Collect the evidence; I'll look at it in a minute

Although we espouse the virtues of evidence-based medicine, and hold the truths of the well-done randomized, placebo-controlled trial to be self-evident, too often we forget to put this evidence into practice, even when it comes to the basics such as controlling hypertension and diabetes.

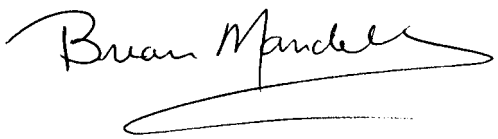
There are plenty of excuses. Written guidelines may be confusing and annoying, and we fear they are tinged by pharmaceutical industry influence. We may subconsciously object to micromanagement of our practice.

But then there are the real evidence-based advances, acceptable recommended treatments and practices, and we far too often neglect them.

On page 793 of this issue, Drs. Hyman and Pavlik point out our inadequacy in diagnosing and treating hypertension. How can this be so often undertreated? Do we not believe the evidence of the trials demonstrating the damage from untreated systolic hypertension? Or are we so busy in the office that we are willing to quickly chalk up mild elevations to a white coat phenomenon, avoiding the need for careful rechecking of positional pressures in both arms, discussion with the patient regarding the disease and its treatment, and writing a prescription for the (formulary-approved) agent?

Unfortunately, this is not the only example of how we are letting our patients down by ignoring evidence. Dr. Lebovitz (page 809) discusses exciting advances in the treatment of type 2 diabetes, yet diabetes remains the number one cause of new blindness and end-stage renal disease in the United States. Both to a certain extent are preventable with aggressive screening and medical interventions.

Much focus has been placed lately on recognizing medical errors and near misses—errors of commission. We need to equally focus on the less dramatic errors of omission of therapeutic and screening interventions, especially interventions supported by those academic principles of quality evidence that we hold so dear. Perhaps in the near future the "system" will help us with "smart" medical records—a physician-friendly system that uses technology to do more than justify our billing practices for Medicare. In the meantime, I try to keep reading, try to remember what I read, and hope to have the time with patients to translate what I read into useful practice.



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