



1 Specific Evidence Based Medicine interventions

Summary of practical points from this section

This section will describe different methods for the implementation of EBM in your division. These include:

- interactive workshops
- academic detailing
- training, eg in internet searching skills
- journal clubs
- other skills for the highly enthusiastic, eg critical appraisal skills.

Not all GPs will want to travel equal distances 'down the road to EBM'. However, a range of activities is likely to reach a considerable GP audience, providing you have the enthusiasm, skills and resources to follow through.

1.1 Introduction

You will need to decide for yourself which strategy best suits your division, members and resources. This chapter outlines the possibilities and includes strategies used in our local project together with other ideas based on what might be achievable with limited resources. It mentions what might occur within the division itself, such as policy development or the promotion of EBM leadership, and goes on to explain in detail initiatives such as academic detailing, workshops or the formation of 'journal clubs'.

1.2 Division level strategies

Provide leadership in the championing of 'evidence'.

Strong leadership is favourable to behaviour change. Divisions can impress upon GPs the importance of an evidence based approach to clinical practice by taking a leading role in promotion of evidence. This could be applied to the promotion of newly established evidence based guidelines, the promotion and appraisal of 'new' evidence as it arises and the support of evidence based opinion leaders in the local medical community.

Develop a CME policy

Divisions play a major role in organising local CME. As such they have a good deal of discretionary power, together with a degree of responsibility for the content and style of the CME they run. GP feedback might indicate that CME activities vary in both quality and usefulness. Some presenters may rely too heavily on anecdotal information or drug company resources for the knowledge they impart and their advice may digress from well established clinical practice guidelines. As such, divisions which are trying to promote 'best practice' through EBM might feel as though they are not following their own advice. In this respect, Divisions' CME committees could resolve to be more selective in choosing CME activities both in terms of the content (presenters with reputation of evidence based practice) and process (using CME techniques that have been shown to be effective). They could also adopt a CME policy.

It is important that a policy is not seen as a way of policing or censoring CME, rather it is simply a way of encouraging presenters to be explicit about the knowledge base of their topic. Moreover, on the grounds that the application of scientific rigor improves the standard of CME, promoting EBM can be seen as part of continuous quality improvement. Policy development should involve the membership of the division together with CME co-ordinators and presenters. It should aim at providing the best quality knowledge to the division membership in educational activities. An example of an EBM policy is given below.

Example of Divisional CME policy

A guideline for presenters

Thank you for agreeing to be a Continuing Medical Education (CME) presenter for the Monash Division of General Practice (MDM). You might be aware of the increasing enthusiasm for an evidence based approach in keeping up to date in medicine and the Division, acting on behalf of its membership, is keen to take a leadership role in this regard.

MDM recognises that high quality CME is based on rigorous, scientific research, and understands that a major purpose of CME is to encourage the uptake of the results of research into clinical practice. At the same time, MDM is also aware that not all knowledge derives from research based evidence, and that a large part of clinical practice relies on expert opinion. In addition, it does not wish to limit the diversity of CME activities nor prevent the introduction of new ideas. Nevertheless, the Division believes that the application of current, best evidence in making decisions about the care of individual patients is commensurate with quality general practice, and it therefore wishes to promote the explicit use of evidence in its CME program. It also believes that CME should be consistent with locally accepted guidelines.

Given widespread GP interest in an evidence based medicine framework for CME, MDM therefore suggests the following to you for your consideration.

Clarifying what is evidence based and what is not

When feasible, information imparted at CME activities should be based on scientific evidence. When it is not feasible to do so, or if the topic does not lend itself to an evidence based approach, this could be made known to the attendees. The source of evidence should be cited together with, where possible, the level of this evidence. The funding body for clinical trials together with any association with the presenter, should be disclosed. Presentations should be consistent with current evidence based guidelines, or indicate where variations to the guidelines exist.

