Evidence-Based Practice

A CRITICAL APPRAISAL

Edited by
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with
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Evidence-Based Practice

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Chapter 1

Introduction: the Context of Evidence-Based Practice

Liz Trinder

Introduction

The emergence of evidence-based practice has to be one of the success stories of the 1990s. In the space of ten years the movement has had a significant impact on health care and policy. In the UK there are centres, amongst others, for evidence-based medicine, evidence-based child services and mental health services. This organisational framework has been accompanied by a panoply of practice manuals, journals and newsletters, toolkits and software packages, websites and e-mail discussion groups. The depth of influence within UK medicine has been paralleled by a breadth of expansion internationally. The movement has rapidly become a global phenomenon transcending national boundaries. An international network to support the development of evidence-based medicine has developed swiftly in the form of the Cochrane Collaboration, which now has centres in the UK and continental Europe, North and South America, Africa, Asia and Australasia.

Although the emergence of evidence-based medicine has been rapid and dramatic, just as extraordinary has been the adoption of the key concepts of evidence-based medicine in other disciplines and professions under the generic title of evidence-based practice. Over the last few years evidence-based approaches have been developed in most health fields, including evidence-based dentistry, nursing, public health, physiotherapy and mental health. Progress has not stopped there: uniquely it would appear that an approach originating in medicine is being advocated and adopted in more distant fields of professional activity, including social work, probation, education and human resource management.

The purpose of this book is to stand back from the flurry of excitement and activity that has accompanied the development of evidence-based practice, and to take stock of what has occurred and what challenges remain for the diverse fields of professional activity that have engaged or are beginning to engage with evidence-based practice. The book aims to address three major questions:
(1) **What is evidence-based practice?**

The roots of evidence-based practice can be found in the emergence of evidence-based medicine in the early 1990s. Chapter 2 provides an introduction to the core concepts, processes and procedures of evidence-based medicine and should be a starting point for those who are unfamiliar with its basic principles. Over the last few years many other disciplines within and outside of medicine have adopted the 'evidence-based' tag and can therefore be considered under the generic title of 'evidence-based practice'. The book as a whole presents individual case studies to show how evidence-based practice is being developed within primary care, mental health, public health, nursing, social work and probation, education and human resource management. Each case study outlines what evidence-based practice initiatives are being developed within particular disciplines and how evidence-based practice is being defined or interpreted.

One of the strengths of the case-study approach is that it makes it possible to compare and contrast the varied stages of development, and varied interpretations, of the concept of evidence-based practice across the disciplines. What becomes apparent is that in the disciplines closest to hospital medicine (general practice, mental health, public health) the development of evidence-based practice both appears to most closely resemble the original formulation of evidence-based medicine, as well as to have progressed furthest. Elsewhere, the notion of evidence-based practice has been subject to considerable reinterpretation (most notably in social work and probation) and, despite the presence of some powerful advocates, has met with a higher degree of ambivalence or resistance. The appropriateness of this variation is considered in Chapter 10.

(2) **What are the strengths and weaknesses of evidence-based practice?**

Although the rise and expansion of evidence-based practice has been spectacular, it has been accompanied by considerable criticism from opponents, both in medicine and in other fields. Supporters and advocates of evidence-based practice claim that the approach results in the best practice and the best use of resources. In contrast, opponents have countered with claims that evidence-based practice is a covert method of rationing resources, is overly simplistic and constrains professional autonomy. In particular, critics have pointed out that there is no evidence that evidence-based practice actually works. Contributors were therefore asked, in the case studies chosen, to outline the responses to evidence-based practice in their discipline from practitioners, managers, researchers and consumers, as well as to provide their personal perspectives on the relevance and helpfulness of evidence-based practice. What is immediately apparent is that there is limited consensus on the merits of evidence-based
practice. Chapter 10 outlines these divisions between the champions and critics of evidence-based practice and undertakes the difficult, and controversial task of critically appraising the strengths and weaknesses of evidence-based practice as a cross-disciplinary approach.

