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1 **The challenges of evidence implementation – it’s all about the context**

2 Here in the northern hemisphere winter has arrived, whilst those of you in the southern
3 hemisphere are hopefully basking in the delights of summer. As we contemplate the
4 different healthcare challenges we each face, it leads me to dwell on the importance of
5 context and how we ensure that the healthcare we deliver is appropriately tailored to those
6 on the receiving end of this care. Despite the historical and unquestionable positioning of
7 evidence-based practice at the forefront of effective global healthcare, clear gaps between
8 what is traditionally defined as evidence and implementation of this evidence in everyday
9 practice continue to exist. This is a universal issue, not limited to any specific type of
10 healthcare delivery, healthcare profession or country. As the evidence-based healthcare
11 (EBHC) movement evolves, it has been acknowledged that not only knowledge utilization,
12 but the way in which knowledge can be transformed by both individuals and communities
13 into a form that may not mirror the original evidence but suits individual patients, is
14 becoming increasingly important. Exploration, as well as being an essential component of
15 empirical research, is an indispensable human endeavor and we must continue to examine
16 the individual, organizational and contextual factors underpinning effective evidence
17 implementation. The role of evidence in the wider context of healthcare delivery is a topic
18 of considerable interest to practitioners, policy makers, and more importantly, patients and
19 service users at the receiving end of healthcare. There is no “one fits all” answer, as each
20 country and indeed each organization, large or small, where healthcare practice is delivered
21 is influenced by context. Understanding this context is the key to implementing effective
22 change.

23 Whenever we consider where we are and where we would like to go, it is always important
24 to consider how we got to where we are now. Evidence-based healthcare was initially
25 derived from the concept of evidence based medicine (EBM), a term first proposed by
26 Gordon Guyatt, leader of an international group of clinicians formed to consider results of
27 recent research when treating patients, first appearing in print in 1992 (Evidence based
28 Medicine Working Group 1992).¹ Whilst this initial focus of EBM was on bedside decision-
29 making, the underpinning ideas have been evolving for centuries, with roots in psychology,
30 sociology and philosophy, and a large part of the underpinning vocabulary invented and
31 developed by statisticians and epidemiologists.² Similar interest within nursing in a topic
32 labelled “research utilization” had also began in the 1970s when one of the first articles
33 “Adopters and Laggards” was published.³ Despite waning interest in the 1980s, this field
34 grew rapidly in the 1990s with the development of several research utilization models, often
35 criticized for their focus on individual aspects of implementation and a failure to account for
36 wider organizational issues. A substantive body of work using the BARRIERS scale developed
37 by Funk et al.⁴ led the field in identifying common barriers that nurses face when
38 implementing evidence. However, whilst work using this method may be of historical
39 interest to track evolution of attitudes towards evidence in relation to changes in the
40 profession, it is unlikely to determine a way forward for nurse leaders and clinicians.⁵
41 Evidence-based medicine was radically expanded, adopted and adapted under the guise and
42 term of evidence-based practice/EBHC⁶ to include all aspects of healthcare rather than
43 being limited to medicine. The term knowledge utilization arose and became popular in the

1 1990s and is considered a more inclusive term encompassing research, scholarly practice
2 and programmatic interventions aimed at increasing the use of knowledge to solve human
3 problems. Despite all these advances researchers, policy makers and practitioners continue
4 to struggle with the final and arguably the most crucial step in the process, evidence
5 implementation.

6 Within the last 15 years, researchers have increasingly recognized that despite the efforts of
7 the EBHC movement to reduce the gap between research and practice, robust evidence
8 alone is not enough to facilitate knowledge mobilization within an organization, resulting in
9 a weak relationship between the strength of the evidence base and clinical behavior
10 change.^{7,8} As Gabbay and le May⁹ argue in their inspirational text, “Clinical Mindlines”, not
11 only does this gap still exist despite massive efforts by the establishment, but there is a
12 glaring disparity between policy makers’ approaches to promoting EBHC and what social
13 scientists, psychologists and philosophers have long told us about the nature of knowledge
14 and its use in the real world. Authors such as McKillop et al.¹⁰ have argued that approaches
15 to evidence implementation continue to take a push/pull approach with a focus on the
16 nature of evidence, “science push”, and on individual implementation behavior, “demand
17 pull”, both of which they suggest fail to consistently influence practice decisions as they fail
18 to understand the messy world of health care practice. The translation of research into
19 decision-making and healthcare practice continues to be a challenge with variable uptake of
20 evidence and mixed success of various implementation projects.¹¹

21 Since its inception in 1996, the Joanna Briggs Institute, along with the worldwide Joanna
22 Briggs Collaboration, have made it their mission to promote and facilitate EBHC. A sea of
23 change is underway and whilst the importance of evidence synthesis remains high, there is
24 an increasing focus on meeting the challenges of implementation with the instigation of
25 new tools such as CAN-IMPLEMENT¹¹ designed to accommodate local needs. I urge
26 practitioners and health providers to continue to experiment and explore with
27 implementation strategies that appreciate the importance of context to achieve the
28 ultimate goal of feasible, appropriate, meaningful and effective healthcare delivery.

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