

A STUDY OF FAMILY PHYSICIAN SCOPE OF PRACTICE IN ONTARIO

by

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Abstract

The broad aim of the research described in this thesis was to develop a more comprehensive understanding of scope of practice (SOP) within medicine in Canada, with an emphasis on family and general practice in Ontario. A more specific objective was to determine the common conceptual elements of SOP, what differences there are in how SOP is conceived, and what implications these differences have for health policy, physician regulation, continuing professional development and practice. This study aimed to answer three research questions, resulting in chapters two, three and four of this thesis. A sequential qualitative methods approach based on a modified institutionalist conceptual framework of ‘ideas, interests and institutions’ guided the overall approach to this study.

Chapter 2 reports on a conceptual scoping review of the federal and provincial policy statements on SOP, and on the academic and grey literature relevant to medicine focused on SOP in different health professions. The review showed that SOP is discussed as relating to one of three general categories: professional regulation; the individual practitioner; and career paths and responses to a changing health system. The review also identified six common factors related to SOP: expectations; geographic or situational context; service provision; education and training; areas of practice, and unique practice experience and characteristics.

Chapter 3 reports on a study in which ten semi-structured interviews were conducted with representative individuals from federal and provincial stakeholder groups that impact or are concerned with physician SOP in Ontario. This study showed that education and training, the practice environment, and legislation and regulation are three main factors that impact what physicians do in practice.

Chapter 4 reports on a study in which focus groups and interviews were conducted with twenty-four Ontario-based family physicians and general practitioners. The study identified four main themes: ‘what my practice looks like’; ‘professional preparedness and support’; ‘the business of being a doctor’; and ‘doctors are people, too’. The study found that the primary driver for SOP throughout physician careers is their personal lives and that their SOP has more to do with who physicians are as people than with who they are as professionals.

Chapter 5 highlights implications for the professional autonomy of medicine and discretion of physicians. Conclusions and ideas for future research are also discussed.

Keywords:

Scope of practice, medicine, physicians, family physician, Ontario, health policy, legislation, regulation, certification, education, training, professional advocacy, medico-legal liability, health workforce, stakeholders, qualitative, meaning, understanding, properties, factors.

Co-Authorship Statement

I declare that this thesis includes materials that are the result of joint research collaborations. The following includes a list of the manuscripts containing material produced in this thesis, with the nature and scope of work from co-authors.

What does ‘Scope of Practice’ in the Medical Profession Really Mean, and Why Does it Matter? (*In Preparation for Submission to Healthcare Policy*). S. M. Myles and E. F. Wenghofer developed the research question, literature search and analysis strategies. These were subsequently distributed to R. H. Ellaway and M. T. Yeo, who contributed further revisions and refinements to the approach and decisions within each step. The document and literature search and analysis were conducted by S. M. Myles. The research team worked collaboratively to further refine the analysis and presentation of results.

Organizational Stakeholder Perspectives on Physician Scope of Practice in Ontario (*In Preparation for Submission to Healthcare Policy*). S. M. Myles and E. F. Wenghofer developed the research question. They also developed the data collection and analysis procedures, and then discussed these with R. H. Ellaway and M. T. Yeo, who contributed further refinements to the decisions within each step. The interview questions were created by S. M. Myles and subsequently reviewed, edited and finalized by the research team. The data collection and analysis were conducted by S. M. Myles and discussed with E. F. Wenghofer. The research team worked collaboratively to further refine the analysis and presentation of results.

Ontario Family Physicians’ Perspectives on Physician Scope of Practice: What is it, What Drives it and How Does it Change? (*In Preparation for Submission to Canadian Family Physician*). S. M. Myles and E. F. Wenghofer developed the research questions, data collection

and analysis procedures. Subsequently, they discussed these with R. H. Ellaway and M. T. Yeo, who contributed further refinements to the decisions within each step. S. M. Myles created the questions asked of participants which were reviewed, edited and finalized by the rest of the research team. The data collection and analysis were conducted by S. M. Myles and discussed with E. F. Wenghofer. The research team worked collaboratively to further refine the analysis and presentation of results.

S. M. Myles initially drafted and subsequently revised each of the manuscripts. E. F. Wenghofer (doctoral supervisor), R. H. Ellaway, and M. T. Yeo (thesis committee members) assisted with table creation and provided edits for and critical feedback on successive drafts of each manuscript.

I am aware of Laurentian University's Policy on Authorship and I certify that I have properly acknowledged the contribution of other researchers to my thesis. I have obtained written permission from each of the co-authors to include the above materials in my thesis. I certify that this thesis, and the research to which it refers, is the product of my own work.

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List of Abbreviations

CBME	Competency based medical education
CFPC	College of Family Physicians of Canada
CFTA	Canadian Free Trade Agreement
CGT	Constructivist Grounded Theory
CHWN	Canadian Health Workforce Network
CMA	Canadian Medical Association
CMPA	Canadian Medical Protective Association
CNA	Canadian Nurses Association
CPD	Continuing Professional Development
CPSA	College of Physicians and Surgeons of Alberta
CPSBC	College of Physicians and Surgeons of British Columbia
CPSM	College of Physicians and Surgeons of Manitoba
CPSNB	College of Physicians and Surgeons of New Brunswick
CPSNL	College of Physicians and Surgeons of Newfoundland
CPSNS	College of Physicians and Surgeons of Nova Scotia
CPSO	College of Physicians and Surgeons of Ontario
CPSS	College of Physicians and Surgeons of Saskatchewan
EMR	Electronic medical records
FNSSC	Federation of National Specialty Societies of Canada
Gov Nu	Government of Nunavut
GT	Grounded Theory

HCC	Health Council of Canada
HFO	HealthForceOntario
HIRC	Health Insurance Reciprocal of Canada
HPA BC	Health Professions Act of British Columbia
HPAR AB	Health Professions Act Regulations of Alberta
HPRAC	Health Professions Regulatory Advisory Council
LLL	Lifelong learning
LLP	Linking learning to practice
MA NB	The Medical Act of New Brunswick
MA NL	The Medical Act of Newfoundland and Labrador
MA ON	The Medicine Act of Ontario
MA PEI	The Medicine Act of Prince Edward Island
MA QC	Medical Act of Quebec
MOHLTC/MOHLTC ON	Ontario Ministry of Health and Long-Term Care
MPA NWT	Medical Profession Act of the Northwest Territories
MPA YK	Medical Profession Act of Yukon
MPR NS	Medical Practitioner's Regulations of Nova Scotia
MRAs	Medical Regulatory Authorities
OCFP	Ontario College of Family Physicians
OHIP	Ontario Health Insurance Plan
OLMA	Ontario Labour Mobility Act
QD	Qualitative Description / Qualitative Descriptive

RHPA MB	Regulated Health Professions Act of Manitoba
RHPA ON	Regulated Health Professions Act of Ontario
RHPA PEI	Regulated Health Professions Act of Prince Edward Island
Royal College	Royal College of Physicians and Surgeons of Canada
SOP	Scope of Practice
SOPs	Scopes of Practice
YMC	Yukon Medical Council

Chapter 1: Introduction

In this chapter I introduce the topic of physician scope of practice (SOP), I provide an overview of this thesis in its entirety, and I review the literature on SOP and present a rationale to investigate SOP in medicine with an emphasis on family practice in the Ontario context. I then go on to state my objectives, research questions, and operational definitions. Next, I articulate the overarching conceptual framework of my thesis. Then, I discuss my overall qualitative methodological approach to this study, I describe the study design, and I acknowledge my funding and study support.

1.1 Introduction to Physician SOP

Physician SOP is perceived in various ways by different stakeholders. Individual physicians may understand their SOP differently based on their practice realities (Saucier et al. 2011; Saucier et al. 2012), such as the locations and settings in which they practise, the individuals to which they provide services, the types of services they provide, and the resources and professional supports available to them (Hutten-Czapski et al. 2004; Tepper 2004; Wong and Stewart 2010). Physicians' understanding of SOP may also differ from that of legislators, medical regulators, and medical educators (Baranek 2005). Differing interpretations of SOP can contribute to a lack of clarity and confusion surrounding SOP within medicine.

Regional variations in physician practice patterns add to the confusion over SOP (Canadian Institute of Health Information 2009; Chan and Shultz 2005; Tepper et al. 2005; Konkin et al. 2004; Peterson et al. 2005; Veugelers et al. 2003). For instance, rural and remote practising family physicians often have a broader SOP than their urban counterparts (Abbot et al. 2014; Baker et al. 2010; Bosco and Oandasan 2016; Grzybowski and Kornelsen 2013; Schmitz et al.

2015). More physicians practise in urban areas (Goertzen 2005; Pong 2008; Ryan-Nicholls 2004; Soles et al. 2017; Strasser 2015; Wenghofer et al. 2011), and there is a widespread shortage of specialist services in rural and remote areas (Bacenas et al. 2015; Humber and Frecker 2008; Iglesias et al. 2015; Kornelsen et al. 2006). This maldistribution of physicians and the services they provide means that physicians practising in underserved areas need additional competencies to serve their patients appropriately (Aubrey-Bassler et al. 2007; Baker et al. 2010; Pong et al. 2012; Skariah et al. 2017). Indeed, the broader SOP and expanded service provision essential to rural practice has led some to argue that rural medicine is a separate subspecialty (Reid et al. 2014; Simmons 2009; Smith and Hays 2004) that needs its own curriculums and training requirements (Bosco and Oandasan 2016; Glasser et al. 2008; Habjan et al. 2012; Strasser and Neusy 2010; Tesson et al. 2008; Strasser et al. 2016).

SOP is also a critical issue in physician governance and practice (Norcini and Mazmanian 2005; HealthForceOntario [HFO] 2006). For example, legislators and medical regulatory bodies use the concept of SOP when creating laws and policies and issuing licenses for professional practice (College of Physicians and Surgeons of Manitoba [CPSM] 2003; College of Physicians and Surgeons of Saskatchewan [CPSS] 2014; CPSS 2019; College of Physicians and Surgeons of Ontario [CPSO] 2015; Government of Canada 2017; Government of Ontario 1991a, 1991b; Government of Saskatchewan 1981). Despite this, there remains much uncertainty and ambiguity regarding what SOP actually entails. Physicians are entrusted to exercise their best professional judgement in defining their SOP in practice and to practise accordingly (CPSO 2012a).

However, SOP does not necessarily correspond with specialty certification (Goldsand and Thurber 2003). A medical license technically entitles physicians to practise across the breadth of medicine. Some physicians' practice 'drifts' within or beyond areas in which they are licensed or

have received formal education. Factors, such as previous training, professional incentives, and the possibility of malpractice litigation or other medico-legal liability concerns, can influence the decisions physicians make about their SOP – i.e., how they limit or exceed their SOP (Caulfield et al. 2002; Lahey and Currie 2005; Ries 2016; Robertson 2002; Studdert et al. 2005).

How and why physicians' scopes of practice (SOPs) change also warrants investigation. Much emphasis is placed on SOP during the front end of physicians' careers – i.e., education, licensure, and certification (Melnick et al. 2002) but less later in their careers even though SOP can change throughout a physician's career (Beaulieu et al. 2008; Chan 2002; Katon et al. 2001; Ringdahl et al. 2006; Tepper 2004). In situations where significant practice changes occur, such as incorporating aspects of practice beyond one's education and licensure or switching from one specialty to another, physicians may be providing care in areas that are specialized or outside their typical SOP (Breon et al. 2003; Probst et al. 2002; Tulloh et al. 2001). A lack of clarity regarding physician SOP can make it difficult to create assessment mechanisms to ensure that competence is maintained when SOP can change throughout a medical career (Frank et al. 2010; Klass 2007; Melnick et al. 2002; Oandasan 2012; Saucier et al. 2012). Patient safety should be a primary consideration whenever physicians react to or initiate SOP changes, regardless of career stage or practice context (American Medical Association 2013; Arizona Medical Board n.d.; Jablonski 2010; North Carolina Medical Board 2011).

1.2 Thesis Overview

This thesis presents a body of research intended to develop a more comprehensive understanding of SOP within medicine. I examine how SOP is understood from multiple perspectives – e.g. legislation, regulation, certification, education, professional advocacy, health

workforce planning, medico-legal liability, and by individual physicians – with an emphasis on family and general practice in Ontario. I selected this emphasis because approximately one third of family physicians in Canada practise in Ontario (Canadian Medical Association [CMA] 2018), family medicine is likely the broadest primary care specialty, and recent governmental health policy agendas in Ontario have focused on primary health care provision by family physicians.¹ My intent is that this work will impact policy change for practice through presenting two types of evidence. First, by determining the meanings and uses different stakeholders concerned with various areas of physician governance and practice ascribe to SOP. Second, by examining how these stakeholders understand family physicians' SOP in Ontario.

Using a sequential qualitative methods study design (Morse 2010), I used a modified institutionalist conceptual framework (Deber and Mah 2014) to guide my inquiry. There were three stages to this research. Each stage addressed one question and is reported in one of three following chapters in this thesis. To that end, chapters 2, 3 and 4 were each written with a specific audience and journal in mind.

Stage one (described in chapter 2) took the form of a study that explored the ambiguity surrounding what is meant by SOP in general and in specific regulatory contexts. With an emphasis on medicine in Ontario, I undertook a conceptual scoping review of federal and provincial policy statements on SOP, and on the academic and grey medical literature on SOP in different health professions. I designed the review using methodologies developed by Glover Takahashi et al. (2014) and Arksey and O'Malley (2005). I found that SOP is used vaguely and applied and interpreted differently in these documents. I also showed that SOP is discussed as

¹ Please see section 1.3.7 in this chapter for a further articulation and elaboration of this rationale.

relating to one of three general categories: professional regulation, the individual practitioner, or career paths and responses to a changing health system. Finally, I identified six properties related to SOP that permeate these documents: expectations, geographic or situational context, service provision, education and training,² areas of practice, and unique practice experience and characteristics.

Stage two (described in chapter 3) explored the elusiveness of the factors, drivers and determinants identified across policy fields in medicine that influence SOP. Using qualitative description (QD) (Sandelowski 2000) and incorporating constructivist grounded theory (CGT) (Charmaz 2006) data collection and analysis techniques, I conducted semi-structured interviews with representatives of federal and provincial stakeholder and policy-forming groups – medical regulators, educators, certification bodies, professional associations and health workforce planning networks – that impacted or were concerned with physician SOP in Ontario. The findings from this study identified convergent perspectives on what SOP involves. In particular, these stakeholder groups identified three prevalent factors that influence what physicians do in practice: education and training, the practice environment, and legislation and regulation.

Stage three (described in chapter 4) explored the paucity of research into how primary care physicians understand their own SOP, their perspectives on factors that influence their SOP and

² In this thesis, education refers to classroom learning in which knowledge, skills, and attitudes for practice begin to be acquired. In contrast, training refers to practical education in which knowledge, skills, and attitudes introduced in the classroom setting are further developed and applied in a number of settings as part of a health care team under the supervision of a senior clinician registered in a particular specialty. I acknowledge that education and training are often used interchangeably. Clinical clerkships and residency training include elements of education as defined above, and are stages of undergraduate and graduate medical education, respectively.

how and why these factors might change over time. Using QD (Sandelowski 2000) and incorporating CGT (Charmaz 2006) data collection and analysis techniques, I conducted focus groups and individual interviews with Ontario-based family physicians and general practitioners who practised in different contexts, had different practices and practice experiences, and were at different stages of their careers. Analysis of participant responses identified four main themes: ‘what my practice looks like’, ‘professional preparedness and support’, ‘the business of being a doctor’, and ‘doctors are people, too.’ Participants used different language to discuss SOP than that found in medical regulatory documents – e.g. legislation, policies - and expressed by organizations which govern their practice. Their practice and SOP had changed and evolved throughout their careers due to factors both within and beyond their control – e.g. patient expectations or needs, government decisions, personal considerations, professional aspirations or interests. For these physicians, the primary driver for SOP was their personal lives – e.g. work-life balance, family, age, career stage, health, career aspirations, all of which had as much if not more to do with who they were as people than as professionals. I also found that these physicians had sought mentorship, support, and engagement in their education and training and in professional practice for their SOP throughout their careers, particularly during professional transitions (such as from residency into independent practice). I concluded from this that, to ensure competence for practice, the medical profession should situate continuing competence and lifelong learning in the context of physicians’ lived experiences, in addition to its institutional constructs and organizationally mandated constraints.

Chapter 5 provides an overarching discussion to summarize and connect the three stages of my research and my main findings. I reprise my research questions, fulfill the specific objective of this research and highlight implications for regulation of the medical profession. In particular,

I focus on the professional autonomy of medicine and discretion of physicians. Also, I identify assumptions about SOP that this research highlighted, and consider strengths and limitations of this study. I conclude with ideas for future research.

I now go on to provide a review of the literature and through this to identify gaps in knowledge about the term SOP in medicine generally, and unexplored perspectives regarding the SOP of physicians specifically.

1.3 Literature Review

The purpose of this literature review was to ascertain the state of knowledge about the term ‘scope of practice’ (SOP). First, I discuss SOP in relation to the Canadian and Ontario health care systems. In particular, I discuss the extent to which legal and regulatory frameworks, and approaches to health policy making and workforce planning, reflect health system realities to meet patient needs. I then identify a number of problems surrounding the term SOP, I recognize a tension between the need for greater specificity for SOP and flexibility to account for health professional regulation and changes in health care, and, I discuss two prevailing approaches to health professional regulation in Canada, overlapping health professional SOPs and interprofessional tensions. Additionally, I identify a need to re-evaluate prevailing interprofessional discussions of SOP to first sufficiently understand what SOP is and means within a single profession.

I next focus on SOP in medicine. Definitions of SOP are ambiguous or omitted from provincial medical legislation. I assert that achieving clarity about SOP within medical legislation is important due to a potential disconnect it creates between the expectations of policy

makers, medical regulators and physicians. Additionally, I suggest three reasons for the lack of clarity surrounding SOP in medicine.

Lastly, I explore research on or related to the SOP of physicians generally and family physicians specifically, as well as identify an opportunity to further investigate physician SOP with an emphasis on family practice. To conclude, I summarize this literature review discussion and identify two knowledge gaps regarding SOP that this thesis intends to fill. Ultimately, there is a need for a more explicit and comprehensive understanding of the term SOP and its uses throughout medicine. Using family medicine as an example, I suggest that this understanding should be derived from the perspective of physicians.

I searched the academic and grey literature using Google and Google Scholar, as well as the Canadian Health Workforce Network library, TRIP, Web of Science, and Ovid MEDLINE databases for relevant sources pertaining to the scope of this thesis. My search term combinations included: *“health professional”* (+ *“regulation”*) + *“SOP”*; *“health profession”* + *“use”* + *“SOP”*; *“devise”* + *“health professional”* + *“SOP”*; *“health profession”* + *“SOP”* + *“definition”* (or *“interpretation”*); *“SOP”* + *“medicine”*; *“physician”* + *“SOP”*; *“family physician”* (or *“general practitioner”*) + *“SOP”*; and *“SOP”* + *“medical legislation”* + *“policies”*. I primarily consulted literature from Canada and the United States, and to a lesser extent Australia and the United Kingdom. The 152 sources I included in this review consist of 99 articles, 21 reports, 14 book chapters, and 18 miscellaneous sources – e.g. professional toolkits and other resources, position statements and papers, public consultations, legislation, regulatory policies. All items were published in English before January 2019.

Having outlined the literature review discussion, I will now discuss SOP in relation to the Canadian and Ontario health care systems.

1.3.1 SOP in the Canadian and Ontario Health Care Systems

The physician-centric nature of Canada's health care system was noted by a Canadian Academy of Health Sciences expert panel who convened to examine collaborative care models and optimal SOPs for health care providers (Nelson et al. 2014). They stressed that a fundamental problem with current health service delivery models was the organization of models of care and health professional SOPs based on political considerations and traditions. Their recommended reforms included changing legal and regulatory frameworks from siloed to a more collaborative, patient-centric health system so as to better meet population health needs (Nelson et al. 2014).

Scarce human, infrastructural, technological and other resources can also curtail the health care system's ability to meet patient needs and deliver quality care. This is particularly true in underserved areas such as rural, remote, and northern environments (Ontario Ministry of Health and Long-Term Care [MOHLTC] 2010). Responding to this, the Commission on the Future of Health Care of Canada, the Standing Senate Committee on Social Affairs, Science and Technology, and the MOHLTC have each suggested that health professional SOPs, as defined by legislation and regulation, be reviewed and expanded to increase access to services (Kirby and LeBreton 2002; MOHLTC 2010; Romanow 2002). As such, expanded health professional SOPs play an important role in health workforce planning. Yet, it is questionable as to whether current approaches to health policy decision making and workforce planning reflect current health system realities in Ontario. For instance, the province currently does not have a health workforce

plan that aligns population health needs with health system priorities while accounting for full and expanded SOPs for regulated and unregulated health workers (Moat et al. 2016).

Having discussed SOP in relation to the Canadian and Ontario health care systems, I will now discuss the lack of clarity, precision, and ambiguity surrounding the term SOP.

1.3.2 Lack of Clarity, Precision, and Ambiguity Surrounding the Term SOP

According to the Health Council of Canada (HCC), an unambiguous understanding of the SOPs of health professionals is elusive but necessary to achieve an enhanced, clearer understanding of SOP for health workforce planning purposes (Baranek 2005). In June 2003, the HCC held a national summit to address this topic. A pre-summit “*gap analysis*” report indicated that licensure criteria and the SOP for a single profession were not standardized nationwide (Baranek 2005; Cant et al. 2011; Duffield et al. 2011; Kleinpell and Hudspeth 2013). This was attributable to province-specific laws, regulations, licensure criteria, and practice standards which govern health professional practices (McNamara et al. 2002). The analysis also found a discrepancy in definitions of SOP amongst regulatory bodies and in clinical practice (Baranek 2005). The SOP of health professionals is determined by numerous stakeholders at the national and provincial levels (Ontario Hospital Association 2003), which have different objectives within each jurisdiction and do not often collaborate to devise or define SOP and associated competencies (Baranek 2005).

A standard is not apparent from the literature for professions to follow when devising their SOP. The generation of, or changes to, professional SOPs can cause tensions within and between professions that are exacerbated by union contracts with payers of health care, and self-regulation issues (Tomblin Murphy and O’Brien-Pallas 2002). Nevertheless, guidance exists for

health professions to determine, operationalize, or change their SOP. For instance, in a joint position statement, the CMA, Canadian Nurses Association (CNA) and Canadian Pharmacist Association (2003) approved five principles – flexibility, coordination, focus, collaboration and cooperation, patient choice – and nine criteria – competencies and practice standards, risk assessment, education, legal liability and insurance, accountability, quality assurance and improvement, evidence-based practice, setting and culture, and regulation – to consider when determining or changing an individual’s SOP. What different professions do, the methods they use, and the activities they engage in are also well documented (Conference Board of Canada 2007; HFO 2007a; Health Professions Regulatory Advisory Council [HPRAC] 2001). For example, the College of Family Physicians of Canada (CFPC) (2000) has specialty-specific descriptions of what its members do, the types of services, treatments and levels of care they provide, and where these services are provided – i.e., health care facilities, home environment, and specific geographic locations or communities.

There is no uniformly agreed upon interpretation of SOP (Lobb 2015). Legislation and professional policy statements typically refer to professional roles, functions, tasks and competencies (Baranek 2005). These statements also use or make reference to phrases that are used interchangeably with the term SOP, such as “*scope of employment*,” “*the practice of medicine*,” “*domains of practice*,” and “*standards of practice*” (Baranek 2005). However, whether these terms are synonymous with SOP is questionable. For example, the CMA views professional roles as situational behavioural patterns and expected responses during interactions between individuals; however, it views SOP as practice boundaries and competency specific to professional groups (CMA 2000). According to Baranek (2005), it is difficult to detect an adequate expression of the scope of a profession in a single document. In their health

professional SOP reviews, Baranek (2005) and the HPRAC (2007) identified six interpretations of SOP.³

The use of SOP by health professions is also somewhat unclear, and can lead to concerns regarding competence, performance and appropriate assessment for SOP throughout health professional careers. Visocan and Switt (2006) identified a tendency for health professions to describe their SOP as broadly as possible. However, while a broader professional SOP may afford more clinical independence, the medical community has raised concerns about the breadth and maintenance of professional competencies (Baker et al. 2010). An individual practitioner may not possess sufficient skills and knowledge to perform all aspects of a profession's SOP (McCauley and Hager 2009). It also cannot be assumed that acquiring additional knowledge, advanced competencies and a larger available clinical SOP constitutes competence (Nieminen et al. 2011). Occurrences including career interruption, re-entry to practice, relocation or migration and career stage often necessitate reassessment of competence (CPSO 2018; Klass 2007). Competence assessments must be relevant to health professionals' current SOPs, and thus extend beyond initial training and credentials (Klass 2007).

Having discussed the lack of clarity, precision, and ambiguity surrounding the term SOP, I will now discuss a possible tension between the need for greater specificity - i.e., clarity, precision - and flexibility for SOP as reflected in health professional regulation, overlapping professional SOPs, and resulting interprofessional tensions.

³ Please see the introduction section in chapter 2 of this thesis for an elaboration of the various SOP interpretations.

1.3.3 SOP Tensions: Specificity, Flexibility and Health Professional Regulation

A tension potentially arises between the need for greater clarity, precision and consistency regarding SOP, and the need for flexibility to account for jurisdictionally-specific realities and potential health care system changes. National and provincial professional associations have identified a need for a “*flexible and transparent*” system to delimit and adjust the roles and boundaries of their respective memberships in response to continual changes in the Canadian health care system (Baranek 2005). Advancements and changes in technology and medical knowledge (Caulfield et al. 2002; Canadian Medical Protective Association [CMPA] 2012) can have consequences for professional competencies, which include re-training of professionals and the creation of new professions or sub-specialties (Battershill 1994). Also, some procedures previously performed by one type of specialist or professional are increasingly or commonly performed by other specialists or professionals (Battershill 1994). These health care developments point to the fluidity of SOP as a concept (Visocan and Switt 2006), which may in turn impact regulation of health professional SOPs.

Traditional regulatory approaches include statutes to regulate health professions that afford an exclusive SOP that only allows individuals who are members of the profession to provide these services. However, in recent years, a number of Canadian provinces have changed their laws to create “*umbrella legislation*” for regulated health professions (Lahey et al. 2014). For a summary of health professions legislation regulating health professions throughout Canada, please consult Ries (2016, pages 97-98). Contrary to the traditional regulatory approach, umbrella legislation provides non-exclusive descriptions of the activities and professional practice areas of regulated professions, thus altering SOP statements. In this kind of framework,

regulated professions' SOP may possess overlapping or shared activities (British Columbia Ministry of Health n.d.).⁴

Indeed, overlapping SOPs among health professionals are becoming increasingly common (British Columbia Ministry of Health n.d.; McNamara et al. 2002; O'Reilly 2000) and pose a challenge to professional claims to exclusive SOPs (Baranek 2005; McNamara et al. 2002). For example, according to the Government of Alberta, "*No single profession has exclusive ownership of a specific skill or health service and different professions may provide the same services*" (Alberta Health n.d.). SOP disputes and tensions pertaining to what can be done by which professionals under what circumstances – i.e., exclusionary boundary issues – occur between and within professions. Overlapping SOPs have the potential to result in professional turf wars, role confusion, a lack of trust amongst professionals, and inefficient use of health professional resources (Baerlocher and Detsky 2009; Baranek 2005; Lahey and Fierlbeck 2013; Moat et al. 2016; Nelson et al. 2014).

Ontario's health professional legislative and regulatory framework encourages overlapping and expanded health professional SOPs (Lahey and Currie 2005; McNamara et al. 2002). The province has also made commitments to interprofessional practice and collaborative care provision as part of its health workforce strategy (HFO 2007b, 2010). As much as there are overlaps in SOP with this framework and strategy, there are also gaps between the clinical abilities of a number of health practitioners and the legal authority granted to them. This can lead to differences in what practitioners are both educated and allowed to do (White et al. 2008).

⁴ For additional information, please consult Ries (2016, pages 98-99), Lahey and Currie (2005), and the British Columbia Ministry of Health (n.d.).

These differences can exacerbate health workforce shortages and reduce the efficiency and cost effectiveness of health resources (Gatrell and Elliott 2009; Tepper et al. 2005). The implications of these issues for care provision has stimulated much work on interprofessionalism and collaborative practice in health care (Beaulieu-Volk 2015; Bourgeault and Mulvale 2006; Lahey and Currie 2005; Legault et al. 2012; Oandasan et al. 2006; Orchard et al. 2005; Reeves et al. 2010; Ries 2016; San Martin-Rodriguez et al. 2005; Zwarenstein et al. 2009). For summaries of, and more information on, the broader literature in this area please consult Sommerey (2014) and Legault et al. (2012).

The above challenges necessitate a re-evaluation of our understanding of professional SOPs. Discussions about SOP and practice barriers typically address interprofessional issues, collaborative practice and professions outside medicine (Ries 2016). However, the SOP issues among professions are not necessarily the same as those within an individual profession. How, then, can SOP issues between professions be adequately addressed if we do not know *what* SOP is and we have an insufficient understanding of what SOP means *within* a profession? Having asked this question, I will now focus on the term SOP in medicine.

1.3.4 SOP in Medicine

Provincial medical legislation, such as Ontario's *Medicine Act* (1991) and *Regulated Health Professions Act* (1991),⁵ requires physicians to restrict their practice to areas of medicine

⁵ In 1991, Ontario adopted the “*umbrella*” legislative framework described above. Please see the introduction section in chapter 2 of this thesis for an additional description of health professional regulation in Ontario. Please consult O'Reilly (2000) for an in-depth discussion of the history, process, outcomes, actors, considerations, consequences and conflicts related to this legislative and regulatory shift within Ontario's broader health policy

in which they are educated and have experience. However, definitions of SOP and definitions of a change in SOP are either ambiguous or are omitted from these statutes. There may therefore be a disconnect between what medical legislation and regulation explicitly states and what it infers that physicians can do. Given that physicians are expected to use their judgment for their professional practice, this possible disconnect might generate a difference of opinion between what medical regulators expect physicians to do, and what physicians think they are capable and willing to do. For example, if a family physician or general practitioner elects to deliver babies or perform caesarean sections, should this be done to the standard required of a board-certified obstetrician/gynecologist? This standard has prompted inquiry into the quality and outcomes of care provided by generalists compared with specialists (Aubrey-Bassler et al. 2007).

My interpretation of this is that the lack of clarity surrounding SOP may be attributed to three causes. First, there is a scarcity of research that focuses on SOP as a general concept (White et al. 2008). Second, documents and literature that address SOP have yet to provide a consensus. The aforementioned lack of collaboration among stakeholders when determining SOP (Baranek 2005), and lack of standardization of physician licensure and regulation may contribute to this predicament (Baranek 2005; Cant et al. 2011; Duffield et al. 2011; Kleinpell and Hudspeth 2013). Third, the lack of clarity surrounding SOP may be the result of varied approaches to, and interpretations or understandings of, SOP generated within different areas of research. For example, health services research may look at what physicians do, whereas policy-

landscape. Please see the literature summary and study rationale section of this introduction, and the introduction and discussion sections in chapter 2 of this thesis, for information on how the medical regulatory authority in Ontario has further clarified and included SOP in its regulatory framework and has initiated public consultations regarding SOP.

oriented research may focus on required education, certification and credentials. Similarly, different stakeholders may have different objectives and approaches to determining SOP. Factors identified in the literature that influence the practice of physicians may reasonably be assumed to be the factors that influence the SOP of physicians.

Having suggested reasons for the lack of clarity surrounding physician SOP in the literature, I will now consider existing research on or related to the SOP of physicians.

1.3.5 Overview of Research on or Related to the SOP of Physicians

Researchers have investigated provider factors that may influence SOP, such as gender (Chan and Austin 2003; Incitti et al. 2003; Wenghofer et al. 2009; Wenghofer et al. 2011), time since completion of medical training (Chan 2002; Melnick et al. 2002), age (Matthews et al. 2012; Pong 2011; Watson et al. 2005; Watson et al. 2006) and family medicine certification (Green et al. 2009; Jaakkimainen et al. 2012; Wenghofer et al. 2011). Practice factors, such as group and non-specialized practice (Hutten-Czapski et al. 2004; Slade and Busing 2002), geographic location and practice pattern variation (Jin et al. 2003; Peterson et al. 2005; Veugelers et al. 2003), rural and urban practice settings (Dauphinee 2006; Matthews et al. 2012; Pitblado 2012; Weeks and Wallace 2008; Wenghofer et al. 2011; Wenghofer et al. 2018), and practice location outside cities with medical schools (Chan 2002; Chan and Austin 2003) have also been explored. Relationships between provider and practice factors, such as the relationship between physician backgrounds, where physicians received their education and training, and future practice locations have also been investigated (Heng et al. 2007; Hancock et al. 2009; Hogenbirk et al. 2011; Pong et al. 2007; Strasser et al. 2010). Other studies have focused on payment schemes (Gosden et al. 2000; Gosden et al. 2001), resource availability and access to

professional supports (Matthews et al. 2012), and policy and education initiatives to address physician shortages or maldistribution in underserved areas (Curran et al. 2007; Rabinowitz et al. 2008; Tesson et al. 2005).

The concept of SOP has also been explored by examining how to adjust health professional SOPs to respond to emergencies (Institute of Medicine Forum on Medical and Public Health Preparedness for Catastrophic Events 2010). Arguments to expand and/or reaffirm the SOPs of health professionals (Fairman et al. 2011; Merrick et al. 2012), of specialties within a health profession (McCorkle et al. 2012; Prine and Lesnewski 2005), or within various practice settings (Kleinpell and Hudspeth 2013) have been made. Frameworks within workplaces to ensure that new roles and tasks associated with expanded health professional SOPs are performed safely, effectively, and competently (Chippendale and Gardner 2001), and the need to make medical education and health care specific to different practice contexts (Habjan et al. 2012; Strasser and Neusy 2010; Strasser et al. 2016) have also been discussed. Additionally, researchers have explored barriers to SOP (Villegas and Allen 2012), and have considered whether medical regulatory authorities (MRAs) and licensure criteria adequately protect the public from workplace credentialing decisions and decisions physicians make regarding their SOPs (Gunnar 2005). Moreover, researchers have questioned if medical education is adequate to prepare physicians for their future SOPs and practice environments (Backer et al. 2006; Baker et al. 2010; Beaulieu et al. 2008; Freed et al. 2009).

