**Evidence-Based Medicine Neglects Individual Needs**

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The movement called rational use of medicine (RUM) is about controlling both drug formularies and information.

RUM encompasses various expressions used to define and promote three interrelated notions which are not entirely synonymous but which have a common objective: reducing the role of medicines. It is based on a belief in the relative ineffectiveness of drug innovation, prescription abuse, and general unsustainability of the cost of medicines in developed and developing countries alike.

(1) Rational use of medicines/drugs (RUM/RUD) reflects the top-down approach of national and international organizations, using "national drug policies," "standard guidelines," and various government instruments to define a politically acceptable level of expenditure on medicines, according to centrally set targets. This is the control element of the strategy.

(2) Evidence-based medicine (EBM) measures the expected incremental benefit of new products over existing medicines and alternative treatments. This is the measurement part of the strategy, to evaluate the efficacy and effectiveness of pharmaceutical products.

(3) Relative effectiveness of medicine/health technology assessment (HTA) is frequently used in European Union documents to refer to the above, maintaining the identical overall objective--evaluating the clinical and/or cost-effectiveness of medicines, but generally with primary concern for health budgets rather than for patient outcomes.

**Restrict Access to Information**

Perhaps most importantly, the drive for RUM policies involves restricting patients' access to information.

RUM/EBM policies favor national approaches (i.e. public health administrative solutions) which tend to ignore the fact that individuals have different needs and require individual solutions. Access to information which may be conducive to such an individual-focused approach is therefore restricted, be it for physicians or for patients.

For the most part, EBM is a retrospective look at clinical studies and head-to-head comparisons of medicines and medical procedures. It may involve a careful look at the science, but in practice it's very limited. All the studies are population-based, have rigid exclusion criteria, and can't integrate new information or innovations.

The result is decidedly and transparently a narrow one: to eliminate "practice variation" to what has been known to work--in the past.

### Varying Needs

Of course, we want our health care to be based on evidence. But the phrase is misleading. As it turns out, "evidence-based medicine" often ignores the most critical evidence of all: the individual patient.

The idea behind EBM--empowering physicians with sound evidence to incorporate into their treatment decisions for individual patients--is a good one. Unfortunately, EBM is being distorted by health administrators (and HMOs in the United States) in ways that impose top-down, one-size-fits-all restrictions on patients and their doctors. EBM is cost-based rather than patient-based.

EBM, while a laudable enterprise, uses the tools and concepts of the last century when a new toolkit is required for this century's new and evolving health solutions.

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