What is evidence-based practice?

We have all heard the term ‘evidence-based practice’ and it trips off the tongue with ease, usually accompanied by a complaint that we do not have enough or good enough evidence in our profession. That may be true, but there is more out there than we suspect or make time to read, and do we know ‘good’ evidence when we see it? Future tutorials will cover searching for and critically appraising evidence.

Evidence-based practice has relevance to every strand of our work. Managers need evidence to strategically manage services and inform commissioners about the type of services they need to provide. Knowing what evidence underpins our practice helps assure quality and effectiveness. We aspire to base our assessment and intervention decisions on evidence. Speech and language therapy consultants, specialist clinicians and RCSLT advisers are up to date with the evidence in their specialist area, and can be a resource within services for managers, SLTs and other professions in the multidisciplinary team.

The RCSLT has a long-term commitment to EBP in professional practice. One strand of the RCSLT Research Strategy vision states: “Career pathways must place EBP at the centre of CPD and career progression. This culture of EBP will run through work-based activity, formal education, management of services and research, and will be vital for the progression of the profession and the delivery of the best care to service users.”

So what is EBP? Several authors give us definitions that help us to unpick the meaning and realise its relevance to us as SLTs.

“Evidence-based practice is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients, integrating individual clinical expertise with the best available external clinical evidence from systematic research.” (Sackett et al, 1996 p71). “…the integration of the best research evidence with our clinical expertise and our patient’s unique values and circumstances.” (Straus, et al, 2005 p1). “…the conscientious, explicit, and judicious integration of the best available: 1) external evidence from systematic research; 2) evidence internal to clinical practice, and; 3) evidence concerning the preferences of a fully-informed patient.” (Dollaghan, 2007 p2). From these we can distil three basic principles of EBP that have immediate relevance to all of us (figure one).

The knowledge and expertise of the clinician is fundamental because we have to investigate and appraise the evidence (whatever its source) so we can provide objective and balanced information for our client. The client brings their own values, beliefs, needs and knowledge. The best available external evidence may be a systematic review or a randomised control trial (the most robust evidence), or may be from an expert colleague or systematically collected outcome data from our own practice (the least robust evidence). Whatever the level of evidence, we should appraise it with the same rigour and objectivity.

Research and EBP form part of a virtuous circle we all contribute to (figure two). For more details on this visit: www.rcslt.org/members/research/intro and read ‘Clinical Effectiveness: Getting the evidence into practice’.

We want to hear about your EBP activity for a future special feature, please email h.b.stringer@ncl.ac.uk with ‘Bulletin EBP’ in the subject field and tell us what it is, who is involved and how it impacts on your practice.

CPD activity
To increase the continuing professional development value of these articles there will be web links and references for suggested reading in the ‘Research’ section in the Member’s area of the RCSLT website each month. Visit: www.rcslt.org/members/research/intro. Test your knowledge: What are the main features of evidence practice? What are the levels of evidence? Reflection: How do you convey information about the evidence to your clients? 

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