From critical appraisal to critical thinking

In my last editorial, I explored how structured appraisal tools, such as the Critical Appraisal Skills Programme (CASP, 2026) and Joanna Briggs Institute checklists (JBI, 2026), can help to provide a structured approach to evaluating evidence in wound care. I also provided a set of questions to ask yourself when appraising evidence (Holloway, 2026). Collectively, these tools should help bring consistency and rigour to how we evaluate research, particularly in a field where study quality is often variable and methodological limitations are common. However, these approaches on their own may not make us more critically thinking clinicians. If we are to embed evidence-based practice, I would argue we need to cultivate a culture of critical thinking across clinical teams.

Critical appraisal tools provide structure and prompt us to consider study design, bias, reporting quality and applicability to practice. Appraisal tools and frameworks offer busy clinicians a pragmatic way to engage with evidence, particularly in time-constrained environments. However, these tools should not become tick-box exercises. Completing a checklist does not automatically mean that evidence has been meaningfully interrogated. A study may appear to score well, but there may be concerns about its relevance, generalisability or underlying assumptions. In practice, critical appraisal is not simply about answering structured questions - it is about asking the *right* questions. This requires judgement, curiosity and, at times, a willingness to sit with uncertainty. Without these, there is a danger that clinicians may develop a false sense of confidence in the evidence, rather than a nuanced understanding of its strengths and limitations.

In addition to critical appraisal, we also need to grow our critical thinking skills in wound care. For example, when considering whether research is clinically meaningful, does the study address an important clinical problem and are the findings applicable to the individuals in front of us in the clinical setting in which we work? Methodologically critical thinking requires the identification of missing or unclear details in a study, identifying potential sources of bias, including funding or design choices. So, after reading a piece of evidence, think about whether you are convinced this evidence supports a change in practice. This kind of thinking is particularly relevant when evaluating new products or interventions, where marketing information may be persuasive, but the underpinning evidence less robust.

Being able to think critically about evidence needs to be embedded in undergraduate education across all health and allied care professions to support multidisciplinary team (MDT) approaches. Yet there may also be a danger of reducing critical thinking to a technical skill that needs to be acquired, rather than viewing it as a clinical mindset. Thinking critically thinking requires an individual to have a questioning approach which can feel uncomfortable as fear of being wrong may discourage individuals from speaking up. The consequence of this is that practice is based on habit, anecdote or "it's always been done in that way".

How do we move to an accepted clinical culture of critical thinking? We need to allow MDT members to ask questions and encourage opportunities to facilitate evidence being discussed openly and in a constructive way. We must acknowledge that there may be uncertainties, but, ultimately, we want to ensure that clinical decisions are collectively reasoned and defensible. For this to happen, individuals within a team must feel psychologically safe, which can be facilitated by inviting all team members to contribute and welcoming questions about accepted current practice. Additionally, move to a mindset where differences of opinion are thought of as opportunities for learning. Normalise the *not knowing* and look for ways to seek out evidence collaboratively. One approach may be case-based discussions as a mechanism for embedding critical thinking in everyday clinical practice.

In conclusion, remember that evidence-based practice is a combination of best available evidence, clinical expertise and patient preferences/values (CASP 2024). Critical appraisal tools help us engage with the first of these, they do not automatically equip us with the confidence or culture required to act on it. To move forward, we must shift our focus. It is not enough to ask whether clinicians know *how* to appraise evidence – we must also ask whether they feel able to question, discuss, and challenge it in practice because this is central to patient safety and quality of care. Thinking critically is part of the solution, but creating a culture where critical thinking is supported and valued is of equal importance.

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References

CASP UK (2024) What is evidence-based practice? https://casp-uk.net/news/what-is-evidence-based-practice/ (accessed 02.06.2026)

CASP UK (2026) CASP tools and checklists. casp-uk.net/casp-tools-checklists (accessed 02.06.2026)

Holloway S (2026) Why evidence appraisal matters in wound care. *Wounds UK* 22(2): 8–9

JBI (2026) Critical appraisal tools. https://jbi.global/critical-appraisal-tools (accessed 02.06.2026)