

Delineating Blurred Lines: The Experience of Defining Core Competencies in Canadian Surgical Residency Programs

Nebras Alghazawi , MD
Meredith Young , PhD
Marco A. Mascarella , MD, MSc

Andrei Aldea , MD
Gabriella Le Blanc , BSc
Lily HP Nguyen, MD, MSc

Competency-based medical education (CBME) depends on identifying the outcomes necessary for a physician to be deemed “competent” in their field¹ and building the curriculum and assessments needed to support the development of these competencies. Implementing CBME requires operationalizing national standards^{1,2} and considering how these standards will be enacted in a given setting and for a given patient population. But who decides what the core competencies are for a given specialty?

Our research team was tasked with determining which surgical procedures should be considered “core” knowledge for otolaryngology-head and neck surgery (OTL-HNS) residents in Canada through a national consensus exercise. Canadian OTL-HNS residency training is regulated by the Royal College of Physicians and Surgeons of Canada (RCPSC), which uses a national competency framework.¹ However, individual specialty organizations are tasked with the identification of medical-expert-specific competencies, or core procedures that are specialty-specific. Our plan was straightforward: we included as stakeholders members from all Canadian OTL-HNS surgical subspecialties in order to collaboratively define core competencies. We believe that our experience and the challenges we faced in attempting to identify core competencies in OTL-HNS may be of value to others involved in operationalizing CBME.

We approached the identification of core competencies cautiously, influenced by a 2009 US study highlighting the challenges of determining specialty-specific competencies,³ which showed that graduating US residents in general surgery performed only 18 out of 121 essential procedures more than 10 times. Opportunities to practice were limited, and 63 procedures considered “essential” were reported as never being done.² Considering the proximity of OTL-HNS to

other surgical specialties, we recognized the potential impact that defining core competencies for OTL-HNS might have for other specialties. We employed a Delphi approach to consensus building involving key stakeholders, including the RCPSC’s specialty committee in otolaryngology, representing all subspecialties and program directors.⁴

Disagreement is expected in a Delphi consensus process.⁴ Participants are provided with group responses and asked to reconsider their own responses in light of the group’s feedback. Through multiple iterations, consensus gradually forms. However, in our case, stakeholders were divided when it came to clearly defining a subset of unique core competencies in OTL-HNS, causing a stall in consensus. Stakeholders perceived certain surgical procedures as overlapping across multiple specialties and believed that designating these overlapping competencies as “core” could lead to competition among specialties for the same procedures, given their clinical rarity. On the other hand, not including certain procedures as core competencies could limit the scope of OTL-HNS practice. Resistance grew as stakeholders raised concerns about the downstream consequences of identifying certain procedures as core competencies, including limitations on specialty practice, impacts on professional identity and boundaries, and possible repercussions on interprofessional environments. Ultimately, the Delphi project failed and was abandoned. Information specific to our Delphi process can be found in the online supplementary data, as our discussion here is less about the specifics of the Delphi, and more about what we learned through its failure.

Inability to Reach Consensus

The exact reasons for the failure of our consensus project are difficult to pinpoint. Upon reflection and considering participant concerns, we believe it failed due to the challenging task of explicitly defining professional identity through procedure identification. The perceived medical and ethical implications of monopolizing certain competencies, as well as the

DOI: <http://dx.doi.org/10.4300/JGME-D-22-00833.1>

Editor’s Note: The online version of this article contains additional context on the Delphi exercise.

potential downstream effects on surgeons and their fields, played a role. Although Accreditation Council for Graduate Medical Education- and RCPSC-defined competencies are shared throughout all specialties, specialty-specific core competencies contribute to defining the nature and “business” of each specialty, and defining professional boundaries and scope of practice both legitimizes and limits the profession. This explicit delineation and the need for residents to prove competency in each attribute were key factors contributing to the contentious nature of this consensus-building exercise.

