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Perspective

Towards thirty years of evidence-based practice (I): A critical reflection on the healthcare outcomes.

Hacia treinta años de práctica basada en evidencia (I): una reflexión crítica sobre resultados de la atención en salud.

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A little more than five lustrums have passed since evidence-based practice, first under the name of evidence-based medicine, started to become a focus of attention with its own characteristics, actively promoted by those who believed that this approach could facilitate, in a rapidly changing world, the process of making the necessary changes to successfully face the challenges posed to health systems.[1]

Consequently, and despite mixed opinions derived from skepticism about the ability of this approach to provide effective solutions in daily practice, and some confusions related to its potential benefits to those systems,[2,3] its conceptual bases began to support the idea of a practice that, over the years, has led to various changes in educational, scientific, clinical, managerial and political fields in the global context.

If the emergence and evolution of evidence-based practice are carefully considered today, it is clear that its early adaptation to the purposes of other disciplinary areas in the vast field of health sciences, such as nursing or dentistry,[4-7] among many others, was not a result of snobbery but motivated by its transforming potential. However, beyond the motivations of the pioneers and the growing interest of health personnel, researchers, and other actors in this approach, various factors have prevented its generalization as a care-providing model.

One of them, of course, has been the multiple interests in this field,[8] which is among the most important ones in the world economy. But those interests are far from being the greatest barrier to the widespread employment of evidence-based practice.

Factors such as intradisciplinary tradition and culture have generated, in organizations and health systems, strong resistance to the introduction of new procedures of greater efficiency and effectiveness, which are even supported by solid evidence, and to the abandonment of practices that other results of robust research do not support.[9] Additionally, insufficient skill development, for the creation, discovery, evaluation, and application of evidence, among professionals with the willingness to fully integrate such an approach into their daily activities, is another negative issue.[10-12]

If these and other factors are taken into account, it is worth asking how much the healthcare outcomes have been improved as a result of the systematic use of evidence in practice at a global scale, and over these almost thirty years.

Answering this question is certainly not an easy task, mainly because the realities of the many national health systems, and even their disaggregated

levels, are very diverse in terms of professional, financial, and technological capabilities, among others.

However, although improvement seems to be apparent and widespread where the evidence-based approach has been applied, the persistence of the aforementioned personal barriers, and others of an organizational and systemic nature, has meant that the degree of their implementation it is relatively low, even more so when compared to the number of actors who consider it beneficial and have expressed their desire to use it.[9-11,13]

In fact, the real problem is not the quality of the results obtained when resorting to evidence-based practice for solving individual problems, since there are plenty of examples of the benefits of the adequate use of evidence for that purpose, and the negative consequences of neglecting its use due to *"expert"* opinions based on tradition.[1,9]

The question is how to go from improving the quality of individual interventions to improving the outcomes of general care in health systems thanks to the generalization of this approach.

Since the beginning of evidence-based practice, it has been emphasized that its widespread adoption depends largely on environments that promote its learning and use, and the experiences accumulated so far confirm this fact.

However, this requires macro policies in which not only do the respective government entities participate in the design, but also the direct care providers, health managers, information and knowledge managers, researchers, educators, university authorities, organized groups that give voice to and make the needs, interests, expectations, and concerns of users of health services visible, and even representatives of companies in key industries, such as pharmaceuticals and biomaterials.

All of them advised by experts in evidence-based practice who help identify the greatest obstacles to their implementation and find the best alternatives to overcome them.

The involvement of these and other actors is crucial since the exclusion of one of them could prevent the occurrence of the necessary changes so that the evidence-based practice contributes significantly to achieving a substantial improvement in the results of the care provided to the population.

For instance, if in the undergraduate and postgraduate university programs in health sciences of certain national scope, a set of mandatory skills common to all of them and directly related to evidence-based practice are not defined, hardly your health system will come to possess a sufficient number of organizations and networks in which its objectives derive from a language shared by professionals at all levels. This language refers to knowledge, skills, attitudes, and values required for the promotion, undertaking, and management of the creation, discovery, evaluation, and application activities of the aforementioned evidence.

Be that as it may, what can be seen in retrospect today regarding the adoption of evidence-based practice at a global level, beyond those differences between health systems, indicates that, in general, there have been no dramatic changes in the results of the care provided from the population perspective, which in no way can be attributed to the characteristics of that approach but to the aforementioned barriers.

Data on non-compliance with health goals support this statement,[14] such as some of those associated with the goals that until 2015 were known as the Millennium Development Goals. Therefore, obtaining better results at the population level, through the integration of evidence-based practice as the articulating axis of both activities in health centers and preventive interventions in communities, is still an ambitious goal to achieve.

And it should be the concern of all professionals involved in the provision of health services for many reasons, such as the fact that these better results would imply a substantial reduction in the costs of care by alleviating the general burden of disease, which would make their long-term provision more sustainable.

It has even been shown that these costs increase, with the same or worse results, when the way of trying to solve the same health problems is very varied due to the poor integration of evidence to the respective decision-making.[15] Something that in some way, the views of David Sackett and other pioneers of evidence-based practice had already hinted at, since behind them lies the idea that continued work guided by such an approach could bring enormous benefits to health systems, especially by a general increase in effectiveness as a result of higher quality clinical interventions and better prevention.[16,17]

A better understanding of this among the global community of actors related in one way or another to health care is, perhaps, the first and main task to be undertaken in terms of evidence-based practice.

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