The art and science of clinical medicine and editorial policy

The article by Dr. Alison Colantino et al in this issue (page 245) on when to resume anticoagulation after a hemorrhagic event is relevant to the discussion of clinical decision-making that I started here last month. My thoughts then were prompted by a commentary by Dr. Vinay Prasad on incorporating appropriate study outcomes in clinical decision-making (*Cleve Clin J Med* 2015; 82:146–150).

In the clinic or hospital, we make many decisions without being able to cite specific applicable clinical studies. I base some decisions on my overall impression from the literature (including formal trials), some on general recall of a specific study (which I hopefully either find time to review afterwards, or ask one of our trainees to read and discuss with our team the next day), and others on my knowledge of clinical guidelines or clearly accepted practice. Most clinical decisions are made without any directly applicable data from available clinical studies. This is the "art" of medicine.

Should this art make its way into our clinical journals, and if so, how extensively, and how should it be framed? It is relatively easy when we are talking about the science of clinical practice. Journals receive the (hopefully complete) data, get peer reviews to improve the paper, and publish it with the authors' opinions presented in the discussion section. Then, dialogue ensues in the published literature, in educational lectures, and in blogs posted on the Internet. But where does the art go? Does it belong in our traditionally conservative textbooks or newer go-to online resources, which emphasize the need for authors to provide updated specific references for their treatment recommendations? We believe that after our best efforts at peer review it is appropriate to publish it in the *CCJM* because hopefully it can provide additional perspective on how we deliver care to our patients.

In the arena of new therapies, regulatory approval requires hard data documenting efficacy and safety. And that often leaves me without approved or sometimes even "proven effective" therapies to use when treating patients with relatively uncommon conditions, such as refractory uveitis with threatened visual loss or idiopathic aortitis. Yet I still need to treat the patient.

Another aspect of the art of medicine relates to how best to use therapies that have been approved. We have had antibiotics for many decades, but data are still being generated on how long to treat specific infections, and relatively few scenarios have been studied. Huge media coverage and (mostly) appropriate hype were generated over the need to treat patients with postmenopausal osteoporosis as diagnosed by dual-energy x-ray absorptiometry. But even after evidence emerged regarding atypical femoral fractures in patients receiving long-term bisphosphonate therapy, the question of how long treatment should continue remains more art than science.

The field of anticoagulation has seen many recent advances. We have new heparins, new target-specific oral anticoagulants, and a lot of new science on the natural history of some thrombotic disorders and the efficacy and safety of these new agents. But how long to treat specific thrombotic conditions, which agent to use, how intense

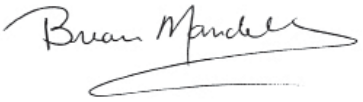
doi:10.3949/ccjm.82b.04015

the anticoagulation needs to be, when to use bridging therapy, and, as discussed by Dr. Colantino et al, when to resume anticoagulation after a hemorrhagic event mostly remain part of the art of medicine.

I highlight the Colantino paper in the context of both clinical and editorial decision-making because it is an example of experienced clinical authors discussing their solutions to thorny clinical scenarios we often face with inadequate data. While some journals avoid this approach, we embrace the opportunity to provide thoughtful expert opinions to our readers. We push authors from the start of the editorial process and through aggressive peer review to provide evidence to support their practice recommendations when appropriate. But we also encourage them to make recommendations and describe their own decision-making process in situations that may not be fully described in the literature.

Most of our readers do not have ready access to consultants who have had years of experience within multidisciplinary teams at referral institutions regularly managing patients with permutations of these complex clinical problems. Though generic consultation advice must be evaluated within the context of the specific patient, we hope that by framing the clinical issues with relevant clinical science the opinions of experienced authors will be of use in guiding your (and my) approach to similar clinical scenarios.

If you think we are not striking the right balance between the science and the art of medical practice, please let me know.



BRIAN F. MANDELL, MD, PhD
Editor in Chief