Furthermore, to encourage appropriate assessment for SOP, and competence for SOP, research has been conducted on: the SOPs for which physicians are trained vis-a-vis their potential practice activities and their observed practices (Melnick et al. 2002; Rethans et al.

2002); the need to appropriately evaluate physicians for specific SOPs at various career stages (Melnick et al. 2002); the importance of the competence and knowledge required for specific SOPs in different geographic locales (Breon et al. 2003; Probst et al. 2002; Simmons 2009; Tulloh et al. 2001); and to decipher, measure or predict physician SOP (Ie et al. 2015; Newton 2011; O'Neill et al. 2014; Wong and Stewart 2010). There is an important difference between quantifying SOP and understanding SOP, as it may not be possible to measure some aspects of SOP. Research that is designed to describe and unpack SOP may generate an enhanced understanding of SOP by identifying aspects of SOP that may not be quantifiable.

More specifically, several investigations have focused on the practice patterns and SOP of family medicine and primary care physicians. Researchers have identified predictors of family physician SOP in specific settings (Baker et al. 2010; Hutten-Czapski et al. 2004) and professional identities associated with family practice (Beaulieu et al. 2008). Researchers have also investigated the breadth and change in SOP of primary care providers, in particular family physicians (Beaulieu et al. 2008; Katon et al. 2001; Ringdahl et al. 2006). The breadth of family physicians' SOPs may be attributed to cost-cutting measures and other health care reforms (Katon et al. 2001), primary care services compensating for specialist care shortages in underserved areas (Abbot et al. 2014; Bacenas et al. 2015; Grzybowski and Kornelsen 2013; Iglesias et al. 2015; Soles et al. 2017), and reactions to family physician colleagues narrowing or focusing their SOPs (Bazemore et al. 2012; Beaulieu et al. 2008; Tong et al. 2012; Walsh et al. 2011; Xierali et al. 2012). Additionally, research has highlighted focused or special interest practice areas of family physicians (Gutkin 2011; Sisler et al. 2013) which can indicate the extent to which SOP is broad or narrow.

Factors associated with providers, practice resources, organizational structures – e.g. solo practice, interprofessional teams – and geography can also greatly influence the breadth of the SOP of family physicians (Aubrey-Bassler et al. 2007; Coutinho et al. 2015; Wong and Stewart 2010). Recent studies have shown that factors such as the practice setting can lead to drastically different SOPs within a single specialty requiring different competencies (Grzybowski et al. 2013; Hutten-Czapski 2013) even though the required competencies have not changed as they are based on a physician’s certification. In trying to meet their patient and community needs, physicians may acquire additional training to accommodate changes in their SOPs (Grzybowski et al. 2013; Hutten-Czapski 2013) and to enhance their ability to handle circumstances beyond their prior education and experience (Backer et al. 2006; Baker et al. 2010; Beaulieu et al. 2008).

Having explored research on or related to the SOP of physicians, I will now take a closer look at the SOP research focusing on family practice and identify family medicine as a useful context to further explore issues associated with SOP.

1.3.6 SOP Research Focusing on Family Practice

Given that family physicians can end up having different SOPs despite having the same education and credentials, and that the medical profession and family physician population may have divergent perspectives about SOP, family medicine is a useful context for exploring issues associated with SOP. Despite ostensibly being a single specialty with similar education and credentials, the SOPs of family physicians can vary significantly. This is in part because SOP potentially extends beyond education and credentials. It is influenced by geographic location, patient needs, available resources in the practice setting and the types of settings in which physicians practise (Grzybowski et al. 2013; Hutten-Czapski 2013; Smith and Hays 2004; Wong

and Stewart 2010). Family practice is not the same in rural, remote and urban areas (Pitblado 2007; Tepper et al. 2005; Wenghofer et al. 2014; Wenghofer et al. 2018). Urban family physicians can almost always refer patients to local specialists, while family physicians practicing in rural and remote areas need additional knowledge and skills normally required of specialists to provide an equivalent range of services (Aubrey-Bassler et al. 2007; Baker et al. 2010; Pong et al. 2012; Skariah et al. 2017; Smith and Hays 2004; Wenghofer et al. 2018). The SOPs of family physicians may also differ depending on whether individual physicians elect to focus or limit their clinical practice areas (Chan 2002; Tepper 2004; Walsh et al. 2011).

Registration, certification, and licensure criteria reflect perspectives and expectations about SOP held by the medical profession in accordance with the breadth of the discipline in which a physician is licensed (Melnick et al. 2002). Individual physician practice profiles, patterns and experiences might generate perspectives and expectations about SOP that are different from those of the medical profession. While trained and certified to possess a broad SOP within their specialties, physicians often impose upon themselves narrower SOPs (Bazemore et al. 2012; Coutinho et al. 2015; Tong et al. 2012; Xierali et al. 2012) and specialize idiosyncratically (Melnick et al. 2002). For example, an individual physician may exclusively treat women, or spend a significant amount of time performing a specific procedure (Melnick et al. 2002). Physician SOPs change over time and narrow as physicians age (Pong 2011). SOP changes are in part a function of the workloads and tasks physicians choose to assume throughout their careers, who uses their services and “*a response to community needs*” (Walsh et al. 2011).

1.3.7 Summary of Literature and Rationale for the Study

In summary, the literature on SOP clearly suggests that the SOPs of physicians are not at all standardized or consistent throughout Canada, even more so for family physicians. The literature I reviewed identified a wide variety of factors which can influence SOP, which suggests that a certain degree of flexibility for SOP is required to account for health legislation, policies, regulations, licensing criteria, and practice standards in each province and territory. Flexibility is also required to adapt to changes in health care or policy, and advances in medicine or technology that might impact SOP – i.e., change, evolution, expansion, narrowing or focusing. SOP is central to physician regulation and competence. Accordingly, a more explicit and comprehensive understanding of the term ‘SOP’ and its uses throughout medicine would seem to be needed.

I identified two key knowledge gaps in the literature. The first was that an explicit and comprehensive understanding of the term SOP and its uses in medicine was lacking in the academic and grey literature and in policy statements on SOP – e.g. medical legislation. The scope in which physicians must be competent needs to first be identified to ensure that they practice safely in their respective settings. The scope of abilities that physicians must maintain should be determined to ensure continued quality of care throughout their careers. To ensure that patient needs are met, it is important to know how SOP impacts patient safety (if physicians stray far within or outside of initial education, training and certification), access to care as medical practices and the profession evolves, and the ability to get the right services for patients by the right providers at the right time.

We need to know what SOP is, what the term means, how is it used, and how it is operationalized. Answers to these questions may help guide what levers to push for policy, regulation and practice. There are multiple interpretations and statements that are frequently used interchangeably, but are not necessarily synonymous, with SOP. The widespread use of the term SOP has seemingly produced an assumption that everyone in the medical profession thinks about it in the same way. I will examine this assumption.

The second knowledge gap that I found was that no studies examine how physicians think about their own SOPs. The literature has shown that family physicians possessing similar credentials have different SOPs. It has also detected a potential misalignment of the expectations and perspectives of the medical profession and its membership, and a distinction between the scope of the discipline in which a physician is licensed and a physician's SOP. Thus, directly asking family physicians about how they understand their SOP is essential *because* the medical profession is self-regulated. In independent practice, physicians are responsible for determining their competency and learning needs (Davis et al. 2006; Eva and Regehr 2008; Mann et al. 2011). Using family medicine as an example, I will therefore examine how physicians think about their own SOP.

Addressing SOP with a focus on Ontario family physicians is a rich point of inquiry to fill the above identified knowledge gaps about the term SOP in medicine. I chose to conduct a provincial case study because both health care delivery and its associated regulations are organized along provincial lines in Canada (Lavis and Mattison 2016; Lazar 2013; Martin 2017). The MRA in Ontario has a mandatory change in scope regulation (CPSO 2018) and has conducted a number of recent public consultations on SOP (CPSO 2012a, 2012b; CPSO 2013a,

2013b; CPSO 2016a, 2016b). These consultations identified ambiguity and inconsistency regarding what SOP as a term entails, its use as a concept within medicine, and potential unintended outcomes and concerns for family physicians, their SOPs and practice patterns (CPSO 2012b; CPSO 2013a; CPSO 2016a). Also, Ontario contains approximately one third of Canada's family physician population (CMA 2018). Family medicine is one of the broadest primary care medical specialties, with the responsibilities of family physicians encompassing primary, secondary and tertiary levels of care (CFPC 2007; Flood 2002). In particular, family physicians and general practitioners provide a majority of primary care services (Pong 2012; Wong and Stewart 2010).

Primary health care provision by family physicians has been a focal point of recent governmental health policy agendas in Ontario. For example, the Ontario Action Plan for Health Care encouraged stronger links and enhanced access to family health care (MOHLTC 2012), suggesting that if Ontarians initially receive the “*right*” care provided by the “*appropriate health care professional*,” their conditions are less likely to worsen and thus require treatment in the hospital (MOHLTC 2012). Family physicians occupy a central “*gate keeping*” role for public access to the health care system (CFPC 2007; Flood 2002). The previous Ontario Liberal government built on these priorities in its Action Plan to ‘put patients first’. The first of its four primary objectives aimed to improve access to the right care, which included more immediate access to family physicians and expanding scopes or removing barriers to full professional practice (MOHLTC 2015).

1.4 Objectives, Research Questions and Operational Definitions

1.4.1 Study Objective

My broad aim in this research was to develop a more comprehensive understanding of SOP within medicine in Canada with an emphasis on family physicians and the Ontario context. To that end, I sought to determine how different stakeholders concerned with various areas of physician governance and practice understand SOP. More specifically, the objective of my research was to determine the common conceptual elements of SOP, where differences in how SOP is conceived lie, and the implications of these differences for health policy, physician regulation, CPD, and practice.

1.4.2 Research Questions

My goal was to investigate how physicians' SOP broadly, and family physicians' SOP specifically, is understood from multiple perspectives, encapsulated in the following three research questions:

- (1) How is SOP discussed and used in medical regulatory documents relevant to the Ontario context?
- (2) How do organizational stakeholders representing various policy fields in medicine understand and operationalize factors, drivers, determinants and elements that shape, limit and influence physician SOP and changes in SOP in the Province of Ontario?
- (3) How do Ontario family physicians understand their own SOP, including (i) what factors, drivers, determinants or elements influence (i.e., shape or limit) their SOP, and (ii) how and why might these factors change their SOP throughout their careers?

In asking these questions, I assumed that family physicians reflect on their SOP in their various practice settings. I also assumed that organizational stakeholders and family physicians think about physician practices in terms of SOP. Additionally, I assumed that SOP is influenced by multiple factors; that it changes over time; and that it is not synonymous with competence established at initial certification.

1.4.3 Operational Definitions

Within these questions are key terms that require interpretation. My operational definitions and their relation to the research questions are summarized in Table 1.1.

Table 1.1: Key Terms, Operational Definitions and their Relation to my Research Questions.

Term	Operational Definition	Relation to Research Questions
Regulatory	Small ‘r’ regulation that includes and is related to MRAs, but also that which extends beyond to include other areas that govern the confines of physician practice (i.e., restrict what physicians can do). In this study, I wanted to focus on the medical profession and specific aspects of governance and medical regulation. This definition was created using the conceptual framework described in sections 1.5.3 to 1.5.5 as a guide.	To answer question one, I focused on relevant legislation, MRA, certification and medico-legal liability documents.
Organizational stakeholders	Organizations at the federal and provincial/territorial levels involved in the governance and support of physician practice specifically, and physicians as part of the broader health workforce generally. In this study, I wanted to focus on the medical profession and specific aspects of governance and medical regulation. This definition was created using the conceptual framework described in sections 1.5.3 to 1.5.5 as a guide.	To answer question two, I focused on regulation, education, certification, professional advocacy and health workforce planning. Within medicine, these areas represent various ‘policy fields.’
Policy fields	Areas within medicine in which	

	organizational stakeholders operate with their own mandates, interests and objectives. Depending on the context or issue, these may be congruent or conflict with each other. In this study, I wanted to focus on the medical profession and specific aspects of governance and medical regulation. This definition was created using the conceptual framework described in sections 1.5.3 to 1.5.5 as a guide.	
Family Physician	A physician who is certified by the CFPC, or a general practitioner who is neither certified by the CFPC nor certified by the Royal College of Physicians and Surgeons of Canada (Royal College) (Wenghofer et al. 2011).	To answer question three, family physician encompasses all physicians who are licensed to practise medicine independently – i.e., not on a provisional, educational or other practice license requiring supervision – with a primary practice address in Ontario.
Physician factors	Individual attributes which physicians ‘bring with them’ to any practice environment (Wenghofer et al. 2009). Physician factors may include: age, gender, number of years in medical practice, country in which medical training was received and specialty certification.	To answer question three, factors are subdivided into personal provider (physician) and environmental (practice) factors.
Practice factors	The characteristics of the immediate practice setting or environment in which physicians work. These factors may change if a physician moves from one location to another (Wenghofer et al. 2009). Practice factors may include: health system structure – e.g. funding, delivery, organization – type of practice, geographic setting/location, patient base and associated needs, available resources – i.e., total number of clinical and administrative staff, equipment – access to professional supports outside the primary practice setting, practice volume, active hospital appointment and teaching appointment and/or experience.	

Having identified my research objectives, questions, operational definitions and their relation to the research questions in this study I next articulate the overarching conceptual framework I used for this study.

1.5 Overarching Conceptual Thesis Framework

I used a modified institutionalist conceptual framework that focuses on the elements of ‘ideas, interests and institutions’ used for policy analysis, as per Deber and Mah (2014), to guide the overall approach to my research. I selected this framework because my research objective considers implications for health policy and my research questions, as reflected in the operational definitions above, have relevance for policy. Designing my research using this lens ensured that I incorporated each of these elements, which are not totally separate from each other, in each of the three stages.⁶ This framework also guided participant selection,⁷ and it was the lens through which I interpreted the results of each stage of this research and the cross-cutting themes and tensions in my overarching thesis discussion in chapter 5.

Before I discuss each of the three elements – i.e., ‘ideas, interests and institutions’ – in this conceptual framework and how I used them in this study, I will provide a background for this approach.

⁶ Please see the methods section in this introduction for a description and depiction of the study design for this research.

⁷ Please see the methods section in this introduction for a discussion of the participants included in each stage of this research.

1.5.1 Neo-institutionalism and Policy Making

Theories of policy making negotiate the interplay between the state and society; they differ on the importance of, and balance of power between, these two entities (Baranek, Deber and Williams 2004). The state refers to political institutions within a geographic territory concerned with “*the organization of domination, in the name of a common interest*” (McLean 1996 in Baranek, Deber and Williams 2004). The state enjoys sovereignty over its inhabitants and possesses authoritative roles and legal norms to exercise its sovereignty. Society refers to individuals and groups living in a territory and includes individuals, interests and interest groups (Baranek, Deber and Williams 2004). There is a tendency in the policy literature to explain policy as a result of interest group politics and societal interests, with the state being a minor actor; or, as a result of internal state dynamics and structures with societal interests providing the setting or background for these to play out (Baranek, Deber and Williams 2004). Neo-institutionalism necessitates that the state be understood within its historical or societal context, and that the state, its institutions and the ideas it advances are central in shaping that context (Baranek, Deber and Williams 2004).

Neo-institutionalism also emphasizes the effect or influence formal and informal institutions have on policy outcomes (Brooks 2000).⁸ It is premised on the notion that the values and preferences of policy actors are shaped by their “*structural position*”; institutions are thought to structure political realities by defining “*the terms and nature of political discourse*”

⁸ A policy outcome can be interpreted as an end goal of a policy – i.e., what success looks like after a policy is planned and implemented. It can also be interpreted as the result of, or what occurred as a result of, a policy being created and implemented – e.g. outcomes or parts thereof can be viewed as positive or negative, intended or unintended.

(Coleman and Skogstad 1990). It is also premised on the assumption that “*historically constructed institutions*” create conditions that influence policy maker and interest group behaviours; it identifies the state as an actor with its own interests (Babich and Beland 2007). Neo-institutionalists conceptualize the impact institutions have on political processes in terms of path dependency (Boyчук 2008). Path dependency emphasizes the ways institutions produce “*historical pathways*” and condition future events (Baranek, Deber and Williams 2004). It also emphasizes the degree to which earlier policies may make it challenging, but not impossible, to backtrack (Deber and Mah 2014). Neo-institutionalism highlights the significance or ability of past policy decisions to constrain future policy actions. Although it cannot help us forecast which paths will be taken or when decisions will be revisited, modified or different paths pursued, this approach may assist to clarify potential obstacles to policy change (Tuohy 1999). To that end, neo-institutionalism emphasizes the distinction between structures, processes and outcomes to form ideas about policy making.

1.5.2 Ideas, Interests and Institutions

The modified institutionalist conceptual framework I used for this study focused on the policy elements of ‘ideas, interests and institutions’ (Deber and Mah 2014). I chose this policy analysis approach for its ability to demonstrate the interplay of these elements in policy making, and that the prevailing power and influence of ‘ideas, interests and institutions’ depends on the particular issue or situation under consideration. The concepts of ‘ideas, interests and institutions,’ which are not totally separate from each other, were incorporated in each stage of this research. In stage one (chapter 2), ‘institutions’ are emphasized. In stage two (chapter 3), ‘interests’ are highlighted. In stage three (chapter 4) and in the overarching discussion

connecting stages one, two and three (chapter 5), ‘ideas’ are prominently featured. These elements are discussed in turn below.

1.5.3 Ideas

‘Ideas’ influence how individuals and groups view the world, think about politics, what is important and what should happen in society (Deber and Mah 2014). Public policies are created within frameworks of political ‘ideas’ that inform thinking about what is a public problem, what methods are available to address it and what assessments can be made afterwards (Manzer 1994). ‘Ideas’ can be thought of as determinants of policy that can be used to understand problems and any actions intended to solve them. ‘Ideas’ can also be viewed as tools to exercise political power that can be used to mobilize or convince other ‘interests’ to support a particular standpoint (Manzer 1994). When fundamental ‘ideas’ about preferred policies or outcomes differ, evidence can elucidate considerations such as facts, trade-offs and probable outcomes of specific policies. Yet, evidence cannot control achievements to which people aspire (Deber and Mah 2014).⁹ My research sought to understand underlying ‘ideas’ about SOP in medicine generally, and family medicine specifically.

1.5.4 Interests

‘Interests’ are when individuals with common goals assemble and organize within formal structures and act together to influence policy to advance their common interest(s) (Baranek, Deber and Williams 2004; Pross 1975). According to Manzer (1994), ‘interests’ refer to policy

⁹ For more information on ‘ideas,’ including four categories of ‘ideas’ that are identified and distinguished in the policy and political science literature, please consult Deber and Mah (2014), Brooks (2009), and Baranek, Deber and Williams (2004).

preferences, motivations and goals of state and societal actors operating within a particular policy field or interested in a specific policy issue.¹⁰ The ability of stakeholders with particular interests to promote their goals depends in part on their institutional characteristics and those of the state within which they function, as well as the relationships among other interest groups and relevant state components (Baranek, Deber and Williams 2004). Kellow (1988) notes that policy debates are often determined by who participates and the ground rules within which they operate – i.e., the ‘scope of conflict’. The influence some ‘interests’ have relative to others is attributable to the reciprocal benefits offered by the state and interest groups. For example, public officials must generate support for their objectives to achieve them. If interest groups do not exist for a particular issue, or perspective on an issue, the state encourages their creation (Baranek, Deber and Williams 2004). ‘Interests’ are therefore of paramount importance to policy making. The roles of ‘interests’ include: communicating political demands; soliciting support for these demands from others; turning these demands into public policy; and connecting people to the political system. The power held and influence exerted by ‘interests’ varies depending on the particular issues they focus on (Deber and Mah 2014).¹¹

Different ‘interests’ will approach SOP from different perspectives and may have different ‘ideas’ about SOP. The ‘interests’ represented in this thesis include family physicians and organizations that govern and support their practice or membership within the broader Ontario

¹⁰ In this thesis, ‘interests’ refer to the particular goals of a group and the group itself – i.e., stakeholders with shared interests, interest groups.

¹¹ For more information on ‘interests,’ including their memberships, how they are categorized, how they vary in their organization and objectives and their ability to have political influence, please consult Deber and Mah (2014), Pross (1992), and Immergut (1992).

health workforce. The policy fields represented by these organized ‘interests’ are the regulation, education, certification and professional advocacy of physicians, and health workforce planning. Each ‘interest’ advocates for the practice and earning potential of (family) physicians, patient and community needs, and public safety in accordance with their respective mandates. I engaged the above ‘interests’ in this research via one-on-one and group discussions.

1.5.5 Institutions

‘Institutions’ refer to the structures developed by groups to make social and economic decisions, and to the formal and informal sets of rules that structure exchanges between individuals and groups by shaping and constraining their behaviour. These rules can be carried out by government or other bodies depending on their nature (Deber and Mah 2014). Johnson (2005) notes that government is often referred to as “*the state*” by political scientists. The state can be described as a political organization with a full-time specialized professional workforce – e.g., bureaucrats, police service, revenue agency – that exercises foremost political authority over a defined territory and its population. It has predominance of coercive power at the local level great enough to preserve obedience of the laws within its jurisdiction (Johnson 2005).

‘Institutions’ – e.g. legislation, or lack thereof, government structures – can influence “*the shape and power of ideas, the authority of societal interests, and policy outcomes*” (Baranek, Deber and Williams 2004). ‘Institutions’ do not solely determine policy outcomes. Yet, they strengthen the power and influence of particular ‘ideas’ and ‘interests’ over others and shape political struggles around policy issues. ‘Institutional’ changes can alter the restrictions actors use to make strategic decisions and can reform objectives and ‘ideas’ that motivate political action (Baranek, Deber and Williams 2004).

Formal ‘institutions’ represented in this thesis include legislation, MRA, certification and medico-legal liability documents – e.g. policies, regulations, by-laws, position statements. These documents regulate physicians’ conduct – i.e., permit and restrict what physicians can do – in practice under specific circumstances and in various contexts. Informal ‘institutions’ represented in this thesis include professional self-regulation,¹² professional autonomy and discretion,¹³ and the social contract¹⁴ between physicians and the government on behalf of society. Formal and

¹² As part of medicine’s social contract with society, the profession has the responsibility to regulate itself. This includes establishing the standards by which physicians enter the profession and practice medicine, teaching the medical community how to exercise those standards, enforcing those standards, and disciplining those who violate those standards (Bertkau, Halpern and Yadla 2005).

¹³ Evetts (2002) makes a distinction between an ideal form of professional autonomy and professional discretion. The former is influenced by what is in the best interest of patients. The latter reflects decision-making based on organizational factors and requirements, which include social, bureaucratic, economic and political conditions and constraints. Discretion enables physicians to evaluate conditions and cases, and exercise judgement regarding advice, treatment and performance (Evetts 2002). I acknowledge that professional autonomy and professional discretion are sometimes used interchangeably. Autonomy can be applied at the collective and individual level within a profession. In this thesis, professional autonomy refers to the application of autonomy at the collective level – i.e., the ability of medicine to “*police its boundaries and regulate the initiation of new members*” (Lin 2014), as well as advocate for improvements at the population and health system levels (Doctors of BC 2016). In contrast, professional discretion refers to the application of autonomy at the individual level, which “*involves individual discretion and control over the terms and content of daily work*” (Lin 2014) as per Evetts’ (2002) interpretation articulated above.

¹⁴ In exchange for the privilege of self-regulation, the medical profession is obligated to provide appropriate, quality health services by competent practitioners where and when they are needed (MOHLTC 2012; Wynia 2008). The parties to this contract each have a set of expectations. Society expects: assured competence, altruistic service, ethical practice, morality and integrity, accountability, transparency, and promotion for the public good. In

informal ‘institutions’ can conceptualize, shape and constrain SOP, as well as physicians’ abilities and what they choose to do in theory and in practice. I specifically looked for how they do so in participant statements. ‘Ideas’ about SOP expressed by or in different ‘institutions’ may reflect tensions associated with SOP and regulation of the medical profession more broadly.

Having articulated the overarching modified institutionalist conceptual framework for this study, I will next discuss the qualitative methodological approach to this study.

1.6 Qualitative Methodological Approach to the Study

Applied questions about health organizations, policy and practice require an in depth understanding of the *what*, the *why* and the *how* concerning the phenomenon under study (Bourgeault et al. 2010) over and above its frequency, incidence and prevalence. To address my research questions, the design of this research needed to be open to a more nuanced, comprehensive and enhanced understanding of SOP. The complex nature of SOP, health policy and health care systems dictate that this cannot be achieved with the sole use of quantitative measures (Bourgeault et al. 2010; Caronna 2010; Green and Thorogood 2004). Such complexities have prompted policy makers and practitioners to employ qualitative health research methodologies and methods (Bourgeault et al. 2010).

A qualitative stance can be used to evaluate policies and identify perceptions of different stakeholders concerned with physician SOP (Collin 2010). Organizational mandates and individual experiences can be interpreted in different ways that demonstrate what is contested

exchange, physicians expect: trust, autonomy, self-regulation, a value-driven and adequately funded health care system, participation in public policy, shared responsibility for health, a monopoly on services, and monetary and non-monetary rewards (Cruess 2006).

and negotiated about SOP. Examining policy through a qualitative lens may provide valuable descriptions of pertinent, yet assumed aspects of policy, practice and SOP that greatly influence practitioners and what they are permitted to do (Bourgeault et al. 2010). I used two qualitative methodologies to help me carry out each stage of this research. In stage one of this study, I used a scoping methodology (Arksey and O'Malley 2005; Glover Takahashi et al. 2014) to conduct a conceptual scoping review to examine how medical regulatory documents use the term SOP.¹⁵ In stages two and three of this study, I used qualitative description (QD) (a combination of sampling, data collection and analysis techniques) as a methodology (Sandelowski 2000) to examine, unpack and describe SOP and its components, as well as to gain insights from informants to achieve a more comprehensive understanding about SOP (Kim et al. 2017; Neergaard et al. 2009; Sullivan-Bolyai et al. 2005).^{16,17}

Having discussed the overall methodological approach to this study, I will now discuss the constructivist approach guiding the data collection and analysis procedures for stages two and three of this study.

¹⁵ Please see the methods section in chapter 2 of this thesis for more information about the scoping methodology and the rationale for its use.

¹⁶ Please see the methods section in chapters three and four of this thesis for more information on the QD approach, the rationale for its use, and the incorporation of accompanying data collection and analysis techniques for chapters three and four of this thesis.

¹⁷ Please see the methods section of this introduction for a discussion of the selected data collection and analysis techniques accompanying QD for chapters three and four of this thesis.

1.6.1 Methodological Approach to Guide Data Collection and Analysis Procedures in Stages Two and Three

Qualitative research in health care focuses on social processes and practices, how they are created and the contextually specific meanings ascribed to them (Lempp and Kingsley 2007). Understanding multiple and varied perspectives regarding physician SOP can provide important insights into how different stakeholders approach the work of family physicians and the discourses they (re)produce on this subject (Bourke et al. 2013). An emphasis on multiple views and individual practice realities suggests that the constructivist paradigm is a fitting approach to guide the data collection and analysis methods for stages two and three of this research. In particular, I selected Charmaz's (2006) constructivist grounded theory (CGT) method to guide these data collection and analysis procedures. Before I outline my rationale for this selection, I will provide a brief overview of social constructivism and grounded theory (GT) for context.

(Social) Constructivism

Ideas forming this approach are based on Berger and Luckmann's *The Social Construction of Reality* (1966) and Lincoln and Guba's *Naturalistic Inquiry* (1985), among other seminal works. Creswell (2009) and Crotty (1998) identify three key assumptions to which social constructivists ascribe. First, individuals want to “*understand the world in which they live and work*” (Creswell 2009), and further, construct meaning as they “*engage with the world they [interpret]*” (Crotty 1998). Second, individuals make sense of their surroundings based on social, historical and cultural perspectives that bestow meaning to the world in which they live. Third, meaning is socially generated through interaction at the community level (Creswell 2009;

Crotty 1998). Ultimately, social constructivists wish to interpret “*the meanings others have about the world*” (Creswell 2009).

Constructivists are interested in processes of human interaction in various and specific contexts (Creswell 2009). For instance, health systems and policies, like the politics and decision-making that create them, can be seen as necessarily local (Raphael and Bryant 2006). As products of the societies in which they are devised, health systems and policies are a reflection of the societies in which individuals wish to live (Agren 2003). Constructivism asserts that our realities are socially constructed within our minds, that “*there exist as many ... constructions as there are individuals,*” and acknowledges that constructions might be shared despite the existence of multiple realities (Guba and Lincoln 1989). Social constructivists suggest that individuals develop multiple and varied subjective meanings of experience. A constructivist approach to inquiry therefore relies on examining participant views and constructed meanings of their circumstances (Creswell 2009).

Constructivists also see knowledge, particularly within a research context, as being generated through the interaction between researcher and participant(s). The meaning(s) ascribed to knowledge are constructed through this relationship, as opposed to the researcher assuming the role of a distant, objective observer to the process and final product of an investigation (Denzin and Lincoln 2003).

Situating the data collection and analysis procedures for stages two and three within the constructivist paradigm allowed me to: (i) examine SOP with regard to the meanings people – individually and collectively – ascribe to it (Denzin and Lincoln 2003); (ii) account for the subjective thoughts, beliefs and experiences of participants pertaining to SOP (Schwandt 2004);

(iii) acknowledge the different realities – and perceptions thereof – that influences family physician SOP in Ontario and what can be known about it; and (iv) include me as an active participant in the research process, whose knowledge and experiences contributed to the co-construction and interpretation of the data to generate new knowledge about SOP (Denzin and Lincoln 2003).

Grounded Theory

Grounded theory (GT) is a social constructivist perspective that focuses on shared meanings and interprets facts to both reflect and “*inhere values*” (Giacomini 2010). First introduced by Glaser and Strauss (1967) as a qualitative sociological method, GT has been increasingly used in health research (Gardner et al. 2012; Morrissey 2012; Russell Henderson 2009; Wuest et al. 2002). GT has been used to understand health professional roles and the relationships among these professional populations (Yantzi 2005). While the GT approach is primarily concerned with the creation and development of theory (Strauss and Corbin 1994), stages two and three of this study did not constitute a formal approach to GT research as sampling decisions geared towards theory generation, theoretical development throughout data collection and analysis, presentation of a theory and hypothesis generation (Hutchinson et al. 2011) were not incorporated in the design because they are GT characteristics aimed at making contributions to theory. Theory construction was not an aim of this study.

Six common characteristics are included in GT study designs (Hutchinson et al. 2010; Russell Henderson 2009). As this thesis used GT techniques for the purposes of data collection and analysis (Kennedy and Lingard 2006) within a QD study design, it only included three. First, an iterative process ensured that data collection and analysis occurred simultaneously throughout

the research process. Earlier data collection informed subsequent data collection and analysis which remained open to new ideas (Hutchinson et al. 2011). For example, concepts, ideas and themes devised during early data collection can inform data collected later in the study through the modification of interview or focus group discussion guides (Strauss and Corbin 1994). This process allows for previously unconsidered themes to surface that may be important to understanding the research problem. These emergent themes can be “*developed and refined*” in later phases of the study (Yantzi 2005). Second, the process by which codes and categories were devised during analysis reflected the data and considered many observations. Third, variations and patterns in the data were sought by making comparisons – within or between cases, over time – throughout the analysis process (Hutchinson et al. 2011).

GT methods were appropriate for my research due to their emphasis on social processes (Glaser and Strauss 1967; Strauss and Corbin 1990). GT was also a fitting choice because of its inductive approach to data collection (Morse 2001). It permits the inquiry to “*begin with an area of study and what is relevant to emerge*” (Strauss and Corbin 1990). Rather than proving or disproving a hypothesis or idea, participants relay their subjective experiences to the researcher about a subject of mutual interest. From here, pertinent ideas and issues materialize (Mills et al. 2006). An inductive approach can help attain an enhanced understanding of unclear, imprecise concepts, such as SOP. Greater clarification can be attained through the generation of concepts related to SOP (Russell Henderson 2009). Such clarification and conceptual development are achieved through a rigorous process and techniques for collecting, managing and analyzing data (Glaser and Strauss 1967).

I selected Charmaz's (2006) CGT method to guide my data collection and analysis procedures for several reasons. First, Charmaz's version of GT is firmly rooted in the constructivist paradigm (Russell Henderson 2009). Second, it is an "*emergent approach*," the methods of which are flexible such that unanticipated data may be accommodated (Charmaz 2006; Russell Henderson 2009). Third, it resituates and renegotiates the relationship and interactions between the researcher and participants. Accordingly, it allowed me to position myself as the author of the final product (Mills et al. 2006) and it accepted my role in collecting, interpreting and analyzing the data (Charmaz 2006; Russell Henderson 2009). Fourth, it stresses that there are multiple meanings and realities in relation to the data collected, and that how the data is analyzed contributes to the final product (Mills et al. 2006). Thus, there was potential for study participants and I to co-construct concepts pertaining to SOP, which possessed educational value in and of itself. Fifth, "*it regards interaction to be dynamic and subject to change*" (Charmaz 2006; Russell Henderson 2009). Consequently, I used CGT to explore SOP because SOP can change over time throughout physician careers. Also, the interactions of health policy, systems and services stakeholders, as well as changes in health care shape understandings of SOP (Baranek 2005; Caulfield et al. 2002; CMPA 2012). As interactions between these various stakeholders change and as health care continues to change, so too can understandings of SOP. Finally, CGT acknowledges that my approach to this topic and how I conducted this research was not "*neutral*" (Macdonald and Schreiber 2001; Russell Henderson 2009). Information about my positionality vis-à-vis this topic and how I conducted this research can be found in my reflexivity statement in section 1.8 of this chapter.

Having set out the overall qualitative approach to my research and the ways in which I used CGT to guide the data collection and analysis procedures for stages two and three of my research, I will next describe the methods I used.

