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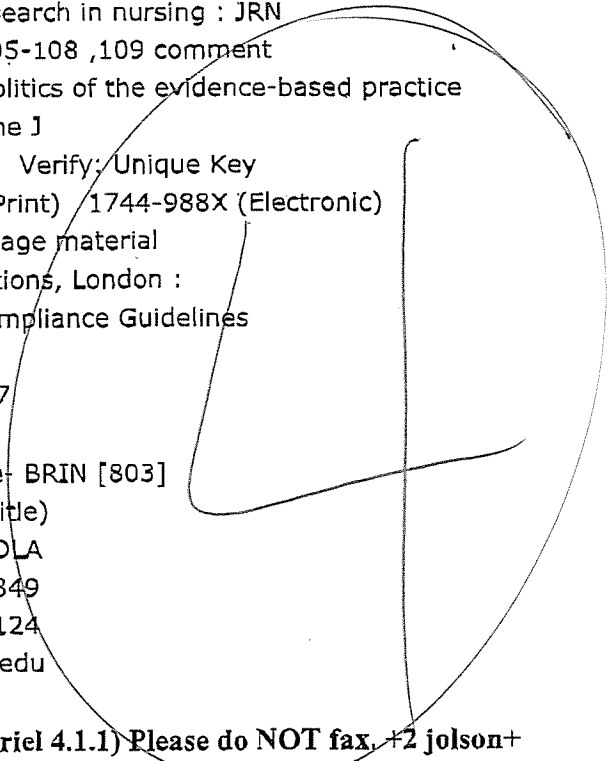
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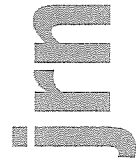
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The politics of the evidence-based practice movements

Legacies and current challenges

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Abstract In the United Kingdom the election of the Labour government in 1997 signalled the arrival of evidence-based policy making based on a philosophy of 'what counts is what works'. Mirroring the emphasis on evidence-based policy-making has been a concern about encouraging the use of evidence in practice. As an ideology it has penetrated the consciousness, discourse and working practices of professionals. However, despite the apparent engagement with evidence-based approaches to care, there remain a number of key areas that stimulate discussion and warrant debate. This discussion paper highlights some of these issues and considers their implications. Specifically, the political context of the evidence-based movements is considered and the resulting consequences outlined. These include issues about how nursing has signed up to evidence-based practice, the way in which evidence is conceptualised and the continuing gap between evidence and practice. Finally, a number of issues are presented that need to be tackled if there is a genuine desire to improve the evidence base and increase its influence on policy and practice.

Key words Evidence-based practice, evidence, policy, politics

The most savage controversies are those about matters as to which there is no good evidence either way.

Bertrand Russell (1872-1970) *Unpopular Essays*

Introduction

In 1997 a new dawn broke in the United Kingdom's (UK) politics when a Labour government was elected espousing a philosophy of 'What counts [matters] is what works'. The intention was to signal the end of ideologically driven politics and the arrival of evidence-based policy-making. Subsequently numerous policy documents have articulated the need to develop policy by drawing on and integrating best evidence (e.g. The New NHS, DoH, 1997). Whilst this remains the mantra of the UK government, enacted mainly through its modernisation agenda, equally it could be the rallying call of administrations in most developed countries around the world. As such, evidence-based practice achieved the status of 'an idea whose time has come' (Harrison, 1998).

Mirroring the emphasis on evidence-based policy-making has been a concern about encouraging the use of evidence in practice. A number of reasons have been suggested for the increasing emphasis on using evidence in policy and practice which include: the growth of a well-informed and educated public, an information explosion and corresponding improvements in information technology, a need for cost containment and increased productivity in service delivery, a growth in the size and capabilities of the research community and an increasing emphasis on governmental scrutiny and accountability (Davies et al., 2000). As Nutley et al. (2003) remind us, this agenda has permeated various parts of public service including education, social care, criminal justice and healthcare. Despite the different manifestations of evidence-based practice in these sectors, there are a number of commonalities that have been identified, including issues about the nature of evidence and its synthesis, relevant and timely dissemination of new knowledge and concerns about utilisation issues (Nutley et al., 2003).

