Comparing the Scopes of Geriatric-Focused Physicians in Canada: A Qualitative Study of Core Competencies

Authors:

Rebecca H. Correia, Amina Jabbar, Henry Yu-Hin Siu, Sophie Hogeveen, Darly Dash, Fabrice I. Mowbray, Andrew P. Costa, Meredith Vanstone

1. Rebecca H. Correia, BSc [a, b]
correirh@mcmaster.ca
2. Amina Jabbar, MSc, MD, FRCPC [a, b]
jabbaram@mcmaster.ca
3. Henry Yu-Hin Siu, MSc, MD, CCFP (COE) [c]
siuh3@mcmaster.ca
4. Sophie Hogeveen, PhD [a, b]
hogevees@mcmaster.ca
5. Darly Dash, MSc [a, b]
dashd@mcmaster.ca
6. Fabrice I. Mowbray, MScN, RN [a, b]
mowbrayf@mcmaster.ca
7. Andrew P. Costa, PhD [a, b]
acosta@mcmaster.ca
8. Meredith Vanstone, PhD [c]
vanstomg@mcmaster.ca

Affiliations:

a. Department of Health Research Methods, Evidence and Impact, McMaster University | Hamilton, Ontario, Canada
b. Big Data and Geriatric Models of Care (BDG) Cluster, McMaster University | Hamilton, Ontario, Canada
c. Department of Family Medicine, McMaster University | Hamilton, Ontario, Canada

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Corresponding Author: Rebecca Correia
Email: correirh@mcmaster.ca
Address: 10-B Victoria Street South, Kitchener, Ontario, Canada, N2G 1C5

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31 **INTRODUCTION**

32 Ensuring equitable access to geriatric-focused medical care is an ongoing challenge,
33 given the limited number of physicians with geriatric-specific training or expertise.[1] Adults over
34 the age of 65 are among the fastest-growing cohorts in the developed world, living longer than
35 ever, with high rates of multimorbidity and geriatric complexity.[2]

36 Longstanding deficits of medical expertise in the care of older adults are recognized.[1,3,4]
37 Little is known, however, about how specialists with overlapping scopes of practice coordinate
38 care in ways that most efficiently and equitably increase access to their services. Physicians may
39 lack confidence and competence to manage the complex needs of some older adults,[5,6] leaving
40 three Canadian medical specialties to contribute the majority of care for older Canadians:
41 family physicians with certification in Care of the Elderly (FM-COE), geriatricians, and geriatric
42 psychiatrists. While there is evidence to support decision-making within individual specialties
43 about systems of care,[7–10] there is a lack of reporting on shared medical knowledge and
44 synergies in the care of older patients.

45 Competencies provide a foundational base of knowledge required to practice in a
46 particular domain of medicine, outlining the fundamental expectations of trainees.[11–14] While
47 competencies do not represent firm boundaries of knowledge or skills, they provide a starting
48 point for a program of study that will identify scopes of practice. Prior work has described the
49 processes of identifying and establishing competencies for geriatric-focused medical
50 disciplines,[12–15] but much remains unknown about their convergence. Therefore, to identify
51 areas of overlap in scopes of practice and points of distinction between the three geriatric-
52 focused specialties, we compared the competencies for FM-COE, geriatricians, and geriatric

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3 53 psychiatrists. This work aims to stimulate critical thinking about the opportunities for physicians
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6 54 to collaborate in the care of a shared patient population, in ways that recognize their unique
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8 55 perspectives and professional identities.

METHODS

Study design and setting. In this qualitative study, we used a comparative approach to document analysis in order to identify overlap between the competencies of Canadian FM-COE, geriatricians, and geriatric psychiatrists, as defined by their respective regulatory colleges.[16]

Data collection. The College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) provide publicly available documentation of the competencies required to be a certified practitioner of FM-COE, geriatric medicine, or geriatric psychiatry. We identified documents on the CFPC and RCPSC websites by searching for the terms "competenc* AND Canada AND care of the elderly OR geriatric psychiatry OR geriatric medicine" (n=6).[17–20] We consulted experts in each specialty to confirm the completeness and relevance of these documents.