1.7 Overall Study Design and Methods

Qualitative methods, including document analysis, key informant interviews and focus groups, have greatly contributed to the study of health professions and professionals (Collin 2010), the findings of which have provided evidence to influence professional practices, health policies and the planning of health services (Green and Thorogood 2004). I designed the overall study to develop a more nuanced, comprehensive and enhanced understanding of SOP as it pertains to family physicians in Ontario.

The methods design for this thesis consists of three stages. Each stage addresses one of three research questions stated above. I present my thesis around chapters two, three and four.

Stage one (described in chapter 2) focused on how SOP was discussed and used in medical regulatory documents relevant to the Ontario context (research question one). I wanted to broadly and thoroughly investigate the literature about SOP relevant to medicine in Ontario. To that end, I conducted a conceptual scoping review of major Canadian federal and provincial policy statements on SOP, and on the academic and grey literature that focused on SOP in various health professions, with an emphasis on medicine in Ontario. In addition to books, reports and articles, documents included in the review and analysis include federal and provincial legislation; policies, regulations and guidelines instituted by MRAs; position statements,

discussion papers, competency frameworks and curricula issued by national certification bodies; and perspectives released by medico-legal liability associations.¹⁸

Stage two (described in chapter 3) focused on how different stakeholder and policy-forming groups in Ontario understand and/or operationalize physician SOP (research question two). Building on stage one, I wanted to further explore discussions within the medical profession about SOP relevant to medicine in Ontario (CPSO 2012a, 2012b; CPSO 2013a, 2013b; CPSO 2016a, 2016b). To that end, I conducted ten semi-structured interviews in total between July and November of 2015 with representatives from federal and provincial MRAs and associations – i.e., Federation of Medical Regulatory Authorities of Canada, CPSO; certification bodies – i.e., CFPC, Royal College; medical schools and associations for medical education – i.e., Northern Ontario School of Medicine, Association of Faculties of Medicine of Canada; professional medical associations – i.e., CMA, Ontario Medical Association; and health workforce planning networks – i.e., Canadian Health Workforce Network – relevant to Ontario.¹⁹

Stage three (described in chapter 4) focused on how Ontario family physicians understand their own SOP, including what factors influence their SOP, and how and why these factors might change their SOP throughout their careers (research question three). Building on stages one and two, I wanted to address two key knowledge gaps about SOP relevant to medicine in Ontario. I wanted to examine the assumption that, due to the widespread use of the term SOP in the

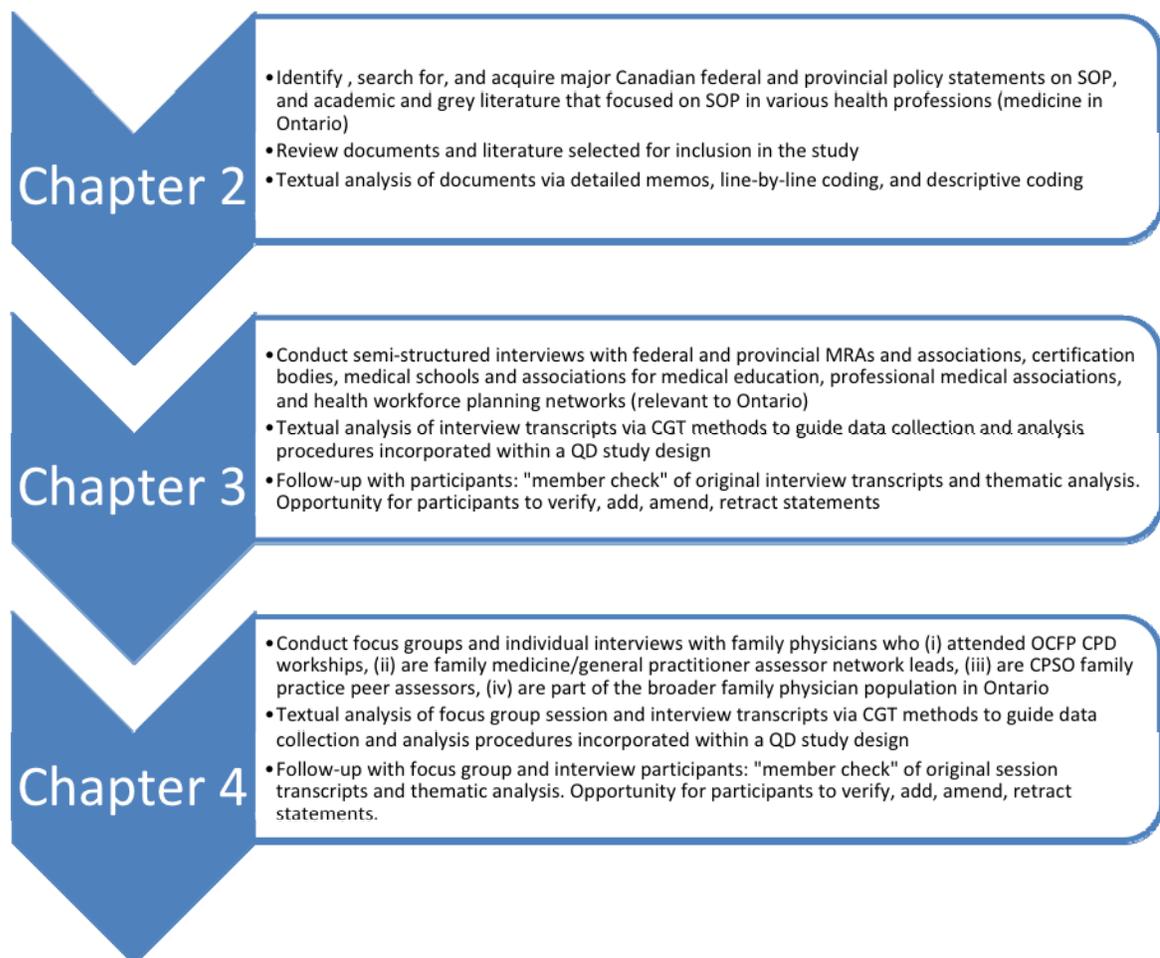
¹⁸ Please see the methods section in chapter 2 of this thesis for more information on the research strategy, literature search and document analysis procedures.

¹⁹ Please see the methods section in chapter 3 of this thesis for more information on the research approach; data collection procedures including participant recruitment strategy, rationale for participant selection and data analysis procedures.

medical literature and discussions about SOP within medicine, SOP is thought about in the same way throughout the medical profession. I also wanted to examine how physicians think about and understand their own SOPs to address this unexplored perspective in the literature focusing on physician SOP. To that end, I conducted focus groups and individual interviews between January and September of 2016 with Ontario-based family physicians (n=24) situated in different contexts with different practices at different career stages. Participants included attendees at Ontario College of Family Physician (OCFP) CPD workshops, family medicine/general practitioner assessor network leads, CPSO family practice peer assessors and the broader family physician population in Ontario.²⁰ Please see Figure 1.1 for a summary of each chapter and staged approach.

²⁰ Please see the methods section in chapter 4 of this thesis for more information on the research approach; data collection procedures including participant recruitment strategy, rationale for participant selection and data analysis procedures. Please see the results section in chapter 4 of this thesis for participant basic practice and demographic information.

Figure 1.1: Diagram of Thesis Design and Methods



1.8 Reflexivity Statement

The value, contributions and use of qualitative research are increasingly recognized in health care literature with social and cultural aspects (Al-Busaidi 2008), and in the health services and policy literature (Chafe 2017). Such research aims to assist our understanding of phenomena of interest by focusing on the meanings, experiences and views participants ascribe to them (Al-Busaidi 2008). Accordingly, it is important to incorporate “*quality control*” strategies, such as researcher reflexivity, to ensure the quality and rigour of these bodies of work (Berger 2015).

Questions about reflexivity are encompassed within more expansive debates about knowledge generation. In this process, the researcher focuses on “*self-knowledge and sensitivity*” to assess his or her role in how knowledge is created (Berger 2015). This includes acknowledging and recognizing the effect that one’s positionality has on the research process and outcome (Bradbury-Jones 2007; Guillemin and Gillam 2004; Pillow 2003; Stronach et al. 2007). One’s age, gender, biases, beliefs, personal interests and experiences, political and ideological stances, among other personal characteristics, impact what is ultimately produced (Berger 2015; Hamzeh and Oliver 2010; Padgett 2008). As it is impossible for a researcher to fully separate him or herself from their research (Giltrow et al. 2014), the purpose of this reflexivity is to articulate my stance as a researcher, my involvement as the primary instrument in this research (Holloway and Galvin 2017), and how my experiences and relationship (or lack thereof) to the participants might have influenced how the data was collected and analyzed in this study. I selected the topic of SOP in medicine based on my personal and academic background, interests and experiences, as well as what I hope to accomplish by conducting this research.

My research interests intersect at the areas of health policy and health services. These interests were initially influenced by previous inquiries into access to essential services of underserved populations. These interests continue to be influenced by various aspects of my identity, which include my sense of general social and civic responsibility – i.e., tax-payer and voter – a daughter, a wife and possibly a future parent, a friend, and a doctoral student. I was born, raised and have resided in Ontario, Canada my entire life. I predominantly receive primary care from physicians who are governed by Ontario regulations and health policies. Previous study in the field of political science, as well as previous research investigating the Supreme

Court of Canada, health law and policy, and professional, political and public ‘interests’ has fostered a strong interest in all aspects of policy formation, as well as evidence-based and practice-informed health policy-making. This keen interest in policy drove the policy emphasis of, and aspirations for, this research. As was stated above, it is my hope that this study will add to the growing body of qualitative social science and applied health policy research, the results of which may impact health policy and planning change for practice (Bourgeault et al. 2010).

Berger (2015) suggests that the researcher’s positionality may shape the nature of the interactions and the relationship between the researcher and the researched; consequently, this may impact the information participants share. Being an ‘outsider’ – i.e., not an organizational stakeholder or a physician – presents potential advantages and disadvantages in how I was perceived by participants and how they shaped their stories in the research setting. Perceptions about my role as a researcher may have encouraged participants to take a few approaches to the information they shared – or did not share – about their organizational approaches to SOP and SOP in their practices. First, participants may have felt that they could freely share their thoughts and experiences to educate me such that this work might inform health policy or system change. Second, organizational stakeholders may have felt that they must ‘toe the company line’ about information they are able to share with the public. Third, physicians may have been reserved with some information they shared based on the perception that I might misunderstand or misinterpret what they said or judge them.

As a trainee, I interacted with provincial MRAs, national certification bodies, and professional associations concerned with various areas of physician governance and practice. I knew who to contact and/or gain access to individuals who could contribute knowledge to this

study through interviews and focus group discussions (Berger 2015). Some of these entities are represented as organizational stakeholders and provided data for this study. While I collaborated with and consult for these organizations, I did not represent, work for or have membership with them.

Through my interactions with these organizations, there was potential for me to have insight into their understandings of, and approaches to, SOP through my knowledge of their policies, position statements, initiatives and programming. I also had personal knowledge about some physician participants and their practices. It is possible that my personal experiences and knowledge may have influenced my interpretations of participants' experiences and meanings they ascribe to SOP. In an effort to minimize anything I personally inferred rather than inferred from the data, I used member checking and rigorous data analysis procedures to verify that I did not insert personal knowledge or insights into the data analysis and focused strictly on the knowledge that was contributed to this study.²¹ I discussed these procedures and my findings with my thesis committee throughout the research process.

Kacem and Chaitin (2006) note that the worldview and background of the researcher influences the way one asks questions, selects the perspective to filter and make meaning of data collected, and shape a study's findings and conclusions. I acknowledge my role in deciding the story this study and each stage thereof tells, including the evidence and quotations presented from the interviews and focus groups that follow. It was important for me not to focus too

²¹ Please see the methods section in chapters three and four of this thesis for more information on the member checking and data analysis procedures.

intently on, or give extra consideration to, emergent themes that were consistent with my views or inclinations.

The findings and conclusions reported in chapters three, four and five reflect the co-construction of knowledge by, and the voices of, both the researcher and participants. I neither disclosed my thoughts about SOP to participants, nor did I ask questions or identify and group themes in a way that would further explore this topic beyond participant statements. I kept a research journal during all phases of study conceptualization, data collection and analysis. I made reflective notes and memos during the data analysis process to reduce researcher bias, which helped me distance myself from the data and identify emerging themes. Additionally, I acknowledge that I developed relationships and trust with study participants and supporters throughout the research process. This encourages me to ensure that this study generates meaningful findings for participants and a return on their investment – e.g. time, information – in this work.

1.9 Research Ethics, Funding and Study Support

Ethics Approval

Ethics approval for this thesis was granted by the Laurentian University Research Ethics Board on December 15, 2014 (REB File ID: 2014-11-07) (Appendix A).

Funding

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Study Endorsement

This study received a letter of support from the College of Family Physicians of Canada on February 17, 2015 which was distributed with participant recruitment materials for stages two and three of this study (Appendix B). As is indicated in the letter, this study might “*provide a deeper understanding of practical and policy implications in health care across Canada*” as well as insights for family physicians throughout Canada. In particular, findings of this study can help to “*identify key aspects of [SOP] related to physician competence and quality of care*” which is beneficial to “*ensure safe practice for specific [SOPs].*” This study can also contribute to the maintenance of certification and licensure of participating physicians, who upon fulfilling the remainder of the College’s reporting requirements for a linking learning to practice activity can earn CPD credits.

1.10 Conclusion

I began this chapter with an introduction to the topic of physician SOP, followed by an overview of the entire thesis. In the literature review, I identified two key knowledge gaps which form the basis of my research. I examined the assumption that everyone in the medical profession thinks about the term SOP in the same way. Using family medicine as an example, I also examined how physicians think about their own SOP. Next, I presented a rationale to investigate the term SOP in medicine with an emphasis on family practice in the Ontario context, and on the physician perspective. My research questions investigate how SOP is understood from multiple perspectives to achieve a more comprehensive understanding of SOP within medicine.

I used a modified institutionalist conceptual framework that focuses on the elements of ‘ideas, interests and institutions’ to guide the overall approach to this thesis. The concepts of

'ideas, interests and institutions' are present and emphasized to different degrees throughout this research. A qualitative approach and methods were required to address my research objectives and questions. I used document analysis (question one), key informant interviews (question two), and individual interviews and focus groups (question three) to answer my research questions. My reflexivity statement outlined a number of potential researcher biases, particularly in regards to how I collected, analyzed and presented the data in this thesis. My acknowledgement of financial and stakeholder support present other limitations and potential audiences for this research.

The next three chapters will present the results of each stage of this research, each addressing one of three thesis research questions.

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Chapter 2: What does ‘Scope of Practice’ in the Medical Profession Really Mean, and Why Does it Matter?

Abstract

Much ambiguity surrounds what is meant by a physician’s scope of practice (SOP), both in general and in specific regulatory contexts. This study describes, analyzes and organizes different concepts of SOP based on their recurring and unique properties. A conceptual scoping review was conducted on major Canadian federal and provincial policy statements on SOP, and on the academic and grey medical literature that focused on SOP in various health professions, with an emphasis on medicine in the Ontario context.

Findings indicate that the term ‘SOP’ is used vaguely and applied and interpreted in different ways, sometimes within the same document. Statements about scopes of practice related to (1) professional regulation, (2) the individual practitioner and (3) career paths and responses to a changing health system are distinguished. Six properties related to SOP – expectations, geographic or situational context, service provision, education and training, areas of practice, unique practice experience and characteristics – are also identified. Given that SOP is an important policy concept, vagueness in discussions about SOP and failure to distinguish different interpretations is an impediment to clarity and coherent thinking in this area. This study identifies issues for medical regulators to consider when using the term SOP within their frameworks. In so doing, it hopes to contribute not just to a better understanding of SOP but also to a clearer understanding of related policy issues, and ultimately to better policy-decision making.

2.1 Introduction

The concept of a physician's scope of practice (SOP) is used in a variety of different ways. Different definitions, understandings or interpretations have different implications. We have examined this in the context of the province of Ontario in Canada. Achieving greater clarity regarding the differing usages and meaning of SOP can support a more effective use of this concept.

A professional's SOP defines what they are capable of doing and what they are allowed to do in executing their professional role. The SOP of Ontario's health workforce illustrates this point. The "*controlled act model*" (Lahey and Currie 2005) in Ontario's *Regulated Health Professions Act* ([RHPA ON] 1991) institutes performance standards for individual professions, protects the activities that comprise the SOP of respective professions, and accepts overlapping and expanded scopes of practice (SOPs) among health professions (Lahey and Currie 2005; Morris 1996; McNamara et al. 2002). Given the work the concept of SOP does, it is not surprising that there is much discussion and debate surrounding SOP and how it is delimited.

Discussions and debates related to the SOP of health professionals typically address interprofessional issues. Examples include consultations on interprofessional collaboration (Health Professions Regulatory Advisory Council [HPRAC] 2008b; HPRAC 2008c; Ontario College of Family Physicians [OCFP] 2009), health professional SOP reviews for registered nurses in the extended class, chiropody and podiatry (HPRAC 2008a; HPRAC 2015), and discussions surrounding provisions in auxiliary legislation that are incongruent with SOP regulations, that do not account for increases in professional SOPs or that limit the ability of some health professionals to practice to the fullest extent of their competencies (College of Nurses of Ontario 2008; Dietitians of Canada (Ontario) 2008; Enhancing Interdisciplinary

Collaboration in Primary Health Care Initiative 2005; Excellent Care for All Act 2010; Legislative Assembly of Ontario 2016; Regulated Health Professions Statute Law Amendment Act 2009). More recently, the policy and professions' responses to external factors impacting SOP, such as amendments to the *Criminal Code of Canada* to include circumstances that permit medically assisted dying (Canadian Medical Association n.d.-a; Canadian Nurses Association [CNA] 2015; Hoskins 2016; Ontario College of Pharmacists 2016), have also been the focus of SOP discussions.

SOP is an issue not only between professions, but also within a given profession, and SOP issues may appear differently within and between professions. Since 2012, there has been much discussion about SOP within the medical profession in Ontario. That year, the College of Physicians and Surgeons of Ontario (CPSO) noted a trend of physicians 'drifting' within or beyond the areas in which they practise and were formally trained. The CPSO subsequently explored the possibility of further clarifying SOP within its regulatory framework over and above its existing policy that reviews the training, certification and experience of physicians, and recommends additional training when required prior to a physician changing his or her SOP to ensure effective and safe practice transitions (CPSO 2008a; CPSO 2015). The CPSO considered whether to issue "*defined scope certificates*" to new registrants (CPSO 2012b). This initiative was abandoned after a public consultation within the profession identified its shortcomings and potential unintended consequences (CPSO 2013a; CPSO 2013b) and challenges to further clarifying or more explicitly defining SOP. In spring 2016, the CPSO solicited feedback from stakeholders including the medical profession, health system organizations, other health professionals and the public regarding SOP as a concept and the College's current Changing Scope of Practice Policy (CPSO 2015; CPSO 2016a). From these consultations, it is evident that

there remains significant uncertainty, ambiguity and inconsistency surrounding what the term SOP (or a change in SOP) actually entails, its use as a concept by the broadest health profession, and within this, repercussions for the broadest primary care specialty (family medicine) (CPSO 2012a; CPSO 2013a; CPSO 2016b).

Baranek (2005) asserted that no one document can adequately articulate the scope of a profession. Her comprehensive review of interprofessional issues associated with legislative, regulatory and policy statements for three professions identified six different interpretations of SOP: (1) the eligibility requirements for membership in a profession; (2) the tasks professionals are educated and trained to perform; (3) what legislation permits professionals to do in the jurisdictions in which they practise; (4) the tasks professionals actually perform in the practice environment; (5) the practice standards of a profession; and (6) outside expectations of a profession and its membership (Baranek 2005; HPRAC 2007). Given the work SOP does and the implications of how it is delimited, establishing the SOP within a profession often entails a lengthy and complicated process (Lillibridge et al. 2000), requiring understanding, acceptance and consensus regarding who can or should do what to whom, where, why and in what circumstances (Baranek 2005; Besner et al. 2005). We build on Baranek's 2005 review of SOP interpretations to focus on how multifaceted and variant SOP is in one profession – medicine.

There exists a dearth of information in the literature on how SOP is used or interpreted by relevant stakeholders representing different regulatory and policy perspectives within medicine. Physicians' SOP is determined by a spectrum of stakeholders including government, medical regulators, educators, certification bodies, professional medical associations and employers at the federal and provincial/territorial levels (Ontario Hospital Association 2003). These stakeholders have different objectives and often do not work together to establish SOP and its associated

competencies (Baranek 2005). Our study explores and analyzes how SOP is discussed and used in medical regulatory documents relevant to the Ontario context. From this analysis, we propose a way to identify and organize the various meanings and properties associated with SOP and consider the implications of these different aspects of SOP.

2.2 Methods

For the purposes of our study ‘regulatory’ refers to small ‘r’ regulation which includes and extends beyond medical regulatory authorities (MRAs) to include related areas that govern the confines of physician practice – i.e., restrict what physicians can do. As we wanted to focus on the medical profession and specific aspects of governance and medical regulation, we emphasized relevant legislation, MRA, certification and medico-legal liability documents. These documents represent aspects of self-regulation that have jurisdiction over SOP.

2.2.1 Research Strategy

We conducted a conceptual scoping review by utilizing an established scoping methodology by Glover Takahashi et al. (2014) as well as an earlier scoping method outlined by Arksey and O’Malley (2005) that was adapted by Glover Takahashi et al. Scoping reviews strive for broad and thorough investigations of the literature in an area under study (Arksey and O’Malley 2005) and may provide understanding about what is known about the topic of interest under examination in the literature (Levac et al. 2010). We followed the steps for conducting a scoping review outlined by Arksey and O’Malley (2005), namely: (1) identifying the research question; (2) identifying relevant literature and documents, (3) selecting literature and documents for inclusion in the study; (4) extracting the data; and (5) collating, summarizing and reporting the results.

2.2.2 Approach to Search for Literature Reviewed and Document Analysis

We first conducted a search of provincial/territorial MRA and Department of Health and Social Services websites for major federal and provincial policy statements on SOP. While this case study focuses on Ontario, we included legislation from other Canadian provinces and territories, as well as SOP statements from MRAs outside of Ontario as federal legislation may also impact SOP. Next, we conducted a general search of the medical literature that focused on presentations and concepts of the term SOP in various health professions found in the academic and grey literature to see how SOP is described in other professions, and whether the terminology used appears to be more consistent, clear or exact than the language used for physician SOP. Finally, we conducted a search of the literature for concepts and presentations of SOP in different areas of physician governance and practice – e.g., MRA, licensure, credentialing. Literature focusing on law, liability, legislation, MRAs, certification and health policy pertaining to health professionals more generally were also included when applicable to the medical profession.

The literature search and analysis strategy were developed by SM and EW and distributed to RE and MY who contributed further revisions and refinements to the approach and decisions within each step. A medical librarian did not assist with the literature search, the determination of databases searched, search term combinations, or publication limits. The document and literature search and analysis were initially conducted by SM. The research team worked collaboratively to further refine the analysis and presentation of results.

We searched the academic and grey literature using the Canadian Health Workforce Network (CHWN) library, TRIP, Web of Science, and Ovid MEDLINE databases, as well as Google. The searches consisted of different search term combinations as listed in Appendix C.

The grey literature search within the CHWN library and Google also included stakeholder organizations with the search term combinations to search for documents speaking to the regulatory perspectives of interest. Examples include: “*physician*” + “*SOP*” (+ “*liability*”) + “*Canadian Medical Protective Association*” and “*physician*” + “*SOP*” (+ “*credentialing*”) + “*Royal College of Physicians and Surgeons of Canada.*” We included items in English published before June 2017, and that were specifically connected to Canadian medical professionals (i.e., MD degree designation). In accordance with the above stated interpretation of regulatory, our focus on the medical profession and aspects of self-regulation that have jurisdiction over physician SOP, we largely excluded from the search government ministry documents which have jurisdiction over how SOP is applied – e.g., a majority of documents from HealthForceOntario and the Ontario Health Insurance Plan (OHIP) Schedule of Benefits and Fees.

2.2.3 Analysis

After a first full text review of the documents, we categorized them according to whether they were to do with legislation, MRA, certification or medico-legal liability. We read the documents a second time looking for content, general themes and nuanced details therein. During this second full text review, we made detailed memos and used line-by-line coding to: (1) track thoughts, ideas, questions and comments about the content; (2) identify key words, phrases and passages from which themes could emerge; (3) compare content and nuanced details among sources to identify common themes and concepts in the documents; and (4) reflect on the choice and grouping of codes, themes and subthemes. Descriptive coding was used to group the data into themes and concepts for analysis. As coding progressed, analytic memos were used to

search for patterns, (sub)categories, (sub)themes, and concepts within sources. Codes were categorized and those possessing similarities were grouped together to more easily determine frequency of themes, concepts and related information.

2.3 Results

The search generated 235 results across the academic and grey literature, 78 of which were ultimately selected for further analysis (Appendix D). Selected documents included those produced by MRAs and associations whose membership consists of MRAs; health professions regulatory advisory committees/councils; national specialty societies; national certification bodies (including SOP reviews for other health professions submitted by provincial chapters); medico-legal liability associations; and government which provided descriptions of practice, articulated SOP, and discussed SOP reviews and reforms. Documents which did not address physicians, collaborative practice or joint liability issues between physicians and other health professionals were not selected for analysis. Medicine in Canada is a self-regulating profession with the authority to determine its SOP. However, in many documents and policies, one has to read between the lines to infer SOP from broad, non-exclusive phrases (Government of British Columbia n.d.), or concepts that comprise, relate to or are used interchangeably with this term. Examples include: “*standards of practice*,” “*the practice of medicine*,” “*domains of practice*,” “*scope of employment*,” “*scope of services*,” “*scope of professional activities*,” “*scope of procedures*,” “*scope of care*,” “*scope of abilities*,” “*scope of training and recent experience*,” “*scope of clinical activities*,” “*scope of work*,” “*areas of care*,” “*areas of practice*,” “*areas of service provision*,” and “*breadth of practice*” (Acker et al. 2014; Baranek 2005; Canadian Medical Association [CMA] 2012; College of Family Physicians of Canada [CFPC] 2015;

College of Physicians and Surgeons of New Brunswick [CPSNB] n.d.- b; College of Registered Nurses of Nova Scotia 2012; Cothren et al. 2008; Grondin et al. 2013; King et al. 2009; O’Neill et al. 2014; Ontario Medical Association 1996; Schmitz et al., 2015; Tepper 2004; White 2000). Notwithstanding that these phrases are used interchangeably with SOP they may mean different things depending on the context in which they are used.

We identified different and recurring concepts, characteristics and properties of SOP definitions – both explicit and implicit – that contribute to differences in how SOP is viewed or interpreted. We also identified different kinds of SOP, which we organized based on key words, phrases, descriptions, concepts and themes pervading throughout the documents. These differences are summarized in Table 2.1.

Table 2.1. Summary of Differences for Kinds of SOP and Recurring Concepts, Characteristics and Properties of SOP Definitions

Properties	Professional Regulation	The Individual Practitioner	Career Paths and Responses to Changing Health System
Expectations		What medical professionals are permitted or expected to do by the profession, colleagues, patients, public	
Geographic or Situational Context		What licensed professionals in a jurisdiction can do, defined temporary and situational exceptions (i.e., emergency)	SOP determined by practice environment SOP change by relocating somewhere with a different health care system
Service Provision	Services that may or may not be provided within medicine, methods used to provide services Continuous service provision to maintain competence	Practice parameters expressed as the range of services or procedures provided	SOP determined by the procedures one performs or treatments one provides
Education and Training	Boundaries of medical discipline and credentials as potential constraints to service provision Eligibility to perform professional activities based on education, credentials, training	Expectation to practice within education and experience Professional boundaries re: specialty certification	Learning skills relevant to evolving skills, roles, activities and knowledge within medical specialties Specialized competencies acquired through additional training
Areas of Practice	Eligibility to perform professional activities based on areas of practice	Practice parameters expressed as areas of medicine or practice	
Unique Practice Experience & Characteristics	Emphasis on current/recent practice experience to maintain competence	Experience acquired for various work settings/institutions (i.e., privileges)	Practice experience as reflected by the limits of one's clinical expertise or guided by personal interests/career aspirations

2.3.1 Regulation of the Profession – What the Profession is and what it Does

Documents refer to SOPs that emphasize what the profession includes and excludes – i.e., broad, general and vague descriptions of “*the practice of medicine*” (Canadian Medical Protective Association [CMPA] n.d.), services that may or may not be provided within, the methods they use to provide medical services, and lists of licensed, protected and restricted acts (An Act Respecting the Practice of Medicine 2011; Consolidation of Medical Profession Act 1988; Epstein et al. 1998; Forum of Labour Market Ministers Labour Mobility Coordinating Group 2009; HealthForceOntario [HFO] 2007; Health Professions Act [HPA BC] 1996; HPRAC 2007; Medical Act [MA QC] 1997; Medical Profession Act [MPA YK] 2002; Ministry of Health and Long Term Care [MOHLTC ON] 2016; MPA NWT 2010; RHPA MB 2009; Regulated Health Professions Network Act 2012; The Medical Act [MA NL] 2011):

The practice of medicine is the assessment of the physical or mental condition of an individual and the diagnosis, treatment and prevention of any disease, disorder or dysfunction ... In the course of engaging in the practice of medicine, [members are] authorized, subject to the terms, conditions and limitations imposed on [their] certificate of registration, to perform the following ... (Medicine Act [MA ON] 1991)

Despite the flexibility associated with these SOPs, such interpretations are at times viewed to be constrained by statute and licensure; specifically, statutory provisions, the characteristics and boundaries of the medical discipline in which one practices, associated licensure, credentials, competencies and areas of expertise (Frank et al. 2014; OCFP 2008; Royal College of Physicians and Surgeons of Canada [Royal College] 2013a; Royal College 2013b; Royal College 2014). In Ontario legislation, the *Medicine Act's* definition of the practice of medicine stated above, in conjunction with the 14 licensed and protected/restricted acts authorized in the *RHPA ON* (1991) provide a foundation for how SOP is operationalized (Federation of Health Regulatory Colleges of Ontario 2014).

Furthermore, the notion of eligibility is used to discuss SOP by referring to who can have access to a profession's SOP. This includes who has "*authorization to perform [the profession's]*" roles, functions, range of "*reserved acts,*" "*restricted activities,*" and tasks (College des Medecins du Quebec 2014; College of Physicians and Surgeons of Alberta [CPSA] 2012; CPSA n.d.; College of Physicians and Surgeons of British Columbia [CPSBC] 2012; College of Physicians and Surgeons of Manitoba [CPSM] 2012; College of Physicians and Surgeons of Nova Scotia [CPSNS] 2014; CPSO 2008a; CPSO 2015; CPSO n.d.; College of Physicians and Surgeons of Saskatchewan [CPSS] 2012; CPSS 2014a; CPSS 2014b; Government of Nunavut [Gov Nu] 2007a; Gov Nu 2007b; Gov Nu 2007c; HPRAC 2006; HFO 2007; MA ON 1991; RHPA PEI 1988; RHPA ON 1991; Yukon Medical Council [YMC] n.d.). Eligibility to perform professional activities and the circumstances in which they are performed is based on acquired education, qualifications/credentials and experience; one's "*areas of practice,*" knowledge, specialty and expertise; the services, procedures and skills for which they have received training; and associated clinical competence and judgement in practice (Canadian Free Trade Agreement [CFTA] 2017; CPSO 2008a; CPSO 2015; CPSO n.d.; HFO 2007; HPRAC 2006; MA ON 1991; RHPA ON 1991). To maintain this eligibility and clinical competence, there is an emphasis on current/recent experience and continuous service provision for a stipulated period of time (CPSA 2010; CPSA n.d.; CPSM 2003; CPSNB n.d.- b; HPRAC 2006; YMC n.d.). For example, the YMC is one of a number of MRAs that uses regulatory instruments, such as practice standards and policies, to communicate requirements for physicians intending to change their SOP or re-enter practice:

[Physicians who intend] to substantially change [their] medical practice by adding medical services which they have not provided on a frequent or continuous basis over the previous three (3) years ... must provide [satisfactory] documentary evidence ... attesting

to the acquisition of training, experience, and/or competence to perform the proposed change in medical services, and may be required to [satisfactorily] complete an assessment and training or retraining ... prior to initiating the proposed change in medical services. (YMC n.d.)

The YMC similarly stipulates that *[physicians intending] to return to medical practice after an absence or retirement of three (3) years or more*” must notify the Council, and, if returning to practice after this time period, *“must undergo a review ... and may be required to complete an assessment and retraining ... prior to returning to medical practice”* (YMC n.d.).

