Announcing the Arrival of Best Evidence

The editors, staff, and publishers are pleased to announce the electronic release of *Best Evidence: Clinic* and *Evidence-Based Medicine* (EBM). The EBM website (http://ebm.bmj.com) was launched in July 1995. *Evidence-Based Medicine* was added in July 1996, and the combined product will be named Best Evidence in a future issue.

Best Evidence is undoubtedly the fastest and least expensive way to access the critical information you need in your daily practice. The electronic version also contains:

- the EBM notebook
- a search engine
- guidelines and policies
- references

The EBM website is updated daily and now includes the full text of*BMC Medicine* (an evidence-based medicine journal) and *Best Evidence*.

Learn more about the EBM website at http://ebm.bmj.com.

Workshops for teaching evidence-based practice

Workshops were held during the 2nd U.K. Workshop on Teaching Evidence-Based Medicine, held at University College London (UCL) Medical School in February 1996.

The workshop covered the following topics:

1. The basic tenets of clinical epidemiology were taught to me 15 years ago at Oxford University in a 2-week block led "Community Medicine," the course had the work attendances figures in the entire undergraduate curriculum. We were issued a set of equations and potted definitions that were filed—along with the pithy chain and other medical maltagli— in a binder labelled "Night Before File," the contents of which would be memorised, regurgitated, and gratefully forgotten as the examination season came and went. Much later, in the field of evidence-based medicine since 1980 has been aimed at getting clinical epidemiology out of the "Night Before File" and into the clinic; the operating theatre, and (most difficult of all) the everyday vocabulary of managers, commissioners, and purchasers. Practised at the bedside and around the contracting table, evidence-based medicine forces health professionals to unite a scientific (hypothetico-deductive) paradigm with the source of the figures and apply them which they were not originally trained. To grasp of statistics, whereas those who like to add up figures must learn to find out which the data, risk populations, and evaluation of the risk populations, and evaluation of the process to evaluate their success, A group of public health physicians were, within the safety of their group, staging a stock press conference to assuage public anxiety about the safety of measles-mumps-rubella vaccine. The deleagtes, who created these diverse teaching scenarios from their own experiences, were simultaneously required to consider the artificial situation they had created ("You are medical students; I am teaching you about likelihood ratios") and the meta-situation ("I am someone who is learning to teach; how could I do this more effectively?"). Each group member had an allocated role to play in the simulated teaching scenario, but they and the tutors could at any stage call a "time-out" and comment on the metasituation.

The first UK workshop to follow the McMaster University model was held at Oxford University in June 1995. It led to the formation of the U.K. Consortium on Teaching Evidence-Based Medicine (supported by an educational grant from the North Thames Regional Office) in which centres throughout the United Kingdom have shown that undergraduate students taught by problem-based methods reflect more on their learning, memory less, and role play more happily engrossed in pretending to be in a different situation.

"Read the clinical scenario (about a patient aged 18 months with a single febrile seizure) and the attached case control study on the long-term prognosis after febrile seizure in infants. Decide whether and to what extent a single uncomplicated febrile seizure increases the risk of subsequent epilepsy, and using a role-play or other appropriate teaching techniques, decide how you would convey this information to the child's parents."

"This EBM note was also published as an editorial in *ACP Journal Club* 1997;126:A-14-16."

"Evidence-based practice is based on a systematic approach to the literature with a focus on critical appraisal and the attachment of critical appraisal of the validity and usefulness of what is found, application of the results to real patients and real at-risk populations, and evaluation of the practitioner's performance (1). This approach, which requires content (the factual changes we need to know) below (how we go about learning and applying the facts), requires different skills and attitudes from those that most of us had when we left university. How do people acquire these new skills and attitudes, and how can they be most effectively taught?"

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Physicians in February 1997. A core textbook has been published (7), and we hope to explore the use of more imaginative teaching materials (such as video scenarios) in future workshops.

The responses to questionnaires issued before the UCL workshop showed that, for many delegates, implementation of evidence-based medicine at their home institutions was limited as much by lack of time, information technology skills, "political acceptance," and confidence as by lack of knowledge (8). Postworkshop responses showed that despite these barriers, 40% of the 88 delegates intended to introduce new teaching programmes in clinical schools, health authorities, or National Health Service trusts, and these delegates, all but one planned to use small-group, problem-based learning in substantial portions of the curriculum.

An important challenge for medical educators in the United Kingdom is to recognise that the competent student (and clinician) is one who knows how to cope with an immense and rapidly changing body of knowledge and not one who excels in recalling the ephemeral. The deans of medical and nursing schools must develop an infrastructure that allows problem-based, self-directed learning methods to develop within the didactic, lecture-based curricula, which have seen no fundamental changes for 2 centuries or more. As one delegate asked me without a trace of irony, "Is there any way of having small-group seminars when you haven't got any seminar rooms?"

The UCL workshop achieved undeniable short-term gains in terms of the number of complex scientific articles read and understood (estimated at around 15 per delegate), new skills acquired (35% of the delegates before the workshop and 85% after were confident in using MEDLINE), altered attitudes (particularly to multidisciplinary learning), and exposure to new educational techniques. Despite these gains, the long-term influence of this type of workshop on the educational strategies used in traditional British medical schools and the behaviour of busy health professionals in the National Health Service has still to be determined.

At our 6-month reunion workshop this October, our first question to delegates will be this: Has the evidence-based medicine you learned in this workshop been incorporated into your daily practice and has its key message been passed on to others in a way that they can understand? Or have your notes, worksheets, and good intentions been placed back on the shelf next to the "Night Before File"?

For further information about the 4th U.K. Workshop on Teaching Evidence-Based Practice, contact us by e-mail at ebp@ucl.ac.uk.

Trisha Greenhalgh, MD

References
8. 2nd U.K. Workshop on Teaching Evidence-Based Health Care: report of the workshop. Available on disc (Word for Windows format) from the Department of Primary Health Care, University College London Medical School, Whittington Hospital, London N19 5NF, England, UK. Price £7.50.

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Fertil Steril | Gastroenterology |
Heart (formerly Br Heart J) | Geriatrics |
J Am Acac Dermatol | J Am Coll Cardiol |
J Am Geriat Soc | J Clin Epidemiol |
J Fam Pract | J Infect Dis |
J Reprod Med | J Med Aust |
Med Care | Neurology |
Med J Aust | Spine |
Neurology | Stroke |
| Thorax | Trisha Greenhalgh, MD |
Workshops for teaching evidence-based practice

Trisha Greenbalgh

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