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Letter to the Editor

The Cinderella of Evidence-Based Medicine?

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"The stepmother gave her the meanest work in the house to do; she had to scour the dishes, tables, etc., and to scrub the floors and clean out the bedrooms. The poor girl had to sleep in the garret, upon a wretched straw bed, while her sisters lay in fine rooms with inlaid floors, upon beds of the very newest fashion, and where they had looking-glasses so large that they might see themselves at their full length. The poor girl bore all patiently, and dared not complain to her father, who would have scolded her if she had done so, for his wife governed him entirely.

When she had done her work, she used to go into the chimney corner, and sit down among the cinders, hence she was called Cinderwench. The younger sister of the two, who was not so rude and uncivil as the elder, called her Cinderella. However, Cinderella, in spite of her mean apparel, was a hundred times more handsome than her sisters, though they were always richly dressed." (Cinderella; Jacques Perrault).

High level evidence comes from summarized data from several hundred or even thousands patients. We do believe that the average of the results of the huge number of patients included in a prospective clinical trial can be directly applied to our case. But is it really so? There are lies, damned lies, and statistics. The best evidence from big randomized clinical trials is restricted to a limited profile of patients. And individual response to therapy cannot be adequately predicted only with data abstracted from clinical trials. Any extrapolation from the average to the specific individual must be done wisely as even the best evidence is unable to guarantee the effectiveness in the individual patient. Otherwise, a relevant amount of real knowledge comes from the experience with concrete patients. We do not use to talk friendly with colleagues about the essence of design of most relevant randomized clinical trials. As professionals, our usual relation is based in commentaries about our real world experience. We comment about the surprising, unexpected, and/or difficult evolution of the patient we are treating: how he/she surprised us, how we confronted the problems, how we missed or found relevant details that helped to reach a solution, and how he/she responded to the proposed therapy. Not only the results from big clinical trials, but the formal reports from this normal practice experience are in the essence of medical teaching. However these case reports are as the Cinderella of evidence-based medicine.

In more prevalent pathologies no one looks only for the knowledge based on individual cases as this evidence is not summarized and it is usually biased by what happened with the best and the worst case or, simply, with the last one. But in uncommon diseases, the published individual experience really helps to guide decision. We all know that there are illnesses: processes with a common etiology, the same natural history, similar manifestations, and predictable responsiveness (though not uniformly) to the same treatments. However, the experience dealing with the patients teaches that there are no illnesses but ill people. And, we do need to learn from real patients to become good doctors: we cannot even become a doctor if we have only a theoretical knowledge of medicine, however broad and deep it may be. It is each patient who makes us doctor. To access the abstract knowledge of the disease, we must begin from the concrete particular case. In the process of knowledge and teaching there is a continuous tension between individual and universal, concrete and abstract. Dealing, knowing, questioning about the individual case (this problem in this person) makes us as doctors. To pay attention to this case is a cause and a consequence of the desire to know more and to do better. Boredom and routine oppose the ability to feel happily surprised in our daily practice. The experience from a case has still a place, and is relevant enough to enter the whole system of sharing medical experience. This experience is not only the anecdote (the extreme, the limit…) we refer to our colleagues to gain their attention; this report represents the practical experience in infrequent and complexes pathologies that helps other doctors to confront similar scenarios where they will not found better evidence to back them up. There are also areas of medicine that require more the experience with concrete patients as they have more difficulties to produce high-quality evidence enough to guide their decisions. This is the case, for instance, of the uncertainty principle of Palliative Care that expresses that when more needed are the scientific evidences to help

to manage patients (that is, when death approaches), more difficult it is to obtain these evidences (as interventional research is almost impossible because of clinical and ethical limits).

In the fairy tale, Cinderella used to spend long hours all alone, home comfort were not for her, she has no nice rests and comfort for she had to work hard all day, and only when evening came was she allowed to sit for a while by the fire, near the cinders… According to these data, can we assume that case reports are the Cinderella of evidence-based medicine? Behind case reports lay clinical interest and rigorous work that positively impacts personalized patients. But no public recognition is expected, only some condescension towards this apparently naïve initiative. Summarizing: required, hidden, valuable, unappreciated… May be, indeed, case reports behave like the Cinderella of evidence-based medicine.