Good intentions and received wisdom are not enough

There is a common view among social and public health scientists that there is an evidence-based medicine (EBM) juggernaut, a powerful, naive, and overarching attempt to impose an inappropriately narrow and medical model of experimentation onto a complex social world. We have both recently come across hostility among social scientists, and public health or health promotion practitioners or theorists, to attempts to apply EBM principles (for example, systematic reviews or experimental designs) in social or public health settings (for example, sex education in schools, health promotion campaigns, or community development). We believe such hostility to be misplaced, and to be based on a number of misconceptions.

The first misconception is that systematic reviews and experimental designs have a wholly biomedical provenance. As Ann Oakley has pointed out, the use of experimental designs was well established in United States by the 1930s, and from the early 1960s to early 1980s there were many randomised experiments for evaluating public policy interventions in United States, these being considered the optimum design. Much of the early literature on experimental designs (including blinding) came from the social sciences, as a response to the perceived need to be able to make valid causal inferences.

The second misconception is that the “real world” is too complex, messy, or culturally/historically specific for the appropriate application of EBM principles. Objections on the grounds that experimentation is often unethical or impractical in real life are common; however, experimental evaluation is more common in social settings than is often realised, and many apparent practical or ethical difficulties can be overcome. For example, a review by Berk, Boruch and colleagues describes RCTs of the effects of prison rehabilitation programmes, “welfare-to-work” type income supplements, electricity pricing as means of managing demand, and of the educational effects of the children’s programme “Sesame Street”.

The third misconception is that social and public health interventions do not have the capacity to do harm, and that having good intentions is therefore a sufficient basis for policy making. There are enough examples of well meaning interventions with adverse effects to suggest that this is not the case. A weekly exercise programme among the disabled, expected to have beneficial effects, until enough rigorous evaluations are available to demonstrate these impacts. In the United States in the 1980s there was uncertainty among politicians about the effectiveness of a supplemental food programme for women and children. However, a synthesis of good quality evaluations showed that it had modest positive effects on birth weights. Other, and sometimes unintended, positive effects may only be convincingly demonstrated in large, prospective, well controlled intervention studies.

We suggest that the antipathy towards evidence-based principles in social science and public health is often based on misunderstandings about the principles of evidence-based policy; reluctance to accept that well intentioned interventions may do more harm than good, or be ineffective and thereby a waste of public money and time; and...
unjustified defeatism in the face of apparent operational or ethical problems. Rather than thinking of EBM as a biomedical orthodoxy whose applications to social policy, education, the criminal justice system, etc, should be resisted, we believe that the thoughtful extension of evidence-based principles to all these realms of public policy is important for all those who wish to improve human well being.

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*J Epidemiol Community Health* 2000 54: 802-803
doi: 10.1136/jech.54.11.802

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