

Informed Practice and Policy: Challenges and Opportunities*

by
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Overview

Our ethical obligations to clients call on us to make informed decisions and to make best efforts to minimize avoidable suffering in a context of limited resources, clashing values, and rampant propaganda in the helping professions including inflated claims about "what we know" and "what we do not know." How can we do this? What are the obstacles? What promising developments can help us to address these obstacles? These questions are at the heart of this presentation. Toward their exploration, four related questions arise:

1. What are we now doing?
2. What should we be doing?
3. How can we close the gap between what we do and what we should do?
4. What norms of discourse (talking and writing) contribute to finding answers (e.g., welcoming critical questions)?

Views and innovations that address these questions are discussed including involving clients and potential clients in all phases of making practice and policy decisions.

Our ethical obligations to clients provide a guide for selection of practices and policies. They include beneficence, avoiding harm, informed consent (autonomy and self-determination), and social justice (e.g., equity). We are obligated to try to minimize avoidable miseries and maximize equitable distribution of scarce resources, attending to various kinds of costs, while dealing with clashing values and misinformation in the media as well as in professional sources, promoted in part by the biomedical industrial complex (Gambrill, 2010a; Moncrieff, 2008; Rapley, Moncrieff, & Dillon, 2011). Our ethical obligations suggest directions to make informed (in contrast to uninformed or misinformed) decisions.

What Are We Doing?

Exactly what services do we now offer in relation to what problems and hoped-for outcomes? Are problems clearly described as well as their outcomes? Are related reports clear or do they suffer from what Combs and Nimmo (1993) describe as palaver – extended, often confusing messages designed to create credibility rather than to accurately inform readers about what is done to what effect (and what is not). Do we know how many people we have helped or harmed regarding each service? What problems and related valued outcomes are ignored? There are wide variations in practices and

* Prepared for Colloquium, April 12, 2012, Institut national d'excellence en santé et en services sociaux, Montreal, Quebec Canada. Portions of this paper are from Gambrill, E. (2010), Evidence-based practice and the ethics of discretion. *J. of Social Work*, 11, 26-48; and Gambrill, E. (2010), Evidence-based practice: Antidote to propaganda in the helping professions? *Research on Social Work Practice*, 20, 302-320.

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policies. Are they all equally effective? Do some do more harm than good? Gray (2001) suggests that current service patterns have the following characteristics:

- “overenthusiastic adoption of interventions of [unknown] efficacy or even [demonstrated] ineffectiveness;
- failure to adopt interventions that do more good than harm at a reasonable cost;
- continuing to offer interventions demonstrated to be ineffective;
- adoption of interventions without adequate preparation (such that the benefits demonstrated in a research setting cannot be reproduced in the ordinary service setting);

What Should We Be Doing?

How well do our current choices of practices and policies reflect client/consumer interests and related theory and research findings? Do we take advantage of available knowledge and ignorance to fulfill our ethical obligations, for example to involve clients as informed participants and to pursue answers to important questions? How many physicians inform patients about their absolute risk of an outcome in contrast to providing information only about relative risk which is highly misleading (e.g., see Gigerenzer, 2002; Paling, 2006). What are the gaps between what we do and what we should be doing?

Obstacles

The helping professions are big businesses, especially in countries without a National Health Service. Conflicts of interest abound as evidenced by exposure of conflicts of interest between academic researchers and Big Pharma. Professionals as well as clients are often bamboozled by false claims in professional journals and textbooks as well as in the media about what is helpful and what is not. Ionidis (2005) argues that most published research findings are false. Propaganda in the helping professions is a key obstacle to meeting ethical obligations to clients/consumers. Propaganda is defined as encouraging beliefs and action with the least thought possible (Ellul, 1965). The major kind of propaganda in the helping profession consists of inflated claims of knowledge: (a) claims regarding the effectiveness of certain products and services, including assessment methods; (b) claims about what is a problem or risk; (c) claims about alleged causes of concerns; (d) claims about the competence of professionals; and (e) claims regarding what certain research methods can or cannot test. We may be informed only about relative risk of an outcome which is highly misleading (see Gigerenzer, 2002; Paling, 2006). Inflated claims of knowledge (or ignorance) on the part of researchers are passed on to gullible educators and students who then act on these bogus claims. We live in a sea of propaganda pitches, including propaganda in the helping professions and related industries such as big pharma (the pharmaceutical industry), biotech companies, the psychological assessment industry, and the health insurance industry (Gambrill, 2012a). Propaganda promoted by pharmaceutical companies has become so prevalent and conflicts of interests between academic researchers and such companies so huge, that a vigorous backlash is now in progress.

