Great expectations from the chair of evidence-based health care and knowledge translation

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Evidence-based medicine (EBM) has been introduced to the Kingdom of Saudi Arabia (KSA) over a decade ago and the first workshop for critical appraisal training was organized in 1997 by the Family Medicine Department of King Saud University (personal communication). Following that pioneering workshop the ideology of EBM was embraced religiously by many academic and service institutions with the development of many active groups, including Jeddah group for EBM, Madina group, and others. This EBM activity is noticeable in other Arab countries as well, such as Egypt, Syria, Bahrain, Sudan, Jordan, Sultanate of Oman, and the United Arab Emirates (UAE). The development of these groups was followed by the development of collaborative groups such as the National and Gulf Centre for EBM, and the Arab Federation for EBM. All these groups have been very active in spreading EBM by organizing workshops for doctors and other allied medical staff in the form of foundation knowledge of EBM and training of the trainers courses and workshops. More recently, 13 countries from the East Mediterranean region Joined the Evidence Informed Policy Network (EVIPnet), one of the WHO organizations that work towards establishing an evidence-informed health policy in participating countries.[1]

A step forward was taken by the Ministry of Health in the Kingdom of Bahrain by establishing a branch of the United Kingdom Cochrane Center in 2005 in Bahrain.[2] The main objectives of the center are to provide training for authors of systematic reviews and to work as a communication link between authors and different Cochrane groups, in addition to its role in translating Arabic medical literature.[2]

Some individual efforts paid dividend, and during the last few years, we have noticed an increasing number of Cochrane authors from the Arab World including Egypt, Bahrain, Sudan, KSA, UAE, and Syria.[2]

The main goal behind EBM or evidence based healthcare (EBHC) is to improve the quality of healthcare, and to standardize an effective care for patients according to the best available evidence. Then, the concept was generalized from individual health provider or individual setting, to include evidence-based health policy (EBHP) to indicate the adoption of the legislative and the statutory organizations, such as the Ministry of Health, to EBHC, and to base its decision of fund allocation, among other considerations, on evidence for the most effective and cost effective medication, and health technology. More recently, the concept of knowledge translation (KT) was introduced, to indicate the process by which evidence is communicated from researchers to the end users including clinicians, patients and policy makers. The Canadian Institute for Health Research defines KT as "the exchange, synthesis and ethically-sound application of research findings within a complex set of interactions among researchers and knowledge users. In other words, knowledge translation can be seen as an acceleration of the knowledge cycle; an acceleration of the natural transformation of knowledge into use."[3] However, many difficulties face this adoption of EBHP all over the world, including the prospect by which health problem is considered a priority, the different languages that the scientists and the politicians speak, and the time frame in which each group operates.[4] To overcome these difficulties, bridges of communication should be established between end users including policy makers, and the evidence generators to facilitate KT.[5] These bridges are missing from the Arab World as much as the

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systematic training of knowledge synthesis, knowledge brokering, and knowledge translation. This systematic training goes beyond the workshops, it involves continuous capacity building and represents the core requisite for establishing the infrastructure for EBHC.[5] The "know-do" gap is internationally recognized,[6] and the Arab World is not an exception; however, to address this gap, we should see more contribution in the international literature from the Arab World reflecting their recognition of the difficulties unique to the region, and their opinion of how to bridge this gap. We should create a systematic postgraduate training in areas, such as health technology assessment, evidence-based clinical guidelines generation and adaptation, health economics, and others. The training of EBM for clinicians at the postgraduate level is the foundation for KT at the clinician- patient level;[7] hence, modern methods of teaching should be employed such as e-learning, with the intention to improve the impact of this training in reducing the knowledge-practice gap. Computer-based training has many advantages over classical workshops including flexibility in time and place for a busy clinician, and the possibility to reuse the software to enhance the mastery in EBM knowledge and skills.[8] Other advantages of e-learning includes the provision of a standardized validated curriculum with the possibility of certification in competencies of EBM from a recognized academic body, such as the Saudi Commission for Health Specialties, or the Arab Board for Medical Specialization. Moreover, e-learning can be implemented at a regional level in the Arab World thereby, establishing an EBM or EBHC-network in the region, which share many health priorities, and similar knowledge practice gap. Such endeavor was proven to be possible as demonstrated by the EU-EBM project.[7] Sheikh Bahamdan Chair of Evidence-Based Health Care and Knowledge Translation (EBHC-KT) was established in June 2008, in King Saud University, as part of the university plan to promote research. The Chair of EBHC-KT must be considered as a step forward in bridging the gap between evidence and practice by adding to its activities the responsibility of KT. The expectations from the Chair of EBHC-KT are great, and the gap between evidence and practice is huge at all levels of health decision making. A KT center, according to the above definition, is expected to promote not only a high quality research, but a health priority oriented research that addresses health issues of local and regional importance. In the same context, it is expected to promote the local capacity building for research to avail the high quality evidence, which addresses the local health problems.

Considering the scarcity of high quality evidence from research in the Arab World,[9] and the lack of organizations for health technology assessment, and the fact that for a long time, the Arab World will be dependent on the internationally produced evidence for clinical and health policy decision making, any organization for KT will be expected to translate research data into ideas and statements (research synthesis), and to reach-out for clinical decision and health policy makers (knowledge brokering) by creating channels and common language of communication between research and users of research, not only at a local or regional level, but by international networking, to facilitate transfer of knowledge between similar communities.

The task for the Chair of EBHC-KT is enormous, and the limited time for funding and the financial constraints are among the major hurdles facing the Chair, but establishing the foundation for a pioneering role will always be an uphill journey.

Conflict of interest. *The authors are members of Sheikh Bahamdan Chair of Evidence-Based Health Care and Knowledge Translation.*

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