2.3.2 The Individual Practitioner – What Individual Physicians Can or Cannot Do

Predominantly, the documents refer to SOPs that emphasize what medical professionals are permitted or expected to do. Systems of registration, licensure and certification are used to discuss SOP by identifying or establishing professional boundaries in regards to conditions, restrictions, terms and limitations on one’s class of registration, licensure, specialty certification, certificates and practice (CFTA 2017; CPSM 2003; CPSNB n.d.-a; College of Physicians and Surgeons of Newfoundland and Labrador [CPSNL] 2015; CPSNS 2014; HPA AB 2000; Health Professions Act Regulations [HPAR AB] 2009; MA NB 1981; MA ON 1991; MA PEI 1988; Medical Practitioner’s Regulations [MPR NS] 2015; The Medical Profession Act 1981; RHPA ON 1991). For example, when discussing the functions and responsibilities of MRAs, the RHPA ON 1991 states that *“Council may make regulations ... prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class ...”* This includes *“refusing to issue a certificate to [applicants] or imposing terms, conditions or limitations on [certificates] of registration if ... such action is necessary to protect the public interest”* - i.e., if a member is deemed to be incapacitated, or as a result of complaints, criminal or disciplinary proceedings relating to an applicant’s or member’s competency, conduct

or character (RHPA ON 1991). These practice parameters are stated in terms of “*areas/fields/branches of medicine,*” “*areas of (clinical) practice,*” the range of services, procedures, tasks and treatments that can be provided, and geographic location (HPAR AB 2009; MA MB 2009; MA NL 2011; MA ON 1991; Medical Profession Regulations 2010; MPR NS 2015; RHPA ON 1991). Beyond legislation and professional regulations, parameters for practice are expanded upon in background papers published and commissioned by national certification bodies. For example, in their review of family medicine within rural and remote Canada, Bosco and Oandasan (2016) articulate that rural family physicians “*are more likely to ... perform a broader range of clinical procedures*” than their urban counterparts; are “*skilled to carry out both clinical and surgical procedures and tasks,*” and “*develop additional competencies, driven by community needs, in the absence of other specialists who would more traditionally provide needed services.*”

Additionally, geographic and regulatory specificity are used to discuss SOP by referring to what can be done by professionals licensed in a particular jurisdiction. This includes the activities in which one may engage, who can perform professional activities, and the circumstances in which professional activities are performed (CMPA and Health Insurance Reciprocal of Canada [CMPA-HIRC] 2007). Alternatively, circumstances, area(s) of specialization and practice considerations are used to discuss SOP by referring to what is ordinarily expected and typically done by a “*normal prudent practitioner*” of the same standing and experience within a given set of circumstances, area(s) of specialization and practice (CMPA 2008). Yet, there appear to be defined temporary and situational exceptions recognized by MRAs:

“In non-emergency situations, there are clear expectations around [SOP]...In a health emergency, federal, provincial and local emergency plans may call upon physicians to practice in an area of medicine in which they are not educated and experienced... Once the health emergency is over, the physician should no longer practice in the new area. (CPSS 2012)

Regulatory policies, guidelines, and practice standards outline specific contexts tied to specific geographic locations and circumstances – e.g., public health emergency or pandemic - that make it acceptable for physicians to act beyond their education and experience (CPSNL 2009; CPSNS 2010; CPSO 2009; CPSS 2012). However, it does not necessarily create an expectation that specialized care beyond one’s competence or expertise should be attempted. MRAs have established criteria for physicians to extend beyond their SOP in an emergency or other unforeseen circumstance: (1) the care needed must be urgent; (2) a more skilled or appropriate physician to address the situation is unavailable; (3) not providing care in a particular instance would result in worse consequences than providing it (CPSBC 2012; CPSNL 2009; CPSNS 2010; CPSO 2009; CPSS 2012).

Moreover, institutional, policy, regulatory, educational, credential and experience specificity are used to discuss SOP by referring to what licensed professionals are permitted to do in the institutions in which they work (CMPA-HIRC 2007). For example, documents pertaining to joint liability protection for physicians and midwives advise “[*familiarity*] with the [*SOP*] of each team member (e.g. midwife, family physician, obstetrician) in the jurisdiction and institution in which they work” (CMPA-HIRC 2007). Irrespective of where physicians practice, expectations of colleagues, patients and the public are also important considerations for professional conduct and what physicians should be able to do (Campbell et al. n.d.).

2.3.3 Practitioner-Specific Career Paths and Responses to Changing Health System

Realities

SOPs are also discussed with reference to the unique characteristics of one's practice – i.e., one's “*scope of employment*” (CMPA-HIRC 2007; CMPA 2008; CMPA and Canadian Nurses Protective Society 2013). Much emphasis is placed on professional, clinical and personal judgment pertaining to the limits and conditions of one's practice, competence and training; professional decision-making authority; responsibility and accountability for aspects of patient care delivery, and role in health outcomes (CMPA 2008; CMPA 2010). For example, documents that discuss expanding SOPs of health professions outside of medicine, collaborative health care delivery models, and medico-legal risk state that “*it is not straightforward to determine individual responsibility for outcomes*” because “*interprofessional practices ... involve multiple encounters, events and conditions treated by multiple professionals ... over many years*” (CMPA 2010). To begin to simplify complications arising from interprofessional practice, these documents prescribe clear communication in interprofessional health care settings to delineate “*roles and responsibility of each team member ... based on his or her [SOP] and the individual's knowledge, skill and ability*” and to understand “*how health care decisions will be made, and who is responsible and therefore accountable for health care delivery decisions*” (CMPA 2010).

Yet, physician practice characteristics and careers are not static. Similar to the characteristics of physician practices and careers, some documents view SOPs to be dynamic, transformative and fluid, changing or evolving throughout physician careers, with the health system, policy climate, profession and individual professionals over time. This flexibility is evidenced by an acknowledgement within continuing professional development (CPD) programs

of evolving skills, roles, activities and knowledge within medical specialties. For example, SOP is the third educational principle of the Royal College's Maintenance of Certification Program, which instructs that "*[l]earning activities must be relevant to the evolving knowledge and skills of a Fellow's specialty, professional roles and responsibilities, and areas of expertise*" (Federation of National Specialty Societies of Canada [FNSSC] n.d.). The words "*evolving,*" "*new,*" "*redesigned,*" "*expanded*" and "*limited*" to describe physician practices and SOPs appearing in such documents are viewed as reactions to health system pressures (CFPC 2014; CFPC 2015; Royal College 2013b; Royal College 2014) – such as "*health workforce shortages, increasing patient needs, scientific and technological discovery, personal interests and professional aspirations*" (Royal College 2013b). These words are also viewed to be anchored in, consistent with, and indicative of the level/extent of specialized competencies acquired through additional education and training, and a reflection of practice experience – i.e., the limits of one's clinical expertise (CFPC 2014; OCFP 2008; Royal College 2013a; Royal College 2014).

Within Ontario's medical regulatory framework, an individual physician's SOP is flexibly articulated as being determined by the patients one cares for, the procedures one performs, the treatments one provides and the environment(s) in which one practices at any and every point in one's career. A significant change in any of these elements constitutes a change in SOP, such as practising outside of one's discipline/switching specialties or relocating somewhere with a different health care system. A change in SOP also occurs when a physician returns to a SOP in which he or she has not practised for at least two consecutive years (CPSO 2015).

2.4 Discussion

Existing information in the literature and ‘institutions’ expressed in documents that govern physicians indicate multiple interpretations, descriptions, variations and meanings of SOP yet similar terminology, thereby making it difficult to determine what SOP means in the medical profession. Essentially, relevant stakeholders entrenched in their own policy agendas are talking about the same thing: what a physician is allowed to do versus what a physician should do. Until we understand and deconstruct the different lenses and perspectives from which stakeholder interpretations are derived, we will continue to experience much difficulty advancing SOP discourses.

Variations of SOP may be due to the fact that SOP and licensure criteria for the medical profession in Canada are not standardized (Cant et al. 2011; Chang 2014; Duffield et al. 2011; Kleinpell and Hudspeth 2013). This lack of standardization can be attributed to the provincial and territorial laws, regulations, licensure criteria and practice standards which govern physician practices (CMA 2015; Conference Board of Canada 2007; Constitution Act 1867; Royal College 2013b). Given that these acts of physician governance cross many policy areas and are in part siloed and geared toward different purposes makes a common conceptualization of SOP nearly impossible.

Inconsistent approaches to SOP within the profession may contribute to an inaccurate assumption that SOP means the same thing to all actors within medicine irrespective of the purposes of stakeholders, policy arenas, and associated organizational silos and constraints. Perhaps SOP is not and cannot be a singular term, but rather would be more fruitfully understood as a complex, multifaceted idea belonging to and intersecting many policy realms. Moreover, to understand what the term SOP is doing, we cannot think of it as having some common meaning

across all contexts but have to examine the policy context in which SOP is used to clarify what aspect SOP is actually being discussed. Depending on the policy context from which one operates, the elements and associated concepts of this term will differ.

Regulatory statutes traditionally grant medicine the broadest health professional SOP (The National Council of State Boards of Nursing 2009) to encompass most aspects of treatment and care (Goldman and Schafger 2011). In Ontario, physicians have access to nearly all controlled acts under the *RHPA ON* (1991). Provincial medical legislation predominantly refers to the requirement of physicians to practise in the areas of medicine in which they are “*educated and experienced*” (MA ON 1991; MA QC 1997; Medical Professions Act 2000; RHPA ON 1991). With few exceptions, descriptions of SOP, and what constitutes a change in SOP, are either ambiguous or omitted from provincial medical legislation. Alternatively, the term SOP is frequently mentioned in other professional documents, reports and policy statements in the Ontario context. Yet, as stated above, consistent uses, descriptions, interpretations and evaluations of this term are seldom found (Hanover Research 2010; Shimoni and Barrington 2012; White et al. 2008). The term SOP in policy documents typically refers to processes, procedures, professional roles, functions, tasks, responsibilities, activities, services and competencies one is authorized, educated and competent to perform by virtue of holding a license, certification or registration (CMA 2001; CMA, CNA and Canadian Pharmacists Association 2003; CNA 2015; College of Registered Nurses of British Columbia 2013; HFO 2007; HPRAC 2015; Ries 2016; Salte 2015). Policy documents also tend to use tasks and roles to describe professional practice which become quickly outdated. Technological advancements and changes in medical knowledge (CMPA 2012; Caulfield et al. 2002), health system realities, delivery, patient and community needs (Nelson et al. 2014), and resulting regulatory and policy

responses directly determine professional competencies and the ability to achieve them. For instance, certain medical procedures formerly performed by one type of specialist are increasingly being performed by others or other health professionals (Battershill 1994). Training and education may not always keep pace with these advances and changes. Education must develop in tandem with policy changes for physicians to attain these changing competencies.

SOP discussions cannot be had in isolation within individual policy arenas without impacting what others in the profession are doing. Policy arenas, or SOP discussions conducted therein, need to be bridged if possible. Policies made in isolation are inevitably going to cause issues and tensions. Several tensions associated with SOP and medical regulation emerged from the themes found in our analysis. The first tension considers the normative and descriptive aspects of SOP. That is, what ought to be permitted within SOP – i.e., what is permissible or what physicians should be able to do – vis-à-vis what is permitted within SOP and what physicians actually do in practice. There is a distinction between what a medical license technically permits for SOPs within a jurisdiction and the clinical activities or responsibilities physicians may assume, and SOPs that are legislated, regulated or dictated by policies for individual physicians and by the institutions in which they work. Inherent in the former is a questionable implication that a practitioner can possess the breadth of knowledge, competencies and skills within medicine. A medical license represents the upper limits of what all practitioners trained within particular specialties may or should know how to do in practice. The former may be mistaken for the latter. Legislation, regulation and policies are indicative of what practitioners arguably should, actually can and are permitted to do in practice. Essentially, the SOP for an individual practitioner represents a subset of the profession's larger SOP (HPRAC 2015), and

while individual physicians are permitted to do certain things in practice, it does not necessarily mean they should.

The second tension we found addresses the flexibility vs. specificity of SOP statements and the question of how much and how little flexibility and specificity are needed. Concerns expressed by the profession to the CPSO's consultation on defined scope certificates identify the need for flexibility in SOP statements (CPSO 2013a; CPSO 2013b). Increased specificity potentially discounts individual physician practice realities, personal interests or career aspirations, and/or population and patient needs. It may also inadvertently conflict with regulatory policies, other documents and the types of SOP identified therein, as well as pit types of SOP against each other. For example, specificity may conflict with policies providing for unique circumstances where physicians may be called upon to provide care, or account for emergencies or instances outside of one's typical practice situation which are potentially compromised if physician practices are constrained in an emergency or pandemic (CPSO 2013a).

Alternatively, some feedback expressed in the CPSO's more recent consultation on SOP advocates for more specificity in SOP statements for the public's interest, patient safety, and safe, competent physician practices (CPSO 2016b). The need for adequate education, training and CPD was expressed for some aspects of practice – e.g., chronic and interventional pain management, methadone prescribing, psychotherapy, dermatology, the performance of cosmetic procedures. There were also reservations about the impact that over-credentialing has on the ability of primary care and family physicians to contribute to patient care (CPSO 2016b), as having the credential does not necessarily guarantee competence based on the way that some CPD is structured – e.g., online course, minimal instruction and/or patient interaction. Continuous changes in the medical profession, throughout physician careers, and in

the evolution of how SOP is understood require more clear and precise expressions to assist physicians and regulatory authorities in structuring their CPD, remediation and assessment strategies. Arguably, SOP is the perspective upon which CPD and these strategies should be based (Federation of Medical Regulatory Authorities of Canada 2015; FNSSC n.d.).

The third tension focuses on professional autonomy and discretion vs. professional accountability and reflects a broader tension between the rights and obligations of physicians and the responsibilities of medical regulators to the public. This consists of the legal and constitutional rights inherent in sections 2 and 6 of the *Canadian Charter of Rights and Freedoms* (1982) and mandated self-regulation (RHPA ON 1991) of physicians that afford to them control over the content of care with restrictions – a monopoly to provide or not provide certain services (Charo 2005; Wicclair 2008), as well as the contexts and conditions in which they provide medical care – i.e., how and where one practices (Lomas and Barer 1986). These rights are balanced with the profession’s obligation to provide appropriate, quality health services by competent practitioners (MOHLTC ON 2012) where and when they are needed, and to fulfill its social contract with society as part of the privilege of self-regulation (CPSO 2008b; Cruess and Cruess 2000; Cruess 2006; Cruess and Cruess 2008; Klass 2007; O’Reilly 2000; Starr 1982; Wynia 2008). Regulators have the difficult challenge of balancing the idiosyncratic practice choices of their memberships to have SOPs with varying degrees of breadth and focus based on personal interests, career goals, or to respond to patient and community need (CFPC 2014; CFPC 2015), and its obligations to the public when the SOP assumed by physicians may not be what is needed in the locations they choose to practice and by the patients and populations to whom they provide services.

Achieving greater clarity and precision about the discussions and use of SOP within regulatory documents is important because the medical profession and individual practitioners may hold different views about SOP (Melnick et al. 2002). Differing perspectives may reflect the fact that medical certificates and rotating internships technically entitle physicians to practise across the breadth of the medical profession and that physicians' SOPs are not necessarily consistent with their training and specialty certification; physicians have potentially different SOPs despite possessing similar education and credentials (Grzybowski et al. 2013; Hutton-Czapski 2013; Smith and Hays 2004; Wong and Stewart 2010). A disconnect potentially exists between what is explicitly stated in regulation and what is inferred yet expected to be known. Physicians are entrusted to use their best professional judgment regarding how they practise within their specialty and to practise accordingly (CPSO 2012b). This might result in a difference of opinion between what physicians think they are prepared to do and what regulatory authorities expect them to do.

For example, more clarity and precision in articulations of the policy context in which SOP is used would greatly assist with physician labour mobility mandated by *CFTA* (2017) and supported by the *Ontario Labour Mobility Act* ([OLMA] 2009). In this context, the purpose of these statutes is to eliminate or reduce measures created or implemented by MRAs that restrict the ability of physicians who are licensed in another Canadian jurisdiction to become licensed in Ontario (OLMA 2009). A quandary materializes if physicians migrate between or locum in a province with an articulated description of SOP – such as Ontario – and/or a jurisdiction with no stated description – such as the Northwest Territories (North West Territories Department of Health and Social Services n.d.). Professional judgment based on one's understanding of SOP from another jurisdiction or legal and regulatory environment could result in liability or patient

care concerns if there are inconsistencies between regulatory expectations and what individual physicians think they can do – vs. what they can actually do competently. This distinction is important given that all CPD programs aimed to ensure ongoing competence and performance depend on the ability of physicians to identify their strengths and weaknesses, and that physicians generally perform poorly when self-assessing their abilities and competency (Davis et al. 2006; Eva and Regehr 2008; Mann et al. 2011).

It is important for regulators to critically evaluate their internal structures and regulatory instruments pertaining to SOP as there might be a greater cost both to the profession and the public for not doing so (Wenghofer 2015). As part of the privilege of self-regulation (Klass 2007; Morris and Clarke 2011; O'Reilly 2000), the medical profession has a responsibility to maintain societal trust and uphold its social contract (CMA 2005; CMA n.d.-b; Freidson 1989; Shah 2003). Should the terms of this social contract not be met, the profession invites the possibility of direct regulation by another entity for failure to conduct quality assurance on itself. It is important that medical regulators understand what they are regulating, monitoring and evaluating as it pertains to SOP so that they implement policies and programs their memberships can identify with and find meaningful (American Board of Internal Medicine 2015).

There are a number of limitations to this study. As with any document analysis, there is potential for researcher bias in the documents and analysis strategies selected. The exclusion of a number of government ministry documents which have jurisdiction over how SOP is applied, such as a majority of documents from HealthForceOntario and the OHIP Schedule of Benefits and Fees, is a limitation. Documents and themes were deliberately selected to investigate the intricacies of SOP as it pertains to specific aspects of physician governance. As was previously stated, we wanted to focus on the medical profession and self-regulatory functions that have

jurisdiction over SOP. Second, there is potential for information bias due to the literature and document inclusion criteria, and the availability, survival, currency and content contained in the documents selected for analysis. Third, there are national disparities in physician SOP data due to how SOP is monitored, documented, evaluated and governed. As such, this discussion may have limited applicability outside of Ontario. However, jurisdictional differences within each province are equally complicated. Similar tensions are likely to be found to greater or lesser degree in other jurisdictions so although the specifics may vary, we believe the findings to be generally applicable. Fourth, the focus on medicine potentially limits the generalizability of the results to other professions. We acknowledge that it would not be possible to do justice within medicine without exploring boundary issues among professions; inter- and intraprofessional conflicts appear differently. Yet, there is no reason to think that the type of tension structure identified within medicine is not similar to those experienced within and between professions. Future research may replicate this study to look at other jurisdictions and health professions to see how these tensions and results compare with those of other populations.

Despite these limitations, this study provides insights into the various meanings and properties associated with current uses of SOP which may initiate much-needed policy discussions among stakeholders who currently determine the SOP of physicians at the local policy level, and encourage more consistent and precise terminology for SOP at the national policy level (Baranek 2005; Cant et al. 2011; Duffield et al. 2011; Kirby and LeBreton 2002; Kleinpell and Hudspeth 2013; Lobb 2015). Also, this study organizes different meanings of SOP and their associated properties with the potential to include new and emerging forms of SOP. Additionally, this study identifies tensions within regulation of which to be mindful when devising SOP statements. Moreover, this study highlights issues for MRAs to consider when

addressing and using the term SOP within their regulatory frameworks, as well as the importance of identifying and clarifying the policy context or parts of SOP being discussed. Contributing to a better understanding of SOP and to a clearer understanding of related policy issues may ultimately lead to better policy-decision making.

Future research is needed to investigate non-clinical or non-procedural activities and non-traditional work settings that are largely absent from existing discussions around SOP. This gap in the literature does not permit us to capture a complete picture of physician SOP and potentially leaves segments of the physician population under-represented and under studied. Future inquiries can also focus on producing more qualitative evidence to examine current understandings of physician SOP via key informant interviews with stakeholder organizations across the spectrum of medical regulation that offer interpretations or descriptions of SOP. Such discussions can elaborate upon information and perspectives contained in outdated or existing documents, address items not included, the reasons for those omissions and upcoming or in process initiatives. Crucially and compellingly, prevalent interpretations of and statements about SOP found in the literature are not necessarily synonymous with how physicians, individually or collectively, think about and view SOP. Absent from numerous inquiries about, or related to, the SOP of physicians are investigations into how physicians think about their own SOPs. These investigations may focus on a subset of the physician population, specifically family physicians and general practitioners. As family medicine is likely the broadest primary care specialty, and repercussions and concerns for the SOP and practice patterns of family physicians were identified in the feedback for the CPSO's recent public consultations on SOP (CPSO 2012a; CPSO 2013a; CPSO 2016b), conducting focus groups and interviews with these physicians would be a viable point of departure to further understand SOP within the medical profession.

Furthermore, given the profession's mandate to regulate in the public's interest, and the role of the public as consumers of health services, public and patient expectations regarding what they want or think physicians should be able to do (Melnick et al. 2002) further complicate this issue and may potentially generate additional interpretations of, and concepts associated with, SOP.

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Chapter 3: Organizational Stakeholder Perspectives on Physician Scope of Practice in Ontario

Abstract

Scope of practice (SOP) refers to what health professionals are able and authorized to do in their professional capacity in a particular jurisdiction. SOP has different meanings across the medical profession and is used differently in different policy contexts. Moreover, despite increasing discussion about SOP within the medical profession, the factors, drivers, determinants and elements that influence SOP across policy fields in medicine remain elusive. To address this knowledge gap, this study identifies different ways that physician SOP is understood and/or operationalized by different stakeholder and policy-forming groups, and to identify perspectives on what is involved in SOP. Using a qualitative descriptive study design and incorporating constructivist grounded theory data collection and analysis techniques, ten semi-structured interviews in total were conducted with representatives of medical regulators, educators, certification bodies, professional advocates and organizations concerned with health workforce planning in the Canadian province of Ontario.

Findings indicated that despite variation in how the concept is used, there is a convergence of opinion regarding what drives SOP. Policy discourses about SOP within medicine generally focus on what physicians do in practice, which is influenced by three prevalent factors: education and training, the practice environment, and legislation and regulation. These factors can serve as a starting point or common framework from which to have SOP discussions. The medical profession encounters numerous challenges associated with SOP – e.g. significant practice and SOP differences in different practice environments, practice drift – as it struggles to

operationalize this concept. Organizational stakeholders across policy perspectives are discussing nuanced differences about SOP. Essentially, they are talking about different aspects of the same thing. One of the implications from this study is that the medical profession needs to shift how it approaches and implements SOP policies, initiatives and programming, not least because policy fields in medicine are so interconnected. These SOP discussions cannot be had in isolation. Stakeholders must determine how to collaborate within and among organizations to clarify and, where possible, normalize their articulations of SOP to establish a more coherent professional discourse around this concept.

3.1 Introduction

The term scope of practice (SOP) has become increasingly important in Canadian healthcare systems (Baranek 2005; Lobb 2015; Nelson et al. 2014) as it articulates what health professionals are able and authorized to do in their professional capacity in a particular jurisdiction.²² SOP is a key concept in health care as reflected in health professional SOP reviews (Health Professions Regulatory Advisory Council 2015), and political discussions about the inconsistency between legislated and regulated SOP, and the ability of health professionals to practice to their full SOP (Legislative Assembly of Ontario 2016). The medical profession traditionally has had the broadest SOP (The National Council of State Boards of Nursing 2009) and greatest professional autonomy (Wenghofer and Kam 2017) compared to other health professions. These features make medicine an especially illuminating starting point to further contemplate this concept. Accordingly, we focused on medicine in this study.

²² Please see the introduction and results sections of chapter 2 in this thesis.

Despite increasing discussion about SOP within the medical profession (Canadian Medical Protective Association [CMPA] 2010; College of Family Physicians of Canada [CFPC] 2015; College of Physicians and Surgeons of Ontario [CPSO] 2013a; CPSO 2013b; CPSO 2016; Royal College of Physicians and Surgeons of Canada [Royal College] 2013a; Royal College 2013b) and in the literature (Beaulieu-Volk 2015; Coutinho et al. 2015; Grondin et al. 2013; Ie et al. 2015; O’Neill et al. 2014; Risso-Gill et al. 2014; Skariah et al. 2017; Wong and Stewart 2010), there is still a lack of clarity as to what factors, drivers, determinants and elements influence SOP across policy fields within medicine. Comprehending the variety of ways in which SOP is approached in different policy contexts should enable a more coherent and integrated dialogue across different policy and programming initiatives.

We previously examined how SOP has been discussed and used in medical regulatory documents, including legislation and documents produced by medical regulators, certification bodies and medico-legal liability associations.²³ We found that SOP has inconsistent meanings both within the medical profession and in different policy contexts. The current study, also conducted in the context of the Canadian province of Ontario, builds on this previous work to explore how different stakeholder and policy-forming groups in the province understand and operationalize physician SOP. The study question was: “how do stakeholders representing various policy fields in medicine understand and operationalize factors, drivers, determinants and elements that shape, limit and influence physician SOP and changes in SOP in the Province of Ontario?”²⁴

²³ Please see the discussion section of chapter 2 in this thesis.

²⁴ The constituent components (i.e., key words and phrases) of this question reflect six questions asked of participants in each interview. Please see interview guide (Appendix E) in this thesis.

To address the aforementioned knowledge gap, this study included stakeholders from a range of policy and organizational contexts to explore their perspectives on SOP. We focused on stakeholders from various ‘policy fields’ within medicine including physician regulation, education, certification, professional advocacy, and health workforce planning.

3.2 Methods and Methodology

3.2.1 Study Approach

An exploration of the different factors, drivers, determinants and elements of how SOP is understood requires a methodology that can account for the contextually variant meaning of SOP in different organizations and policy fields.²⁵ We used a qualitative descriptive (QD) study design to examine, unpack and describe SOP and its components (Sandelowski 2000). QD offers a comprehensive summary of a phenomenon or event of interest. This approach seeks *descriptive validity* or an accurate account that most individuals (participants and researchers included) observing the same phenomenon would agree on. It also seeks *interpretative validity* or an account of the agreed upon meanings participants attribute to a phenomenon (Maxwell 1992). QD has been used to examine phenomena related to health care (Polit and Beck 2009, 2014), to gain insights from informants about a phenomenon that is poorly understood, and when a description of a phenomenon is sought (Kim et al. 2017; Neergaard et al. 2009; Sandelowski 2000; Sullivan-Bolyai et al. 2005).

QD study designs typically incorporate sampling, data collection and analysis techniques (Sandelowski 2000). We used techniques from constructivist grounded theory (Charmaz 2006) to guide the data collection and analysis (Kennedy and Lingard 2006) although we were not

²⁵ Please see the discussion section of chapter 2 in this thesis.

looking to generate theory from this study. Data was analyzed as it was collected so emerging findings could inform subsequent data collection and analysis. Inductive line-by-line coding was used to analyze the transcripts from which broader groups of codes and themes were identified. Comparisons within or between cases and over time were made during the analysis to find variations and patterns in the data (Hutchinson et al. 2011). The data collection and analysis procedures below were developed by SM and EW, and then discussed with RE and MY who contributed further refinements to the decisions within each step.

3.2.2 Rationale for Participant Selection

Healthcare falls under provincial jurisdiction in Canada (Lavis and Mattison 2016; Lazar 2013; Martin 2017). However, provincial health systems are influenced by, and reflective of, national statutes such as the *Canada Health Act* (1984) and *Canadian Free Trade Agreement* (2017). Provincial legislation, such as the *Regulated Health Professions Act [RHPA]* (1991) and the *Medicine Act* (1991) as well as physician practice standards (CPSO 2015) must be drafted, implemented and amended according to relevant national statutes. Although physicians take national exams to be eligible to receive medical licenses in Canada, medical licenses are administered provincially. Physician practice standards are also province-specific. A mix of national and provincial organizations participating in this study reflects the national and provincial influences on the health system and policies governing Canadian- and Ontario-practising physicians.

In reference to the stakeholders and policy fields mentioned above, we wanted to focus on the medical profession and specific aspects of governance and medical regulation. As medicine is self-regulated, we focused on aspects of regulation that govern the confines of physician practice (i.e., restrict what physicians can do). Given our focus on the profession itself and

specific policy areas within the profession, we included organizations which have jurisdiction over SOP and how SOP is regulated, as well as organizations that influence how these organizations regulate and implement SOP. We excluded government ministry agencies (e.g. Ontario Health Insurance Plan [OHIP], HealthForceOntario) which have jurisdiction over how SOP is applied by virtue of their mandates.

3.2.3 Data Collection and Procedure: Study Population, Sample Size and Strategy

Purposive, convenience and snowball sampling were used to identify potential participants with experience and expertise working with physician SOP from undergraduate medical education through to independent practice representing: (i) health workforce planning; (ii) medical regulatory authorities and associations; (iii) national certification bodies; (iv) medical schools and associations for medical education; and (v) professional medical associations relevant to Ontario. Our recruitment strategy aimed to yield two participants per area to generate a balanced and evidence-informed understanding of SOP from these five policy fields in medicine. Potential participants were invited to participate in semi-structured interviews either in person or over the phone. They were electronically sent a cover letter, an informed consent form and a letter of endorsement from the CFPC.

The interviews were conducted by SM. The interviews ranged from ten to sixty minutes. Participants were asked a common set of six open-ended questions about organizational understandings, operationalizations, drivers and determinants of SOP as well as changes in SOP. Additional probing and follow-up questions were asked (Appendix E). Interview questions were created by SM and subsequently reviewed, edited and finalized by the research team. All interviews were audio recorded and transcribed verbatim by a transcription service. Notes were taken during the interviews with additional memos (Charmaz 2006) and field notes (Charmaz

2006; Holtslander 2007; Russell Henderson 2009) made after each interview to capture immediate thoughts about the discussion. To ensure confidentiality, participants were assigned a unique code corresponding with their interview transcript, recordings and notes. To further preserve participant confidentiality, we do not identify whose comments and observations we have quoted in this study.

3.2.4 Data Analysis

Our analysis focused on the differences of perspectives across organizational stakeholders and policy fields about SOP rather than the distinct perspectives of individual organizations or policy fields. All interview recordings and transcripts were analyzed by SM and discussed with EW. SM categorized the data through discussions with EW. Additional notes and memos were made, expanded on and compared with the memos and field notes made during data collection. SM continuously compared, analyzed, coded and grouped the transcript content on multiple levels (Charmaz 2006) to combine the categories, concepts and meanings ascribed to them related to SOP (Holtslander 2007). During initial coding, the data was studied line by line to devise categories and concepts. Initial codes were generated using participants' own responses to label words, lines, or sections of the data, which allowed us to identify themes that could be investigated further (Charmaz 2006; Holtslander 2007; Russell Henderson 2009). During focused coding, the most frequent initial codes were identified, sorted, combined and organized (Charmaz 2006). Focused codes were generated into categories and incidents – the indicators of a category or concept (Holton 2007) – and subsequently, further developed, refined (Holtslander 2007) and grouped. During theoretical coding, the focused codes were analyzed, paying particular attention to how concepts and categories related to one another. The focused coding process creates the relationship between the codes and themes generated in the analysis. During

focused coding, codes and concepts established in initial coding are organized into higher level categories. Theoretical coding enables the saturation of core categories identified during focused coding. Core categories represent themes in the analysis (Alemu et al. 2015). A member check with participants was conducted by email and over the phone to ensure the accuracy of themes and sub-themes generated from the analysis. Participants had the opportunity to add, amend, clarify or retract any statements from their transcripts.

3.3 Results

Ten interviews in total were conducted with organizational stakeholders from regulatory organizations (the Federation of Medical Regulatory Authorities of Canada and the College of Physicians and Surgeons of Ontario); educational organizations (the Association of Faculties of Medicine of Canada and the Northern Ontario School of Medicine); certification bodies (the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada); professional associations (the Canadian Medical Association and the Ontario Medical Association); and a health workforce planning organization (the Canadian Health Workforce Network [CHWN]).

Broadly, participants discussed SOP in terms of “*what physicians do.*” Despite the differences in their organizational mandates, we found convergence of opinions across the diverse participants. We organized participant responses around three main themes: (1) education and training; (2) the practice environment; and (3) legislation and regulation. Although participants addressed different aspects of these themes, we did not detect overt contradictions or disagreement between participant statements, only different perspectives on common issues. For example, when discussing education and training, some participant statements mentioned

generalism in medical specialties and physician training and practice (i.e., a need for more broadly skilled practitioners throughout the profession), while other participant statements focused on specialization in this regard – i.e., specialization as a natural occurrence commensurate with physicians’ expertise. Similarly, some participant statements mentioned a broad(ening of) SOP, while other participant statements mentioned a narrow(ing of) SOP – e.g., practice drift due to career stage, professional exposures, level of interest or comfort of physicians to incorporate certain aspects of care within their practice. Either way, they acknowledge that there are associated issues with both generalism and specialization in specialties, training and practice, as well as with the broadening and narrowing of SOP. These themes are summarized in Table 3.1.

Table 3.1: Themes and Sub-Themes Related to Organizational Stakeholder Understandings, Operationalizations, Factors, Drivers, Determinants and Elements that Shape, Limit and Influence SOP and Changes in SOP

Education and Training	Practice Environment	Legislation and Regulation
Stage in educational pipeline or career Specialty certification Minimum standards, core competencies or proficiencies Broad/generalism vs. Narrow/specialized – (i) training continuum; (ii) SOP of individual physician practices; (iii) range of service provision and SOP within specialties	Geography (and what happens in practice) – (i) rural vs. urban vs. North vs. South; (ii) relevance to/meeting societal, population, patient or community needs (e.g. broad or expanded vs. narrow or specialized practice); (iii) composition of health workforce and available professional supports (e.g. interprofessional collaboration, teamwork, task shifting, professional boundaries) Health systems as part of the practice environment within	Reactions to external factors or top down decisions (e.g. court decisions) Self regulation, professional/clinical autonomy, practice self-limitation Individual practice profile, career progression or path Policy – (i) range of activities providers are authorized to perform; (ii) services offered by discipline/fields of medicine; (iii) specialty certification, registration, qualifications and practice

	which practices are situated, by which care is delivered and financed – (i) health workforce planning; (ii) care delivery and payment models, referral patterns, workload within the profession (i.e., physician SOP vs. SOP of various disciplines within medicine and other professionals); (iii) incentives/funding, technology, medical advances	restrictions/limitations Demonstrated current competence/competency in practice Physician SOP (generally) vs. SOP of various disciplines within medicine and other professionals
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3.3.1 Education and Training

Participants identified education and training as “*underlying elements*” (Interview 6) of SOP. More specifically, education and training influences corresponded with “*breadth of training at pivotal moments*” (Interview 9). Undergraduate medical education covers the scope of the profession – broad; residency training covers the scope of the specialty – still broad yet begins to narrow; fellowship training is more specialized and covers the scope of the subspecialty – narrow; and continuing professional development (CPD) allows individual physicians to maintain and add specific skills and knowledge to their practices throughout their careers. Participants indicated that CPD is required to maintain practice and SOP, that CPD should be tailored to look at different practice outcomes over time or as practices change, and that collection of more data during the CPD phase of physician careers will help to more precisely determine the SOP of practitioners.

