



Comment on Antithesis

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It is not the aim of this section to put an end to all discussion about a particular topic: quite the contrary, we want to open up a debate among readers. I will not, therefore, go through the very interesting, highly cultured, and to some extent provocative antithesis of Saraceni ¹ in detail, but will focus mainly on some possible (and common) misunderstandings about evidence-based medicine (EBM).

— EBM is not static: in fact it relies on science, which is not a static objective Truth, but the continuous search for a multidimensional truth. In fact, one possible problem arising from a scientific approach is relativism.² Consequently, by definition, EBM evolves constantly as knowledge grows.

— EBM was not born for the purpose of distributing resources.³ It was conceived to reduce bad treatment (without evidence), and suggest the most effective therapy for each individual patient (evidence based clinical practice, EBCCP).⁴ Anyway, the distribution of our limited resources on the basis of an objective criterion like EBM is correct in my opinion, provided we also have the instruments to cater for the exceptions, which should be recognised and accepted (and paid for).

— EBM is not cookbook Medicine.³ By definition, statistics mean being correct for 95-99% of patients, but individuals are not necessarily among this 95-99%. This is why EBCCP has been proposed. This is why Medicine is a scientific Art (*i.e.*, artistic application to single individuals of scientific results obtained in populations). This is why the best physicians are those who effectively treat the 1-5% of patients that differ from the others (and that usually requires solutions that theoretically are not considered correct by EBM, but that in reality are fully EBCCP). Bad physicians include those using cookbook EBM (all patients given the same treatment); but even worse are physicians who do not apply EBM, that guarantee at least a minimum “average”

good treatment. Moreover, since physicians treat a huge number of patients (a population), their general behaviour should be in line with EBM (with a few exceptions).

— New PRM treatments derive in the main from the results of basic science (*e.g.*, from mirror neuron discovery);⁵ EBM simply tells us that the only way to check, and accept (or reject) these theories is not through other theories, but by verifying their clinical effectiveness. EBM is democratic, since it is not the power of people (theory against theory) but that of results (it either works or it does not).

— PRM looks at persons and not at health conditions.⁷⁻⁹ As a consequence, we have to include in our research personal and psychological strategies as well as social factors. PRM may make our research more difficult and challenging, but it does not drive us out of EBM.

I would like to finish with Dr Saraceni. While thinking that EBM is insufficient, he states that we need to search for something new, to integrate with EBM. While concluding that EBM is a very good approach for PRM, I underlined that perhaps we need to adopt the classical EBCCP model.¹⁰ Thesis and antithesis seem to converge, recognising the uniqueness of PRM. Nevertheless, in my view we should not rely on “basic science”,¹¹ but need to climb the pyramid of evidence toward RCTs and metanalysis, accepting the challenge of EBM.

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