

PERSONAL VIEW

GPs and the information revolution

There was a report in the *Times* of 19 October that I found inspirational, despite the sad circumstances. Surgeons in Australia, struggling to treat someone who was critically injured in the Bali bombing, made a frantic call to the British Library in London at 3 am. One of the surgeons had remembered reading an article in a medical journal about treating severe blast victims but could not track down a copy. Within 20 minutes library staff had scanned the document and sent it to the team in Australia.

I found this a powerful and moving example of the value of knowledge in modern medical practice. Wouldn't it be wonderful if a national newspaper featured a story like this involving a

general practitioner or a practice nurse. But it probably would not hit the headlines—after all, we are not often in life and death situations. However, we make hundreds of clinical decisions each week that in the long run can affect morbidity and mortality. Many decisions require access to the most up to date information. And it not just clinical decisions—look at our involvement in primary care organisations and service redesign.

The example from the *Times*, albeit an extreme one, is a reminder of the importance of keeping up to date and being able to locate information when we need it. We have been talking about the information revolution for several years. How is it working out in primary health care? Is enough being done to tackle knowledge management? Has the focus of attention shifted because of other competing agendas?

Some recent examples from my own practice have made me think even more about knowledge management and its potential value in primary care. These are: rash illness in pregnancy (parvovirus); information for patients about group B streptococcal infection; non-cardiac chest pain; decision support software for anti-coagulation; choice of treatment for glycaemic control in type 2 diabetes; and choice of antidepressants in breastfeeding mothers. In all these cases the use of information directly influenced patient care and safety. It would have been much more rewarding if I had been able to locate this information earlier and with greater ease. In some cases the information changed my original decision. So I know that I need to do much when it comes to information management.

Most GPs and practice nurses will be using clinical information to a significant degree, particularly in the management of chronic diseases such as coronary heart disease and diabetes, but our approach tends to be unsystematic. How long will this sustain us?

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I feel we need to embrace information much more positively—particularly with the changing nature of the clinical content of general practice. The new GP contract, with its evidence based framework, is looming. This will create a need for additional knowledge and skills. There is also a much more fundamental reason why we need to go further, which is to do with maintaining trust between patients and doctors.

I recently accompanied a relative to hospital to see a consultant oncologist. The consultant took a strong knowledge based approach and presented me with up to date information and choices which impressed me. We expect nothing less of hospital specialists.

Increasingly, more will be expected of us as specialists in family medicine, although it is much harder to keep abreast of a generalist discipline. What is needed is a determined and enthusiastic effort to realise the information revolution in primary health care. Of course, there is a major education and training implication. And it will need resources, and national and local support.

There are solutions to many of these issues—the hard part is the cultural shift. This means overcoming certain barriers such as the ambiguous attitude that some GPs sometimes take towards evidence based health care, arguing that it works against a holistic approach. We should remember that our generalist values and skills could help us practise both scientifically and holistically. Modern general practice consultation and communication models can enable us to use and share evidence effectively with patients. Using best practice information does not mean the end of patient or clinical autonomy. Instead it can be empowering for both doctors and patients.

The choice is clear: either we aspire to a strong research and knowledge base for general practice or we don't. Fortunately, most GPs have already made their choice and are using and sharing evidence every day. Much of this is not new—general practice has a long and distinguished tradition of keeping up to date, of evolving to offer a dynamic service. We just need to go that bit further by having an explicit and systematic approach to knowledge management.

This is not something that should be seen as being of interest only to academics. All family doctors should be concerned about it, particularly now, as people are talking about a new kind of general practice and general practitioner. Let us embrace the information revolution.

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SOUNDINGS

If I ruled the world

In the first year of my dictatorship I will ban sugar coated doughnuts, atonal music, phenylbutazone, and hospital public relations departments. With the ruthlessness of irrational dictators I will outlaw multivitamin pills, ties with horizontal stripes, malpractice lawyers, useless expensive drugs, and hot and cold water taps that turn in opposite directions.

Handsome women will not chew gum with their mouths open, petty bureaucrats will not notify their 500 employees of their two days' absence from the office. Committees, especially on ethics and audits, will meet only on Saturdays, only for 30 minutes, no chairs provided. The police will destroy all answering machines announcing "I am away from my desk . . . but your call is very important to us."

There will be other excesses. The priests of evidence based medicine will be proscribed, their proselytes reduced to meeting in catacombs. Banned will be charts with idiotic problem lists instead of diagnoses. In journals the number of authors will not exceed that of patients studied, and abbreviations will be forbidden, thus allowing articles to be read without reference to a glossary. Generic drug names will have no more than three syllables: "me too" drugs will be limited to four in any class; and drug company sponsored studies will be closely scrutinised for inherent biases in their protocols.

Banned will be computed tomography for stress headache, endoscopies for obvious gastritis, cardiac catheterisations for costochondritis. Doctors will make rounds in a quiet environment, nurses will accompany them, charts and x rays will be at the bedside, and comatose patients will not watch television during rounds. Some doctors will take calligraphy lessons or their noses will grow by an inch for every illegible word written.

Just as in Francophone Montreal, there will be a language police. Passengers will not "deplane"; patients will not be "clients," doctors not "providers," clinics not "health centres," and prepaid plans not "health maintenance organisations"—because they do nothing of the sort. The young will not be allowed to pontificate that the world is going to hell, nor the old reminisce about the good old days.

The dictatorship will last 70 years, then be overthrown by agents of the evidence based movement.

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