

Editorial

## Inverting the Evidence Hierarchy

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I am doubly grateful to Ashok Handa and his co-editors of JNDS, first for inviting me to write a guest editorial for this exciting new journal, second for asking me to write about something other than COVID-19. JNDS is an exciting new venture not least because it plugs a gap that has been increasingly apparent in recent years in evidence-based medicine, the gap of individual experience.

When David Sackett launched his program as the founder Director of Oxford's Centre for Evidence Based Medicine, he defined the field (in his seminal book, *How to Practice and Teach EBM*) as combining best research evidence with clinical experience and with individual patients' values. Yet contemporary evidence-based medicine is largely taken up with the first of these, with best research evidence. Clinical experience is all-too-often subordinated to evidence-based guidelines: these are indeed only guidelines, not, as Gill Leng the Deputy Director of NICE repeatedly reminds us, tram lines; but clinical experience is in practice subordinated by them, nonetheless. While as to individual patients' values, the third element of David Sackett's original definition, individual case histories, as the vehicle for understanding what matters or is important to a given patient, come right at the bottom of the hierarchy of contemporary EBM.

This is why JNDS as a journal of clinical case histories, is such an exciting new venture. Clinical case histories may (perhaps rightly) come at the bottom of the evidence hierarchy, but they come right at the top of the values hierarchy. It is above all through clinical case histories that we come to understand individual patient's values (what matters or is important to the patient as a unique individual).

Plugging the gap in EBM in this way is timely, not least because, with the 2015 UK Supreme Court Montgomery judgement, understanding individual patient's values has become central to consent to treatment.

From the deafening silence by which Montgomery has been met by many of our medical Royal Colleges, it might be thought to be a case of plus ça change, plus c'est la même chose. There is a germ of truth in this. As the judgement itself makes clear, its ruling on consent, although consistent with wider developments in international Human Rights law, is no mere legal invention. It is based instead, directly and explicitly, on contemporary best practice, notably as in guidelines on consent from the GMC (General Medical Council). To this extent, then, nothing changes – best practice pre-Montgomery is still best practice post-Montgomery. But by the same token, the stakes for all of us in clinical practice have been considerably raised. Pre-Montgomery, understanding our individual patients' values was optional (it was a matter of GMC guidelines); post-Montgomery, understanding our individual patients'

values is mandatory (it is now a legal tram line for consent).

With that shift, from regulatory guideline to legal tram line, everything changes, and, surely, changes for the better. Yes, there is scope for misunderstanding – Montgomery/GMC best practice in consent is not (as some have supposed) a charter for a 'patient decides' form of health care consumerism; it is about shared decision-making between clinician and patient based on evidence and values. Yes, even so understood, there are legitimate concerns – 'I do this already', 'my patients don't want this', 'we don't have time to do this' – but these are concerns that pre-date Montgomery. Now, at least, we have to face them.

Just how we go about this is beyond the scope of this editorial. But that it will involve in one way or another a change in the way we train the next generation of doctors seems unarguable. Which brings us back to JNDS. As a journal of clinical case histories produced by some of the brightest and best of the next generation of doctors, JNDS may well prove to be plugging a gap for us all.

### Further Reading

David Sackett's definition of evidence based medicine as combining best research evidence with clinical experience and patients' values comes in the introduction (page 1) of Sackett, D.L. Straus, S.E., Scott Richardson, W., Rosenberg, W., and Haynes, R.B. (2nd edition, 2000) *Evidence-Based Medicine: How to Practice and Teach EBM*. Edinburgh and London: Churchill Livingstone. He goes on to define values as "the unique preferences, concerns and expectations each patient brings to a clinical encounter".

GMC guidance on consent, consistently with the shared decision-making model embodied in Montgomery, is called Consent: Patients and Doctors Making Decisions Together. The guidance is available at: <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent>.

The Montgomery judgement is available in full at: *Montgomery v Lanarkshire Health Board*: <https://www.supremecourt.uk/cases/uksc-2013-0136.html>.

Some of the implications of Montgomery for surgical care are explored in Handa, IA., Fulford-Smith, L., Barber, ZE., Dobbs, TD., Fulford, KWM., and Peile, E (2016) The importance of seeing things from someone else's point of view. *BMJ Careers* on-line journal (published in hard copy as 'Learning to Talk about Values') at: [http://careers.bmj.com/careers/advice/The\\_importance\\_of\\_seeing\\_things\\_from\\_someone\\_else's\\_point\\_of\\_view](http://careers.bmj.com/careers/advice/The_importance_of_seeing_things_from_someone_else's_point_of_view) and in, Ward, J., Kalsi, D., Chandrashekar, A., Fulford, K.W.M., Lee, R., Herring, J.H., and Handa, A (forthcoming, *Patient, Education and Counselling*). Shared decision making and consent post-Montgomery, UK Supreme Court judgement supporting best practice.