When probability becomes true!

Per Hartvig Honoré

Evidenced-based medicine has become the wise stone in pharmacotherapy. All information on treatment outcome for a certain indication in a specific patient group is collected and the best treatment forms guidelines for therapy. It is advised that the guidelines are followed in the clinic to assure the patient receives the best treatment. It not only includes pharmacotherapy but also non-pharmacological treatment that will support and alleviate suffering.

Evidence-based medicine is the mainstay of quality control of pharmacotherapy made by the clinical pharmacist. Patients not treated according to evidence-based medicine included in the inclusion criteria will then be reported and discussed with the responsible physician. Unfortunately, evidence-based medicine does not take into account all patients irrespective of whether or not they are subject to a correct diagnosis and indication. For example, evidence-based medicine shows that 75% of patients treated with the best measures will benefit from the treatment. For the remaining 25% there is usually no best treatment advised, only a second-line treatment. In the worst cases, patients have to receive several treatments and eventually be described as 'drug resistant'. This wording is unfortunate as it suggests that the patient is wrong rather than that the drugs are not sufficiently good. This highlights a problem: evidence-based medicine has become true rather than only probably the best treatment.

A good doctor may know which patients for whom the first-line treatment is not optimal. He will choose another alternative according to his experience and might even be blamed for not following evidence-based recommendations. On the other hand, this doctor will save the patient from non-working drugs, side effects and further suffering. This is the 'art of medicine', which is very important to ensure the best treatment is given to all.

The clinical pharmacist does not have enough knowledge about the patient, his disease, his signs and his feelings and behaviour. He must therefore have support from evidence-based medicine where he may find the best treatment for the majority of patients, but not for all. This problem is highlighted in an article by Javelot *et al*[1] which assesses drug-drug interactions in the psychiatric ward.

This is a very important limitation that must be carefully considered. Clinical pharmacists can never substitute for the clinical doctor because of lack of knowledge, experience and the feeling of the 'art of medicine'. However, clinical pharmacists have pointed out some important discrepancies between doctors' handling of patients and evidence-based medicine. Evidence-based medicine is a cause for concern if maltreatment is ongoing, but it is not taking the 'art of medicine' into its full perspective. The clinical pharmacist must be aware of the limitations of his advice.

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