without compromising on patient care. The IAP will have to take up the onerous responsibility of coordinating training activities for prospective researchers, identifying priority research areas, deciding on research sites (based on research question, availability of expertise, and patient population), monitoring data collection and ensuring quality research. IAP may be able to meet this challenge if it collaborates with Medical colleges and organizations such as the Indian Council of Medical Research (ICMR).

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Evidence Based Pediatrics: A Welcome Addition

"Read not to contradict and confute; nor to believe and take for granted; nor to find talk and discourse; but to weigh and consider."

So said Francis Bacon and in a nutshell, it summarises what evidence based medicine and EURECA is all about. I read with interest the article on role of CRP in predicting bacterial infection with fever(1) and the accompanying editorial(2) in the February 2008 issue. I welcome this initiative of *Indian Pediatrics* and agree with them on "tailoring evidence from the western world" to make it relevant in the Indian context. But this is only half the story. These evidence based reviews not only give useful information to the reader but should also serve to enhance the skills of the person doing the review. Besides improving patient care, this would lead to a gradually increasing number of Indian doctors having a good knowledge of searching medical literature, critically appraising studies and developing the art of writing reviews. This is a resource in short supply(3). A further spin off could be improving one's biodata by getting some publications and who knows some of them may end up being Cochrane reviewers. Archimedes, the evidence based section of the Archives of Diseases in Childhood has shown to be an educational experience for the reviewers(4) and by active participation of the readers of Indian Pediatrics, similar outcomes can be achieved. For this to happen successfully, there may be a need of guidance from Indian Pediatrics on how to carry out such reviews, a list of possible topics which need addressing in the Indian context (*e.g*., nimuselide versus paracetamol or ibuprofen in control of fever) and support of a group of clinicians and researchers with experience in evidence-based work who could mentor first time reviewers.

A small clarification also needs to be made regarding the evidence based reviews in the Archives of Diseases in Childhood. These are based on "best available evidence" and are not limited to randomised controlled trials or meta-analysis as these are often not available or feasible. In such a scenario, the next best evidence in the hierarchy of evidence(5) becomes relevant.

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Reply: Evidence, EURECA and Evidence-Based Child Health

Thanks for the complimentary note to *Indian Pediatrics* on the initiation of the section on Evidence-Based Child Health, *EURECA* and the suggestions to the readership of the Journal. However, it may be pointed out that *EURECA* is not meant merely 'to tailor evidence from the western world' to the Indian setting, but has been designed to foster a culture of "promoting and practicing Evidence-Based Child Health".

The 'evidence' does not only answer the 'decision question' (*What should I do?*), but is oriented to answer a specific 'clinical question', that may or may not be synonymous with the decision question(1). Unfortunately, 'evidence' often does not provide answers to decision questions for two reasons. First, evidence from systematic reviews (usually) demonstrates 'efficacy' (or absence thereof) of interventions in specific clinical settings, but not necessarily 'effectiveness'. Second, there may not be any evidence on a particular clinical question.

Put simply, 'efficacy' answers the question, *"Does this intervention work?"* and sometimes (though less often), *"Can this intervention work?"* On the other hand, "effectiveness" should answer the question, *"Will this intervention work if it is used in my/our setting (based on current best evidence)"*, assuming of course that the intervention is available, accessible, acceptable, applicable and affordable ('five A' criteria). By extension, it leads towards the question (and answer to), "*Should I use this intervention or not?"*. This requires weighing the evidence (obtained from systematic reviews or otherwise) in the context of the setting where it is applied. This necessitates an understanding of the biological aspects of the patient(s), presence of co-morbidities, patient values (such as preferences, compliance pattern, socio-economic impact etc), health-care setting and last, but not the least cost considerations. Therefore, in our country which has diverse modes of health-care delivery with variable 'quality', application of the same evidence in different settings, may result in different 'effectiveness' in terms of outcome.

Although it is often not possible to work out these considerations scientifically within and through the frame-work of a systematic review, *EURECA* tries to capture this complex concept informally (subjectively) through the term, "Extendibility"(1). A more formal (objective) way could be to undertake Health Technology Assessment (HTA) of a particular intervention that incorporates best evidence from systematic reviews, and also considers the other important issues. Thus HTA is more likely to be able to answer questions of 'effectiveness' than an appraisal of evidence alone; and thereby be able to answer decision questions.

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