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Guest editorial

POM + EBM = CPD?

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There are many ways of combining three letters out of an alphabet of 26; yet still there are overlaps which can confuse meaning. So the first duty of anyone using an acronym is to say what it denotes. Here, POM is "problem-oriented medicine", EBM is "evidence-based medicine", and CPD is "continuous professional development". These designations, familiar as they are to clinicians, define what is meant by these terms, but fall well short of describing them for the general reader, something which must now be done.

Problem-oriented medicine, described and advocated by Lawrence Weed,[1] is an approach which elicits and categorises the patient's *problems*, both those described by him or her and those discovered on physical examination or in the course of investigation. The list of problems, with the action proposed for each, forms the basis of the clinical record. This approach has the great merit of focusing on what is actually troubling the patient, and it includes the important task of listening to what he says. All approaches to difficult matters have their limitations; those of POM include the inarticulacy of some patients, the impatience of some doctors, the accumulation of problems as age advances, and the inelasticity of time.

Evidence-based medicine has been defined as "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients".[2] That is a good description of optimal clinical practice, especially as the importance of "individual clinical expertise" is recognised as a component of EBM in addition to evidence from "systematic research". Particular emphasis is laid on evidence from controlled clinical trials. These have indeed been a major advance in defined situations; but in the "messy" situations common in real life, there may be inconsistency between trials, and this cannot always be resolved by meta-analysis. Moreover, results derived from groups are not necessarily appropriate to individual patients.[3] And of course time is no more elastic for EBM than it is for POM.

There is no inherent antithesis between POM and EBM; focus on what is perceived by the individual patient does not rule out a systematic search for evidence relevant to his treatment. Such a search can be enhanced by computer literacy, but there remains a place for textbooks, journals, and even discussion with colleagues who may be more familiar with a particular clinical problem. The question raised in my title is whether the skills of POM and the systematic approach of EBM, when summated, would suffice to constitute adequate **continuous professional development** (my third acronym, which I hope is self-explanatory, once spelt out).

The need for CPD, or its homely equivalent "keeping up to date", has been recognised for decades, and much effort has been put into meeting it by pharmaceutical firms (which were commendably early in this field), by the health departments, and by medical schools, colleges, societies and other organisations. The renewed emphasis of recent years stems from the rapid increase in medical knowledge, which brings new opportunities, but also the increased risks which arise from more potent medicines and other new interventions. Until fairly recently, although there were some financial inducements, participation in further education was largely voluntary, which sometimes meant that those who received it were also those least in need; but now market forces and a culture of complaint are encouraging an element of compulsion.

The techniques of EBM should prove valuable in enlarging the knowledge base; and there should also be an input from the patient-centred discipline of POM.

But my final contention is that developed skills in unearthing problems, and sophisticated access to ever-expanding sources of medical lore, important though they are, are not enough to fulfil completely the purpose of CPD, which must be to raise the standards of clinical care, in the interests of patients as much as those of doctors (interests which coincide much more than they diverge). The third necessary element is that of **attitude**, something which concerns the rights and duties of both doctor and patient. The point was well made, during a meeting on medical audit, by David Pyke, then Registrar of the Royal College of Physicians. Speaking of the "complaints and criticisms made of doctors", he said, "most derive from lack of thoughtfulness leading to absence of information, explanation, reassurance—in a word (which I am trying to avoid) communication".[4] I share this slight unease about "communication", for two reasons—as commonly used, it stresses the mechanics of communication more than the substance of what is to be communicated; and although a necessary part, it is certainly not the whole of what

is needed to establish proper rapport between patient and doctor.

Communication is a means to an end, a state of justified trust between patient and doctor—what was described by the sociologist Talcott Parsons as a "fiducial relationship". For that relationship to be achieved, the consultation must be grounded not on knowledge alone, but also on benevolence between doctor and patient, and on respect by each for the autonomy of the other (yes, doctors too have a right to autonomy, even if they must sometimes sacrifice it for the sake of a patient). Justified trust comes from the build up of experience in the responsible and sensitive care of numbers of actual patients: this can be colloquialised as "part of the job"; but it is also an essential element of professional development, complementary to POM and EBM and certainly no less important.

Two decades have passed since I was fully engaged in clinical practice, and the normative assumption at that time was one of trust. I hope it is not just the nostalgia of the elderly which makes me sad to see the zareba of "safeguards" which is being built up almost week by week in the attempt to ensure the impossible, that no mistake will ever be made.

So, I would rewrite the equation of my title as "POM + EBM < CPD", the missing element being the creation of **justified trust**, which comes from relevant experience informed by good will.

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References

1 Weed LL. Medical records that guide and teach. *New England Journal of Medicine* 1968;**278**:593-600, and 652-7.
2 Sackett DL, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based medicine: how to practice [sic] & teach EBM*. Edinburgh: Churchill Livingstone, 1998.
3 Black D. The limitations of evidence. *Journal of the Royal College of Physicians of London* 1998;**32**:23-6.
4 Pyke D. *Pyke's notes*. London: Royal College of Physicians of London, 1992: 43.