

Will the Triple C curriculum produce better family physicians?

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NO

We all want to train good family physicians. This is nothing new. And a look around the country at deeply engaged colleagues, both young and old, makes clear the commitment of our discipline to high-quality care and education. What is new is the College of Family Physicians of Canada's Triple C curriculum, self-described as a *competency-based curriculum* that is *comprehensive*, focused on *continuity*, and *centred* in family medicine. So there are actually 5 Cs, the "triple" part of which (*comprehensive*, *continuity*, and *centred*) support the double Cs of *competency-based curriculum*. We are now awash in a sea of C confusion—one of the most common Triple C conversations I hear among teachers is an attempt to recall the correct 3 Cs.

But is this enormous proposed curricular overhaul likely to lead to the training of better family physicians? Comprehensiveness, continuity, and family medicine-centred care are all well described in the 4 principles of family medicine and are already embedded in our values and current curricular structures. So the novelty, and the hope for "better," presumably comes from the competency aspect of the curriculum. The rationale given by our national College for this curricular change centres on increasing efficiency and being more socially accountable. Yet competency models have not been proven to increase either efficiency or accountability. We are proceeding on faith rather than with evidence.

If we cannot define "good," how will we know what is better?

As we start to invest considerable energy and resources in rolling out this new curriculum, we should perhaps pause and consider whether we will be able to assess its effects. How will we actually know if the family physicians of Triple C training are better physicians? In truth, medical educators have not yet managed a working definition of the *good doctor*, let alone rigorous standardized measures of high-level professional functioning.^{1,2} The recent Future of Medical Education in Canada Postgraduate Project report highlights that it is "widely acknowledged that even after many years, [postgraduate medical education] still does not know how to effectively teach and

assess the CanMEDS competencies."³ Hence, experience from our Royal College colleagues shows the difficulty of effectively implementing a competency-based curriculum.⁴ Moreover, even if we were to succeed in developing measures for the products of our educational system, it is hard to imagine that we would be able to separate the specific Triple C effects on trainees from many other changes that might affect their education (such as the development of new team models of primary care and quality improvement initiatives).

We must also be cautious about assuming that "new" is necessarily better. Over the past century medical educators have put great effort into advancing and renewing medical education. Generation after generation we have produced reports on how to improve training for the doctors of the future. Embedded in most prescriptions for change is a sense that things have recently gone awry. Think back to your family medicine residency training days—did your teachers suggest that your generation was found lacking compared with your predecessors? I certainly had that perception 2 decades ago. Current residents share with me their sense that teachers suggest disparagingly that they have an "easy road" through training with reductions to duty hours in residency programs, and look askance at expressed desires for work-life balance. We must be clear about defining the problems that require fixing and then design specific educational interventions targeted at those issues rather than repeatedly rediscovering the same issues and attempting to solve them through whatever is the currently trendy educational approach.

Limitations of competency models

So what is concerning about the competency-based approach? Competency-based education builds on the premise that we can define all important outcomes and then measure them in a comprehensive and meaningful way. Yet there is no evidence to support this assertion. Moreover, there is a growing body of medical education literature that raises practical, pedagogic, and theoretical concerns about constructions of competence. In spite of considerable effort by educators around the world, assessment tools still tend to anatomize and fragment competencies, particularly those that are more complex than technical-skills acquisition.^{5,6} The design of outcomes-based learning objectives potentially limits

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the creativity and flexibility of both teachers and learners, disempowering both as they are required to conform to standardized measures.⁷ Competency definitions also tend to focus on what can be measured and specified, hence reducing attention to reflective, experiential, and holistic aspects of care.⁸ Surely reducing creativity in teaching and learning, while limiting understanding of the complexity of practice, is unlikely to lead to the production of better family physicians.

Another limitation of current competency approaches relates to the fact that they are individualistic in design, and thus do not adequately incorporate essential societal and structural issues in health care. Moreover, descriptions of competency are frequently used to stake out professional turf. Reeves and colleagues note, for example, that competencies are used by professions to claim ownership over particular activities, “reinforcing conventional discourses about professional norms, behaviours and attitudes, and perpetuating existing domains of professional legitimacy.”⁹ Surely the last thing we want from competency-based approaches is to limit flexibility and innovation.

Conclusion

Considering how we are doing and contemplating ways to change how we educate our trainees is part of being reflective educators. Another essential part of being reflective educators, however, requires watching carefully for the consequences of changes we make. Our discipline has been well served by the 4 principles of family medicine; for decades our committed teachers have ably guided residents out of the false security of biomedical models and narrow definitions of evidence into the messy and complex world of real-life primary care. We should be wary of burdening our teachers with new nomenclature and an array of new teaching and assessment tools without evidence that these will make a positive difference. Not only are we unlikely to be able to measure “better,” we must ensure that we do no harm with the introduction of this approach. We risk diverting the attention of dedicated and creative family medicine teachers away from thoughtful interaction with learners into less-thoughtful interaction with curricular checklists

and evaluation forms. We would be remiss if we did not watch very carefully for such potential unintended consequences of Triple C implementation.

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Competing interests

None declared

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CLOSING ARGUMENTS

- Competency-based frameworks are as yet unproven curricular models—enthusiasm currently exceeds the evidence.
- Checklists and standardization might limit flexibility and creativity both for teachers and for learners.
- We must make sure that we do not lose important holistic, experiential, and reflective aspects of training as we seek to document and measure educational outcomes.
- Given the theoretical and practical concerns surrounding competency models, it is important to monitor closely for both intended and unintended effects.



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