

# **No evidence without context**

About the illusion of  
evidence-based practice in  
healthcare

The Hague, June 2017

# Summary

Evidence-based practice (EBP) emphasises the scientific underpinnings of professional actions. It has initiated the development of professional guidelines, quality indicators and volume standards. EBP has brought about a revolution because any professional is able to claim authority after a critical assessment of the scientific literature. As a result, the reliance on a consensus within a specialist discipline has had to make way for reliance on statistics and numbers. This development began in the 1980s in the professional domain of medical care. In the meantime, other disciplines both within and beyond the healthcare sector, governmental authorities, supervisory bodies and health insurers have embraced the principles and tools of evidence-based practice. Under the influence of EBP, accountability, transparency, standardisation and control have become the predominant governing principles within the healthcare sector.

EBP has substantially improved the quality and safety of care.

Uncertainty and evidence play a more explicit role in practice, which has greatly improved systemic reflection on the consequences of medical actions. Tools have also been developed for translating scientific research into recommendations for practice. There is however a flip side as well. This boils down essentially to the fact that the knowledge that EBP is based on is a condensation of reality.

Firstly, care is given in a context in which the question of the nature of good care plays a role. An inherent risk of EBP is that it will reduce good, patient-oriented care to what is evidence-based. The right thing to do can vary with the patient and the situation. Moreover, opinions of what constitutes good care are subject to change.

Secondly, the knowledge that EBP relies upon is based on standardised situations and on what is quantifiable, preferably in randomised experiments. Such knowledge does not take sufficient account of the differences between patients and their personal values, the variation in implementation in practice, or the dynamic setting in which care is given. There are also forms of care that cannot be investigated using the EBP methodology. To put it another way, the knowledge that EBP is based on claims to be universally applicable, and that knowledge is impersonal: it has no relationship with the professional or the patient as people. This is ignoring the multifaceted nature of real situations and the fact that knowledge is always personal. Although EBP is formally the result of integrating external evidence, clinical expertise and patient values, the EBP movement has not paid sufficient attention to how this must be done.

Thirdly, EBP and professional guidelines (plus the quality indicators based on them) have become an authority in their own right. If guidelines and quality indicators are not applied critically, this plays into the hands of undesirable standardisation of healthcare. In particular, the environment within which care professionals operate exacerbates this: high pressure of work, care that is organised separately for each discipline, and the use of evidence-based principles by governmental bodies, health insurers and disciplinary colleges. Care professionals spend more time providing quality information for external accountability than they gain by learning from it. Scientific research needs attention as well. Unintentionally, a research system has arisen that contains incentives for irrelevant and unreliable research, while many elements of customary care have been investigated

insufficiently. Taken as a whole, this is directing healthcare towards whatever can be investigated and substantiated using the EBP methodology. This is at the expense of healthcare domains for which this is difficult or impossible, and of healthcare that is not commercially interesting.

Evidence as *the* basis of good healthcare is therefore an illusion. In addition to external knowledge, good and patient-oriented care requires other sources of knowledge that EBP underutilises: clinical expertise, local knowledge, knowledge from the patients themselves, knowledge of the context – the living conditions and preferences of patients and the setting within which care is given – and of the values that are involved. Because any decision involves a specific demand in a specific context, healthcare decision-making can be seen as an experiment in putting together the various sources of knowledge. The uncertainty that is inherent in this must not be denied – it should indeed be embraced. Every decision can be and should be a learning moment.

Because of the lack of clarity in the content and the shortcomings of EBP, the Council for Public Health and Society is pleading the case for context-based practice rather than evidence-based practice. This is because of the importance of the specific context, of the patient and of the healthcare setting, where the various sources of knowledge are used as the basis for decisions. This goes beyond a mere local implementation of external evidence. It means a continuous process of collective learning and improving. It also signifies a different approach to education, research and supervisory practices.

For the individual patients' care, this means that healthcare professionals must adjust the practice of shared decision-making to fit the context of the patient, and pay more attention to listening than to the dissemination of information. This practice can be assisted by decision tools that help discover what patients find important. Patients' organisations need to take the initiative for developing the decision tools, together with healthcare providers and other parties involved. An essential skill for healthcare professionals is that they must be capable of weighing the various sources of knowledge and integrating them into practice, with an eye for the context and the considerations involved. Developing this competence is something they ought to be doing together with all relevant parties involved, including colleagues from other disciplines and patients. This capacity goes hand in hand with embracing the uncertainty about the nature of good care. There is already a great deal of attention paid to such skills in the training of healthcare professionals. However, there needs to be more space here for social sciences and humanities, for interdisciplinary education and active input from patients.

The learning capacity of healthcare professionals and healthcare organisations is enhanced when attention is paid to the working environment. In the early stages of healthcare processes, particularly during the diagnosis and decision-making phases, healthcare organisations should put more time aside for learning. This investment will pay itself back because the effort spent in diagnosis and treatment will be reduced.

In the current healthcare system, quality monitoring is outsourced to third parties and has become separated from the healthcare professionals themselves. The emphasis has shifted to external accountability, standardisation and control. The Council believes it is important to shift this practice towards a situation in which healthcare organisations and healthcare professionals decide for

themselves what constitutes good care and arrange their organisations and working methods to suit.

To this end, healthcare professionals should start up a dialogue about good healthcare within their own healthcare organisations, not only amongst themselves but also with their managers and patients. Healthcare organisations should take the initiative to enter this dialogue with other interested parties: other healthcare providers in the region, health insurers, patients' organisations and municipalities. Tools for this could for instance include quality measures and other local data, the system of patient tracers, annual reports and patients' stories. Because of the principles involved, this dialogue has to take place in an open "moral forum". This moral forum or "agora" can be seen as the vehicle for legitimising healthcare decision-making about what goals are being aimed for and using what resources. The importance of that legitimisation means that the dialogue is not optional: it becomes obligatory. This is how the parties involved fulfil the public tasks that they have been assigned, and how they can be held accountable for the results achieved. In order to ensure the development and the quality of this moral agora, it is important that it becomes part of the governance of healthcare institutions.

This shift has consequences for the system of scientific research. Utilising external evidence in the local situation is more than merely a question of implementation. It must be part of a learning process in which the effect of contextual factors on the outcomes is made explicit. Researchers and those financing healthcare research must therefore pay more attention to the effect of the context of the practice within which healthcare is provided. This can be done for example by making use of local data from practice, and by combining quantitative and qualitative methods in the same studies.

When making recommendations about how packages should be managed, the National Health Care Institute should take account of the context within which care is provided and of other sources of knowledge than scientific evidence. This can be encouraged by involving professionals, patients and the general public.

Finally, the focus for quality supervision and care contracting needs to shift from uniform quantitative outcomes of care towards learning and improving on the part of care professionals and care organisations.