Evidence-based practice has become a policy imperative but it is also one that healthcare seems to have broadly, although not exclusively, embraced. As an ideology it has penetrated the consciousness, discourse and working practices of professionals. However, despite the apparent engagement with evidence-based approaches to care, there remain a number of key areas that stimulate discussion and warrant debate. This discussion paper aims to identify and unpack some of these issues by tracing the history and development of evidence-based practice, examine what it means to whom and why, reflect on the nature and role of evidence and finally consider why, as a result of the way in which evidence-based practice has evolved, there remain challenges in getting evidence into practice. In framing these issues and highlighting key questions, the impact, real and potential, on policy, practice and research will also be considered. The issue of evidence-based practice will be considered in general, but specific reference made to nursing and nurses where relevant. The body of literature on evidence-based practice is vast; therefore the aim here is to characterise the existing evidence in order to stimulate discussion and debate.

The origins of evidence-based practice

The point of origin for the evidence-based practice movements as they are known today could be traced back to the 1980s when the term evidence-based medicine (EBM) emerged. Used originally to describe the clinical learning strategy developed at McMaster's Medical School in Canada, EBM marked a paradigm shift away from medical practice based on observation and experience towards one characterised by a systematic search for rigorous scientific evidence (Evidence-Based Medicine Working Group, 1992). Davidoff and colleagues identified five linked ideas central to EBM:

Firstly, clinical decisions should be based on the best available scientific evidence; secondly, the clinical problem — rather than habits and protocols — should determine the type of evidence to be sought; thirdly, identifying the best evidence means using epidemiological and biostatistical ways of thinking; fourthly, conclusions derived from identifying and critically appraising evidence are useful only if put into action in managing patients or making health care decisions; and finally, performance should be constantly evaluated.

(1995: 1085)

These principles built upon Archie Cochrane's earlier promotion of the randomised controlled trial (RCT) as the best way to ensure that finite resources get used on the most effective treatments (Cochrane, 1971). His call for more effective and efficient

use of resources in health services not only provided a stimulus for developing methods and approaches for assessing effectiveness itself but also set the co-ordinates for what is understood to constitute 'evidence'. A key underlying assumption in EBM is that not all evidence is equivalent; an issue that will be discussed later.

Political context for evidence-based practice

A tongue-in-cheek article in the *British Medical Journal*, written by the Clinicians for the Restoration of Autonomous Practice (CRAP) Writing Group (2002), amusingly highlighted what was felt to be a deep dichotomy between common sense and evidence-based medicine. This self-irony can be partly understood by the context in which the evidence-based movements emerged. Although rejected by many proponents of evidence-based practice, one reason for the political enthusiasm for it relates to the notion of rationing; whether that be implicit or explicit. Politicians are able to account for their spending of the public's money. Through evidence-based practice they can more easily claim that public money is being spent wisely on the best, most effective treatments for patients. In healthcare systems where costs need to be contained, but demand continues to inflate over time, not all patients or potential patients can have their demands met (Harrison, 1998). Evidence-based practice offers a mechanism for pushing maximally effective care and of discarding ineffective practices and techniques, thereby making cost-savings (Dopson et al., 2003). However, whilst a position not commonly acknowledged, research evidence may also reveal the effectiveness of interventions and thereby increase the demand for them. In the UK, the recent public backlash about the availability of drugs for people with Alzheimer's (www.nice.org.uk) demonstrates that the issues of rationing and transparent decision-making about effectiveness and efficiency do not always sit comfortably together.

Another assertion is that evidence-based practice is a means for controlling doctors (and for that matter the 'professions' more generally). The rise of managerialism and need for increased transparency in public services provides a challenge to the power base of the established professions (Traynor, 1999; Trinder, 2000). Harrison (2002) and Harrison et al. (2002) present a model of medicine that is called 'scientific-bureaucratic medicine'. In this model the idea that personal experience (however critically examined) is the primary source of valid knowledge is rejected. Instead, it asserts that ...

valid and reliable knowledge is mainly to be obtained from the accumulation of research conducted by experts according to strict scientific criteria.

(Harrison, 2002: 469)

Furthermore this model assumes that working clinicians are either too busy or not skilled enough to find and interpret this knowledge for themselves. As such, practice should be influenced by the expert distillation of research findings into guidelines and protocols, which are communicated to practitioners for them to use in practice. As Harrison (2002) suggests, the logic of guidelines is algorithmic; that is, practitioners will be guided towards particular courses of action based on what ought to be done, thus relegating clinical experience in favour of standardised, research-based approaches to care. As such, practitioner's decision-making is being directed (or controlled) and arguably their professional practice basis eroded. As Traynor remarks:

Whether individual clinicians and their professional groups accept or express hesitation about EBP, the movements have contributed to a subtle reshaping of professional identity.