(3) How can we explain the emergence and spread of evidence-based practice?

It is unusual for ideas emerging from practitioner researchers to have such a dramatic and widespread impact on policy and practice, and it merits investigation. The individual case studies outline some of the background conditions that have presaged the adoption of evidence-based practice. The remainder of this chapter draws these threads together and looks more broadly at the similar background conditions that have prompted and facilitated the widespread endorsement of evidence-based practice. The core argument is that the emergence and rapid expansion of evidence-based practice must be understood against a background of increasing preoccupation with managing risk, critiques of science and professionalism and the emergence of managerialism and consumerism.

Why has evidence-based practice emerged?

It might seem rather an odd task to try to examine the reasons for the emergence of evidence-based practice. Certainly for those within the movement, and for many of those outside, its very success seems to be a clear indication that it is quite simply a self-evidently good idea. Evidence-based practice relays a devastatingly effective and simple message: the argument that practice should be based on the most up-to-date, valid and reliable research findings has an instant intuitive appeal, and is so obviously sensible and rational that it is difficult to resist.

Enthusiasts of evidence-based practice argue remarkably clearly and consistently across the disciplines, with four main points emerging:

(1) Research–practice gap

A common refrain in all the case study chapters, and in wider evidence-based practice and in professional literature, is the limited extent to which professionals utilise or draw upon research findings to determine or guide their actions. Instead it is suggested that professionals rely upon a range of other, less reliable, indicators such as:

- knowledge gained during primary training
- prejudice and opinion
• outcomes of previous cases
• fads and fashions
• advice of senior and not so senior colleagues.

(2) Poor quality of much research

In addition, it is argued that much of the research that is available is methodologically weak, in particular that it is not based on the 'gold standard' of well-conducted randomised controlled trial (RCT) designs, or is inapplicable within clinical or practice situations. This argument is made by exponents of evidence-based medicine, as well as within other areas of professional practice including social work, probation, education and human resource management.

(3) Information overload

The sheer quantity of research available, however, creates problems in itself. Particularly in medicine, practitioners are unable to keep up with the continuing global output of research findings, nor do they have the skills or means to be able to distinguish between rigorous and useful research, and poor or unreliable research.

(4) Practice which is not evidence-based

The consequence of factors (1) to (3) is that practitioners continue to utilise interventions which have been shown to be ineffective or harmful, that there is a slow or limited adoption of interventions which have been proven to be effective or more effective, and that there continue to be variations in practice.

Allied to the clarity and intuitive appeal is the portability factor. Evidence-based practice has its origins in medicine but is essentially a process or methodology, and one which claims a neutral, almost contextless stance. Hence the process appears capable of expansion to a wide range of disciplines involving human services, and even beyond (e.g. evidence-based veterinary practice or evidence-based agriculture). Given the research-practice gap reported in many disciplines, the low utilisation of research by practitioners and criticisms of the relevance of academic research, the evidence-based practice approach appears to have offered a tailor-made solution to these problems, and one which has been readily adopted throughout the health professions and beyond.

Although the obvious merits of a practice based clearly on good evidence and the tireless work of advocates can explain some of the success of evidence-based practice, these factors alone cannot provide a sufficient explanation. Other good ideas have not succeeded in the same way, nor
have other equally dedicated groups of professionals been so influential so quickly. Instead, this section will examine a range of other factors. In essence, the argument is that evidence-based practice has developed so quickly because both its central concerns and the form that it takes resonates with and mirrors significant contemporary issues and concerns, namely those of risk, audit and effectiveness, rationalism, transparency, professional accountability, consumerism, empowerment and the needs of the information society. Evidence-based practice is quite simply a product of its time. The following sections therefore examine the context within which evidence-based practice has developed, examining two distinct, though related trends – the emergence of the risk society and the 'appliance of science'; and the emergence of managerialism and the audit society.