Data analysis. Two researchers (AJ and RC) reviewed the documents in full and used a data extraction template to independently examine and code the documents using a directed (deductive) content analysis approach.[21] Directed content analysis uses an existing framework to organize data and enable comparison across specialties.[16] The CanMEDS and CanMEDS–Family Medicine (FM) Frameworks were used to examine the relevance of competencies to the seven CanMEDS Roles: Medical Expert/Family Medicine Expert, Communicator, Collaborator, Leader, Health Advocate, Scholar, and Professional.[22,23] We compared the presence of competencies within each CanMEDS Role across each of the specialties; AJ and RC documented

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75 memos independently and in duplicate to identify any patterns. Results were compared to
76 identify areas of disagreement, which were resolved through discussion. An inductive content
77 analysis was then used to identify themes within each CanMEDS Role and categorize similar
78 competencies. Ethics approval for this project was not required, given that data were publicly
79 available online.

80 **RESULTS**

81 **Table 1** displays the results of our analysis, for both unique and shared competencies,
82 grouped by the CanMEDS Roles. In each category, concordance is described before difference.

83 **Medical Expert/Family Medicine Expert:** The competency lists of all three provider
84 types indicate proficiency in eliciting patient histories and tailoring health promotion and
85 disease prevention interventions. All providers are expected to differentiate normal and
86 abnormal aging, and consider the contributions of a patient's comorbidities, frailty, and
87 functional status, when determining patient prognosis. Appropriately prescribing
88 pharmaceuticals and preventing, diagnosing, and managing delirium, are recognized as core
89 competencies. Providers should be able to assess issues related to capacity and competency
90 (i.e., personal decision-making and driving). All providers are expected to examine, diagnose,
91 and manage neurocognitive disorders (i.e., dementia), and associated behavioural changes or
92 disturbances. All providers should be able to enquire about caregiver stress and capacity, and
93 be prepared to facilitate end-of-life discussions.

94 Geriatricians and FM-COE are expected to be competent in best practices for fall
95 prevention and screening to identify predisposing factors of falls. They should be able to
96 diagnose and manage osteoporosis and fracture risk, and develop rehabilitative approaches.

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Geriatricians and FM-COE are also expected to perform detailed medication reviews, assess urinary incontinence, diagnose and manage pain, and manage palliative and end-of-life care issues.

Items unique to geriatric psychiatrists include they must be knowledgeable about psychotherapeutic constructs, psychopharmacology, and therapeutic approaches. They are expected to exhibit extensive knowledge about mental illnesses and psychiatric disorders. Geriatricians are responsible for performing comprehensive geriatrics assessments and diagnosing and managing bowel dysfunction.

Communicator: All providers are expected to elicit and synthesize information from patients, families, and care providers, and consult with colleagues when required or requested. They should be able to recognize and mitigate communication barriers by providing assistive devices, and ensure adequate communication during transfers of care.

Geriatric psychiatrists and geriatricians are expected to prioritize issues for patient encounters by recognizing their roles as specialists. Exclusively, geriatric psychiatrists must be proficient in the use of telepsychiatry.

Collaborator: All providers must be competent in performing timely consults, exhibiting respect towards team members, and collaborating on assessments and care management. They are expected to respect the scopes of practice, differences, and overlapping responsibilities of other providers. They should be able to engage in shared decision-making with families and caregivers in team discussions and case conferences. All providers are expected to identify learning and improvement opportunities, and plan and deliver learning activities.

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Geriatric psychiatrists must distinctively describe other geriatric mental health care teams' roles and responsibilities. They are also expected to demonstrate leadership and act as an expert resource on issues such as mental health legislation.

Leader: All providers must be familiar with community resources (e.g., geriatric and social support services) to facilitate equitable patient access and use. They must also engage in the stewardship of health care resources by allocating resources for optimal patient care and avoiding over-investigation. Additionally, providers are expected to mediate and resolve conflicts that may arise. All providers should be able to employ quality improvement methods to evaluate and improve healthcare systems, allocate resources, and manage cost-appropriate care. They must also understand the structure and function of the healthcare system relevant to caring for older patients.

Geriatricians must be competent in the use of health informatics to improve the quality of care and optimize patient safety.

Health Advocate: All providers should be flexible to meet patient needs and preferences for care management. They must recognize and manage elder abuse, neglect, and mistreatment. All providers must be competent in advocating for essential hospital and community resources and services, as well as systems-level change.

