EVIDENCE-BASED PRACTICE FORUM

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Challenging the Rhetoric and Reality: Only an Individual and Systemic Approach Will Work for Evidence-Based Occupational Therapy

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During the last decade the evidence-based movement has spread around the world. This is a remarkable achievement. The potential positive impact of evidence-based practice and policy making is unquestionable, particularly on the quality of health care. This is for two prime reasons. First, evidence-based practice supports the ethical imperative to “do no harm.” There is now an increased probability that individuals will receive health care that benefits them with greater protection from harmful interventions (Smith, Ebrahim, & Frankel, 2001). The second reason is related to the need to know what works, whether at the level of specific interventions, care packages, or whole services. This means that there is an equal imperative to generate robust research of clinical and cost-effectiveness.

Yet, there has been much deliberation within this forum, and elsewhere, about the rhetoric and reality of evidence-based practice. The debate has focused upon methodological and pragmatic factors (Ballinger & Wiles, 2001; Christiansen & Lou, 2001). For example, one debate has been about whether systematic reviews and meta-analyses of randomised controlled trials, which give the numbers needed to treat or harm or both, can enhance the clinical reasoning process when working with people with complex, enduring health problems and occupational needs. There is also the task of persuading health care professionals to change their treatment approaches and use research to confirm or refute their routine practice. In this paper I hope to extend the debate by introducing a dualistic approach to evidence-based practice. This dualism involves placing the traditional, individual practitioner-focused strategies within an organizational framework of service improvement. I will argue that a twin focus upon individuals and the whole system is necessary if evidence-based occupational therapy is to become a reality.

The National Health Service (NHS) in England provides a model of how evidence-based practice has evolved. During the last few years there has been a significant shift from individual approaches towards a whole system of service improvement across primary, secondary, and community care. I will describe the key features of each approach—individual and systemic—and provide examples from the current quality assurance framework (as shown in Figure 1) to illustrate the system of setting, supporting, and monitoring national standards of care. I am sure that other countries may learn lessons from our experience in England.

Traditional, Individual Approach to Evidence-Based Practice

An individual practitioner approach is embedded in the definitions of evidence-based medicine and practice (Bury & Mead, 1998; Sackett, Rosenberg, & Gray, 1996). All definitions focus upon the triumvirate of (a) clinical expertise, (b) the best available evidence from systematic research, and (c) the consent of the person concerned when making decisions about the care of a patient.

Practitioners are expected to take a step-by-step approach towards meeting the goal of evidence-based practice. A five-stage process is usually described (Bury & Mead, 1998; Hammell, 2001; Straus & Sackett, 1998):

• Defining the question from the perspective of the patient or overall service delivery. Question formulation involves specifying the problem, the intervention, and the outcome
• Searching the literature for the most robust, current, and relevant research
• Critically appraising the validity and usefulness of the evidence
• Applying the research findings by integrating this evidence with clinical expertise while respecting the wishes of the patient and their carers
• Evaluating the impact upon the service in relation to indicators such as value for money, the effectiveness in meeting the health needs of the patient, and the performance of the practitioner

In England there are many resources to assist individuals as they tackle each stage of the process. These range from Effective Health Care bulletins produced by the NHS Centre for Reviews and Dissemination (NHS CRD) to Critical Appraisal Skills Programmes (CASP) which teach commissioners and practitioners to find and understand research papers. The NHS CRD is an example of an infrastructure that supports decision makers. This organization was established in January 1994 and is funded by the NHS Executive and the Health Departments of Wales and Northern Ireland. The aim is to provide the National Health Service with important information on the effectiveness of treat-
ments and the delivery and organization of health care. The NHS CRD does this by conducting and disseminating systematic reviews about health care interventions via the Effective Health Care bulletins. The NHS CRD also maintains online databases that contain abstracts of quality assured systematic reviews and economic evaluations of health care. All these resources are freely accessible via the NHS Centre for Reviews and Dissemination Web site at the University of York: http://www.york.ac.uk/inst/crd/welcome.htm.

Interestingly, even though such resources are readily available, they do not really transform the rhetoric of evidence-based practice. Studies undertaken in different countries with a variety of health care professions reveal a similar set of practical problems. The barriers to implementing the five-stage process of evidence-based practice include:

- Lack of quick and easy access to resources such as librarians, libraries, and the Internet with the wealth of information such as online journals
- Limited time to read research findings within a busy working day
- The incomprehensible nature of research reports, especially difficulty understanding the terminology and statistics (Closs & Lewin, 1998; Karlsson & Tornquist, 2002; Law & Baum, 1998; Young, Glasziou, & Ward, 2002)

There is also increasing recognition of the different skills required for searching, appraising, and using evidence. Most practitioners need to be skilled at relating the evidence to particular patients. This involves explaining the risks and benefits of interventions and weighing the robustness of conflicting evidence (Woodcock, Greenley, & Barton, 2002).

The barriers become greater when an individual approach to evidence-based practice takes place within the work setting. Even when the best available evidence is known, organizational, and economic factors militate against professionals changing their established practice. In 1999 the NHS CRD published an Effective Health Care bulletin about getting evidence into practice. This bulletin contained a systematic review of different ways of disseminating research findings and strategies to change the behavior of health professionals. It concluded that “the naive assumption that when research information is made available it is somehow accessed by practitioners, appraised and then applied in practice is now largely discredited” (National Health Service Centre for Reviews and Dissemination [NHS CRD], 1999, p. 1). Behaviour change is complex: It requires a whole system approach. Such a systemic approach requires the health care organization to invest in a range of strategies to help individuals become evidence-based practitioners.

