UiO : Det medisinske fakultet

En filosofisk modell for kliniske beslutninger

Professor Eivind Engebretsen, Institutt for helse og samfunn

Hva er evidens-basert medisin?

- "Evidensbasert medisin er bevisst, eksplisitt og overveiet bruk av best tilgjengelig kunnskap i beslutninger om individuelle pasienter" (Sackett, *BMJ*, 1996, min oversettelse)

Hvorfor EBM?

- "…vi fortsetter å basere våre kliniske beslutninger på en utdanning som i stadig større grad blir utdatert eller på overfortolkning av erfaringer med individuelle pasienter" (Rosenberg, *BMJ*, 1995, min oversettelse)

Hvordan integrere kunnskapskildene?

Real versus Rubbish EBM (T. Greenhalgh)

- «Real»: Pasientsentrert og tilpasset den enkelte, evidens integrert med klinisk ekspertise og pasientpreferanser

- «Rubbish»: Automatisk bruk av retningslinjer

- Fortolkning er en uunngåelig OG nødvendig del av EBM

Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

Journal of Evaluation in Clinical Practice ISSN 1365-2753

Unpacking the process of interpretation in evidence-based decision making

Eivind Engebretsen PhD,[1] Nina Køpke Vøllestad PhD,[1] Astrid Klopstad Wahl PhD,[1] Hilde Stendal Robinson PhD[2] and Kristin Heggen PhD[1]

[1]Professor, [2]Researcher, Health Sciences, Institute of Health and Society, Faculty of Medicine, University of Oslo, Oslo, Norway

Introduction

Evidence-based medicine (EBM) has promoted the conscientious and systematic use of the best available scientific evidence in clinical decision making [1]. From an EBM point of view, only experimental evidence, especially results from randomized controlled trials and meta-analyses of trial results, count as strong evidence. Experiential evidence based upon expert opinion is classified as weak and placed at the bottom of the evidence hierarchy. EBM is often contrasted with traditional clinical medicine which considered pathophysiological reasoning and expert knowledge as the principal sources of clinical decision making. In a recently published article in *Journal of Evaluation in Clinical Practice*, Jeannette Hofmeijer describes EBM as a revision of medical epistemology and points to the neglected role of expert opinion and the lack of focus on the principles of reasoning underpinning EMB [2]. More specifically, she shows how EBM involves important processes of interpretation. Hofmeijer is mainly concerned with the role of interpretation in the production of scientific knowledge within the EBM tradition, and she illustrates how the quest for evidence relies upon interpretation both in formulating a hypothesis and in accepting the accumulated evidence as sufficient. We will argue a related but still different perspective demonstrating the principles of reasoning involved in the *integration* of experimental ing has been argued, and concepts such as clinical intuition [6], tacit knowledge [7], wisdom [8] and collectively defined 'mind lines' [9] have been introduced to challenge a unilateral focus on implementing research evidence. More recently, the literature on patient-centred medicine and shared decision making has emphasized the importance of involving patients in medical decisions and suggested useful methods and approaches [10,11].

In spite of these attempts, the principles of reasoning according to which the knowledge sources are combined and applied are still poorly understood. There are few, if any, models and concepts available which make explicit the *interpretational operations* involved when combining and applying the knowledge components. We intend to throw light on this process by drawing on a four-step model of knowing developed by the Canadian philosopher Bernard Lonergan [12].

What do we do when we know?

Lonergan's topic is the mechanisms of knowing in general and his principal philosophical question is *What do we do when we know?* His aim is to *promote self-awareness* about how knowledge comes about. To Lonergan, this has not only philosophical interest. By consciously attending to what we do as knowers, we can develop our ability to make reliable and transparent judgements.

Bernard Lonergan (1904-1984)

Insight: A Study of Human Understanding (1957)

What do we do when we know?

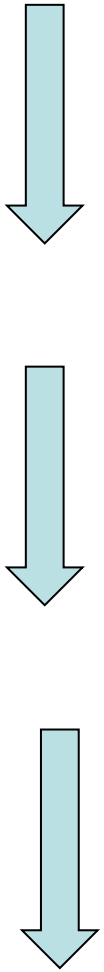
Observasjon
- data / det som krever forklaring