Participants commented on the inclination of physicians to incorporate specific aspects of care within their SOP based on the areas in which physicians receive training and practice, and the length of time since they have been exposed to or performed certain activities. Several

participants cited the management of labour and delivery to highlight how a physician's level of comfort might impact their willingness to do certain tasks on a daily basis. For instance, a physician who trained thirty years ago "*to do an attendance at childbirth [but] has not attended a mother in labour for the past thirty years*" may not feel comfortable despite that competency falling within their SOP (Interview 10):

[P]hysicians have a broad SOP ... [they] may have been trained to do [x, y, z ... but they haven't done that, so they don't feel ... comfortable doing that. And I think we need to recognize that. Physicians have a broad scope, but they narrow that depending on their level of interest ... what stage they are in their career ... that kind of thing. (Interview 10)

Another factor shaping SOP is the level of confidence physicians feel about what they do in practice throughout their careers; "*[t]he biggest thing is that there's an expectation that [physicians are] only going to practice in areas where they feel confident that they are providing the best care possible*" (Interview 2). Participants discussed the ways in which SOP changes based on the level of a physician's expertise. Over time, a physician's SOP may expand or shift, "*people deepen, broaden, and to some extent specialize within the scope*" (Interview 4). Participants acknowledged that practice and SOP changes over the course of physician careers, stating that "*physicians have always drifted in their practices*" (Interview 1), and that what physicians do, and what they do not do, may change over time. For example, SOP may change because: (1) a physician becomes more experienced; (2) the nature of medicine changes – due to advances in knowledge or technology, or changes in health policy resulting from legislative, political, or judicial decisions; (3) financial or economic incentives to practise a certain way; (4) a physician moves to a new context; (5) a physician chooses or is obligated to shift his/her practice to meet patient needs or fulfill personal interests; or (6) a physician changes practice contexts *and* is required to meet patient needs or to fulfill personal interests.

Participants were uncertain, and thought others throughout the profession were also uncertain, about the minimum standards, core competencies or proficiencies that should be maintained by all physicians and those in particular specialties. Physician practices can drastically differ even within a single specialty; “*we have some [13,000] family doctors in the province with very few of them doing the same thing. Very few of them [have] the same interests in terms of how they want to see the system unfold to support their needs*” (Interview 6). Many participants identified a need to establish a common base or core of “*what it means to be [this type of] doc*” (Interview 2), for “*anyone with a [medical license to] be able to perform CPR regardless of SOP [or specialty certification]*” (Interview 4), or to enable “*all physicians ... across all settings [to] do X*” (Interview 10). There are competing trends of “*narrowing of SOP or sub-specialization*” (Interview 8) and a push for expanding SOP through generalism in physician training and practices. Participants perceived a need for more broadly skilled practitioners in all specialties “*and the importance in valuing generalism*” (Interview 8). This included a perceived need for a degree of generalism amongst specialists to take general call or core schedules in various specialties in hospitals, and for physician specialties across the profession to maintain broader scopes of practice (SOPs) for longer durations before specializing.

Participants discussed the recent transition from time- and rotation-based curricula towards competency-based curricula – e.g., Triple C, Competence by Design – as a way for physicians to achieve and maintain core competencies acquired in training through to independent practice to ensure competence for their SOP. They also stressed the need to stop treating education as a once and done, single point in time, endeavour:

So, you've taken your education, you're done, you know you're good for life ... And that's like so incredibly wrong, like there have to be things that you need to maintain your competencies in, so that again we can say all doctors can do X ... I mean we have to move away from inoculation. (Interview 10)

The competencies physicians must attain to begin their careers are determined by the specialties in which they become certified – i.e., a broad ‘set menu’ of competencies. These may differ from the competencies physicians must maintain or attain for their SOP throughout their careers – i.e., has no ‘set menu’ of competencies. The extent to which competencies for practice and SOP are narrower compared to those for education depend in part on the practice setting. For instance, the competencies some physicians attain during their residency training may not be broad enough for their SOP if they become rural, remote, or northern practitioners. The challenge for physicians in independent practice when retraining – e.g., CPD – is to focus on the things they are most likely to encounter in practice while maintaining working competencies for things they rarely see in practice. This is particularly important for comprehensive generalists, such as family physicians, who provide a broad range of services. Participants highlighted the importance of clearly articulated core education and training expectations for regulatory and educational purposes. These expectations must concurrently respond to the environments in which physicians practise, and within this, to changing patient, community and population health needs.

3.3.2 Practice Environment

Practice context is a key determinant of SOP. For instance, participants distinguished between practice experiences of rural- and urban-based physicians, “*an urban doctor would have a very different experience with patient care than a rural physician would*” (Interview 6). A number of participants observed that rural practitioners tend to have a broader SOP than their urban counterparts because of the areas of practice and skill sets – e.g., emergency medicine,

obstetrical deliveries, surgical assisting, anaesthesia – they need to incorporate into their practice. Additionally, participants distinguished between the practice experiences, required skill sets and SOP of physicians within a single specialty practising in different environments:

[I]f ... a family doctor who has trained in family medicine ... spent [their] entire career working [in] an academic urban environment where [they didn't have] admitting privileges to a hospital, and [their] practice [primarily consisted of] patients in an ambulatory non-acute setting [relocates to a rural northern environment] ... [they're] still practicing family medicine, [but] the [patients and problems they see] might be quite different ... working in that environment would require a different skill set ... to be more in tuned with the local resources. (Interview 2)

These observations speak to the need for physicians to acquire and adapt their expertise, competencies and SOP based on the requirements of the practice setting/environment, such as available professional supports and resources – i.e., composition of health professionals and associated expertise – as well as to respond to emergent population, patient and community needs and expectations.

Participants identified a responsibility for the profession to ensure that the right services and appropriate care are provided where they are needed, and to expand health workforce capacity to meet population and community needs and expectations. For multiple participants, the key is “*not to have a sort of fixed, predetermined notion of what the [SOP] for a particular physician ... would be*” (Interview 8). Particular communities may require more narrow or focused practices, such as sub-specialization, or broader or expanded SOPs. This may mean providing enhanced mental health, emergency, surgical or disease services in some contexts but not in others. Community needs and expectations of their physicians – individually and collectively – influence their SOP and the CPD they undertake.

Participants acknowledged that interprofessional collaboration, teamwork and perceptions of professional boundaries within different practice contexts influences the SOP of physicians;

“as scopes change not only for physicians, but for other health professionals, it’s important for physicians and physicians in training to understand the scopes of various disciplines and other health professionals” (Interview 7). Exposure to team learning and context-specific healthcare team environments early in medical education was noted as facilitating shared workloads and blurring the boundaries between health professionals in some settings. Such observations led to discussion of SOP and task shifting in the practice environment. Task shifting is an area where health policy makers and practitioners need to understand the abilities, competencies and training of other health professionals. For instance:

[There could be] an inappropriate transfer of tasks to a healthcare provider ... that doesn't have the competency. Or that competency isn't particularly well understood by those who are making decisions about who to designate or allocate those tasks towards ... [Practitioners] may have had minimal training in some of the tasks that have been delegated or transferred to them. [T]hat can be inappropriate ... we should ensure that there isn't the inappropriate transfer of tasks to health workers who do not have the competency to do those tasks ... That's where you get into unintended consequences.
(Interview 10)

Task shifting presents an opportunity for policy makers and physicians to relearn relationships – i.e., who does what – within the healthcare system. In doing so, they can concurrently address the apparent “*insufficient understanding and knowledge*” (Interview 6) of the different SOP and abilities of different providers such that when a professional group attains more responsibility everyone in the practice environment can better understand what this means. For instance, as health professionals’ SOP change, so too do their professional workflows and workloads; care pathways, referral patterns and billing opportunities; and care delivery models, all of which can further alter their SOP. Achieving a shared understanding of health professional abilities and competencies can potentially enhance confidence and relationships between healthcare providers. This can, in turn, increase understanding of the opportunities among them where they

practice, and it can assist policy makers with health workforce planning within the healthcare system.

SOP is impacted not only by what happens in the practice environment but also by the broader health system within which physicians are situated and through which care is delivered and financed. Participants identified that stakeholders within medicine at times struggle to have “*informed, collective*” conversations regarding SOP (Interview 9). Such conversations can assist organizational stakeholders to identify the actual SOPs of physicians throughout their careers for improved demand and supply side health workforce planning. For example, information shared during these exchanges can be used to determine the extent to which a flexible workforce is needed, or differentiate the SOP required within a given specialty in a particular location. Stakeholder collaboration and interaction can ensure that changes made to SOP are relevant for changing societal, population and community needs.

Furthermore, SOP is shaped by how physicians are “*recognized and rewarded for the services they provide*” (Interview 8):

It may be rewarding to operate at the top of one’s license or low in one’s SOP. [It may be] less challenging ... less rewarding in a professional sense, but maybe quite financially rewarding to actually operate quite low in the [SOP]. Self-employed physicians have more independence, yet, financial rewards with practicing one way (versus another) tend to shape nature of the practice and one’s associated [SOP]. (Interview 8)

Incentives and premium payments in physician service agreements are used to influence patterns of health care delivery and service capacity – i.e., for physicians to emphasize specific aspects of their SOP – to address particular areas of need – e.g., diabetics. Related to physician compensation is the range of services associated with particular disciplines and associated payment and care delivery models. Such structures allow physicians to apply their skills and services in areas that correspond with their “*best abilities*” or “*areas of interest*” (Interview 6).

They also outline certain obligations for care delivery – e.g., service areas – within particular practice environments and structures – e.g., family health team or organization. Yet, they do not necessarily remunerate for challenges or differences physicians experience providing patient care throughout the province. The SOP physicians assume is in part a consequence of what and how physicians can bill for the services they provide. Billing numbers are tied to a physician’s medical specialty. Mechanisms, such as the Focused Practice Designation Program, have been negotiated between the CPSO and OMA to allow physicians in the process of changing their SOP — or that possess additional competencies outside their specialty certification who acquire designations under this program — to receive payment and referrals for services provided. For example, if a physician certified in orthopaedic surgery is switching to family medicine, this physician will be able to receive payment for services attached to family medicine billing codes he or she provides during this professional transition. Similarly, family physicians who are registered in this program with experience in obstetrics may receive referrals to deliver babies.

3.3.3 Legislation and Regulation

SOP is impacted by what regulators say physicians can and cannot do, as well as what is included and excluded from the profession as defined by legislation, political or judicial decisions. Participants identified recent decisions about medical aid in dying and medicinal marijuana as procedural evolutions in practice – i.e., new treatments or techniques – that physicians may be required to add to their SOP:

[P]hysician assisted death ... is a new element of practice that will need to be very well described, very well ... set up so that we can ensure that ... physicians have the competencies to ... provide that new [SOP] as appropriate ... [T]he most urgent piece is how it affects the physicians currently in practice, but also that has to trickle down to our training programs, both in residency and in medical school. (Interview 7)

Physicians must exercise their professional discretion to decide how they will practise amid changing professional realities. The balance between professional autonomy and discretion, practitioner responsiveness to changing professional realities and patient/population health needs is an essential consideration for self-regulation. Because physicians are responsible for shaping their practices, they impose limits on their SOP or abilities within their SOP. Physicians use their professional judgment to assess their competence to provide care in particular areas, or towards specific skills or services. Many participants noted that physicians “[work] within their set of competencies” (Interview 3), “practice in areas in which they are competent ... and continue to maintain competence within [their] assumed SOP” when providing services (Interview 2), and “that education, training and experience ... be recent” (Interview 1).

Medical and technological advances also drive regulatory and evolutionary changes within medicine, and by extension, the SOP of physicians. Work formerly done by one specialist is now being done by other specialists or sub-specialists within the same general area of medicine. For example, general surgery “previously did a lot more than it might do today” whereas orthopaedic surgery currently has a broader SOP than it did previously (Interview 5). Also, new techniques and treatments – i.e., evolutions in procedures that make them less invasive – as a result of changes in technology have contributed to the creation of subspecialties – e.g., interventional cardiology – which both alters the SOP of the parent specialty and generates a SOP for the new specialty.

Task shifting occurs not only among professions but within professions. Regulated competencies of physicians and other clinicians impact the SOP of physicians. Changes in professional competencies and SOP and the emergence of new health professional designations – e.g., physician assistants – may also alter physician SOP and encourage physicians to practice to

the limits of their SOP – i.e., address more complex cases or those they are uniquely trained to treat. The challenge within medical regulation is to balance the SOP of individual physicians with unique practices, career progressions or paths within larger groups of physicians:

[O]ur focus with respect to scope has been on individual physicians and groups of physicians ... We don't talk much about SOP in terms of interdisciplinary SOP all that much. [The f]ocus is not team-based care ... We may have inadvertently become less attuned to the interdisciplinary aspects of care ... there isn't a good mechanism to regulate team-based care because we tend to look at the individuals. So, I don't think that's an unintended consequence, but I think that's a reality of our focus on scope. (Interview 3)

Medical regulation appears to support task shifting within the profession. Participants recognized that individual physicians and their associated SOP change throughout their careers, and have practices ranging from comprehensive to focused that may include, reflect or emphasize specific niches, areas of interest and developed expertise. However, medical regulation does not appear to clearly support task shifting among professions.

Additionally, legislation and regulation shape SOP by identifying specific areas of medicine or a range of services physicians are authorized to practice or provide. It can be difficult to assess whether a physician is practising within their SOP, particularly if physician practice activities do not correspond with their specialty certification – e.g., c-section coverage for family physicians/general practitioners in remote areas – or if training programs for what physicians need do not exist – e.g., sleep medicine, interventional pain management – where they currently or want to practice. When specialty training programs do not exist, medical regulators devise minimum training requirements which impact SOP and establish competence for SOP in these areas. SOP is addressed via reactive regulation when the profession reacts to observed patterns among its membership – e.g., trends of physicians from various specialties switching to

a particular specialty – or when an incident occurs and a patient is harmed – e.g., development of SOP policies after a non-surgeon performed cosmetic surgery that resulted in a patient’s death.

3.4 Discussion

Organizational stakeholders across policy fields in medicine focus on what physicians do when talking about SOP in policy discourses. How we limit or expand what physicians do in practice is greatly impacted by education and training, the practice environment, and legislation and regulation. These factors and drivers alter the size of the ‘physician practice activity’ box. These factors and drivers can also serve as a starting point from which to have SOP discussions. Having a common framework and clear discussions about which driver of SOP is being discussed within an organization’s mandate is important for achieving a more widespread understanding of SOP throughout the profession. In a time of constrained resources and multiple policy changes, failing to work from a similar framework on the same issue is potentially detrimental across the profession. A lack of communication can result in stakeholders operating at cross purposes or a duplication of efforts, as well as conflicts in legislation, messages to its membership, and services provided to the public.²⁶ Thus, it is important to know how this reality impacts organizational stakeholder responsibilities for what physicians do and the steps they take to fulfill these responsibilities. This has ramifications for how SOP policies are created, implemented and shifted.

²⁶ Please see the discussion section of chapter 2 in this thesis for examples of conflicts in legislation between the *RHPA (1991)*, *the Medicine Act (1991)*, and the *Ontario Labour Mobility Act (2009)*, and mixed messages to membership expressed in legislation and regulation (through licensure, policies).

Our findings reflect the ways in which organizational stakeholders grapple with the challenges associated with SOP and what they think drives SOP. For example, participant responses suggest significant practice and SOP differences between urban and rural environments. These responses are consistent with literature that identifies a broader SOP for rural and remote practising family physicians (Abbot et al. 2014; Bosco and Oandasan 2016; Grzybowski and Kornelsen 2013; Schmitz et al. 2015), which includes expanded service provision (Pong et al. 2012) and additional competencies (Aubrey-Bassler et al. 2007; Baker et al. 2010; Skariah et al. 2017) compared to their urban practising counterparts. The challenge for organizational stakeholders is that they must account for the needs of physicians who practice in both of these contexts. It is important that policies, regulations, practice standards and other requirements or guidelines are devised to take into consideration the various contexts in which physicians practise. The effects of certain decisions – or lack thereof – can positively or adversely impact physicians’ ability to meet patient needs depending on where they practice.

Participant responses also identified that SOP can both broaden and narrow. There is an assumption within medical regulation of a need to predominantly monitor physicians who drift beyond their SOP (CPSO 2012). Yet, evidence in the literature shows trends of narrowing or more focused SOPs over time, particularly among family physicians (Beaulieu et al. 2008; Bazemore et al. 2012; Tong et al. 2012; Walsh et al. 2011; Xierali et al. 2012). Our findings suggest that stakeholders are currently just as – if not more – concerned with ‘too narrow’ as ‘too broad’ SOPs to meet patient needs. Practice drift beyond and within specialty certification or SOP in physician practices poses a challenge for medical regulation to ensure physicians practise competently and safely within their SOP. Addressing issues associated with both types of practice drift simultaneously is difficult. Courses of action that might effectively address ‘too

narrow' SOP might compound the ability to address 'too broad' SOP, and vice versa. The extent to which physicians generalize or specialize within their practice has ramifications for CPD in that it has to fill idiosyncratic (core) competency gaps for practice.

How organizational stakeholders struggle with the above challenges, and whether that equates to operationalizations of SOP, is debatable. How one understands, operationalizes, or interprets SOP indicates how they grapple with this concept and what they think drives it in practice. SOP is not straightforward within medicine. As illustrated by the above challenges, the profession appears to be struggling with the extent to which SOP should be more clear-cut across policy fields and how this would be best achieved. Depending on the situation – i.e., on a case-by-case basis – stakeholders work to strike a balance between maintaining the status quo, keeping SOP open, broad and unduly fuzzy, and making SOP more clear-cut, which could unduly narrow SOP. Once the scale is tipped in this regard, particularly if in the direction of the latter option, the profession can then take steps to more explicitly operationalize SOP. In the medical profession's attempts to operationalize SOP, important considerations about process, implementation and implications of SOP are potentially being overlooked. The challenges medicine encounters with SOP are in part attributable to the processes by which SOP is embedded in policy. They are also attributable to the processes used to delimit and delineate SOP. Over time, there are changes to what constitutes SOP – what is included and excluded – the processes by which these decisions are made and how SOP is interpreted. As such, increased focus should be devoted to the principles and processes by which SOP is decided and how negotiations of professional boundaries are articulated.

To our knowledge, few studies have explored organizational stakeholder understandings or operationalizations of health professional SOPs in Canada. Selinger and Berenbaum (2015)

examined how provincial dietetic regulatory bodies define SOP, as well as the similarities and differences in these definitions. The focus was on the purposes for which and processes by which SOP statements are created. Specifically, Selinger and Berenbaum (2015) emphasized the concepts of creating a SOP, using a SOP, and perceived or expected outcomes of SOP.

We sought a variety of perspectives in designing this study. Despite different organizational mandates and purposes, we found a convergence of participant opinions regarding what drives SOP. One explanation for this is that policy fields in medicine are interrelated and interdependent. When speaking from their perspectives, participants were not solely talking about their respective policy fields but rather relating to other policy fields in their responses. This is not surprising. There is frequent communication among organizational stakeholders and policy perspectives in medicine. In practice, communication channels overlap via meetings, conferences, committee memberships, public consultations and employment. It is important to note that in these communications, nuanced differences about SOP are discussed. These nuances are important because they indicate that stakeholders are talking about different aspects of the same thing. Although stakeholder organizations recognize and acknowledge other policy fields and share common ideas about SOP, this not reflected in how they act. After dialoguing together, stakeholders continue to work in a siloed manner. This is somewhat surprising. While organizations operate within their mandates, they also understand that similar struggles related to SOP are occurring across organizations. There is a need for the profession to shift its approach to, and implementation of, SOP policies, initiatives and programming. SOP discussions within and among organizations cannot be had in isolation. Further, organizations cannot act in isolation on matters pertaining to SOP. The mandate and perspective of one organizational stakeholder both impacts, and is impacted by, different stakeholders representing their own policy

perspectives. Also, the policies of one organization can have direct, tangible effects on the policies of another and what each of them can do. This in turn directly impacts the services patients receive, and the quality of these services. Stakeholders within medicine must determine how to engage in continued open discussions and collaboration within and among organizations and achieve individual organizational goals with respect to SOP without reverting back to policy or organizational silos to implement SOP policies, initiatives and programming.

There are a number of limitations to this study. There is potential for researcher bias with the use of key informant interviews, participant selection and sampling strategies. The exclusion of government ministry agencies, such as HealthForceOntario and OHIP, which have jurisdiction over how SOP is applied is a limitation. Participants were deliberately selected to investigate the intricacies of SOP and specific dimensions of physician governance and practice. As was previously stated, we wanted to focus on the medical profession and self-regulatory functions that have jurisdiction over SOP. We acknowledge that the inclusion of the health workforce planning perspective (CHWN) was the result of snowball sampling. In hindsight, given the absence of government ministry agencies, and we could have also excluded this stakeholder organization and policy field perspective. Researcher biases may also impact the interpretation of participant responses. Research team deliberations throughout the research process in conjunction with the member check and rigorous analysis procedures were used to counteract these biases. There is potential for social acceptability bias in participant responses based on what they were asked, how questions were posed to them, and beliefs about what the interviewer wanted to hear.

The number of interviews conducted was limited by funding constraints and the sampling strategy used to identify potential participants. This study was funded by a Health System

Research Fund Grant from the Ontario Ministry of Health and Long-Term Care. The time frame for this funding limited our data collection and analysis window. If we had more time, we would have added more interviews. Also, we were unable to secure the representative participation of some organizational stakeholder and policy field perspectives we sought. These are considerations for future work. Although these are potential limitations of this study, theoretical saturation was reached (Charmaz 2006). The vast majority of content offered by participants addressed different aspects of the three themes identified in this study. No additional themes could be generated. Our use of QD is another potential limitation. However, our intent was to explore and unpack SOP, and to describe what we found. Other qualitative methods – e.g., ethnography, narrative, phenomenology – would not have been as appropriate for this inquiry.

Additionally, our particular health professional and geographical focus likely limits the generalizability of these results. National disparities in physician SOP data and differences in how SOP is monitored, documented, evaluated and governed may result in limited applicability of this discussion outside of Ontario. We also acknowledge that inter- and intraprofessional SOP and boundary issues appear differently. However, jurisdictional differences within each province are equally complicated. There is no reason to believe that the education and training, practice environment and legislative and regulatory considerations identified within medicine are different from those experienced within and between other professions. Although health professional and geographic contexts may vary, we believe the findings to be broadly applicable.

Future research may seek to replicate this study with organizational stakeholders representing health professions outside of medicine in Ontario and in other Canadian provinces to compare these results with those of different populations and in different contexts. Future investigations may also seek to incorporate organizational stakeholder and policy field

perspectives not included in this study. Additionally, future studies may seek to examine interprofessional or interdisciplinary team SOP, and the potential to create mechanisms to regulate team-based care. Physicians infrequently practice in isolation. Participants highlighted team-based interprofessional care, task shifting, and adaptability around SOP in the practice environment. Specifically, the importance of knowing and understanding the SOP, abilities, competencies and training of team members from various disciplines and health professions. Yet, participant responses also indicated that medical regulation does not address interdisciplinary SOP and is less attuned to interdisciplinary aspects of care.

Moreover, further inquiries may also address the knowledge gap in the literature regarding physician perspectives of their own SOP.²⁷ Understanding physician perspectives of SOP can help organizational stakeholders to more effectively and meaningfully regulate, monitor, assess and evaluate SOP through policies, quality assurance programs, continuing competence and professional development requirements (American Board of Internal Medicine 2015). As a largely self-regulating profession (Klass 2007; Morris and Clarke 2011; O'Reilly 2000), and one where individual physicians typically identify and address their own learning needs (Davis et al. 2006; Eva and Regehr 2008; Mann et al. 2011), a more complete understanding of SOP is crucial to each of these functions (Federation of Medical Regulatory Authorities of Canada 2015; Federation of National Specialty Societies of Canada n.d.).

In conclusion, we believe our analysis of multiple organizational stakeholder and policy field perspectives represents the most comprehensive study of its kind within medicine. Our findings indicate that the medical profession encounters numerous challenges inherent in SOP as

²⁷ Please see the discussion section of chapter 2 in this thesis.

it struggles to operationalize this concept. Despite these challenges, our findings detect general agreement about the factors that drive what physicians do in practice: education and training, the practice environment, and legislation and regulation. Stakeholders must determine how to collaborate within and among organizations to clarify and, where possible, normalize their articulations of SOP to establish a more coherent professional discourse around this concept. Despite open communication channels, the profession continues to work in silos to address comparable struggles related to SOP, which does not reflect this convergence of ideas about SOP. We suggest that this disconnect between thought and behaviour in part lies in a problem of process, particularly as it pertains to approaches to, and implementation of, SOP within medicine.

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Chapter 4: Ontario Family Physicians' Perspectives about their Scope of Practice: What is it, What Drives it and How Does it Change?

Abstract

There have been many studies that investigate the scope of practice (SOP) of family physicians. However, none of these studies have expressly taken into account the perspective of family physicians. As a result, there is little to show what SOP means from the point of view of family physicians, how family physicians think about their own SOP as it changes over time, what factors shape and influence their SOP, or how can they change their SOP in the face of these factors. This study contributes to the growing literature on physician SOP by adding this hitherto unexplored physician perspective. Understanding physician perspectives on SOP, and in particular the factors that shape their own SOP, can aid understanding not just of the factors that shape physician practice, but also of just how these factors are perceived and weighed by physicians to the extent they can decide, more or less explicitly, what their SOP is and will be. Using qualitative description and incorporating constructivist grounded theory data collection and analysis techniques, focus groups and interviews were conducted with twenty-four Ontario-based family physicians to address the above knowledge gap.

Participants used different language to discuss SOP than that found in the 'institutions' and expressed by organizations which govern their practice. They understood their SOP in terms of their current practice, professional preparedness and support, the business aspects of being a doctor and who they were in their personal lives. SOP has as much if not more to do with who they are as people than with who they are as professionals. The SOP of these family physicians changed and evolved throughout their careers due to factors within and beyond their control.

These family physicians sought mentorship, support and engagement for their SOP throughout their careers, particularly during transitions such as from residency into independent practice. To ensure competence for practice, the medical profession should situate continuing competence and lifelong learning in the context of physicians' lived experiences in addition to its 'institutional' constructs and organizationally mandated constraints.

4.1 Introduction

Family physicians serve a central gate-keeping role for their patients' access to, and navigation of, the health care system (College of Family Physicians of Canada [CFPC] 2007; Flood 2002). Although the responsibilities of family physicians encompass primary, secondary and tertiary levels of care (CFPC 2007; Flood 2002), they provide a majority of primary care services (Pong 2012; Wong and Stewart 2010). They have the broadest potential patient base compared with other medical specialties, as well as a broad knowledge base that overlaps with many medical specialties. On a daily basis, family physicians must determine what cases they can safely and competently handle in their practice and what cases they should refer, and when, to a specialist colleague. Given the roles, responsibilities and care provision of family physicians, it is important to consider the concept of scope of practice (SOP) in the context of family medicine.

Researchers have previously considered the SOP and practice patterns of primary care providers by measuring or deciphering their SOP via questionnaires and inventories of SOP in general (Ie et al. 2015; O'Neill et al 2014; Wong and Stewart 2010) and in specific settings (Baker et al. 2010; Hutten-Czapski et al. 2004). Others have compared intended scopes of practice (SOPs) of family medicine residents with reported SOPs of family physicians (Coutinho

et al. 2015). Previous studies have also tried to determine the SOP of, and have suggested curricular guidelines for, small rural community practice (Skariah et al. 2017), used administrative data to describe the content of primary care (Katz et al. 2012), and examined the breadth of, and change in, the SOP of family physicians (Beaulieu et al. 2008; Katon et al. 2001; Ringdahl et al. 2006). Some studies focused on SOP becoming more focused or narrowing over time (Bazemore et al. 2012; Beaulieu et al. 2008; Tong et al. 2012; Walsh et al. 2011; Xierali et al. 2012), while others highlighted special interests or focused areas of practice of family physicians (Gutkin 2011; Sisler et al. 2013).

Physicians' perspectives of SOP as a concept are notably absent from these studies; in particular, how they think about SOP and how they think about *their own* SOP. There is therefore little evidence to gauge what SOP means from the point of view of family physicians, how they think about their own SOP as it has changed over time, what factors shaped and influenced their SOP, or what control they have over their SOP. Understanding physician perspectives on SOP, and the factors that shaped their own SOP in particular, can add to our knowledge of just how physicians control and are controlled by their SOP.

In a previous study²⁸ we examined how different organizational stakeholders in Ontario – e.g., medical regulators, educators, certification bodies, professional associations, health workforce planners – understood and operationalized physician SOP. We found that policy discourses about SOP in medicine focused on what physicians did. We found that SOP was therefore shaped by physicians' education and training, their practice environment, and the legislative and regulatory environment in which they worked.

²⁸ Please see the discussion section in chapter 3 of this thesis.

In this study, we build on our previous work to explore family physicians' perspectives of their own SOP in terms of what they do in their own practices and how various factors influence their SOP. In particular, we wanted to know how family physicians think about their own SOP as it has emerged and changed over time, and what factors have influenced and changed their SOP. The question this study sought to answer was “how do Ontario family physicians understand their own SOP, including (i) what factors, drivers, determinants or elements influence (i.e., shape or limit) their SOP, and (ii) how and why might these factors change their SOP throughout their careers?”²⁹

4.2 Methods and Methodology

4.2.1 Operational Definitions

We used the term *family physician* to encompass all physicians who were licensed to practise medicine independently – i.e., not on a provisional, educational or other practice license requiring supervision – with a primary practice address in Ontario. These physicians were either family physicians certified by the CFPC, or general practitioners neither certified by the CFPC nor certified by the Royal College of Physicians and Surgeons of Canada (Royal College).

We considered *physician factors* as those that focused on the individual attributes which physicians ‘bring with them’ to their practice environments (Wenghofer et al. 2009). Physician factors may include: age, gender, number of years in medical practice, country in which medical training was received and specialty certification.

²⁹ The constituent components (i.e., key words and phrases) of this question reflect five questions asked of participants in each focus group and interview. Please see question guide (Appendix F) in this thesis.

We considered *practice factors* as the characteristics of the immediate practice setting or environment in which physicians were working. These factors may therefore change if a physician moves from one location to another (Wenghofer et al. 2009). Practice factors may include: health system structure – e.g., funding, delivery, organization – type of practice, geographic setting/location, patient base and associated needs, available resources – e.g., total number of clinical and administrative staff, equipment – access to professional supports outside the primary practice setting, practice volume, active hospital appointment, and teaching appointment and/or experience.

4.2.2 Rationale for Geographic and Medical Specialty Focus

In Canada, both healthcare delivery and associated regulations are organized along provincial lines (Lavis and Mattison 2016; Lazar 2013; Martin 2017). The College of Physicians and Surgeons of Ontario (CPSO), the province’s medical regulatory authority, has a policy that requires physicians to notify the CPSO if they plan to change their SOP (CPSO 2015). Since instituting its SOP policy in 2000, the CPSO has conducted a number of recent public consultations on SOP (CPSO 2012a, 2012b; CPSO 2013a, 2013b; CPSO 2016a, 2016b). These consultations reveal significant ambiguity and uncertainty regarding SOP, including its use as a concept within medicine and related repercussions for family medicine.³⁰ Approximately one third of Canada’s family physicians practice in Ontario (Canadian Medical Association 2018). Compared to other provinces, Ontario has more physicians practising in rural and urban environments (Pong and Pitblado 2005). Family physicians are greatly relied upon in rural parts of the province (Pong 2011; Pong et al. 2012) in part due to physician maldistribution privileging

³⁰ Please see the introduction section in chapter 2 of this thesis.

urban areas (Wenghofer et al. 2011). Compared to their urban counterparts, the SOP of rural and remote family physicians is broader, includes expanded service provision and additional competencies.³¹ Family medicine is likely the most comprehensive primary care medical specialty. Cost-cutting measures and other health care reforms as well as primary care services compensating for specialist care shortages may contribute to the breadth of family physician SOPs. (Abbot et al. 2014; Bacenas et al. 2015; Grzybowski and Kornelsen 2013; Iglesias et al. 2015; Katon et al. 2001; Soles et al. 2017).

4.2.3 Study Approach

We used a qualitative descriptive methodology (QD) to examine, unpack and describe SOP (Sandelowski 2000). QD has been used in qualitative research that examines phenomena related to healthcare (Polit and Beck 2014) to gain insights about a poorly understood phenomenon from informants and when a description of a phenomenon is sought (Kim et al. 2017; Neergaard et al. 2009; Sandelowski 2000; Sullivan-Bolyai et al. 2005). QD study designs usually involve sampling, data collection and analysis stages (Sandelowski 2000). While we did not aspire to generate theory from this study, we used constructivist grounded theory (CGT – Charmaz 2006) techniques for the data collection and analysis stages of the study (Kennedy and Lingard 2006). Data collection and analysis occurred in tandem so that emerging findings could inform later data collection and analysis. Inductive line-by-line coding was utilized to analyze the transcripts and identify broader groups of codes and themes. Comparisons within and between cases as well as over time were made during the analysis to find patterns and variations in the data (Hutchinson et al. 2011). SM and EW developed the data collection and analysis procedures

³¹ Please see the discussion section in chapter 3 of this thesis.

which were subsequently discussed with RE and MY who contributed further refinements to the decisions within each step.

4.2.4 Rationale for Participant Selection

We used a purposive sampling strategy to target specific groups of physicians practicing in different parts of the province in order to achieve adequate participation numbers. Participation rates among physicians and other health clinicians in research activities tend to be low (Cook et al. 2009; Flanigan et al. 2008; Thorpe et al. 2009; VanGeest et al. 2007; Wiebe et al. 2012). Previous studies have noted that focus groups tend to include a disproportionate representation of southern urban physicians (Twohig and Putnam 2002), often because participants in urban centres are more accessible to researchers (Goldman and McDonald 1987). We wanted to include rural, remote and northern geographic locations in this study because urban and rural practising family physicians have been shown to have different SOPs (Abbot et al. 2014; Baker et al. 2010; Bosco and Oandasan 2016; Grzybowski and Kornelsen 2013; Schmitz et al. 2015). Therefore, we enlisted the help of the CPSO, CFPC, and Ontario College of Family Physicians (OCFP) to identify and reach out to rural, remote and northern practising family physicians outlined in the recruitment procedure below.

