

COMMENTARY

COMMENTARY ON “STRATEGIES FOR REHABILITATION PROFESSIONALS TO MOVE EVIDENCE-BASED KNOWLEDGE INTO PRACTICE: A SYSTEMATIC REVIEW”

Why do people not always do the right thing, when it is quite clear what it is? This fundamental question (as every parent asks when their children cross the road without looking) is approached by Menon et al. (1). Similar thoughts enter the mind of the physician when the patient with an ischaemic stroke continues to smoke after discharge with full knowledge of the harm it causes. Since the Cochrane era began it has become even more obvious to the healthcare worker that what we assume is correct is not always the case. We have now entered the era of evidence-based medicine (EBM, a term first coined in 1992), which aims to apply the best available evidence gained from the scientific method to medical decision-making. This means that all of us who graduated before the millennium, have not received education on EBM as part of our training. EBM is, according to Sackett et al. (2), the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. One part of EBM deals with the practice of evidence-based medicine at the organizational or institutional level, which includes the production of guidelines, policy, and regulations leading to evidence-based healthcare. The other part of EBM deals with evidence-based individual decision-making (EBID), which is EBM as practiced by the individual healthcare professional.

A good deal of knowledge is available in Cochrane reports and guidelines. But do people actually practice evidence medicine? Ten years ago, approximately 50% of Canadian physicians used EBM often (3), and the most important barriers to increased use of EBM by practising clinicians appeared to be lack of knowledge and familiarity with the basic skills. An Italian study from this year (4) showed a lack of skills in EBM, rather than a lack of interest in the matter. So how do we teach EBM, and does knowledge of EBM have an impact on everyday practice? There have been some studies that examine knowledge transfer interventions for improving knowledge, attitudes, and practice behaviours of occupational therapists and physical therapists. The present paper (p. 1024–1032) is a systematic review of these efforts. The findings were that although knowledge transfer might increase knowledge of EBM, altering clinical practice is less easy. In the studies, physical therapists who had been the subject of different types of knowledge transfer of EBM were more likely to alter their practice. Occupational therapists who had received one type of knowledge transfer also increased their knowledge, but the physical therapists did not. Do the different professions interpret knowledge differently and should knowledge transfer be tailored differently? Is there a difference depending on what

type of knowledge is transferred (i.e. “professional knowledge” or “team-based knowledge”)? A recent qualitative study of physicians (4) identified that in making clinical decisions they more often rely on clinical experience, the opinions of colleagues and EBM summarizing electronic clinical resources than on referring directly to EBM literature. However, even if confidence in making decisions based on clinical experience increases over time, few physicians reported having systems for tracking their clinical experience in designing treatment plans and patient outcomes (5). Whether the use of databases in medicine in general, and in rehabilitation in particular, will yield a higher quality of care is not yet clear, even if this is advocated by health authorities as well as by accreditation organizations. Since EBM was coined at McGill, it seems appropriate that the developers (6) of the StrokEngine (<http://www.med.mcgill.ca/strokengine/>) from McGill, which aims to help healthcare professionals to find evidence, now try to understand how to make us do the right thing.

REFERENCES

1. Menon A, Korner-Bitensky N, Kastner M, McKibbon A, Straus S. Strategies for rehabilitation professionals to move evidence-based knowledge into practice: A systematic review. *J Rehabil Med* 2009; 41: 1024–1032.
2. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996; 312: 71–72.
3. McAlister FA, Graham I, Karr GW, Laupacis A. Evidence-based medicine and the practicing clinician. *J Gen Intern Med* 1999; 14: 236–242.
4. De Vito C, Nobile CG, Furnari G, Pavia M, De Giusti M, Angelillo IF, et al. Physicians' knowledge, attitudes and professional use of RCTs and meta-analyses: a cross-sectional survey. *Eur J Public Health* 2009; 19: 297–302.
5. Hay MC, Weisner TS, Subramanian S, Duan N, Niedzinski EJ, Kravitz RL. Harnessing experience: exploring the gap between evidence-based medicine and clinical practice. *J Eval Clin Pract* 2008; 14: 707–713.
6. Korner-Bitensky N, Roy MA, Teasell R, Kloda L, Storr C, Asseraf-Pasin L, et al. Creation and pilot testing of StrokEngine: A stroke rehabilitation intervention website for clinicians and families. *J Rehabil Med* 2008; 40: 329–333.

Submitted September 1, 2009; accepted September 14, 2009

Katharina S. Sunnerhagen, MD, PhD
From the Institute of Neuroscience and Physiology, Section
for Clinical Neuroscience and Rehabilitation, The
Sahlgrenska Academy, University of Gothenburg.
Gothenburg, Sweden. E-mail: ks.sunnerhagen@neuro.gu.se