

The Cochrane Library: access for all Australians

A dream becoming a reality

THE COCHRANE LIBRARY is now available free to all Australians who have Internet access. At the 3rd Annual Meeting for Australasian Contributors to the Cochrane Collaboration, held in Melbourne in October this year, the Federal Minister for Health and Ageing announced this important milestone — universal access to high-quality health information. Just as ready access to “clean” drinking water has come to be seen as a public health milestone of the 19th century, so, in the future, ready access to “clean” health information might well be dubbed as a major public health achievement of this century. The United Kingdom and Ireland, as well as several other countries in Europe, also have free access and the Library is also available free to developing countries. Such access will have a direct impact on satisfying clinicians’ daily information needs, and an indirect impact on their practices through the information accessed by patients, consumer organisations, policymakers, and others. So where will this lead us? To understand some of the implications requires an understanding of both the history and the future of the Cochrane Collaboration.¹

In 1979, a challenge came from the UK epidemiologist Archie Cochrane, who stated: “It is surely a great criticism of our profession that we have not organised a critical summary, by speciality or subspeciality, adapted periodically, of all relevant randomised controlled trials.”² Meeting Cochrane’s challenge required two important steps: (i) assembling all controlled trials in one database, and (ii) completing and maintaining systematic reviews of these trials. The first step corresponds to the Cochrane Central Register of Controlled Trials, which now includes over 350 000 trials, and the second to the Cochrane Database of Systematic Reviews, which currently contains 1456 complete Cochrane reviews, and the protocols for 1101 planned reviews.

How did the Cochrane Library come to be? In Cochrane’s 1979 article¹ he challenged the medical profession in general, but singled out obstetrics as the specialty most in need of an evidence base from controlled trials. When Iain Chalmers (who had worked in obstetrics) became Director of the UK National Perinatal Epidemiology Unit in 1978, he initiated a classified bibliography of randomised trials of interventions in pregnancy, childbirth and early infancy, using both electronic searches and manual searches of over 60 journals.

This bibliography provided the raw material for an international collaboration to prepare systematic reviews, which were eventually published in 1989 in a seminal, two-volume, 1500-page book entitled *Effective care in pregnancy and childbirth*.³ The book concluded with a chapter summarising which interventions (of the 283 assessed) were supported by reasonably strong research evidence (100 were deemed effective, 36 promising, 86 of unknown benefit and 61 so

unlikely to be useful that they should be abandoned). Importantly, not only was a paperback summary prepared for women published concurrently, but also a six-monthly electronic update of the systematic reviews — the Oxford Database of Perinatal Trials.

This “pilot” project was well received. In 1992, the UK National Health Service provided crucial support for Chalmers to work with others to extend the process to other areas of healthcare. Recognising that the work could not be done by a single group or country, the international Cochrane Collaboration was founded in 1993 at the first Cochrane Colloquium, held in Oxford. Two years later the Cochrane Database of Systematic Reviews was launched, and the late Chris Silagy, inaugural Director of the Australasian Cochrane Centre, became the first elected Chair of the Steering Group, guiding the growth of reviews prepared by members of 49 Collaborative Review Groups, which, collectively, are responsible for covering most health problems.

At the 1995 Cochrane Colloquium, David Sackett described the Cochrane Collaboration as a plane that took off while it was still being built. In 2002, the Collaboration is flying at a respectable

altitude. But what still needs to be done for Cochrane’s dream to become a reality? One sobering fact is that less than 10% of more than 350 000 published controlled trials have been synthesised within Cochrane reviews.

To complete the journey will require three things:

- Review efforts will need to be sustained and extended by appropriate support and training in systematic reviewing. The science of research synthesis will need to develop an academic capacity and infrastructure equivalent to those of other fields of specialised medical endeavour.
- To maximise clinical relevance and uptake, the Library interface and reviews have to become more attuned to the needs of users and the users need to be more sophisticated in applying evidence.
- Reviewers will need to have access to all trials, not just those published in electronically indexed journals. Registration of all trials at inception is necessary, and is becoming a reality (see the meta-register at www.controlled-trials.com).