(2000: 167)

There has been criticism of evidence-based medicine, as witnessed in a whole issue of the *Journal of Evaluation in Clinical Practice* in 1997. Similarly, nurses and nursing has raised some concerns, which have been counter-argued (e.g. DiCenso et al., 1998). Despite this, as Estabrooks has remarked, evidence-based practice rapidly became a 'growth industry' (1998: 16). Since EBM's conception, the Cochrane Collaboration was born, various evidence-based journals have emerged and considerable investment has been made in centres that have been set up to encourage the delivery of care based on evidence of 'what works'. For example, in the UK the National Institute for Clinical Excellence (NICE) and the Health Technology Board for Scotland have been set up; in the US, the Agency for Health Care Research and Quality; and, in Australia, The National Institute for Clinical Studies. These initiatives demonstrate that evidence-based practice has become a truly cross-national movement. The way in which it has been adopted by the healthcare disciplines is of interest because it highlights some of the tensions in the way it has been interpreted, promoted and applied.

Definitions and discourse

Traynor (2002) suggests that whilst the evidence-based movements share some key ingredients and tenets within clinical professions, they also differ in their styles across professions. Not surprisingly, as he suggests, this might be because different professions operate in different contexts. This point is reflected in the way in which evidence-based practice has been defined by various disciplines and professions. Table 1 summarises a number of definitions related to the evidence-based movements, for relevance these have been selected from nursing, medical and healthcare arenas more generally.

From these definitions some core similarities can be seen, but it is also obvious that they are articulated with different emphases. All recognise the role of research; some recognise a broader information base than research and some acknowledge individuals and decision-making. Rolfe (1999) cynically suggested that nurses and midwives have not reached a consensus on what evidence-based practice is or how it should be practised. Indeed it might appear that most definitions are variations on a theme of those originally proposed by the proponents of EBM; they have simply been tailored to suit the particular author's (or profession's) preferences and the particular discipline's philosophies. Recently, Dawes et al. (2005) proposed that the concept of evidence-based medicine be broadened to evidence-based practice to reflect the fact that healthcare teams and organisations have adopted a shared evidence-based approach. It remains to be seen how, and if, this suggestion becomes accepted and adopted.

More fundamentally, French (2002) questions the epistemological integrity of the concept of evidence-based nursing. He argues that there is more belief in the concept than actual meaning and, by applying the theory of symbolic interactionism, concludes: 'EBP symbolism lacks consensus and ... there is very little evidence to support the contention that a new construct or process exists' (2002: 255). This is a particularly interesting analysis if one considers how concepts such as research utilisation, which has been part of nursing for a number of decades (e.g. *Conduct and Utilization of Research in Nursing* (CURN) project, Horsley et al., 1978), relate to evidence-based practice. Estabrooks (1998) argues that research utilisation is a subset of evidence-based practice. French (2002) also identifies some other concomitants, such as clinical judgement and professional practice development. More

Table 1 Definitions, sources and attributes of the evidence-based movements

Definition	Source	Key attributes
<p><i>Evidence-based medicine:</i> is the process of systematically finding, appraising and using contemporaneous research findings as the basis for clinical decisions.</p>	Rosenberg and Donald, 1995: 1122	<ul style="list-style-type: none"> Using research as a basis for clinical decision-making. Points to a need to systematically find research and assess its quality before applying.
<p><i>Evidence-based medicine:</i> the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.</p>	Sackett et al., 1996: 71	<ul style="list-style-type: none"> Explicit role of research in decision-making. Research as external evidence. Recognition of individual clinical experience. Application to individual patients.
<p><i>Evidence-based practice:</i> Using research findings derived chiefly from randomised controlled clinical trials or other experimental designs to evaluate specific interventions.</p>	Gerrish and Clayton, 1998: 58 — from nursing literature	<ul style="list-style-type: none"> Use of research. Specify use of randomised controlled trials (rcts).
<p><i>Evidence-based practice:</i> A shift in culture of health care provision away from basing decisions on opinion, past practice and precedent toward making more use of science, research and evidence to guide clinical decision making.</p>	Appleby et al., 1995: 3	<ul style="list-style-type: none"> Use of science, research and evidence in decision-making.
<p><i>Evidence-based nursing:</i> de-emphasizes ritual, isolated, and unsystematic clinical experiences, ungrounded opinions, and tradition as a basis for nursing practices, and stresses instead the use of research findings and, as appropriate, quality improvement data, the consensus of recognized experts, and affirmed experience to substantiate practice.</p>	Stetler et al., 1998: 48–49	<ul style="list-style-type: none"> Use of research. Broader definition of what to base practice on — including internal and external evidence.
<p><i>Evidence-based nursing practice:</i> is the conscientious, explicit, and judicious use of theory-derived, research-based information in making decisions about care delivery to individuals or groups of patients and in consideration of individuals' needs and preferences.</p>	Ingersoll, 2000: 152	<ul style="list-style-type: none"> Echoes Sackett et al.'s definition. Extra dimension to research — theory derived. Decision-making levels of individual and group.

