Using evidence for the care of practice team populations

We thank the authors on both sides for an interesting and informative debate on evidence-based medicine (EBM) and its application in primary health care.[1,2] Dr Upshur and Mr Tracy note that EBM can be problematic because it does not take into account factors such as comorbidities or patient needs.[1] Drs Labrecque and Cauchon remind us that EBM is defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[3] Family medicine should be informed by good science.[2]

We wonder if the debate incompletely addresses the issue by focusing on the care of individual patients. The generation of evidence usually involves research in populations or groups at risk, and the results are therefore often more applicable to populations than to individual patients. As an example, care might be based on research addressing the following question: Does this population of patients at high risk benefit from the use of angiotensin-converting enzyme inhibitors (ACEIs)?[4]

Certainly, evidence can inform and guide care for individual patients, in conjunction with patient values and preferences. However, an important issue for us is the use of EBM for the care of populations in primary health care. At the North York Family Health Team in Ontario, 68 family physicians and more than 40 allied health professionals manage the care of 65 000 patients out of 17 clinical locations. We look after more than 4000 patients with diabetes. Following the implementation of electronic medical records (EMRs), and through a collaboration with the Canadian Primary Care Sentinel Surveillance Network, the College of Family Physicians of Canada, and Canada Health Infoway, we now have access to powerful tools allowing us to measure care for our practice populations.[5]

While we strive to provide excellent care to individual patients, monitoring the health of the population we serve is also important to us. For example, current guidelines recommend the use of ACEIs or angiotensin receptor blockers (ARBs) for patients with diabetes at high risk of microvascular outcomes.[6] We found that 33% of our patients with diabetes with an albumin-to-creatinine ratio greater than 2 did not have prescriptions for ACEIs or ARBs in their EMRs in the past year. There is no doubt that some patients should not be prescribed these medications owing to individual factors such as frailty combined with hypotension. Some patients might make an informed decision that they do not wish to take ACEIs or ARBs. Also, medications might be incompletely recorded in the EMRs. However, there might be patients who could benefit from the treatment and are not receiving it. Following team-based discussions, our physicians will each be provided with a confidential list of their patients with elevated albumin-to-creatinine ratios who were not prescribed ACEIs or ARBs so that they might be individually reviewed.

Team-based data, combined with the thoughtful use of evidence, can be used to inform population-based clinical care, monitor quality improvement efforts, and plan programs in primary care using standards agreed upon by the team. The addition of evidence at a practice team population level could provide signals that the management of individual patients might need review. This could augment the ability of physicians and allied clinicians to individualize care through evidence-informed management; care plans could be reviewed and modified for individual patients when evidence is not available or is not appropriate.[7] We look forward to future discussion and debates on EBM that include this approach.

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