Editorial

Guest Editorial

Evidence-based practice and the need for conceptual clarity

Early formulations of evidence-based practice (EBP) presented it simply as an extension of research-based practice which 'de-emphasizes intuition and clinical experience' (Evidence-Based Medicine Working Group, 1992) and devalues 'the experience of experts' (Davidoff et al., 1995). As the concept has gradually developed, it has become increasingly concerned with the contribution of the practitioner to clinical decision-making, and has therefore fallen under the remit of practice development (PD) (see, for example, Gerrish, 2003). However, it could be argued that this broadening out of the scope of EBP to include concepts that have traditionally been the province of PD has been at the expense of conceptual clarity. This problem of definitions is particularly acute for practitioners, and a search of the academic and professional literature will reveal a mixture of confusion, lack of clarity and contradictions about what evidence is, which types (if any) might be of greatest importance to the practitioner, and how the practitioner might integrate this research evidence with other factors such as intuition and expertise into a clinical decision.

Some of these contradictions might be explained by the gradual development of the concept of EBP over the past 12 years. If this was indeed the case, we would see clear differences between earlier and later definitions. However, even a cursory glance at the recent literature will show that these contradictory concepts of EBP continue to exist side by side, occasionally even within the same paper. An alternative explanation might be that these differing views emanate from a deliberate (although perhaps subconscious) desire to present different messages about EBP to different audiences, in particular to researchers (research is the most important element of EBP), managers (EBP is a safe and rational process based on written clinical guidelines) and practitioners (EBP values the experience and expertise of practitioners above all else).

Some of the more pressing questions that practitioners might ask, with answers to each that can be found in the literature, include:

What is the relative importance of qualitative and quantitative research studies as sources of evidence?

- Qualitative research is inferior to quantitative research in all cases.
- Qualitative research has a role to play in conjunction with quantitative studies, but cannot stand alone as a source of evidence.
- Qualitative research is superior for certain types of questions (but not for questions of effectiveness).
- Each individual case must be judged on its own merits.

What is the relative importance of experience and/or expertise as sources of evidence?

- The distinction between experience and expertise is often not articulated, and the terms are sometimes used interchangeably.
- Experience/expertise does not qualify as evidence or is contrasted with evidence, and should not form part of evidence-based decisions.
- It is one factor to be considered, but stands outside the definition of evidence.
- It is the deciding factor in evidence-based

decisions, but stands outside the definition of evidence.
- It is at the bottom of the hierarchy of evidence.
- It is devalued or de-emphasized as a form of evidence.
- It is a superior form of evidence.

Should evidence be ordered in a hierarchy according to its usefulness and effectiveness?

- There is a single hierarchy of evidence with systematic reviews/randomized controlled trials (RCTs) at the top.
- There are different hierarchies for different types of questions, with RCTs being the 'gold standard' for questions of clinical effectiveness.
- There are unique hierarchies for each question.
- There are no hierarchies and each source of evidence has equal weighting.

How can evidence from different levels of the hierarchy be combined in an evidence-based judgement?

- Only 'best' evidence is considered, and we should start at the top of the hierarchy and work down until we find it.
- All evidence is considered, but evidence from the top is weighted more than evidence from the bottom.
- RCTs are the 'gold standard', but they can be over-ridden by clinical experience.

While almost all practitioners might now claim to know what EBP is, I suspect that few will have clear ideas about how to do it beyond some fuzzy notion of combining evidence from research with their own experience as practitioners. But as Gerrish rightly points out (2003:107):

> Simplistic definitions of evidence-based practice that state that research evidence is to be integrated with clinical expertise and patient preference fail to provide a clear indication of what is involved.

EBP surely has a serious contribution to make to the development of practice. However, there is a pressing need to clarify not only what is to count as evidence, but perhaps more importantly, what it means for practice to be based on evidence.

References

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