Why primary care guidelines are not prepared by family physicians

In the September issue of *Canadian Family Physician,* Drs Pimlott and Allan make a case for why primary care guidelines should be prepared by family physicians.[1,2] I applaud them for raising critical issues around guideline development that include conflicts of interest, the hidden curriculum, and the ever increasing number of guideline documents we have to translate into practice. While I wholeheartedly support the intent of the premise they promote, some might argue that it lacks contextual credibility.

For example, few would argue that much of what we do in clinical practice is intended to be driven by the best available evidence. A large component of many primary care guidelines involves pharmacotherapeutic intervention. In fact, drug costs represent the second-largest component of health care spending in Canada and family physicians prescribe about 80% of medications across many therapeutic areas. Unfortunately, family physicians play a minimal role in drug research and this likely explains why they are not more represented on guideline development panels.[3]

Underrepresentation in other research areas might also be a contributing factor. Without this fundamental research engagement, which could promote studies that are relevant to primary care and possibly mitigate some concerns around conflicts of interest, why should primary care physicians feel entitled to have more representation on guideline panels? What if the shoe were on the other foot and our specialist colleagues were asking for a seat at the table without making the type of contribution that has been traditionally linked to guideline development?

Although many of the criticisms around current guideline development offered by our colleagues are certainly relevant and very important, the suggestion that our leadership, including the College of Family Physicians of Canada, not endorse guidelines targeting primary care unless they are led by primary care physicians seems unrealistic. If the latter were the case, what is the alternative scenario given primary care's limited role in the type of knowledge generation that ultimately fills endless pages of guideline documents? What would primary care have left to endorse or use as a guiding light given the current guideline development process?

Critical appraisal on its own without original research from primary care surely cannot be the primary prerequisite for guideline development by primary care physicians. We have to consider that many of the problems related to guideline use and outcomes in primary care are not driven by underrepresentation on guideline panels, but by our lack of involvement in generating original knowledge that is directly relevant to primary care.

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Competing interests

Dr D'Urzo has received research, consulting, and lecturing fees from GlaxoSmithKline, Sepracor, Schering-Plough, Altana, Methapharm, AstraZeneca, ONO Pharmaceutical, Merck Canada, Forest Laboratories, Novartis, Boehringer Ingelheim (Canada) Ltd, Pfizer Canada, Skyepharma, KOS Pharmaceuticals, and Almirall.

References

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Response

Dr D'Urzo has responded to our articles[1,2] and suggested that the most important issue driving family physicians' underrepresentation in their own guidelines is that they do not participate in or perform original research.

We agree that in the past family physician researchers have not been well represented in clinical research. The causes of this have been multifactorial, ranging from issues such as the lack of training and career tracks for family medicine researchers to the lack of funding opportunities for family medicine research. However, even several decades ago, many family physicians were making inroads in clinical research.

We disagree that this is currently true. Over the past decade or more family physicians have been leading a multitude of clinical research projects and networks within primary care research. The future of family medicine research looks brighter with each passing year.[3,4] One area of research where non–family physician specialists are far more likely to be involved than family physicians is in randomized controlled trials of pharmacotherapies (for a multiplicity of reasons), but

this might not be a liability when it comes to participating in guidelines.

All that said, we believe this alone would have little effect on family physicians' ability to participate in developing their own guidelines. Family medicine–driven clinical research will undoubtedly improve the care of our patients. However, we think it is a mistake to assume that the ability to carry out solid clinical research alone will lead to inclusion of primary care clinicians in guidelines. Further, we would argue that researchers focused in specific areas might not be ideal guideline participants. The predisposition bias and overreliance on their own research would compound the known challenges experts seem to have when interpreting evidence.

For those of us who have participated in clinical practice guidelines led by non–family physician specialists, we have seen that the selection of those with specific areas of interest and research focus is a pervasive problem contributing to many of the common biases and issues seen in clinical practice guidelines. In addition, many of these same individuals have industry affiliations that can compound their biases. So, even as family physicians participate in more primary care research, we would argue that any researchers (primary care, specialty, doctoral, etc) should only play a minor role in any guideline team.

We would like to address 2 final issues raised by Dr D'Urzo.

First, critical appraisal skills alone cannot be considered the primary requisite for guideline inclusion. To clarify, critical appraisal often implies the ability to use simplified checklists of criteria to determine validity and reliability. We believe that the skills required for a thorough analysis of the medical literature and its application to primary care go far beyond that and those are the precise skills we require in guideline participants. Paradoxically, these skills are not consistently found in all researchers. So yes, critical analysis and application skills are necessary over research experience.

Finally, we do not believe it is unrealistic for our leadership, including the College of Family Physicians of Canada, to limit endorsement of guidelines targeting primary care that have not had adequate primary care involvement or governance. It is somewhat sad that any primary care clinician believes otherwise. It will take leadership from the highest levels to ensure this becomes the priority it so desperately needs to be—otherwise, this pervasive problem will never change.

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None declared

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Response

I appreciate the response by Drs Pimlott and Allan to my letter and I believe we share the same good intentions on the issues we are discussing.[1,2] There is no question that primary care has made great strides in research in recent years, but as I stated in my initial letter, the premise promoted by my colleagues is not consistent with the current realities that drive guideline development. Among the principles of family medicine[3] is included the notion that we are prudent stewards of scarce resources. Given the substantial economic implications of prescriptions generated in primary care, I would disagree that not participating in this type of research would not translate into a liability in terms of participation in guidelines. If family physicians were designing pharmacotherapeutic clinical trials with a better balance between internal and external validity with relevant primary care outcomes that translated into improved, cost-effective care, this would likely get the attention of policy makers and public payers and put us in a position where we might be more fiscally responsible for our clinical decisions. At a minimum, we would be more able to develop strategies to be more accountable for the health care costs we generate. The latter possibility would be an important foundational piece in moving toward the development of primary care guidelines by primary care physicians collaborating with colleagues in other specialties.

I also appreciate the suggestion that bias might come into play if researchers with focused interests (often non–family physician specialists) are driving the guideline agenda, but this is simply a symptom of the lack of primary care engagement. To suggest that the future might be different is fine, but it does not reconcile the current challenges we face and the trajectory we should launch to achieve our goals.

I have been and continue to be a strong supporter of the College of Family Physicians of Canada, but I am not able to let this loyalty stand in the way of providing constructive advice about how we might best position ourselves to be leaders in clinical care and research.

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