Evidence-Based Practice: Ethical Questions for Nursing

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Evidence-based nursing practice is a global phenomenon, the purpose of which is to standardize and guide nursing practice based on exclusionary quantitative scientific inquiry. What are the origins of this standard terminology found in medicine, nursing, and other healthcare professions? What are the educational and ethical implications for evidence-based nursing practice from a nursing theoretical perspective? The author will begin a discussion of ethical questions for the discipline to consider as the evidence-based practice movement gains momentum in healthcare arenas worldwide.

The word *evidence* contains the Latin root *videre,* which means *to see.* Evidence-based practice (EBP) and synonymous cousin terms such as evidence-based medicine and evidence-based nursing practice reflect a very important global paradigm shift in how to see or view disciplinary healthcare outcomes, how it is taught, how practice is conducted, and how healthcare practices are evaluated for quality. A common thread that emerges with the terminology reflects a belief that healthcare professions are moving away from professional practices that have origins based on tradition. It is no longer acceptable for healthcare professionals to continue doing things the way they have always been done, without questioning whether or not that is a best approach. Instead, the healthcare professions are moving toward thinking that practice decisions *ought to be* made with the best available knowledge or evidence (Rubenfeld & Scheffer, 2006). What are the historical origins of EBP?

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Historical Overview of EBP

Most people give credit to Archie Cochrane, a British epidemiologist and medical researcher who contributed to the development of epidemiology as a science, and who in the 1970s saw a need to examine the economics of healthcare and determine the financial cost/benefit ratio of medical treatments for the purpose of cost containment of healthcare (Traynor, 2002). In 1993, Cochrane and others founded the Cochrane Collaboration that has become the center of the worldwide EBP movement in medicine. The Cochrane Collaboration is an international, non-profit, independent organization that focuses on interventions, precise and thorough library research searches, and evaluation of evidence, and considers the randomized controlled trial (RCT) as the gold standard of research evidence. The Cochrane Collaboration organization prepared the Cochrane Reviews and aims to update them regularly with the latest scientific empirical evidence. In prepared writings, members of the organization (mostly volunteers) state that they work together to provide *evidence* to help people make decisions about healthcare. Some people read the healthcare literature to find reports of randomized controlled trials; others find such reports by searching electronic databases; others prepare and update Cochrane Reviews based on the evidence found in these trials; others work to improve the methods used in Cochrane Reviews; others provide a vitally important consumer perspective; and others support the people doing these tasks. The Cochrane Collaboration website (www.cochrane.org) provides information on the purposes of the organization and promotes ways for lay persons, as well as healthcare professionals, to become directly involved.

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The term *evidence-based medicine* was coined in the 1980s. The McMaster Medical School in Hamilton, Ontario is generally credited with making this critical approach to medical education. Called the Evidence-Based Medicine Working Group, now called the Evidence-Based Clinical Practice Working Group, the McMaster approach heralded a movement away from valuing authority to valuing empirical research as a basis of learning (Sackett, Richardson, Rosenberg, & Haynes, 1997).

Meanwhile, in the early 1990s in the United States, the federal government committed federal monies to set up the Agency for Health Care Policy and Research (AHCPR) that established interdisciplinary teams to gather and assess available research literature and develop evidence-based clinical guidelines. Nurses were prominent members of these interdisciplinary teams who performed this early work. In the mid-1990s, AHCPR was changed to the Agency for Healthcare Research and Quality (AHRQ) and it now has a clearinghouse for clinical guidelines (http://www. guidelines.gov) and has established centers in the United States. In the last decade, many professional nurses and universities have joined the movement and ascribed to the thinking and valuing of empirical research as the only systematic method for obtaining evidence for improving outcomes in clinical practice.

The Discipline of Nursing and Evidence-Based Practice

Within the discipline of nursing, there has been greater emphasis placed on what has been coined *EBP*. Many nurse professionals have chosen to view the EBP movement as a systematic approach to determine the most current and relevant evidence upon which to base decisions about patient care (Melnyk & Fineout-Overholt, 2005). In an article by Brancato (2006), nurse educators have joined the bandwagon with assertions that "if evidence does not inform the nurse's clinical judgment, nursing practice can become rapidly outdated and patient care can ultimately suffer" (p. 195). Additionally, it was noted that because RNs in clinical practice report that their educational preparation for accessing and using EBP is lacking (Pravikoff et al., 2005; The Advisory Board Company, 2005), new educational initiatives must be directed toward integrating EBP into professional nursing education programs. Many nurse professionals in academia and other healthcare professionals (Inglehart, 2005) believe that EBP has the "potential to improve the quality of nursing services delivered and to make the services more affordable" (p. 5).

