Adopting Evidence-Based Practices—Our Hesitation Waltz

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A century ago, Abraham Flexner published his seminal report that transformed American medical education. The Flexner Report strongly advocated that medical education be standardized and grounded in science in order to counter prevailing trends that allowed the proliferation of practices with little or no scientific validity, delivered by inadequately trained practitioners. Certainly, we can see in the Flexner Report the roots for current efforts to promote evidence-based practices (EBPs). Indeed, it seems a given today that the practice of medicine must be founded upon the best science. This applies as well to other mental health-care disciplines, nursing, psychology, and social work, among others. This issue of Schizophrenia Bulletin features the most recent update of the Schizophrenia Patient Outcomes Research Team (PORT), and so it seems timely to consider why controversy still swirls around the promotion of EBPs in schizophrenia and more broadly in mental health and medicine in general. Why the hesitation to adopt scientifically based practices?

The rationale and strategies for identifying and promoting EBPs have been discussed extensively elsewhere, and in the PORT articles in this issue, and hence will not be repeated here. The Institute of Medicine defines EBP as “the integration of best research evidence with clinical expertise and patient values.” By summarizing the latest research evidence for the effectiveness of available schizophrenia treatments, the PORT treatment recommendations represent 1 of these 3 critical components of EBPs. Building upon these definitions, a worthy EBP has evidence for effectiveness; demonstrates benefits that outweigh risks, as well as benefits sufficiently substantial to justify costs; and is practical and feasible for translation into everyday practice. While research evidence alone cannot supplant clinical expertise and individual patient preferences and experience, scientific knowledge, as Flexner emphasized, plays a critical role in best practices. EBPs increase the chances that initial treatment choices will be effective and safe for the individual. While every individual is unique, science informs us of what is more likely to work, all other things being equal, and thus reduces the odds of unnecessary initial trial and error and expense. Likewise, EBPs are a place to turn when current treatment regimens are not working.

So what is the fuss about EBP adoption? Certainly, there are usual barriers to EBP adoption, the slowness of the dissemination of research findings, resistance to change, inadequate financial support for new treatments, and so on. A recent issue of this journal documented the demands of disseminating evidence-based psychosocial treatments. A short list of common “red flag” responses from clinicians to presentations about EBPs illustrate some of the pitfalls in their adoption.

I’m the expert and I care about people. I know that what I do works.

This is nothing new. We’re already doing this.

We don’t need to wait for research. We know from experience that what we do makes a difference.

These are fine, but they won’t work for my patients because …

A corollary warning sign from payers and service systems is “We only reimburse for services that are evidence-based.” At best, this reflects an inadequate understanding of the nature of EBPs, ignoring the value of clinician expertise and patient values when a treatment has received inadequate scientific attention. At worst, it represents an inappropriate rationale for rationing or denying care in order to reduce expenses. This can provoke counterresponses from providers who label their current practices as “evidence based” regardless of the science, hence truly muddying the waters.

Surely, as clinicians we seek to provide the best care. Most clinicians are scientifically trained, so they typically accept the value of scientific information as well as its limitations, especially generalizing from group means to the individual.

There is the claim that EBPs represent “cookbook medicine,” implying that EBPs promote a “one size fits all” approach with the intention of eliminating clinician and patient choice and stifling therapeutic innovation. But what is wrong with a good cookbook? Anyone who spends time in a kitchen knows that recipes offer a guide to success and that the experienced
cook adjusts the recipe based upon experience and tastes, his or her own as well as those being served. Failure to heed any well-tested recipe often leads to culinary failure. Following some evidence-based standards of care hardly needs to eliminate individualization of care.

Finally, some more subtle cultural undercurrents may affect EBP adoption. At least in the United States, significant segments of the population, presumably including health-care providers, distrust and oppose regulation. Adoption of public policies that give preference to EBPs may thus arouse suspicions of government intrusion. “Town-gown” issues may also enter into the equation in the form of tensions and misunderstandings between frontline practitioners and academic “experts.” Current public attention to alleged conflicts of interest among major researchers has also damaged the credibility of some of the science cited in support of EBPs. Also, a recent political cartoon in the United States, “Doonesbury,” laments the rise in popularity of antiscientific conspiratorial theories based upon “(beliefs) in many things that can’t be verified,” such as ghosts, alien abductions, and staged moon landings. Pondering whether there are any counterforces to such trends, a professor in the cartoon responds that there are only the “reasonists … who believe in an evidence-based world.” He goes on to reassure the questioner that “It’s a tiny group, not so influential.” Fortunately, Doonesbury need not represent the evolving interface between science and practice in helping persons with schizophrenia.

References