Organizational cultures may discourage rather than welcome critical appraisal (Bogenschneider & Corbett, 2010). Uncertainties abound. Uncertainties include the natural course of behavior, whether certain interventions will be successful, and whether they will be implemented with fidelity. Clients may not know what they want. We are vulnerable to a variety of cognitive biases that may lead us astray such as confirmation biases and hindsight bias (Gambrill, 2012b). We overestimate our competencies and are subject to wishful thinking. We are gullible and easy prey for propaganda pitches as illustrated by the spectacular success of the medicalization of hundreds of problems-in-

living as mental illnesses and promotion of drugs as a remedy (Gambrill, 2012a; Rapley, et al., 2011). If a report of research includes a picture of a brain, we are more likely to believe the article reports accurate findings (McCabe & Castel, 2008). Policy making is a very complex process requiring consideration of many different kinds of evidence (Davies, 2004). Hindrances suggested by state legislators and administrators to evidence-informed policymaking “included institutional features; characteristics of the evidence supply, such as research quantity, quality, accessibility, and usability; and competing sources of influence, such as interest groups” (Jewell & Bero, 2008).

Opportunities

There are many promising developments designed to decrease concerning gaps between what we do and what we should do, some of which continue to be ignored. For example the process and philosophy of evidence-based practice as described by its originators is typically ignored or misrepresented. Facilitators to the use of evidence include “linking research to concrete impacts, costs, benefits; reframing policy issues to fit the research; training to use evidence-based skills; and developing research venues and collaborative relationships in order to generate relevant evidence” (Jewell & Bero, 2008.).

Draw on EBP as Described by Its Originators

The process and philosophy of EBP is designed to forward effective use of professional judgment in integrating information regarding each client’s unique characteristics, circumstances, preferences, and actions, and external research findings, attending to application, evidentiary and ethical concerns. It is designed to decrease the gaps between research and practice in order to maximize opportunities to help clients and avoid harm. It is a guide for thinking about how decisions should be made. It is a way to handle uncertainty in an honest and informed manner, sharing ignorance as well as knowledge (Chalmers, 2003). Evidence-based health care refers to use of best current knowledge and decision making about groups and populations (Gray, 2001). It is assumed that professionals often need information to make important decisions, for example, concerning risks a child confronts in his home or what programs are most likely to decrease domestic violence.

A key reason for the creation of the process and philosophy of EBP was the discovery of gaps showing that professionals were not acting systematically or promptly on research findings. There were wide variations in practices related to the same hoped-for outcomes. There was a failure to start services that work and to stop services that do not work or that harm clients. Yet another origin was increased recognition of the flawed nature of traditional means of knowledge dissemination such as continuing education programs, textbooks, editorials, and peer review. In place of critical, systematic reviews of research we often find haphazard reviews which do not inform readers how authors searched, where they searched, what criteria they used to review studies and do not include a search for unpublished as well as published reports. Conclusions drawn based on uncritical reviews are often misleading. Those who take part in the preparation of guidelines often have ties to pharmaceutical companies.