The risk society

A current preoccupation of social theory is the extent to which we are living in changing times. Debate will continue as to whether we are living in high modern or post-modern times, nonetheless most commentators would concur that contemporary society is characterised by dramatic social change, occurring at an ever increasing pace. Further, this degree of change is associated with a heightened awareness of risk and a preoccupation with its management (Beck 1992), culminating in an 'age of anxiety' (Dunnant & Porter 1996). Science, and public perceptions of science, play a crucial role in this.

The work of Anthony Giddens (1991, 1993, 1994), one of the foremost contemporary social theorists, is highly pertinent to understanding the development of evidence-based practice. Giddens argues that in traditional societies a sense of 'ontological security' (the confidence people have in their self-identity and social and material environments) was anchored firmly in the locality, in the kinship system, the local community, religion and tradition. Now in contrast, Giddens argues that we are living in a time of endings and transitions, with the emergence of a post-traditional society. Instead of fixed and locally based traditions, post-traditional societies are subject to and shaped by globalised, rather than local, social and economic forces. The traditional authorities of the past, in particular the church, are far less influential, and social bonds are increasingly made by individuals in particular situations (reflecting 'lifestyle choices'), rather than inherited from the past. The changes in family forms, the rise in divorce and single-parenting and the declining role of the extended family are just some illustrations of this.

Perhaps the most important consequence of the shift to post-traditional societies for our discussion of evidence-based practice is the notion of risk. In pre-modern times Giddens points to the centrality of concepts of 'fortuna' (fortune or fate) where catastrophe was attributed to acts of god or
nature. In post-traditional times there is a heightened sense of risk, coupled with a sense that contingencies are generally humanly created, as well as inescapable. The transformation of human activity in modern times requires considerable and constant amounts of trust in expert systems (what Giddens terms 'abstract systems') (Giddens 1991). Even the relatively simple task of driving to work requires the lay person to trust numerous unknown others, including other drivers, as well as car manufacturers and repairers, traffic planners and driving test examiners. It is impossible for either individuals or organisations to avoid externally generated risks, ranging from food additives and genetically modified food to stock market crashes and political upheaval. The results are unsettling.

The promise of modernity, however, is that risk can be assessed and controlled by expert knowledge, or at least procedures put in place to minimise risks (Giddens 1994: 111). Yet although we are ever more dependent upon science, we appear increasingly aware of its limitations. Our confidence in science and experts is tempered by two factors. First, there is a recognition that many risks are generated by the very expert systems which we are required to trust. Second, given the very fluidity of modern life, and the constant re-examination of tradition and social practices, there are no guarantees that particular bits of knowledge will not be revised (Giddens 1991: 39-40). Giddens argues that although lay people are required to trust experts this trust is typically ambivalent, a bargain with modernity 'governed by specific admixtures of deference and scepticism, comfort and fear' and founded upon a recognition of the limitations of expertise (Giddens 1994: 90).

One particular and pertinent example is the critique of professionalism over the last two decades. Whilst it would be easy to overstate the degree of this critique, it is certainly the case that the esteem in which professionals, including doctors, were held in the earlier part of the twentieth century has diminished - though ironically standards of practice would be generally higher now than in previous decades. Criticisms of professional competence, discretion and self-regulation have come from policy-makers and managers (see under Managerialism and the audit society below). From lay sources, the growth of consumer and self-help groups, coupled with intensive media scrutiny, have led to charges of paternalism as well as a challenge to claims of a monopoly of expertise. More recently internal critiques have also emerged, including the pessimistic 'nothing works' found in probation (see Chapter 7), as well as the growth of the evidence-based practice movement.