The Institute of Medicine (IOM) (2003) further envisioned and extended the definition of EBP as "the integration of best research evidence, clinical expertise, and patient values in making decisions about the care of individualized patients" (p. 56). It clarified the defining characteristics of *best research evidence* as quantitative evidence such as clinical trials and laboratory experiments, *evidence from qualitative research*, and *evidence from experts in practice*. The IOM specified that *clinical expertise* comes from knowledge and experience over time and *patient values* are those unique circumstances of each patient. In defining the characteristics for what constitutes evidence, the IOM (2003) did not limit the definition of evidence as findings only found in quantitative research methodologies and instead chose to include evidence emerging from findings in qualitative research designs and most importantly, clinical expertise is found when healthcare professionals take the time to elicit *patient values*. The IOM (2003) enumerated tasks that are considered essential to EBP and included such things as knowing where and how to find best evidence, formulating clinical practice questions, searching for answers to those questions with evidence, determining validity and appropriateness of the evidence for a specific patient population, and determining how and when to integrate new findings into clinical practice. It is very clear that the EBP movement is a global priority for the healthcare professions. What are some ethical considerations for the discipline of nursing when contemplating what defines the term *clinical evidence* and *outcomes for clinical practice*? What *should* and *ought* the leader in the discipline of nursing think about when considering joining and coparticipating with the bandwagon of the EBP movement?

The Ethics of Evidence-Based Practice in Nursing

Within the healthcare disciplines, a powerful evidence-based discourse is evolving with the publishing of specialized journals and best practice guidelines. These publications are popular in political arenas and proliferating to the extent that higher education programs in nursing and other healthcare disciplines are using these guidelines for the purposes of assessing outcomes of professional health science education and the practice of the discipline.

According to Holmes, Murray, Perron, and Rail (2006), as a global term, evidence-based health sciences (EBHS) means clinical practice that is based on scientific inquiry. If a healthcare professional performs an action, there should be evidence that the action will produce desired outcomes to patients as well as provide a means for ensuring healthcare cost containment. One of the purposes for the movement is to provide healthcare clinicians a resource library database for increasing access to what is believed to be valid research. The Cochrane database was established to provide this resource. The collection of research articles, however, has specific criteria in that it must be based on randomized control designs. All other research, which constitutes 98% of the literature, is deemed scientifically imperfect (Traynor, 2002).

Holmes and colleagues (2006) argued that at first glance, the EBHS movement appears to be beneficial, since a positive patient outcome is a primary healthcare objective. However, popular use of this rigid quantitative, positivistic approach is evolving into a situation whereby evidence-based health science is widely considered *the truth*. When only one method of knowledge production is promoted and validated, "the implication is the health sciences are gradually reduced to EBHS" (Holmes, p. 181). The legitimacy of health science

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knowledge that is not based on RCTs and quantitative research designs comes to be questioned, if not dismissed altogether, thus eliminating the philosophical possibilities of other ways of coming to know. This author believes such notions are unacceptable for the discipline of nursing. The healthcare disciplines must also responsibly question whether international, national, or state governments conveniently function as a means to utilize such randomized control research findings for the purposes of justification for making cuts to healthcare funding. Purposeful, engineered actions such as these may be ethically viewed as potentially *harmful* to humankind.

Healthcare disciplinary professionals, who are wedded to the notion of *evidence,* often reflect a worldview that is essentially Newtonian and mechanistic. Commonly held beliefs include notions that reality is objective, that it exists, and that it is somewhere *out there*, absolutely independent of the human observer, and of the observer's intentions and observations. They refer to facts and dismiss humanly lived *values* as unscientific. Reality is real and mechanical; a fixed set of objects, an empirical cause and effect relationship, where objective truth replaces personal and interpersonal significance and meaning. From a different nursing paradigmatic view, viewing persons and *evidence* in this way is dehumanizing, marginalizing, and discounts the innumerable ways of persons coming to know.

