



The College of Physicians and Surgeons of Ontario

EXPECTATIONS OF PHYSICIANS INTENDING TO PRACTISE AS MEDICAL OFFICERS OF HEALTH CHANGING SCOPE OF PRACTICE PROCESS

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.

With regard to public health practice, there are a variety of educational/training paths that a physician takes in order to practise as a medical officer of health (MOH) – this encompasses all roles, i.e., MOH, Associate MOH, or Acting MOH – including temporary, short-term appointments.

Under *O. Reg. 566 of the Health Protections and Promotions Act (HPPA)*, a Board of Health has a duty to appoint a medical officer of health who is a physician licensed to practise independently in Ontario, who possesses the qualifications and requirements prescribed for the position and whose appointment is approved by the Minister of Health and Long-Term Care. In particular, the *Act* specifies that the person must be a holder of:

- (a) fellowship in community medicine from the Royal College of Physicians and Surgeons of Canada;
- (b) a certificate, diploma or degree from a university in Canada that is granted after not less than one academic year of full time postgraduate studies or its equivalent in public health; or
- (c) a qualification from a university outside Canada that is considered by the Minister to be equivalent to the qualifications set out in clause (b).

Commonly physicians are hired for MOH positions when they have either started or are in the process of completing a Masters in Public Health (MPH) or Master of Health Sciences (MHSc) certificate, i.e., to satisfy the requirements in (b) or (c). In the case of Acting MOH positions, often physicians are hired with none or minimal formal training.

A Working Group composed of representatives from the Public Health Division of the MOHLTC; two medical officers of health (a RCPSC-certified specialist in community medicine, and a physician with a Masters in Public Health); and an academic RCPSC-certified specialist in community medicine developed the following decision-making framework to assist the College in evaluating requests from physicians intending to practise as MOHs.

Regardless of the educational path undertaken, the Working Group has decided that a physician must meet one set of competencies in order to practise safely as an MOH. The unique set of competencies required for public health practice are specified in a document developed by an external pan-Canadian Medical Officer of Health Competencies Working Group entitled *A Set of Minimum Competencies for Medical Officers of Health in Canada – Final Report* dated March 2009, available at www.nsscm.ca. This document served as a framework in informing the College's decisions around training, supervision and assessment.

The College must ensure that physicians who are entering public health practice with an MPH designation or another acceptable educational program have, in fact, completed training that includes all of the competencies necessary for an individual to safely practise public health medicine. It is hoped that, by engaging with the College, individual physicians will be better able to choose a program, courses and training experiences that will best prepare them for practising public health medicine and meet the *HPPA* requirements.

The tools developed by the Working Group will have broader application to practice assessments of physicians engaged in public health practice. While our process will initially apply to physicians who have undergone or are undergoing a change in scope of practice, eventually the College will adapt the process for use in our Peer Assessment program. This successful program began in the 1980's, initially for family physicians and is intended to assist physicians in identifying opportunities for growth in their practice. Over the years, assessment protocols have been developed for a number of other medical specialties. Once in place, the College will be able to assess *any* physician who practises in the area of public health and who has been identified through the random selection process. Many physicians have indicated their satisfaction with the assessment process and benefits to their continued professional development.

WORKING GROUP'S RECOMMENDATIONS

The Changing Scope of Practice policy applies to physicians who have accepted or are in the process of applying for an MOH position (MOH, Associate MOH, or Acting – including temporary, short-term appointments) **on or after June 1, 2003** and who do *not* possess RCPSC certification in community medicine.

The policy requires physicians to self-report to the College when they have changed or intend to change their scope of practice. The College facilitates and oversees the change in scope of practice process if the College determines that the change in scope of practice is *significant* and