4.2.5 Data Collection and Procedure: Study Population, Sample Size and Strategy

We used purposive, convenience and snowball sampling to select and locate potential participants attending continuing professional development (CPD) courses offered by the OCFP and family practice peer assessor meetings offered by the CPSO. We also sought to include CPSO family physician and general practitioner assessor network leads and Ontario family physicians beyond these groups throughout the province. Individuals who did not meet our

definition of family physician were excluded from the recruitment process. SM, with assistance from the OCFP and CPSO, invited potential participants to participate in focus groups and interviews in person or over the phone. Staff from the OCFP and CPSO electronically sent potential participants a cover letter, an informed consent form, and a letter of support from the CFPC on SM's behalf. The OCFP and CPSO also assisted SM to communicate with participants via email to conduct polls and/or schedule focus groups at locations and times of participants' preference and convenience. Once a date and time was reached for a majority of participants for a particular focus group, participants who had scheduling conflicts communicated directly with SM to schedule separate individual interviews. Once transcribed, SM subsequently added the data from each interview to the data from its corresponding focus group.

Prior to each discussion, SM, with the assistance of OCFP and CPSO staff, requested voluntary basic practice and demographic background information from participants – e.g., practice context/environment, primary practice address postal code, whether they have a full family practice or a narrower practice – in person and electronically via handwritten responses. The focus groups and interviews were conducted and facilitated by SM and ranged from approximately 25 minutes to two hours. Participants were asked a common set of five open-ended questions regarding their understanding of their SOP, as well as factors that determine, limit, shape and change their SOP (Appendix F). SM created the questions which were subsequently reviewed, edited and finalized by the rest of the research team. All discussions were audio recorded and transcribed verbatim by a transcription service. Minimal notes were taken during each discussion to ensure optimum facilitator engagement. Memos (Charmaz 2006) and field notes (Charmaz 2006; Holtslander 2007; Russell Henderson 2009) were made immediately afterward to document initial thoughts about the conversation. Participants were

assigned a code corresponding with their focus group or interview transcript, recording, notes and, if provided, practice and demographic information to ensure participant confidentiality.

There was a potential CPD incentive for participating physicians. The focus groups and interviews contributed to what the CFPC classified as a linking learning to practice (LLP) activity.³² To that end, participating physicians could earn 2 Mainpro-C and 2 bonus Mainpro M1 CPD credits if they fulfilled the remainder of the College's reporting requirements for a LLP exercise (CFPC n.d.). Successful completion of these requirements would contribute towards their maintenance of certification and licensure.

4.2.6 Data Analysis

SM conducted a descriptive analysis of the basic practice and demographic background information. SM analyzed all audio recordings and transcripts several times, and discussed them with EW. In further discussions with EW, SM categorized the data. Additional notes and memos were made, added to and compared with those made during data collection. Transcript content was continuously compared, analyzed, coded and grouped on multiple levels (Charmaz 2006) by SM to combine the categories, concepts and meanings ascribed to them related to SOP that emerged (Holtslander 2007). During initial coding, the data was studied line by line to devise categories and concepts. Using participants' own responses – i.e., simple, precise phrase – initial codes were generated by labeling words, lines, or sections of the data to identify themes for further investigation (Charmaz 2006; Holtslander 2007; Russell Henderson 2009). During

³² There was a self-reflexive component to the questions asked in this study that encouraged participants to contemplate their own SOP, as well as how SOP is understood more broadly within their specialty. For more information on LLP activities, please consult College of Family Physicians of Canada. 2018. "Linking learning exercises." Retrieved September 11, 2018. https://www.cfpc.ca/Linking_Learning_exercises/.

focused coding, the most frequent initial codes were identified, sorted, combined and organized (Charmaz 2006). Focused codes were generated into categories and incidents, and subsequently, further developed, refined (Holtslander 2007) and grouped. During theoretical coding, the focused codes were analyzed, carefully considering how concepts and categories generated related to each other (Alemu et al. 2015).³³ To ensure representativeness of themes and sub-themes generated from the analysis, a member check via email was conducted with participants. Participants could also add, amend, clarify, or retract any statements from their transcripts.

4.3 Results

Four focus groups were conducted involving twenty-four Ontario-based family physicians. Focus groups one and two had seven participants each. Focus groups three and four had five participants each. Twenty-three of twenty-four participants provided basic practice and demographic background information. Reported special interests and focused practices were: care of the elderly, mental health, sexual health, public health, walk-in/urgent care, consulting, and administrative medicine. Reported practice settings included a student health service, a youth and social services organization, and retirement homes. Additional reported practice information or activities included: patients treated – e.g., university students; practice settings or units worked – e.g., emergency room, nursing home, chronic convalescent unit; locums – e.g., Northwest Territories; areas of care – e.g., obstetrics, palliative care, coroner; procedures performed – e.g., vasectomies, surgical assisting; and non-clinical activities – e.g., research,

³³ Please see the methods section of chapter 3 in this thesis for information on the process which creates the relationship between the codes and themes generated in the analysis.

teaching, lecturing. The basic participant practice and demographic information is summarized in Table 4.1.

Table 4.1. Voluntary Basic Participant Practice and Demographic Background Information

Characteristic	N (%)
Age	n=22 M= 48.2 (29-70)
Gender	
Male	11 (45.8)
Female	13 (54.2)
Years in Practice	n=23 M=19.9 (<1-43)
Country of UGME	
Canada	18 (81.8)
United Kingdom	4 (18.2)
Primary Practice Address	
Southern Ontario	16 (80)
Northern Ontario	4 (20)
Primary Practice Activities	
Comprehensive Family Practice	17 (77.3)
Focused/Special Interest Practice	5 (22.7)
Primary Practice Setting	
Solo Office Practice	2 (9.5)
Clinical Group Office Practice	7 (33.3)
FHT or Other Interdisciplinary Team-Based Practice	5 (23.8)
Hospital	2 (9.5)
Other	5 (23.8)

Participants' SOP was the result of a continuous cycle of personal and professional transitions, exposures and experiences throughout their careers. We identified four main themes: (1) what my practice looks like; (2) professional preparedness and support; (3) the business of being a doctor; and (4) doctors are people, too. These themes are described and summarized in Table 4.2. Table 4.2 outlines the themes and corresponding subthemes, indicated by descriptors, participants discussed regarding how they understand their own SOP; the factors, drivers,

determinants or elements that influence their SOP, and how and why these factors might change their SOP throughout their careers.

Table 4.2. Themes and Sub-Themes Related to Family Physician Understandings of the Factors that Influence and Change their SOP

Theme	Descriptor
What My Practice Looks Like	<ul style="list-style-type: none"> • Practice environment • Expectations of colleagues, expected standard of care in the community • Focuses within/breadth of practice • Areas of practice, care or specialization • What I do and do not do • Patients/patient base • Practice type/arrangement • Activities comprising practice – as part of overall practice
Professional Preparedness and Support	<ul style="list-style-type: none"> • Education and training • Mentorship – in training and in professional practice • Available professional supports/resources – associated challenges
The Business of Being a Doctor	<ul style="list-style-type: none"> • Government, politics and policy • The cost of doing business – e.g., remuneration, what the government pays for/covers re: health insurance plan, overhead costs, cost of specific items, treatments • Clinical and non-clinical aspects of practice/activities • Expectations of patients for practice – i.e., changing dynamics of the doctor-patient relationship
Doctors are People, Too	<ul style="list-style-type: none"> • Personal considerations/factors – e.g., work-life balance, family, age, career stage, health • Personal and professional comforts, strengths, interests • Career aspirations, job prospects, professional opportunities • Experiences through time in practice

4.3.1 What My Practice Looks Like

This theme focused on how the locations and settings in which family physicians practice can determine their SOP. Practice requirements and expectations for care in different environments, as well as labour mobility, can impact SOP. Participants also equated SOP with what they do and do not do in practice. This includes the patients they see, the type of practice

they have, their clinical and non-clinical practice activities and the time they allocate to these activities. These factors drive this aspect of the SOP of family physicians.

Participants saw geography and the practice environment as key elements in determining their SOP:

In the larger centers, either you're mandated out of certain areas because of economics or ... specialists taking over certain things ... and you have to limit or change your [SOP] to ... something a little bit different. I think geography for us, especially in Northern Ontario, is a huge driving force in terms of what you should be doing. In our town, it's very unusual for a physician not to have active hospital privileges ... I think our scope is very much geography-driven. (FG2-P11 – male mid-career doctor in Northern Ontario)

The communities in which physicians practice, the needs of those communities, and regional and jurisdictional variations in healthcare delivery can also shape SOP, “*I was practicing in an Aboriginal setting ... fly-in-only reserves [were] part of our practice. I felt I was just putting Band-Aids on very profound social problems. It really was my inspiration to go into public health*” (FG2-P10 – male mid-career doctor in Southern Ontario). Further, expectations of colleagues and the standard of care expected in the community can also shape SOP:

When my husband and I moved to a small, rural community, we knew that we wanted to do comprehensive family practice, we knew that we wanted to be at a hospital that was family doctor run, but I don't think that we totally understood the extent of the number of hours that would take and what the impact was going to be ... [A]t one point ... [we] looked at every sort of different call schedule that we were on ... we had one in 14 weekends where we saw each other, and there's no way ... we totally grasped that when we signed up. And the problem is, once you're in that, you are a necessary part of the functioning of that hospital and that community, and your practices – it's a lot easier to pick up work than it is to step away from work because there's an entire community and colleague network that relies on you ... We were really cautious about [getting into comprehensive practice], and yet it was still far, far larger than we ever could've imagined. (FG2-P8 – female mid-career doctor in Southern Ontario)

Some participants felt unprepared for the requirements of comprehensive practice, despite educating themselves and understanding that caring for rural and isolated populations requires generalists and a broad SOP.

Family physicians with experience practising in rural areas overwhelmingly reported having broader SOPs than their urban practising counterparts. Ensuring that their patients could receive as much care and treatment as close to home as possible because of the costs of traveling to larger referral centres for specialist care – e.g., time away from work, transportation and accommodations costs:

[T]ravel is very difficult for our patients as well ... we end up doing a lot of things that perhaps an urban physician may not do because they have eas[ier] access to ... specialists. We ... prepare our patients before we transfer them too ... so that my patient doesn't have to go two or three times, or having to stay in a hotel for a week ... that enlarges my work time as well. (FG3-P17 – male late career doctor in Northern Ontario)

While participants made general SOP comparisons between the requirements for practising family medicine in different settings – e.g., comprehensive practice in small towns vs. more narrow or focused areas of practice in larger centres – they acknowledged that SOPs were not only dependent on practice locations.

Participants also discussed the variability, versatility, diversity and unique nature of family medicine and reaffirmed their professional identity as family physicians:

The interesting thing is that my [SOP] is a little bit more narrowed, but what happens then is you start to see yourself more like a specialist. So, I feel a little more like an adolescent specialist now, or say a mental health specialist, or ... a sexual health specialist ... at universities. So, it's really interesting because family practice is quite unique in that way ... in that you can go from one area of practice to another area of practice, and your [SOP] can broaden. So, I ... do locum work over the summer, and it'll be much, much broader; and then during the school [year] I do something that's ... more narrow. And does that change that I'm family doctor? No. It just simply changes my [SOP] which is defined by what I do on a day in and day out basis. (FG2-P8 – female mid-career doctor in Southern Ontario)

Participants described SOP in terms of the procedures they perform, the services and types of care they provide, the kinds of environments in which they work and institutional policies – i.e., credentialing committee policies. Changes in any of these factors might impact their SOP, “I

have ... about three decades worth of practising [relatively consistently] with not a great deal of change other than the fact that as communities grow ... volume in the hospital and the complexity of care in hospital changed” (FG4-P24 – male late career doctor in Southern Ontario).

In some cases, participant expectations had not matched up with the realities of their practice – such as the types of medicine they practice compared with what they were trained to do. Participants attributed the realities of their practice and their SOP in part to “*who walks in the door that day*” (FG1-P4 – male mid-career doctor in Southern Ontario) and what they bring with them. That is, the needs or ailments of their patients, and what they address in practice – e.g., poverty, addiction, mental health. For some participants, this is determined by a choice or interest to serve specific patient populations – e.g., women, older adults. Others “*work from cradle to grave*” (FG3-P18 – male late career doctor in Northern Ontario); they care for people across the lifespan, in some cases spanning generations. A number of participants identified a reciprocal relationship between their patients and their practice, noting that their practice grows (up) and ages with them, “*When I arrived in my little community, I was a new, young physician, with a new, young patient population. I’ve grown up with my practice, so now I’m doing less pediatrics and well woman care, and more elder care*” (FG3-P19 – male mid-career doctor in Northern Ontario). Participants reported consciously allocating time to specific areas of care according to the disease profile of their patients. For instance, they might spend a lot of time treating chronic diseases due to high rates of COPD, asthma or different kinds of cancer in their patient population.

Practice type or arrangement and time devoted to practice activities also had an impact on SOP. For instance, some participants discussed how the SOP of a solo practitioner can differ

from a practitioner in a group practice arrangement. In addition to the areas of care for one's own practice, responsibilities might also include colleague coverage as part of on-call services – i.e., emergency shifts, antenatal care and deliveries as part of obstetrics service provision.

Participants described both clinical and non-clinical tasks or practice commitments – e.g., full time vs. part time, steady vs. occasional – within their SOP, *“a major part of my practice is ... teaching because I'm at an academic hospital ... I would say 30 percent of my week is education focused in a teaching sphere, so I should probably not forget that ... it's a massive part of my job”* (FG4-P22 – female early career doctor in Southern Ontario).

4.3.2 Professional Preparedness and Support

This theme focused on what prepares and supports family physicians in practice. We identified three factors that drive this aspect of family physicians' SOP: their education, training and the locations in which they trained and practice; the mentorship they receive during their schooling and career, including career and practice transitions; and their access to available professional supports and resources.

A number of participants identified the influence of their education and training on their SOP, *“I would say where you're trained in terms of your medical school and your residency program is a big indicator of what your [SOP] is going to be when you're finished”* (FG2-P11 – male mid-career doctor in Northern Ontario). Exposure to different practice environments during training provided participants with opportunities to get a general sense of potential SOPs. Some felt like these exposures gave them an idea of what they were getting themselves into, particularly if they ended up practicing in places similar to where they trained: *“I [felt] like I knew what I was getting into when I started my practice, because I ... took over our previous doctor's practice [right out of residency] and I worked there. I did a month or so as a resident*

first, so I had some idea of what it entailed” (FG1-P7 – female early career doctor in Southern Ontario).

Alternatively, others felt that their training did not give them a full sense of the realities of practice:

[S]tarting off as a locum in a practice you’re, I think as a resident, really like shielded from real life of practicing medicine ... I envisioned in my first year, I’d be doing a lot of different ... things or more things that I’m currently doing, but it’s really limited by if I’m working covering two locums at once then I’m stuck at the office until eight or nine doing paperwork, so I did not expect it. (FG1-P6 – female early career doctor in Southern Ontario)

This was particularly pronounced for those participants who had completed their medical education and residency training outside of Canada. They identified the paradigm shift they experienced coming to terms with the way family physicians work in Canada.

Participants discussed how the mentorship they had received during their education, through CPD activities, and throughout their professional practice had informed and shaped their SOP. Some had sought mentorship and career advice to help establish understanding and manage expectations about desired career paths, potential SOPs, and their compatibility with life decisions:

We made very different life choices; I think that’s the reason why our [SOPs] ended up differently ... [I]t would’ve been really nice before I sunk all this money into ... extra training and extra courses and doing stuff abroad and trying to get that experience if someone had told me listen ... you’re already married to someone ... who has no desire to leave Canada, you should probably rethink [what you want to do] ... [I]t would’ve been really nice to have that career advice ... much earlier on. At the same time, I recognise that it’s difficult to get that career advice earlier on. (FG4-P20 – male early career doctor in Southern Ontario)

Participants suggested that CPD could include tools or a framework to help them honestly and realistically assess their SOP throughout their careers. Participants were not sure what a tool or framework would look like. However, they had ideas about elements that can help family

physicians think through different aspects of their current situations that will dictate their SOP. These elements include training, job opportunity, financial and personal considerations.

The mentorship family physicians received during training influenced their SOP when in independent practice:

[I wouldn't say that] the mentors during residency or medical training that you have ... limits your scope, but I think it definitely shapes what ends up being appealing to you when you see what types of things they're doing, if they're happy in their position, if they ... are doing work that you find fulfilling or interesting or it seems like they find something [else] more interesting. (FG4-P22 – female early career doctor in Southern Ontario)

Participants reported experiencing a significant learning curve during the transition from residency training in to independent practice. They thought that resources or mentorship during this critical juncture would have been helpful, particularly for “*things that are not part of one's formal education*” (FG4-P23 – female early career doctor in Southern Ontario) such as how to fill out certain forms or how much to charge for the forms. While such mentorship could take different forms, some participants indicated that this happens organically within the practice setting through conversations with more experienced colleagues.

Mentorship appeared to be just as important for the SOP of clinicians beyond the early career stage as they moved between positions or pursued different opportunities:

[T]he lack of good mentorship as a new person in a big centre, you really feel like you're just in this silo ... I feel like I don't have that mentor ... someone to make me think more and reflect more and build more and do more. If I had done it differently, I may have looked for something a bit more engaging. (FG3-P16 – female mid-career doctor in Southern Ontario)

Participants pondered the possibility of looking beyond physician colleagues to professional governance structures for mentorship and support “*in expanding or narrowing [their SOP] to the education and mentorship experience [they] would need behind that to feel confident either in an*

area [they] want to become more specialized or [to] broaden [their] scope” (FG4-P23 – female early career doctor in Southern Ontario). While there was uncertainty regarding the form this mentorship and support could take, participants expressed a desire for a more intense experience than that afforded by continuing medical education to link one’s SOP goals to community needs in order to illuminate what needs are not being met. A “top-down view to see which patients [and communities] are ... falling through the cracks” (FG4-P23 – female early career doctor in Southern Ontario) was identified as helpful.

In addition to mentorship, participants identified other professional supports, resources and associated challenges for practice to impact SOP: *“definitely location and external supports are really important in maintaining a comfort [in] ... doing the work that we do” (FG2-P13 – female mid-career doctor in Southern Ontario). Differences in access to professional supports across the province, and the type of practice one might have were discussed:*

[F]amily medicine ... in Southern Ontario, it was very different; very much more constrained sort of practice ... with a lot more supports that I didn’t have in Northern Ontario ... [T]he second I arrived in ... the community I’m on call, covering, and responsible for an area larger than the size of France and covering the ER and high-risk situations ... Having said that, I was so glad to be in a group practice that I had more seasoned colleagues that could bail me out, help me out with the very difficult first few months ... They were very short-staffed up there, and one in four call. Almost immediately, I had to [carry that weight], but I have to say – having seasoned colleagues made that experience actually tolerable. (FG2-P10 – male mid-career doctor in Southern Ontario)

Participants reflected on assessing the potential for cross coverage and the composition of the health workforce in their immediate setting and surrounding areas as considerations to help them determine what they might need to incorporate or drop from their SOP. For instance, the available service provision for a particular area of care in the community might “[make]

somebody feel that [their] services are not required” (FG4-P24 – male late career doctor in Southern Ontario):

I gave up obstetrics two years ago partly because there were four family doctors doing obstetrics [in the city in which I practise]. Slowly but surely the group dwindled down, and I was the last one standing; I mean the obstetricians were fairly supportive, but it got to be pretty difficult to just keep doing that. (FG2-P12 – female late career doctor in Southern Ontario)

Participants acknowledged that nurses and midwives helped them to face many of the challenges they had encountered in practice, particularly in Northern Ontario.

Participants providing care in larger catchment areas in Northern Ontario identified a lack of specialists as among the biggest practice and SOP challenges they encountered. If specialists or particular specialties were not available, participants indicated that health care issues typically get offloaded to the primary care physician:

[W]e act as ... mini specialist[s] ... I have done two appendectomies, a couple of hernias, tons of surgical assisting because we didn't have other people to specialize and do this ... [Our] catchment [area] is almost 150,000 [with] only three gynaecologists, just one paediatrician, one ENT. (FG3-P17 – male late career doctor in Northern Ontario)

The recruitment and retention of family physician colleagues was reported as an urgent challenge by late career Northern and late career rural Southern participants. They were reluctant to retire or to scale back their practice out of concern for their leaving their patients doctorless, “*we ... have large practices; [we would be dumping] almost 15,000 patients which is one-third of the city. And that is a very scary thought when we are not able to recruit new physicians coming in”* (FG3-P17 – male late career doctor in Northern Ontario). The opportunity to recruit and retain family physician colleagues to one’s practice informed some participants’ decisions to give up parts of their SOP to create service vacancies.

4.3.3 The Business of Being a Doctor

This theme focused on the policies that shaped how family physicians manage their practices and, therefore, their SOP. This included how – and how much – they got paid, what they did and did not get compensated for, the costs of owning and operating their practices, and clinical and non-clinical aspects of their work. This also included the expectations that healthcare consumers have about the services they received and the providers of those services.

Participants discussed how the political climate where they practice impacted their SOP:

I think unfortunately the political situation in Ontario ... is not conducive, in my opinion ... to practising what I was taught, the way I was taught, the way that I would like to continue practising ... I think depending on what we are ... forced to do, a [SOP] changes with new guidelines which come about, you know we are taught, okay, this is the guidelines, this is what we expect you to do, we expect you to screen, we expect you to treat things differently – I think that changes our [SOP]. (FG3-P18 – male late career doctor in Northern Ontario)

The influence of policies and procedures on shaping SOP was reflected in the ways that the government funded and financed the health care system – i.e., what a government paid for or covered within its provincial health insurance plan – and how family physicians were remunerated where they worked:

[A] lot of our new graduates have taken financial remuneration to come to our area ... [this] comes with an expected [SOP]. The contract that we provide here, at the hospital, and they provide you funding to come to [Northern Ontario] is they give you expectations regarding practice size, the fact that you have to maintain active in-patient hospital privileges and some other things ... Some people do sign a financial contract which [defines] what their [SOP] should be. (FG2-P11 – male mid-career doctor in Northern Ontario)

While contracts may ‘spell out’ or define a physician’s SOP, some participants questioned the ability of a contract to fully capture SOP, “[some duties are clarified] but there’s so much involved in our job it would be impossible to list it in a job description” (FG4-P23 – female early career doctor in Southern Ontario). These questions were amplified when the SOP described was

particularly broad – e.g., including obstetrics, emergency room coverage, or providing care in fly-in indigenous reserves – and where the practice setting and broader environment lacked infrastructural supports, “*even when you have a contract that defines your SOP ... it doesn’t matter what it says on a piece of paper [when you’ve never seen anything like what you’re encountering]*” (FG2-P10 – male mid-career doctor in Southern Ontario).

Participants often attributed their SOP or changes in their SOP as reactions to policy decisions. For example, participants discussed being incentivized by how they were paid for certain services – e.g., allergy shots and testing. They generally described the scenario in which they might choose to give up something they enjoy in favour of something else they did not enjoy as much, but for which they were better compensated for their time. Areas of care that were not covered within provincial health insurance plans could limit what family physicians incorporated within their SOP. For instance, participants identified having the ability to offer specific services – e.g., travel medicine – but would do so to the extent that there was patient demand and a willingness to pay.

Participants also identified their roles as business owners, who in part determine how much they are paid for their services. Some late career participants recalled instances when they had to use their savings to subsidize their practice and expressed concern about their financial future and retirement. Costs associated with owning and operating a medical practice – e.g., overhead, supplies, pension plan deductions, employee salaries, treatment/procedure and service costs – impacted what family physicians decided or could afford to do:

[I]t's not worth my while doing pap testing in my office ... it doesn't pay, period, and yet I'm bonused on it ... [Y]ou're not paying me upfront but you're giving me \$200 at the end of the year; how does that economics work? ... That's one example. Vaccination is the other one ... [B]y the time I've paid for the syringe and my time, I'm making nothing, \$3.75 for a vaccination, and yet it's a very important aspect of medicine ... I still hang onto my

vaccinations ... but [I've made arrangements for nurse practitioners to do all my pap tests at our local Health Unit]. So, I mean, that's a shift in practice. (FG3-P17 – male late career doctor in Northern Ontario)

Participants discussed the time and financial investments – e.g., office practice management – they make which affect their SOP, hours of work and time they devoted to direct patient care. For example, some physicians took on payroll, bookkeeping, stock keeping and inventory duties to offset the costs of running their practice.

Participants felt the business aspect of medicine was a key aspect and driver of their SOP that they were less prepared for than they thought. Some early and mid-career participants discussed their transition from resident to independent practitioner in this light:

I don't think we're prepared for all of the administrative, non-medical stuff that goes along with medicine ... I didn't feel like I was ... I initially was like how do people do this[?] ... I knew there was a lot of paperwork in this job but ... the amount that actually piles up kind of blindsides you[. It's] a part of practice that I really didn't expect. The medicine part I expected, the 50 percent of stuff that I do in a day that's not 'medicine related' including bureaucracies and policies of working for a large downtown hospital [was a] bit of a surprise to me. (FG4-P22 – female early career doctor in Southern Ontario)

Participants acknowledged some courses in residency training that generally addressed professional management and “*the business part of medicine*” – i.e., setting up and operating a medical practice – yet thought trainees “*have been very poorly trained or even rather badly warned about*” these realities (FG4-P24 – male late career doctor in Southern Ontario). It was suggested that the profession could do more to educate trainees about the “*non-medical side of practice*” (FG4-P22 – female early career doctor in Southern Ontario) to address some of their expectations for practice.

Additionally, participants identified the expectations of healthcare consumers to influence SOP. Participants discussed the pressure to practise defensive medicine in instances where

providing desired services – e.g., ordering tests – were not required, and would have placed unnecessary financial costs on the healthcare system:

[T]he shift [in] ... people expecting things, there's just this very high expectation that, you know I ask for this, this is what I want, give it to me or I'm going to complain. And that is a very difficult thing to manage in a publicly funded [system], and I think that really drives our [SOP] as well ... [T]here are many days when I feel ... that I've been more of a service provider than I have been ... a physician. That I am managing ... peoples' expectations, not their illness but their expectations. (FG3-P16 – female mid-career doctor in Southern Ontario)

Participants reflected on the impact of technological advances – i.e., the Internet – increased patient access to information, and their desire to seek expertise outside the doctor's office – e.g., Dr. Google, The Doctors, The Dr. Oz Show – as contributing to patient expectations and a changing dynamic in the doctor-patient relationship. These occurrences present a new challenge for practice – i.e., self-diagnosing, and proposing, inquiring about or exploring treatment and procedural options. Participants welcomed patient involvement and interest in their own health and well-being, yet noted that this could change or question the idea of what constituted medical expertise and who was a medical expert.

4.3.4 Doctors are People, Too

This theme focused on personal considerations, life decisions and events, interests and aspirations, experiences in practice, and how the interactions of these factors impacted what physicians were able to do in practice throughout their careers. These were factors that drove this aspect of the SOP of family physicians.

Participants mentioned a range of considerations and factors as driving their SOP throughout their careers, such as relationships outside of practice – i.e., family, spouse – age, career stage, health, work-life balance, and life choices. They characterized their SOP as a natural progression and intersection of their personal, family and professional lives. They also

cautioned against making sweeping judgements about SOP because it was individualized and personal to each physician:

I think we have to be very cautious in making judgements from one physician to another as to the reasons that people have become more focused in their practice or remained broad based ... because many of these things are also determined by family circumstances, relationships, partners, children, children with needs, etcetera ... I've been fortunate ... to do most of the things that I like for [much] of my career[. I'm not sure if that's common]. (FG4-P24 – male late career doctor in Southern Ontario)

Participants discussed aspects of practice they would have liked to have incorporated in their SOP but that had not been feasible for them at the time: *“I had full intention of doing obstetrics ... but had another baby myself and thought, you know, I really couldn't cope with that. So really that limited it; it was just something I needed to give up at that point”* (FG2-P13 – female mid-career doctor in Southern Ontario). Life choices, such as deciding to get married or starting a family, were also described as impacting SOP. Work taking time away from family – e.g., afterhours and weekend clinics – was a factor for both men and women, both in regards to what they did in, and how they structured, their practice. A number of participants discussed the support and understanding they needed from their families to be able to maintain some aspects of their SOP – e.g., ‘putting up with them’ leaving during dinner time, or helping them shovel the driveway and clean snow off the car in the middle of the night to deliver a baby. Spousal happiness or preferences also influenced where participants practiced, and by extension, their SOP, *“[my wife loves Northern Ontario], that was the only reason I stayed [there] – if she told me she wanted us to relocate I would have moved ... [S]pouses are very important”* (FG3-P18 – male late career doctor in Northern Ontario). Spousal employment opportunities or requirements, particularly in physician-physician partnerships, also influenced where participants practiced.

Participants discussed how family needs more broadly influenced SOP. In some cases, the financial needs of one's family, such as living expenses and school tuition, influenced what they do in practice and for how long. In other cases, circumstances dictated the ways in which they decided to practice:

[M]y husband is a physician as well, and we have a family, and I know that my [SOP] has largely changed as a result of our personal needs. [It largely resulted from] our personal needs ... I gave up [emergency medicine] because one of our children got sick. So that was my job, to [give it up] and make myself more available. When something else happened in the family, my [SOP] had to change again ... We are ... parents and ... family members and care givers for our family. [O]ver time, it has had a massive influence on where I practice and why I practice the way I do. (FG2-P8 – female mid-career doctor in Southern Ontario)

Participants indicated that their circumstances, needs and their resulting SOP were not static. For instance, when their children were younger and more dependent on their parents, SOP often shrunk. When their children got older and more independent, family physicians felt ready to expand their SOP. Grandchildren were also a motivating factor for SOP decisions in that participants spoke of wanting to retire or close their practice and do locums occasionally so they could spend more time with their grandchildren.

Age and career stage impacted both anticipated and actual SOPs, “*when I finished my training ... I had ... a vision [I was going to] have a bigger [SOP] ... Not to say that [I] can't explore [other] things later ... I'm still early [in my career] so I still have lots of time to do (other) things*” (FG1-P6 – female early career doctor in Southern Ontario). Participants also identified age and career stage as drivers of SOP that determined whether they could maintain certain aspects of their practice. Late career family physicians discussed feeling slower and having decreased energy levels when trying to work the hours they used to work. They also discussed areas of practice they wanted to incorporate or had to give up as their practice changed

such as having to give up emergency room shifts two to three times a week as practice grew.

SOP evolves as the practice and careers of family physicians progress and transition:

My [SOP] has changed over my career. It is in many places a matter of emphasis. So, for example, when I started my career, there was a heavy emphasis on emergency and internal medicine on the acute care ward. And then as time went on, the emphasis moved more towards the clinic. (FG3-P19 – male mid-career doctor in Northern Ontario)

In addition to areas of medicine and practice settings, participants mentioned incorporating non-clinical roles or jobs at different stages in their careers, such as administrative management, running organizations, and regulatory college assessments.

Although they may have wanted to have a large SOP, participants knew they needed to be practical so as not to do a disservice to their patients, their colleagues and to themselves given their age and health. Regardless of age, participants discussed personal health issues or concerns that required them to limit their SOP, work hours and to make necessary lifestyle changes such as withdrawing into 9-5 practice. Feelings of burnout were a recurring issue: *“I just got to the point where, like most of you, I became weary of working 80 hours a week, being in the office every weekend, rounding every day” (FG2-P9 – male late career doctor in Southern Ontario).*

Such demanding schedules made it difficult for some participants to achieve a work-life balance:

I'm very fulfilled in medicine but I have missed out on a few other things ... [interests] I've neglected ... for a little too long. So now I am desperately trying to get there. But I find it very difficult to give up what I have done for 40/50 years of my life. So, it's a struggle for me ... my primary love is still medicine, but I still want to do other things. (FG3-P17 – male late career doctor in Northern Ontario)

Participants with such inclinations favoured altering their SOP and work-life balance, transitioning out of practice slowly over abruptly stopping such as by cutting back practice to two days a week.

Personal and professional interests, strengths and comforts influenced SOP. Participants reported their SOP could be shaped by areas of practice they wanted to concentrate on in their work – e.g., sports medicine, psychotherapy, palliative care, dermatology. Some participants declared special interests and issues that they were passionate about addressing as part of their practices – e.g., homeless and inner-city medicine, addiction and mental health. Other participants wanted to incorporate things beyond general family medicine – e.g., work with the medical regulatory authority – in their SOP. Personal preferences or perceived limitations also caused participants to avoid certain areas of practice. What family physicians were comfortable doing or considered to be a strength in their practice changed over time:

I hadn't done obstetrics for about 18 months by the time I went back to work ... I felt like I had sort of lost my skills even though prior to that I felt really good about my skills, I'd delivered a lot of babies, I was confident. But then I was new ... [time goes by and] you don't feel like you still have the skills anymore. (FG3-P16 – female mid-career doctor in Southern Ontario)

The interests, strengths and comfort level needed to undertake certain activities in practice informed the CPD family physicians chose or were required to do. These considerations could also influence the direction(s) their SOP took at different stages of their careers.

Career aspirations, job prospects and professional opportunities influenced participants' SOP in regards to the types of work they incorporated in their practice, and the patients they would like to see, “*I have actually received training in care of the elderly, which I'm not doing now. But when we move later this year, the hope is to do inpatient and outpatient consults in geriatrics in addition to my office practice.*” (FG1-P2 – female early career doctor in Southern Ontario). Availability of work and where participants had been able to secure employment determined their SOP, “*at the moment it's where I can get a job*” (FG1-P3 – female early career doctor in Southern Ontario). Instances when professional opportunities had not panned out

limited SOP, “*There was a locum opportunity at the geriatrics hospital where I was working at ... it did not work out, so I guess not having that locum also determined that I wasn’t going to do geriatrics this year*” (FG1-P2 – female early career doctor in Southern Ontario). Similarly, opportunities that had panned out had often taken participants’ careers and SOP in different directions:

the reason that I went into occupational medicine was that one of my patients was a physician ... when he was retiring, he said ‘would you like to take over my job?’ [And when NOSM got started] they approached all general practitioners and family physicians to see if we were interested in teaching ... I said yes ... The reason [I’m doing complex diabetic care] was again because I was asked ... if I was interested in doing that ... So that’s why my [SOP] has sort of ballooned in different ways. (FG3-P18 – male late career doctor in Northern Ontario)

While participants were intrigued by these potential opportunities, income and job stability, as well as ensuring their work situation was sustainable – e.g., roster a manageable number of patients – determined what aspects of SOP were feasible for them to pursue or maintain.