Teaching GPs about clinical effectiveness

Presentations should, if possible, make GPs aware of the hallmarks of clinical effectiveness. These include:

- Clinical endpoints or, where not available, explicitly labeled surrogate endpoints. This means referring to outcomes such as mortality or morbidity rather than physiological parameters.*
- The absolute risk reduction of disease, death or morbidity and, by calculation, the 'number needed to treat'. This gives a better indication of the usefulness of an intervention than the relative risk reduction.*
- The reporting of effectiveness rather than efficacy. Effectiveness takes into account the practicalities of implementing the intervention in the population.*
- The total cost of the intervention and not just cost to the patient.*

We are interested in your feedback about this guideline for CME presenters, and in particular, whether it helped you understand more about the interests of your GP audience.

*Management Committee, Monash Division
September, 2000*

Develop a divisional program policy for EBM

Divisions might decide to encourage project officers to integrate the principles of EBM into the various division programs. To formalise this, it might be expedient to develop a divisional policy which encourages both project developers and project officers to seek out, or at least be aware of, the evidence concerning their particular programs. This includes the evidence of effectiveness of both the intervention and the particular method of intervention. For example, a project which might wish to promote selective screening for a particular illness ought examine the evidence about the natural history of the illness together with the evidence that screening makes a difference to clinical outcomes. The project should then be based on methods which have been shown to be effective.

Emphasising the importance of evidence shouldn't entice the division into policing or censoring program activity. Different, innovative approaches to a program or new directions on an old theme should be encouraged but nevertheless should be properly evaluated.

1.3 Workshops

Principles

The idea of workshops is to provide an interactive learning environment where participants, with the help of facilitators, are able to work in small-group settings to resolve specific problems or discuss issues and thereby actively participate in the learning process. The theoretical basis lies in adult learning theory which emphasises responsibility and participation in the learning process and relates learning to current practice through a problem or task centered approach. The workshop format is also very flexible in terms of the number of participants, the learning strategies adopted and the ability to deal with knowledge, skills and attitudes in the one setting.

Speakers and facilitators

Workshops are usually led by a presenter or co-ordinator who, in the case of EBM, might be an academic GP (or a specialist) with an EBM background. It is important to discuss in detail the content of the workshop with the presenter as part of the planning process.

On the grounds that at least part of the workshop will be conducted in the small group setting, a number of facilitators will also be necessary to promote discussion and deal with group dynamics. Tips for facilitators are listed in the accompanying table.

Tips for facilitators of small groups (adapted from Hays and Veitch ¹)

Set some ground rules at the beginning of session.
Ensure that all participants have the opportunity to contribute.
Seek clarification of viewpoints as required.
Watch for non-verbal responses.
Use first names and eye contact.
Move from foreground to background as discussion proceeds.
Intervene if necessary to keep discussion on track.
Let group deliver the answer, rather than providing it for them.

Planning

Planning strategies for EBM workshops are similar to those for academic detailing and are covered in section 1.4 of this resource.

Method

Issues that might need to be considered are as follows:²

Introduction

Depending on the size and length of the workshop, the presenter and/or facilitator may wish to involve the audience in an 'ice-breaker' or self-introduction session so that the participants can get to know each other. This might be important if the functioning of the workshop depends upon the establishment of early rapport. On the other hand, the type of 'ice-breaker' must be compatible with its audience because they can be intimidating and may have different effects in different cultural settings.

Outlining

With adult learning, it is important to let participants know what is expected of them for the session. An outline of the learning activity at the beginning together with a summary of what is planned for the session communicates to the learners where each activity lies within the learning framework.

Participation

The idea of a workshop, as distinct from a didactic lecture, is to promote GP participation. Small group discussion, practical exercises or problem-solving tasks are all techniques which allow participation and promote adult learning. This is where facilitators are important and it is vital that they encourage all GPs and not just the vocal ones to contribute to discussion.

Pace and Strategies

Adult learning also relies on variation in the pace and methods within each session. This helps maintain interest and allows for the natural variations in learning speed within the population.

Content

The content of the workshops will be determined, to some extent, by the presenters chosen. In principle, the workshops should illustrate the principles of EBM using clinical examples in an interactive environment. Although it might be tempting to concentrate on teaching the 'skills' of EBM (ie the '5 steps'), it is just as important to emphasise EBM 'thinking', that is the change in the underlying approach to clinical management which EBM entails. Understanding this will promote GPs' enthusiasm to thereafter adopt the 'skills' of EBM.

