Clinician's Commentary on O'Donovan et al.¹

Nationally and internationally, physiotherapy regulators are charged with the statutory responsibility to ensure public protection through the appropriate regulation of physiotherapy practice. A common responsibility of regulatory organizations is ensuring that registrants remain competent beyond entry to practice. They achieve this by offering programmes that are substantially similar, although they bear a variety of names, such as *continuing competence*, *quality assurance*, and *quality management*. (In this commentary, we use *quality assurance*.) These programmes also vary in their methodologies: More structured programmes commonly use formal methods such as examinations, practice visits, and mandatory participation in continuing education sessions, whereas less structured programmes may use professional portfolios or other methods to support reflection on practice and quality improvement.²

Although quality assurance responsibilities have existed for at least 25 years, there is little available evidence in the physiotherapy community of the impact of programmes intended to maintain clinician competence. Thus, the College of Physiotherapists of Ontario (CPO) and the research team of Campbell, Norman, and O'Donovan are commended for leading the way by conducting and publishing research about its quality assurance programme.

Norman and colleagues first described the results of repeated peer practice assessments, one component of the CPO's quality assurance program, in a 2015 *Physiotherapy Canada* article.³ Their results suggested that physiotherapists who had undergone a second assessment within 5–7 years had higher ratings than those undergoing assessment for the first time;³ this finding supports the assumption that the structured practice assessment process and the feedback it provides facilitates practice improvement. The results also set the stage for the further analysis of sub-optimal practice assessment results reported by O'Donovan and colleagues.¹ Exploring the factors that contribute to sub-optimal performance is intriguing research, and, as regulators move toward risk-based regulation or data-driven regulation, it is most welcome.

As O'Donovan and colleagues¹ identified, regulatory organizations, governments, and the public are increasingly recognizing the importance of actual professional actions as a measure of competence rather than theoretical knowledge, participation in continuing education courses, and other, often ill-defined measures. As Klass⁴ pointed out, when a professional is “assessed at entry-into-practice, their personal characteristics and abilities are the issues at hand”;^(p.530) however, this “once in, good for life”^(p. 531) approach to competence fails to recognize that, over time, professional standards and expectations change, and physiotherapy practice continues to evolve.⁴ We appreciate the CPO's intentional effort, in framing its practice assessment program as a quality improvement program, to describe its activities as those of gradual and steady advancement of personal and professional “minimum acceptable levels of performance.”^{4(p. 533)}

Quality improvement is a desired regulatory outcome. Providing support for physiotherapists so that they can maintain their competence in an era of rapid changes in professional knowledge, skills, abilities, and expectations is highly valued.

Understanding the associated risks to competence is the first step toward developing the appropriate supports.

Norman and colleagues³ previously found that a very small proportion of physiotherapists who had undergone practice assessment had a single sub-optimal score, much less a repeated negative outcome. In their study, O'Donovan and colleagues¹ further analyzed the practice assessment data and found that specific practice characteristics, including working in private practice contexts and working in sole or small practice settings, are correlated with repeated poor performance on practice assessment.

The sub-optimal practice assessment scores O'Donovan and colleagues¹ most frequently encountered were in the areas of record keeping and clinical reasoning. The majority of record-keeping deficits related to clinical aspects—inadequate documentation of assessment and reassessment, analysis of findings, and details of intervention—followed by administrative deficits, such as not properly ensuring that legal requirements were met.¹ Although documentation practices are often maligned, the importance of optimal documentation practices cannot be overstated. Accurate documentation is a key means by which physiotherapists can demonstrate that they are providing high-quality patient care. The deficits reported in this area are a key finding, one that can and should guide the development of practice supports.

Although their findings should be interpreted with caution because of the small sample size, both Norman and colleagues³ and O'Donovan and colleagues¹ have demonstrated the ability of practice assessments to contribute to practice improvement, as measured against standards of practice, and to identify the risks to competence.

When administering quality assurance programmes, physiotherapy regulators currently appear to treat all registrants uniformly. This fails to acknowledge that different practice contexts, environments, and patient populations, as well as other factors, affect the risk of dyscompetent practice. Risk to the public is increasingly the focus of regulatory efforts, but moving toward risk-based regulation requires a clear definition of *risk*. Regulatory data should be used to inform decisions about all policy and programmes, and this is enabled by research such as that of O'Donovan and colleagues.¹

O'Donovan and colleagues¹ suggested that as the CPO's quality assurance program evolves, it should use risk factors to identify a stratified sample of registrants to include in the practice assessment program,¹ thereby helping to ensure the efficacy of the CPO's efforts. Physiotherapy regulators in other Canadian jurisdictions may want to implement similar stratification in their own continuing competence or quality assurance programmes to ensure that they provide attention, feedback, and support to those most at risk. However, in implementing such a stratified approach, organizations must recognize that any identified risk factors are simply correlations; practice in a specific context may create risk, but it does not confirm dyscompetent practice. Similarly, practice in a low-risk context does not ensure competent practice; it simply minimizes risk.

As O'Donovan and colleagues¹ have found, there is a need to consider other relevant factors, such as demographic characteristics, that may also pose risks to competent practice. Because these are the first results published about the risks to competence, regulatory organizations should not abandon their efforts to address the needs of their registrants in general; rather, they should use these results to further refine their approach and focus on strategies to mitigate any decline in competence. This would be a most beneficial outcome for both the public and members of the profession.

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