Participants continued to learn about their SOP the more they practiced, “*with experience comes understanding of the boundaries of what’s [covered and] not covered within your [SOP]*” (FG4-P20 – male early career doctor in Southern Ontario). Participants discussed positive and negative experiences that had informed their decisions to embrace or avoid certain areas of care, “*I guess shaping my practice has been ... bad experience to some degree[.] I did obstetrics for a while [and] I found it very difficult*” (FG1-P1 – female late career doctor in Southern Ontario).

Participants also recalled experiences that fostered feelings of confidence for their current SOP:

I did practice in New Zealand for a while, which was a whole different experience ... I was sort of first call ... [and was] in a very small community [with an incredibly supportive colleague] ... Certainly my self-confidence when I came back was greatly improved because we did, you know, almost [everything]. (FG2-P13 – female mid-career doctor in Southern Ontario)

For some participants, it was not their own professional experiences, but their observations of others which helped them learn what would and would not work for them to define the confines of their SOP. Ultimately, the general sentiment was that family physicians cannot truly know their SOP until they are immersed in their practice, *“everyone's going to such a different scope ... no matter what type of family medicine you practice, it's impossible until you get into it to really know”* (FG4-P22 – female early career doctor in Southern Ontario).

4.4 Discussion

Participants in the study understood their SOP and perceived factors that impacted their SOP over time, in terms of: what their practice looks like, professional preparedness and support, the business aspects of being a doctor in this jurisdiction, and who they are as people and their life outside of work. Factors identified in the first and second themes – i.e., the practice environment and education and training – are similar to what is documented in the SOP literature (Coutinho et al. 2015; Ie et al. 2015; O’Neill et al 2014; Risso-Gill et al. 2014; Skariah et al. 2017; Wong and Stewart 2010). The third and fourth themes – business and personal – and the factors identified therein have not been well documented in this literature. An obvious reason for lack of attention to these themes and associated factors is that the perspective of physicians on their own SOPs, from which perspective these themes and factors most starkly come into view, has not been adequately taken into account in the literature. It could also be due in part to assumptions that SOP is driven or influenced primarily by factors linked to professional role and identity, or that are clinical in nature, at the level of direct physician-patient interactions. Our earlier work^{34,35} emphasized direct physician-patient interactions in a clinical setting. Participants

³⁴ Please see the results section in chapter 2 of this thesis.

in this study expanded on this in discussing how those interactions in clinical settings made them feel, and how they impacted their SOP more broadly. Clearly, SOP is about much more than what physicians are trained to do. In some instances, they have a lot of control over their SOP, in other instances they do not. Physicians offer a unique perspective about which to think about SOP. For example, our findings suggest we need to rethink the artificial separation between individual provider – physician – factors and environmental – practice – factors to more accurately reflect the mutual influence among personal and professional interactions that comprise the lived experience of family physicians.

The prevailing message gleaned from participants in this study, regardless of age, career stage, gender, or practice context was that doctors are people, too, and this can have a major impact on SOP. For instance, family was cited as a major consideration for how, where and when family physicians practice, as well as if or how much longer they will practice. Broadly, our findings are similar to, and consistent with, factors and considerations in the recruitment and retention literature and practice intention literature. Specifically, these factors include practice support (Coutinho et al. 2015; Dufferin et al. 2016); employer constraints (Coutinho et al. 2015); growing up or exposure to training in similar settings/environments (Asghari et al. 2017; Eide 2015); supportive work environment (Asghari et al. 2017); family and spousal support (Asghari et al. 2017; Eide 2015; Mayo and Mathews 2006); work-life balance, remuneration (Dufferin et al. 2016; Eide 2015; Mathews et al. 2012).

For decision makers to effectively regulate SOP, understanding physician perspectives about how they think about and shape their own SOPs is essential. Physician decision making

³⁵ Please see the results section in chapter 3 of this thesis.

shapes SOP in that physicians have discretion and some control with respect to how their SOPs have emerged and changed over time. Personal factors play a significant role as physicians actively shape their practice through exercising their discretion. Political priorities, policy goals and regulatory instruments that refer to SOP do not necessarily reflect who physicians are, what physicians want or is important to them, or what is going on in their lives at any time. Our participants were clear that their SOP is very much embedded in these kinds of factors. SOP is personal to each physician, which is precisely why it is challenging to craft and implement SOP policies that all physicians can relate to.

Participants identified non-clinical aspects of their practice and SOP – i.e., activities in which they are not engaged in direct patient care – as both impacting their clinical SOP, and being part of their overall SOP. Most physicians in Canada balance dual identities of health care provider and small business owner (Calnan 2015; Spyridonidis and Calnan 2011). They work in independent practices that are privately owned, as demonstrated by the prevalence of *“independent, physician-owned and [-operated] solo and small-group family practices”* (Hutchinson et al. 2011). As private contractors in the public health system, a majority of physicians are not salaried (Canadian Institute for Health Information 2008). Thus, SOP is largely a product of the current policy environment and health system structure in which family physicians practise, including how health care is organized, funded and delivered. Decision makers should consider the interaction between physician and practice factors when developing policies related to SOP. Also, certification bodies should consider this interaction as well as the health policy and system environment when structuring CPD for physicians to address their SOP needs. Participants indicated that they, or new entrants into the profession more generally, were ill-prepared to function as owner-operators of medical practices early in their careers. The

CanMEDS-Family Medicine 2017 competency framework, which describes the roles, responsibilities and required competencies to support family physicians' work in Canada (Shaw et al. 2017), does not discuss this aspect of practice in depth. The key and enabling competencies enumerated within the 'leader' role merely list the planning and management of "*a professional practice in an efficient and ethical manner*" under the management of finances and health human resources in a practice (Tepper and Hawrylyshyn 2017).

Reitz and colleagues (2018) identified factors that contribute to the decisions of family physicians to pursue and continue full-spectrum rural medical practice. More specifically, their participants "*describe[d] large shifts in their scope across a career, but took satisfaction in their [discretion] to make these changes at their pace and level of readiness.*" Participant statements in our study indicate that the SOP of family physicians changes and evolves over time due to a number of physician and practice factors both within and outside of physicians' and the medical profession's control – e.g., patient expectations, personal factors/considerations, government decisions, professional aspirations or interests. The longer a family physician is in practice, the greater the opportunity for his or her SOP to change, whether these changes are self-imposed or the result of external circumstances. Some participants felt they had considerable discretion to make SOP changes as they wished. Other participants felt their discretion in this regard was significantly limited due to personal and professional circumstances. Collectively, these findings raise questions about the perceived level of discretion and the actual level of control family physicians possess over their SOP and what they do.

There were a few limitations to this study. Firstly, there was potential for social acceptability bias in participant responses. To mitigate this bias, we took steps to assure and maintain confidentiality by assigning unique participant codes corresponding with identifying

materials – e.g., data, notes, practice and demographic information. There was also potential for researcher bias with the use of focus groups and interviews, as well as the participant selection and sampling strategies employed in this study. They were selected to counteract non-response, low response, and participation rates of physicians in research. It is possible that the study participants and their responses may neither reflect a typical sample, nor represent the views, of the general family physician population. Our ability to provide a complete description of the study sample was limited. The practice information requested of participants was voluntary. Not all participants provided this information, or if they did, they did not do so to the same degree. Researcher bias may also impact how participant responses are interpreted. To counteract these researcher biases, research team deliberations throughout the research process, member check and rigorous analysis procedures were used.

Funding constraints and the sampling strategy used to identify potential participants limited the number of focus groups and interviews. This study was funded by a Health System Research Fund Grant from the Ontario Ministry of Health and Long-Term Care which limited our data collection and analysis window. We would have added more focus groups and interviews if we had more time, and are considering this for future work. Yet, theoretical saturation was reached (Charmaz 2006). Content offered by participants predominantly addressed different aspects of the four themes identified in this study such that no additional themes could be generated. The use of QD is another potential limitation of this study. However, as our intent was to explore and unpack SOP and to describe what we found, other qualitative methods would not have been as appropriate to use.

Furthermore, the focus on family medicine in Ontario limits the generalizability of these results. This discussion may have limited applicability outside of Ontario, and in practice

contexts within Ontario not represented in this study, due to disparities in physician SOP data and how SOP is governed, monitored, documented and evaluated throughout Canada. We also acknowledge that professional boundary and SOP issues appear differently between and within professions. However, differences within each province are equally complex, and there is no reason to believe that the considerations identified within family medicine are not similar to those experienced in other medical specialties, and within and between other professions. While specialty, health professional and geographic specifics may vary, we believe these findings to be generally applicable.

Despite these limitations, this study provided important information about how physicians understand and think about their SOP, as well as how SOP is actually shaped to be considered for policy, legislation and regulation – i.e., what informs physicians’ decisions about their SOP, what factors influence and have influenced their SOP. This study also encouraged the generation of a practice and evidence-informed understanding of SOP with an emphasis on physician voices to be considered for medical education – undergraduate through to CPD – and lifelong learning (LLL) for practice. If the medical profession wants buy-in for its CPD and LLL endeavours, it cannot ignore physicians’ lived experiences in addition to its ‘institutional’ constructs and organizationally mandated constraints. The profession might not place extra emphasis on CPD for the experiences of new and early career physicians because these physicians may more so be guided by ‘institutional’ and organizational influences than their more seasoned colleagues. Having recently completed their education and requirements for board certification and licensure, their knowledge base is extensive and fresh. Having recently been assessed, they are more likely to do things ‘by the book’ in practice. Family physicians are asking for regular and sustained engagement, support and mentorship throughout their careers, particularly during the

transitional years from residency through the first several years of independent practice. CPD and LLL requirements and endeavours should be thought about in these terms. Doing so may help to ensure competence for clinical practice, perhaps as effectively as peer practice assessments, CPD credits, and other regulatory instruments or methods of assessment.

There is support for this assertion in the context of pharmacy in Ontario. In their examination of competence as a lived experience of pharmacists labelled as incompetent by the College of Pharmacists of Ontario, Austin and Gregory (2019) identified that framing competence as a “*binary ‘either-or’ process*” may be shaped by the tools and methods used to define this construct, and further, that some measures – e.g., passing or failing a licensure exam, revocation or suspension of a license after a single dispensing error – may both foster anxiety and lead to behaviours that conceal learning needs from regulators, educators or employers. Framing competence in this way may not accurately express or represent the lived experience of pharmacists labelled “*incompetent,*” and may be counterproductive to remediation and the enhancement of professional skills (Austin and Gregory 2019). Austin and Gregory (2019) suggest that disengagement is an unintended consequence or impact of policies, practices, and systems that regulate and assess health professionals. They identify disengagement as a significant “*cause and consequence*” of the phenomenon termed “*competence drift*” (Austin and Gregory 2019).

This study also highlights personal and professional dilemmas family physicians encounter, and considerations they balance, when deciding what to do in practice throughout their careers. There are potential gaps between what family physicians would like or are willing to do, what opportunities are available to them and where, and what is required of them to meet community or population needs. In its diligent work to serve the public’s interest, the medical

profession may have lost sight that doctors are people, too. As SOP evolves over the course of family physician careers, the primary driver is life – family physicians as people rather than as professionals. Perhaps it is easier to focus on the professional rather than the personal because of a culture and myths perpetuated within medicine that depict physicians as invincible, as if they were not vulnerable to the sicknesses and frailties to which we are all subject (Gay 2011; Thompson et al. 2001). This culture is not only perpetuated but celebrated, leaving physicians prone to burnout if they feel they are ‘failing’ or falling short of professional expectations. As explained by participants in this study, outside of work doctors are also caregivers and patients. Responsibilities and priorities of caring for family members or following their own doctor’s orders for their health and well-being impact their SOP periodically, temporarily, long term, or indefinitely.

Many physicians in Canada experience burnout and struggle with mental illness (Rheume 2016; Wiskar 2012). Burnout can develop slowly due to long work hours and prolonged caregiver stress (Wiskar 2012). Physicians have reported that their personal lives have been adversely affected by their choice of profession (CMA 2003), which is not surprising given that a number of stressors physicians experience are inherent to the demands of the profession (CMA 2010). This study highlights that family physicians are pulled in different directions in their personal and professional lives. Patients can easily get ‘lost in the shuffle.’ Is there something that can be done to create healthier, more understanding and supportive work environments to assist family physicians? While family physicians cannot control their practice environments, they can control what they do in these environments; they can exercise personal agency and practice self-care by removing themselves or limiting their SOP. The sentiments expressed by participants in this study emphasizing personal and professional fulfilment, personal

relationships and family, and work-life balance as influencing their SOP are consistent with lifestyle strategies and interventions documented in the literature to manage health care worker stress, reduce burnout and increase career satisfaction. These include assuming control over work hours and schedule, exercise and getting adequate sleep (Keeton et al. 2007; Goldman 2014; Ruotsalainen et al. 2015; Tucker et al. 2015; Wiskar 2012).

Future research may explore these issues with Royal College certified specialists or other health professionals in Ontario and in other Canadian jurisdictions to compare these results with those of different populations in different contexts. Future investigations may also address the expectations others – e.g., patients, colleagues, community, public at large – have of physicians for their SOP. Additionally, future studies may examine the gap between the SOP assumed by physicians based on choices they make or are made for them, the SOP required of physicians to meet population needs, and the implications of this for safe care delivery and patient safety. Furthermore, future inquiries may assess if the expectations between physicians and the public about physician SOP are similar to those between physicians and ‘institutional’ structures within medicine as expressed by stakeholders and other policy-forming groups in order to determine where synergy and disconnects lie.

In conclusion, we believe our analysis of family physician perspectives on SOP, informed by their experiences with their own SOPs, represents a unique study of its kind within family medicine. Despite being situated in different contexts, at different career stages, and having different practice experiences, Ontario-based family physicians understand their SOP in terms of: what their practice looks like, professional preparedness and support, the business aspects of being a doctor and who they are as people and their life outside of work. The SOP of family physicians changes and evolves throughout their careers due to factors within and beyond their

control. This raises broader questions about the perceived discretion and actual control that family physicians have over their SOP, which encompasses so much more than clinical family practice. Family physicians seek mentorship both for drivers of their SOP for which they feel unprepared – e.g., ‘non-medical,’ business aspects of medicine – and during professional transitions – e.g., between residency and first few years in independent practice. SOP is personal to each family physician, emerges from interactions between their personal and professional lives, and is embedded in their lived experiences. The main driver of SOP throughout family physician careers is life, and SOP is more greatly impacted by their personal rather than their professional identity. To ensure continuing competence for family physicians’ SOP, the medical profession should think about CPD and LLL in the context of physicians’ lived experiences in addition to its ‘institutional’ constructs and organizationally mandated constraints.

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Chapter 5: Discussion

The preceding three chapters presented the results of each stage of my research, each addressing one of my three research questions. In this final discussion chapter I restate the broad purpose and reprise the questions for this research, I summarize the main findings of this research and I ground some of them in the literature. I next fulfill the specific objective of this research, and I use the conceptual framework of ‘ideas, interests and institutions’ to connect the preceding three chapters with an emphasis on medical regulation, medicine’s social contract with society, and the professional autonomy of medicine and discretion of physicians. I then go on to identify assumptions about scope of practice (SOP) that this research highlights, I consider some strengths and limitations of this study, and I recognize implications of this research for regulation of the medical profession with a focus on the professional autonomy of medicine and discretion of physicians. Finally, I suggest ideas for future research, and I state my overall conclusions.

5.1 Reprising Purpose and Questions

Broadly, the purpose of my research was to achieve a more comprehensive understanding of SOP within medicine in Canada, with a focus on family practice in Ontario. My research questions were:

- (1) How is SOP discussed and used in medical regulatory documents relevant to the Ontario context?
- (2) How do organizational stakeholders representing various policy fields in medicine understand and operationalize factors, drivers, determinants and elements that shape, limit and influence physician SOP and changes in SOP in the Province of Ontario?

- (3) How do Ontario family physicians understand their own SOP, including (i) what factors, drivers, determinants or elements influence (i.e., shape or limit) their SOP, and (ii) how and why might these factors change their SOP throughout their careers?

The findings summarized in section 5.2 below address these research questions in turn.

Of the three questions, I had the most difficulty answering question two because I was unable to decipher with certainty how organizational stakeholders operationalize SOP. Rather, my findings indicated that the medical profession faces a number of challenges associated with SOP as it struggles to operationalize this concept. More specifically, my findings revealed the ways in which organizational stakeholders struggle with challenges, such as practice drift and significant SOP differences in different practice environments, and what they think drives SOP. How organizational stakeholders struggle with these challenges and whether this amounts to operationalizations of SOP is open to discussion. From this, I could only infer that how organizational stakeholders understand, interpret, or operationalize SOP indicates how they struggle with this concept and what they think drives SOP. Overall, my findings indicated that SOP is not straightforward within medicine. The profession seems to be struggling with the extent to which SOP should be more sharply defined across policy fields and the best way to accomplish this.

My findings reveal what causes some of the issues surrounding SOP. My answer for question one suggests that vagueness in discussions about SOP and a failure to distinguish interpretations of SOP in medical regulatory documents impedes clarity and coherent thinking. It also stresses that SOP discussions within individual policy arenas need to be bridged if possible because they impact what stakeholders in other policy arenas throughout the profession do with respect to SOP. Similarly, my answer for question two proposes that organizational stakeholders

must determine how to collaborate and communicate within and among organizations to clarify and normalize their articulations about SOP where possible, resulting in a more coherent professional discourse around SOP. It also suggests that challenges encountered by medicine with SOP are partly attributable to the processes by which SOP is embedded in policy, and that considerations about process, implementation and implications of SOP – i.e., how SOP is decided and how negotiations of professional boundaries are articulated – are potentially being overlooked in the profession’s attempt to operationalize SOP. Additionally, tensions and concerns associated with SOP and medical regulation make it challenging to execute policies that all physicians in their respective practices can relate to. These include: flexibility vs. specificity of SOP statements; professional autonomy and discretion vs. professional accountability; and SOP is personal to each physician, emerging from interactions between their personal and professional lives, and is embedded in their lived experiences.

It is not surprising that similar reflections were expressed and considerations were identified in my answers for questions one and two given the data sources for stages one and two of this research – i.e., medical regulatory documents and representative individuals from organizations which produce these documents. Having reiterated the broad purpose and reprised the questions for my research, I will now elaborate on the above insights to summarize the main findings and their implications reported in each stage of the study.

5.2 Summary of the Main Findings

There were three main findings for stage one of the study (reported in chapter 2). First, I found that the term SOP was used vaguely and applied and interpreted inconsistently, sometimes within the same document. Second, statements about SOP within medical regulatory documents

were distinguished as being related to professional regulation, the individual practitioner, and career paths and responses to a changing health system. Third, I also identified six properties related to SOP – expectations, geographic or situational context, service provision, education and training, areas of practice, unique practice experience and characteristics – in those documents. The implications of these findings are that phrases used interchangeably with SOP may mean different things depending on the context in which they are used. It would seem that SOP is not a static or monolithic entity, but rather a multifaceted and dynamic concept.

There were two main findings for stage two of the study (reported in chapter 3). First, there was a convergence of opinion among organizational stakeholders regarding what drives SOP. Second, policy discourses about SOP in medicine generally focused on what physicians do in practice. How we limit or expand what physicians do in practice is greatly impacted by education and training, the practice environment, and legislation and regulation. These factors shape SOP and changes in SOP. These findings have implications for how the medical profession both communicates about SOP, and approaches and implements SOP policies, initiatives and programming. The three factors mentioned above can be used to initiate discussions about SOP within medicine. Nuanced differences about SOP are being considered in policy discussions, which indicates that organizational stakeholders are talking about different aspects of SOP. Having a common framework and clear discussions about SOP is important to achieve a more widespread understanding about SOP throughout the profession. Also, it is important for organizational stakeholders throughout medicine to continuously dialogue and work together (within and outside of their organizations) on matters pertaining to SOP because policy fields in medicine are interrelated and interdependent. The policies of one organization can affect the policies of another and what each of them can do, which in turn can impact the services patients

receive and the quality of these services. Stakeholders within medicine must determine how to achieve organizational goals with respect to SOP without reverting back to policy or organizational silos.

There was one main finding for stage three of the study (reported in chapter 4). Participating Ontario family physicians understood their SOP in terms of: what their practices look like, professional preparedness and support, the business aspects of being a doctor and who they are as people and their lives outside of work. The implications of this finding are that SOP is personal to each physician and emerges from interactions between their personal and professional lives for which they seek continued mentorship, support and engagement. In particular, they seek mentorship during professional transitions and for drivers of their SOP for which they feel unprepared. Also, SOP is about much more than what family physicians are trained to do for clinical practice. Non-clinical aspects of practice and SOP both impacts clinical SOP and is part of SOP overall. Additionally, SOP changes and evolves due to factors within and beyond family physicians' control. As SOP evolves over the course of family physician careers, the primary driver is life. Moreover, SOP has more to do with who family physicians are as people than who they are as professionals.

I now go on to ground my findings in the literature. In particular, I will focus on findings related to who physicians are as people, education and training and the practice environment.

5.2.1 Grounding Findings in the Literature

My participating organizational stakeholders and family physicians identified that SOP changes throughout physician careers for different reasons. Organizational stakeholders also observed that the competencies physicians must attain or maintain for their SOP throughout their

careers may differ for certification and in independent practice, which may reflect the dynamics of the practice setting. These sentiments are reflected in recent medical education literature with a particular focus on continuing professional development (CPD). Horsley and colleagues (2010) identify education throughout physician careers, particularly CPD, to be pertinent to what physicians do in practice and to determining and maintaining SOP over time as it changes. Similarly, the Academy of Medical Royal Colleges (2010), Chakhava and Kandelaki (2013), and Kam and colleagues (2019) assert that CPD should be practice-based. To wit, that CPD “*should support specific changes in practice*” (Academy of Medical Royal Colleges 2010) and is crucial “*to bridge the gap between medical education and practice*” (Chakhava and Kandelaki 2013). Once medical trainees transition into independent practice, SOP and CPD “*become moving targets according to environment, people, and changes over time*” (Kam et al. 2019). Among Kam and colleagues’ (2019) overarching findings is that SOP is of central importance to CPD because SOP effectively becomes the curriculum for independently practising physicians and their CPD. In particular, SOP is integral to determining CPD needs and content (Kam et al. 2019).

Beyond the level of the individual physician, participating organizational stakeholders were uncertain about the minimum standards and core competencies that should be maintained by all physicians and physicians in particular specialties, regardless of certification or SOP. I also found a predominance of traditional – i.e., clinical – settings and procedural activities in SOP discussions, in the SOP literature, and in the medical regulatory documents I examined. This echoes discussions in the CPD literature which emphasize that the aim of CPD is to improve patient care through better clinical performance (Sullivan 2018), and that physicians should participate in CPD to critically analyze their clinical practice and “*develop practice-driven*

clinical learning objectives” (Chakhava and Kandelaki 2013). Kam et al. (2019) similarly observed that CPD is typically more structured around clinical activity than it is around other kinds of physician roles – i.e., required CPD is somewhat unclear for non-clinical practices. Examples include physicians who assume teaching, research, administration, consulting/advisory or public service roles full time, and public health physicians who have moved away from clinical practice (Kam et al. 2019).

Participating family physicians reported having special interests or focused practices in public health. Public Health and Preventive Medicine has a focus and knowledge base that are complimentary to clinical medicine. This specialty is primarily concerned with the health of populations or groups, and focuses on disease and injury prevention and control. Through interdisciplinary and intersectoral partnerships, public health physicians monitor, measure and assess population and community health needs, and they develop, implement, and evaluate methods to improve levels of health (Royal College of Physicians and Surgeons of Canada 2018). By comparison, clinical medicine focuses on service provision and care delivery for individual patients and navigating individuals within the health care system, typically as gatekeepers – i.e., family physicians and other specialists who perform complex diagnostic assessments and provide treatment – or as ancillary services – i.e., pathology, radiology. Physicians who maintain active practices in family medicine and public health may find it challenging to maintain these complex and potentially conflicting skill sets (FG4-P20). Depending on a variety of factors (such as career stage, specialty, and practice context) a physician’s SOP may be exclusively clinical or non-clinical, but it could also be a mix.³⁶

³⁶ Clinical training, academic training in a relevant discipline (e.g. public health) to learn core academic content – i.e., epidemiology, biostatistics, health promotion, disease prevention and control - and public health rotations in a

My findings showed that non-clinical aspects of practice are included within family physicians' overall SOP. My findings also underscore the importance of non-clinical aspects of practice for professional competencies and CPD. However, competency frameworks used in residency training and CPD do not reflect SOP. For example, the CanMEDS-Family Medicine (CanMEDS-FM) 2017 competency framework describes the roles, responsibilities and required competencies to support the work of family physicians in Canada (Shaw et al. 2017). The term SOP is not mentioned within the key and enabling competencies of this framework. Rather, the first key competency of the family medicine expert role requires family physicians to “[practise] generalist medicine within their defined scope of professional activity” (Lawrence and Schultz 2017). The CanMEDS 2015 Physician Competency Framework, from which the CanMEDS-FM 2017 framework was adapted, provides guidance as to the abilities that specialists outside of family medicine in Canada require to meet patient needs (Frank et al. 2015). Similar to CanMEDS-FM 2017, CanMEDS 2015 addresses SOP with regard to clinical practice in the medical expert role and associated key and enabling competencies (Bhanji et al. 2015). Other roles in the CanMEDS-FM 2017 and CanMEDS 2015 frameworks, such as ‘collaborator’ (Newton 2017; Richardson et al. 2015a), ‘leader’ (Dath et al. 2015; Tepper and Hawrylyshyn

variety of areas (e.g. environmental health, health policy) are the three main components of Community Medicine residency training. Community Medicine specialists work in a variety of non-clinical settings such as public health agencies, universities and other research institutions, and non-governmental organizations. They also work in clinical settings. As clinical medicine training is required for certification in Community Medicine, these specialists are eligible for licensure to practise medicine. Some Community Medicine specialists complete Family Medicine training and certification, and can practise as family physicians. Community Medicine specialists may do clinical work as part of their practice – i.e., vaccination or healthy sexuality clinics (Public Health Physicians of Canada 2017).

2017), and ‘scholar’ (Ramsden 2017; Richardson et al. 2015b), and their associated competencies, include non-clinical activities identified in my focus group discussions – e.g. teaching – and practice information provided by participating family physicians– e.g. research. However, these roles and competencies again fail to explicitly address SOP. National certification bodies might consider how to make SOP more explicit in the roles and competencies within these frameworks, in particular to consider some of the non-clinical aspects of SOP that I have identified in this study.

My research arguably contributes to a growing body of literature which identifies the practice environment (Aubrey-Bassler et al. 2007; Curran et al. 2010; Ie et al. 2015; Skariah et al. 2017; Wong and Stewart 2010) and health systems, including the legislative and regulatory frameworks by which these are governed (Lahey and Currie 2005; Lahey and Fierlbeck 2013; Lahey et al. 2014; Ries 2016), as key determinants of SOP. Participating organizational stakeholders and family physicians in my study attributed a number of aspects of SOP to the contexts in which physicians practise. These include: the types of practices or arrangements in which physicians practise, whether physicians have a broad or a more specialized practice, the patients that physicians see, how physicians treat their patients, how physicians are paid, the resources or supports available to physicians, and the broader health care system. The need to attend to patients, resources and professional supports are key to Martin’s (2017) framework for relationship-based primary health care. The question of who is able or available to provide services in a particular context is as important and consequential to SOP as is how health care delivery is financed and structured (Martin 2017).

In this thesis the issues I have identified reflect intersections of broader discourses about medical education, particularly CPD, professional competencies, and the practice environment in

the literature. My research parallels these different literatures in at least six ways. This includes identifying that: (1) SOP is dynamic; (2) education is pertinent to determining and maintaining SOP over time; (3) CPD should be practice-based; (4) the practice environment is a key determinant of SOP; (5) relationships and interactions within the health care system – e.g. between and among health professionals and patients – impact SOP; and (6) clinical activities, settings and roles are emphasized within these discourses and literatures. Alternatively, my research contrasts and adds to these discourses and literatures in at least two ways. First, by highlighting the importance of non-clinical aspects of practice – i.e., activities, settings and roles – for SOP, CPD, and professional competencies. Second, by identifying how SOP might be considered and made more explicit within professional competency frameworks.

Having grounded some of my findings in the literature, I will now fulfill the specific objective of my research.

5.3 Fulfilling the Objectives of this Research

The specific objectives of my research were to determine the common conceptual elements of SOP, where differences in how SOP is conceived lie and the implications of these differences for health policy, physician regulation, CPD and practice. I found much overlap between the kinds and properties of SOP identified in medical regulatory documents (chapter 2), and the factors driving SOP identified by organizational stakeholders and Ontario-based family physicians (chapters 3 and 4). The main concepts related to SOP identified in the preceding three chapters are or pertain to: education and training, geography and the practice environment, and legislation and professional regulation/governance. The differences and nuances in how SOP is conceived primarily arise from the contexts in which they were discussed; what was emphasized

and how specific concepts were discussed – i.e., where the importance lay; and the themes and subthemes I identified in each sub-study. There appear to be differences in the language used to discuss SOP by family physicians, organizational stakeholders, and medical regulatory documents. Individual physicians used different language from the legislative, governmental, and organizational definitions, such as those from medical regulators and certification bodies, that are used to regulate the profession and govern their practice – e.g., negligible use of the words “*competence*” and “*competencies*” by participants. This is notable because language shapes the ways in which one thinks about SOP.

For example, the first three themes in chapter 4 – ‘what my practice looks like’, ‘professional preparedness and support’, and ‘the business of being a doctor’ – reflect the properties, themes and subthemes I identified in chapters 2 and 3. ‘What my practice looks like’ encompasses the practice environment, which is a stand-alone property in chapter 2 (geography/situational context) and a main theme in chapter 3. Similarly, ‘professional preparedness and support’ encompasses education and training, which is a stand-alone property in chapter 2 and a main theme in chapter 3. Also, ‘the business of being a doctor’ encompasses policy and professional governance/licensure, which is a main theme in chapter 2 (SOP regarding professional regulation), and is similar to the main theme of legislation and regulation in chapter 3. The most significant conceptual difference in how SOP is conceived is reflected in the theme from chapter 4 that ‘doctors are people, too’. I have summarized the conceptual commonalities and differences related to SOP in chapters 2, 3 and 4 in Table 5.1.

Table 5.1: Common Conceptual Elements and Differences Related to SOP in Each Chapter

Properties, Themes, Subthemes & Factors Related to SOP	Medical Regulatory Documents (Chapter 2)	Organizational Stakeholders (Chapter 3)	Ontario Family Physicians (Chapter 4)
Legislation & Regulation/Governance	X	X	X
Individual Practitioner	X	X	
Career Paths & Responses to (Changing) Health System (includes technological & medical advances)	X	X	
Expectations (e.g. patient, public, professional, physician)	X		X
Geography & The Practice Environment	X	X	X
Service Provision (i.e., services physicians are allowed or choose to provide)	X	X	
Education & Training	X	X	X
Areas of Practice	X		X
Practice Experiences	X		X
Stage in Education and/or Career		X	X
Specialty		X	
Competencies/Competency (i.e., what physicians are expected or choose to know, maintain, or incorporate in their practice)		X	
Broad SOP/Narrow SOP		X	X
Patients/Patient Needs		X	X
Professional Supports		X	X
Health Workforce Planning		X	
Referrals		X	
Workload		X	
Incentives/Funding, Compensation & Costs		X	X
Reactions to External/Top-Down		X	

Properties, Themes, Subthemes & Factors Related to SOP	Medical Regulatory Documents (Chapter 2)	Organizational Stakeholders (Chapter 3)	Ontario Family Physicians (Chapter 4)
Decisions			
Policy		X	X
Practice Activities		X	X
Physician SOP vs. SOP of Other Medical Disciplines & Professionals		X	
Personal Considerations			X
Comforts, Strengths, Interests			X
Career Aspirations, Job Opportunities			X
Clinical & Non-Clinical Activities			X
Practice Type			X
Mentorship			X

The implications of these conceptual differences related to SOP for policy, regulation, CPD and practice are addressed in sections 5.6 and 5.7. I now go on to connect chapters 2, 3 and 4 representing each stage of this research using the conceptual framework of ‘ideas, interests and institutions.’ To do so, I will emphasize medical regulation, medicine’s social contract with society, and the professional autonomy of medicine and discretion of physicians.

5.3.1 Connecting Issues Around Medical Regulation, Medicine’s Social Contract, and Professional Autonomy of Medicine and Discretion of Physicians

In this section, I revisit the conceptual framework (Deber and Mah 2014) introduced in chapter 1, highlighting how each stage of my research incorporated these concepts. ‘Institutions’ that devise and define SOP were emphasized in stage one (chapter 2). ‘Interests’ and their ‘ideas’ about SOP were highlighted in stage two (chapter 3). ‘Ideas’ of a specific ‘interest’ about SOP were prominently featured in stage three (chapter 4).

Looking broadly across my research, the main ‘ideas’ that have emerged, and that ‘institutions’ and ‘interests’ spoke to, relate to consistent tensions involving the professional autonomy of medicine, the discretion of individual physicians, and professional accountability. It is important for organizational stakeholders to consider the tensions within medical regulation when devising SOP statements. These include: normative vs. descriptive aspects of SOP (what physicians should be able to do compared with what is allowed within SOP and what physicians actually do), flexibility vs. specificity of SOP statements (policies that are too specific may constrain the ability of physicians to provide care outside of their typical SOP in an emergency situation that is permitted by other policies), and professional autonomy and discretion vs. professional accountability (the SOP assumed by physicians may not be what is needed by those to whom they provide services). Findings reported in chapter 3 indicate that when grappling with challenges related to SOP, organizational stakeholders must account for the needs of physicians in different contexts within various regulatory instruments such that physicians can meet patient needs where they practice. Due to its self-regulation, medicine has a social contract with society to respond to patient and community needs and to ensure that these needs are met. To actualize and fulfill the social contract, individual physicians must be equipped and prepared to meet the needs of those who walk through their door.

