

EDITORIAL

Evidence-based medicine: it's not just about the evidence

Linked Comment: www.youtube.com/IJCPeditorial

Linked Comment: Duggal and Menkes. *Int J Clin Pract* 2011; 65: 639–44.

EBM is a philosophy

Duggal and Menkes (1) make the case that evidence-based medicine (EBM) is fraught with limitations that render it inadequate in clinically relevant decision-making. They suggest that practice-based evidence be used to bridge the gap between research and clinical practice and form a new paradigm of evidence-based practice (EBP).

However, there is no need for new acronyms but merely a restating of what the philosophy of EBM is all about. The term EBM has been misused and much maligned, usually with reference to limitations of extant controlled data regarding the management of the type of patients one sees in routine clinical practice. It seems that everyone needs a reminder from time to time that EBM is not just about the evidence, but how we use it.

Sackett et al. have summed it best in an editorial that appeared 15 years ago in the *BMJ* (2); the key points as directly quoted are bulleted below (italics mine):

- EBM is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of *individual* patients.
- EBM means *integrating* individual clinical expertise with the best available external clinical evidence from systematic research, but EBM is not restricted to randomised trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions.

- Individual clinical expertise is defined as the proficiency and judgment that individual clinicians acquire through *clinical experience* and *clinical practice*.
- Considered are *individual* patients' predicaments, rights, and *preferences* in making clinical decisions.
- Good doctors use both *individual* clinical expertise and the best available external evidence, and neither alone is enough.
- Without clinical expertise, practice risks becoming tyrannised by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an *individual* patient.
- External clinical evidence can *inform*, but can never replace, individual clinical expertise, and it is this expertise that decides whether or not the external evidence applies to the *individual* patient at all and, if so, how it should be integrated into a clinical decision.
- EBM is not 'cookbook' medicine.

Duggal and Menkes (1) state that 'EBM' and 'EBP' are often used interchangeably, leading to confusion. They opine that EBM, as defined, focuses only on research evidence and, in contrast to EBP, does not extend to other factors in clinical decision-making. Their suggested fix is to replace 'EBM' with 'research evidence' to help to clarify these concepts. This would be a mistake. Abdicating EBM's original thrust as a meaningful tool for clinicians and relegating it to the mere description of research outcomes

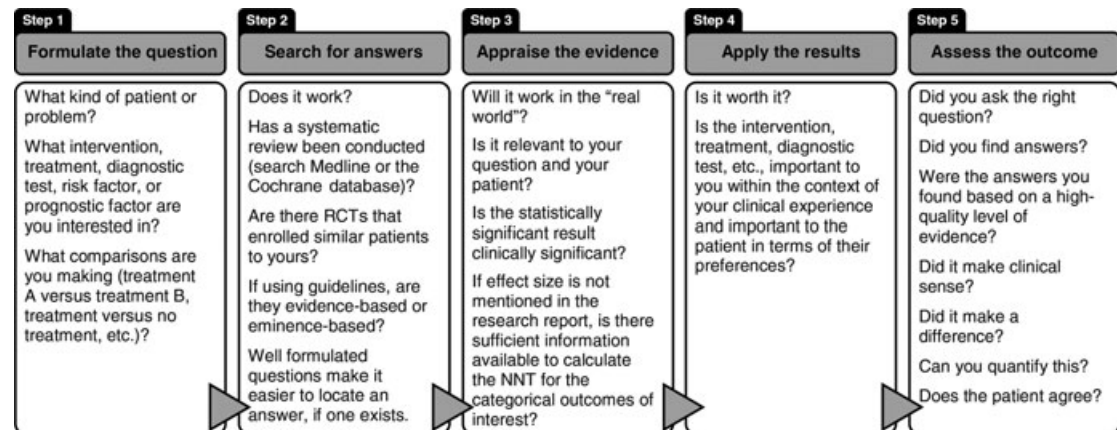


Figure 1 The 5-step evidence-based medicine process

does not do justice to the two decades of progress made in articulating the EBM process. Better to point out to others when the term EBM is being usurped to criticise the limitations of the current available body of evidence from controlled trials or when it is invoked to force practice pathways, guidelines and mandates for the provision of health care to populations. EBM is a clinician's purview, whose philosophy is for the care of the individual patient. Indeed, at the top of the EBM evidence hierarchy is *not* the meta-analyses and systematic reviews of randomised controlled trials, but rather the N of 1 trial [table 1A-1 in (3)].

There is no need to change what we call EBM. We can restate that EBM is not just about the evidence and is actually substantially more nuanced and complex. As a philosophy and process, it allows the individual clinician to make explicit what goes into making a clinical decision for the patient in front of us. Perhaps we can say that the product of EBM is the generation of EBP, with the understanding that evidence comes from both research and practice. Reproduced in Figure 1 are the five steps for success (4). Key issues, as always, are asking questions about how relevant the answers are to

your patient and ultimately 'checking your work' when assessing the outcome (step 5).

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EDITORIAL

UICP THE INTERNATIONAL JOURNAL OF
CLINICAL PRACTICE

Nurses deliver on urinary continence in primary care!

Linked Comment: Albers-Heitner *et al.* *Int J Clin Pract* 2011; **65**: 705–12.

Curing sufferers of a chronic medical condition, or improving their quality of life without risk of side effects is challenging. In this Journal Albers-Heitner *et al.* describe a multicentre randomised controlled trial in which the effect of engaging a specialist nurse in a primary care incontinence service was compared with routine treatment in four centres in Holland (1). Patients reported significant improvements in cure rate and quality of life in response to this simple intervention.

Bladder, urethra and pelvic floor function as a unit. They comprise smooth and striated muscle. Their control involves central and peripheral nerves as well as sympathetic and parasympathetic regulation. Optimal urethral luminal mucosa is required too; this may be dependent on oestrogens. Commonly the symptom of incontinence arises either from functional disorders of bladder filling and storing or disorders of emptying or due to descent of the pelvic floor. The most common form of incontinence is stress incontinence that

**Community
nurse
interventions
are successful
and liked by
patients**