The 'appliance of science'

If Anthony Giddens and many other commentators are correct when they identify a crisis of belief in science and expertise, why has a movement so
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firmly based in science and rationality been so successful? This is particularly interesting at a time when the social sciences have moved in precisely the opposite direction, away from the positivism of the post-war years, to emphasise the socially constructed and therefore fluid and uncertain nature of knowledge (e.g. see Lyotard 1984). Some of these concerns have been echoed in medicine (e.g. see Marinker 1996; Greenhalgh & Hurwitz 1998) although their influence is limited compared to the momentum of the evidence-based practice movement. Elsewhere, in social work, education and medicine, the influence of the social sciences is more substantial and can partly account for the much more muted acceptance of evidence-based practice (see Chapters 6, 7 and 8).

Again Giddens is helpful in providing an explanation for the emergence of a scientific movement. He argues that four adaptive reactions are possible when questioning traditional authorities and expert systems (1991: 135-7):

- **Pragmatic acceptance**: where there is an assumption that risks cannot be controlled and so temporary solutions are sought amidst underlying anxiety
- **Cynical pessimism**: a world-weary or humorous response to risk, and celebration of the here-and-now
- **Radical engagement**: where action rather than rational analysis and discussion are used to challenge perceived sources of danger - e.g. the environmental movement
- **Sustained optimism**: a position of faith.

It is the fourth strategy, of sustained optimism, that is most relevant to the discussion of evidence-based practice. Giddens defines sustained optimism as a position where continued faith is held in reason and science, and, despite public ambivalence, there is a belief that experts can find social and technological solutions for major problems and that rational thought, and especially science, still offers the best sources of long-term security.

The development of evidence-based practice fits squarely within Giddens' strategy of sustained optimism. Evidence-based practice has emerged within a context where there is a heightened sense of risk, and increasingly reliance upon as well as increased distrust of expertise. However, rather than rejecting or questioning science, evidence-based practice requires that a much more rigorous science should be applied far more systematically by practitioners. In a context where the competence of practitioners is being questioned more than ever - witness the furore over the Bristol pediatric heart surgeons - the solution is to turn to science more, rather than less. Evidence-based practice remains firmly committed therefore to the modernist promise that risk can be assessed and controlled by expert knowledge, meaning in this context that the potential harm of
interventions is minimised and the potential benefits maximised. This requires more rather than less science, and new mechanisms for risk management.

The question is what sort of science does this require? In a risk-conscious world tinged with doubt and scepticism about science and expertise, Beck (1992) argues that the goal of science has shifted from a positive goal of social change to a defensive attempt to protect from harm where risk assessment becomes central, but by its very nature imperfect. According to Beck, there has been a shift from a confident 'primary scientisation' or science of discovery, to a more cautious 'reflexive scientisation' based on an incremental model which resists challenge. What evidence-based practice does is to provide a methodology and set of procedures to produce an incrementally developing, but endlessly revisable, body of knowledge, rather than big theories or authoritative figures.

**Managerialism and the audit society**

The second major influence on the emergence of evidence-based practice has been the significant changes that have occurred in public services in many western democracies in the last two decades. The cluster of developments which have occurred, including the rise of managerialism, the emphasis on value-for-money and the growth of audit have all contributed to shaping the goals and form of evidence-based practice.

Alongside the preoccupation with risk, the last two decades have also witnessed the emergence of audit and managerialism in many western democracies. Since the mid-1970s, significant changes in the organisation, practice and culture of public services have occurred. From the late 1970s the impetus for change was initially driven by requirements to rein in the burgeoning growth in public expenditure. Yet the changes have now moved far beyond attempts to exert tighter fiscal control. Instead we have also witnessed the emergence of neo-liberal ideologies of micro-government, political discourses of accountability and performance, and economic discourses of value-for-money, including economy, efficiency and effectiveness (Power 1997: 43-4). In effect, what has occurred is a significant shift towards giving managers the right to manage, instituting systems of regulation to achieve value-for-money (economy, efficiency and effectiveness), and thereby producing accountability to the taxpayer and customer. In contrast to the period of expansion and growth in the 1950s and 1960s, the issue of value-for-money, including effectiveness, has become a central goal for public services (see Chapter 5). Thus over the last 20 years, a whole raft of reforms have been introduced in public services, framed within a managerialist discourse of responsibility, transparency, efficiency and customer orientation and accompanied by charters, missions, visions and performance tables (Clarke & Newman 1997: 35).
This shift towards managerialism is based on an explicit critique of the three traditional authorities of the post-war welfare state – the triumvirate of political representatives, bureaucrats and professionals. Where resources are finite and demands potentially endless and conflicting, managerialism has been presented as the solution which can rise above politics, of interfering politicians or self-interested professionals, in the interests of rational, efficient and accountable decision-making about resources (Clarke et al. 1994; Clarke & Newman 1997).

