Theme Groups

1. Evidence based curriculum
2. Tools for teaching
3. Teaching methods
4. Assessment tools
5. e-learning
6. Change management
7. Evidence based diagn

WELCOME TO THE WORLD CAFÉ

1. Evidence based curriculum

BMC Medical Education

BioMed Central

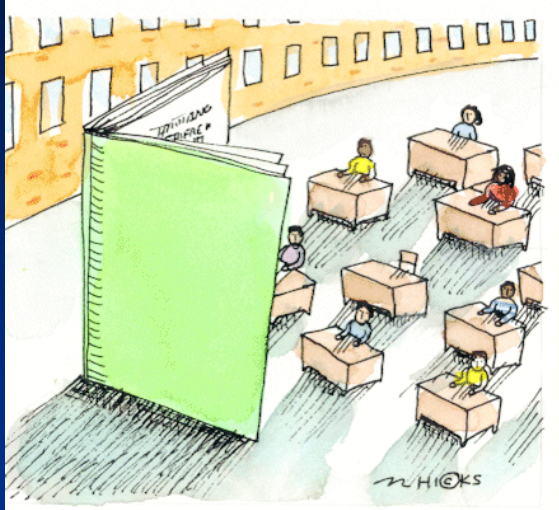## Sicily statement on evidence-based practice

Martin Dawes*[1], William Summerskill[2], Paul Glasziou[3],
Antonino Cartabellotta[4], Janet Martin[5], Kevork Hopayian[6], Franz Porzsolt[7],
Amanda Burls[8] and James Osborne[9]

Address: [1]Department of Family Medicine. McGill University, Montreal, Canada, [2]The Lancet, Jamestown Road, London, UK, [3]Department of Primary Health Care, Centre for Evidence-Based Practice, Oxford University, Oxford, UK, [4]Gruppo Italiano per la Medicina Basata sulle Evidenze (GIMBE), Passaggio L. da Vinci, 16 – 90145 Palermo, Italy, [5]London Health Sciences Centre, Department of Physiology & Pharmacology, University of Western Ontario, London, Ontario, Canada, [6]School of Medicine, Health Policy and Practice, University of East Anglia Norwich, UK, [7]University Hospital Ulm, Clinical Economics, Ulm, Germany, [8]Department Public Health and Epidemiology, University of Birmingham, Birmingham UK and [9]United Bristol Healthcare Trust, Bristol, UK

Email: Martin Dawes* - martin.dawes@mcgill.ca; William Summerskill - bill.summerskill@lancet.com; Paul Glasziou - paul.glasziou@public-health.oxford.ac.uk; Antonino Cartabellotta - editor@gimbe.org; Janet Martin - Janet.Martin@lhsc.on.ca; Kevork Hopayian - k.hopayian@btinternet.com; Franz Porzsolt - Franz.Porzsolt@medizin.uni-ulm.de; Amanda Burls - A.J.Burls@bham.ac.uk; James Osborne - james.osborne@ubht.swest.nhs.uk
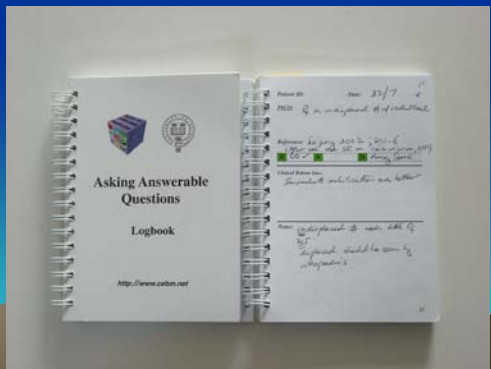
* Corresponding author

2. Teaching Tools

Name: TOPIC:

1. The patient & clinical question

2. Search strategy

3. The study – Question (PICO) an

5. What are the results?

6. How do the results apply

Name: ANGHARAD
SMYTH   TOPIC: management of children with severe acute asthma

1. The patient & clinical question
child with history of chronic asthma develops severe acute attack

Q = Would oral steroids or inhaled steroids be more effective at ↓ acute attack symptoms / preventing recurrence attacks