The presence of rare procedures that overlap with other specialties is not unique to OTL-HNS, but it provided insights into the complexities of implementing a CBME curriculum involving specific procedures. Let’s consider a rare procedure that may be mastered only during fellowship practice. If it is deemed core to the specialty, it must be included in the curriculum. However, this presents a challenge, as the training context may not offer enough cases for residents to demonstrate competency. Omitting this competency conflicts with professional identity and scope of practice. Furthermore, when rare procedures overlap with multiple specialties, it raises the issue of professional monopoly. If every specialty considers a procedure to be core, who gets priority for training their residents? To better understand the concerns and objections of our stakeholders, and to deconstruct why our project failed, we applied 2 lenses based on our experience with, and feedback from, the Delphi process—professional identity and professional monopoly.

Professional Identity

Professional identity encompasses attributes, beliefs, and shared experiences within a group of individuals in their professional roles, but can be influenced by shifting workforce structures.⁵ It provides a sense of belonging and identification as a physician or a specific type of physician—such as a subspecialty surgeon. Surgeons’ professional identities are multifactorial, shaped by relationships, individual factors, external influences, and professional experiences.⁶ During our process, stakeholders expressed that outlining rare, yet crucial competencies challenged their own professional identities and scope of practice. Defining a scope of practice for CBME may have been perceived as an attempt at rigidly defining what it means to be a certain kind of specialty surgeon. For instance, including a rare procedure as required for competency would mean that if residents were not able to demonstrate that competency, they would be rendered incompetent in a CBME program. However, omitting this rare

competency for lack of clinical educational volume would place it outside the realm of a specialty with which one identifies. Naming core competencies for a nationwide CBME curriculum unintentionally disrupted closely held identities tied to specific competencies or procedures.

Professional Monopoly

Describing surgical specialties based on neat categories of core competencies and key procedures raises important questions when procedures are shared across specialties. These shared procedures present challenges in determining who should have access to limited patient cases for training. When multiple specialties share certain surgical procedures, it is not an issue if the case volume is sufficient for training all residents. However, challenges arise when a rare procedure shared between specialties is deemed core by one or more programs, leading to questions of priority and access. Including a rare competency within one specialty may monopolize the procedure, affecting training and remuneration. For example, the blepharoplasty procedure is within the scope of plastic surgery, OTL-HNS, dermatology, and ophthalmology (see FIGURE for other examples). Attempting to isolate competencies to specific specialties creates tensions between professional monopoly and scopes of practice. Providing preferential access to become proficient in a competency deemed core for multiple specialties becomes a challenge. Establishing professional monopolies by dividing procedures and competencies across specialties can potentially shrink the scope of practice for each of the subspecialties, leading to downstream consequences for medical professionals and access to care for patients. Monopolization may result in reduced access to care.

Strictly defining competencies for CBME curricula entails a process of professional demarcation—setting a list of qualifications that must be met by all trainees. One way to examine our stakeholders’ struggles with professional demarcation is Witz’s model of professional closure. This model conceptualizes occupational monopoly as a means of laying claim to resources and skillsets.⁷ Witz’s model suggests that different strategies can be used to maintain occupational monopoly—*demarcation closure* and *dual closure*. These strategies have been observed in interprofessional teams in practice,⁸ and we found them a useful lens for understanding our failed Delphi efforts. Under Witz’s model, as a means to resist the attempted demarcation of OTL-HNS from competing specialties, stakeholders employed the dual closure strategy—they halted the demarcation and hence maintained current blurred boundaries and

