What Does "Evidence-Based" Practice Really Look Like?

By Robert Mootz, DC

When I passed that pesky, magical 45-year threshold some time ago, I sucked in my gut and went to the first allopathic PCP doc I’ve regularly seen for personal health care since college. I did it based on my own "evidence-based" recognition that the wretched aging process (and a reluctant acknowledgement that my lifestyle) had put me into new health-risk categories for which early detection and intervention could enhance both my longevity and quality of life.

Although I worked in interdisciplinary practices a decade ago, and saw many patients undergo allopathic procedures and management, I had not personally submitted to such, as I was quite happy being under chiropractic care exclusively for the past 20 years.

Although I knew what I really needed to do (basically, diet and exercise), I figured I needed to be on the books of a good primary care physician who could advocate for me and my preferences, should I find myself in an urgent clinical situation down the road. And a number of those useful screening tests I may need to consider having in the next decade are not in my own scope of practice or chosen area of expertise. I asked him where any good internists were in the area (I’ve not practiced locally for 10 years), and he suggested a couple, none of whom were accepting new patients. So, he pulled his professional strings and got me in with a great "evidence-based" guy.

And this is what it looked like: My first complete physical exam yielded a fat guy (me) with mild hypertension and family history of cardiovascular disease. So, the MD pulled out some nice little reference cards from his drawer, based on stuff like the Haynes studies and other pointy-headed-sounding terms, and read off a bunch of things about the risk of more serious cardiovascular disease for people with my family history, weight and lifestyle.

The doctor explained that I should have some lab tests to assess lipids, to get more information upon which to assess risk and consider treatment options. He specifically mentioned that research has shown folks with my risk categories may be able to intervene in ways that reduce the risk of progression of cardiovascular disease, so in his estimation, they were worth doing, even though I was going to have to finance a hefty co-pay (which might have been better spent on some really yummy Belgian chocolate). The results of the tests would help us determine if and what management we needed to consider.
And yup, this fat guy indeed had some very elevated "bad stuff." And the doctor pulled out some more cards and showed me where I fit on various risk guidelines, even commenting on the quality of the research studies that had been done on the subject. (I suspect, in part, because he knew I was a doctor and health services researcher, and he figured this might resonate well with me.) He described how various options stacked up for dealing with it - the pros and cons of committed diet and exercise, use of medications, etc. I communicated my preferences and resistance regarding drug therapy, and he pulled out some more reference cards (all conveniently located in a drawer in the examining room) on outcomes from various interventions. He described what his experience had been with other patients of his who had avoided drug therapy - mainly, that they usually failed - and we proceeded to set up a "treatment" plan.

To my great dismay, "treatment" actually turned out to be a chocolate and sleep-in deprivation plan. He set up specific progress markers I needed to reach within certain time frames before I would have to be subjected to that drug discussion again.

So, for four months, I got up early and hit the elliptical every day, followed throughout the day by the sheer torture of a completely unreasonable chocolate and microbrew avoidance program. And then I had my follow-up, having met two progress markers (losing 20 lbs and lowering BP 20 points), but having run amok on another (worsening of lipids by nearly 50 percent). This surprised him (and crushed me). I asked if we should re-run the test. He said "hmm ... I'll be back," and awhile later, he came in with an abstract that talked about inclusion of more aggressive muscle/weight exercise possibly having a bigger, quicker effect on lipids than just the pansy, aerobic stuff I negotiated with him last time. And he opined that the reliability of this lab test was really good, so he didn't think he should put me through another stick and co-pay. Besides, he posited, I probably should consider doing this anyway, given my family history.

And then we had the drug talk, which included a request by me to look at the cheat cards he was referring to more closely (and me noting some of the drug study cites with the term "meta-analysis" in them). He advocated that "the meds appear to show a nearly 30 percent reduction in risk of CV disease." And he opined that this was probably a pretty important consideration in my case, since a boatload of my close relatives have succumbed to MI and stroke. He suggested I could do the more intense exercise concurrently, and then re-evaluate dosage some months out. I reiterated my preference to avoid meds altogether, except as a last resort, and he said, "How about if I give you six months on a more rigorous exercise program?" before he tortured me with even more assertive drug talk. But if my lipids were still running amok, he indicated that the next drug talk would be very "robust." I suspected by this point that he may have been familiar
with the psychological motivation literature, as well, and was seriously pushing compliance-with-exercise buttons on me.

In any event, two years later, 40 pounds lighter, with normal blood pressure and normal lipids, and exercise-compliant (but sadly, still chocolate and sleep-in deprived), my mind has recently cognated on what evidence-based spine-care encounters with chiropractors might look like. Spine care is particularly relevant, not only because we chiropractors do a lot of it, but because it may actually be a bit more difficult to develop evidence-based medicine (EBM)-type scenarios for. You see, the amount of good data on something such as the range of options for H2 blockers for gastroesophageal reflux is much more readily available than studies, for example, on the range of the multitude of chiropractic techniques for folks who have suffered cervical acceleration-deceleration injuries.

At the Annual Research Agenda Conference for Chiropractic earlier this year, devoted to "Best Practices," Frank Zolli, DC, EdD, gave one of the closing talks, offering a series of relevant "so-what?" questions about best practices. Are best practices just another fad? How would they actually impact practice? Aren’t best practices really just a tool to limit care and restrict us to musculoskeletal conditions?

With apologies to Frank for shortchanging his comments and context, I think he raised worthy points. While the terminology du-jour is always "the next big thing," the relationship between practice and research is ongoing, and they will always influence each other. Enough good science, in retrievable fashion, truly can have utility for practitioners. I think my little tale above reflects a pretty pragmatic and optimal way in which one doc and one patient actively considered evidence to jointly make decisions about health care options in practice.

As Frank pointed out, folks have great concern that payers and special interests will misuse evidence and guidelines to unfairly restrict what we do. But I have news about third parties misusing "evidence" and "guidelines" to limit what doctors do: Guidelines or not, the contest between payers and doctors is here to stay, and special interest initiatives will exist, evidence or not. Having better evidence and using it appropriately are critical for all to play on the up-and-up. In fact, the incidence of providers and vendors misappropriating the evidence is probably on the same order of magnitude as that of payers.

Our challenge is to enhance the availability and usability of high-quality, relevant science to help us improve the efficiency and outcomes from our care. Using evidence to better inform decisions about care options is what it’s all about. And when we have that and implement it ourselves, it helps strengthen our
case with others. (Warning: Sometimes, the evidence may identify that we may need to change our own status quo.)

I was impressed with how my internist overtly considered science in his routine management of me, along with discussing options and sharing his viewpoints with me. It was a health care encounter that factored in my preferences, his experience, and the evidence he had at hand. I received personalized, competent care in which evidence was used both to guide the outcome and facilitate my compliance, resulting in an effective, conservative intervention. Might such an approach serve as a model for evidence-based chiropractic-care encounters?

Robert Mootz, DC
Associate Medical Director for Chiropractic,
State of Washington Department of Labor and Industries
Olympia, Washington
thinkzine-at- msn.com

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