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Editorial Comment: Differences in Definitions of EBPH and Evidence: Implications for Communication with Practitioners

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Abstract

Through interviews of 12 members of an expert panel – importantly, involving both practitioners and researchers/academicians – Aronson and colleagues sought to understand how evidence-based public health (EBPH) is defined, what counts as "evidence", and what EBPH actually looks like when operationalized in a local health department. What Aronson and colleagues have shown us is how critical it is that in both creating and implementing EBPH, especially in practice-based research, practitioner and researcher/academician develop a shared understanding of EBPH before the dance begins, especially for practice-based research.

Keywords

evidence-based public health, dissemination, implementation

You like potato and I like *potahto*

You like tomato and I like *tomahto*

Potato, *potahto*, tomato, *tomahto*,

Let's call the whole thing off

When Fred Astaire sings these lyrics to Ginger Rogers in the classic "Shall We Dance" (1937), the couple is trying to reconcile differences on the way to a hopeful matrimony. Understanding language in its context and seeking clarity rather than making assumptions about intent is what they are ultimately longing, as in any healthy, lasting marriage. The marriage analogy and use of language is what comes to mind in reading the article on evidence-based public health (EBPH) by Aronson and colleagues. Through interviews of 12 members of an expert panel – importantly, involving both practitioners and researchers/academicians – the investigators sought to understand how EBPH is defined, what counts as "evidence", and what EBPH actually looks like when operationalized in a local health department (LHD). Not surprisingly, the authors found a range of responses on each topic that in general can be described as "soft data" and processes, to "hard data" and a focus on outcomes. When an LHD engages in EBPH one may see anything from understanding local context, to bringing data into decision-making processes, to testing interventions.

One view of these results is that they simply reflect the state of the field of knowledge: "hard" scientific data about outcomes, derived from rigorous and careful testing of interventions, exists for only a small handful of the myriad of activities that take place through state and local health departments – the type of "evidence" described in the *Guide to Community Preventive Services*[1] and *The*

Guide to Clinical Preventive Services.[2] In the absence of hard scientific data about outcomes, we are all forced to back-track on the logic model, and use the best available evidence – which may be expert opinion and experience – about processes - such as Administrative-Evidence Based Practices[3] – that *should* logically move us in the right and desired direction. Thus a key take-home message in this article is not that any one definition of EBPH is right or wrong, but what the range of responses means for the field of Public Health Systems and Services Research (PHSSR)…and this gets us back to dancing. What Aronson and colleagues have shown us is how critical it is that in both *creating* and *implementing* EBPH, practitioner and researcher/academician develop a shared understanding of EBPH *before* the dance begins, especially for practice-based research. Failing to do so will put us in the place that Fred Astaire bemoaned:

> But oh, if we call the whole thing off then we must part,
>
> And oh, if we ever part then that might break my heart.

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