

alone and only a further 17.5% by both GP and hospital.<sup>3</sup> The shift of oral anticoagulation monitoring, I feel, has already taken place in some parts of the country. Neither of these articles supports Fitzmaurice's claim that they 'highlight the need for improved anticoagulation monitoring in general practice.'<sup>4</sup>

It is of interest that the August issue of the *Journal* contains an advert for an 'Anticoagulation Management in Primary Care Study/Training Day' organized by the Department of General Practice of the University of Birmingham. I hope they have a good response from local GPs.

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## Evidence-based medicine

Sir,

The shift to develop an evidence-based culture in primary care is exciting; however, I applaud Jacobson *et al.*'s article 'Evidence-based medicine and general practice' (July *Journal*),<sup>1</sup> as they have highlighted the need for an active debate about the integration of evidence-based medicine within primary care.

As a philosophy, evidence-based medicine arose out of clinical epidemiology and was originally promoted by hospital specialists.<sup>2</sup> It is defined as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.<sup>3</sup> To date, the emphasis has been more focused on making specific decisions about the medical care of individuals in secondary and tertiary care settings.

In promoting evidence-based medicine within primary care, it needs to be appreciated that there are distinct differences between secondary and primary care, and

that the development of evidence-based primary care needs to be handled carefully. Clinical problems in general practice are often diffuse and difficult to define clearly. Prevalences, presentations, pathologies, and predictive values are all different in primary care. Sensitivities and specificities of diagnostic tests derived in hospital settings may not be directly applicable within primary care patient populations.

In general practice, it is always necessary to appreciate the big picture in terms of, for example, the breadth of information used to make decisions and the combined perspectives in relation to both population care and individual patient care. Jacobson *et al.* have highlighted the need to maintain the broader perspective by examining the integration of the evidence with individual care — in particular, the importance of considering biomedical, personal, and contextual perspectives in reaching a diagnosis.<sup>1</sup> At the population level, GPs as commissioners of care need to be equally concerned about another type of epidemiology: public health epidemiology. In Canada a few years ago, a debate raged between the clinical epidemiologists (the advocates of evidence-based medicine) and the classical epidemiologists. Writing in 1988, Last considered that 'the uncritical enthusiasm with which [clinical epidemiology] is being embraced in many medical schools constitutes a danger to health.'<sup>4</sup> Clinical epidemiology is not synonymous with epidemiology. Commissioning groups of GPs need to acquire skills in both clinical epidemiology (evidence-based medicine) and public health epidemiology to ensure appropriate development of primary care. In my view, none of the many new books on evidence-based medicine directed at GPs meet the need for a basic text that general practice registrars could use in order to learn something of the science and art of classical epidemiology.

Ironically, the more books that are written on evidence-based medicine and general practice, the more obvious it becomes that the primary problem is a major deficiency in the evidence base in primary care. In 1995, Owen pointed out that 'medical research has yet to address in any meaningful manner what symptoms and signs indicate in primary care: just how useful is a particular symptom at predicting a certain disease, which symptoms are not useful, and which symptoms will rule out disease.'<sup>5</sup> The recent Medical Research Council review on primary care research and development (R&D) indicated that there is a specific and urgent need for basic information on the clinical epidemiology of common problems (to support evidence-

based practice), primary patient assessment, and the early diagnosis of chronic diseases (Jenkins H. Personal communication). Critical appraisal skills have limited value if there is nothing to appraise. More energy should be directed to generating research that relates to matters relevant to the day-to-day care of patients in general practice: I know how to appraise papers but I don't know the best way to treat warts effectively!

The advocates of evidence-based medicine promote a hierarchy of evidence, randomized controlled trials being held up as the gold standard. In developing primary care research to support evidence-based practice, randomized controlled trials certainly need to be encouraged, but there is also a need to explore the use of other methodologies; for example, case control, cohort, and qualitative studies.<sup>6,7</sup> The overriding desire must be to ensure that the R&D undertaken is rigorously executed (i.e. protocol based, peer reviewed, and publishable) and appropriately generalizable. The promotion of evidence-based medicine should not be permitted to distort the research agenda within primary care.

The promotion of evidence-based medicine in primary care presents unique opportunities but also distinct threats to primary care development. I would encourage further debate on the generation of a more rational, or dare I say 'evidence-based', approach to the promotion of evidence-based medicine within primary care.

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