recently, knowledge utilisation and transfer have also entered the discourse. So is evidence-based practice in fact an umbrella term for a number of different related concepts rather than a discrete entity in itself? Such questions raise the issue of a need for clarity; both in the language that is used, but perhaps more fundamentally in being clear about the concepts that we use and on/from what basis we are using them.

In relation to nursing, it could also be suggested that evidence-based practice was, and continues to be, taken up in a relatively uncritical or unquestioning manner. In 1997 Kitson cautioned that . . .

nursing may embrace the evidence-based movement without fully understanding the rules. And as written at the moment, the rules are about medical diagnosis, single clinical interventions, RCTs and meta-analyses . . . there is a limit to nursing evidence conforming to these criteria.

(1997: 38)

On reflection, has evidence-based practice been adopted by nurses without thinking about what it really means to nursing and the process of caring? Few would dispute the merit in the aim of evidence-based practice as improving patient outcomes or practice (with the intention of improving outcomes), but this is predicated on an assumption that using research evidence in practice is always a good thing; an assumption that might not hold true in every situation (Davies et al., 2000; Rogers, 2003; Piterman, 2005). Furthermore, the way in which evidence-based practice has been adopted by nurses and the definitions outlined above highlight the problematic nature of the meaning of 'evidence'; not just for nursing but for healthcare more generally. These issues are more fully discussed in the following section.

Conceptualising evidence for evidence-based practice

The debate about what constitutes evidence for evidence-based practice is not new (e.g. Kendall, 1997; Upshur, 2000; Dobrow et al., 2004; Rycroft-Malone et al., 2004; Scott-Findlay and Pollock, 2004; Lomas et al., 2005). The original definition of evidence-based medicine laid the foundations for the sort of evidence that is most valued today. While Sackett et al. (1996) acknowledged that evidence-based medicine should not be restricted to randomised controlled trials (RCTs) and meta-analyses, in reality these are the types of evidence that reside at the top of evidence hierarchies. Although descriptive studies are listed in evidence hierarchies, non-experimental studies represent a weaker form of evidence and therefore tend to have less influence in the findings from systematic reviews. As Rycroft-Malone et al. (2004: 83) state, this epidemiological view of evidence has been compelling, and significant to the debate for the following reasons:

- Research evidence, and more particularly quantitative research evidence, tends to be more highly valued than other sources of evidence in the delivery of health services.
- As a consequence, there has been a concentration across all levels of healthcare delivery on the importance of getting research evidence produced, synthesised, disseminated and used in practice.
- The prominence ascribed to research evidence has meant the relative neglect of other forms of evidence in the delivery of healthcare, in terms of making them available for critical scrutiny and public review. Thus, the potential interaction of

research evidence with contextual, individual practitioner and patient variables has been disregarded.

Clearly, an RCT is the most relevant design for studies of effectiveness; however there are many issues and research questions, particularly in relation to the work of the professions allied to medicine, that are not amenable to an RCT. Perhaps as a consequence of this reductionist view of evidence, whilst there has been an information explosion to the extent that practitioners feel overloaded, there is paradoxically a lack of evidence relevant to (nursing) practice. The extent of the available evidence seems to consist of a few things we know, a few things we think we know (and probably do not) and many of things we do not know.