To meet their patients’ needs, physicians need support from the profession – i.e., in regulation and through CPD – to meet their SOP needs as they experience transitions in practice. Physicians drifting within or beyond their specialty certification in practice pose a challenge for medical regulators to ensure that physicians practise competently within their SOP. Similarly, competence for SOP is not static. As patient and community needs change, so too do the SOP needs of physicians to respond to these needs. Given that SOP and CPD are moving targets

(Kam et al. 2019), so too are the competencies that must be acquired or maintained to meet patient needs on the fly. Findings reported in chapters 3 and 4 indicate that required competencies can also change according to context – e.g. providing care in a university setting during the school year and locum coverage during the summer months. Recognizing that SOP should be adaptable to meet patient and community needs, and selecting CPD activities based on what is needed within specific practice contexts, can allow for meaningful CPD to occur (Kam et al. 2019).

The issue of whether the scopes of practice (SOPs) of physicians meet patient and community needs was reflected in my findings in this thesis. Patient needs were incorporated within my operational definition for the term factors. Despite not explicitly seeking this out, my literature review considered the ability of the Canadian and Ontario health care systems to meet patient needs, including the extent to which approaches to health policy making and workforce planning meet patient needs. Similarly, my literature review also included publications that attribute SOP and the acquisition of additional training to patient needs and as a response to community needs. Additionally, my rationale for this study emphasized the importance of knowing more about SOP as a way of ensuring that patient needs are better met. Participants in my study identified patient and community needs as an influence on SOP and a reason why SOP may change throughout physician careers. Patient needs were also considered within challenges for medical regulators to consider regarding SOP, as was the impact of policy decisions on the ability of physicians to meet patient needs. Findings reported in chapter 4 indicate that physicians may need assistance from the profession to help link CPD and SOP goals to community needs and highlight unmet needs. These findings also identify potential gaps between what physicians want to do in practice and what is required of them to meet community needs.

This reflects a challenge for the medical profession to address in connection with SOP and CPD identified in other work I conducted during my doctoral studies, which suggests that there may be a gap between the SOPs that physicians assume and the SOPs that the patients and communities they serve require. Ideally, in a patient-centred system, physicians exercise professional discretion in structuring their SOP and CPD so as to respond to patient needs (Kam et al. 2019). Findings reported in chapter 4 bring into question the perceived level of discretion and actual level of control family physicians possess over their SOP. If a gap exists between physicians' SOP and the SOP required to meet patient and community needs, to what extent is this due to physician choices or factors beyond physicians' control? How much discretion do physicians actually have over their SOP?

In theory, medicine has autonomy over its SOP through self-regulation (Cruess 2006; Lin 2014; O'Reilly 2000). However, my findings indicate a potential mismatch between the professional autonomy of medicine at the legislative and regulatory levels, and discretion over SOP at the individual physician level, both in theory and in practice. Some organizational stakeholders suggested that SOP choices may be guided by how physicians want the health system to work best for them, or to navigate the health system to their advantage. Alternatively, I found that family physicians had different opinions regarding their ability to exercise their discretion in practice. They did not feel that they have as much discretion as they thought they would possess throughout their careers, or, as is perceived by organizational stakeholders, the public or in medical regulatory documents. I continue this discussion in section 5.6 to recognize implications of my findings and this research for the professional autonomy of medicine and discretion of physicians.

Having connected the previous three chapters representing each stage of this research, I will now identify assumptions about SOP across medicine and medical regulation that this research highlights.

5.4 Assumptions About SOP Across Medicine and Medical Regulation

My research highlights five assumptions about SOP across both medicine and medical regulation. First, that SOP means the same thing throughout the medical profession. Second, that clinical settings, interactions, and activities – e.g. physician-patient interactions; procedures, treatments or services for patient care delivery - mainly impact SOP and what physicians do in practice. Third, that SOP is synonymous with specialty certification. Fourth, that SOP throughout physician careers is primarily influenced by professional roles, responsibilities and identities. Fifth, that organizational stakeholders should mainly be concerned about physicians ‘drifting’ beyond their SOP or specialty certification to ensure continued competence, safe practice and to meet community and patient needs. These assumptions reflect prevalent understandings about SOP, and what is or can be known about this construct. That this research challenges these assumptions indicates that there is still much to learn and know about SOP. It also indicates that there is room, if not a necessity, to let go of some of these assumptions and to expand our thinking about this construct.

Having identified assumptions about SOP that this research highlights, I will now consider some strengths and limitations of this study beyond those discussed in chapters 2, 3 and 4.

5.5 Strengths and Limitations of this Study

I note some limitations (in addition to those previously considered in this thesis) that may affect the findings reported in this study. I primarily consulted literature from North America –

e.g. Canada and the United States, and to a lesser extent Australia and the United Kingdom for the introductory literature review and each stage of the study. The limited consideration and inclusion of international evidence in this research potentially limits the generalizability of my findings outside of Canada. Also, I did not compare my findings to those of international studies. I do not know if my suggestions about making SOP more explicit within professional competency frameworks or governance structures to address non-clinical aspects of SOP identified in this study are applicable and transferrable to competency frameworks and governance structures in other countries. I also do not know if the implications for policy, medical regulation, CPD, and practice identified in this study are applicable elsewhere. However, there is no reason to believe that SOP discussions within medicine in Canada are not similar to those occurring in other countries. Although the policy considerations pertaining to SOP may differ, I believe these findings to be generally applicable.

Despite these limitations, I employed rigorous research processes and methods in this study from inception to completion (Morse et al. 2002) to ensure that I presented a truthful representation of participant voices and experiences with my use of qualitative description (Bradshaw et al. 2017). For each stage of this research, I documented how I met the criteria of credibility, confirmability, dependability, and transferability to demonstrate the quality of the data generated (Bradshaw et al. 2017) which informed my findings and conclusions. I also identified themes and factors that are not well documented in the SOP literature. Exploring the business and personal aspects of being a physician and the factors within these themes suggest areas for further research.

This study has implications for the development of competency based medical education (CBME) in Canada. The medical profession has developed and implemented CBME (College of

Family Physicians of Canada 2011; Frank and Harris 2014) for physicians to achieve and maintain core competencies acquired in residency training, and to ensure competence for their SOP through CPD. Organizational stakeholders included competency and competencies in their operationalizations and understandings of SOP. However, the family physicians I spoke to did not use these concepts when considering their SOP, and they identified different needs in preparation for their practice experiences. Medical educators and national certification bodies might consider and incorporate the ways in which family physicians understand their SOP within CBME so as to achieve and maintain “‘*contextual*’ competence for practice and licensure” (Taber et al. 2010).

Having considered additional strengths and limitations of this study, I will now recognize implications of this research for regulation of the medical profession. In particular, I focus on the professional autonomy of medicine and discretion of physicians. I introduced this discussion in section 5.3.1 and elaborate on it here because of its policy relevance. Medicine is self-regulated and continuing medical education is self-directed. As I stated in the introduction and in chapter 3 of this thesis, physicians in independent practice are largely responsible to determine and address their competency and learning needs. In order to address these issues, I must first address the concepts of professional autonomy and discretion because they are fundamental to regulation of the medical profession and physicians – i.e., the underpinnings of these concepts are fundamental to policy discussions within medicine.

5.6 Implications for Regulation of the Medical Profession: Professional Autonomy of Medicine and Discretion of Physicians

My research questioned assumptions with respect to how much autonomy and discretion medicine and physicians possess, and the freedom they have to exercise it, at the level of the

profession and the individual physician. The legal and constitutional rights enshrined in the *Canadian Charter of Rights and Freedoms* and the mandated self-regulation of medicine are two sources of autonomy for the profession and discretion for individual physicians. Professional autonomy grants physicians collectively, with restrictions, control over the care they provide, as well as how and where they provide medical care.³⁷ There is an important distinction between the professional autonomy that is enjoyed by a profession for the public's interest, and professional discretion that is exercised by individual professionals. A question that arose out of my findings is: in a publicly funded system, do physicians have a right to choose or to prioritize what they want – personally and professionally – for their SOP independent of what the public needs?

My answer is both yes and no, which sends a conflicting message to the profession, physicians, and the public. Professional discretion allows individual physicians a degree of latitude to pick and choose what they do in practice – i.e., assess whether they are competent to do what they want or need to do and act accordingly. Professional autonomy both does and does not grant this latitude. I will unpack this paradox using practice location and government strategies to direct or redistribute physicians throughout Ontario as an example. As I previously stated, practice location is intimately related to SOP. Moreover, the medical profession must fulfill its social contract with society to maintain the privilege of self-regulation. For the profession to fulfill its social contract, physicians need to provide the care that is required where

³⁷ Professional autonomy has economic, political and clinical dimensions. In the context of medicine, economic autonomy is the right to decide the level of remuneration and resources available for work. As health and medical experts, political autonomy grants a profession the right to make policy decisions. Clinical autonomy affords the profession the right to set standards for, and assess the clinical performance of, its membership (Elston 1991).

it is required. As Mintz (2018) suggests, greater physician accountability to patients and the places in which they work is possible. Family physicians in my study indicated that the expected standard of care in the community and expectations of colleagues impacted their SOP. Further, Pong (2008) claimed that “*severe and persistent*” physician maldistribution is unacceptable within a Medicare system for which two of its basic principles are accessibility and universality. Removing some financial barriers to health care – i.e. implementing the Ontario Health Insurance Plan (OHIP) - becomes meaningless if services and providers are extremely difficult to access or unavailable, or if expectations of communities for the standard of care they receive and of colleagues to deliver that standard of care cannot be met.

Yet, organized medicine in Ontario has opposed attempts by the Ontario government to implement programs of a “*direct nature*,” such as physician supply mechanisms, it deemed to be “*coercive*” (Pong 2008). For example, the Ontario government introduced *The Savings and Restructuring Act* in the mid-1990s, which included provisions that permitted the Minister of Health to designate areas of the province as over-serviced with physicians and to refuse to issue OHIP billing numbers to new physicians who wanted to practise in those areas. This attempt to direct new physicians to underserviced areas was opposed in particular by the Professional Association of Internes and Residents of Ontario, and was consequently not implemented. Similarly, the Ontario government discontinued the fee discounts measure, which gave lower OHIP fee payments to new physicians who chose to practise in areas with an over-supply of physicians (Pong 2008). Family physicians in my study indicated that financial and economic considerations influenced their SOP. Over and above remuneration, which was the focus of these strategies, as a result their SOP was determined by what the government covers within OHIP

from year to year (along with overhead costs, retirement options, and other business-related considerations).

Unlike financial and economic policy instruments to curb physician practices, the Ontario government has avoided policy instruments to address the personal considerations and factors – e.g. work-life balance, family – family physicians reported to have influenced their SOP. This is understandable as lifestyle preferences, family relationships, and spousal preferences or career aspirations are largely outside of government control. Also, public policy may be too imprecise or heavy-handed an instrument to address issues “*that are highly personal or idiosyncratic in nature*” (Pong 2008). We should therefore exercise caution when making judgements about SOP decisions from one physician to another.

Of the three regulatory tensions related to SOP mentioned above, the crux of the matter is between professional autonomy and discretion vs. professional accountability. Clearly, the Ontario government contemplated how it might influence where physicians practice to address inequitable health professional distribution. In the first instance, the proposed measures were ineffective and potentially violated physicians’ constitutional rights to practice freely where they choose.³⁸ My findings suggest that these proposed measures also reflect an incorrect assumption

³⁸ Section 6(1) and (2) of the *Canadian Charter of Rights and Freedoms* grant to all citizens and permanent residents the right to enter, remain in and leave Canada; to move to or reside in any province; and to pursue work or gain livelihood in any province. Physicians have successfully challenged physician supply mechanisms in the British Columbia Supreme Court. In *Waldman v. British Columbia (Medical Services Commission)* [1997], the policy in dispute stipulated that physicians would be entitled to different levels of payment for the services they provide depending on whether they practised in “underserved,” “adequately serviced,” or “over-served” areas. The government of British Columbia unsuccessfully argued that the policy was needed to improve the supply of accessible health care throughout the province. While the Court accepted the province’s argument that this measure

that “governments can easily [regulate, innovate, or impose economic systems] to manage physician incentives...without due attention to their preferences” (Laporte 2018). Family physicians in my study reported that their SOPs – and the ability to exercise discretion - were influenced by their personal preferences and professional comforts, strengths, interests and aspirations. They also indicated that their SOPs were influenced by government decisions. In the second instance, it would be inappropriate for government to propose or institute measures whose express purpose is to influence physicians’ personal lives when attempting to sway physicians’ professional decisions. This being the case, physicians may need to be flexible regarding some aspects of their discretion. Otherwise, regulators will take something away at the risk of an outside entity – e.g. government – becoming involved. The mandate of regulators is to regulate the practice of a profession to protect and promote the interests of the public, not the professional (Balthazard 2017). The medical profession must decide if the priority is public need or to satisfy its membership, and respond accordingly. It cannot serve both masters well, which might mean less discretion for physicians. Is the medical profession prepared to reassess its professional identity and to philosophically shift how regulators regulate physicians?

One way of addressing this is to challenge regulators’ working assumptions and expectations about the actual discretion that physicians have over their SOP. The regulatory

served the objective of maintaining quality health care, it did not find a rational connection between this measure and objective. The Court argued that the causal relationship between this measure and physicians’ behavior “*is not scientifically measurable*” and must be “*demonstrated on the basis of reason and logic*” (Waldman [1997] at 152). The Court applied this standard to the province’s arguments favouring this measure and rejected the proposition that the financial disincentives within this measure would redistribute physicians to underserved areas (Manfredi and Maioni 2002).

emphasis on physician autonomy more so focuses on what physicians as members of the profession can and cannot do and how well they do it – i.e., to ensure competence for performance in practice, rather than on how much control physicians have over what they do. Legislation and regulation are two principal sources of authority over physician conduct in practice. Yet, just because legislation and regulation permit physicians to do something, it does not mean that they will (such as delegating service provision to other qualified care providers). Similarly, just because regulation indicates that physicians should not do something, it does not mean that they will not (such as providing specialist care beyond initial education and experience to meet patient needs).

In theory, by virtue of its self-regulation, the medical profession may feel it should be able to do what it wants within legislative parameters. Beyond changes to legislation as a result of political or judicial decisions, it may also feel that no other external entity should be able to tell it what to do. Regulators determine how much control to give physicians over what they can do in practice. Within regulatory parameters, physicians can choose their SOP. This view of professional autonomy and discretion is simplistic and quite narrow. My results indicate that family physicians view their ability to exercise their discretion over their SOP more broadly, holistically and with greater complexity. Based on their experiences in practice, family physicians in my study reported that there are limits to their ability to choose their SOP and that their SOP is impacted by many factors, some of which are beyond their control. Throughout their careers, family physicians attempt to balance and react to numerous personal and professional considerations, such as life – their own and that of their family – patient needs, government decisions, and managing the expectations of the public, the profession and their patients. As family physicians have varying degrees of control over what they do in practice, they may

exercise their discretion to counteract perceived unmanageable or undesirable aspects of their practice.

A second approach to the challenge of inconsistency in SOP thinking requires rethinking how physicians are regulated. My findings indicate that there is much variation in family practice. Organizational stakeholders in my study suggested that family physicians are doing different things in their respective practices. Family physicians reported that their SOP is impacted by their personal lives. From these statements, I infer that no two family physicians' SOPs are identical; one SOP size does not fit all. Conceptually and practically, physicians cannot be put in a box and treated the same way in practice as they were during their undergraduate and post-graduate education. Yet, this is what is occurring in practice. Physicians in training and in independent practice in Ontario are regulated according to their specialty certification. Family physicians who are of the opinion that they lack the support to do what is required of them to care for their patients, and who believe that these feelings are not addressed, are potentially being sidelined.

In a recent public consultation about SOP initiated by the College of Physicians and Surgeons of Ontario (CPSO), respondents expressed concern and frustration that family physicians unsafely extend beyond their SOP or make patient referrals to other family physicians or general practitioners in lieu of the appropriate specialist. A common scenario cited was the treatment of skin conditions by "*untrained physicians*" practising dermatology and cosmetic medicine (CPSO 2016). Family physicians may take courses or acquire certificates of added competency in dermatology to meet patient and community needs. For example, a family medicine group may wish to provide primary care dermatology services in response to long waiting times or lack of access to this specialty where they are located (Kam et al. 2019).

The CPSO's consultation respondents also suggested that family physicians do not have the training to do what they are doing in some cases, and that there is no substitute for residency and/or fellowship training. If this is the case, the exercise of every physician's discretion may have to be limited according to their credentials. If the expectation is that every physician practise exclusively within the SOP of the specialty or sub-specialty in which they are certified, then this must occur across the board without exception. Patients will pay the price for this approach to regulation. Much needed care they might not otherwise receive will be taken away. The alternative option is for the profession to ensure and encourage that all physicians regardless of certification have access to the CPD they need to maintain or add to their skill sets as is required.

Having recognized implications of this research for regulation of the medical profession, I will now suggest how future research can build on findings reported in this thesis.

5.7 Future Research

I identified a degree of uncertainty about the minimum standards and core competencies that should be maintained by physicians regardless of their specialty certification or their SOP. I also identified an emphasis of clinical settings and activities in SOP discussions, in the SOP literature, and in medical regulatory documents. Additionally, family physicians in my study included non-clinical aspects of practice within their overall SOP. Future inquiries could examine what is the CPD required to maintain competencies for non-clinical specialties, non-clinical SOPs or aspects thereof. Similarly, future research should examine the non-clinical personal and professional factors identified in this thesis that were found to influence SOP.

Participating physicians in my study identified an interaction between their personal and professional identities in their lived experience as family physicians. Although this phenomenon is largely absent from the SOP literature, some themes that emerged from my research are covered in other literatures. The recruitment and retention literature and practice intention literature identified factors and considerations that are similar to, and consistent with, findings reported in chapter 4. However, to further explore how much control physicians have over their SOP, future research should continue to incorporate the physician perspective and voice. Future research should also approach SOP with a more interdisciplinary lens – i.e., more holistically and broadly – linking to other literatures that may not engage SOP directly, but that are relevant to SOP. For example, if looking at SOP from a physician health and well-being or occupational health lens, the physician perspective is important to consider for two reasons. First, it is necessary to effectively drive and influence SOP. Second, because physicians have rights of discretion and are entitled to have their perspective and well-being considered as a matter of rights and professional ethics – e.g. commitment to self-care, conscientious objection, refusal to accept patients for legitimate reasons (Canadian Medical Association 2018).³⁹ SOP discussions

³⁹ Over and above the rights and ethics which bestow upon physicians this entitlement is the professional responsibility to demonstrate a commitment to physician health and well-being to foster optimal patient care within the professional roles of the CanMEDS 2015 and CanMEDS-FM 2017 physician competency frameworks (Snell et al. 2015; Pauls and Horton 2017). Accompanying this key competency are enabling competencies that promote self-awareness to manage influences on personal well-being and professional performance; manage personal and professional demands for sustainable practice, and promote a culture that recognizes, supports, and responds to physician needs (Snell et al. 2015; Pauls and Horton 2017). The profession has supports in place to address physician health issues, concerns, and behaviours that have personal and professional impacts, such as Physician Health Programs (Ontario Medical Association 2019). However, physicians would benefit from more support from

may change when framed in terms of what physicians, as people, are owed or deserve or are entitled to – i.e., work-life entitlements and balanced practices (Kersley et al., 2005; Kodz et al. 2002; Lewis et al. 2000). From the standpoint of occupational health, as reflected in the occupational health literature, working life includes people’s interests and their entitlements or rights, such as compassionate, family, or parental leave (Baughman et al. 2003; Beauregard and Henry 2009; Estes and Michael 2005).

More comprehensive information from physicians is also needed to better understand SOP – i.e., beyond what physicians can bill for and closed ended practice information questions for annual licensure renewal. For example, physicians can be a valuable source of continuous feedback to explain how advances in technology or knowledge, or changes in legislation or policy, impact what they do in practice. Yet, the questions asked of physicians about their SOP, and how these questions are asked, usually do not permit this level of detail. Knowing this level of detail is important. Medical regulators should be able to more effectively regulate SOP if they have a more complete understanding and picture of what physicians are doing in practice and why. It is difficult for regulators to regulate what they do not know or see.

Furthermore, more research is needed to better understand the implications of the conceptual differences related to SOP identified in this study for policy, regulation, CPD and practice. Training for and regulation of physician practice needs to consider how SOP varies according to context. To respond to patient, community and population health needs, physicians,

the profession to achieve and maintain the aforementioned competencies. The profession has a responsibility, through socialization, to change the perpetuated and celebrated culture within medicine mentioned in chapter 4. This responsibility extends to the environments in which physicians work to provide healthier, more understanding and supportive settings in which to practise.

the medical profession and government need to have a better understanding of who is falling through the cracks and why. Family physicians in my study reported that they were not necessarily aware of all unmet needs in their communities. As Glazier and Kiran (2018) point out, while physicians are accountable to their patients, not every patient has or can access a primary care physician. Walk-in clinics, urgent care and emergency rooms may be the first - and a sporadic - point of contact with the health care system for hard-to-reach populations (Glazier and Kiran 2018). Future SOP research might utilize or benefit from aggregate reporting of information from electronic medical record (EMR) systems⁴⁰ to help physicians to identify and address contextually specific SOP and associated learning needs (Alberta Medical Association n.d.). For aggregate reporting of this information to be feasible and subsequently used in research, privacy, confidentiality, and medico-legal concerns would have to be addressed. For example, patients would have to provide express consent for their personal information to be shared outside the circle of care. Also, legal and regulatory requirements for electronic records must be complied with— i.e., must meet the specific needs for which the data collected is being used – and data sharing – principles and contractual provisions – including confidentiality and non-disclosure agreements (Canadian Medical Protective Association 2014).

In summary, at least four aspects of research are needed going forward. First, work is needed to identify and address the SOP, CPD and learning needs of physicians for the contexts in which they practice, and to maintain competencies for non-clinical specialties, SOPs and aspects thereof. Second, we need to explore non-clinical personal and professional factors that influence SOP. Third, there is still a need for better understanding of SOP as well as what physicians do,

⁴⁰ Ontario MD currently lists 12 certified active EMR system offerings (Ontario MD 2019).

particularly where it goes beyond that which physicians routinely provide, are asked, or what is easily accessible. Fourth, we need to explore how much control physicians have over their SOP. Related to this is approaching SOP investigations using a more interdisciplinary lens linking to other literatures that are relevant to SOP. When pursuing these lines of inquiry, the physician perspective and voice should be used whenever possible.

5.8 Conclusions

My research has shown that there is considerable overlap between the categories and properties of SOP, as well as the factors that influence SOP among the various data sources. The main conceptual elements related to SOP I found were: education and training (throughout physician careers); practice context (geography broadly and the practice setting specifically); and professional governance (in particular legislation and regulation). I found general agreement that the term SOP in medicine refers to what physicians are permitted to do in practice. Yet, I also found nuanced differences about how people think about SOP, and what aspects of SOP they pay attention to. This is particularly evident from the family physician perspective, which raised considerations not typically discussed in the SOP literature or in medical regulation. Different ‘interests’ and ‘institutions’ use different language to discuss SOP in medicine. The lack of clarity and consistency of language regarding SOP can lead to policy disconnects about SOP throughout the medical profession. Establishing a common framework and clarity of concepts for SOP, or identifying either which property or from which context SOP is being discussed, may assist with lessening potential policy divides and advancing SOP discourses within medicine.

Regulation of and training for physician practice must consider how SOP varies according to context. Medical regulators, educators, and certification bodies should be able to more

effectively regulate SOP, educate physicians for their SOP, and support physicians to identify and address their SOP needs through CPD if they know more about what physicians need for their SOP, what physicians do in practice and why, as well as where and how they are doing what they do. Physicians are best positioned to help us better understand SOP because they know the answers to these questions. I found that family physicians seek continued mentorship, support, and engagement during professional transitions and for drivers of their SOP for which they feel unprepared. Moreover, they consider non-clinical aspects of practice to be part of their overall SOP and to impact their clinical SOP. I found that SOP is personal to each physician and emerges from interactions from their personal and professional lives. I also found that SOP changes and evolves throughout their careers due to factors within and beyond their control. Furthermore, I found that SOP has more to do with who family physicians are as people as opposed to who they are as professionals.

An individual does not cease to be a person when they become a doctor. A moral requirement exists to care about the good of physicians, insofar as they are people too, for two reasons. First, because content, fulfilled, and healthy physicians likely support the public good – i.e., delivery of high-quality care, good patient health and system outcomes. Second, because it is important to care for those who care for us. This is the case whether care is provided out of a personal choice or obligation, or a professional duty. Physicians, like other workers, are patients too, and deserving of care and concern for their well-being (Scheepers et al. 2015; Wallace et al. 2009a; Wallace et al. 2009b). The implications of ‘doctors are people, too’ suggest that there is much more to convey beyond how to influence physician behaviour and SOP in the service of patients and for the public good. Such implications raise important considerations when

normative issues about the professional autonomy of medicine and discretion of physicians are in play.

My research identified three tensions which leads us to ask questions that are important to address for policy. The main tension related to SOP that I found was that between professional autonomy and discretion vs. professional accountability. A question that emerged from my research was the extent to which the medical profession and physicians fulfill their social contract with society. This contract initially occurs at the level of the profession to respond to patient and community needs, and to ensure that these needs are met. To actualize and fulfill the social contract, physicians, regardless of specialty certification, need support from the profession in regulation and through CPD to meet their SOP needs throughout their careers. In a patient-centred system, SOP and CPD should be patient-driven to respond to these needs as they change. However, the case of family medicine in Ontario suggests that there are limits to the professional autonomy of medicine and discretion of individual physicians regarding SOP when weighed against the public interest. The medical profession must decide if it is prepared to reassess and shift how it regulates physicians to uphold its social contract with society and to meet the SOP needs of physicians.

In theory, medicine has autonomy over its SOP through self-regulation. The regulatory emphasis on physician autonomy focuses on what physicians are allowed to do – and how well they do it – rather than on how much control physicians have over what they do. The case of family medicine in Ontario suggests that family physicians view their ability to exercise their discretion over their SOP more broadly, holistically and as more complex than do medical regulators. It also suggests that in practice physicians do not have as much discretion as they thought they would have, or as the profession or the public presume them to have. Family

physicians are limited in their ability to choose their SOP, and have varying degrees of control over what they do in practice as they attempt to balance and react to numerous personal and professional considerations throughout their careers.

My findings highlight several new avenues that could be explored in future studies. These inquiries include: (1) identifying SOP and CPD needs for the contexts in which physicians practice, and for maintaining competencies for non-clinical specialties and SOPs; (2) exploring non-clinical personal and professional factors that influence SOP; (3) investigating how much control physicians have over their SOP; and (4) using a more interdisciplinary lens to investigate SOP. Future research on physician SOP should continue to include the physician perspective and voice because physicians are uniquely positioned to provide more comprehensive information about their SOP.

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Appendix A: Approval for Conducting Research Involving Human Subjects: Research Ethics Board – Laurentian University



APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS
Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New / Modifications to project / Time extension X	
Name of Principal Investigator and school/department	Sophie Kam, supervisor E Wenghofer, School of Rural & Northern Health
Title of Project	A Study of Family Physician Scope of Practice in Ontario
REB file number	2014-11-07
Date of original approval of project	Dec 15, 2014
Date of approval of project modifications or extension (if applicable)	March 6, 2015 Feb 02, 2016 July 20, 2016 January 17, 2017
Final/Interim report due on: (You may request an extension)	May 30, 2017
Conditions placed on project	

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, *Laurentian University Research Ethics Board*

Appendix B: Letter of Support for the “A Study of Family Physician Scope of Practice in Ontario” Project



February 17, 2015

Sophia Kam
Interdisciplinary Rural and Northern Health PhD program
Laurentian University
935 Ramsey Lake Rd
Sudbury, ON P3E 2C6

Sent via mail: skam@laurentian.ca

RE: Letter of support for the “A Study of Family Physician Scope of Practice in Ontario” project

Dear Ms. Kam,

The College of Family Physicians of Canada (CFPC) is pleased to offer you support for your research project entitled “A Study of Family Physician Scope of Practice in Ontario”.

The CFPC represents more than 32,000 members. It is the professional organization responsible for establishing standards for the training, certification and lifelong education of family physicians. The College provides quality services and programs, supports family medicine teaching and research, and advocates on behalf of family physicians and the specialty of family medicine. The CFPC accredits postgraduate family medicine training in Canada’s 17 medical schools.

Research of the scope of practice of family physicians in Ontario is advantageous to not only family physicians and primary care providers, but can also provide a deeper understanding of practical and policy implications in health care across Canada. That is, your project, while Ontario-based, could provide insights for family physicians throughout this country.

Findings of this study will help identify key aspects of scope of practice related to physician competence and quality of care. This is beneficial as it is central to many elements of physician governance and practice, and can ensure safe practice for specific scopes of practice. Participants taking part in this study may also be eligible for linking learning with practice (LLP) activity, and have the potential to earn Mainpro-C and Mainpro M1 continuing professional development credits from the CFPC.

The CFPC fully supports your research project, we are confident that its conclusions will be of extraordinary value and interest to family medicine, and we look forward to seeing the results of your study.

If you need anything further, please do not hesitate to contact me at emang@cfpc.ca or 905-629-0900 ext 325.

Sincerely,

Eric Mang
Executive Director, Member and External Relations

c.c.: Dr. Francine Lemire, Executive Director and Chief Executive Officer, CFPC
Dr. Cathy Faulds, President, OCFP
Ms Jessica Hill, CEO, OCFP
Dr. Jamie Meuser, Executive Director, Professional Development and Practice Support, CFPC
Mr. Artem Safarov, Director, Health Policy and Government Relations, CFPC
Dr. Cheryl Levitt, Director, Research, CFPC
Ms Amy Outschoorn, Director, CPD, CFPC

Appendix C: Academic and Grey Literature Search Term Combinations

Search Number	Search Term Combinations			
1	Health professional	scope of practice	Canada	
2	Health professions	scope of practice	Canada	
3	Health professions	scope of practice	reports	
4	Health professions	scope of practice	reports	Canada
5	Health professions	scope of practice	reports	Ontario
6	Health professional	scope of practice	Ontario	
7	Health professions	scope of practice	Ontario	
8	Health professional	scope of practice	regulation	
9	Health professions	scope of practice	regulation	
10	Health professional	scope of practice	licensure	
11	Health professions	scope of practice	licensure	
12	Health professional	scope of practice	credentialing	
13	Health professions	scope of practice	credentialing	
14	Health professional	scope of practice	legislation	
15	Health professions	scope of practice	legislation	
16	Health professional	scope of practice	liability	
17	Health professions	scope of practice	liability	
18	Physician	scope of practice	Canada	
19	Physician	scope of practice	Ontario	
20	Physician	scope of practice	reports	
21	Physician	scope of practice	reports	Canada
22	Physician	scope of practice	reports	Ontario
23	Physician	scope of practice	regulation	Canada
24	Physician	scope of practice	regulation	
25	Physician	scope of practice	licensure	Canada
26	Physician	scope of practice	licensure	
27	Physician	scope of practice	credentialing	Canada
28	Physician	scope of practice	credentialing	
29	Physician	scope of practice	legislation	Canada
30	Physician	scope of practice	legislation	
31	Physician	scope of practice	liability	Canada
32	Physician	scope of practice	liability	
33	Physician	scope of practice	medico-legal liability	Canada
34	Physician	scope of practice	medico-legal liability	

Appendix D: Canadian Physician List of Sources

**Included in Document Review Analysis

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Appendix E: Interview Guide for Semi-Structured Interviews

The following is an interview guide regarding organizational stakeholder understandings of physician SOP used in one-on-one in person or over the phone semi-structured interviews. Questions were intentionally stated broadly because they were asked of individuals representing different areas of physician governance and practice. Questions were phrased such that each participant could speak to them regardless of organizational affiliation, and not be 'led' to an anticipated outcome as a result of how the questions were asked. Post-interview, the interviewee was acknowledged for their time.

Participants were asked to discuss SOP from their organization's perspective. The following questions were asked during each interview:

- 1) What does scope of practice mean within your organization, and further, how do you operationalize scope of practice within your organization's mandate?
- 2) According to your organization's mandate and purpose, what drives or determines a physician's scope of practice, and what are factors that influence scope of practice?
- 3) How does your organization address different changes that occur in scopes of practice, and further, what are important elements that shape or limit a physician's scope of practice?
- 4) From your organizational perspective, are there any consequences of changing how scope of practice is defined or understood, and further, are there any unintended consequences of doing so? If so, what are they?
- 5) How much and what knowledge does your organization feel physicians should possess for their scope of practice, and further, what factors should determine the extent of this knowledge?

6) Is there anything of importance I haven't asked you regarding scope of practice or that you wish to add?

Probing questions asked based on participant answers to the main questions:

- Is there anything else?
- Can you tell me more about ...?
- Repeat participant's statement in a way that suggests that more information is desired
- Yes? Go on ...
- Can you give me an example of ...?
- Would you like to talk a little more about ...?

Referring Back as Follow-Up Questions:

- What do/did you mean by [insert respondent's statement]?
- Can I ask you a few more questions about ...?
- Can we further discuss ...?

Appendix F: Focus Group and Interview Question Guide

The following is a question guide regarding family physician understandings of their SOP used in focus group discussions and interviews in person or over the phone. Questions were intentionally stated broadly so as not to ‘lead’ participants to an anticipated outcome. Questions were phrased such that each participant could speak to them, regardless of their SOP, practice profile, practice patterns, and practice context or environment. At the end of each focus group and interview, participants were thanked and acknowledged for their time.

The following questions were asked during each focus group and interview:

- 1) How do you understand your scope of practice? Please describe your practice/How would you describe your practice?
- 2) In your opinion, what drives or determines your scope of practice? What are important elements or factors that help shape your scope of practice? Limit your scope of practice?
- 3) Has your scope of practice changed throughout your career? If yes, how? To what factors do you attribute these changes in scope?
- 4) With regard to your scope of practice and practice environment, context or setting:
 - (a) Did you know what you were getting into?
 - (b) When did you realize the realities of your situation?
 - (c) Under what conditions did this become apparent?
 - (d) When or under what conditions you believe you should have been made aware of the realities of your practice?
- 5) Is there anything of importance I haven’t asked you regarding your scope of practice or that you wish to add?