Why evidence-based practice at all? Revisiting a polemic in light of new critiques

Prof Kim Walker & Dr Jed Duff

Introduction and background

It seems like an age ago now when back in mid-1997, I attended the launch of the Joana Briggs Institute for Evidence-based Nursing in Adelaide, South Australia. At the time I was working at the then NSW College of Nursing and my boss thought it appropriate that the College send a representative along to hear what all the fuss was about! I was also working with colleagues in the Faculty of Nursing and Midwifery at the University of Technology Sydney teaching into their recently launched professional doctorate program in nursing and midwifery; I was asked to write a paper for the candidates about the phenomenon of evidence-based practice exploring its philosophical and political underbelly, as it were. This piece then became, (somewhat ironically, given the first editor I sent it to rejected it out of hand as too ‘controversial’) what is now my most cited paper: Why evidence-based practice now?: A polemic (Walker 2003).

Essentially, this text advanced a four-pronged critique of EBP classifying it as a particular ‘regime of truth’ (Foucault 1980) as I proposed that it was grounded in the discourses of empiricist and positivist epistemology, economic rationalism and Richard Rorty’s version of pragmatism (1980; 1991); these it seemed to me at the time, gave EBP the special attention it was receiving then (and, of course, it still enjoys today). These ‘technologies of power/knowledge’ (Foucault 1972; 1980), I argued then, shaped EBP as something both authoritative and legitimate because to question these tenets of EBP would itself be somewhat of a heresy because so many subscribed to EBP’s veracity and relevance. Indeed, some of the most vociferous critiques at this time were from medically trained clinicians and academics who expressed their dismay that medicine could be so easily high-jacked by such a movement that, again ironically, was ‘not based on evidence but on authoritative knowledge, [which was] precisely the type of approach EBM was meant to replace’; this was even acknowledged very recently by none other than David Sackett himself, one of the so-called ‘fathers’ of EBP (Smith & Rennie 2014).

It struck me then as passing strange that the healthcare professions were suddenly, or so it seemed, talking about the need to base our practices on evidence when I thought we already were! Little did I realise that we were not, or at least were not always doing so in a systematic, rigorous and coordinated fashion. When I was a practicing clinician back in the 1980s, the language of EBP was nowhere to be heard and clinical practice was informed by what we now rather disparagingly call the ‘expert opinions’ of senior health professionals (who probably, but not necessarily, also read the scientific journals from time to time), hospital and government level policy and procedure documents, as well as multifarious local traditions and routines and habits (of mind and action).

Patients then, came and went from the system and mostly seemed to benefit from our ministrations; the ‘quality and safety’ agenda was largely implicit and certainly not much talked about in day-to-day practice. All that has changed of course and these days the healthcare agenda is intensely preoccupied with quality and safety, risk aversion and mitigation and all under the banner of evidence-based practice. As well now, we are exhorted by the leadership to embrace patient centred care (which is unquestionably a good idea) but as the current critiques of evidence-based practice make clear, is also a crucial element that the proponents of the EBP movement have failed to adequately incorporate into the actual practice (versus the ideology) of EBP (Greenhalgh et al 2014; Greenhalgh et al 2015). But more of this to come.
A brief overview of the rise and rise of EBP will help us set the scene for our latter day critique and will enable us to identify why some of what ailed EBP from its outset back in the late 1980s early 1990s persists to this very day. Clearly, the title to our paper is rhetorical, if not polemical, because neither of us is promulgating a return to the ‘dark days’ of basing healthcare practices on tradition, folklore and the mere opinions of authoritative experts. That said, we are suggesting that to leave the movement unchecked and as it stand now, is also a folly and troublesome for those of us who hold deep convictions that we need more evidence in practice not less.