Topics

The topic selection will depend on the number of workshops in the series, the presenters available and local factors. Below are some possible workshop topics.

- a) *Knowledge management*:- GPs' role in the information explosion. How to be effective knowledge workers.
- b) *EBM thinking*:- How does evidence help GPs in making clinical decisions? The concepts of clinical effectiveness and risk. How to phrase a clinical question to search for the answer.
- c) *Searching*:- Where to start looking for evidence. How to construct an effective search strategy.
- d) *Critical Appraisal*:-Appraising drug rep information, clinical guidelines, systematic reviews.
- e) *Clinical Epidemiology*:-Absolute and relative risk reduction. Interpreting cardiovascular risk tables. Calculating and using number needed to treat.

Clinical examples

The use of clinical examples is important to illustrate the principles which have been described. Usually, good examples are those where recent analysis of the evidence has challenged the status quo (antibiotics and acute otitis media), or where the conclusions from the evidence are counter-intuitive (spacers v nebulisers with bronchodilator delivery). However, presenting only examples which challenge current practice might cause too much controversy and lead to loss of credence, so it is worthwhile also presenting cases where the evidence confirms the status quo (aspirin and coronary heart disease).

Program

The following is a summary of the series of 4 workshops run by the Monash Division of General Practice in 2000.

Table 2. EBM workshop program.

Title	Topics covered	GP tasks *	Evaluation
Common problems in general practice: how to handle the information overload	<ul style="list-style-type: none"> the information revolution management of knowledge in clinical practice barriers to clinical effectiveness 	<ul style="list-style-type: none"> discussion the concept of knowledge versus skill in practice ways of coping with information overload homework 	Process and knowledge
An evidence based approach to respiratory illness in general practice	<ul style="list-style-type: none"> clinical effectiveness risk and risk reduction Cochrane systematic reviews 	<ul style="list-style-type: none"> looking at and appraising a systematic review use of the resource 'Clinical Evidence' homework 	Process and knowledge
Searching for evidence in general practice	<ul style="list-style-type: none"> using the internet to find evidence PubMed Boolean methods introduction to cardiovascular risk tables 	<ul style="list-style-type: none"> providing clinical questions homework task- searching the internet for guidelines 	Process
Managing cardiovascular risk in general practice: an evidence based approach (see also box in 3.4)	<ul style="list-style-type: none"> critical appraisal of cardiovascular trials application of cardiovascular risk tables 	<ul style="list-style-type: none"> appraising the HOPE study applying CV risk assessment to case studies homework task- analysing a study 	Process

* A financial incentive was provided to GPs to complete a task at home.

Evaluation

Process evaluation can be done with the standard post-event questionnaire. This should examine GP satisfaction with the content, timing, format and logistics of the workshop. A questionnaire could also ask GPs about their 'self-efficacy', that is whether they are more confident they can achieve the goals set out for them in the workshop. This type of evaluation is limited in its usefulness because it can only measure GPs perceptions of the activity or their self-efficacy rather than actual changes in knowledge, attitudes or practices.

Impact evaluation gives more information but is more difficult to complete as it would involve a comparison of before and after measurements and ideally would require the use of a validated evaluation tool. Nevertheless, these tools do exist and impact evaluation could be achieved by enthusiastic divisions. Care needs to be taken when using evaluation tools developed for different purposes as the content of the sessions may not match.

1.4 Academic detailing

Principles

The term 'academic detailing' was first used in North America in the early 1980s to describe a method of one-to-one exchange with GPs to promote improvements in prescribing. It has developed other names since, such as 'educational outreach' and 'educational visiting', to emphasise its role in continuing medical education and the fact that it is conducted in the GP's premises.

There is good evidence from systematic reviews of the literature that academic detailing is an effective strategy to implement change in general practice.² Likewise, the continuing use of this very expensive technique by the pharmaceutical industry for promoting their products suggests, at least on face value, that it works.

Academic detailing is, to a large extent, social marketing, with the GP as the consumer. It applies the principles of marketing (ie selling) in the one-to-one setting, to 'increase the acceptability of a .. (new) practice in a target group' as Kotler defined it in 1982.³ Social marketing is based on the analysis of consumer behaviour which is grounded in anthropological, sociological and psychological theories of the human condition.