Differing perspectives on what constitutes evidence

Considering the life span of the evidence-based movements, there has been very little debate and discussion about what constitutes evidence. The culture surrounding evidence-based practice has been such that quantitative evidence has been pre-eminent and the accepted truth; a climate that has perhaps stifled debate. Broadly there are two camps regarding what constitutes evidence for evidence-based practice; one that argues for a broader evidence base (e.g. Kendall, 1997; Upshur, 1999, 2000; Rycroft-Malone et al., 2004) and the other that urges a restriction of the term 'evidence' to mean 'research findings' (e.g. Scott-Findlay and Pollock, 2004). Rycroft-Malone et al. (2004), building on the work of others such as Upshur (1999, 2000) highlight that, in reality, practitioners draw on multiple types of evidence from both propositional and non-propositional sources, which are likely to include research, clinician's experience, patient experience (of themselves as a person and their illness) and local information/data. They go on to suggest that to practise evidence-based, patient-centred care . . .

practitioners need to draw on and integrate multiple types of evidence that have been critically and publicly scrutinised. Furthermore, these processes are not acontextual — the melding of this evidence base occurs within a complex, multi-faceted clinical environment.

(2004: 83)

On the other hand, authors such as Scott-Findlay and Pollock (2004) argue that clinical experience and patient experiences are influences on decision-making but not types of evidence informing the decision-making process. Furthermore they argue that labelling them as evidence is in fact 'disguising' them so they will be seen as valuable. Clearly these issues not only have practical implications, but they are also rooted in epistemology and ontology concerning the way in which we relate to the world in relation to knowledge creation and interpretation. However, it could be argued that, whilst practitioners make decisions on a minute-by-minute basis, a number of pieces of information influence and therefore inform this process, including, perhaps, clinical experience, patients' preferences and research evidence. The challenge remains however in determining how these influences are weighted, how they are blended and to what extent they impact positively on patient outcomes.

A systematic review conducted to ascertain what counts as evidence for health system guidance (Lomas et al., 2005) surmised that evidence could be either colloquial or scientific. Outside the research community, the colloquial ('anything that establishes fact', 2005: 3) definition dominates, whereas researchers tend to restrict their view of evidence to information gathered by a prescribed set of processes. The view that is taken determines how it is included in health system guidance; if defined as science, its inclusion as part of guidance is ascertained through methodological

tests; if colloquial, its inclusion is determined by relevance. How illuminating this distinction is at the patient-practitioner decision-making level remains to be debated. Arguably, whilst healthcare is making attempts to be more scientific, presenting some types of evidence as 'colloquial' may be undermining. Additionally, the distinction made within the review between inside and outside the research community may serve to further widen the gap between the producers and users of evidence. However the other issue this review usefully raises is that of context.

Evidence, context and social construction

Arguably, because of the way the evidence-based movements have evolved, context has been relatively neglected in favour of a focus on evidence as a product and individuals as consumers of the produce. The scientific-bureaucratic model of medicine outlined earlier indicates why this has been the case. Of particular relevance to this argument is Dobrow et al.'s (2004) theorising about what constitutes evidence for evidence-based policy-making. Whilst shifting the level up from the individual-clinical level to the population level, their arguments, it is believed, are relevant to understanding more about the link between evidence and context. According to their interpretation, the philosophical and practical aspects of evidence support two distinct orientations and these orientations reflect fundamentally different relationships between evidence and context. The first is the philosophical-normative orientation, where the relationship between evidence and context is mutually exclusive. That is, evidence has inherent value as determined by its structural characteristics and properties (i.e. validity and reliability). So what constitutes evidence is largely a function of the quality of it, with the supposition that higher-quality evidence should lead, in turn, to higher-quality decisions. In contrast, the practical-operational orientation to what constitutes evidence is context based, with evidence defined with respect to a specific decision-making context. In this orientation, evidence is not static, but characterised by its emergent and provisional nature.

The idea that evidence is not certain, acontextual and static comes to life when the findings of multi-site evidence-based practice projects such as the Promoting Action on Clinical Effectiveness Programme (PACE) and case study meta-analysis are reviewed (Dopson et al., 1999, 2002). Their analysis confirms a view that evidence is socially constructed; that is, different people will view evidence differently. So, not only might evidence be contextually bound (depending on what philosophical position you adopt), but also individually determined, therefore it is not static, tends to be contextual and is not as certain as some would like it to be. Perhaps as Rycroft-Malone et al. suggest: 'there is no such thing as "the" evidence' (2004: 84).

These issues are significant when the policy agenda is considered. From a policy perspective, guidelines are viewed as an important clinical tool in the quest to promote evidence-based practice and, as such, their development both at a national and local level is ever increasing. Guidelines are 'the' evidence upon which practitioners are expected to base their practice, an arguably naïve approach for two reasons. First, as outlined above, there is some evidence to suggest that clinicians need to particularise (research-based) recommendations to the patient and context. Second, pushing out evidence in the form of guidelines does not mean practitioners will automatically use them in their everyday practice. Politically the focus has been on evidence syntheses. The consequences of this approach to promoting evidence-based practice has meant that there has been a neglect of the process(es) of implementation and thus a continued gap between evidence and practice.