2. Search strategy
Pubmed
search (child* acronyms) AND ASTHMA
AND oral steroids or synonyms
AND inhaled steroids or synonyms
identified 300 papers ⟶ CG = 21 ⟶ CR + prednisolone = 13

3. The study – Question (PICO) and Appraisal (RAMbo) prednisolone
Q = How does efficacy inhaled fluticasone compare to prednisolone in management of acute severe asthma in ≥ 5 yr olds mAtE

P = 100 children ≥ 5 yr with FEV$_1$ <60% predicted on admission
I = bronchodilators, O$_2$ + 2mg/kg oral prednisolone
C = " " " + 2mg inhaled fluticasone (8 puffs)
O = FEV$_1$ change as % of predicted value (↓ time O ⟶ 240min)
R = computer-generated lists M (b) = double-blinded (placebo inhaler
A = 3/103 not included in analysis + prednisolone syrup used)

5. What are the results?   groups sim except sex (p<0.05)
in pred group: FEV$_1$ improvement ↑ (18.9±9.8 % points v 9.4±12.5)
(p<0.001)
↑ no. excellent response (18 v 5)
↓ no. poor response (4 v 16)
rate hospitalisation ↓ (81% v 10%)
(home phase – I or c x v 7 days post-discharge due to poor participation)

6. How do the results apply
Study indicates in AdE, children presenting with severe acute asthma should be treated with oral pred rather than inhaled corticosteroids (+ nebulised β-ag + O$_2$)
balance may still lie with administering oral steroids EBM Themed Med IV despite potential long-term side effects
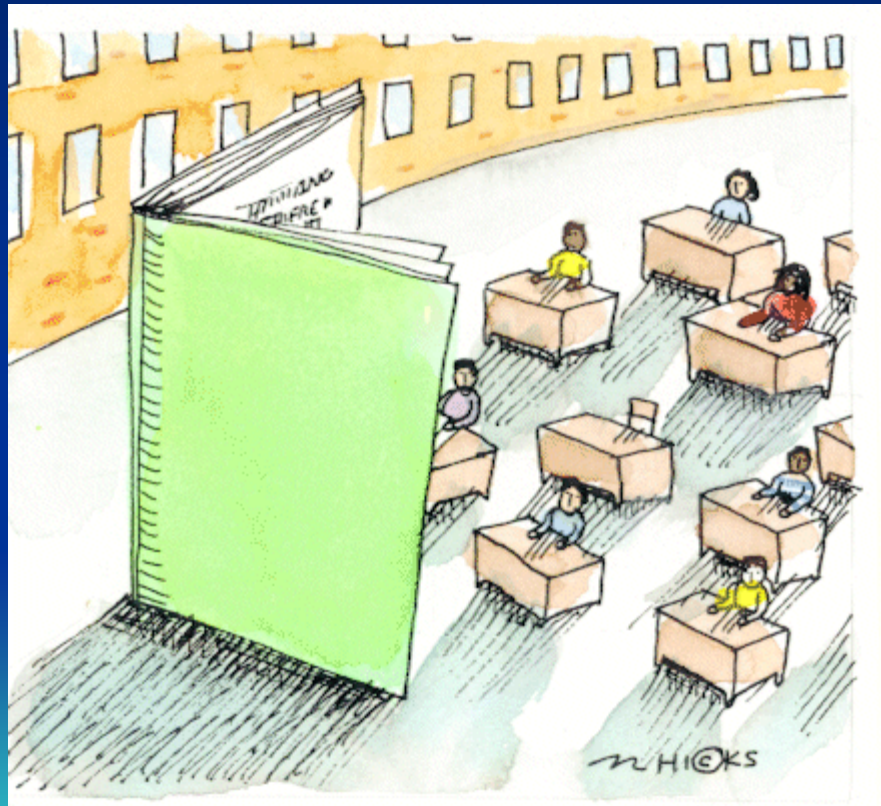study possibly showed pred benefit at ↓ acute attack recurrence but patient participation poor

Author: Ref:

	Description	Numbers	
Patients			
Intervention			
Comparator			
		CER (%)	IER (%)
Outcomes	1		
	2		
Randomized			
Ascertainment			
Measures			
RD ifference	CER – EER		
RRR	RD/CER		
NNT	1/RD		

