Medicine crisis based on evidences

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Editor

In a recent assay by Grenhalgh et al., published in the British Medical Journal[1], it is suggested that the evidence-based medicine (EBM) movement may have fallen into crisis. This perception, shared by many of the critics this proposal had since the beginning, is probably linked with an excessive expectation that has left many people clearly dissatisfied. The EBM approach aspired to rescue the scientific bases of medicine in order to apply them to everyday decisions, as opposed to decisions supported by opinions, non-systematized experiences, intuitions or incidental readings. However, right from the start, it already posed serious methodological difficulties that hindered its adoption as a regular tool. For example, clinicians almost never could postpone decisions until a thorough literature search, an analysis on its validity and reliability, and a supported judgement on the applicability of the evidence to the case in question were made. Additionally, most physicians not only do not have time, but they lack the training required to carry out the procedure, since they have to be experts in search strategies, methodological analysis and other methods. This was tried to be solved by means of secondary publications, where experts conducted a review of literature and offered it distilled to clinicians, already subjected to analysis and evaluation, and they in turn could trust in whatever the experts would have concluded without having to review each article individually. This is where systematic reviews arised from, many of them with meta-analyses, those published by the Cochrane Library, and even clinical practice gudelines. It also became clear that not every expert on a theme is trained to conduct systematic reviews, which were identified as a special literature research modality that not only requires special training, but also nearly absolute dedication, a level of professionalization that experts in their field often lack. At the beginning, the value of clinical expertise was also underrated, although later this was rectified and it was incorporated as a valuable element of decisions, even of those based on evidence. Systematic reviews experts' methodological rigor resulted in a large number of reviews being inconclusive, thus ending up to be useless for clinicians. Evidences were classified according to their importance for the patients, which led to the emergence of the term *patient-oriented evidence that matters* in an attempt to narrow down the spectrum of what had to be reviewed, which even so is unmanageable. In short, the use of EBM in clinical practice was found to be quite impractical, both in its modality of individual review of original research works to aid clinical decisions and in that of consulting secondary information sources and systematic reviews that were not reaching to practical conclusions, which was precisely what physicians needed. It also became clear that the review of a single work or a few of them was not enough to make well supported clinical decisions, since there are many studies with conflicting results. Additionally, methodological matters got detached and left the patients behind, which resulted in many EBM promoters overrating the ability to find evidence and not so much the skills to apply it to everyday cases.

To all of the above, some more facts must be added: the increasing excess of information makes it impossible analyzing it entirely; the lack of responses in the literature to many of the questions clinicians ask because evidence has not yet been created; the lack of correspondence between the circumstances of controlled clinical trials (with their inclusion and exclusion criteria) and those of everyday patients; the need to respond to the patient rather than to scientific truth; the fact that many patients have several simultaneous diseases (comorbidity), in which case is more difficult to apply EBM; the fact that the patient's opinion is often not considered; the fact that the term has worn down, especially when it has been wrongly, abusively used or when it has been used as an advertising argument, and like these, many more circumstances.

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Today, we hear about EBM evolving into the so-called "real evidence-based medicine", which considers the patient's priority, the need for individualized evidence to have a format that both clinicians and patients understand, the need for measures that are applied to be the result of an expert judgment and not merely blindly following certain rules, the need for decisions to be shared with the patients through understandable conversations and for more solid doctor-patient relationships to be built. In other words, scientific evidence should not serve to separate phisicians from patients, but to bring them together. Patients should be offered better, better presented, better explained and more personalized evidence, more customized to their circumstances; healthcare professionals should not restrict themselves to being experts on search for evidence and critical methodological evaluation, but on judging the relevance to the case and on the ability to make shared decisions; those who generate secondary sources, such as evidence summaries, clinical guidelines or decision-making tools, should take into account those on whom they are going to use them, for which purposes and under which circumstances; medical journals' editors should ask not only for methodological rigor in publications, but also for indications to their applicability; the scientific evidence connotation should be respected, but subjected to its usefulness for patients; the analytical method should stop being weighted above its clinical transcendence and should be materialized into a methodology that turns EBM in an instrument at the service of the profession and the patients, bearing in mind that its ethical foundation lies in one of its founding statements: to offer each patient the best existing alternative.

References

1. Greenhalgh T, Howick J, Maskrey N. Evidence based medicine: a movement in crisis? BMJ. 2014;348:g3725.