
Evidence-based medicine in Norway

LANGUAGE COLUMN

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The designation *evidence-based medicine* was launched in 1991. The Journal of the Norwegian Medical Association introduced the Norwegian translation *kunnskapsbasert medisin (knowledge-based medicine)* in 1995.



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The term *evidence-based medicine* (EBM) was first used by the Canadian doctor Gordon Guyatt in 1991 (1, 2). The following year, Guyatt and colleagues published a groundbreaking article using this term in the title. They wrote that a new paradigm in medicine was about to take shape (3).

Since that time, increasing attention has been paid to evidence-based medicine, and it has gained entry into medical and healthcare research and practice. The 'EBM movement' has grown significantly, both in scope and influence. The fact that the *BMJ* ranked evidence-based medicine as one of the 15 most important milestones in medical history since 1840 is illustrative of this (4, 5).

Today, evidence-based medicine represents a hegemonic way of thinking and acting – in research as well as clinical practice. However, scholars and clinicians have also debated whether evidence-based medicine implies a reductionist and positivist concept of knowledge.

The study

We have investigated how evidence-based medicine was introduced in Norway and followed the discussion around the concept during its establishment phase. The topic of our study is therefore the history of its entry into the Norwegian language and conditions of possibility (6).

Given its wide circulation and professional communication profile, the Journal of the Norwegian Medical Association has played a key role, both in Norwegian medical science and in conveying Norwegian medical information to the general public, and it is the source of our empirical material. We have performed searches in PubMed, the Journal's own search portal (available electronically since year 2000), the Journal's annual registries from 1991–99, the digital National Library (bokhylla.no) and the media archive Retriever. Inspired by text analysis methodologies we have studied tendencies and conflicts of opinion regarding how the term *kunnskapsbasert* (*knowledge-based*) is explicitly and implicitly defined through usage.

The beginning

In 1995 both evidence-based medicine and knowledge-based medicine were first used as collective terms in the Journal in an editorial commentary by Magne Nylenna, who was editor at the time (7). In that year, Nylenna wrote five different texts with the term evidence-based medicine/knowledge-based medicine in the title. The readers were also introduced to the concept through several news-related notices and articles.

The following year, Nylenna wrote in a language column that he had chosen to use knowledge-based medicine instead of evidence-based medicine 'to refer to clinical practice that is based on scientific documentation' (8). Nylenna argued that a direct translation to Norwegian was difficult. After detailed discussions in the editorial group, they had arrived at the conclusion that '*kunnskap*

(*knowledge*) is the Norwegian word that best reflects the main intention behind the concept' (8). We observe that this was more than a question of translation; it also had an epistemological aspect. By selecting 'knowledge' rather than 'evidence', Nylenna and the Journal of the Norwegian Medical Association simultaneously distanced themselves from the associations with 'evidence' and 'unequivocal facts', and thus from the positivist connotations that are tied to the English expression.

In Norway, the association between evidence-based medicine and knowledge-based practice was clarified and institutionalised in 2004 through the establishment of the Norwegian Knowledge Centre for the Health Services.

An ambiguous term

Our analyses show that the term 'knowledge-based medicine' contains an ambiguity. On the one hand, the emphasis on evidence implies a break with medical authority. The purpose of evidence-based medicine is to make medical knowledge generally available, as well as to render the basis for medical assessments open to public criticism and evaluation. This emphasis on democratisation is especially prominent in the Norwegian discussion of the concept. On the other hand, this implies a tightening of the requirements for application of knowledge whereby clinical decisions must be capable of being documented and must be embedded in outcomes of research. The actual criteria for what constitutes relevant medical knowledge may therefore be said to be withheld from public debate.

Greater distance between doctors and patients?

The Norwegian debate on knowledge-based medicine shows the paradoxical relationship between the requirement for evidence on the one hand, and public enlightenment on the other. Knowledge-based medicine has undoubtedly made knowledge about health issues a matter for the public by contributing to public scrutiny and debate regarding the basis for clinical decisions. However, it is open to question whether the new knowledge concept has had an alienating effect and helped increase the distance between doctors and patients by marginalising knowledge that does not fall within the definition, or is placed far down in the knowledge hierarchy, where systematic reviews and meta-analyses are ranked higher than randomised controlled trials and clinical experience, while patients' values, preferences and experiences are positioned lowest. In any case, it is essential that discussions on the knowledge concept and criteria for what constitutes relevant medical knowledge continue to be central to the debate on medical knowledge and practice.

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