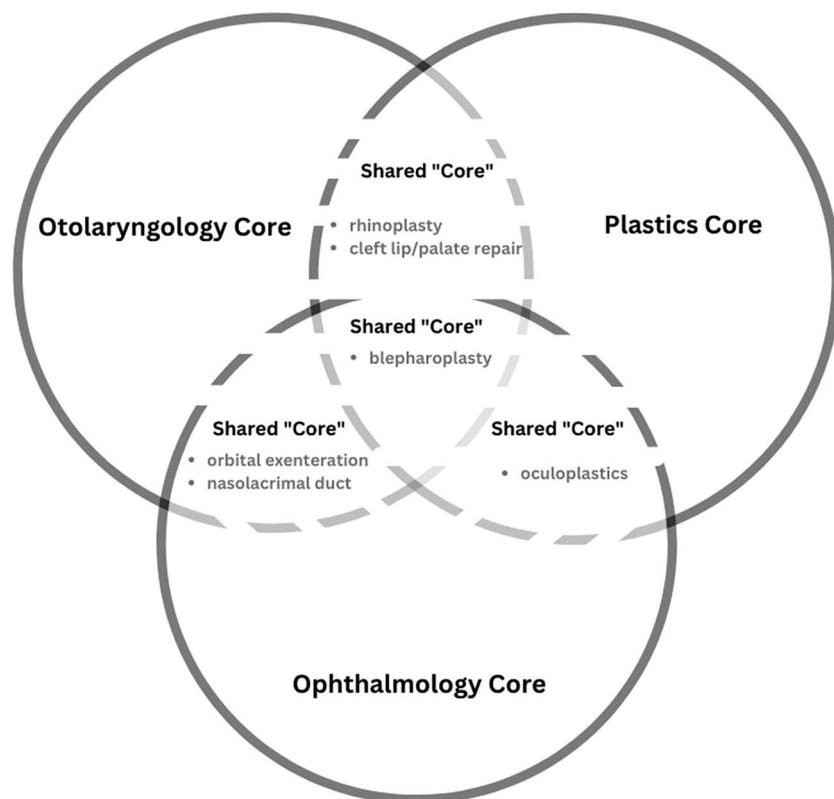


FIGURE
Illustration of Overlapping “Core” Competencies Reflecting Procedures Shared Among Surgical Specialties

scopes of practice. Consideration for professional and occupational monopoly allowed us to better understand the discomfort of our participants and to understand the tensions brought to bear on defining rare procedures as core competencies.

Reflection

While our attempt to determine the core competencies and address residency training complexities for a surgical specialty in Canada ended prematurely, it was not fruitless. Our experience sheds light on the challenges of consensus approaches in fields with rare procedures that overlap with multiple specialties, with resulting challenges to professional identity and scope of practice.⁹⁻¹² This experience demonstrates how dividing competencies among specialties, without overlap, can sharpen professional boundaries; reinforce professional monopoly, likely undermining the identities and scopes of practice of several specialties; and ignore training center variations in patient populations and needs. Creating a CBME-based curriculum requires finding a compromise that respects the breadth of each specialty’s practice while fostering healthy interspecialty discussions about overlapping scopes of practice. This is particularly necessary

for relatively rare procedures, in which sufficient numbers of “competent” professionals will affect patients’ access to care.

Leaving small overlapping scopes of practice with blurred disciplinary lines allows disciplines to grow organically in the ever-evolving medical context. This approach fosters collaborative input from, and hopefully reduces conflict among, multiple specialties. The Delphi process may have failed as a national approach to CBME by unintentionally neglecting this blurring of boundaries and challenging stakeholders in the areas of professional identity and monopoly. In pursuit of patient-centered care, safety, and quality, recognizing blurry boundaries between specialties in certain scopes of practice may hold value. Our experience in engaging stakeholders from multiple specialties to openly consider the potential unintended consequences of sharply defined competencies—for training, patient care, and CBME—leads us to conclude that blurred practice boundaries may be essential to ensure competent physicians.

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All authors are with McGill University, Montreal, Quebec, Canada. **Nebras Alghazawi, MD**, at the time of writing, was a Medical Student, McGill University Faculty of Medicine, and is now a Family Physician practicing emergency medicine in Gatineau, Quebec; **Meredith Young, PhD**, is Associate Professor, Institute of Health Sciences Education, and Department of Medicine; **Marco A. Mascarella, MD, MSc**, is an Otolaryngologist and Assistant Professor, Department of Otolaryngology-Head & Neck Surgery; **Andrei Aldea, MD**, at the time of writing, was a Medical Student, McGill University Faculty of Medicine, and is now a Family Physician, Urgences Pédiatriques Center for Pediatric Emergencies and Specialized Care, Montreal and is associated with McGill University; **Gabriella Le Blanc, BSc**, at the time of writing, was a Medical Student, McGill University Faculty of Medicine, and is now a Resident in Otolaryngology, McGill University; and **Lily HP Nguyen, MD, MSc**, is a Pediatric Otolaryngologist and Associate Professor, Department of Otolaryngology-Head & Neck Surgery.

Corresponding author: Lily HP Nguyen, MD, MSc, McGill University Health Centre, Montreal, Quebec, Canada, phan.nguyen@mcgill.ca