

Commentary

Honoring Our Evidence Base

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The term “evidence-based medicine” is in vogue—in psychiatry, as in all medical specialties. Actually, from the beginning of the 20th century and the Flexner Report,¹ modern medicine has claimed to rest its practices on science. This solid grounding in fact has distinguished our profession from cults, charlatans, and other unscientific practitioners. Because the sick are so vulnerable, society vests physicians with special privileges. In return, medical doctors are expected to keep up to date in their specialties and employ evidence-based practices.

In psychiatry, an increasing number of guidelines, algorithms, and consensus statements assist us in this task. The American Psychiatric Association regularly publishes and updates treatment guidelines for a growing number of disorders. The Texas Medication Algorithm Project creates and studies treatment algorithms for various conditions.² Consensus statements involve complex and sophisticated polling of experts in a given area, based on their knowledge as well as clinical experience.³ In general, these different templates tend to agree with one another, although there are a few differences among them in first-, second-, and third-line treatments for specific disorders.

How is the practitioner to apply evidence-based medicine in modern psychiatry? Blending guidelines, the *Physician's Desk Reference* (PDR), and the scientific literature in our field, a clinician should have little difficulty

in the early stages of a patient's treatment. For example, most doctors choose a selective serotonin reuptake inhibitor (SSRI) as a first choice for a patient with uncomplicated major depressive disorder or a second-generation antipsychotic for a patient with schizophrenia. When we make such obvious and conservative selections, the clinical note need not be extensive. The choice speaks for itself.

As clinicians leave behind the realm of easy-to-treat, uncomplicated patients for the real world of treatment-resistant, comorbid, and complex cases, the plot thickens. Frequently, the evidence base fades at that point. There may be few (if any) randomized, double-blind, controlled, prospective trials involving patients like Ms. X, with her multiple psychiatric, substance abuse, and medical disorders and lack of response to standard treatments. Even in such cases, however, a doctor's thinking must be rigorous, scientific, and as close to evidence as possible. Diagnoses and treatments should be grounded in data and not “faith based.” Too often, even well-trained physicians believe in magic and the wisdom of gurus.

When we must leave all rigorous knowledge behind, the patient needs to be a willing traveler on a journey into the unknown. The physician's obligation is to share the uncertainty with the patient. Certainly, there is nothing improper in the use of medications outside of PDR guidelines (whether in dose or indications), as long as the thinking is logical and reasonable and the patient truly gives informed consent. As practice diverges from the standard and conservative, it behooves a doctor to write more extensively in the chart about the rationale and plan, as well as the informed consent discussion.

Modern medicine has become more complex. So has the specialty of psychiatry. We have more treatments and greater potential for interactions and other misadventures. Categorical boundaries between diagnoses and among pharmacologic groups have become less crisp and distinct, as we await greater information from the unfolding human genome.

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Despite many modern advances, much of medicine remains an art. "Listening with the third ear," staying attuned to the nuances of human communications, and using empathy and compassion are still essential for good practice. But whether we are treating easy or complex cases, employing first-line treatments or concocting novel and creative regimens, we must always think systematically and rigorously and stay as close to the scientific evidence as humanly possible. Lifelong learning is much more than a cliché.

REFERENCES

1. Flexner A. Medical Education in the United State and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching. New York, NY: Carnegie Foundation for the Advancement of Teaching; 1910. Bulletin No. 4
2. Miller AL, Chiles JA, Chiles JK, et al. The Texas Medication Algorithm Project (TMAP) schizophrenia algorithms. *J Clin Psychiatry* 1999;60: 649-657
3. Expert Consensus Guideline Series: Optimizing Pharmacologic Treatment of Psychotic Disorders. *J Clin Psychiatry* 2003;64 (suppl 12):2-97