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Electronic Letters to:

R Ashcroft and R ter Meulen

**Ethics, philosophy, and evidence based
medicine**

J Med Ethics 2004; 30: 119 [Full text] [PDF]

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Electronic letters published:

▼ **EBP misrepresentation**

David J Brookman (4 May 2004)

EBP misrepresentation

4 May 2004



David J Brookman
*University of
Newcastle, Australia*

Dear Editor

Send letter to

journal:

Re: EBP

misrepresentation

Email David J
Brookman

I have read the recent theme issue on evidence based medicine and the various articles have raised some disquiet, mainly because they seem to be applying a concept of evidence based practice which assumes centralised imposition of rules, rather than the generally accepted concept of seeking and analysing the best evidence, using clinical judgment and adapting these to the patients wishes,

Most authors appear to have made the assumption of medical epistemology being an absolute form of knowledge, and attack EBP (Evidence based practice) as providing imperfect knowledge, I was expecting a variant of the ontological argument to emerge but thankfully the Cartesian absolutism did not progress. Medical diagnosis is similarly treated as an absolute – though we regard ourselves as “knowing” a diagnosis it is not the meaning of the verb “to know” as applied by the majority of your authors. “Knowing” to a medical practitioner, is (or should be) a probabilistic assumption. “Knowing” a diagnosis means we have matched in our memories a set of facts with what we observe, or clinically judged to be present, it is a label for classification and prognosticating it is not an absolute reality which most of your authors seemed to have assumed. “Knowing” a treatment similarly means we have matched a label (diagnosis) with past memories it is similarly subject to weaknesses of our memory systems, and our emotions. “Knowing” means that the assertion is highly probable not an absolute. While EBP has been hijacked by governments, government sponsored disease

lobby groups, and even the pharmaceutical industry and so called guidelines produced it is inevitable that they will reflect the prejudices and beliefs of the writer(s), and may reflect the extent of knowledge up to the time the editor sends the final to the printer, that this may be several years before the reader comes to apply it means that, though evidence based, it is no longer current evidence. That this process has occurred is irrelevant to the process of evidence based practice as the principle of EBP means the practitioner will assess the guidelines as they would any other set of information. A person considering the use of a guideline should, as a first step see when it was published, and what evidence is quoted. If there is no evidence base quoted throw the damn thing away. Another major concern was the expressed belief of some authors in the immutability of knowledge. Though we have an agreed set of diagnostic labels their application varies throughout world, we cannot even reach consensus on the diagnosis of death (one of the epidemiologists binary states) – our knowledge will always be imperfect and subjective. The application of EBP (it is a process not a philosophy) aims to reduce the subjectivity of externally acquired knowledge (i.e. what we do not observe ourselves) because we recognise the imperfections of the system which generates that knowledge. Poor experimental design, fraud, selective publication, omission of key data to push a product, poor statistical technique all act to mislead us when we are discussing options with our patients and what the Cochrane collaboration, and meta analysis, and systematic review do is hopefully weed out the misleading data. Of course any systematic review will be subjective – we can reduce subjectivity(or social values) not abolish it. As individual practitioners our response to our patients and their diagnoses becomes coloured by our experiences, we are animals we wish to avoid pain both physical and emotional, one poor outcome may colour our advice to the detriment of the patient – it is because of this we need a source of up to date clinical evidence even though it will always be imperfect and incomplete. In the past when medicine was less dynamic textbooks sufficed as this source of evidence but reliance on textbooks in our computerised society is decreasingly valid.

The application of EBP to quality improvement is also a process, people who do not realise the realities of dealing with autonomous human beings may assume that failing to prescribe what is suggested by current evidence reflects poor practice – the only person who can make that judgment is the practitioner – it is they who negotiates the treatment plan, it is they to whom the patient expresses their fears beliefs and prejudices and no one else can be party to that special arrangement. The application of EBP in quality improvement is flagging deviation from evidence and asking the practitioner to reflect on why they reached that course of action. Evidence

based practice is a tool, just as a computer is a tool. Neither represent a replacement of clinical judgment, or clinical skill and that they are misused by the ignorant to try to alter our behaviour is not valid grounds for rejection. Evidence based practice simply a further change in the practice of medicine that our successors will master over time, and some of us are trying to master now. My apologies for the brevity of the arguments but this is merely a letter.