The real impact of managerialism, however, has been on the processes for target-setting, regulation and monitoring introduced throughout the public services in support of value-for-money objectives. The introduction of the medical audit and the Citizens Charter are just two examples. Not only are these developments important in terms of their objective of achieving value-for-money, they are also important in the sense that the achievement of value-for-money is sought through the introduction of processes, which in turn are presented as rational, non-political, neutral and transparent (Power 1997).

Michael Power’s (1997) analysis of the rise of what he terms the ‘audit society’ is helpful in identifying why such a major shift towards issues of effectiveness, accountability and transparency has occurred. Mirroring Giddens’ analysis, Power argues that the explosion of auditable management control systems has occurred at a time when there is a heightened awareness of risk and a diminution of trust in experts. The solution has been to lessen reliance upon experts and instead to transfer trust into audit systems. An apparently greater sense of safety and control is thus generated as the emphasis shifts, from trust in individuals, towards an audit of the quality of expert services.

Similar concerns and processes are observable with evidence-based practice. Power, in a definition that might equally apply to evidence-based practice, notes that:

‘The audit explosion is to do with the need to install a publicly auditable self-inspecting capacity with attempts to link ideals of accountability to those of self-learning’.

(Power 1997: 67)

The focus on effectiveness, though to a far lesser degree efficiency and economy, is the central driving force of evidence-based practice. It is also clear that the focus on proceduralisation and the types of procedures involved in evidence-based practice mirrors many of the managerial reforms introduced over the last two decades. As we argued above, the core of evidence-based practice is its procedures rather than its substantive output. In its few short years, the Cochrane Collaboration, for example, has generated an astounding array of procedures, checklists and guidelines.
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spanning the entire process from identifying evidence (including procedures for hand-searching), through evaluating evidence, collating and summarising evidence, to presenting and updating reviews of evidence. Like audit systems, the main rationale behind proceduralisation provided by the Cochrane Collaboration and other evidence-based practice initiatives, is a requirement to make every attempt to exclude bias and to ensure accountability and transparency, through the institution of standardised, rational and neutral procedures.

Giddens (1993) argues that in an uncertain world, social institutions ward off externally generated disturbances by becoming increasingly self-referential and inward-looking through what he terms the 'sequestration of experience'. The reaction to the messiness and uncertainty of individual patients/clients and situations is to establish boundaries outside which alternative ideas and experiences are set. In the case of evidence-based practice, alternative methodologies and ideas are excluded by procedure. The potential messiness of the real world – patients with multiple and complex conditions – is met by a battery of procedures designed to render the complex manageable through the procedural production of evidence. Challenges to the approach are met by further proceduralisation utilising the same rationale. Thus, for example, a system is being set up to prevent and manage conflicts which occur within the Cochrane Collaboration by the creation of a conflict support group, an internal ombudsman, and a document on handling and resolving conflict (Cochrane Collaboration 1998b).