Evidence-based implementation

The research base for practice has grown massively, with approximately 10,000 new randomised controlled trials included in MEDLINE every year and 350,000 trials identified by the Cochrane Collaboration. In parallel the guideline houses continue to develop recommendations for practice by synthesising this research-based evidence. Despite this, studies have also shown that 30%–40% of patients do not receive treatments of proven effectiveness and that 20%–25% get treatments that are not needed or are potentially harmful (Grol, 2001; McGlynn et al., 2003). Specifically in relation to the uptake of guidelines, a national evaluation project found that the implementation of national guidance in the UK is highly variable (Sheldon et al., 2004). So whilst there is a growing evidence base upon which to act, it does not appear to be translating into practice.

Linearity and complexity

There is an increasing recognition that 'pushing out' or disseminating research information has only limited success (Nutley et al., 2003). If implementation was straightforward, the production and dissemination of evidence in the form of guidelines, followed by an education or teaching package would lead to an expectation that practitioners would automatically integrate them into their everyday practice. Some early models that describe implementation of evidence into practice promote a linear process (for example Milbank, 1993; Haines and Jones, 1994) where the emphasis is on informing and monitoring with a view to changing practice. This rational–logical view of implementation mirrored that of evidence production. However, more recently there has been a slow shift to recognise that, in fact, the process of implementing evidence in practice is more complex. Findings from projects such as PACE reinforces this shift by highlighting the multifaceted nature of implementation, not easily represented by rational models.

A recent systematic review of the diffusion of innovations literature (Greenhalgh et al., 2004) adds further emphasis to this argument by introducing the analogy of a 'contact sport'. Whilst the diffusion of innovations is not synonymous with the implementation of evidence into practice, a great deal of the review is applicable. The analogy of a 'contact sport' has been developed further by Rycroft-Malone (2005) who suggests that getting evidence into practice necessitates the challenge, negotiation and overcoming of various boundaries, objects and players:

In a contact sport such as ice hockey or rugby, the interaction between a number of different elements determines the nature of the game, the spirit in which it is played, and the ultimate outcome — win or lose. The same could be said of getting evidence into practice: It is the interaction of various ingredients that determines the success of the outcome.

(2005: 1)

Interplay of factors

Politically there has been a focus on developing the skills and knowledge of individual practitioners to appraise research and make rational decisions. So, for example, emphasis has been placed on skilling-up individual nurses to be able to find and critically appraise research evidence in the hope that this will influence its transfer into practice (e.g. *Making a Difference*, DoH, 1999). In parallel, models and frameworks that were developed to encourage nurses' use of research in practice focus on the role that individuals play in the process (e.g. Titler et al., 1994). However, despite all

these efforts and considerable investment, for the most part research evidence is still not used routinely in practice. Getting research into practice is a complex process, which requires more than a focus on addressing individual influencing factors. Addressing the education of individual nurses by, for example, enhancing their critical appraisal skills is unlikely to affect their ability to use research in practice; moreover, it is unrealistic to expect it to do so. A systematic review by Estabrookes et al. (2003) that examined individual nurse characteristics and how they influence research utilisation found that, apart from attitude to research, there was little to suggest that any potential individual determinants influence research use. The individual nurse cannot be isolated from all the other bureaucratic, political, organisational and social factors that affect change. The implementation of research-based practice depends on an ability to achieve significant and planned behaviour change involving individuals, teams and organisations. People are not passive recipients of evidence; they are stakeholders in a problem-solving process called evidence-based practice. Therefore it is argued that there needs to be a shift in focus away from individuals to the multiple factors that affect implementation success.

It has been proposed that the successful implementation of evidence into practice is dependant upon the nature of the evidence being used, the quality of context and the type of facilitation required to enable a successful change process (Kitson et al., 1998; Rycroft-Malone et al., 2002). It is proposed that the most successful implementation seems to occur when evidence is scientifically robust and matches professional consensus and the patient's preferences, the context receptive to change with sympathetic cultures, strong leadership and appropriate monitoring and feedback systems, and, when there is appropriate facilitation of change, with input from skilled external and internal facilitators. In considering the role of evidence, context and facilitation in the implementation agenda, a number of issues come to the fore.

