
Longitudinal melanonychia	I
Acute paronychia	I
Periungual warts	I
Herpetic whitlow	I
Nail bed malignancy NOS	III
Median canaliform dystrophy	I
Digital mucous cysts	I
Fordyce spots	I
Geographic tongue	I
Fissured tongue	I
Hairy tongue	I
Oral lichen planus	II
Malignanciesof the oral mucosa	III
Benign hyperkeratosis of the oral mucosa	I
Apthous stomatitis	II
Actinic cheilitis	II
Zoon's balanitis	II
Perianal streptococcal disease	I
Vestibular papillomatosis	II
Bowenoid papulosis	II
Staphylococcal and streptococcal skin infections	I
Erysipelas	I
Erythrasma	I
Pitted keratolysis	I
Green nail syndrome	I
Sporotrichoid spread NOS	III
Ulcerating plaque NOS	II
Tinea corporis	I
Tinea capitis	I
Onychomycosis	I
Tinea pedis	I
Tinea cruris	I
Tinea faciei	I
T. capitis, kerion variant	II

Candidiasis	I
Deep fungal infection NOS	III
Kaposi sarcoma	II/III
Syphilis	I/II
HPV mediated disease	I
HSV1 and 2	I
Varicella zoster virus	I
Eczema herpeticum	II
EBV disease	II
HHV-6	I
Measles	I/II
Erythema infectiosum	I
Kawasaki disease	I/II
Enterovirus infections	I
Hand foot and mouth	I
Molluscum contagiosum	I
Cutaneous larva migrans	I
Scabies	I
Head lice	I
Body lice	I
Crab lice	I
Bed bugs	I
Normal cutaneous effects of ultraviolet exposure	I
Corns and Calluses	I
Talon noire	I
Chondrodermatitis nodularis helicis	I
Skin signs of child and elder abuse	I
Xanthelasma	I/II
Infiltrations of the skin NOS	III
Granuloma annulare	I/II
Necrobiosis lipoidica	II
Inherited disorders of connective tissue NOS	III
Hypertrophic scars	I
Keloids	I
Striae	II
Erythema nodosum	II
Lipodystrophy NOS	III
Vascular/lymphatic malformations NOS	II/III
Venous ulcers	II
Lymphedema	II
Arterial ulcers	II
Diabetic and neuropathic ulcers	II

Venous lake	I
Spider angioma	I
Actinic keratosis	I
Basal cell carcinoma	I/II
Squamous cell carcinoma	I/II
Seborrheic keratosis	I
Lichenoid keratosis	I
Dermatosis papulosa nigra	I
Stucco keratosis	I
Porokeratosis	I
Cutaneous horn	I
Benign adnexal tumor NOS	II
Benign keratinocytic tumor NOS	II
Epidermal cyst	I/II
Pilar cyst	I/II
Benign adnexal cyst NOS	II
Nevus sebaceous	I
Sebaceous hyperplasia	I/II
Sebaceous neoplasms	II
Benign nevi	I
Ephelides	I
Café au lait macules	I/II
Beckers Nevus	I
Solar lentigines	I
Dermal melanocytosis	II
Blue nevus and its variants	I
Common acquired melanocytic nevi	I
Mucosal melanotic macule	I/II
Melanocytic nevi of special sites; acral, flexural, genital	I
Spitz nevus	I/II
Atypical (dysplastic) melanocytic nevus	I
Congenital pattern nevus	I
Nevus spilus	I
Recurrent melanocytic nevus	I
Melanoma	I/II
Vascular neoplasms NOS	III
Angiokeratoma of Fordyce	I
Solitary angiokeratoma	I
Pyogenic granuloma	I
Cherry angioma	I
Kaposi sarcoma	III
Angiosarcoma	III

Glomus tumor	I
Merkel cell carcinoma	II/III
Skin tags	I
Angiofibroma	II
Dermatofibroma	I
Fibrous tumours NOS	III
Lipoma	I/II
Tumor of muscle, adipose and cartilage NOS	III
Solitary mastocytoma	II
Urticaria pigmentosa	II
Telangiectasia macularis eruptive perstans	II