There are several aspects of academic detailing which may explain its effectiveness. The most obvious is consumer orientation, with its ability to focus on or 'target' the market (the GP) and ensure that the setting (place, time, person) for the educational message is on the consumer's terms, that is, in familiar surroundings at a convenient time with recognisable people and language. The other crucial concept is the application of marketing tools, which involves identifying the needs, expectations and dissatisfactions of the market and designing and redesigning the 'product' to fit. This is 'tailoring', and the setting of academic detailing places the detailer in a unique position to assess the potential for change in each GP and to respond by reshaping the message to maximise the probability of change.

Within the framework of social marketing other health promotion principles, such as the 'stages of change' model, might apply, but a full explanation of these is not within the scope of this manual.

Techniques

The techniques of one-to-one detailing encompass communication skills and interpersonal behaviour theory which most health professionals studied as undergraduates. There exist specific courses for refreshing or training in these skills, but divisions are not usually funded to allow for such further education. There are a couple simple guidelines to follow.

f) **Engage early**

It almost goes without saying that unless the detailer involves the GP in some sort of discussion, the benefits of being in the one-to-one setting on the GP's terms will be lost. Without this a lecture or tutorial would perform the same function. Engaging the GP early in the detailing serves two purposes; it helps the GP to get to know the visitor, and importantly allows the detailer to establish where the GP stands on the issues in question, ie where on the road to EBM? Establishing rapport and allowing the GP to direct the session are also important tactics, and the detailer may have to change the set plan or abandon it altogether should the circumstances dictate.

g) **Body language**

Most health professionals are aware of the influence that body language may have on the one-to-one personal interaction. The relevant principle with academic detailing is to mimic the body language of the GP, or at least avoid defensive or aggressive postures.

h) **To rep or not to rep?**

A dilemma facing the novice EBM academic detailer is whether or not to copy pharmaceutical representatives. On the one hand, it might be important to dissociate oneself from the vested interest, the hard sell and the corporate image of the pharmaceutical industry to create an impression of scientific unbiasedness, which is after all, part of what is being sold. On the other hand,

pharmaceutical reps practice marketing techniques known to be effective in the market-place, so to deliberately attempt something different may jeopardise the success of the program. A solution to this might be to adopt the best of both styles, using marketing tools to impress upon GPs one's lack of bias. It is important to remember that many GPs see the division as their own resource, so they will instinctively accept the detailer's independence from vested interest.

Costs

Academic detailing is resource intensive. A program to promote EBM through practice visits will cost between \$40,000 and \$50,000. A breakdown of costs is given below. This is based on a 6 month program. The planning, training and implementation phase of a program will take at least 4 months and additional time will be required for evaluation and writing up or publishing results. Experience suggests that an academic detailer can visit at most 15 GPs a week, and one can expect 50% and 60% of GPs to accept the visit.

Program budget (6/12)	Cost
Personnel	
Program director	\$27,000
GP payments/ incentives	\$5,000
Consultative Group	\$4,000
Admin	
Stationery	\$2,000
Travel	\$500
Resources	\$1,000
Computer, telephone	\$1,500
Total	\$41,000

A time-table might be:

Planning: consultative meeting, canvas membership, background reading, establish resources	8 weeks
Mailouts, phone-calls	2 weeks
Practice visits	8 weeks
Evaluation, writing up	6 weeks

Planning

The degree of preparation which is necessary for academic detailing will depend on the resources and time available. Some divisions may have resources to allow for formal training in specific techniques while others will have minimal preparation time. It is reasonable to allow a third of the total time for planning and preparation. Two key issues which might be fundamental to the success of the program are firstly, recruitment, which includes the methods of communication with GPs, and secondly, the content and method of the presentation itself.

Recruitment is a marketing exercise in itself. The principles of familiarity, common language and mutual goals and expectations apply. Another important principle derived from health promotion theory is that of 'self-efficacy', which is the belief that one is able to achieve a given task. That is, GPs are more likely to participate in the program if they believe they can achieve the tasks set out for them. If they have minimal knowledge of EBM or clinical epidemiology they are unlikely to participate for the sake of curiosity, so the aims of the program must be phrased in familiar terms.

