Evidence-based learning for general practice

THE terms evidence-based practice and evidence-based learning seem to have appeared suddenly and become a hot topic. For some, it may be a *bête noire,* and for others it undoubtedly seems a popular new fashion. Like most paradigm shifts, the idea has taken a long time to develop[1] and includes many familiar features that individually have been called by other names. The purpose of this Editorial is to begin to tease out what evidence-based learning and practice means from the point of view of a general practitioner, and what its practical implications are.

General practice is broad-based and we need to define the evidence which informs our practice accordingly. For example, we need to know whether antibiotics are more beneficial than nothing for otitis media. Randomized control trials,[2] and systematic reviews of randomized control trials,[3,4] will help to meet this need for information. We also need to know who is coming and not coming for cervical screening, for example. Here evidence from surveys will help.[5] We also need to know why people do or do not come for screening; evidence from in-depth interviews will help here.[6]

General practice departments frequently started life in departments of epidemiology and public health medicine. In this context, general practice researchers learned hypothesis-testing methods which are philosophically related to Popper's idea of falsificationism.[7] Popper's approach emphasized the importance of theory as well as theory testing. Unfortunately, epidemiologists frequently play down theory when they appraise evidence, making only passing reference to possible confounding variables. When we want to understand or solve a problem in general practice, measurement is not sufficient on its own. We need to use our intuitions to create theories which are conjectures about what is going on.[8] We can then place models and measurement in juxtaposition, using each to interrogate the other.

Popper's philosophy was itself too narrow to embrace the exploratory methods which are appropriate in making sense of the attitudes and behaviour of individuals and groups in society. After his retirement as an epidemiologist, Geoffrey Rose worked as a peripatetic RCGP advisor for general practitioners interested in research. When I wanted to know what patients thought about doctors using computers during the consultation, he suggested I use a qualitative approach.[9] He emphasized that many questions that can be stated as a hypothesis are hardly worth answering by that means. General practitioners benefited from this eclectic advice.

A challenge for doctors in practice is how to access up-to-date evidence. For some general practitioners who are older, with large list sizes, the distilled summaries of systematic reviews provided directly by groups like the Cochrane Collaboration, York University, and Anglia and Oxford Regional Health Authority offer pithy word-bites: 'Aspirin benefits the acute MI patient' came through clearly in spring 1995 from the NHS Centre for Reviews and Dissemination.[10]

The next generation of general practitioners, and by implication their current teachers, who are general practice course organizers and trainers, are more likely to achieve radical change. Since the advent of the Critical Reading Paper as part of the MRCGP examination, general practitioners involved in teaching and learning have become aware of the new skills they need to acquire.[11] There is performance anxiety about this, because it is anxiety-provoking to find that there are skills which medical schools have not provided, but which are now regarded as fundamental. At the same time, all professionals recognize that their knowledge and skills as a profession cannot stand still.

Searching skills are not difficult to acquire. General practitioners have integrated computers into their routine clinical work to a greater extent than most of their hospital colleagues, and many surgeries have electronic links with their Family Health Services Authorities. The next step is to get medical librarians to teach GP registrars, trainers and others to search for relevant papers using computer systems. Most will start with Medline, which is an automated version of the printed Index Medicus, and go on to other databases like the Bath Information and Data Service when they are needed. Training practices particularly will want to make electronic links with data providers, so that they can do searches without having to go outside the surgery. The British Medical Association library provides its members with free access to Medline.

The next step is to acquire appraising skills. This is a longer process. I have described an approach myself.[12] This starts with the need to: pose practical questions from general practice; suggest models of what might be going on; search for and appraise qualitative and quantitative evidence;[13,14] and then return to the practical question. Major problems are that searches are futile for many relevant questions in general practice as there is little evidence, and that which exists is of variable quality. This is frustrating, but practitioners know they operate in a context of contingency and uncertainty. A rolling cycle of learning generates some tentative answers, and many gaps and questions for researchers in the future.