Question (left side label: Question)
Appraisal (left side label: Appraisal)
Outcomes (left side label: Outcomes)
www.cebm.net

Clinical Bottom-line:

Further Actions:
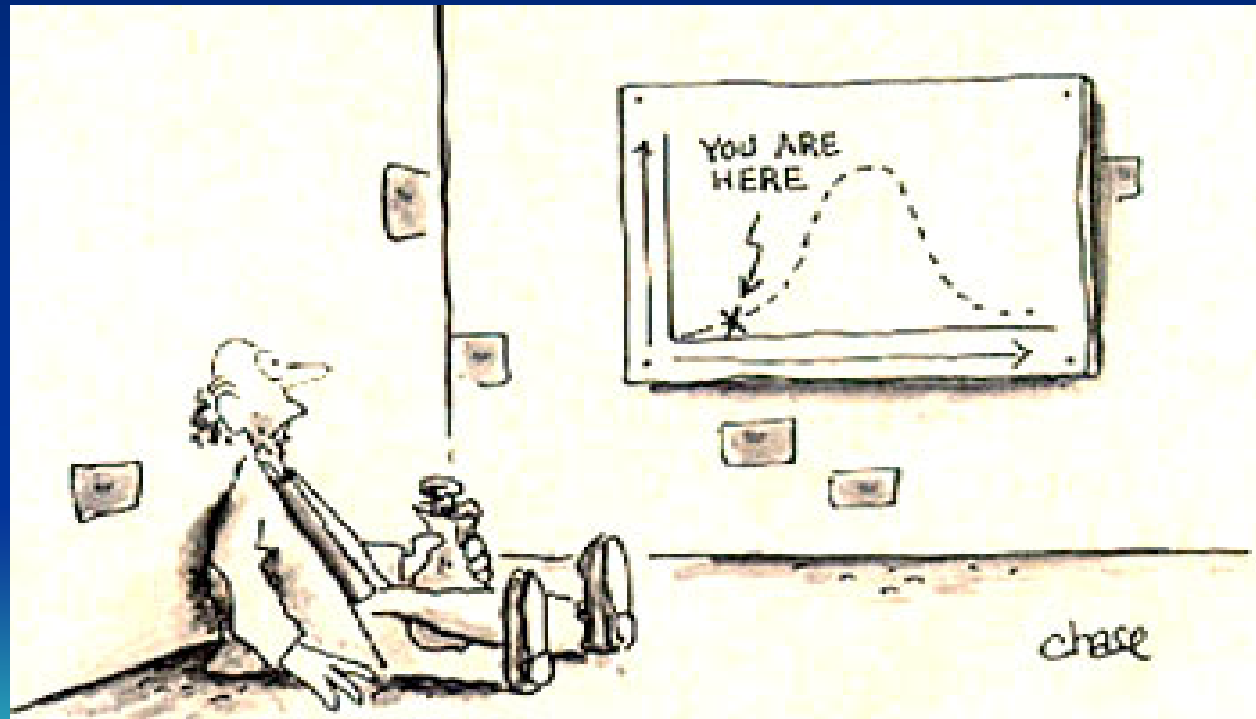
Asking Answerable Questions

Logbook

http://www.cebm.net

Gr...   Question Logbooks

3. Teaching methods

4. Assessment tools

5. e-learning

6. Change Management

- Prochaska, precede proceed, ABNA
  - We have plenty of models of change but there is still a major problem - real life
- Health professionals familiarity with tests & therapies
  - We do things because they are familiar - that is how I can see 18 patients in a morning
- Patients continuity of care, trust,
  - Patients like and trust the medication they are taking. Adding to, or changing is not simple.

- New evidence about effectiveness of new tests and new therapies
  - If I did everything the drug reps, POEMs, EBM journal or even PEARLS advised my practice would be chaotic.
  - I would have all my hypertensive patients changing treatment all the time and they would all be on different drugs.
  - Then there is the harm - never start a patient on a drug that is less than 10 years old or 3 million patients.

- So how do you choose which one to undertake. What systems are there for priority checking?
  - How do you practice this when 80% of family doctors don't have computer systems.

- Priority choosing-how much change is good for you and how much is bad for you?
- Models used in emergency medicine by Eddy Lang

7. Evidence based diagnosis