The most successful way of recruiting GPs for the program is likely to be face-to-face questioning, and even though this is not logistically possible as a routine method, opportunities to speak personally to GPs about the program should be taken if they arise. Otherwise the program should be introduced by a mailed flyer and appointments made for academic detailing after speaking with the GP by phone.

i) **Mailouts**

A mailed flyer is a good way to introduce GPs to the program and the personnel involved, and is essential if a before-and-after survey is being done. It also alerts the GP to the concept of a practice visit and the coming phone call. It should of course be snappy and to the point.

j) **Phone calls**

It is imperative to get verbal consent from the GP prior to making the appointment. It is not only polite but also differentiates divisional activities from corporate ones. It is nevertheless time-consuming because GPs are hard to pin down due to busy schedules, different hours of practice, etc.

k) **Incentives**

It is useful, although not imperative, to offer incentives for GPs to partake in the program. It is fair and reasonable to compensate GPs financially for their time at the standard rate (which will work out to about \$50 per GP for each visit). An alternative is to offer EBM resources such as journal subscriptions (eg *Clinical Evidence* or *Bandolier*) or CD-ROMs (eg *Cochrane Library* or *Best Evidence*). Academic detailing visits are usually too short for RACGP CME points.

The content of the academic detailing need not be finalised prior to rehearsal; indeed, rehearsals should be seen as part of the process of content development. Allow time to change the content, the demonstration materials and handouts following feedback from trial runs. Consider asking a few friendly GPs to give critical feedback. The sessions should be planned to last 20 minutes.

Content

It is likely that some GPs will not have thought about the evidence behind what they do for many years, some will not have access to the internet, some might think EBM is irrelevant or politically driven or the work of the anti-Christ. On the other hand, some might be very keen to practice in a more scientific way and others might be using the internet on a daily basis to search for evidence. The advantage of academic detailing is that you can find out where each GP stands on 'the road to EBM' and then tailor your message to move the GP along that road. It might also be important to impart a brief core message about EBM, such as 'the five steps', to all GPs, so that all will be left with some background knowledge of the fundamentals.

The outline of the academic detailing may look like this:

1. Explain what the program is about.

- Reinforce the scientific nature of general practice.
- EBM offers new tools and resources for GPs to self-learn

2. Find out where the GP stands on EBM. This might be by examining

- GP's understanding of EBM
- What EBM resources are available or being used.
- GP's method of answering clinical questions
- Usual CME activities
- Attitude to drug reps
- Encourage discussion

3. Core message/explanation about EBM.

- EBM as quality practice- scientific, up-to-date
- The five steps- questioning, searching, appraising, applying and evaluating

4. Ascertain what the next step or steps might be and find out the barriers to that step.

Barriers might include:

- Time
- Information overload
- Patient expectations
- Skills
- Prevailing opinion
- Organisational
- Beliefs- suspicions about vested interest
- Access to resources

5. Explore ways of overcoming the barriers, with the resources of the division in mind.

Steps might include:

- Explanation of the EBM process
- Explanation that the probabilistic nature of EBM is compatible with clinical practice.
- Understanding that EBM takes nothing away from the 'art' of medicine.
- Dispelling myths about the 'cookbook' approach,
- Using division resources to get online.
- Finding paper-based EBM. Show examples of paper-based EBM
- Using the internet to answer clinical questions.
- Finding the EBM sites on the internet. Illustration of the results of searching the internet.
- Applying evidence in practice
- Explaining the division's role and the services offered by the division.

Demonstration aids

These may include:

- A 'flip-chart' of laminated Powerpoint slides printed on A4 paper, illustrating the 'five steps' of EBM, levels of evidence or barriers to EBM.
- Some examples of what GPs might find when they go looking for evidence on the internet. One page summaries of evidence (from, say, Cochrane Abstracts or the Centre of Evidence Based Medicine) will illustrate the concise nature of the resources available and impress upon the GP the utility of finding the evidence.
- Evidence based guidelines of common problems, for the same reasons.
- Copies of pages from non-internet sources of evidence, in particular, 'Clinical Evidence' are useful to impress upon the non-IT based GPs that easy-to-read evidence is available outside the internet and that EBM is possible without IT.