Fortolkning av data (hva kan dette bety?)
- **Forståelse**

Avveie mulige fortolkninger
- **Dom**

Velge mellom handlinger (hva er det rette å gjøre?)
- **Deliberasjon**

Innsikter medierer mellom nivåene



Innsikt

Innsikt

Innsikt

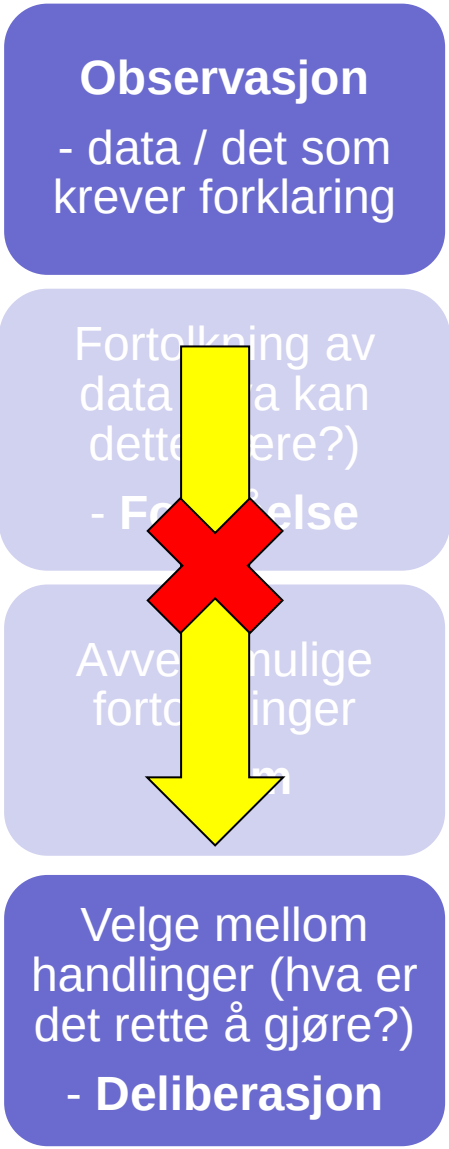
Innsikt = innsikt i egen innsikt, bevisst, selvinnsikt

«Høyere utkikkspunkter»: bevissthetsnivåer

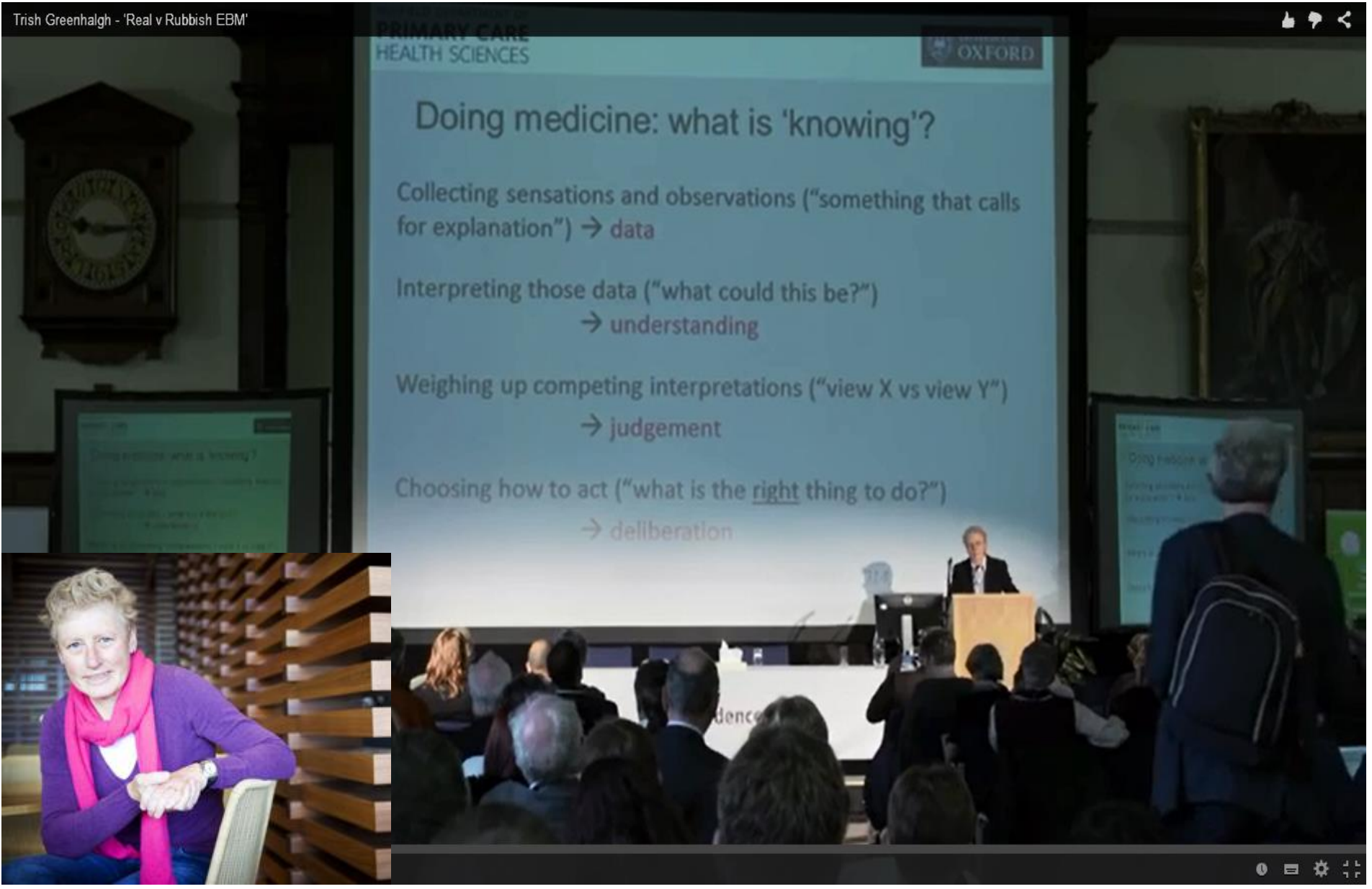
Bevissthet om inntrykk, minner, forestillinger…
- Ideer og begreper

Bevissthet om ideer og begreper…
- Oppfatninger

Bevissthet om oppfatninger
- Beslutninger



Ikke hoppe fra observasjon til beslutning!


