

Information Resources of ACP and Something Else We Need

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Medical practice used to be experience-based. Also, it was expert-based, as experts had more experiences. Japanese people tend to obey authorities, and Japanese medicine has been professor-based or chief-based. Nothing is wrong about it, as far as experts have sound knowledge and good skills in medicine. Authoritative textbooks are often helpful. However, accumulation of newer information has become abundant recently, so that we are almost drifted away from the best information. Appropriate selection and update of information may be beyond the capability of physicians, even experts.

Evidence Based Medicine was introduced into our practice a few decades ago, and it was good news for physicians puzzled in ridiculous amount of information. EBM showed clear stepwise strategies of medical care by skillful clinicians, and was nothing apart from time-honored clinical approach essentially. Misfortune of EBM is an emphasis on data collection and selection (steps 2 and 3). Busy practitioners realized importance of EBM, but abandoned it as they could not spend enough time for literature search. Having fortune on the side of physicians nowadays, many secondary information resources are available today. Those who are good at clinical epidemiology provide useful information for us after conscientious systematic review of numerous literatures. We, ACP members, can access to DynaMed Plus, ACP JournalWise, Clinical Guidelines, Annals org, and many others as the membership benefits. Steps 2 and 3 of EBM is not a barrier any more. Members of ACP should take this advantage. Still, EBM is not a single solution for the best practice.

The evidence is obtained from studies in which target subjects are group of patients with the same disorder. Outcomes are measured for disorders, pathophysiology, or lesions. The goal of the care of your own patient may not be cure of the disorder. Before applying evidence to your patient, you have to appreciate what he is suffering, what he wants you to do, and individualized benefit and risk of intervention for him. Many patients we see today is elderly with multiple comorbidities and concomitant medications. We do not know whether interventions based on the evidence are beneficial for certain patients. In other words, steps 1 and 4 are critical to provide the best care of the patients.

Steps 1 and 4 of EBM cannot be left to others, certainly not to computers. We have to brush up skills of communication with the patients. Many skillful clinical practitioners are actively contributing to ACP. Just to see, to hear, and to feel those clinicians of excellence will furnish you true clinical expertise. This is another invisible benefit of ACP membership.