It might be prudent to avoid using a PowerPoint presentation on a lap-top unless you know the GP well. This method is a turn-off to poorly resourced GPs (particularly those without IT) and can appear too 'flashy' to others (see above 'To rep or not to rep?').

It is part of a good technique to give to the GP hard copies of the information you impart during the session. This might be a locally developed resource or the EBM handbook from Monash Division. If the academic detailing is about overcoming barriers on the road to EBM then it makes sense that the handbook will be focussed on the common barriers. Hence it might contain:

- An explanation about EBM.
- An outline of the five steps of EBM with the associated skills and resources required for each step.
- Information about computerisation for GPs without computers.
- Information about how to get on the internet.
- How to find paper-based evidence.
- Internet addresses.
- How to obtain resources (electronic and paper-based) to learn EBM skills.
- Glossary of EBM and clinical epidemiology terms.

Follow-up and evaluation

Multi-faceted approaches to behaviour change are associated with an increased chance of success, so it is logical to combine the academic detailing with other forms of intervention. The interactive workshops (see below) perform this function but other forms of promotion such as follow-up letters, EBM e-mail bulletins or newsletter articles might help to reinforce the messages. Divisions should also be responsive to requests from GPs for advice about IT, further CME activities, searching, critical appraisal or further practice visits.

The approach to evaluation of academic detailing in the GP setting will depend on the resources available and the aims of the division. Evaluation of practice visits for the sake of feedback can be done on a faxable sheet handed to the GP at the end of the visit. Scope should be given for GPs to critique the method, content, resources used and time taken. We used this method and the sheet is available in the Appendix. Should resources allow, evaluation concerning the change in knowledge, attitudes or practice by the GP can be made. This will require administering a questionnaire before and after the practice visits. We have developed a questionnaire for this purpose and it is available in the Appendix. While questions similar to those on the questionnaire have been used in other settings, the questions themselves have not been validated. It is good advice to pilot any newly developed questionnaire.

1.5 Training

Provide internet search training

Searching reference databases for evidence is an important skill for the evidence based practitioner because poor searching techniques will lead to frustration and loss of self confidence when too many or too few items are retrieved. Search training will improve the 'self-efficacy' of GPs (the belief that they can achieve a given task), which will allow easier implementation of other strategies. This 'self-efficacy' is one of the most important characteristics to target with any behaviour change program.

Divisions with the appropriate resources can provide IT training for GPs concentrating on use of the medical software, the internet and searching skills. Refer here to 'Using the internet to find clinical information: From Chaos to Clarity' available on our Monash Division website.

Provide systems support to enhance evidence based general practice

Switching to an evidence based approach to general practice often requires a change to the way that a practice is run. For example, evidence is easier to find if practices are already computerised, evidence based guidelines are easier to follow if reminder systems are already in place, or if practice staff are already aware of the requirements. Hence, staff training in areas such as information management skills, auditing skills or administering recall/reminder systems might be important steps to overcoming local barriers to evidence based practice. It is often the 'systems' which have to change first before a new idea can actually be realised. Once they are in place the new approach is easier to implement.

Divisions can have a useful role in the promotion of evidence based practice by being aware of this and predicting where the 'system' barriers might lie on 'the road to EBM'. The principles of systems support are also fundamental to the concept of continuous quality improvement as developed in the section titled, '*How does EBM relate to quality improvement in general practice?*'

1.6 Journal Clubs

The journal club framework is an excellent place for GPs to hone their EBM skills. Traditionally, journal clubs consisted of clinicians of the same specialty who would meet at regular intervals to discuss a recent journal article. For each meeting, a member of the group would find an article of particular significance to be circulated prior to the meeting. At the journal club the member would present the article with an appraisal of its conclusions and this would be followed by a discussion about the repercussions of the results on the practice of those present. The meeting would often be out-of-hours and in a member's home.

In the general practice setting journal clubs can involve the presentation of clinical papers, but are also discussion groups where GPs are able to raise among their colleagues the clinical questions which have been generated in their daily practice (see 2.4). Within the evidence based framework relevant topics which have been recently reviewed in the EBM literature would make a good discussion focus.