EBP “requires the integration of the best research evidence with our clinical expertise and our [clients’] unique values and circumstances” (Straus, Richardson, Glasziou, & Haynes, 2005, p. 1). Clinical expertise is drawn on to integrate information from various sources. Clinical expertise includes use of effective relationship skills which have been found to be integral to achieving positive outcomes (e.g., Wampold, 2010). A unique process is suggested to help practitioners to integrate multiple sources of information and handle uncertainties:

- 1) converting information needs related to practice decisions into well-structured questions;

- 2) tracking down with maximum efficiency, the best evidence with which to answer them,
- 3) critically appraising that evidence for its validity (closeness to the truth), impact (size of effect) and applicability (usefulness in practice);
- 4) integrating this critical appraisal with clinical expertise and with our client's unique characteristics and circumstances. This involves deciding whether evidence found (if any) applies to the decision at hand (e. g., is a client similar to those studied? Is there access to services described?) and considering client values and preferences in making decisions as well as other application concerns;
- 5) evaluating our effectiveness and efficiency in carrying out steps 1-4 and seeking ways to improve them in the future (Straus, et al., 2005, pp. 3-4).

Many different kinds of questions arise in practice as clearly noted in original sources. These may concern effectiveness, prevention, risk-prognosis, description, assessment, harm, cost-benefit, and self-development. Different questions require different research methods to critically appraise proposed assumptions as reflected in the use of different "quality filters" to search for and appraise related research (Straus et al., 2005). Original publications concerning EBP emphasize the close connection between evidentiary and ethical issues and describe a unique five-step process, related tools, and systemic requirements designed to help practitioners to honor this connection in every-day practice (e. g., Sackett et al., 1997). Evidentiary status refers to the extent to which knowledge claims have been subjected to critical testing and to what effect. Related material emphasized the importance of giving practitioners the tools needed to make informed decisions in real-time, considering research concerning clients' concerns as well as other vital information such as local resources. Tools were developed to facilitate timely successful completion of these different steps.

Original publications describe a small group teaching method designed to equip professionals with the skills needed to integrate ethical, evidentiary, and application concerns in which students learn in small groups under the guidance of a trained tutor and all learning concerns problems that confront individual clients. This provides repeated practice opportunities to integrate information from many different sources. Many components of EBP are designed to minimize biases, such as "jumping to conclusions," for example, by reviewing research findings related to practice and policy questions. There is a philosophy of technology (e. g., we have an obligation to design tools to help busy practitioners to integrate clinical expertise and external research findings by developing related user-friendly technologies such as the systematic review and the Campbell and Cochrane Databases), that we should critically appraise the technologies that we promote and that we have an obligation to increase clinicians' access to technologies that help them to help their clients in real time, drawing on external research. There is a philosophy of knowledge (e. g., that we should rigorously test assumptions and be transparent in terms of what is done to what effect), and, there is a philosophy of ethics. EBP involves searching for research related to important decisions and sharing what is found, including nothing, with clients. It involves a search not only for knowledge but also for ignorance. Such a search is required to involve clients as informed participants whether this concerns a screening test for depression or an intervention for depression. The process and philosophy of EBP as described by its originators is designed to weed out bogus claims and involve all interested parties as informed consumers.

Other Views of Evidence-Based Practice

Although descriptions of the original vision of the process and philosophy are widely available, this is often, if not typically, ignored (e. g., see Gambrill, 2010a; Gibbs & Gambrill, 2002). In the EBPs approach, researchers and/or administrators decide what practices are "best practices" and "tell"

practitioners what to do. The effectiveness of certain interventions is decided on by some authority, such as the American Psychological Association, and then practitioners are urged to use these “empirically established treatments.” (See Norcross et al., 2006.) Making decisions about individual clients is much more complex which is clearly reflected in the process of EBP described in original sources. There are many other considerations such as the need to consider the unique circumstances and characteristics of each client including their values and preferences and local resources. Indeed, there is a spirited debate regarding the value of practice guidelines and treatment manuals and obstacles to their use such as clients with multiple concerns. Wampold (2010) argues that specific interventions contribute little to positive outcomes, compared to the helping relationship and the person of the therapist.

Perhaps the most popular choice has been propagandistic – using the term EBP as a slogan. Examples include redubbing unrigorous, narrative reviews of research as “evidence-based” (e.g., see Littell, 2008). (See also Gorman, & Huber, 2009).

Harvest Questions that Arise at the “Coal Face” and Use Them to Set Research Priorities

Do we know what questions arise in the everyday encounters between professionals and those they hope to help? We should harvest these to identify questions that arise often but remain unanswered.