Trish Greenhalgh - 'Real v Rubbish EBM'
PRIMARY CARE
HEALTH SCIENCES
OXFORD
Doing medicine: what is 'knowing'?
Collecting sensations and observations ("something that calls for explanation") → data
Interpreting those data ("what could this be?")
→ understanding
Weighing up competing interpretations ("view X vs view Y")
→ judgement
Choosing how to act ("what is the right thing to do?")
→ deliberation

Pasientfortelling	Journalnotat
I was riding my racing bike along the towpath. I was going about 20 miles an hour.	
Something got caught in my front wheel. The bike somersaulted into the air. I came down heavily on the concrete, landing on my arms and the back of my head.	55 yr old female. Fell off bike.
I was very dazed. Both my arms were deformed and useless. My fingers were numb. My helmet was split.	

“20 miles an hour”

“bike somersaulted”

Appendix A - Risk Assessment

My Falls-Free Plan Name: _____ Date: _____

As we grow older, gradual health changes and some medications can cause falls, but many falls can be prevented. Use this to learn what to do to stay active, independent, and falls-free.

Check "Yes" if you experience this (even if only sometimes)	No	Yes	What to do if you checked "Yes"
Have you had **any falls in the last six months**?			☐ Talk with your doctor(s) about your falls and/or concerns. ☐ Show this checklist to your doctor(s) to help understand and treat your risks, and protect yourself from falls.
Do you take **four or more** prescription or over-the-counter medications daily?			☐ Review your medications with your doctor(s) **and** your pharmacist at each visit, and with each new prescription. ☐ Ask which of your medications can cause drowsiness, dizziness, or weakness as a side effect. ☐ Talk with your doctor about anything that could be a medication side effect or interaction.
Do you have **any difficulty walking or standing**?			☐ Tell your doctor(s) if you have any pain, aching, soreness, stiffness, weakness, swelling, or numbness in your legs or feet—**don't ignore** these types of health problems. ☐ Tell your doctor(s) about **any** difficulty walking to discuss treatment. ☐ Ask your doctor(s) if physical therapy or treatment by a medical specialist would be helpful to your problem.
Do you use a **cane, walker, or crutches**, or have to hold onto			☐ Ask your doctor for training from a physical therapist to learn what

As we grow older, gradual health changes and some medications can cause falls, but many falls can be prevented. Use this to learn what to do to stay active, independent, and falls-free.

“helmet was split”

Do you ever feel **unsteady on your feet, weak, or dizzy**?			therapist would help improve your condition. ☐ Review all of your medications with your doctor(s) or pharmacist if you notice **any** of these conditions.
Has it been **more than two years since you had an eye exam**?			☐ Schedule an eye exam every two years to protect your eyesight and your balance.
Has your **hearing gotten worse with age**, or do your family or friends say you have a hearing problem?			☐ Schedule a hearing test every two years. ☐ If hearing aids are recommended, learn **how** to use them to help protect and restore your hearing, which helps improve and protect your balance.
Do you usually **exercise less than two days a week**? (for 30 minutes total each of the days you exercise)			☐ Ask your doctor(s) what types of exercise would be good for improving your strength and balance. ☐ Find some activities that you enjoy and people to exercise with two or three days/week for 30 min.
Do you drink **any alcohol** daily?			☐ Limit your alcohol to one drink per day to avoid falls.
Do you have **more than three chronic health conditions**? (such as heart or lung problems, diabetes, high blood pressure, arthritis, etc. Ask your doctor(s) if you are unsure.)			☐ See your doctor(s) as often as recommended to keep your health in good condition. ☐ Ask your doctor(s) what you should do to stay healthy and active with your health conditions. ☐ Report any health changes that cause weakness or illness as soon as possible.

The more "Yes" answers you have, the greater your chance of having a fall. **Be aware of what can cause falls, and take care of yourself to stay independent and falls-free!**

Hva viser caset?

- Guidelines er kun **data**
- **Fortolkning** er nødvendig for å integrere anbefalingene med pasientdata
- Det må trekkes **en slutning (dom)** for å avgjøre hvilke anbefalinger som er relevante

- En mer selvbevisst kunnskapsprosess i samsvar med Lonergans modell ville ha gitt en annen beslutning / behandling

«Evidence is never self-interpreting and [….] real EBM for one patient may very well turn out to be rubbish EBM for another»

(T. Greenhalgh)