A Systemic Approach: The English National Health Service As an Example

Since the early 1990s, an increasingly synergistic relationship has developed between the provision of high quality health care, clinical effectiveness, and evidence-based practice. All three are such complex, evolving constructs that implementation demands a strategic, organizational approach. Clinical effectiveness is defined as using specific clinical interventions that are known to work, whether for a particular patient or population, in the real-life situation so as to gain the greatest possible health gain within available resources (National Health Service Executive, 1996). Clinical effectiveness is therefore embedded within a system that supports high quality services. Such a whole system approach takes account of the constituent parts. These are:

- Research as the prerequisite for evidence-based practice. Research encompasses primary studies using quantitative–qualitative methods or secondary research such as systematic reviews and meta-analyses
- Service standards, clinical guidelines, care pathways, and patient information as mechanisms for incorporating the best available evidence into routine practice
- Audits and benchmarks as systematic feedback about the extent to which the standards are being achieved, exceeded, or are unmet
- Outcome measures as variables sensitive to clinical change and the patient’s experience as well as those that evaluate organizational aspects such as efficiency, equity, value for money, and cost effectiveness

These elements are now apparent in a Framework for Quality in the NHS in England. Figure 1 shows the range of organizations that are setting and monitoring standards (Department of Health, 2002, p. 54). It is an inclusive framework in that it is multi-disciplinary and multi-agency. All personnel, whether employed by statutory, private, or voluntary agencies, are expected to adhere to national, evidence-based quality standards that focus upon the patient experience.

The Framework for Quality means that the Department of Health sets standards for the organization of services for common diseases such as diabetes and coronary heart disease in the National Service Frameworks.

The National Institute for Clinical Excellence produces rigorously researched appraisals of health technologies and clinical guidelines for specific interventions. The standards are then implemented by organizations responsible for delivering health care to a discrete, local population. Each organization is expected to operate in accordance with national guidelines for corporate, clinical, and research governance. Clinical governance describes the policies, systems, and processes used by an organization to ensure delivery of high quality patient care. Local organizations also support the continued competence of their workforce though initiatives such as lifelong learning so that staff are able to meet the requirements of licence to practice. Finally, there are strong mechanisms for assessing local performance against these national standards. This is through inspections, visits, audits and confidential inquiries, patient and staff surveys, and the publication of NHS performance indicators. The media usually present the latter as league tables that rank the best to the worst performing organizations against a set of national indicators. Thus, there is a transparent, centrally controlled mechanism for service improvement that is accountable to politicians and the public. It is interesting to note that other countries in Europe and beyond have instituted national policies and reviews of quality (Shaw, 2002).

Occupational therapists are contributing to the development and implementation of this Framework for Quality. For example, a representative of the British
Many occupational therapists work with older people. In England during 2000-2001, 210 per 1,000 women aged 85 and over had an initial contact with an occupational therapist (Department of Health, 2001a, p. 7). The contribution of occupational therapy in relation to early and continuing rehabilitation, supported discharge, and the prevention of falls is acknowledged in the National Service Framework for Older People (Department of Health, 2001b).

During 2001–2002, the Commission for Health Improvement conducted and published 102 clinical governance reviews (Commission for Health Improvement, 2002, p. 5). The reviews evaluate the health care organization's capacity to provide patient focused care in relation to seven areas of performance. The areas are: consultation and patient involvement, clinical audit, clinical risk management, research and effectiveness, staffing and staff management, education, training and continued professional and personal development, and use of information to support clinical governance and health care delivery.

The clinical governance review teams comprise lay members, doctors, nurses, senior health managers, and allied health professionals, such as occupational therapists.

I hope that these examples convey how the Framework for Quality is being implemented in England. Readers are encouraged to explore the Web sites in the reference section for more details so they may evaluate my assertions about the complementarity of individual and organizational approaches.

The Future is a Dualistic Approach to Evidence-Based Practice

In the United Kingdom, the government “is committed to enhancing the contribution of research to health and social care, and to the partnership between services and science. [It recognises that] research is essential to the successful promotion and protection of health and well-being and to modern and effective health and social care services” (Department of Health, 2001c, p. 3). A Framework for Quality with national bodies setting and monitoring the delivery of standards within local health communities has been established. The framework works to ensure that there is a synergy between initiatives related to clinical effectiveness, evidence-based practice, quality services, and a skilled workforce. This whole system approach includes commissioning, disseminating, and implementing the results of primary and secondary research via programs related to national research priorities identified in the National Service Frameworks.

In my opinion, such a framework is essential if the aspirations of evidence-based practice and policy making are to become reality. A surfeit of evidence seems to indicate that the traditional, individual approach is not feasible alone; there are just too many barriers. Organizational and cultural change requires a systemic approach to make a difference. Investment in a whole system of service improvement is required if practitioners are to be properly supported. The Framework for Quality in the National Health Service in England (see Figure 1) embodies the strategic thinking and systemic action necessary to make evidence-based practice attainable.

I believe that occupational therapy must be positioned to influence this agenda so that our interventions and services are evaluated within this strategic framework. Practitioners must also be able to use the best available evidence to enhance their contribution along the patient's journey through the health care system. This is the...
dualistic approach. Organizations and individuals share the risks, resources, and responsibilities, while patients and their carers benefit because they are the recipients of safer, more effective interventions.

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References