Geriatricians and geriatric psychiatrists are expected to identify and respond to health policies, identify vulnerable or marginalized populations, and respond to cultural issues. Geriatricians must be competent in identifying patient vulnerabilities that increase their risk for poor health (e.g., inadequate access to primary care) and advocating for evidence-based

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139 primary care. FM-COE should be able to determine the need for immediate interventions
140 (including home visits) to mitigate harm.

141 **Scholar:** All providers are expected to recognize knowledge limitations and gaps in the
142 literature specific to geriatric populations' medical care. They must also be competent and
143 engaged in research by posing scholarly questions, applying scientific methods, and
144 communicating and disseminating findings. They are expected to participate in research,
145 program development, medical education, and other activities that improve health care of the
146 elderly.

147 Geriatricians and geriatric psychiatrists should be able to appraise evidence, research,
148 and literature critically. Exclusively, geriatricians should be able to recognize the influence of
149 role-modelling and its impact on learners' formal, informal, and hidden curriculum.

150 **Professional:** All providers are expected to identify decision-making capacities among
151 patients and obtain and document informed consent. They must be competent in respecting
152 patient privacy and confidentiality while recognizing, fulfilling, and adhering to professional and
153 ethical codes. They are expected to conform to legal obligations, policies, and procedures
154 relevant to substitute decision-making.

155 Geriatricians and geriatric psychiatrists are expected to exhibit appropriate professional
156 boundaries with patients and families. They must be competent in demonstrating a
157 commitment to high-quality care and excellence, while prioritizing personal and professional
158 duties.

159 **INTERPRETATION**

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Summary of findings. Our analysis of the respective practice competencies across geriatric-focused providers, as documented by the individual colleges, is the first effort to define these differences. We identified substantial overlaps in the expected medical expertise of FM-COE and geriatricians, which blurs the scopes and boundaries across disciplines. While there were few substantive differences, such as the expectation that geriatric psychiatrists be conversant with psychotherapeutic techniques and medications, some distinctions may be the result of different priorities to specify particular competencies. For example, while not an explicit competency, it is likely that FM-COE are also expected to maintain appropriate professional boundaries with patients and families. While collaboration is expected among all geriatric-focused providers, the absence of published literature concerning their shared areas of practice and individual competencies may inhibit opportunities for collaboration moving forward.

When examining the priority clinical domains set out by the CFPC, it is not initially apparent where the CanMEDS-FM roles of scholarship, advocacy, leadership, and professionalism are addressed in training. We feel that this discrepancy likely results from the CFPC having multiple guiding documents detailing the professional activities and clinical competencies that a FM-COE physician should exhibit. The CFPC recently published its national standards for “Core Professional Activities” (or CPAs); there is a CPA list specific for PGY-3 residents pursuing an extra year of training in COE.[20] The CPAs list indicates that scholarship, advocacy, leadership and professionalism are expected for FM-COE. Given that FM-COE physicians are family physicians first, the documents reviewed in this paper serve to augment, not replace, the core clinical and professional competencies expected of all family physicians.

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Explanation of findings. Canada has long acknowledged severe shortages in geriatric medicine and services.[3,4] While field experts and leaders encourage and support medical trainees to pursue a geriatric medicine specialty,[24,25] many have acquiesced to the idea that training through the FM-COE pathway may be more efficient.[13,26,27] However, in the development of the FM-COE training pathway, we have missed an opportunity to specify how they are – and even if they are – different from geriatricians. While family physicians with COE training have additional specialization levels that blur the lines between primary care and specialist providers, they boast longitudinal relationships that enable care continuity as their patients age.[27] Similarly, to posit that geriatricians care for the sickest amongst older adults is also not sufficient. That premise surmises that family physicians have little to offer those patients, when in fact, in the context of a complicated health system, that is very much the opposite.[28]

Since 1989, family physicians had opportunities to receive additional certification in an enhanced area of family medicine practice.[29] The eligibility criteria to earn enhanced certifications, including COE, vary as some physicians earn the certification through completion of medical residency, whereas others are eligible through clinical practice or leadership routes.[30] Some family physicians utilize their additional training to practice in multiple care settings and take on specialized roles – similar to their counterparts practicing in similar medicine areas that have undergone different pathways into a specialty.[29,31] Despite similar competency profiles, geriatricians and FM-COE are hired, compensated, and deployed within the healthcare system in very different ways.[8,10,31] Based on our account of the similarities

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among FM-COE and geriatricians (especially in terms of medical expertise), we question why their practices are considered so different.

