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Finding One's Way In Translating Evidence Into Practice

To the Editor:

We thank Dr. Wears for his interest in the emerging scientific discipline of knowledge translation.¹ We too recognize that an important divide frequently exists between the findings of robust and valid clinical research and that which actually gets consistently incorporated into clinical emergency medical practice. However, as academics committed to improvements in the uptake of relevant research evidence, we differ in our view of the potential value of knowledge translation in achieving closure of that gap.

Dr. Wears suggests that knowledge translation-like efforts represent an "imperialistic" and often futile attempt to impose irrelevant or non-applicable research evidence into the clinical work of practicing physicians. Additionally, he asserts that some evidence-based medicine efforts are condescending to clinicians and doomed to failure insofar as they offer answers to overly circumscribed research questions that fall apart in the "messy" world of real-life clinical care. He interprets these as attempts to "force" clinicians to practice in a cookbook or thoughtless pathway-driven mode reminiscent of a factory-like Taylorism that takes the division of labor to the extreme. Beyond his concerns that knowledge translation efforts may deskill doctors, Dr. Wears also suggests (without data) that community emergency department clinicians are suspicious of the academic emergency medicine research community and are thus resistant to their work product.

As a group of individuals who were involved in the 2007 Academic Emergency Medicine Consensus Conference on Knowledge Translation, we respectfully disagree with Dr. Wears' views and suggest that his opinions are only minimally supported by the literature examining why clinicians do not incorporate best evidence into day to day practice.^{2,3} Dr. Wears ignores the patient perspective regarding the potential value of the fruits of high quality and applicable clinical research. Knowledge translation and its partial progenitor evidence-based medicine adopt patient-centered perspectives and differ starkly to the somewhat paternalistic model of "physician knows best" decisionmaking that is being presented.⁴ Dr. Wears also seems to paint the entire research enterprise with the same brush stroke, and fails to distinguish between clinical studies that are specifically aimed at improving patient outcomes and hypothesis-generating research that stops short of producing patient important findings. In so doing he ignores the recent translational research initiative of the US National Institutes of Health, aimed at ensuring that the efforts and funds that go into health sciences research ultimately benefit the health and wellbeing of the public.⁵ We present several other points of disagreement below.

Firstly, we believe that Dr. Wears has misunderstood the major premise of the knowledge translation movement. Also known as implementation science, this field is not a matter of "academic whining" about why practicing physicians (and other practitioners) choose to ignore research. Rather it is based on the realization that barriers to evidence uptake are complex and that overcoming them requires carefully researched approaches that emphasize organizational aspects of care.

Secondly, while we recognize the complexity of comorbid illnesses and the vast spectrum of pathology encountered in emergency medicine, many patients we see present challenges for which compelling research evidence exists.

Third, preliminary knowledge translation research suggests that the attitudinal barriers highlighted by Dr. Wears are relevant to only a small number of contexts and clinicians. The evidence on clinical practice guidelines indicates that clinicians report high satisfaction with these efforts, believe in their ability to improve quality of care, and are primarily concerned with issues of practicality.⁶

Fourth, we recognize that there is a great deal to learn about the barriers and effective facilitators of evidence implementation in emergency medicine. The need for scientifically derived insight into these micro and macro-level questions defined the mission of the Consensus Conference initiative.⁷

Fifth, we concur with Dr. Wears that some of the efforts to implement clinical policy have been unidirectional and counterproductive. An important recommendation emerging from the consensus conference was to reinforce the importance of multistakeholder involvement in the creation of health policy and research initiatives designed to improve patient care. Moreover, the term “knowledge translation” (unlike the old term “knowledge dissemination”) implies a bidirectional flow of information in order to maximize patient care through a collaborative approach which engages researchers, clinicians, and policymakers as equal partners in the process. Knowledge translation seeks to avoid the ivory tower abhorred by Dr. Wears by encouraging a constructive dialogue with all of the relevant players. This bidirectional exchange, when it can be achieved, should substantially allay these concerns.⁸

Finally, we submit that ignoring the integration of high quality research into practice is at variance with professionalism and with the ethics of patient-centered care.

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Appendix. Emergency Care Knowledge Translation Working Group.

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*Dr. Wyer did not participate in the editorial review or decision to publish this letter.

Making Change in the Emergency Department

To the Editor:

Kudos to Robert L. Wears for “Lost in Translation,” his editorial commenting on why emergency clinicians are “resistant” to adopting many of the practice recommendations suggested by “evidence” and “guidelines.” It’s high time that somebody pointed out that the emperor has no clothes.

In a 25-year career as a department director and change agent in emergency medicine, I saw many wonderful advances in emergency medicine become reality: procedural sedation, ankle, knee and spine imaging criteria, proactive analgesia, and many more. I witnessed an equal number of witless time-consuming efforts that did nothing to advance patient care and eventually fell by the wayside: immediate steroids for spinal cord injury and blood cultures in the emergency department (ED) for pneumonia patients being admitted come to mind as 2