From Research Evidence to ‘Evidence by Proxy’?

Organisational Enactment of Evidence-Based Healthcare in Four High-Income Countries

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Evolution of Evidence-Based Practice (EBP)

- Expansion of the notion of ‘evidence’
  - Different types of research, not just RCTs
  - Tacit experiential knowledge(s)
- Institutionalisation of evidence-based practice
  - Centralised production of clinical guidelines
  - Ubiquity of the EBP rhetoric as ‘the new orthodoxy’
- Spread of evidence-based practice across disciplines and countries
  - From medicine to other clinical professions and beyond
  - Internationally, as part of the New Public Management ideology
Research questions

- What forms of codified knowledge are seen as credible evidence?
- What is their impact on evidence-based nursing?
- How do the composition and impact of codified knowledge vary across different countries?
FLAME Project

- ‘Facilitators and Leaders Actively Mobilising Evidence’
- Exploratory study of nursing leadership and facilitation roles in 4 countries
  - Canada
  - Australia
  - Sweden
  - UK
- Up to two healthcare organisations per country
- 55 interviews with nursing managers and facilitators
‘I would imagine my staff, the way they would probably get the evidence is through our policies and procedures—would be 90 percent of how they get their evidence…’

(Nursing manager, Australia)

‘I trust the Trust. … You have to have faith and assurance in the departments that you are gaining that information from that they are using evidence-based guidelines… I wouldn’t know for definite unless I asked to look at their research.’

(Nursing manager, UK)
The chain of codified knowledge

International level
- Original research
- Clinical guidelines

National level
- Performance standards (including those specified by the National Quality Registries)

Provincial/regional level
- Policies and procedures

Organisational level
- Local data
- Clinical audit
- Quality improvement
Codified knowledge: cross-country influences

- Regulatory & performance management environment
  - National standards or registers: mandatory or not
  - Accreditation requirements
- History & time engaged in EBP
  - Supporting infrastructure
  - Culture, embeddedness
- Agency and roles
  - Designated facilitator-type roles
  - ‘Hard’ and ‘soft’ leadership
‘Evidence by proxy’

- Codified non-research knowledge that is, at best, informed by research evidence partly or indirectly but is nevertheless perceived as credible evidence

- Decision supports and other ‘bridging instruments’ replace research evidence rather than enable its uptake

Consequences:
- Over-reliance on ‘evidence by proxy’ leading to the detachment of frontline clinical staff from research evidence
- Clinical specialists, hybrid clinician-facilitators and quality improvement experts as ‘translators’ of research evidence
- Integration of locally collected forms of data, enabling bottom up improvement
Cross-country variability

- Two generic archetypes in relation to how the chain of codified knowledge is maintained:
  - Australia and UK: disciplinary power of standards and audit
  - Canada and Sweden: ‘soft power’ of designated facilitator roles

- Composition and circulation of codified knowledge is shaped by the ideological, historical and other macro-level factors
  - The degree to which the New Public Management paradigm is embedded