Professionalism, empowerment and consumerism

Our argument so far has been that evidence-based practice has emerged in the context of significant change in public services, prompted by the concern with effectiveness and proceduralisation combined with a critique of professional expertise. We have also highlighted the similarities between the goals and processes of evidence-based practice and managerial changes within public services. We are then left with a puzzle as to why evidence-based practice began as a professional activity. If recent changes in public services have had placing greater control over professional discretion as one of their primary goals, why are evidence-based practitioners adopting methods that mirror – in their processes and rationality – managerial interventions? Indeed one of the constituencies where evidence-based practice has had most success is with health service managers, who have provided considerable support and funding for evidence-based practice initiatives, as well as endorsement and utilisation of evidence-based practice outputs (Grahame-Smith 1995).

Part of the explanation for the overlap between the managerial and evidence-based practice agenda is that changes in public services have
focused on ensuring that concern with performance and effectiveness is dispersed throughout organisations and not confined to management as strictly defined (Clarke et al. 1994; Clarke & Newman 1997; Power 1997). The mechanisms by which this has occurred have included recruiting professionals into management positions, devolving management systems (e.g. GP fundholding) and the introduction of audit and performance mechanisms. Thus Clarke & Newman (1997: 35) can declare 'we are all managers now'.

It would be a mistake, however, to regard evidence-based practice merely as a managerial Trojan horse. Clarke & Newman's (1997: 31) analysis of the process of managerial dispersal suggests that the aim of managerialism is to break up traditional areas of power, including professional power, but they add that the process of dispersal also inevitably produces new sites of resistance. One of the major battlegrounds has indeed been over quality. Clarke and Newman argue that the influence of professionalism has not been completely displaced. Instead there has been contestation, where managers using a quality agenda seek to subsume professional autonomy for organisational efficiency, whilst, at the same time, professionals use a quality agenda to defend professional values and user interests (1997: 81, 119). They identify two means whereby this occurs (1997: 76):

- **Subordination**: where professional judgement has to be framed within the context of management of financial realities and responsibilities
- **Cooption**: managerial attempts to colonise the terrain of professional discourse, by, for example, incorporating service quality issues into corporate missions and strategies.

With evidence-based practice, however, we can recognise a third, and initially professional-led, strategy. Both Clarke & Newman (1997: 119) and Power (1997: 50–51) argue that so far, managerialism has focused on issues of economy and efficiency, with relatively less attention to quality and effectiveness. Evidence-based practice has rapidly developed in this gap to produce a professional-defined and led strategy that promises effectiveness. Thus evidence-based practice can be viewed as a radical strategy where professionals fight back and challenge managerial definitions of effectiveness.

Its radicalism takes other forms too. As well as the challenge to managerialism, it also throws down the gauntlet to other traditional authorities, the leaders of professions steeped in experience and authority but not necessarily in the best evidence. In the emphasis on self-learning, and the belief that anyone can learn the skills of evidence-based practice, it is potentially therefore a radically democratising strategy where the most junior members of the profession can be as skilled in identifying the evi-
Evidence as the most respected. Evidence rather than experience becomes privileged.

Evidence-based practice is not just framed as a means to empower individual professionals but also as a mechanism to deliver the safest and most effective interventions for customers and enhance customer choice. Attention to the consumer is of course another of the key watchwords of the late twentieth century, particularly in the neo-liberal form of the consumer as a rational agent exercising freedom, choice and personal responsibility. The emphasis on the customer is evident in a number of ways. First, evidence-based practice promises greater accountability to the consumer by the provision of best evidence. Second, the Cochrane Collaboration has worked hard to involve consumers and consumer groups, through its consumer network and through attempts to provide accessible summaries of evidence. The reformulation of evidence-based practice to incorporate attention to patient wishes within clinical decision-making, alongside evidence and clinical experience (Sackett et al. 1996) might prove more problematic.

The information society

In seeking to question why evidence-based practice has emerged at this moment in time, it is worth looking briefly at technological change and the information society. The explosion of medical information, and the inability of practitioners to digest it, is frequently given as one of the reasons for the development of evidence-based practice (Sackett & Haynes 1995; Haines & Haines 1998). The movement has turned this to its advantage; indeed evidence-based practice would not be possible without the developments in information technology, especially electronic databases and the Internet, which have enabled its practitioners to identify, collate, disseminate and access evidence on a global scale. It has also facilitated the establishment and maintenance of an international organisation like the Cochrane Collaboration, with Cochrane centres and review groups scattered across the globe but united by the Internet and a standardised procedure.

