REVIEW

From mummified guidelines to living evidence-based medicine: three essential tools

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On a tour of the WHO headquarters in Geneva, I wandered past a vast cellar of shrink-wrapped, unused and unread guidelines. These guidelines were rapidly passing, or already past, their "use by" date given that around 7% of clinical "facts" become outdated each year [1]. Although glossy journals, 500-page systematic reviews and grand guidelines are all worthy, clinical impact occurs only when someone reads, digests and acts on the information.

So what does evidence-based medicine look like in the hurly-burly of a busy general practice? Most of the time an observer would see no difference: good history taking, examination, test ordering, empathetic care, communication with patients, etc. What EBM adds are reliable updates and improvements to our knowledge base, but this is an episodic and cumulative process. There are many variations, but from interviews with EBM practitioners from several disciplines and from my own General Practice, there are three key activities I would look for to see if an individual or team was using an evidence-based approach:

1. ***A "log book" of clinical questions.*** Although good general practitioners have vast knowledge in their clinical niche, knowing everything is impossible. Several times a day, or even per consultation, questions arise. Some might be answered immediately, and some will be deferred. To avoid forgetting the question, it needs to be recorded in a "log book" – whether paper, electronic or even a shared whiteboard. Some questions may be answered that day, some over tea, some by e-mail to a clinical librarian or literature searching service, depending on time, skills and resources. However, not any answer will do, the searcher should have the skills to find and appraise the best available evidence

2. ***An evidence-based research alerts service.*** For some important new evidence, we might not have even imagined the question, but will need to be alerted to it. Of course, we are immersed in bad alert services: news columns, colleagues, table of contents of a few favourite journals, etc. Making sense of these muddied floodwaters is energy draining. It is better to have a trustworthy evidence-based team filter these torrents and provide summaries of the few relevant, valid research articles. A good model for an alert service is the ACP journal club, which scans 120+ journals, checks new articles for validity (95% fail here), then gets clinicians to vote on relevance to practice [2], and summarises the best. The ACCESSSS system - http://plus.mcmaster.ca/ACCESSSS - from the McMaster group is a free version that allows you to specify your areas of interest, and sends a summary weekly e-mail – scanning over 120 journals for you!

3. ***Team discussions of evidence.*** Important issues may emerge from the logbook or alerts that require a team discussion of the evidence – and what to do about it. Usually labeled as "journal club", these EBM discussions considerably differ from traditional journals clubs: the topics are based on question logbooks or evidence alerts, not a casual scanning of a handy

journal; the discussion uses and appraises the best evidence, not the most readily available; and a clinical bottom-line is reached. The clinical bottom-line may not be enough to implement any change. "Next actions" may require training, equipment, audits or other information needed, which may need longer-term follow-ups. [3]

There will be many other EBM activities. However, without these core ones, the edifice of evidence is just a silent tomb full of mummified information that does not touch living clinical practice and improve patient care.

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