

Guidance at the Many Edges of Evidence

Position Statements of the American College of Preventive Medicine

David L. Katz, MD, MPH, FACPM, Dorothy S. Lane, MD, MPH, FACPM

Introduction

Evidence has securely claimed its place among the dominant concepts in modern medical and public health practice. To the extent possible, we as practitioners are expected to base our decisions (or recommendations) and actions on the highest standards of available evidence, as well as evidence of benefit at reasonable and acceptable cost. Thus, the putatively simple commitment to apply evidence to the practice of medicine, public health, or both opens the proverbial can of worms: Benefit must be measurable and definable; cost must be measurable; and perhaps the subtlest challenge of all, evidence itself must be defined and measured.

In the various disciplines of preventive medicine, for various reasons, the bar tends to be set quite high for the acceptable application of evidence to practice. First, ours is the discipline in which probability theory, statistics, and classical and clinical epidemiology are most intimately linked to practice, and most explicitly listed among expected competencies.¹

Second, the more elusive individual outcomes are, the more reliable, and therefore the more evidence-based, the predictions of those outcomes need to be to ensure favorable ratios of risk and cost to benefit. Many outcomes in preventive medicine dissipate into statistical anonymity. We can never identify the stroke, cancer, myocardial infarction, or injury we have prevented in an individual; nor the STDs, unintended pregnancies, foodborne outbreaks, work-site trauma, or motor vehicle crashes from which we have successfully defended a population. But with evidence in hand, we know the rate at which such conditions occur in particular populations and how these rates can, theoretically, be changed. By applying the intervention to our patient or population, we expect the risk of the event to decline comparably.

Third, we in preventive medicine are flush with evidence of the very highest caliber. The work of the U.S. Preventive Services Task Force (USPSTF)² pertaining to screening, counseling, immunization, and chemoprophylaxis—collectively, clinical preventive services—has come to set the standard in the rigorous evaluation of evidence

and its application to practice.^{3,4} The laudable processes and products of the USPSTF have now been adapted to community-based preventive service delivery through the ongoing work of the Task Force on Community Preventive Services (the Community Task Force).⁵⁻⁷ Our efforts in both clinical and public health practice thus rest upon as solid a foundation of meticulously considered evidence as one could possibly hope.

But where the rubber meets the road, where the daily decisions and actual activities of prevention practice play out, it is not enough. Our patients—our populations—are not constrained by evidence in the demands they place upon us. Their needs are as likely to take us past an edge of the available evidence as to coincide with the results of any given randomized clinical trial. And at these all-too-frequently encountered edges of evidence, we may either abandon our constituents—our patients and communities—to their own fate, or commit our judgment, our experience, and our expertise to the assurance of a safe and salutary crossing.

The American College of Preventive Medicine (ACPM) finds itself facing a very similar choice, with you, the practitioner, as its constituent. Just as you likely strive to meet the needs of your charges even when they run past the clear implications of clinical trials, so, too, is the College committed to lending its guidance and expertise to your efforts in this hazy area. Its contribution takes the form of ACPM position statements.

In 1996, Woolf et al.⁸ introduced the practice policy statements of the College, emphasizing their role in conveying strictly evidence-based guidelines, often closely linked to the products of the USPSTF. The products of that initiative, published in *AJPM* over the past 6 years, have contributed meaningfully to the art and science of prevention practice.

ACPM will continue to generate, and *AJPM* to publish, practice policy statements. Now, as in the past, these will constitute evidence-based reviews of timely topics in prevention practice. These papers will complement the efforts of the two Preventive Services Task Forces and focus, in particular, on topics unaddressed by either.

But for various reasons, there is a need now for a new product. The expanse of evidence reviewed by the USPSTF and the Community Task Force is impressive, and continuously growing. Also impressive are the resources and methods these groups apply to their

From the American College of Preventive Medicine, Washington, DC
Address correspondence to: David L. Katz, MD, MPH, FACPM, Yale
Prevention Research Center, 130 Division Street, Derby, CT 06418.
E-mail: katzdl@pol.net.

reviews. ACPM cannot hope to generate systematic reviews of comparable quality, nor does the field of preventive medicine need duplicative reviews of any given topic. However, any dedicated reader of the USPSTF reports knows that often there is simply insufficient evidence to recommend “for or against” a particular practice. The same is true of the evidence reviews generated by the Community Task Force. But in your practice today, you do not have the luxury of deciding “neither for nor against” a particular strategy! What is needed, then, is some expert guidance and opinion that pertains to the demands of practice where the evidence is inconclusive, unavailable, or disassembled. ACPM, through the work of its Prevention Practice Committee, is well qualified to provide this in the form of its position statements.

These brief papers will generally highlight the pertinent evidence-based reviews of one or both Preventive Services Task Forces, or, as appropriate, of other groups. Position statements will not contribute new evidence, but will append to evidence-based conclusions the expert opinion and official position of the ACPM. These positions will pertain to the practical needs of clinical and public health practitioners and should, therefore, constitute a useful and comforting extension to the bounds of evidence in which we work. As indicated, position statements will also address how the separate recommendations of our two Task Forces may be assembled into a single approach to the delivery of preventive services.

Now, as before, these products of the College will be prepared under the direction of the Prevention Practice Committee, and be subject to the approval of the College Board. Writing will continue to be a collaborative effort involving members of the committee and outside parties, generally preventive medicine residents under the supervision of on-site mentors. But certain conditions are being changed. The composition of the Prevention Practice Committee is being revised to ensure both that the Preventive Services Task Forces are represented, and that the committee is well constituted to represent the views of ACPM. No authors will be listed up front on position statements, as the source

is, in essence, the College itself; a writing group will be identified at the back of each paper. Let the reader be aware that these promulgated positions of and by ACPM as such are not subject to peer review prior to publication. Practice policy and public policy statements will continue to list authors and remain subject to peer review, as they, unlike position statements, contribute novel content other than opinion.

The use of evidence is, and should be, a priority in the practice of preventive medicine. ACPM will continue to highlight the evidence base for prevention practice. But evidence is a tool in the service of practice, not the bars of a cage that can contain human need.⁹ As the demands of practice push you to and beyond the many edges of evidence, our hope is that the well-considered positions of the American College of Preventive Medicine will secure your footing on common ground as you help your patients and populations navigate uncharted territory on the path to informed decision making.

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