Human Becoming and Possible Meanings for Evidence

Parse's (1981, 1998) human becoming school of thought offers an alternative view for regarding what coconstitutes the meaning of the word *evidence* in the discipline of nursing. From this perspective, the discipline of nursing is both an art and a science. The art of human becoming is guided by philosophical assumptions, which include the belief that persons are indivisible, unpredictable, and ever-changing (Parse, 1998). Humans are intentional, free beings who actively participate in their life and choose ways of becoming. Health is cocreated with others while choosing ways of becoming in a personal commitment to living value priorities. Health is never objective, classified, or judged. Instead, it is described by the person who is living it, and can only be described by the person living it. Thus, the goal of nursing is health and quality of life from the healthcare recipient's perspective. It is not measured according to quantitative measures found in a biomedical paradigmatic model. From a human becoming perspective, *evidence in nursing practice* is the humanly lived experiences and descriptions of value priorities of health and quality of life, as seen through the eyes and lens of understanding of the person, family, and community who are living it from moment-to-moment. Health is quality of life, which as "the incarnation of lived experiences is the indivisible human's view on living moment-to-moment as the changing patterns of shifting perspectives weave the fabric of meaning through the human-universe interconnectedness" (Parse, 1994, p. 17). It is the author's view that humanly lived experiences for what is important in living health described by healthcare recipients in professional nursing practice through the nurse-person, nurse-family, and nurse-community interrelationships *ought and should be honored* as *evidence of values seen through the lens of understanding from those who are uniquely living the meanings of health and quality of life.* These descriptions and value priorities *should* be provided as documentation as *evidence* in healthcare documentation. The value priorities and documentation of *evidence* that is discussed here is congruent with the IOM's (2003) mandate for its extended definition for what constitutes EBP.

To say nursing is *evidence-based* misrepresents the nature of the discipline, which is a complex, intimate, and multidimensional process of interhuman relating. By choosing exclusively to focus on quantitative research methods and research findings found only in randomized clinical trials, persons are marginalized to the standard cookbook instructions for the *how to* of biomedical diagnoses and treatments for the masses. This reductionistic approach is intended to reduce costs and improve the quality of healthcare services, through streamlining what are traditionally considered to be best practices, yet they may serve as a possible means for the cocreation of *harm* instead.

Take, for example, the issue over the continued mounting of unintended medical errors that occur in healthcare institutions worldwide. It has been reported through public health researchers using quantitative research methods that only 10 to 20% of medication or other related types of errors are ever reported, and of those, 90 to 95% cause no harm to patients. Instead, the Institute for Healthcare Improvement (www.ihi.org) has reported that the *harm* that patients suffer, some of it due to errors, is mainly due to flawed systems within which highly-skilled providers operate. Thus, the real work for discovering and documenting *evidence* for improving upon and reducing the number of medical errors begins with the need to tackle such professional practice issues as the lived experiences of harm with healthcare recipients, the infrastructure redesign, and the need for questioning what are considered *best practice standards in healthcare institutions.* Questions arise over the possible definitions of harm and any relationships with accepted protocols, treatment complications, and standard assumptions about preventability. Are *any* complications acceptable? Such challenges for healthcare sciences offer unique opportunities to design healthcare research utilizing other qualitative research methods that promote listening to others' lived experiences, which create opportunities to reduce and possibly prevent unintended harm to those we serve.

Evidence: Saying What You Mean

Journeying with the EBP movement in nursing should be conducted carefully and with great caution. This movement operates hand-in-hand with powerful political structures that use similar scientific assertions with a dominant ideology that promises success for its scholars with grants, publications,

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awards, and recognitions so that others will join the movement wholeheartedly (Holmes et al., 2006). The EBP movement has a hierarchy that has been endorsed by many academic institutions, and that serves to "reproduce the exclusion of certain forms of knowledge production" (Holmes et al., p. 185). The regime enjoys a privileged status and there exists an embedded scientific and ethical obligation to "*speak truth to power"* (Holmes et al., p. 185). The evidence-based enterprise invented by the Cochrane group has captivated our disciplinary thinking, creating for itself an enchanting image that reaches out to our discipline's researchers and scholars. Holmes and colleagues (2006) proclaimed that it has done this

> in the name of efficiency, effectiveness, and convenience, where in the name of efficiency, effectiveness and convenience simplistically supplants all heterogeneous thinking with a singular and totalizing ideology . . . a profound sense of entitlement and a belief that there is a universal right to control the scientific agenda. (p. 185)

They insisted that the health sciences must resist this program of research that collapses words and things and thwarts invention. Paradoxically, it is hoped that an honest plurality of voices will open in the discipline of nursing with the freedom to choose and risk all-at-once that "which is the human condition, and that without which there could be no human action and no science worthy of the name" (Holmes et al., 2006, p. 185). Nurse scholars and researchers must rise up on this occasion to resist the tide of exclusionary methods and structures found in EBP and instead proclaim that the nature of nursing is a human science where persons are respected and honored for their lived experiences of health and quality of life. Healthcare and academic institutions leaders *ought to* honor, award, reward, and promote other scholars who conduct rigorous disciplinary theory-based, scientific quantitative and qualitative research methods and designs, where humanly lived experiences and conceptual findings are regarded as *evidence* with implications for nursing practice. Scholars, rise to this occasion!

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