Finally, we need to recognise that the Cochrane Library synthesises only intervention studies. At the 1996 Cochrane Colloquium, Hilda Bastian, chair of the Cochrane Consumer Network, suggested “people often ask if we can afford to extend the Collaboration beyond the RCT; we also need to consider whether we can afford not to do so”. We will also need more systematic use of non-randomised study data on harms or treatments, and equivalent collaborations for systematic reviews of the accuracy of diagnostic tests, the natural history and prognosis of disease, and other types of clinical questions (see, for example, a description of Bayes Library of Diagnostic Studies and Reviews: www.bice.ch/

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eng/content_e/bayes_library.htm>). In brief, although the announcement of free access to the Cochrane Library is an important and welcome milestone, much work remains to be done to make best use of the presently available results of clinical research relevant to the wellbeing of users of health services.

Sceptics might ask what evidence there is that ready access to such databases will make a difference. Free access might be seen as an ethical obligation — in return for the public's participation and direct or indirect funding of research. However, adequate evaluation is also essential to both assess the impact and to guide improvements. The National Institute of Clinical Studies (<www.nicls.com>), which brokered the free Cochrane Library access, will also undertake an evaluation that will include process measures, such as who is accessing what, and a more detailed study of the difficulties and needs of end-users. However, we should recognise that information access is a necessary, but not

sufficient, condition to bridge the gap between research and practice. It may be far from enough. Hence, more detailed evaluation might be planned to explore factors such as the impact of clinicians' skills in using evidence, attitudes to applying evidence, structural barriers to using proven interventions, and problems in matching evidence to individual patients' needs that limit any potential benefits of free access.

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1. Chronology of the Cochrane Collaboration. Available at <http://www.cochrane.org/cochrane/cchronol.htm> (accessed October 2002).
2. Cochrane AL. 1931-1971: a critical review, with particular reference to the medical profession. In: Medicines for the Year 2000. London: Office of Health Economics, 1979: 1-11.
3. Chalmers I, Enkin MW, Keirse MJ, editors. Effective care in pregnancy and childbirth. Oxford: Oxford University Press, 1989. □

Can we better meet the healthcare needs of Aboriginal and Torres Strait Islander women?

Listening and responding to women will improve cervical screening and other women's health programs

WHEN ASKED ABOUT features of women's health services that would best meet their needs, specific groups of Aboriginal and Torres Strait Islander women, despite their diversity, have given very similar responses.¹⁻³ They want women's healthcare that takes a holistic rather than a narrow "single-disease" or biomedical approach; services that are accessible, flexible and supportive; and providers they can trust, who are respectful and who can communicate well. For many Aboriginal and Torres Strait Islander women, having access to a female provider is critical to their acceptance of women's healthcare services.

The higher cervical cancer incidence and mortality for Aboriginal and Torres Strait Islander women compared with other women, and the available evidence about screening effectiveness, provide a strong imperative for healthcare providers and funders to listen carefully and respond to what women say they want.⁴ The article by Coory and colleagues in this issue of the Journal (*page 544*) quantifies and compares women's participation in cervical screening by analysing data from the Queensland Health Pap Smear Registry.⁵ Participation for women living in rural and remote Aboriginal and Torres Strait Islander communities in Queensland was generally lower than for women living in other areas. Proportions of women in these communities who had had a Pap smear over a two-year period ranged from 19% to 63%. These results suggest women's needs for women's health services are being better met in some communities than others.

In interpreting their analysis, Coory et al used residence in a community where most people were Aboriginal and/or Torres Strait Islander as a proxy for Indigenous status. We believe this is a resourceful and reasonably valid way around Indigenous status not being identified on the Pap smear register. However, one limitation is that we can learn nothing about Aboriginal and Torres Strait Islander women living in other localities (ie, the majority of Aboriginal and Torres Strait Islander women in both Queensland and Australia more generally). It is important that the needs of these women are not neglected because of the lack of quantitative data with which to measure them.

We commend the researchers for acknowledging the sensitivities of identifying data from individual Aboriginal and Torres Strait Islander communities in their research. However, rather than only obtaining permission to do so from a government department, we believe consulting directly with members of the communities concerned at an early stage of the project may have been beneficial. Although such a practice is uncommon in this type of research, and may be challenging and more time-consuming, it may also create or strengthen trust, links and understanding, which could be useful when implementing and evaluating subsequent interventions.

Coory et al suggest that the higher cervical screening participation rates in some communities are an indication of what is achievable, and express support for a strategy of strengthening primary health care. We agree with these conclusions, but disagree that an intervention study where