

GPEvidence.org: A Point-Of Care Resource for Primary Care

Each time we share decision-making with patients regarding treatment, the conversation depends in part on studies applicable to their situation. It would be a tremendous help to have the results of these studies translated from the academic literature to understandable summaries which could be applied during a clinic visit.

GPEvidence (www.gpevidence.org) is a freely available website hosted by the Nuffield Department of Primary Care Health Sciences, University Oxford, UK. Designed primarily for family physicians, it offers readily understandable summaries of the evidence behind treatments for common long-term conditions. Using infographics and clear design, *GPEvidence* highlights the absolute benefits and harms of interventions: absolute risk reduction, numbers-needed-to-treat and absolute chance of harms alongside supportive, contextualising written content. This information can help with single treatment decisions or when prioritising treatments in contexts of polypharmacy. Information is aimed at the professional rather than at patients (in contrast to a patient decision-aid). An illustration of its use is presented in box 1.

Guidelines are an essential part of our practice, but often obscure the size of benefits and give little information about harms(1). The preponderance of relative risk reduction framing in literature exaggerates treatment benefits. Absolute risk estimates are vital to accurately counsel patients(2). Clinicians cannot memorise and stay abreast of information on the absolute benefits and harms of all interventions(3).

GPEvidence provides useful extra information to support person-centred care in a way which is both appropriate and flexible for a particular person and context.

User-centered design. Although treatment effect estimates are straightforward mathematically, they can be difficult make sense of. Humans in general—including clinicians!—find it challenging to interpret

statistics(4). Even when information is understood, there are barriers to its use: pressure to follow guidelines, quality incentives, challenges of communicating choice and shared decision-making, and time constraints(5). To overcome these, a co-design approach(6), where family physicians and patients had active and early input into website development was used, involving in-depth interviews, stakeholder work, co-design workshops, iterative user-testing and accessible content-design principles(7).

Evidence sources. To ensure trustworthiness, reliability, and align with UK practice, most evidence was drawn from the publicly available high-quality evidence reviews from the National Institute for Health and Care Excellence (NICE). Where information was not available from these, pragmatic literature searches were undertaken drawing mainly on Cochrane and other high-quality systematic reviews. A detailed description of this process is described elsewhere(8). It is important to emphasise that *GPEvidence* does not attempt to make recommendations *per se*. Rather, it presents the evidence underpinning guideline recommendations in a neutral, non-directive way.

Applicability to US setting. This global medical evidence-base certainly is applicable for US users, though they may notice that American guideline developers make different recommendations. Different baseline risk scores (such as the ACC/AHA PREVENT calculator or ASCVD score rather than QRISK) may be more applicable to US populations; in these cases, it would be appropriate to use these estimates in place of the UK equivalents – the calculation of treatment benefits from trials will still be correct. Where US guidelines recommend lower thresholds or targets, users will be able to glean a broad estimate of benefits from what is shown on *GPEvidence*, though may have to examine the references of their local guideline to clarify. It would be feasible to develop a US version of *GPEvidence* with a more directly relevant evidence base, including translations; we would be interested in hearing from any potential collaborators.

A common concern for clinicians is pressure to meet guidelines and quality incentives. *GPEvidence* supplies information to enable truly informed consent about treatment options, supporting clinically appropriate exclusions in the EMR.

Updating. *GPEvidence* is updated when NICE guidelines or technology appraisals are updated. This ensures evidence has been subject to rigorous review, but the limitation that new evidence will take some time to be included.

Evaluation. An evaluation using British general practitioner focus groups found they responded positively to *GPEvidence*, perceiving it as a usable tool to support their practice. They described hypothetical changes to prescribing intentions and increases in decisional confidence(9). A Realist evaluation is planned to examine the real-world effect of *GPEvidence* on decision-making and patient experience.

A vision. Evidence-based medicine has arguably transitioned into what we might call “guideline-directed” medicine. Clinical guidelines have many strengths but also limitations such as discouraging person-centred care and the disempowerment of clinicians(10, 11). These problems have been well described over the last three decades, but with only isolated (rather than systematic) attempts to fix them(12). We hope *GPEvidence* is a useful contribution to this endeavour, sitting alongside existing online resources such as UpToDate and EHR-integrated decision support tools. In our view, all clinical guidelines should be accompanied by transparent and usable information to support person-centred care, inform shared decision-making, and empower family physicians individually and as a profession.

Declaration of Interests:

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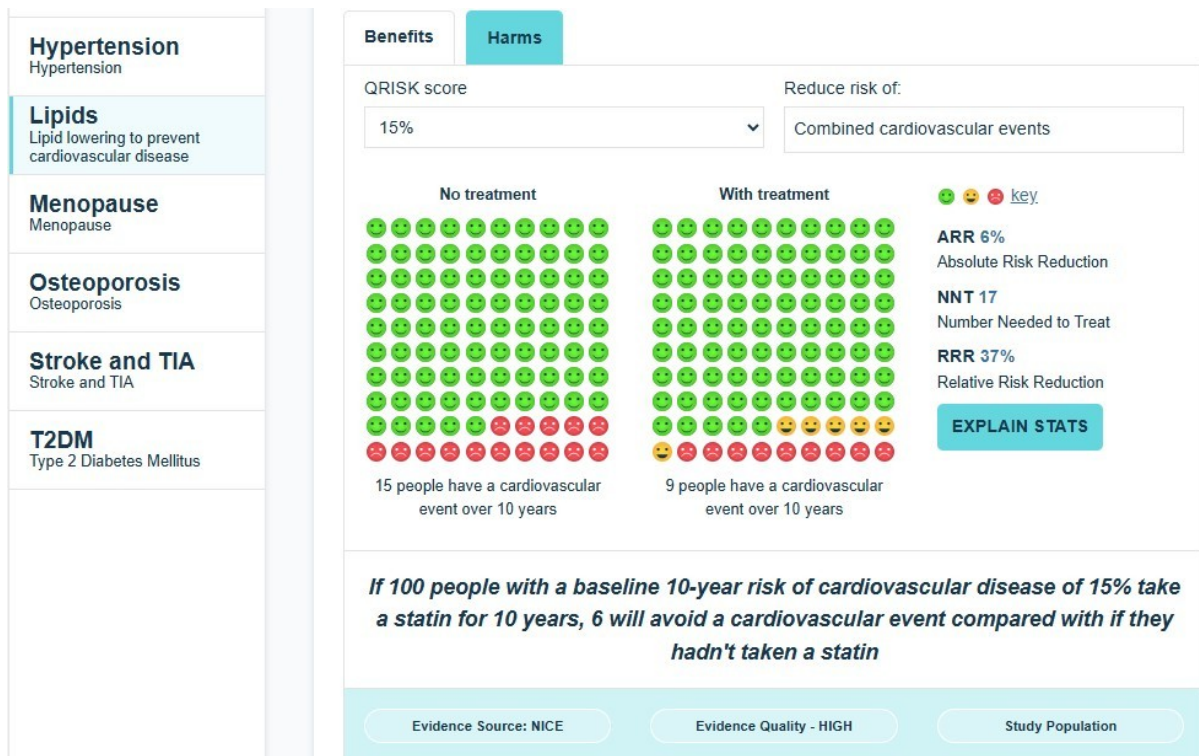


Figure: Screenshot from www.gpevidence.org 13th November 2025

Case example

A 64-year-old patient has had a cardiovascular risk assessment which estimates a 10-year risk of cardiovascular events as 15%. Your clinical guidelines and local quality incentives recommend prescribing a statin. However, your patient is not keen to take medicines in general and is concerned about potential side effects.

During the consultation, you go to *GPEvidence* and locate the section illustrating the evidence for the benefits of statins. A drop-down menu is used to select baseline cardiovascular risk, and an infographic is displayed showing an easily understandable summary of treatment benefits (illustrated). A separate tab shows absolute risk estimates of side-effects and harms.

You then use this information to frame your conversation with the patient. This may or may not involve showing them the screen, delivering the numbers and handing over the decision to them. Some patients will want this degree of autonomy, whereas often it may be more appropriate for the clinician to have a more qualitative discussion, but now empowered by their own improved knowledge of the absolute benefits and harms of the treatment. The BRAN framework (Benefits-Risks-Alternatives-Nothing) provides a good way to structure these consultations.

Box 1: Case example of *GPEvidence* use.