While there is little hard evidence about the success of journal clubs to change physician behaviour, there are several features of journal club activities which are conducive to a favorable learning environment, such as their interactive nature and the informal setting. The RACGP will credit appropriately organised journal clubs with CME points, on condition that the usual criteria are met.

It is likely that an important barrier to the formation of journal clubs is the lack of time and infrastructure to organise the events and it is here where divisions could take the initiative. Scheduling the meetings, organising the distribution of articles and timetables and assisting with venues and catering are possible roles. In addition, divisions could promote the EBM framework by encouraging clinicians to concentrate on evidence based topics for journal club discussion. The development of 'EBM skills' such as critical appraisal or clinical epidemiology could also be promoted by establishing guidelines for the meetings to follow.

Advice from a GP about setting up a journal club (JC)

Journal clubs can be an opportunity for valuable outcomes other than promoting EBM, ie GP debriefing in discussing difficult cases, networking amongst GPs, CME points. There can be a role for divisions in not only fostering the development of new journal clubs but in supporting existing JCs and perhaps encouraging them to include EBM principles in their structure.

Steps to developing a Journal Club:

- *Develop a database of interested GPs by advertising in the divisional newsletter.*
- *Identify a GP who would like to organise the group.*
- *Initial meeting either at a GPs house or at the division. Discuss meeting duration (2 hours), frequency (fortnightly or monthly) and location (rotating through a few GPs homes). Develop the framework of JC meeting content with the GPs (ie present journals, debriefing, expert speakers, subjects to be covered over the next 6 months).*
- *Encourage adoption of an EBM philosophy or charter (see EBM policy in 1.2). This could be given to prospective expert speakers.*
- *Apply for CME points*

Our JC meets fortnightly in 4 different GPs homes. Alternate meetings have an expert speaker. We get 2 CME points per hour.

1.7 Others

Disseminate evidence based guidelines and other evidence summaries through effective educational strategies

The use of evidence based guidelines is one of the ways GPs can move along the road to EBM with the minimum of effort. There has been much work done on the implementation of guidelines into general practice and there are many possible strategies. The NH&MRC produced a detailed document on this topic in 1998⁴ and in October 1999 the Center for GP Integration Studies distributed a brief summary of guideline implementations strategies.

There are several attributes of guidelines without which they are unlikely to be adopted⁵

- there should be a clear purpose
- its content must be updated
- the guidelines should be flexible to accommodate various clinical circumstances
- they should be easy to follow
- they should be linked to patient outcomes.

A major drawback of guidelines is the lack of a single, comprehensive database suitable for GPs, although at least 3 major databases are available on the internet (see Appendix). The multiplicity of guidelines in various shapes and sizes, occasionally in conflict with each other (eg colorectal cancer screening guidelines), also hinders their widespread adoption.

Nevertheless, as EBM cannot be promoted to GPs without a vehicle for bringing evidence to the consultation, guidelines will remain an important component of EBM implementation. Dowie⁶ reviewed research in the United Kingdom to evaluate the implementation of guidelines in general practice and came up with the following recommendations:

- plan meetings and educational activities to promote guidelines
- involve local opinion leaders
- deploy 'academic detailers' to visit practices
- provide audit feedback
- send postal prompts
- provide medical record checklists
- add financial incentives.

Provide a literature search service

Clinicians often mention that they are simply too busy to spend time searching for evidence given the usual demands of clinical work and other priorities. In response to this, and in the interest of improved patient care, some centres have provided a 'search service' for clinicians. The clinical question is written down on a request form which then goes to an 'information officer' skilled in searching databases and analysing evidence. This officer does all the hard work and reports back to the clinician, hopefully within a week.

This idea has been a popular method for evidence based practice within the hospital setting and has been trialed in a few GP Divisions. It requires a lot of resources (both time and infrastructure) but nevertheless may become more popular in the future.

Promote evidence based journals, literature and internet links to EBM

Divisional websites can be used to promote journals, and EBM internet links. The internet is not only a good source of evidence but is also a repository for courses on EBM. Divisions are experienced with many marketing strategies and these can be used to promote EBM resources, both web-based and paper-based, to division members. See the EBM and IMIT branches of the Monash Division website for a range of useful EBM resources.

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