Future directions. We acknowledge that medical care of older adults is a shared responsibility of all physicians. However, there is a need to determine how best to assign responsibility for specialized care of older adults, given physicians' overlapping scopes of practice.[32] Research is needed to characterize the degree to which geriatric-focused providers exemplify these competencies in daily practice and negotiate the scopes of their shared competencies, especially as patient/medical complexity increases. Currently, literature describing the characteristics and practice patterns of FM-COE is sparse,[8,33,34] despite the need to better understand how their medical practice differs from geriatricians. Additionally, more research is needed to characterize the impacts of geriatric-focused providers on practice patterns, patient outcomes and satisfaction, and health service use.

Future work to identify geriatric-focused providers' practice locations may offer insights about access to care. For instance, in rural and remote regions of Canada, community hospitals may not have access to staff geriatric psychiatrists. However, based on our understanding of overlaps in medical expertise, they may be able to leverage the services of either FM-COE or geriatricians. This pattern of gaps and overlaps highlights an opportunity to build capacity in geriatric care amongst their generalist colleagues. For example, in the situation detailed above, collaboration between a FM-COE and generalist psychiatrist may help meet the psychiatric care needs of older adults in that community.

Lastly, the degree of detail used to define the expected level of competence varied across disciplines, which hindered our comparisons. Geriatric psychiatry had a useful way of

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225 framing competencies by specifying the degree of knowledge depth to which trainees and
226 subspecialists were expected to attain, although definitions surrounding the evaluation of
227 competence were not provided. Establishing whether geriatric-focused providers should
228 acquire "advanced" or "expert" level knowledge is essential to tailor and standardize
229 evaluations across specialties.

230 **Limitations.** Comparisons across the three physician types were limited by the
231 organization and degree of detail specified in each competency list. The RCPSC organized
232 geriatric medicine and geriatric psychiatry competencies according to CanMEDS roles, whereas
233 the CFPC framed FM-COE competencies around 18 priority areas of knowledge. Additionally,
234 our analysis was limited to the document review and not the lived experiences of geriatricians,
235 FM-COE, and geriatric psychiatrists. However, expertise of the clinical and academic co-authors
236 were utilized to discern whether competencies that were not explicitly stated in some lists,
237 were implied or relevant to other providers. Lastly, the CFPC competency list reflects the
238 expectations of family physicians who complete COE training through medical residency and
239 may not represent those who earned the COE designation through clinical practice or
240 leadership routes.

241 **Conclusion.** Our work is the first to identify the commonalities and differences in the
242 scopes of competencies among geriatric-focused physicians in Canada. We identified
243 substantial overlaps in the expected medical expertise of FM-COE and geriatricians, and some
244 unique competencies to particular disciplines. However, some competencies are not explicitly
245 documented, and the degree of required knowledge was inadequately defined in some
246 regulatory documents. Therefore, our findings should encourage efforts to develop more

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3 247 robust definitions of medical practice and delineations of scopes of practice for these providers,
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6 248 which may ultimately facilitate more equitable and accessible medical care for older adults.
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Table 1. Summary of the core competencies of geriatric psychiatrists, geriatricians, and FM-COE by CanMEDS Roles

CanMEDS Role	Competency	Geriatric Psychiatrists	Geriatricians	Family Medicine, Care of the Elderly
Medical Expert / Family Medicine Expert	Differentiate normal and abnormal aging	X	X	X
	Consider a patient's comorbidities, frailty, and functional status to prognosis	X	X	X
	Prevent, diagnose, and manage delirium	X	X	X
	Examine, diagnose, and manage neurocognitive disorders (i.e., dementia) and associated behavioural changes/disturbances	X	X	X
	Appropriately prescribe pharmaceuticals	X	X	X
	Elicit patient histories	X	X	X
	Tailor health promotion and disease prevention interventions	X	X	X
	Assess issues related to capacity and competency (i.e., personal decision making, driving)	X	X	X
	Enquire about caregiver stress and capacity	X	X	X
	Be knowledgeable about end-of-life care	X	X	X
	Apply best practices for falls prevention and screening		X	X
	Diagnose and manage osteoporosis and fracture risk		X	X
	Develop rehabilitative approaches		X	X
	Perform detailed medication reviews		X	X
	Assess for urinary incontinence		X	X
	Diagnose and manage pain		X	X
	Manage palliative and end-of-life care issues		X	X
	Be knowledgeable about psychotherapeutic constructs, psychopharmacology, and therapeutic approaches	X		
	Exhibit extensive knowledge about mental illnesses and psychiatric disorders	X		
	Perform a comprehensive geriatrics assessment		X	
	Diagnose and manage bowel dysfunction		X	
Communicator	Elicit and synthesize information from patients, families, and care providers	X	X	X
	Recognize and mitigate communication barriers	X	X	X
	Consider the merits of a second opinion	X	X	X
	Ensure communication during transfers/handover	X	X	X

