Re: Becoming a Phronimos: Evidence-Based Medicine, Clinical Decision Making and the Role of Practical Wisdom in Primary Care

To the Editor: I recently read the JABFM ethics feature titled, "Becoming a Phronimos: Evidence-Based Medicine, Clinical Decision Making and the Role of Practical Wisdom in Primary Care."[1] I have been a Family Medicine physician for over 25 years and agreed with the general claims of the manuscript; the current business approach in health care is often contrary to the tenets of family medicine. Furthermore, the points raised by Cosgrove and Shaughnessy that clinicians should have both clinical and epistemic humility was spot on.

However, I found some of the examples in the manuscript to be overly simplistic and, at times, arguably incorrect. Evidence Based Medicine (EBM) does not "offer a value and context free approach to the care of patients." While business administrators may interpret it that way, EBM specifically calls on clinicians to incorporate patient's values and preferences.[2] I disagree with the claim that "every patient entering an examination room has to leave with a diagnosis [or the clinician will not be paid]." Wise clinicians often express the uncertainty that the authors recommend and do not reach a specific diagnosis, unless one claims that "knee pain, unspecified" (which has an ICD code) is a diagnosis. I have not seen this affect payment and found that many patients welcome this approach while others find it frustrating.

I agree that the term "prediabetes" unnecessarily labels people, but do not concur that the term assumes that "left untreated, diabetes will inevitably develop." Rather, the term is simply a poor shorthand to communicate that people with an A1C between 5.7 and 6.4% have a greater risk of developing diabetes than people with a lower A1C level. I wish that we would use terminology such as "at higher risk for diabetes" but that may be viewed as overly wordy for some.

The manuscript appropriately highlights the problems of over screening in clinical medicine, but then it states that routine screening for melanoma "has led to more harm than good," citing a Cochrane review from 2019.[3] However, that is not an accurate summation of the Cochrane review which concluded that "screening for malignant melanoma is not supported or refuted by current evidence from RCTs."[3]

In summary, I support the plea by Cosgrove and Shaughnessy that clinicians develop practical wisdom. And I wish that the business interests of our current health care system would stop medicalizing the human experience and instead encourage clinicians to demonstrate humility. The purpose of this letter was to point out concerns with some of the specific examples used to support the need for more practical wisdom.

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