General practice academics generally learn the skills of searching for and appraising research evidence, which they could help transmit. University departments are providing short and longer courses for those who want these skills, particularly trainers and course organizers, many of whom already have facilitating skills.[15] Course participants can spread the skills of evidence-based learning to other general practitioners and trainees. The strength of postgraduate teaching and learning in general practice is that it has adopted a problem-centred, independent learning approach.[16,17] This approach and the facilitating skills that go with it have not necessarily been valued or developed in medical schools. A merging of undergraduate and postgraduate education for general practice could bring together and enhance the skills of general practitioners both in facilitating the learning process and in evidence-based learning. We will watch the undergraduate and postgraduate departments that have merged[18] to see if they yield more than the sum of their parts.

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The image of the patient in their relationship with general practitioners

IN the current vogue for television series about medicine, doctors and hospitals (I counted 14 on air this week), the 'extras' are the patients. In much the same way as the animals in series about vets, the patient is a much-neglected character.

If these television programmes echo an outmoded view of patients as the hosts for illness and disease, then what is their current image within the profession of medicine? And what should be their role and status in the contemporary doctor–patient relationship? This television image may not be true in the real practise of medicine, but it makes one wonder about the role and status that is currently accorded to patients. So many academic studies of 'patients', as opposed to illnesses, position them as 'sufferers' or 'copers' of an illness, or the recipients of treatment as in studies of compliance, rather than as active agents (and collaborators) in the maintenance of their own health.[1] Even the term 'patient' has connotations which are taken for granted, but which enshrine a view of passively undergoing medical treatment.

In research conducted some 10 years ago,[2] one source of satisfaction for GPs was as 'family doctors', who participated in 'seeing their patients into and out of the world'. While GPs have on-going relationships with many of their patients, the scope for individual personal relationships is changing, despite the best efforts and intentions of many GPs, as practices seek to meet the demands from the National Health Service (NHS) administration, which has engendered more of a business mentality in general practice and health services.

Since the 1980s, the patient has become a 'consumer' of medical services. This reflected the prevailing culture and increased assertiveness of the individual in business dealings which empowered the consumer and, for example, turned rail passengers into customers. It is evident that the power relationship between doctor and 'patient' has also changed for all time. In transactional analysis terms, the traditional parent–child relationship is no longer viable. This is not to say that it did not have advantages, and probably little consideration has been given to the role this relationship played in limiting demand in the NHS, which is a major issue for all governments. In our research on patients' attitudes and expectations in the treatment of RTI,[3] we found that British patients are among the least 'demanding' for antibiotics out of the nine countries studied, which may come as a surprise. The fixed, long-term relationship, created by the British system of registering with one particular GP or practice, was instrumental in stopping patients shopping around, which in other countries raised their expectations of obtaining antibiotic treatment.

The issue is how should GPs react to this changing status of their patients as consumers: How should they interpret the new relationship, what changes do they need to implement in order to handle the altered status, and how can they positively develop the relationship in a way that is mutually viable and satisfying?

It is all too natural to feel depressed and alienated as working practices and relationships change around doctors without their instigation and beyond their control. The consumer-supplier relationship can easily appear as master–servant to the overworked and stressed employee in any business. One automatic reaction and self-defence mechanism is to develop stereotypical images of patients that focus on those who cause the most grief (demanding, manipulating, exploiting, off-loading, leaning, neurotic, aggressive, and so on) and to overlook the ordinary majority.

In response to the changing relationship, the focus should be on the range of needs which patients are seeking to satisfy in their relationship with the GP and their expectations of the doctor. It is then up to GPs to decide how best to meet those needs and which of them are an acceptable basis for the doctor–patient relationship.

In any analysis of the best way to handle the evolving doctor–patient relationship, we need more in-depth information about the patients' perspectives on the consultation and their aims as active agents in their own medical welfare. The paper by Cromarty entitled 'What do patients think about during their consultations? A qualitative study',[6] published in this issue, shows that the real patients of 'middle England' do not fit many of the stereotypes. They are concerned about the doctor's time, respect the value of it, and limit their consumption to what is 'fair' (in terms of the demands on their GP and the needs of fellow patients) despite their eagerness for insight into their condition. They seek to maintain a good, long-term relationship with their GP.

The main need for the patient in the consultation is for self-understanding of the complaint and its implications for their well-being. However, what Cromarty's paper shows is that patients need to be able to satisfy themselves about the information and advice they are being given. Patients, and consumers