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	Prioritize issues for patient encounters with a recognition that the role is that of a specialist (not a PCP)	X	X	
	Proficient in the use of telepsychiatry	X		
Collaborator	Perform timely consults	X	X	X
	Exhibit respect for team members	X	X	X
	Collaborate on assessments and care management	X	X	X
	Respect the scopes of practice, differences, and overlapping/ shared responsibilities of providers	X	X	X
	Engage in shared decision-making with families and caregivers	X	X	X
	Identify opportunities for learning and improvement	X	X	X
	Plan and deliver learning activities	X	X	X
	Describe the roles/responsibilities of geriatric mental health care teams and demonstrate leadership in teams	X		
	Act as an expert resource on issues such as mental health legislation	X		
Leader	Be knowledgeable about community resources	X	X	X
	Mediate and resolve conflicts within interprofessional teams	X	X	X
	Apply quality improvement principles to evaluate/ improve healthcare systems and cost-appropriate care	X	X	X
	Understand the healthcare system relevant to caring for older patients	X	X	
	Competent in the use of health informatics to improve care quality and optimize safety		X	
	Engage in stewardship of health care resources	X	X	X
Health Advocate	Adapt to meet patient needs and preferences	X	X	X
	Recognize/manage elder abuse, neglect, and mistreatment	X	X	X
	Advocate for essential hospital and community resources/services	X	X	X
	Identify and respond to policies affecting health	X	X	X
	Identify vulnerable/ marginalized populations and respond to cultural issues	X	X	
	Identify patient vulnerabilities		X	
	Advocate for evidence-based health promotion		X	
	Determine the need for immediate intervention, such as home visits			X
Scholar	Recognize knowledge limitations/gaps in literature specific to the medical care of geriatric populations	X	X	X

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	Critically appraise evidence, research, and literature	X	X	
	Pose scholarly questions, select/apply methods to address questions, and communicate/disseminate findings	X	X	
	Participate in research, program development, medical education, and other activities that improve the delivery of services	X	X	X
	Recognize the influence of role-modelling and the impact of the formal, informal, and hidden curricula on learners		X	
Professional	Identify the capacity for decision-making	X	X	X
	Obtain and document informed consent	X	X	X
	Respect confidentiality, privacy, and ethical codes	X	X	X
	Adhere to substitute decision-making policies	X	X	X
	Exhibit appropriate professional boundaries	X	X	
	Demonstrate a commitment to high-quality care and excellence	X	X	
	Prioritize personal and professional duties	X	X	

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Standards for Reporting Qualitative Research (SRQR)*

http://www.equator-network.org/reporting-guidelines/srqr/

Title and abstract

	Line no(s).
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1-2
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	See "Abstract" file

Introduction

Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	32-40
Purpose or research question - Purpose of the study and specific objectives or questions	50-55

Methods

Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	57-59
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	65-66 73-76
Context - Setting/site and salient contextual factors; rationale**	60-63
Sampling strategy - How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	63-66
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	78-79
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	60-66

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Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	67-68
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	63-66
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	65-66
Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	67-78
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	75-76

Results/findings

Synthesis and interpretation - Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	80-158
Links to empirical data - Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	See "Table 1" file

Discussion

Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	160-229
Limitations - Trustworthiness and limitations of findings	230-240

Other

Conflicts of interest - Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	30
Funding - Sources of funding and other support; role of funders in data collection, interpretation, and reporting	28

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

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**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.

Reference:

O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. **Standards for reporting qualitative research: a synthesis of recommendations.** *Academic Medicine*, Vol. 89, No. 9 / Sept 2014 DOI: 10.1097/ACM.0000000000000388

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