Draw on Internet Resources

A continually evolving literature is available describing related tools and guidelines as well as obstacles. The invention of the Internet and related tools is integral to the process of EBP as illustrated by the Cochrane and Campbell Collaborations and the many other sources now available (e.g., Equator, netting the evidence, TRIP, Bandolier, How to Read a paper, DUETs, Medscape, PsychInfo). See also resources such as healthy skepticism, www.ahrp.org and Pharmedout.org. The purpose of the Cochrane and Campbell Collaborations is to prepare, distribute, and maintain high-quality systematic reviews related to specific practice and policy questions. The invention of the systematic review and the creation of the Cochrane and Campbell Collaboration databases of systematic reviews were designed to help busy clinicians to find answers to specific clinical questions that arise in their daily work. The Cochrane and Campbell Collaborations are world-wide enterprises that facilitate the preparation, dissemination and maintenance of high-quality research reviews related to specific practice and policy questions. The conclusions of systematic reviews often differ from those in haphazard reviews which do not control for as many biases.

Involve Clients/Consumers

Clients and consumers should be involved in all stages of practice and policy including planning of research (see Hanley et al., 2001). Clients are involved in EBP and related developments in many ways (Gambrill, 2006). A valuable literature describing decision aids is available (e.g., O’Conner et al., 2009). (See also Coulter & Collins, 2011.) Teaching clients to offer peer led intervention is empowering (e.g., Day et al., 2010).

Hone Critical Thinking Skills

We can hone our critical thinking skills (Gambrill, 2012b) and related values that encourage their use. Consider values described by Paul and Elder (2002).

- Courage: Critically appraise claims regardless of negative reactions.
- Curiosity: An interest in deep understanding and learning.
- Intellectual empathy: Accurately understanding and presenting the views of others.
- Humility: Awareness of the limits of knowledge including our own; lack of arrogance such as promoting bogus claims of effectiveness.
- Integrity: Honoring the same standards of evidence to which we hold others.
- Persistence: Willingness to struggle with confusion and unsettled questions

For some related websites see www.criticalthinking.org, skeptics dictionary, fallacyfiles.com, www.criticalthinkrx.org, Carl Sagan's Baloney Detection Kit.

Agree on and Follow Norms of Discourse that Contribute to Finding Answers

As Walton (2008) argues, critical questions are never out of order when the goal of a discussion is to arrive at the truth. It is vital to develop cultures in which hard questions are welcomed such as "Is there any evidence that the services we offer do more good than harm?" "Does imposing practice guidelines on staff diminish quality of services by forcing staff to ignore important individual differences in clients and/or local circumstances?" "How are problems framed?" "Have problems-in-living been medicalized?" We can draw on Gricean maximums to decrease self-propaganda as well as to avoid propagandizing others:

Maxim of Quantity; (a) Make your contribution to the conversation as informative as necessary. (b) Do not make your contribution more informative than necessary.

Maxim of Quality: (a) Do not say what you believe to be false. (b) Do not promote that for which you lack adequate evidence.

Maxim of Relevance: Be relevant (i. e, say things related to the current topic of the conversation).

Maxim of Manner: (a) Avoid obscurity of expression. (b) Avoid ambiguity. (c) Be brief (avoid unnecessary wordiness). (d) Be orderly.

Take Advantages of Literature On Problem Solving And Decision Making.

There is an extensive literature on decision making, problem solving and judgement that we can draw on in understanding opportunities to exercise discretion wisely and ethically. This literature describes opportunities as well as obstacles to making informed decisions. The carving out of ignorance as an area of study as vital as the study of knowledge is a promising trend (Proctor & Schiebinger, 2008). There are inflated claims of ignorance just as there are inflated claims of knowledge. The hiding of harming in the name of helping stands out as a key kind of avoidable ignorance in the helping professions.

In Conclusion

There are many opportunities to increase the percentage of decisions that contribute to minimizing avoidable miseries and enhancing the quality of life for clients. Our ethical obligations provide a path ahead; they encourage us to welcome clients as partners in our quest.

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