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Editor's choice

Cochrane reviews: relevant more than ever

In The Review Trish Greenhalgh¹ refers back to the halcyon days of editorials and opinion pieces in medical journals that relied on an author's bias, speculation, and conjecture that passed for academic debate in the mid-1980s. She decries Cochrane reviews as narrow, boring articles that seldom answer the 'messy context' of clinical practice. Sorry, but we don't agree. Using narrative reviews that do not systematically identify, assess, and synthesise information produces evidence that is biased, misleading, and may harm patients.²

Surely informed clinical practice means telling our patients about what we know is effective, what we know is ineffective, and what we are uncertain about? The Cochrane Collaboration and other useful sources of synthesised evidence such as the *BMJ* publishing group's *Clinical Evidence* demarcate uncertainty and allow us to use regularly updated evidence when helping our patients. What is wrong with this? Every doctor, irrespective of their clinical discipline, cannot possibly keep up with the burgeoning medical literature. In 2009 1.5 million articles were published in 25 400 medical journals. In narrower disciplines than general practice (diagnostic imaging in cardiology) it is estimated a doctor would have to read 95 articles every day to keep up to date.³ One of several solutions lies with clinical summaries that access and synthesise systematic reviews of evidence that address focused clinical problems. Indeed there is now an established hierarchy of pre-appraised synthesised evidence that enables more efficient access to clinically relevant information. The base of this information pyramid is the individual original studies. It then moves to ever-increasing synthesised evidence: synopses of studies, (evidence-based medicine, ACP journal club); synthesis (The Cochrane Library);

synopses of synthesis (DynaMed); summaries (National Clinical Guidelines, Clinical Evidence), and ends up with point-of-care decision support, a final 'systems' layer.⁴

The Cochrane Collaboration, and the explicit, systematic, and transparent methods that are used, are prime movers in the information revolution that enables safer patient care. Let us not forget that it is Cochrane authors who have shown how the research agenda can be misled at the inception, funding, publication, and reporting stages.⁵ We do not have to look far for examples of drugs that had disastrous consequences for some patients (rosiglitazone and rofecoxib); and other drugs that have questionable clinical benefit (gabapentin and oseltamivir).⁵ While sometimes 'boring', Cochrane reviews are seldom irrelevant. A recent example of a Cochrane review that has important clinical and policy implications concerns the use of general health checks in adults, shown not to reduce morbidity and mortality, despite the fact that the UK government began a policy of health checks for adults in 2009.⁶

We urge readers to take a more critical view of the medical literature and its relevance to their clinical practice. Cochrane reviews remain key components for GPs who wish to remain safe and effective doctors.

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Competing interests

All authors are active members of the Cochrane Primary Health Care Field and Cochrane Collaborative Review Groups.

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Beyond skin: the need for a new approach to the management of psoriasis in primary care, and Iona Heath's Harveian Oration

It is becoming my habitual response as a GP commissioner to take issue with

statements in your journal. I think there is a lack of editorial appreciation of the work that many GP commissioners are doing. We are not all entrepreneurial market-driven Tory radicals; in contrast, the ones I work with just want to make things better for patients and to limit the domination of hospital care. If we are to retain and even enhance the traditional GP role closer to that identified in Iona Heath's Harveian Oration,¹ we need to work hard at transferring resource from secondary care into primary care.

Carolyn Chew-Graham *et al* expressed concern that 'the continued downward pressure on referrals to specialist services may mean that access to best treatments will be limited for patients whose health needs are as significant and complex as those patients with diabetes'.²

Reports from the King's Fund back up the experience across the country, that many referrals from GPs to secondary care reflect an assumption that secondary care management of risk through investigation is preferable to taking the risk on ourselves and trying to prevent the transfer from illness to disease.^{3,4}

We are trying to make sure that patients with illnesses like psoriasis are able to be seen more quickly than they can at present, as many outpatient clinics are clogged up with people who didn't need to be there in the first place, are being seen for too long, and where their care is not being shared between the GP practice and specialists. We have successfully transferred many patients with type 2 diabetes from hospital to primary care, assisted by diabetes specialist nurses, with agreement from consultant diabetologists.

GPs have to accept patients back from hospital care; they are the doctors who can help patients make sense of either their symptoms, illness, or disease, with as little harmful intervention as possible, and can manage all of their problems, not just one. And hopefully with kindness.

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A rock and a hard place

I could not welcome the Schizophrenia Commission's report, published today, more.¹

I am a section 12 approved retired GP. I have decided that I no longer wish to assess patients as to whether they should be detained against their will. The majority of assessments I am asked to do are for 28 days of assessment. My experience is that due to bed cuts, a local bed is very often not available. The patient therefore starts his or her assessment far from home. There then seems to be a low threshold for transfer to a secure unit, then transfer to a more local bed follows.² As a result the patient, often suffering from schizophrenia, is looked after on a temporary basis by several psychiatric teams none of which seem to be making a full assessment. I will be asked to see someone towards the end of this 28-day period and no member of staff can tell me their 'story', stating as a reason that the patient has only recently arrived.

If a patient is not to be detained, reliance has to be placed on the crisis teams. Patients often do not engage with these community-based teams, complaining that they see a different member of the team on each visit and resent having to start their painful story from the beginning each time.² There seems to be a lack of engagement from the crisis team's side too, claiming as a reason that the patient doesn't really want to see them.

I have therefore been left choosing between a rock and a hard place.

Inpatient units are far from satisfactory, but it is important that they should be improved rather than cut, hopefully enabling them to offer the 'good care delivered by kindly, compassionate practitioners' referred to in the report, and to look after more disturbed patients rather than sending them to secure units. Secure beds could therefore be reduced

as the report suggests but the current general adult psychiatric bed shortages are part of the problem.

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Are we medicalising normal experience?

Sometimes in clinical practice the most difficult thing is to do nothing. As a grizzled old professor of mine used to say, 'Less is more'.

There is a real danger that as gatekeepers to the 'sick role', we can be pressured into labelling people with diagnoses that are unnecessary and downright harmful. In my role as both a psychiatrist and a practising GP, I am increasingly seeing colleagues in both disciplines labelling normal life experiences as mental illness. They then appear to peddle the hope that a tablet (often an antidepressant) will sort out the patient's alcoholic husband and noisy neighbours.

Should we be reconceiving normal human experiences as being in need of medical intervention?

DSM-5 is due out next year. For those of you who are unaware, this is the American Psychiatric Association's standard reference work on mental disorders; the Diagnostic and Statistical Manual (DSM). There is a lot of money riding on it.

If it isn't in DSM then the insurance companies generally won't pay for treatment of it. We tend to follow the lead of the Americans and when the ICD-11 (International Classification of Diseases) is revamped in 2015 they will look to the DSM for ideas.

It is widely expected that the diagnostic net will be cast even wider, with bereavement for as little as 2 weeks being labelled as clinical depression. When will