Éditorial/Editorial

In an effort to optimize healthcare, people (that is, patients, providers, and funders) have started to increasingly scrutinize nurses' practices, whether these relate to assessments, plans of care, interventions, or evaluations. What people want to know is, what is the utility, efficacy, and effectiveness of the services being recommended, delivered, and paid for? Do these interventions induce their intended outcomes, or do they cause more harm than good? This trend, which is commonly known as evidence-based practice, has challenged all healthcare practices. There are no sacred practices seemingly beyond the apparently critical gaze of evidence-based practice. From this lens, everything should be subject to critique and critical review.

While the foregoing aim of evaluating everything seems ideal, it is not as comprehensive in practice. What is lost in this new movement is the actual practice of critical appraisal. In decrying the previous approach of providing care based on anecdotal evidence, personal opinion, and historical practice trends, we have failed to maintain the foundational premise of critical reflection: to question and challenge everything. Indeed, the basic tenets are simple: question that which we are told is best; ask how and why one item has been established as ideal; and challenge the prevailing norms, so as to fulfill our professional obligations of providing patient care that achieves patients' goals. Such critical thinking, which should be a central aspect of evidence-based practice, however, is often applied to everything but evidence-based practice itself. Reflecting on if, how, when, and in what ways evidence-based practice helps, including a review of how evidence-based practice is implemented, is required.

What appears to have happened is that, in opposition to a previous mindset, wherein initiatives were simply applied, we now seem to be unable to provide care until the so-called right type of evidence emerges. We have become dangerously immobilized in the absence of evidence. But does this make sense? Is this actually a change in how we care for patients? It seems to be little more than the replacement of one dogma with another. Instead of practicing without evidence (what I suggest is the previous *modus operandi*), we now simply do nothing when there is no evidence (the current approach). How is this different from before though? Does this new approach actually improve patient care, or does it simply create a new form of practice that is equally devoid of critically thinking?. Now, it simply seems that we have becoming unable, or at least increasingly reluctant, to address inequities and suffering due to a paucity of allegedly

good, correct, or adequate evidence. Now, we stand by and blame our unwillingness to change and our fear to act on the new trend of evidence-based practice. I will explain this point using a recent discussion I had at a conference about screening and men's health.

Since 1979, the Canadian Preventative Care Task Force recommended the abolition of the annual health examination. They advocated, instead, for a periodic health examination that was tailored to each patient. Their logic was that indiscriminate annual examinations not only were costly, but also (and most importantly) caused innumerable instances of harm. That is, incidental findings arose from tests with poor sensitivity and specificity in the context of low prevalence figures for the tested-for conditions. The result was needless treatments, which ranged from rather benign interventions to the outright removal of perfectly healthy organs. Some of the damage was irreparable. (As an example of this evolution of screening guidelines, consider the recent changes to recommendations for cervical cancer screening.)

Accordingly, the periodic health examination has been adjusted to maximize the detection of pathologies, while minimizing the potential for harm. However, the pendulum has now swung so far toward evidence-based practice that it has become nearly impossible to recommend new strategies in the abscence of experimental studies that establish sensitivity and specificity values. For example, while we have good data showing that men who engage in receptive anal intercourse (i.e., men who are penetrated anally as part of their sexual practices) have elevated rates of anal cancer due to the acquisition of sexually transmitted human papillomavirus (HPV), clinicians are reluctant to undertaken any sort of examination or screening for such cancer in the absence of a validated screening tool. This leaves us with the situation of known harm (men being diagnosed with advanced stage cancer), and clinicians being reluctant to do any screening because there is no evidence for such screening. Here, we are witnessing the ongoing manifestation of harm and clinicians who refuse to act because now one has yet to establish the sensitivity of a digital anal-rectal examination for cancer detection. (Please note that the examination I am discussing here is known as a DARE, which focuses on detecting abnormalities on the anal verge, and should not be confused with the better-known DRE, or digital rectal examination, which targets the prostate and its associatied pathologies.)

In light of the current situation, I am reminded of words from Oscar Wilde, "everything in moderation, even moderation". Perhaps, in considering this phrase, it is time we apply the same logic to evidence-based practice and be moderate in our excitement for evidence? To simply demand evidence—and often specific forms of evidence only—we have simply replaced one dogma with another. How is this an improvement? It is still an uncritical practice. This does not

mean that evidence-based practice is worthless; it is simply that we need to begin functioning in a world of evidence that is based on shades of grey, not black and white, not good versus bad, and not best practices and other. Indeed, we need to step back and say, evidence is indeed needed and warranted. However, are we so myopic that we cannot be critical of evidence and the evidence-based approach as well? Evidence-based practice ushered into a new era of critically examining healthcare practices. As part of this, we must not lose sight of critical reflection, and accidently adopt a new mindset mindlessly. The absence of evidence does not equal evidence that something does not work. Rather than letting history judge this new approach, should we not begin to do so now?

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