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The Emergence of Evidence Based Practice From the Ashes of Clinical Freedom: Lessons for Paramedic Practice

Abstract

Evidence based practice is now the mainstay of medical practice, however this was not always the case. In the 1980's a debate over the role of research in informing practice was fed by what is now regarded as a seminal article by Hampton (1983). This debate has evolved over the ensuing years and evidence based practice is now an integral part of medicine.

If the paramedic profession is to accept the principles of evidence based practice we may need to re-examine the debate. Informing practice through research requires an understanding of that research and the ability to examine issues from a paramedic point of view. Gaining an understanding of the role of research through re-examining the debate may encourage a renewed focus on prehospital research.

Introduction

Evidence based practice largely owes its rise to a battle fought within medicine in the 1980's. The debate at the time was between those who believed the rise of protocols derived from research threatened the ability of practitioners to make independent decisions based on experience and training (Schwalm & Yusuf, 2011). This article examines the rise of evidence based practice and draws out the lessons for contemporary paramedic practice.

In his article *The End of Clinical Freedom* in 1983, J.R. Hampton examined the role of what is now, over 30 years later, referred to as evidence based practice (EPB). In 1983 practitioners were being challenged by the emergence of quality randomised controlled trials (RCT's) (Hampton, 1983) after the disastrous use of Thalidomide as an antiemetic in the 1960's (Ridings, 2013). This challenged the prevailing practice at the time of relying on experience and training to make treatment decisions. Politics, social issues and economic factors have been the stimulus for EBP and currently standards of care are being questioned more and

more by the patients/clients of health care. The media, policy makers and bureaucrats always highlight the cost of treatment and medication as an issue for legislative attention.

Clinical Freedom

Prior to the 1980's clinical judgement played a large part in decision-making (Hampton, 2011; Hampton, 1983), by in large leaving research the role of informing education, rather than practice. The perception at the time was that evidence based practice would simply result in a plethora of protocol driven instructions which would remove clinicians' ability to develop a treatment based on individual patient needs (Schwalm & Yusuf, 2011).

This fear may not have been entirely borne out in medicine, however in paramedic practice it could be argued that being subject to strict protocols such as those found in the national clinical guidelines give some credibility to the argument of 30 years ago. Clinical freedom may often be elusive for paramedics, however true evidence based practice does allow for freedom based on evidence.

EBP is a means to improve clinical practice, where scientific literature (evidence) forms the basis for clinical decisions. It is not the intention that research results will be able to overtake professional skills or negate patient/client choice. Quite the reverse, only by using clinical knowledge and listening to patients or clients can Paramedics use research results appropriately.

Modern Evidence Based Practice

There is an argument to be made that clinical freedom is not threatened by evidence based medicine. Rawlins (2011) commented that creating an evidence base for clinical decision making does not exclude clinical freedom. When the evidence is often contradictory or disproven by subsequent research, clinical freedom may well play a role in recommending treatment options for patients. Clinical freedom does not have to be limited to basing decisions solely on historical practices, however its focus is on meeting the needs of individual patients, something paramedics are adept at.

Indeed Hampton himself argued for the re-invention of clinical freedom in a subsequent commentary (Hampton, 2011). The high costs of medications show small long-term gains need to be factored into medical decision making (Fojo & Grady, 2009). In the paramedic context the question may well be: the evidence says that this is a good option, but is it the best option for my patient? Clinical freedom may well have a place in assisting the practitioner in making recommendations to their patients regarding medications and treatments.

Increasing Complexity of the Research Base

On the research front, the place of RCTs within the hierarchy of medical evidence has now been well established (Lester & O'Reilly, 2015; Schwalm & Yusuf, 2011),

however there are limitations. To create an EBP ethos Paramedics need to individually and collectively raise questions as to the directions and outcomes of research, and determine the influence research has on their professional standards of practice. An understanding of the terminology, concepts and the history of the evidence based practice movement, and how this has affected health care may assist Paramedics with EBP which has as its ultimate goal: quality treatment and care of patients.

The ever-increasing costs of RCT's leave some to question if other forms of evidence are just as powerful and should be considered (Liamputtong, 2013). Choosing a methodology that is appropriate to the question seems to be the way forward for research and clinical freedom may mean abandoning the idea that a hierarchy in research methodology actually exists (Schwalm & Yusuf, 2011).

Added to the complexity of medical research is the lack of it in some contexts. The research base for paramedic practice is often lacking (Campeau, 2015; O'Meara, Maguire, Jennings, & Simpson, 2015). This has led to reliance on research intended for other professions and contexts that may or may not easily translate (O'Meara, Maguire, Jennings, & Simpson, 2015). For paramedic practice to truly be evidence based the development of high quality prehospital specific research is essential. The use of evidence in the practice setting facilitates sound clinical decision-making, which in turn improves patient care.

Conclusion

Clinical freedom, reborn, may prove a useful tool in assisting clinicians to critically review information from multiple research methodologies and economic analyses. Allowing Paramedics the freedom to consider the most benefit for all of society, rather than just the patient in front of them may be the 'new' version of clinical freedom.

However, this relies on a good base of research and the ability to both understand it and intergrade it into practice. The historical arguments of clinical freedom in medicine remain poignant for paramedic practice today. Without clinicians that are able to integrate the evidence base into their practice we risk becoming the embodiment of the fears expressed in Hampton's original article.

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