A product of its time

The timing of evidence-based practice is therefore not accidental. It has developed within a specific context, particularly the current preoccupations with risk, ambivalence about science and professional expertise, and the concern with effectiveness, proceduralisation and the consumer. Much of the initial success of evidence-based practice can be attributed to its ability to both endorse and redefine some of these concerns, drawing them all together within a coherent and tightly bound package.
The response to the critique of science is to place renewed emphasis on science with a constantly revisable and transparent process that excludes uncertainty and, in an age of anxiety, promises security for practitioners, researchers, managers and consumers. Trust is transferred from the fallible individual and placed in the revised system. In response to the emergence of managerialism, the explosion of audit systems and challenges to professionalism, evidence-based practice has offered a professional solution, itself based upon an even more transparent, neutral and rational process, and one which also claims to represent the interests of, and involve, the customer or consumer. The ability to pull together potentially contradictory but dominant concerns into a seamless self-referential package, fully utilising advances in information technology, has made evidence-based practice difficult to challenge.

Nor is the original location or host for evidence-based practice an accident. It is unlikely that evidence-based practice could have emerged anywhere other than medicine. Two factors contribute to this: nowhere else is there a profession so historically powerful, nor with such a strong scientific research tradition, both of which have been crucial to the content and development of evidence-based practice.

The expansion of evidence-based practice

As is clear from the contributions to this book the pattern of influence and uptake of evidence-based practice has not, however, been uniform. Acute medicine is in effect the epicentre of the movement towards evidence-based practice. Those disciplines closest to this epicentre – other medical specialisms, primary care, mental health – are those which have adopted evidence-based practice most enthusiastically, and with least redefinition. Within the health professions, one of the factors which has facilitated the rapid expansion of evidence-based practice has been the issue of proximity. Evidence-based practice has had its most receptive audience when that audience is one where there are considerable educational, occupational and organisational overlaps with the originating discipline or specialism. Access to the concepts and processes of evidence-based practice has been facilitated by people working in the same organisations, reading some of the same journals and having access to the same training events. In the UK this has been given further impetus by NHS initiatives such as the Centre for Reviews and Dissemination at the University of York. As well as physical proximity, the swift endorsement of evidence-based practice has also been based on cultural proximity, referencing a common language and research tradition.

Neither of these factors – physical and cultural proximity – is clearly present in disciplines such as human resource management, social work and
education which occupy the outer edges. Furthest away from the medical epicentre the energy created begins to dissipate and the impact is more muted and less consistent. Indeed, the further from the centre – in education, social work and human resource management – the more limited the degree of commitment to evidence-based practice and the higher degree of ambivalence, scepticism or even resistance. In the outer-edge disciplines the evidence-based practice message has resonated with small, relatively isolated groups who have been long advocating the adoption of a ‘scientific’ approach to practice – for example the empirical practitioners in social work and the school-effectiveness lobby in education. In each of these disciplines, however, the groups identifying with evidence-based practice fall largely outside the research mainstream of their disciplines, or are far less central or influential than in medicine. Instead these outer-edge professions have alternative, more influential research and practice traditions, with the result that positions taken on evidence-based practice reflect pre-existing ongoing arguments or research traditions within the discipline. Education, social work, human resource management and to some extent, nursing, each have fairly long-developed research traditions which clash with the central ontological, epistemological and methodological tenets of evidence-based practice. The methodological centre of gravity of these disciplines falls largely within the social sciences and qualitative or non-experimental quantitative research, in contrast to medical research where the balance is tilted strongly towards models of research practice and cumulativeness drawn from the natural sciences.

