



## Evidence-Informed Practice? by Dr. Christopher Kent

In a [previous column](#),<sup>1</sup> I discussed the history and definition of evidence-based practice (EBP), and expressed concerns with how the concept has been narrowly construed by some academics and payers. Although there is some minor variation in evidence hierarchies, the randomized, controlled trial (RCT) is usually at or near the top. It seems appropriate to ask the questions, "Where is the evidence to support the premise that EBP results in better clinical outcomes? Are there RCTs which demonstrate that EBP results in better, cheaper and safer health care strategies?" As noted in my earlier article, the answer remains largely negative.

Horn<sup>2</sup> posed another important question: "Why are interventions that were found to be effective in randomized controlled trials (RCTs) not associated with substantially better outcomes in actual practice?" Great question. Here are some possibilities Horn identified:

- The complexity of the care process is not modeled adequately in RCTs.
- Findings from homogenous RCT study samples are not applicable to all patients.
- Inferences about individuals are based on statistics collected for groups.

Horn [further noted](#), "Improving clinical outcomes in actual practice is complex, multidimensional, and likely much more difficult than simply using a few interventions that were found to be statistically significant in RCTs involving a single condition in a homogenous patient population ... In routine practice, many combinations of patient and treatment variables affect outcomes, so a much more comprehensive approach is needed to discover how to improve quality of care."



[Hunink](#)<sup>3</sup> was more blunt, posing the disturbing question, "Does evidence-based medicine do more good than harm? ... If we argue that medicine needs to be evidence based, then logically we need evidence to support EBM. I have yet to find that evidence." Hunink notes that EBP may not just be of questionable value – it could be downright dangerous. "The hierarchy of evidence suggested by EBM may not be justified and can be misleading ... Besides the negative effect that EBM can have on how we appraise the literature, we may waste resources through inappropriate research, especially randomised controlled trials, by blindly conforming to EBM's level of evidence."



Concerns about EBP are also being voiced in the [popular press](#).<sup>4</sup> A teacher at Harvard Medical School, Jerome Groopman, writes that "medical schools have begun training students to abandon heuristics in favor of a purely stats-based approach – airtight algorithms, templates, prototypes, and 'decision trees' that will guide them, step by rigid step, through every conceivable interaction with a patient, like an IT technician with his list of questions." Groopman laments, "The next generation of doctors is being conditioned to function like a well-programmed computer that operates within a strict binary framework."

Undoubtedly, such an approach is attractive to a person who was selected for admission to professional school largely for demonstrating proficiency in taking multiple-choice tests and regurgitating facts. The appeal of such an approach was articulated well by Huxley,<sup>5</sup> who wrote, "The real charm of the intellectual life – the life devoted to erudition, to scientific research, to philosophy, to aesthetics, to criticism – is its easiness. It's the substitution of simple intellectual schemata for the complexities of reality; of still and formal death for the bewildering movements of life."

There is an even more pernicious aspect to the appeal of EBP: The individual practitioner may feel absolved of responsibility for professional decision-making. After all, if the doctor follows the "best practices" promulgated by an all-knowing oligarchy of self-styled "experts," there is no responsibility for a bad outcome on the part of the practitioner, who sincerely believes the patient has received the best care possible.

Never mind that, given the myriad variations in human anatomy, physiology and psychology, an alternative approach might have produced a better outcome. That would require creative thinking, skill, experience and judgment. There is no need to subject oneself to disturbing moments of introspection when the only question asked is, "Did you follow the cookbook?" Of course, payers and hospitals love it, too. It limits their liability, and better yet, makes doctors essentially equal and interchangeable.

Thankfully, evidence-based practice is giving way to evidence-*informed* practice. An additional dimension has been added to the equation – patient preferences. As [Umscheid](#)<sup>6</sup> noted, "Patient preferences are critically important to clinical decision making and patient care. Few clinicians practicing modern day medicine would argue otherwise."

However, commendable as it may be to add patient preferences to the mix, the pitfalls of evidence-based practice remain largely unaddressed. Let's hope chiropractors, payers, and regulators do not fall into the trap of equating quality with homogeneity of care. And let's not lose sight of the fact that the doctor-patient relationship, and the ability to consider the unique needs, desires and peculiarities of individual patients, is what separates doctors from mere technicians.

## References

1. Kent C. "Where's the Evidence for Evidence-Based Chiropractic?" *Dynamic Chiropractic*, Oct. 7, 2008.
2. Horn SD. Performance measures and clinical outcomes. *JAMA*, 2006;296(22):2731-2732.



3. Hunink MGM. Does evidence based medicine do more good than harm? *BMJ*, Oct. 30, 2004;329:1051.
4. Anderson S. "The Talking Cure." Review of Groopman J. "How Doctors Think." *New York*, March 26, 2007:80-81.
5. Huxley A. "Point Counter Point." Quoted in Smith RF. *Prelude to Science*. Charles Scribner's Sons: New York, NY, 1975:8.
6. Umscheid CA. Should guidelines incorporate evidence on patient preferences? *J Gen Intern Med*, August 2009;24(8):988–990.

