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Evidence-Based Medicine from a Clinical Perspective

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The evidence base for much of behavioral medicine practice is immature. Few treatment approaches currently are supported by a body of empirical research that satisfies CONSORT criteria. And yet, clinicians must address the needs of patients who require clinical care now. In response to those contingencies, two kinds of practice bias occur frequently. One is the tendency to refer cases out for medical intervention (e.g., pharmacotherapy, surgery) on the grounds that no alternative behavioral medicine treatment possesses adequate evidence-based support. The other, almost opposite, bias is the tendency to treat a diverse array of clinical problems similarly with forms of therapy (e.g., cognitive behavioral therapy, behavioral therapy) that generally possess empirical support, even though they have not been studied for the clinical condition at hand. The alternative approach recommended here makes constructive use of ignorance. We urge clinicians to incorporate literature search and CONSORT review into the initial stages of treatment planning. Research review occasionally turns up unfamiliar intervention approaches that have been surprisingly well studied, but also allows identification of clinically important treatment questions that urgently need research.

A few domains of behavioral medicine intervention are supported by a relatively mature science base. Smoking cessation treatment represents one example. Here different challenges arise in implementing evidence-based behavioral medicine. One worry frequently articulated by students and practitioners concerns the felt pressure to deliver manualized treatments "robotically" or "mechanically," without flexibility to tailor intervention to the client's individuality. A related concern is that manualization supports market-driven trends towards a "dumbing down" and "minimalization" of treatment, so that therapy can be administered less expensively by paraprofessionals or delivered via computerized expert systems. These issues highlight the critical need for collaboration between practitioners and basic scientists in continuing to grow behavioral medicine's knowledge base. Unless questions are posed about the biobehavioral mechanisms that achieve desired clinical outcomes, practice will tend towards rote technical delivery of procedures, uninformed by insight into the learning principles that promote health. As has occurred in smoking cessation, research then tends to devolve into "tinkering phase" evaluation science that examines dose-response variations on a basic protocol, dissemination or "technologization" of procedures. A vital evidence base will benefit by drawing upon basic science knowledge to generate new understanding of underutilized therapeutic mechanisms. It will also benefit from being responsive to largely unaddressed clinical questions, for example those concerning how to treat correlated unhealthy behaviors, whether to focus treatment on primary health outcomes, intermediate physiological outcomes, psychological processes, or behavior change. ◆

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