



John Hickner, MD, MSc
Editor-in-Chief

Let's talk about the evidence

One of my favorite professional activities is teaching an evidence-based continuing medical education course each year at state Academy of Family Physicians meetings. In 12 intensive hours, 4 evidence-based medicine (EBM) experts guide family physicians, nurse practitioners, and physician assistants through nearly 400 abstracts that summarize recent studies that impact primary care practice.

In some cases, the new studies support current practice and standards of care, but for many topics, the new evidence suggests we ought to change our practice, either by stopping something we are currently doing or by starting to do something new. Who would have thought, for instance, that we should abandon the routine bimanual pelvic exam because the potential for harm is greater than the potential for benefit?

Frequently, however, we conclude a talk by describing the uncertainty surrounding particular issues and the need for more high-quality research. For example, there is scant evidence that vitamin D supplementation in healthy Americans leads to any positive outcomes compared to a decent diet and 15 minutes in the sun each day. Luckily, there are several large randomized trials currently underway that will evaluate vitamin D supplementation.

Who would have thought that we should abandon the routine bimanual pelvic exam? And yet, that is what the evidence tells us.

The strength of the scientific evidence to support screening tests and treatments is important to consider. A study examining changes in 11 American College of Cardiology/American Heart Association guidelines found that, out of 619 recommendations, 90% were unchanged in the updated version if supported by multiple randomized trials, and 74% were unchanged if supported by expert opinion.¹

In *The Journal of Family Practice*, we use the Strength of Recommendation Taxonomy (SORT) that was developed by family physician EBM experts² because it is an approach to grading evidence that takes into account “patient-oriented evidence that matters.” An A-level recommendation is based on consistent and good-quality patient-oriented evidence; a B-level recommendation is based on inconsistent or limited-quality patient-oriented evidence; and a C-level recommendation is based on consensus, usual practice, opinion, disease-oriented evidence, or case series.

We ask our authors to carefully select the level of evidence supporting their clinical recommendations. But your input—and the lively discussion that can often follow—is important, too. Just last month, we published a letter from 2 readers who challenged the evidence-based answer to a Clinical Inquiries question on breastfeeding.

Such ongoing dialogue is useful and enlightening. And we encourage you to write us if you disagree with any of the SORT ratings published in the journal. Let's keep talking about what the evidence says.

1. Neuman MD, Goldstein JN, Cirullo MA, et al. Durability of class I American College of Cardiology/American Heart Association clinical practice guideline recommendations. *JAMA*. 2014;311:2092-2100.

2. Ebell MH, Siwek J, Weiss BD, et al. Simplifying the language of evidence to improve patient care: Strength of recommendation taxonomy (SORT): a patient-centered approach to grading evidence in medical literature. *J Fam Pract*. 2004;53:111-120.

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