

## Evidence-based or status-seduced opinions

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*'There are in fact, two things, science and opinion;  
the former begets knowledge, the latter ignorance.'  
(Hippocrates)*

The professional and accreditation bodies of most healthcare professions now require that their practitioners adhere to evidence-based clinical decision making and that they act only within their scope of clinical expertise.

Although there has been debate over the definition and essential features of evidence-based clinical decision making (Morice, 2006), most health professions agree that it involves a process of systematically reviewing, appraising and using clinical research findings to aid the delivery of optimum clinical care to patients (Rosenberg & Donald, 1995). It has been noted that while empirically supported treatments are an essential component, evidence-based clinical decision making cannot be reduced solely to empirically supported treatments (Spring, 2007). One of the main features of evidence-based clinical decision making is reliance on the combination of hard scientific evidence, clinical expertise, and individual patient needs and choices (McKibbin, 1998). The criteria for judging the quality of evidence that supports treatments is typically represented as a hierarchy where evidence obtained from a systematic review of all relevant randomised controlled trials is considered the gold standard and evidence obtained from case series, either post-test or pre-test plus post-test, is considered the minimum evidence needed (see for example, National Health and Medical Research Council, 1999; Singh & Edzard, 2008).

Despite these clear instructions and guidelines from professional bodies, it seems practitioners do not always use evidence-based treatments. Imrie and Ramey (2000), for example, report that in general medical practice an average of 76% of interventions are supported by some form of compelling evidence, with an average of only 37% of interventions being supported by randomized clinical trials. In the area of complementary and

alternative medicine (CAM), it has been estimated that 7.4% of treatments are evidence-based (Ernst, 2011).

If healthcare practitioners are not always basing their clinical opinions on scientific evidence, what are they basing them on? In their light hearted article, Fitzgerald and Isaacs (1999) suggest some medical practitioners have abandoned evidence-based medicine in favour of alternatives such as *eminence-based medicine* (where the more senior the colleague, the less importance he or she places on the need for anything as mundane as scientific evidence), *eloquence-based medicine* (where sartorial elegance as indicated by the year round suntan, carnation in the button hole, silk tie, Armani suit are powerful substitutes for scientific evidence), *nervousness-based medicine* (where fear of litigation is a powerful stimulus to over investigation and overtreatment. In an atmosphere of litigation phobia, the only bad test is the test you didn't think of ordering) and confidence-based medicine (this they suggest is restricted to surgeons!).

While the basis for clinical decision making by healthcare professionals has been well documented, the basis for patients' decisions about their preferred treatments has received less attention. One humorous report suggests that consumers of CAM may base their choice of treatment according to "celebrity-based medicine". That is, "find out what form of CAM your idol currently uses, and do likewise" (Edzard & Pittler, 2006). While this report relates specifically to CAM patients, little research has investigated the basis for treatment preferences made by patients of other health modalities. The psychology of choice, however, has been well studied and it is recognized that many of our choices are based on anything but evidence. A confident, authoritative figure in imposing surroundings could get a patient to accept any treatment. No matter what the evidence is for efficacy or, in fact, the outcome, both parties may be well satisfied. Advertising companies are all too aware of this phenomenon.

There may also be another factor that influences the basis for opinions given by some healthcare providers

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and for the choices made by their patients. This factor could be referred to as ‘status-seduced opinion’. It occurs when the healthcare professional, because of their perceived status in the ‘clinician/patient’ relationship, is ‘seduced’ into giving opinions about issues that are outside their area of professional expertise and training. Concurrently the patient is ‘seduced’ into believing that their healthcare professional can give expert opinion about areas outside their field of professional expertise because they are perceived as trustworthy within their area of expertise and the advice and opinions are being expressed in the same physical environment and within the same consultation. However, without professional credentials in the treatment of a particular presenting problem, the healthcare professional’s opinion has no more status than that of a lay person. For a healthcare professional to engage in this reciprocal seduction or to allow their patients to believe that their non-expert opinions are professionally valid, amounts to deception and contravene the practice and ethical guidelines of reputable healthcare professional and accreditation bodies. This can occur even if the opinion and advice is being offered with the best of intentions and with the patient’s welfare uppermost in the clinician’s mind.

Consider, for example, a general medical practitioner who, following a consultation with a patient for flu symptoms, is asked by the patient about relationship difficulties they are experiencing with their partner. In response, the medical practitioner, wanting to help their patient, schedules a number of consultations to provide counselling to help their patient resolve their relationship issues. Consider another example. A clinical psychologist is consulting a patient about anxiety issues and in the course of the consultation the patient asks the psychologist for advice on how to deal with their recent weight gain. In response, the psychologist, wanting to help their patient, schedules a number of consultations to provide dietary advice to assist their patient with their body weight issues.

In the above examples, unless the medical practitioner has accredited qualifications in relationship counselling

and the psychologist has accredited qualifications in nutrition and dietetics, it can be argued that their opinions are no more valid than those of a lay person. However, because their opinions are provided in the context of the ‘clinician/patient’ relationship they can be seen by the patient as having equal validity to opinions given in relation to the professional’s area of expertise. When professionals are seduced into giving opinions and advice outside their area of expertise they not only behave unethically, they inadvertently reinforce the practice of the patient seeking advice from unqualified professionals.

In the privileged position that exists between the healthcare provider and their patient, patients are entitled to expect that treatments given by their healthcare provider are evidence-based and that opinions given are only those that are within the healthcare provider’s area of expertise. Surely it is unethical for any practitioner to charge money for treatments that are not supported by sufficient evidence or to provide opinions about subjects for which they are unqualified to give. Regardless of whether these practices provide patients with some perception of benefit, engaging in them risks creating an unnecessary culture of dishonesty. It behoves all healthcare professionals to be vigilant in ensuring their treatments are evidence-based, that their opinions and advice are restricted only to those areas in which they are appropriately qualified and that they refer their patients to the healthcare provider that has the professional skills to deal with the presenting issue.

Keywords: evidence-based healthcare practice, healthcare decision making, doctor/patient relationship, scope of clinical expertise.

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