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FROM THE EDITOR:

Confirmation bias by consumers of clinical research demonstrates the need for implementation science

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In our last issue, we published an Informed Consent paper on management of non-ST segment elevation acute coronary syndrome.¹ The clinical scenario described implied informed consent: the doctor made the decision for the patient. This can be viewed as a cultural norm. Who wouldn't want their heart fixed? But after reviewing the case together with the evidence, I think this could have been an opportunity for shared decision making. Some patients might want everything done, and other patients don't want anything to do with doctors and hospitals.

I asked several practicing cardiologists about this case. One cardiologist said, "There was a recently published paper in the Journal of the American College of Cardiology that said all of these patients should get catheterization."² Of course he was referring to the same paper reviewed in our publication. I realized that from a cardiologist's perspective, some of the sub-group analyses would support that conclusion. Yet, when I read the paper, it seemed like a negative study. This is an example of confirmation bias—the phenomenon where we tend to interpret facts to confirm our pre-existing opinions—and a demonstration of reader response theory. "Reader Response theory... argues that a text does not have any meaning in isolation unless the reader experiences it or reads it. The reader's interpretation can be a personal reaction. It can be a culturally inherited way of interpreting things...It further examines the individual reader or communities' way of experiencing texts."³

Evidence-based medicine typically only looks for bias of the research design, but evidence-based practice must also include the biases of those using the research evidence and how it is deployed in clinical practice. That is why this journal tries to emphasize the social context of clinical research. We believe this aspect of clinical practice has been under-examined. By highlighting these issues, we can bring them into clinical discussions and turn passive, implicit decisions into active, explicit decisions.

References

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