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 diagnosis

1. Evidence based curriculum

BMC Medical Education

BioMed Central

Debate

Open Access

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

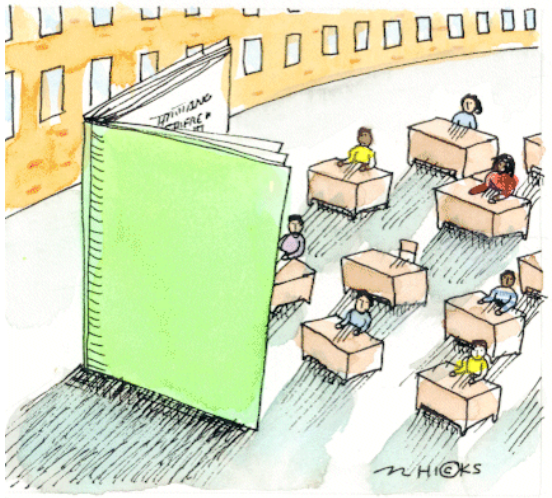
Email: Martin Dawes* - martin.dawes@mcgill.ca; William Summerskill - bill.summerskill@lancet.com; Paul Glasziou - paul.glasziou@public-health.oxford.ac.uk; Antonino Cartabellotta - editor@gimbe.org; Janet Martin - Janet.Martin@lhsc.on.ca; Kevork Hopayian - k.hopayian@btinternet.com; Franz Porzsolt -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

* Corresponding author

Published: 05 January 2005

Received: 03 October 2004

2. Teaching Tools



Group Appraisal Sheets

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 JAMATH 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 re-current attacks

2. Search strategy

Pubmed

search (child* OR synonyms) AND ASTHMA
AND oral steroids OR synonyms
AND inhaled steroids OR synonyms

identified 300 papers → CQ = 21 → CQ + prednisone/= 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 in A&E

P = 100 children ≥5 yr with FEV1 <60% predicted on admission

I = bronchodilators, O_2 + 2mg/kg oral prednisolone

C = " " + 2mg inhaled fluticasone (8 puffs)

O = FEV1 change as % of predicted value (0 time 0 to 240min)

R = computer-generated lists M(6) = double-blinded (placebo inhaler + prednisolone syrup used)
A = 3/103 not included in analysis groups sim except sex (p<0.05)

5. What are the results?

in pred group: FEV1 improvement ↑ (18.9±9.8% points v 9.4±12.5%) (p<0.001)

↑ no. excellent response (13 v 5)
↓ no. poor response (4 v 16)
rate hospitalisation ↓ (31% v 10%)

(home phase – I or c rev 7 days post-discharge due to poor participation)

6. How do the results apply

Study indicates in A&E, 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 despite potential long-term side effects

EBM Theed Med IV

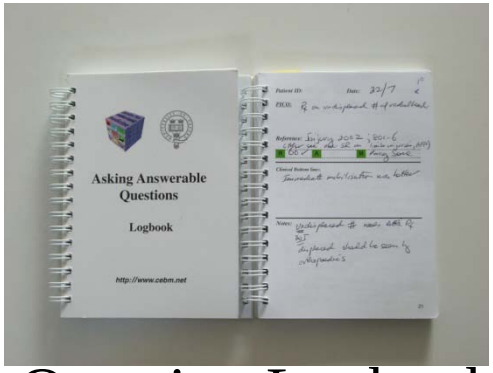
study possibly showed pred benefit at ↓ acute attack recruitment but patient participation poor

www.cebm.net

		Author:	Ref:
		Description	Numbers
Question	Patients		
	Intervention		
	Comparator		
	Outcomes		CER (%) / IER (%)
		1	
		2	
Appraisal	Randomized		
	Ascertainment		
	Measures		
Outcomes	RDifference	CER – EER	
	RRR	RD/CER	
	NNT	1/RD	

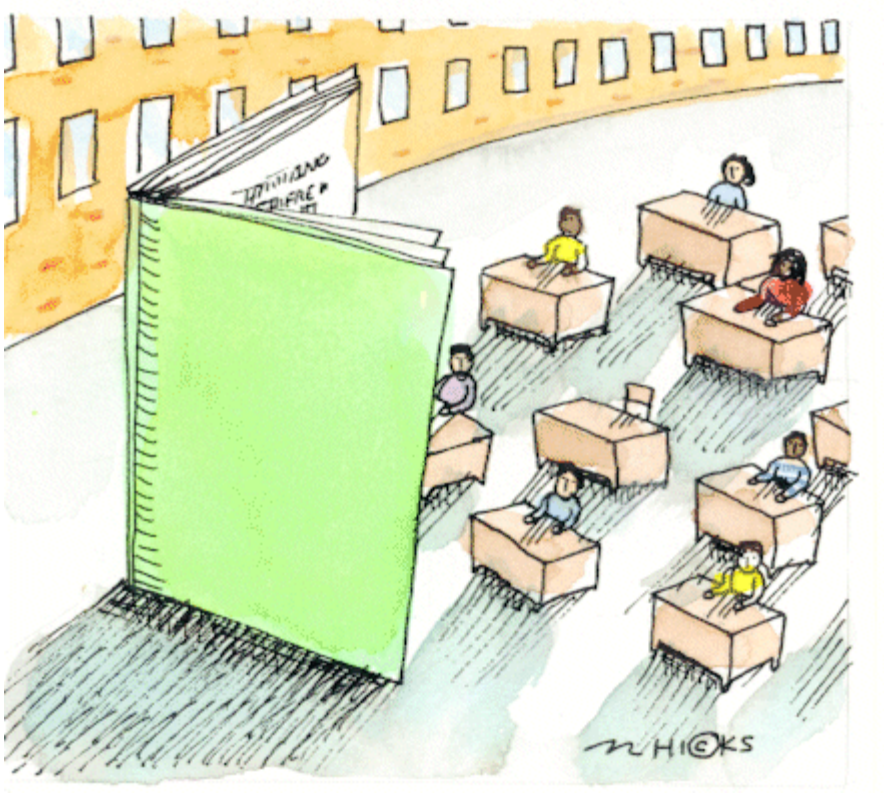
Clinical Bottom-line:

Further actions:

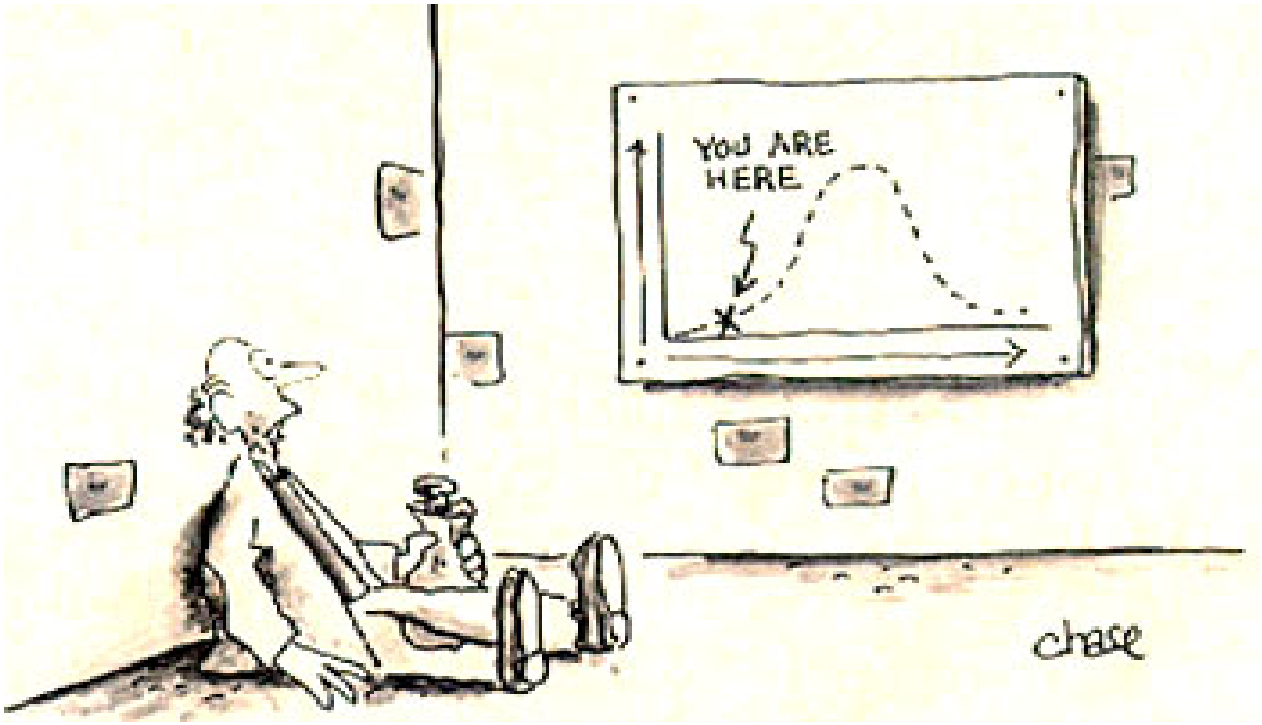


Question Logbooks

3. Best Teaching methods



4. Assessment tools



5. e-learning


HAROLD'S PLANET by Swerling and Lazar
YOGA FOR PEOPLE WHO COULD NOT BE BOTHERED TO GET OUT OF BED
1
2
3
4
5
6
7
8
zzzzz
haroldsplanet.com © 2005

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

TEACHING

- Spin, snout, stats etc
- LR’s
- Bayes
- Probability
- Risk (including communication and understanding of)
- Time (do nothing)
- Heuristics
- Tools
- Searching
- Appraisal
- Case examples
- Clinical decision rules
- Spot diagnosis
- Resources
- Is there a minimum requirement for teachers?

DEVELOPMENT

- Clinical decision rules
- Probability calculators
- Neural networks
- Attribute matching
- Bayesian networks
- Risk acceptability
- ‘Treeage’
- Decision trees
- Web or pc based interface and test ordering
- Dissemination
- Guidelines