EDUCATION

Teaching and learning evidence based medicine skills in accident and emergency medicine

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It seems likely that the earlier application of the findings of high quality research may have reduced mortality and morbidity (a commonly cited example is the delay in implementing thrombolysis for acute myocardial infarction). Evidence based practice seeks to improve the process and outcome of care by using high quality evidence together with clinical expertise and patient values and preferences.

The purpose of this paper is to suggest a curriculum that is suitable for accident and emergency (A&E) medicine, and ways to teach, learn, and assess the skills of evidence based medicine (EBM). The following areas are discussed:

- What is the EBM process?
- Why are EBM skills necessary?
- What should be learned?
- How should this be taught?
- How should this be assessed?

What is EBM and why do we need to be able to practise it?
One needs an understanding of the processes involved in the practice of EBM before planning a curriculum to teach it. EBM is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients". Its practice creates a need for clinically important information and thus requires clinicians to perform a number of actions (Box 1).

Box 1: The process of EBM
1. Convert information needs into answerable questions.
2. Track down with maximum efficiency, the best evidence with which to answer questions (whether from the clinical examination, the diagnostic laboratory, from research evidence, or other sources).
3. Critically appraise that evidence for its validity (closeness to the truth) and usefulness (clinical applicability).
4. Integrate this appraisal with clinical expertise and apply the result in clinical practice.
5. Evaluate one's performance.

The successful application of the principles of EBM entails all these steps; they are interde-
not have the skills to critically appraise published papers.

IMPLEMENTING FINDINGS (WHEN APPROPRIATE) AND EVALUATING THE EFFECTS OF THIS
Acting on the results of an “answer” will often require change. Though the management of change is a skill that is vital to successful management, it is beyond the scope of this report to consider if and how this should be taught in A&E medicine. The ability to evaluate the process and the outcome of care is also essential.

Teaching EBM
Work is needed to establish the best way(s) to teach and learn each part of the curriculum. The acronym CRISIS has been suggested as a way of remembering the characteristics of successful continuing medical education:

- Convenient.
- Relevant.
- Individualised.
- Self assessed.
- Interesting.
- Speculative and systematic.

If one is hoping to cultivate the attitude that lifelong learning is both normal and helpful, it seems prudent to ensure that the teaching of EBM satisfies these criteria.

The most convenient way of learning about EBM is “on the job”. This requires facilities that may not yet be present in every A&E department (particularly the facility to perform electronic searches 24 hours a day). The smaller the distinction between clinical practice and the learning of EBM the better; this will enhance relevance. Ways to achieve this include seniors ensuring that when they are asked questions they are phrased in the three or four part format of EBM (these could then be turned into “educational prescriptions” if the need for an answer is not clinically urgent), or integrating the assessment of trainees’ ability to elicit a specific clinical sign with a discussion of the value of that sign in making or excluding a diagnosis.

Other ways of increasing the relevance of EBM include:
- Emphasising to the learner the clinical uses to which they may put the knowledge or skills acquired. A particularly powerful tool is using the results of a learner’s question, search, and appraisal as the basis for clinical management.
- Establishing which skills or knowledge a trainee has and which they lack (doing this will also contribute towards the goal of self-assessment). Unintentional duplication of previous teaching should be avoided as should the omission of important areas. Individualising the teaching and learning in this way is valuable in its own right.
- Using clinical topics as a basis for EBM teaching that the learner(s) have identified as high priority or ones that are:
  1. Frequent, important, or serious illnesses amenable to medical care.
  2. Conditions for which management methods have recently improved.

3. Conditions where education can improve previously poor management.

Didactic teaching in lectures is often inefficient and demotivating (for teacher and learner alike!). When this format is used this should be coupled with opportunities for both teachers and learners to ask questions and to gain “feedback”. Much could be replaced by required reading, relevant to each part of the curriculum, coupled with tutorials to allow learners as well as teachers to check that important ideas have been understood.

Groups must be sufficiently small that discussions are relevant to and of interest to all members, that all members can actively participate, and that they do not become mini-lectures. Active participation is a more interesting and more effective way to learn than being a passive recipient of teaching.

An element of speculation can be achieved by asking learners (and teachers) how they would manage a particular problem before answers are sought. Discovering one’s instincts are not always correct may provide some motivation to practise in an evidence based way. Although not strictly part of the process of EBM, motivated learners may use questions for which a valid answer cannot be located as a springboard to discussing the design of original research. If the topic is of sufficient importance and the study feasible primary research may be stimulated.

A curriculum helps learners and teachers to be systematic. Without one it is difficult to ensure that all important EBM skills and knowledge will be acquired. The same curriculum should be used for learning and for assessment (otherwise learners will concentrate on the one upon which assessment is based). The schedule for learning should ensure that all “core” knowledge is gained within the first year with other knowledge being added through the remainder of higher training.

“Provided” exercises and “personal” exercises (questions based on clinical scenarios) provide opportunities for trying out the EBM approach:
- Formulating questions.
- Conducting literature searches.
- Appraising papers.

