

## Evidence-based Practice Meets Patient Choice

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There is a strong emphasis on evidence-based practice in teaching health students and it underpins much health research [1,2]. Many emphasize 'patient centred care' combining research evidence, patient context and clinical wisdom into evidence-based patient choice where (ideally) practitioners and patients jointly consider evidence, decisions and recommendations [1,3-6]. Simultaneously, there is increasing call to work with patients and to respect patient choice [3,7]. But what is the outcome when these two principles clash? What happens when a new mother tells a midwife that "I don't want to breastfeed, I want my body back", or when an overweight diabetes patient tells a slim dietician that "I can't be bothered monitoring what I eat; I feel ok most of the time" or when a patient suffering hypertension tells his/her doctor "I don't want to take pills". What happens when evidence and patient choice directly, or even more subtly, clash? The midwife, the dietician and the doctor may take a breath and tell themselves and the patient that they respect patient wishes, they may share information for consideration, but their face and their body language reflect their own commitment to their 'expert' knowledge as to what could be best. Because of this, some patients will not share their views for fear of being judged negatively; rather they keep their opinions to themselves and endure the label of 'non-compliance'. Patient choice is difficult to practice.

Without going to the decision-making 'place' of the patient, the information from and recommendations of health professionals are less likely to be adopted. It is time discussion moved toward providing strategies for busy health professionals to sincerely integrate patient choice and consumer perspectives into their practice. Integrating the triad of research evidence, patient context and clinical wisdom effectively takes time—time to listen to the patient, inform the patient of recent evidence and to jointly discuss diagnosis, treatment and other related issues. It also takes a practitioner who is flexible, open, genuine, reflective and has well developed listening skills. But are health care professionals trained adequately in these skills? And even

if they are, culture, the social determinants of health, communication skills and other barriers remain. Practitioners have a commitment to their disciplinary knowledge that they have trained in for multiple years which is hard for them to reject. Haynes et al. acknowledge this conundrum: "providing evidence to patients in a way that allows them to make an informed choice is challenging and in many cases beyond our current knowledge of doctor-patient communication—very much a problem awaiting the generation of new evidence [4]." It is time we addressed this complexity to improve health outcomes for patients most likely to disengage from health services.

Abandoning years of professional training in the face of "I can't be bothered" may not be possible. But involving patients, sharing information and making joint decisions can overcome many of these problems [1,4]. There remains times when evidence and choice clash. Being prepared for these times is a requirement of good practice—acknowledging and discussing them is a starting point.

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