The mission of IJATT is to publish peer-reviewed reports pertaining to clinical applications of research findings; procedures found to be effective in the recognition, rehabilitation, and prevention of sport-related injuries; and professional practice issues. The major tenet of our mission is to help clinicians find balance between the best available research evidence and their own clinical expertise when making clinical decisions. Over the past 3 years, we have developed a series of editorials to highlight the delicate balance between control and generalizability in clinical research,1 the importance of the integration of external evidence (best available research) and internal evidence (clinical expertise) when making clinical decisions,2 and the necessity of outcomes in legitimizing our professional knowledge and ability.3 However, we have not yet provided framework for patient values and preferences, the often forgotten component of evidence-based practice and practice-based evidence.

In the midst of adding EBP continuing education requirements for athletic trainers, there emerged a trend to consider clinicians as “in the wrong” by using interventions that were not “evidence-based”… and by ‘evidence’, it is implied that this is actually ‘research-evidence’. We tended to look shamefully upon the foundation of our EBP pyramid (undocumented clinical experience) and praise the glory of the randomized controlled trial.1,2,4,5 This is not a completely inappropriate way of thinking, but it certainly was too limited. Even though we would repeatedly state, “the three elements of EBP—the best-available research, clinician expertise, and patient values—are all weighted equally”, we tended to believe that “evidence-based” really meant “research evidence-based”. After the past 3 years, we now consider the clinician’s internal evidence, as an EB practitioner, of equal importance to the best available external evidence.

The last piece of the EBP model, “Patient Values and Preferences”, should also be equally weighed, yet we rarely discuss it beyond the context of talking to the patient to find out what they expect in their interactions with us. What exactly does this mean? We are supposed to gauge the preferences, concerns, and expectations of our patients and their stakeholders throughout the clinical decision-making process. We do tend to discuss the necessity of patient-orient outcomes—metrics and results of success that are meaningful to the patient. However, we often fail to consider the patient’s role in the decision-making process for the interventions we deem most appropriate based on their unique problems and goals. If we employ a “clinician knows best” authoritative mentality to treatment selection, we will eventually fail in two ways. First, in some instances, the treatment selection could be wrong. Not incorrect, as there may be external and internal evidence to support it. However, it could wrong for the patient. This is our first failure. Then, when the patient does not respond as expected, we fault the patient because he/she did not do what we asked of them. Think about how many times you may talk with coaches about athletes not showing up on time for rehab sessions, not coming in to get taped or braced appropriately, not doing the home exercises you’ve given them, etc. This
is our second failure... OUR failure, NOT the patient’s failure. Perhaps we did not take the time to gather critical information from our patients about their true expectations, concerns, and preference throughout the clinical decision-making process.

When we consider “Patient Values and Preferences” as part of the EBP paradigm, we often view this as “what the patient/client wants”. However, there is so much more to this concept. We know that most patients with sports injuries would like to get back to playing their sport as soon as possible. During the intervention phase, we must consider the patient’s Population to which they belong (age, sex, sport, etc.) and we also need to know about the Patient—their personal knowledge, attitudes, cultural knowledge (sporting, ethnic, family, etc.), previous experiences with injury, their unique activity limitations and participation restrictions, etc. This Patient Evidence is extremely important to consider when designing interventions. There are three key elements that the evidence-based practitioner must consider when selecting interventions based on Patient Evidence:

- What is your patient willing to do? (Compliance)
- What is your patient willing to do properly? (Fidelity)
- What is your patient willing to continue to do? (Adherence)

We often discuss Compliance in terms of “this patient isn’t doing what I told him to do, he is not compliant”. Compliance is defined as what the patient is willing to do. Intervention selection should start with a candid discussion with the patient on what he/she will partake in and what the expected results will likely be. Based on your discussions, you can then gauge whether a particular intervention would be a good choice based on the integration of Patient, External, and Internal evidence.

Beyond the willingness to engage in a particular intervention, we must also be candid with our patients about their Fidelity to that program—the willingness to do the program correctly. Are they being faithful to their treatment plan? In their willingness to perform a particular exercise (compliance), are they also willing to do it correctly (fidelity)? This can be a particular technique (e.g., maintaining the appropriate scapular positioning during an exercise at home) or it can refer to the dosage (e.g., “Are you doing this once a day like we discussed?”).

Having an ongoing discussion with your patient about how and when they are performing their exercises and having them demonstrate them for you is a good way to gauge their fidelity to the treatment plan. If you find that they are not being faithful to what you have developed, a deeper reflection and discussion should result. Is the rehabilitation too challenging? Does the patient see the value in the exercise and connect it with their goals, activity limitations, and participation restrictions? Is your dosage plan too overwhelming? Are there other biopsychosocial factors that need to be considered and assessed? Perhaps there may be alternative therapeutic interventions that your patient would be more willing or more capable of doing correctly. Decreased fidelity in this context is not bad. Rather, it is an indication that there are, perhaps, other relevant areas of Patient Evidence that warrant further exploration, education, and communication.

Adherence, the willingness to stick to a program, is the integration of compliance and fidelity over time. It is critical to consider adherence when evaluating the effectiveness of interventions over the long term. If the expected outcomes are not evident, an assessment of how well the patient is performing the intervention is necessary. Another important factor for adherence is good prognostication. How long will the patient need to perform the intervention? How much change should be expected over time? Educating the patient on the evidence-based timelines for expected outcomes is very important. Further, educating the patient by connecting the efficacy of interventions to their potential effectiveness is critical.

Compliance, fidelity, and adherence are three critical factors gleaned from Patient Evidence. These can be assessed up front, throughout the rehabilitation process, and reflected upon after discharge. Further, we must consider how the interactions with our patients (e.g., getting to know their level of compliance, fidelity, and adherence to therapeutic decisions) shift the probability of successful outcomes based on what the Patient Knows (Patient evidence), what the Clinician Knows (Internal evidence), and what the best available Research Indicates (External evidence). Rehabilitation is an ever-shifting paradigm. Continual re-examination and re-weighting of what “should” happen and what “could” happen is necessary in the context of these three sources of evidence.

As we’ve discussed above, incorporating patient evidence can be tricky because we have to balance