The following chapter by Shirley Reynolds outlines the core principles of evidence-based medicine and can be seen as establishing a baseline definition against which the development of evidence-based practice in other disciplines can be compared. In Chapter 3 Toby Lipman examines the development of evidence-based practice in primary care, emphasising the opportunities evidence-based practice gives for continuing self-directed learning of practitioners. John Geddes’ contribution describes the development of evidence-based practice in the multidisciplinary arena of mental health, illustrating both the opportunities for improved practice as well as some of the difficulties in an area where the performance of different professional groups is being compared head to head. In Chapter 5 Muir Gray, one of the leading figures in the development of evidence-based health care, tracks the emergence of evidence-based health care and argues strongly for the importance of making health care decisions which are based on the best available evidence. The following chapters reveal a greater degree of ambivalence about evidence-based practice. In Chapter 6 Richard Blomfield and Sally Hardy note the long history of the subservience of nursing as a profession and express concern that the importation of a scientific model will inhibit the work done by nursing on reflective practice or do justice to the caring aspects of nursing.
In Chapter 7 I look at the emergence of evidence-based practice in probation and social work. In social work the concept has received a mixed response, with enthusiastic adherents drawing on earlier traditions of empirical practice as well as a rather tongue-in-cheek adoption of the name but not the methodological content of evidence-based practice by the more influential group of pragmatist researchers. In probation, by contrast, a narrow managerially led push towards evidence-based practice is being advanced rapidly. In Chapter 8, Martyn Hammersley offers a critique of the early calls for the development of evidence-based education, and in particular questions the relevance of the model for education where practice is primarily based on practical rather than technical decisions.

The last case study, on human resource management by Rob Briner, is the only area of practice that falls substantially outside the public sector and is also the area where evidence-based practice is least developed. He identifies the poor quality of much research in the area of human resource management and argues for, but recognises the barriers to, the development of evidence-based human resource management. The final chapter, Chapter 10, attempts to appraise evidence-based practice critically as a generic cross-disciplinary phenomenon. It examines some of the practical and conceptual difficulties with evidence-based practice and identifies some of the challenges that evidence-based practice has yet to resolve if it is to meet its goal of raising the quality of research and practice.

References


Chapter 2

The Anatomy of Evidence-Based Practice: Principles and Methods

Shirley Reynolds

Introduction

The impact of evidence-based medicine (EBM) on national policy in the UK has been remarkable. In less than a decade it has had a significant impact in many different professional groups and has become a cornerstone of UK health policy. The impact of evidence-based medicine has, to differing degrees, changed professional practice, influenced research activity and challenged professional identities in professions as diverse as medicine, social work, clinical psychology, nursing and education. The application of evidence-based medicine principles beyond medicine has resulted in the broadening of the core concept and the development of evidence-based practice (EBP), a title more suited to the interdisciplinary application of evidence-based medicine principles.

As the broader concept of evidence-based practice has emerged from the more focused concept of evidence-based medicine, so some of the initial principles may have been distorted or lost in the process. Inevitably, as dissemination occurs, different professional groups will interpret and adapt the concept of evidence-based medicine. This has the potential for considerable confusion. For this reason the aim of this chapter is to provide a brief overview only of the core features, principles and concepts of evidence-based medicine. There are many other more detailed sources of information about evidence-based medicine (e.g. Sackett et al. 1997, Grayson 1997); those requiring more detailed, specific information about evidence-based medicine may find the resources listed in Box 2.1 useful. The first section of this chapter introduces the concept of evidence-based medicine and describes the background to the development of evidence-based medicine. The second section outlines the main procedures and methods used in evidence-based medicine. Some common concerns and problems with the concept of evidence-based medicine are highlighted in section three. Although evidence-based medicine has changed the culture of health service provision very markedly, these concerns may constrain
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the extent to which evidence-based medicine is effective in changing behaviours (see Box 2.1).

What is evidence-based practice?

The relationship between research and practice tends to be uneasy. Many professions claim to be based on knowledge derived from scientific