The European Research Journal
http://www.eurj.org
Editorial
e-ISSN: 2149-3189
DOI: 10.18621/eurj.296058

Evidence-based medicine and needs based medicine

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Eur Res J 2017;3(2):99-100

Keywords: Evidence-based medicine, family medicine, needs

Evidence-based medicine (EBM) collides every day with doctor's needs. Reality is different from aseptic world of clinical research. We know that in daily work we carry out some actions supported by scientific evidence, many based on general consensus, others on common sense and a few on our intuitions. It is evidence in literature as many questions concerning the Family medicine have no response and as most of the scientific evidences are not relevant for daily practice [1].

Family medicine most likely must continue to live with the paradox that the rigor of the inclusion criteria and the type of patient selection required for controlled trials are exactly the opposite of what occurs in daily practice. The different ages of life, polypathology and polytherapy are subject to a very high variability, they constantly affect the activities of prevention and therapy and force regularly choices that deviate from EBM, and they decide the priorities guide actions.

But these are not the only parameters physicians should take into account, there are also those that accompany the legal requirements and that often force to a defensive medicine, a conflict behaviour model with EBM and often with interests of the NHS, sometimes illogical clinically, but considered necessary from a legal point of view. The diagnostic and treatment activities need time, time is listening tool. The time available to the noble activity of diagnosis and care is eroded by anything but medical activities, bureaucratic, economic, administrative and secretarial.

Time is a vital need and if this resource will decrease further the whole system of care delivery will blow.

Patients don't know EBM and in an ideal relationship, where the doctor and patient agree on the diagnostic and therapeutic choices, patient's needs should be placed first [2]. It is natural that the quality of life is considered a priority; it certainly varies according to the needs of individuals and the conception that everyone has the same life, the scale of values, and the priorities that every human being has given to own self.

Exactly for this reason the diagnostic and therapeutic approach must be individualized and cannot be standardized. The needs of a hypertensive or diabetic patient are very different if it is a young active or a senior. People demand a personalized therapy, simplified, understood and shared, otherwise there will be poor adherence and persistence [3].

Also the organisation of care model must take into account the individual needs: the time spent, the waiting time, the type of doctor – patient relationship, the continuity of care and costs are the parameters that

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Received: March 3, 2017; Accepted: May 26, 2017; Published Online: May 29, 2017

will determine significant organizational changes. The type of relationship between caregiver and patient must adapt to each individual and can vary from a partnership to a paternalistic model according to the will, the schooling and cognitive skills of each person. Nothing can be encoded while everything is under continuous variability. A future with a return to the past relationship, but changed and conditioned by the requirements of EBM, NHS and probably 'ideological' may appear.

Primary care and family medicine in particular are rapidly changing for a number of factors, including the most significant we have economic, scientific-technological ones and those related to the expectations of the population. he encoded efficiency of NHS collides with a continuous loss of effectiveness, more and more often patients are turning to alternative structures bypassing even those in the NHS should have the gatekeeper function; so the family doctor is becoming your doctor who cannot afford access to private care. And if the future will be the insurance, family medicine will be excluded from the future?

Genetics, bionics (biology – electronics) and biotic (biology – computer science) together with the digital technology will change the diagnostic and therapeutic approach and will give the patients god space for managing their own health. Scenarios can range from a new alliance between doctor and patient to a post-physician era, from the disappearance of the specialties to the recovery of humanities.

Anyway, no change will be independent from innate desire for individual freedom of each individual and of each professional, this desire will be the one that will drive any system for delivering care, this is what we have to keep in mind willing the survival of our Discipline.

Conflict of interest

The authors disclosed no conflict of interest during the preparation or publication of this manuscript.

Financing

The authors disclosed that they did not receive any grant during conduction or writing of this study.

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