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## **Response to Miles and Mezzich “Medicine in crisis and a crisis in semantics”**

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## **Introduction**

Miles and Mezzich [1] offer a welcome and comprehensive account of historical recent developments in healthcare and the role of its practice models. They identify a 'crisis' in medicine, which seems to have occurred in part because the science of medicine has been over-emphasised and the importance of compassion and care de-emphasised. As they point out, this crisis has been perceived to have evolved over the past one hundred years. Evidence Based Medicine (EBM) is suggested to be inadequate to solve the crisis and it may be the case that EBM, in fact, has precipitated it because it ignores patients qua persons. It is also suggested that Patient Centred Care (PCC) seeks to address the imbalance, but that this is inadequate, too. Between these existing views it is claimed that Person Centred Medicine (PCM) solves the crisis by giving persons and evidence their proper roles and relative importances.

The paper [1] is in many ways more sophisticated than other purely critical pieces that merely point to deficiencies in EBM [2]. It goes further than most criticisms to avoid the trap of pitting against each other two exaggerated caricatures in that it argues explicitly for a 'coalescence' of EBM and PCC. But does it avoid the trap entirely? The intuitive response of committed EBM proponents would be that this is simply another misinterpretation, or that the polemic is grounded in a fixed ideology (a claim that could equally be reversed) [3]. We wish to note a number of problems that have been repeatedly present in debates about EBM and will do so below.

## **EBM – representation and misrepresentation**

A persistent problem in discussions of EBM is that it is easy to build a straw man in order to be able to knock it down. Perhaps, if proponents of EBM were more careful or clear, it would be less easy. Indeed, there has been at least one notable attempt to add additional conceptual clarity recently [4]. We suggest that it must be a mistake - on any fair characterisation of EBM - to claim that EBM is a paradigm that is incommensurable with treating patients as persons, or to claim that incorporating evidence into shared decision-making is an innovative concept. If there is any area in which the philosophy of EBM might be said to have made serious progress over the last twenty years, then it is certainly in the more sophisticated articulation of the proper role that patient's values and circumstances play [5]. Contrary to the claim in Miles and Mezzich's paper, we also believe that the distinction between facts and values may actually enhance the EBM thesis, by highlighting that evidence alone is never sufficient to justify a clinical decision.

EBM and PCC, if we resist building straw men of them, seem to us to be climbing the same mountain, but on different sides. We suspect that there is no deep difference. For example, taking issue with the B (based) in EBM, and favouring instead an 'I' (informed), seems to us to be insubstantial, despite claims in the paper that the difference is deeply philosophical and not simply strategic. In addition to the misrepresentation of EBM, a second problem in the general literature is equivocation on the term EBM. Consider that it could be taken as: i) an epistemological thesis (trust evidence which possesses characteristics X, Y, Z); ii) a practical strategy for finding evidence (follow methods A, B, C when searching and appraising evidence) or iii) a rigid strategy for the practicality of making clinical decisions (always do what is supported by the best evidence).

Perhaps the discussion paper thinks of EBM in the third sense here; but again, we are not at all sure that this would be a fair characterisation of EBM because of the tension it artificially creates between facts and individual values. This latter interpretation is certainly not one recognised by medical practitioners or international guidelines for common diseases.

## **Conclusion**

Regardless of the nomenclature, let us agree that we need high quality evidence of all types to inform the decisions we make with (and sometimes for) the patients who entrust their healthcare to us. The debate on what exactly constitutes high quality of evidence continues to rage and we are confident that the paper by Miles and Mezzich will contribute significantly to the necessary clarifications that we might expect over time.

## **Conflicts of Interest**

The authors declare no conflict of interest.

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