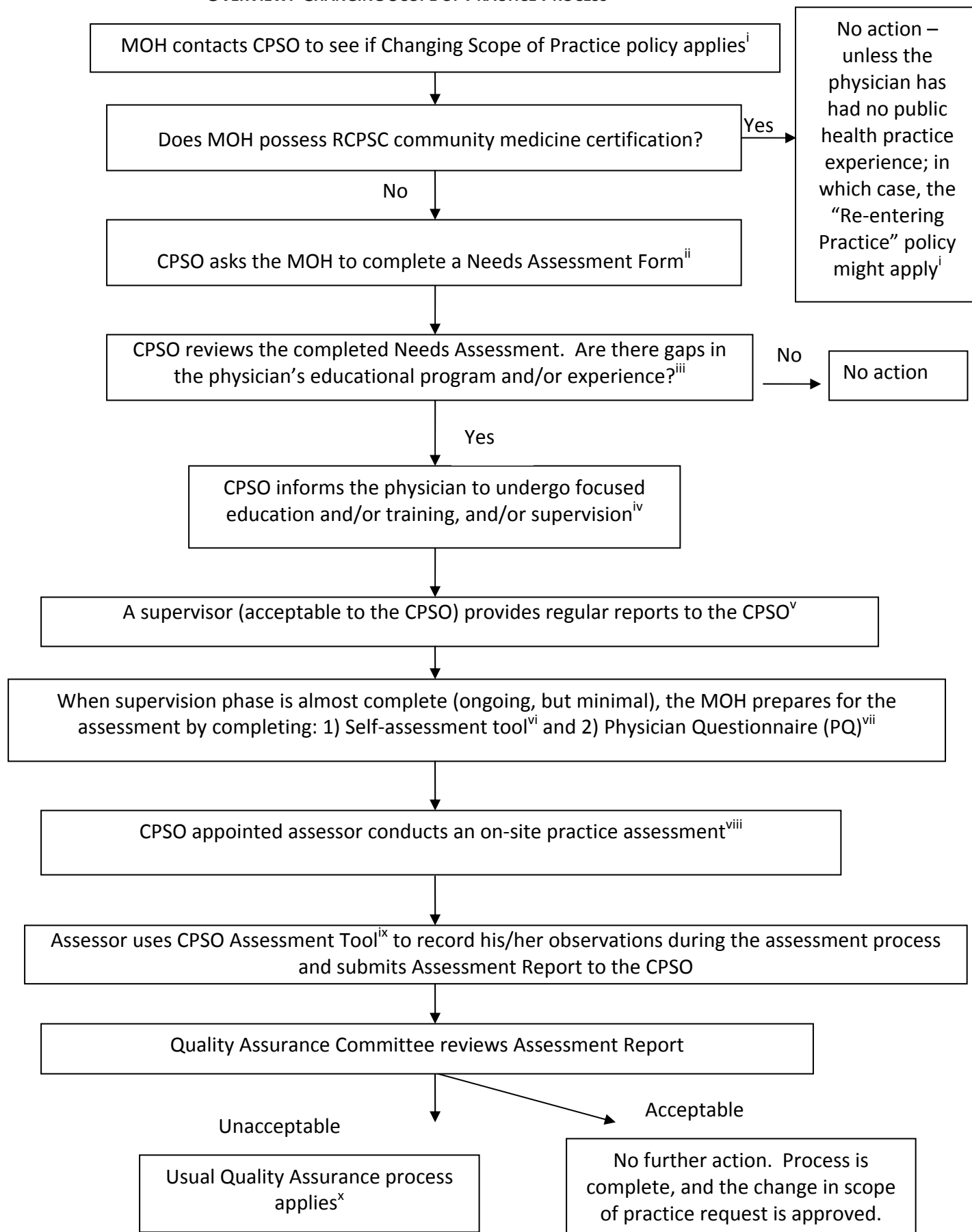
the physician does *not* have the training and/or experience to practise competently in the new area of practice.

Change in scope of practice decisions are based on each physician's individual circumstances. While the change in scope of practice process generally involves training, supervision and assessment, the training and supervision components *may not* apply in every case.

Boards of Health which have recently hired, or are in the process of hiring physicians for all MOH positions – i.e., MOH, Associate MOH, or Acting, including temporary or short-term appointments – should be considering the professional expectations in their hiring decisions. At a minimum, potential recruits and practising MOHs (who do not possess RCPSC certification in community medicine and began practising on or after June 1, 2003) should be referred to the College for information about the Changing Scope of Practice policy and how it may apply to them. The College will work together with physicians and Boards of Health to find individualized solutions that will enable them to fulfill all legislative and professional expectations.

The following diagram provides an overview of the changing scope of practice process and how it applies to physicians who wish to change their scope of practice to include public health – specifically, as Medical Officers of Health.

OVERVIEW: CHANGING SCOPE OF PRACTICE PROCESS



ENDNOTES:

- i) The **Changing Scope of Practice** policy applies to physicians who have accepted or are in the process of applying for an MOH position (MOH, Associate MOH, or Acting – including temporary, short-term appointments) *on or after June 1, 2003* and who do *not* possess RCPSC certification in community medicine. Note that the College’s **Re-entering Practice** policy applies to physicians who have been out of practice for a period of at least three years or who have practised less than a total of six months in the preceding five-year period and who intend to enter the same type of practice in which they were previously involved: <http://www.cpso.on.ca/policies/policies/default.aspx?ID=1626>.
- ii) The **Needs Assessment** form is structured around the eight broad minimum competency categories identified in the national document “*A Set of Minimum Competencies for Medical Officers of Health in Canada – Final Report dated March 2009*” (www.nsscm.ca). These categories represent the specialized knowledge and skills important for public health practice. The physician’s completed Needs Assessment form provides insight about the physician’s training in public health (former training, as well as any training in progress) and practice experience as it relates to these eight competencies. It is common for a physician to be completing a Masters in Public Health (MPH) or Master of Health Sciences (MHSc) certificate while serving in a public health position.
- iii) The CPSO will review evidence of the physician’s training and practice experience in relation to the eight broad minimum competency categories with special focus on the four priority competencies identified by the CPSO:
 - 1) Monitoring and Assessing the Health of the Public
 - 2) Public Health Consultant
 - 3) Investigating and Mitigating Immediate Risks to Human Health, and
 - 4) Communication (this one is a sub-set of the broader competency category called “Communication, Collaboration, and Advocacy for the Public’s Health”).
- iv) The CPSO will determine the nature, level and duration of supervision according to the physician’s individual circumstances. Factors would include a) how much of the educational program has been completed; and b) former relevant training and/or practice experience. For example, supervision will be high in a situation where a physician does not appear to have adequate training or experience in the four priority competencies. Note that changing scope of practice requests are considered on an individual basis and not all steps (training, supervision, and assessment) would apply in every case.

