Flaws in the fabric?

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After a spectacular arrival in the early 1990s (*JAMA* 1992; 268: 2420-2425), evidence-based medicine quickly evolved beyond generating the best research evidence, to acknowledging a need to integrate this evidence with clinical expertise and patient values — to weave the science with the art of medicine. Several of the articles in this issue of the *MJA* highlight that, in Australian clinical practice, the resulting fabric is not without flaws.

What happens, for instance, when clinicians seem to set aside the all-important evidence? A study by Bohensky and colleagues (*page 399*) reports that average rates of arthroscopy for knee osteoarthritis remained essentially static during 2000–2009 in Victoria, notwithstanding credible evidence that arthroscopic debridement and lavage were probably ineffective for this condition (*N Engl J Med* 2002; 347: 81-88). In exploring the factors that influenced the uptake of this evidence, Buchbinder and Harris (*page 364*) acknowledge the key role of clinical experience and expertise, and identify that system factors, such as funding policies, can aid or hinder the effective incorporation of evidence into clinical practice.

Scott and Glasziou (*page 374*) affirm that this is not an isolated instance, listing a dozen examples of widely used treatments that have been shown to be ineffective or harmful in many patients. They propose a set of evidence-based strategies for removing barriers to translating evidence into practice, including a suggestion that professional indemnity not apply in cases of patient harm resulting from clear violation of accepted evidence-based standards.

Not all attempts to weave the best available evidence into clinical practice translate into tangible benefits for patients. Two expert research groups led by Harris (*page 387*) and Zwar (*page 394*) experienced just this dilemma, when they trialled interventions aimed at enhancing evidence-based management of vascular risk factors and chronic obstructive pulmonary disease, respectively, in primary care. Both studies employed a cluster randomised controlled trial design, and both found that improvements in the process of care do not necessarily lead to better health outcomes. They recommended that further, more intensive efforts may be needed to achieve any difference in these outcomes compared with usual care in general practice.

In commenting on their studies, Nelson (*page 363*) argues that for trial results to be generalisable to the general practice population, they should ideally be conducted in the general practice environment by those who understand it — primary care researchers. Perhaps in this way, the evidence can be better woven into practice, and the need for translation will be lessened.

There are other, more intimate, threads to the fabric of evidence-based practice. In putting forward the concept of "narrative evidence-based medicine" (*Lancet* 2008; 371: 296-297), Charon and Wyer spoke of how, at the same time that interest in evidence-based "right" decisions was soaring, there was growing interest in patients' lived experiences, illness narratives and the interior lives of clinicians. Their observations that "illness unfolds in stories, that clinical practice transpires in the intimacy between teller and listener, and that physicians are as much witnesses to patients' suffering as they are fixers of their broken parts" echo throughout Stewart's reflection on leaving a longstanding general practice role (*page 415*).

The Dr Ross Ingram Memorial Prize seeks to bring patient and practitioner stories into the much analysed, contested and politicised fabric of Indigenous health. Our 2012 winners are published in this issue: Lock's beautifully nuanced reconciliation of the personal and political sides of assimilation (*page 417*), and "The Gap", a painting made to depict family healing by Indigenous researcher and artist Robyne Latham (*page 419*).

There is no doubt that the fabric of medicine is made stronger and more resilient from the interweaving of the best available research evidence. Recognising and seeking to repair the imperfections is vital; but, as we all know, it's the flaws in the fabric that point to its authenticity.

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MJA Careers
Career overview — Breast physicians
Centre of care
Breast physicians are the linchpins of breast cancer management

Careers follows p 420

The road ahead

Dr Jack Sloss, from Thursday Island, was one of the first doctors to graduate from Queensland's Rural Generalist Pathway, a supported training and career pathway for doctors intent on a career in rural and remote medicine. In this issue's Career Overview (*page C1*), we meet Dr Sloss and other rural generalist doctors who are at the centre of efforts to address the loss of procedural skills in rural communities.

MJA Careers also profiles Dr Dan Manahan, a rural generalist in Stanthorpe, Queensland in Medical Mentor (*page C5*). In Road Less Travelled, writer and general practitioner Dr Jacinta Halloran explains how medicine can be the stuff of fiction (*page C6*), while our Money and Practice section looks at what it is like to work in a large corporate-owned clinic compared with a small family practice (*page C7*).