Evidence If one accepts the view that evidence is socially and professionally constructed this means that if you take an evidence synthesis, such as a clinical guideline, it cannot automatically be assumed that the recommendations will mean the same thing to individuals and groups. As Nutley et al. (2003) state, research is rarely self-evident to the practitioner but varies according to the context in which it is received and deployed. If evidence is not static or value-free, this has significant implications for whether or not it is accepted and/or used in practice. Consequently any knowledge transfer strategies will need to incorporate sharing views about 'the evidence', possible negotiation and consensus building in order to make it relevant and applicable to the patient, the individual's practice and decision-making, and the practice context.

Context Whilst historically there has been a lack of awareness about the role of context in getting evidence into practice, more recently it has been increasingly evident that there are a number of factors that might make a context more conducive to change (e.g. Iles and Sutherland, 2001; McCormack et al., 2002). In this sense, context has been found to be a potentially powerful mediator of the successful implementation of evidence into practice. Both hard factors, such as resources, and soft factors, such as leadership and teamwork, seem to play a potential role. For example, Sheldon et al.'s (2004) national guideline implementation evaluation found that healthcare organisations that had a culture of consensus, financial stability and strong governance functions were more likely to adopt national guidance, than those

without these features. Capacities such as organisational learning, knowledge management and communities of practice (Nutley and Davies, 2001; Nutley et al., 2003; Gabbay et al., 2003) may be the key to sustained and ongoing change, and therefore would seem important to developing the potential of evidence-based practice because they create 'knowledge pull'. The challenge however is to create organisations with these capacities; a particularly onerous challenge with the other political constraints that healthcare organisations operate within.

Facilitation Change agent roles appear in different guises and with different labels, for example educational outreach, academic detailing, facilitation and knowledge brokers. Roles such as facilitators have the potential to work with individuals and teams to articulate issues (e.g. about 'the evidence'), develop critical thinking and reflection skills, develop conducive contexts and enable the development and implementation of strategies that acknowledge and incorporate the many factors at play (Locock et al., 2001; Harvey et al., 2002; Greenhalgh et al., 2004). As such they have contact with a number of different interfaces making the potential of these roles in implementation significant. These roles however are only just beginning to be understood in more detail and to what effect; as such the research agenda is significant.

In summary, the existing gap between evidence and best practice might be reduced if resources were invested in better understanding the complexities of implementing the burgeoning evidence base and in helping and enabling practitioners with this undertaking. This will require joined up policy-making — that is, investing in understanding the links between the issuing of guidance (e.g. in the form of clinical guidelines) and its use in practice; finding ways to improve the absorptive capacity of service organisations for new knowledge; realising the potential of knowledge management, and investing in work that adds to the evidence-base about what are the most effective (including cost-effective) implementation strategies.

Concluding remarks

Over the last decade, evidence-based practice has evolved as the dominant theme of practice, policy, management and education within health services across the developed world. The aim of this paper has been to summarise and dissect some of the issues and challenges this agenda presents by considering the political origins and resultant evolution of the evidence-based movements. Arguably this broad overview has raised more questions than it has answered, but one of the intended contributions of the paper is to encourage discussion and debate. A critical and questioning stance has been taken, not because the worth of using (good-quality) evidence in practice to improve patient outcomes is not recognised, but in response to what has often been an uncritical adoption of it as a doctrine. For nursing, whilst there are some critical and dissenting voices, appears to be a fully signed up member of the evidence-based movement. If there is a desire (which it is believed there is) to improve the evidence base and increase its influence on policy and practice, a number of important issues need to be tackled. These include:

- Coming to some agreement as to what constitutes legitimate evidence. There is a need to acknowledge the relevance and to value different types of evidence for making decisions about individual patient care and also for policy development.

Whilst the quantitative versus qualitative research debate has become sterile, it remains alive and well in evidence hierarchies. Therefore a policy stance that recognises the fact that some questions relevant to the delivery of patient care require experimentation whilst others do not or are not amenable, would be helpful. Additionally there needs to be greater clarity about the concepts and definitions being used in the literature to describe evidence-based practice-related activity.