Clinical Supervisor	Level of Supervision		
	Low	Moderate	High
<i>Components of Supervision</i>	<ul style="list-style-type: none"> • Discuss challenges, as well as obtain updates on key projects; • Provide ongoing advice/feedback. 	<ul style="list-style-type: none"> • Review documentation relating to key projects, as necessary; • Discuss challenges, as well as obtain updates on projects; • Obtain feedback from physician’s colleagues, as necessary; • Provide ongoing advice/feedback on projects, as well as issues; may recommend courses/workshops 	<ul style="list-style-type: none"> • Review documentation relating to key projects; • Discuss challenges, as well as obtain updates on projects; • Obtain feedback from physician’s colleagues; • Provide ongoing advice and feedback with particular focus on the four priority competencies: <ol style="list-style-type: none"> 1) Monitoring and Assessing the Health of the Public, 2) Public Health Consultant, 3) Investigating and Mitigating Immediate Risks to Human Health, and 4) Communication; • may recommend courses/workshops;
<i>Availability and Frequency of Supervisor meetings/discussion</i>	Available by phone; meet/discuss progress every few months	Available by phone; Meet/discuss progress every month	Initially, available in person or by phone at all times; thereafter, at least weekly meetings/discussions
<i>Autonomy of Physician</i>	Physician is the MRP	Physician is the MRP	Physician is the MRP
<i>Frequency of Reporting to the College</i>	Quarterly reports	Quarterly reports	After first month; thereafter, frequency determined by CPSO

Selection of Supervisor – The physician is encouraged to speak with his/her Health Unit for appropriate suggestions. While the physician may submit names of potential supervisors, the CPSO will review and approve the supervisor (see Guidelines for College-Directed Supervision, “Characteristics of an Acceptable Clinical Supervisor” at www.cpso.on.ca under Policies and Publications> CPGs and Other Guidelines). In certain circumstances, a stipend for the supervisor is provided by the Ministry of Health and Long-Term Care. Physicians are encouraged to speak with their Health Unit about compensation options. The CPSO is not involved with the issue of supervisor compensation.

- v) **Supervision Reports** - Where supervision is indicated, supervisor submits supervision reports according to the content and frequency prescribed by the CPSO (as outlined in signed Supervision Agreement with the CPSO). Supervisors are asked to provide reports using the eight broad minimum competencies identified in the national document. A Report Template is provided for this purpose.
- vi) **Self-reflective Form** - This form is intended to enable the physician to identify self-perceived strengths and weaknesses in each of the competencies. The physician would complete this form normally after approximately one year of supervised practice. The completed form will assist in identifying areas that need to be assessed.
- vii) **Physician Questionnaire** – This form provides the College and the assessor with an understanding of the physician’s practice environment: structure/organization of the Health Unit; a description of the population being served; programs/services offered by the Unit; and the infrastructure/support available. The information would not be used to make any advance assessment or judgment of the practice.
- viii) **On-site Practice Assessment** – The assessment would include:
 1. **Physician Interview** - Questions will focus on:
 - a) Short-term priority competencies (pre-set questions along with more probing questions relating to the physician’s projects in the Health Unit);
 - b) Long-term/urgent competencies (assessor will prepare questions based on the physician’s completed Needs Assessment and Self-Reflective forms);
 - c) ‘Hot topics’ or ‘Lessons’ Learned – assessor will prepare questions relating to current health topics, e.g., HIN1 or dominant/important topics being tackled by the Health Unit, e.g., obesity, etc;
 2. **Interview with Colleagues** – Physician would provide a sample of pre-set questions which focus on Communication, Collaboration, and Leadership competencies.
 3. **Health Clinic Records Review** – In cases where a physician’s public health practice includes clinical work, e.g., patient care at a Sexual Health Clinic, it would only be assessed if it is considered a change from the physician’s former scope of practice.

Costs - Normally borne by the physician being assessed, but in some instances might be covered by the Ministry of Health and Long-Term Care. Certain criteria must be met. The physician is encouraged to speak with his or her Health Unit.
- ix) **Assessment Tool** – Assessor uses a five-point scale to score physician on each competency and notes examples of work that the MOH has done in relation to the competencies; this worksheet is then used by the assessor to prepare a more detailed narrative assessment report. A Template Report is typically provided to guide the assessor’s report writing with respect to format and content.
- x) **Quality Assurance Process** – The Quality Assurance Committee could exercise a number of options: focused training, supervision, and/or re-assessment.