The difference between the two is that in a “provided” exercise the clinical problem is provided by the teacher and in a “personal” exercise by the learner (from their clinical experience). The former (which can be tackled by more than one learner at a time) will provide an opportunity to compare learners. The latter, which would be generated from the experiences of individual learners, maximises the relevance, interest, and individuality of the learning. “Provided” exercises should cover an area in which a diligent search will generate at least one relevant article from a mainstream journal (the expense and inconvenience of interlibrary loans is a hurdle to avoid whenever possible). Debate may be particularly lively if there are papers giving conflicting answers. An example of a provided exercise is given in box 2.
Box 2: Example of a provided exercise
A 24 year old is brought to A&E “breathless”, disorientated, and uncooperative. An
obsevant medical student notes a smell of ketones. Laboratory investigations confirm
the diagnosis of diabetic ketoacidosis with a venous bicarbonate of 4 mmol/l. You start
treatment with fluid and insulin but the
physician to whom you refer the patient is
scathing about your failure to administer
intravenous sodium bicarbonate. The dia-
betologist in the hospital where you were
house physician taught you that bicarbonate
was not needed and you have followed her
advice subsequently. Should you change
your practice?

Running a journal club in an evidence based
way is useful way of practising EBM skills. It
can be highly relevant if the problems consid-
erd are important to learners and if the
conclusions reached are seen to influence prac-
tice.

Assessing competence
The importance of informal appraisal has been
stressed elsewhere. Assessment methods
should be valid, reliable, and practicable.
The ideal would be to assess trainees using EBM
skills in “real time” to deal with genuine prob-
lems (that is, to assess performance rather than
competence). This may prove very difficult
to achieve. There may be no alternative but
to assess learners’ competence in other circum-
stances (though these should minimise artifi-
ciality).

Provided and personal exercises could be
used for assessment as well as for teaching.
It would probably be more realistic to require
these to be conducted and submitted before
the FFAEM examination, to allow access to
 electronic databases and journals. The current
“topic review” element of the examination
could also be used to assess trainee’s ability
to perform a literature search and to appraise the
papers identified. The literature appraisal
 element of the examination should endeavour
to be as objective and consistent as possible. To
this end it may be necessary to include only
methodologically perfect papers or those that
have one or more “fatal flaws”; people argue
about the importance of minor methodological
shortcomings. This part of the examination
would be less abstract if built upon a clinical
scenario. Similar exercises could form part of
the annual assessment of specialist registrars. If
an examination is thought necessary this could
be of the “open book” type, with trainees hav-
ing access to resources that they normally use
to enhance critical literature appraisal.

Conclusions
A&E medicine has the potential to build on the
strength of the FFAEM examination and the
interest of an increasing number of clinicians
to become the first specialty in which all train-
es will acquire the skills needed to practise

EBM. To achieve this the following are needed
(in the order presented):
1. Agreement about the reasons for teaching
and assessing EBM skills.
3. Development of appropriate teaching and
assessment methods.

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of EBM for which he receives an honorarium.

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Appendix: An EBM curriculum for A&E trainees
Fundamental areas of EBM are highlighted in bold.

Topics are cross referenced to the curriculum for
higher specialist training in A&E medicine (in parenthe-
ses).

FORMULATING QUESTIONS
(teaching skills: self directed learning and research
skills: literature survey)
• How? (the four part approach).
• Why use this approach?
• Examples from practice.

SEARCHING FOR ANSWERS
(research skills: literature survey and use of information
technology)
Conducting a MEDLINE search:
• Using a search strategy that is appropriate for
the type of question (therapy, diagnosis, harm,
etiology, prognosis, and systematic reviews and meta-
analyses).
• Medical subject heading (MeSH) and textwords.
• Truncation.
• Combining and limiting sets.
• Publication types.
• Sensitivity and specificity of search strategies.

Understanding limitations of and alternatives to
MEDLINE searches.

ASSESSING THE “ANSWERS” FOUND
(research skills: literature appraisal, data evaluation and
statistics, and scientific study design)
The framework for appraisal:
• Valid.
• Important.
• Applicable.

Critical appraisal of review articles and meta-
analyses:
• Roles of the Cochrane Collaboration and Centre
for Reviews and Dissemination.
• Systematic reviews.
• Understanding of confidence intervals, odds ratio,
and relative risk (as used in meta-analyses).
Critical appraisal of therapy articles:
- "Number needed to treat" statistic and the difference between relative and absolute risk reduction.
- Statistical "power".

Descriptive statistics:
- Different forms of "average".
- Confidence intervals for means and proportions.

Critical appraisal of diagnosis articles:
- Likelihood ratios, pretest and post-test probabilities.
- Sensitivity and specificity, receiver operating characteristic curves.
- Measuring agreement with the $\kappa$ statistic.

Critical appraisal of prognosis articles:

Critical appraisal of articles about aetiology and harm:
- Relative risk and odds ratios.

- Association vs cause, hypothesis generation vs testing.

Critical appraisal of practice guidelines:

Appraising other types of article:
- Clinical decision analysis.
- Health economic papers.
- Case-control studies.

APPLICATION OF ANSWERS THAT ARE VALID, IMPORTANT, AND APPLICABLE
(managerial skills: department policies and teaching skills: medical postgraduates)

Implementing the findings of high quality research: barriers and ways around these.

Teaching EBM, what approaches work?

EVALUATING THE IMPACT OF USING EBM
(managerial skills: clinical audit/quality monitoring)

The role of audit.
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