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From research to clinical practice: (dis)evidence

Da investigação para a clínica: (des)evidências

De la investigación a la clínica: (des)evidencias

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The pandemic has pushed all research not related to SARS-CoV-2 to the background, posing a complex challenge that influences the entire research process, from the design of studies to the use of their results. Measures to control the spread of COVID-19 such as restricting people's movement and access to health care institutions, coupled with the cancellation or alteration of graduate course programs and ongoing research has resulted in the removal of researchers from their settings, increasing the duration of their research, and delaying the introduction of results into clinical practice.

The use of knowledge in health care is not a recent concern in research;[1] authors have argued that this challenge is associated with methodological and ethical issues,[2] scientific rigor, capacity to execute projects, difficulties in funding research, relevance and usefulness in the face of health needs and policies, effectiveness in communication and dissemination, and lack of a scientific culture of collaborative work for the development of products that promote the introduction of results into contexts.[1,2]

These difficulties have been aggravated in healthcare contexts especially in health-illness transitions not associated with the SARS-CoV-2 infection, with probable effects in clinical decision making. Deciding care based on knowledge is a complex process that involves identifying the available evidence for decision making and taking into account the participation of those with care needs and their caregivers.[3] This adaptation of the results to the context and to individual needs breaks with the status quo of globalizing results and requires differentiation and contextualization of studies, with the help of researchers.[4]

These guidelines for the use of evidence reinforce the importance of choosing the therapeutic option that proves to be the most appropriate, following individual clinical circumstances and with the values and preferences of people and caregivers. In many cases, evidence alone is never sufficient to make clinical decisions, analyze cost-benefit, the associated burden, and the costs involved in the decision.[3]

We corroborate the opinion of authors who advocate the presence of research teams in the field and collaborative work to design studies and to assist in the transfer of knowledge to users (health professionals) and beneficiaries (clients and caregivers) of such research.[1,4] However, we have found that policymakers and managers of health units have not weighed the impact of removing researchers from their settings during the pandemic, nor have they considered the effect on the much desired evidence-based practice, maybe because they prioritize unidirectional models of knowledge transfer.

However, moments of crisis should serve to further reflections, accelerate learning and help us anticipate future scenarios with greater decision-making capacity, competence and collaboration among different actors. This editorial challenges researchers to (re)consider their role in the use of knowledge and the challenges of evidence-based practice, questioning research methods and how clinical professionals use research results, but above all, questioning their scientific role and credibility in the use of knowledge,[4] so that the discourse of evidence use is not yet another (dis)evidence in our practice.

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