## Practice Pearls

### TO THE EDITOR:

I would like to respond to the way "Practice Pearls" (*J Fam Pract* 2004; 53:649) was introduced. The editorial describing this new feature (page 598) contrasted the "wisdom of the ageds" with "cultish" discounting of personal experience, and the instructions on submitting "pearls" contrast "good evidence" and "clinical experience." I am concerned that this understanding of evidence-based medicine (EBM) is overly influenced by an understanding of EBM as an enterprise dependent on large meta-analyses and high-powered statistics, and thus primarily the bailiwick of those academics with the training and time needed to spend doing lengthy critical appraisals and writing in-depth reviews.

One of the earlier, and most succinct, definitions of EBM was David Sackett's statement that it is "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients."[1] This statement implies a broader theory of EBM than that which places evidence in opposition to experience.

First, it emphasizes the use of "best" evidence, not of ideal evidence. The process of defining best evidence has led to a number of systems for rating evidence, including the Strength of Recommendation Taxonomy adopted by both *American Family Physician*[2] and *JFP*. No matter what system is used, however, all describe a continuum of ascending evidence quality ranging from "case series" or "usual practice" up to "meta-analyses of randomized controlled trials" (RCTs). Thus even one's personal experience (in other words, one's own, presumably unpublished, case series of clinical experience) *is* evidence, it just happens to be low-quality evidence—but if that low-quality evidence is the best available, then it should be used!

Second, Sackett's definition describes application of evidence to the care of the individual patient. Here again, clinical wisdom or experience come into play as each physician applies evidence gleaned from others' experiences (maybe experiences reported as RCTs, or just case series) to what we know of our own patients in making clinical decisions.

To illustrate (from my personal experience!): when recently faced with a tongue laceration in a small child, I supplemented my extremely limited clinical experience with the results of the only study on the subject I could find on Medline, which indicated repair was unneeded.[3] While the evidence I found was not of ideal quality (SOR=**C**), it nevertheless improved on my meager clinical experience, and I view this as a successful application of EBM in answering a clinical question.

EBM should be seen as fundamentally about applying clinical experience in making clinical decisions. Ideally, the clinical experience used to guide a decision would be high-quality information obtained from rigorous evaluation of experience with multiple patients (ie, a RCT or meta-analysis). In real-world applications, the best evidence may be of much lower quality, yet it is always ethically incumbent on us as physicians to use the best quality evidence available. In order to promote such use of "best" evidence, it will not serve us well to put evidence and experience in opposition, rather we should maintain a critical appreciation for the place our individual experience occupies on the continuum of evidentiary quality.

***William E. Cayley, Jr, MD,*** *Eau Claire Family Medicine Residency, Eau Claire, Wisc. E-mail: bcayley@yahoo.com.*

**REFERENCES**

1. Sackett DL, Rosenberg WMC, Gray JAM, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ* 1996; 312:71–72.
2. Ebell MH, Siwek J, Weiss B, Woolf SH, Susman J, Ewigman B, Bowman M. Strength of recommendation taxonomy (SORT): a patient-centered approach to grading evidence in the medical literature. *Am Fam Physician* 2004; 69:548–556.
3. Lamell CW, Fraone G, Casamassimo PS, Wilson S. Presenting characteristics and treatment outcomes for tongue lacerations in children. *Pediatr Dent* 1999; 21:34–38.