- A greater emphasis on implementation. Politically, there has been an emphasis on evidence generation and synthesis and thus a relative neglect of the implementation. Recognising that implementation is not just an individual practitioner issue but one that also encompasses a variety of factors will be key.
- Acknowledging the complexities of getting evidence into practice. Few studies take into account these complexities. In fact, there appears to be an increasing call for more experimentation, which potentially would lead to the stripping away of 'confounders'. Herein lies the paradox; context and confounders lie at the heart of evidence implementation. They are not extraneous to the object of study; they are an integral part of it. The multiple (and often unpredictable) interactions that arise in particular contexts are precisely what determine the success or failure of the implementation efforts.
- Maximising both pre-qualification and post-qualification education opportunities. It will be important to not only develop people's skills in accessing and evaluating evidence into practice, but to also pay attention to its application to practice. There is also a need to develop practitioners who are critical thinkers and reflective practitioners; there first needs to be questioning of practice to realise there might be a dissonance between current practice and what best practice might/ought to be.
- How to engage the unqualified workforce in the evidence-based practice agenda. There is a pressure to find a way to tune in the largely unqualified workforce, particularly in nursing, to the requirements of evidence-based practice. It may be unrealistic to expect these personnel to aspire to the vision in the same way as qualified nurses, however given they are, and as increasingly in the future they will be delivering the majority of individual patient care, this is a real challenge, but one that requires urgent attention.

In realising the potential of evidence-based practice, there are many challenges ahead, but there are also important lessons to learn from its history and evolution. The real importance of the evidence-based movements is that they symbolise a cultural shift in professional practice and development. This shift is likely to continue in one guise or another for some time to come. This being the case, the issues raised in this paper need to be debated and addressed sooner rather than later.

Key points

- Evidence-based practice has become a policy imperative, but it is also one that health care seems to have broadly, although not exclusively, embraced. However, despite the apparent engagement with evidence-based approaches to care, there remain a number of key areas that stimulate discussion and warrant debate.

- Evidence-based practice offers a mechanism for pushing maximally effective care and of discarding ineffective practices and techniques, thereby making cost-savings. This political context sets the co-ordinates for what constitutes evidence. A key underlying assumption is that not all evidence is equivalent.
- The meaning of 'evidence' is problematic; not just for nursing, but for health care more generally. Broadly there are two camps regarding what constitutes evidence for evidence-based practice; one that argues for a broader evidence base and the other that urges a restriction of the term evidence to mean research findings.
- There is evidence to suggest that evidence is not static, but characterised by its emergent and provisional nature. This means that clinicians need to particularise (research-based) recommendations to the patient and context.
- Politically the focus has been on evidence synthesis. The consequences of this approach to promoting evidence-based practice has meant that there has been a neglect of the process(es) of implementation and thus a continued gap between evidence and practice.
- A number of challenges remain if the potential of evidence-based practice is to be realised, including: coming to some agreement as to what constitutes legitimate evidence, a greater political emphasis on implementation, maximising both pre-qualification and post-qualification education opportunities, and how to engage the unqualified workforce in the evidence-based practice agenda.

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The politics of the evidence-based practice movements

Legacies and current challenges

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It's always a pleasure, and often a relief, to read a well-considered, perceptive and even-handed article about the rise of evidence-based practice (EBP) within medicine and other health and social care professions. For some writers, the movement has touched raw nerves and given rise to unbalanced and scathing retorts. Its associations, both real and imagined, with medicine, 'positivism' and reductionist science have sometimes stimulated a response that nursing is beyond the reach of such positive evidence because it has an irreducible caring essence. The promoters of EBP, on the other hand, sometimes seem to underestimate the complexity and pragmatic character of care delivery in complex organisations which make up the health services of most developed countries. This is not to mention the largely unstudied influence of the unconscious on healthcare activity and what we simplistically refer to as 'decision-making'.

The authors of this paper usefully place the rise of the EB movements into a political and policy context. In the UK, evidence-based medicine (EBM) rose as part of the emergence of R&D in the health service in the early 1990s. Though still controversial in medicine, nursing embraced its principles, at least at a professional level. However, to say that nursing has 'embraced its principles' or that it has 'been adopted by nurses' does little to help us understand the complexity and contradictory character of any given group of nurses' responses to it. And as the authors point out, this 'it' has been presented differently in different contexts. I wonder whether, quite apart from anyone's intention, EBP has become, like nursing models and the nursing process before it, a signifier to a concept like 'the moral imperative of rational progress' that can function as an ever-present opportunity for nurses to be described as failing in implementation. Nursing journals over the years seem to have featured a stream of articles aiming to show nurses failing to measure up to something, sometimes because doctors or managers stop them and sometimes because of personal moral failure.

The problems of evidence, implementation, decision-making and change within organisations have been well articulated by now. For those not familiar with such literature, this paper provides an essential and readable summary.