The hidden curriculum and continuing professional development for family physicians

Nicholas Pimlott MD CCFP FCFP, SCIENTIFIC EDITOR

Virtue can only flourish among equals.
Mary Wollstonecraft

In the 2011 Harveian Oration, British general practitioner Iona Heath traced the roots of the division of clinical medicine into generalists and specialists to the mid-19th century with the Medical Act of 1858.[1] This resulted in the creation of what she describes as

> a single but dualistic profession with common initial training, equal status and useful reserves of mutual respect. Specialists and GPs, though sometimes perceived as opposites, are inextricably dependent on each others' skills and, crucially, most are keenly aware of the extent of this interdependency.[1]

Ideally generalist family physicians and their specialist colleagues are equal but different and complementary practitioners who, together, make health care systems function optimally,[1] but the "hidden curriculum," which pervades undergraduate and postgraduate medical training, promotes a hierarchy between generalists and specialists in which the generalist is portrayed as inferior.[2] Much of this stems from the belief that students who choose family medicine are the intellectual inferiors of those who specialize. There is good evidence this is not the case.[3]

If we scrutinize the medical literature closely, we see that the hidden curriculum extends well beyond medical school and into our lifelong continuing professional development (CPD). One important way that it does so is through traditional clinical practice guidelines (CPGs).

Traditionally, CPG panels have been dominated by specialists who are considered the experts on the evidence, but over the past 2 decades some serious problems have been identified. Traditional CPGs tend to be disease-oriented rather than patient-centred. Their recommendations are not always based on the highest-quality evidence and are overly reliant on expert opinion.[4] Expert panelists are much more likely than "non-experts" (family physicians) to have financial and other conflicts of interest that might influence their recommendations[5-7] and undermine their integrity.

Over the past 3 years, *Canadian Family Physician (CFP)* has published a series of CPGs[8-13] that demonstrate that family physicians working with others (including patients) can develop high-quality, evidence-based CPGs that avoid of many the traditional pitfalls and meet the high standards of *Clinical Practice Guidelines We Can Trust* and AGREE II.[14-16] Further, they "debias" the hidden curriculum as it plays out in CPD. Readers have told us there is a need for such practical CPGs with patient-oriented outcomes. Since publication in 2015, the simplified lipid guideline[9] has been accessed more than 98 000 times in English and 9500 in French on *CFP*'s website, making it the most accessed article in *CFP*'s history. Just 6 weeks after publication, the simplified cannabinoid guideline[12] had been accessed 22 000 times.

Doing guidelines differently presents considerable challenges for family medicine and our specialist colleagues. For specialists it will mean relinquishing their hold on the "evidence," working in truly collaborative ways with family physicians, and not defending the status quo.[17] The implications for family physicians are equally important. We will have to increasingly develop and maintain our skills in critically evaluating the literature to participate effectively and lead the way in future primary care–driven CPGs. This has implications for both training and CPD, and will be crucial to assessing the effect of such CPGs on patient care.

Cet article se trouve aussi en français à la **page 327.**

References

1. Heath I. Divided we fail. *Clin Med* (Lond) 2011;11(6):576-86.
2. Mahood SC. Medical education. Beware the hidden curriculum. *Can Fam Physician* 2011;57:983-5 (Eng), e313-5 (Fr).
3. Woloschuk W, Wright B, McLaughlin K. Debiasing the hidden curriculum. Academic equality among medical specialties. *Can Fam Physician* 2011;57:e26-30. Available from: **www.cfp.ca/content/cfp/57/1/e26.full.pdf**. Accessed 2018 Apr 12.
4. Guyatt GH, Oxman AD, Kunz R, Vist GE, Falck-Ytter Y, Schünemann HJ, et al. What is "quality of evidence" and why is it important to clinicians. *BMJ* 2008;336(7651):995-8.
5. Allan GM, Kraut R, Crawshay A, Korownyk C, Vandermeer B, Kolber MR. Contributors to primary care guidelines. What are their professions and how many of them have conflicts of interest? *Can Fam Physician* 2015;61:52-8 (Eng), e50-7 (Fr).
6. Neuman J, Korenstein D, Ross JS, Keyhani S. Prevalence of financial conflicts of interest among panel members producing clinical practice guidelines in Canada and United States: cross-sectional study. *BMJ* 2011;342:d5621. Erratum in: *BMJ* 2011;343:d7063
7. Detsky AS. Sources of bias for authors of clinical practice guidelines. *CMAJ* 2006;175:1033.
8. Allan GM, Lindblad AJ, Comeau A, Coppola J, Hudson B, Mannarino M, et al. Simplified lipid guidelines. Prevention and management of cardiovascular disease in primary care. *Can Fam Physician* 2015;61:857-67 (Eng), e439-50 (Fr).
9. Farrell B, Pottie K, Thompson W, Boghossian T, Pizzola L, Rashid FJ, et al. Deprescribing proton pump inhibitors. Evidence-based clinical practice guideline. *Can Fam Physician* 2017;63:354-64 (Eng), e253-65 (Fr).
10. Farrell B, Black C, Thompson W, McCarthy L, Rojas-Fernandez C, Lochnan H, et al. Deprescribing antihyperglycemic agents in older persons. Evidence-based clinical practice guideline. *Can Fam Physician* 2017;63:832-43 (Eng), e452-65 (Fr).
11. Bjerre LM, Farrell B, Hogel M, Graham L, Lemay G, McCarthy L, et al. Deprescribing antipsychotics for behavioural and psychological symptoms of dementia and insomnia. Evidence-based clinical practice guideline. *Can Fam Physician* 2018;64:17-27 (Eng), e1-12 (Fr).
12. Allan GM, Ramji J, Perry D, Ton J, Beahm NP, Crisp N, et al. Simplified guideline for prescribing medical cannabinoids in primary care. *Can Fam Physician* 2018;64:111-20 (Eng), e64-75 (Fr).
13. Pottie K, Thompson W, Davies S, Grenier J, Sadowski CA, Welch V, et al. Deprescribing benzodiazepine receptor agonists. Evidence-based clinical practice guideline. *Can Fam Physician* 2018;64:339-51 (Eng), e209-24 (Fr).
14. Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. *Clinical practice guidelines we can trust.* Washington, DC: National Academies Press; 2011. Available from: **www.nap.edu/read/13058/chapter/1**. Accessed 2018 Apr 9.
15. Brouwers MC, Kerkvliet K, Spithoff K. The AGREE reporting checklist: a tool to improve reporting of clinical practice guidelines. *BMJ* 2016;352:i1152. Erratum in: *BMJ* 2016;354:i4852.
16. Dickinson JA, Bell NR, Grad R, Singh H, Groulx S, Szafran O. Choosing guidelines to use in your practice. *Can Fam Physician* 2018;64:357-62 (Eng), e225-31 (Fr).
17. Messerli FH, Hofstetter L, Agabiti-Rosei E, Burnier M, Elliott WJ, Franklin SS, et al. Expertise: no longer a sine qua non for guideline authors? *J Hypertens* 2017;25:1564-6.