Fernandez and colleagues (2015) in a neat overview of the origins of EBP trace it back to the early 20th century when in the USA hospitals began the transformation from being ‘a shelter for the sick’ to the sophisticated and prestigious monoliths they are today ‘where medical care is based on scientific principles’ (Timmermans & Berg 2003). Concomitantly, medical education was undergoing a reform whereby doctors were exposed to improved surgical training and clinical epidemiology was introduced into medical curricula (Flexner 1910; Zimerman 2013; Rosenberg 2002). These and other influences such as the trend toward standardisation of healthcare policies and procedures, the introduction of managed care to help reign in burgeoning costs and dilute medical dominance in decision-making, the accelerating use of electronic databases and systems for organising large data sets during the latter part of the 20th century, have coalesced to turn EBP into something its founders probably never imagined or, for that matter, intended for it, to become.

So not meaning here to bag EBP out completely and start on a more upbeat note, there have been some noticeable successes such as improvements in asthma care in the early 1990s by basing it on guidelines developed through consensus (but based on RCTs and observational studies) and more recently, the UK’s NICE guidelines on VTE prevention after surgery which have considerably reduced serious adverse events (Greenhalgh et al 2014). But, that said, we also know that despite evidence pointing to the clear lack of benefit in performing arthroscopic washouts of knee joints that this practice persists regardless of such evidence (Greenhalgh et al 2014). Such a situation points to some disparities in the ways EBP is perceived by clinicians and as Greenhalgh and colleagues note the so-called ‘quality mark’ attached to the movement has ‘been misappropriated and distorted by vested interests’ (p 1.).

But what we want to explore in the remainder of this paper is what some of these ‘distortions’ and ‘vested interests’ are and how and why they might have crept in to the discourse of EBP. Of course, doing this also impels us to consider what ‘corrections’ need to be installed so that the integrity and value of EBP is restored to its original intent, which surely is to improve the quality and safety of our clinical care and the effectiveness and appropriateness of the outcomes of that care for our constituents.

So let’s begin with our first critique: the matter of shared decision-making in EBP. In the aforementioned critique of EBP (Walker 2003) and in which the analysis was framed with reference to the epistemological influences of empiricism and positivism, it was noted that the clinicians’ voice and opinions, their knowledges and expertise, seemed to matter much more than those of the patient; this is a problem that persists to this day and is recognised by a number of commentators such as Rycroft-Malone and colleagues (2004: 85) who argue that ‘two types of evidence are available and need to be accessed by practitioners: evidence from patients’ previous experiences of care and evidence derived from patients’ knowledge of themselves, their bodies and social lives’.

We suggest that while this a noble sentiment, it is far more difficult to implement and embed in practice due to the asymmetrical relations of power between the clinician and patient which is bolstered by the different value proposition clinicians place on knowledge that is not ‘scientifically’
derived or validated versus that which is; this tends to result in a propensity to treat patients’ knowledge and expertise as different both in kind and in degree. And while the old ‘medical paternalism’ in healthcare might be far less conspicuous than say it was 40 years ago, we can testify from our own observations in the clinical setting and in feedback from patients and other health professional staff, that it is alive and well in many institutions today. Indeed, we would argue that EBP can actually bolster that idea of medical paternalism because it places so much weight on the nature of the evidence itself (the very notion of the so-called ‘gold standard’ of the RCT, for example, further legitimates such an epistemological bias). Compounding this asymmetry is the fact that such scientific knowledge is not readily accessible by the ‘lay’ person who does not enjoy equal understanding of what the science might be saying because the language in which it is pitched is foreign to all but the medically trained!

This reality points us nicely to our second critique which is that the evidence hierarchy established by the early proponents of the movement enshrined a linear and objectivist approach to evidence as we all know today that places systematic reviews of RCTs at the apex and ‘expert opinion’ at the base. Even counting a patients’ knowledge of themselves, their bodies and social lives under the rubric of ‘expert opinion’ still leaves it as a significantly less authoritative body of knowledge than its counterparts further up the hierarchical tree. Of course, the very notion of a ‘hierarchy of evidence’ is itself merely a social construction and therefore open to challenge (Glasby & Beresford, 2006), although we have uncovered only rhetorical objections to it rather than any serious attempt to subvert it; professionals who have endured long and arduous periods of professional formation through their various degrees and related education and professional developmental programs are understandably loathe to forsake the hard won ‘hard’ knowledges they have garnered in their pursuit of the title nurse or doctor! Indeed the various heuristics (rules of thumb) developed by clinicians as they move from novice to expert (after Dreyfuss & Dreyfuss et al, 1987) do tend to create a predisposition for them to stick to rules they have learnt along the way; and now with the introduction of ever more guidelines, standards and protocols to inform decision-making clinical care can indeed be seen to be directed towards rather than informed and enlightened by them in the context of other modes of knowing such as intuition and common sense. As Greenhalgh et al note well, ‘real evidence based medicine is not bound by rules ... to equate ‘quality’ in clinical care with strict adherence to guidelines or protocols, however robust these rules may be, is to overlook the evidence on the more sophisticated process of advanced expertise’ (2014: 3).

Our third and final critique is somewhat more contentious and hard-hitting and it concerns the rise and rise of medical fraud and manipulation of the very boundaries of exactly what constitutes an illness itself as well as undermining the integrity of the research process. As reported by columnist Sophie Scott in the Drum recently (25 Oct 2013: 8:11am) ‘three major Australian universities are currently investigating serious allegations of alleged research misconduct. The claims range from possibly manipulated images, falsified data to – unbelievably – allegations that a study with published results never took place’. What are we to make of such claims? The pressure, and now something of a cliché in academic circles, to publish or perish in respect of academic career progression, is at least partly responsible for such phenomena, but not completely. The machinery of research such as ethics review committees and other obstacles to the conduct of research (albeit well intentioned if not well executed) could conceivably lead less than scrupulous researchers to circumvent such tedium altogether in order to get their work into the public domain; conflicts of interest over sponsorship of clinical trials too, could well lead to dodgy behaviour in the pursuit of such funding and especially so in respect of producing ‘publishable’ (i.e. positive) results from research in order to promote one particular drug or therapy over another.
As Greenhalgh et al suggest, ‘the drug and medical devices industries increasingly set the research agenda. They define what counts as disease (for example, female sexual arousal disorder, treatable with sildenafil and male baldness, treatable with finasteride) and predisease ‘risk states’ (such as low bone density, treatable with alendronate) (2014:1).

Conclusion

In bringing this paper to an end we acknowledge that we live in times where EBP is most certainly a necessary and very good thing for healthcare providers and recipients alike; we do not however, suggest that in and of itself, it can be healthcare’s saviour as it confronts the many, and great, challenges it does today in terms of spiralling healthcare costs, overwhelmingly huge amounts of evidence available, increasingly sick patients with multiple co-morbidities and ever advanced age. Add to the mix the omnipresent disparities in power relations between the various health disciplines and professions (the nirvana of a perfectly functioning interdisciplinary team is still, for far too many, an impossible dream) and the ‘silos’ in which they continue to operate, then it becomes increasingly difficult to figure out how best to reach some sort of shared understanding of why we need to change the way we think and do EBP.

In tandem with Greenhalgh et al (2014: 7) then, ‘we argue for a return to the [EBP] movement’s founding principles – to individualise evidence and share decisions through meaningful conversations in the context of a humanistic and professional clinician-patient relationship’. Doesn’t sound that hard, does it? We guess the issue is that until such time as we can have proper informed debate between the health professionals as to how we might achieve such a goal, then it will likely continue to evade us. One strategy we have found especially useful is manifest in the very positions we currently occupy as conjointly appointed academic researchers working in and out of the health service itself. In our facilities and roles we have daily contact with clinicians, managers, educators and other researchers and patients, and in continuous and collaborative dialogue with them, we can conduct the EBP debate in real terms and in real time, about real-world issues such as how best to get the evidence into practice in such a way so as to respect and honour the wishes of the patient and yet not overly compromise the authority and decision-making and disease/treatment content expertise of the healthcare professional.
References:


