Editor's preface

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Evidence" is a word we have come to dislike. It is tossed about with reckless extravagance: last year alone MEDLINE listed 16 716 new articles with "evidence" as a keyword. Even *CMAJ* trumpets the term in red on our cover and contents pages. But what does it mean?

In this issue Brian Hutchison and colleagues, of McMaster University, report on their study to determine whether clinicians are actually practising evidence-based medicine (page 185). Using "standardized patients" trained to pose as newcomers to the practice, they tested 62 primary care physicians and found that they failed to perform or offer about 33% of the procedures and laboratory tests classified by the Canadian Task Force on the Periodic Health Examination as grade A manoeuvres (those for which there is good evidence of benefit) and that they did perform or offer about 22% of grade D manouevres and 5% of grade E manoeuvres (those which the evidence shows may have no benefit or even be harmful). They also report on the marked variation in the amount of time spent with each standardized patient and in the resultant fees charged to the health insurance plan (page 197). Robyn Tamblyn, of McGill University, comments on the use of standardized patients in physician practice research (page 205).

So, is it evidence that is lacking, or is it that physicians just don't know how to use it? Geoffrey Norman and Susan Shannon, of McMaster University, searched the literature for evidence that teaching evidence-based medicine in medical schools actually works (page 177). The few studies they found had conflicting results. David Sackett, of the Centre for Evidence-Based Medicine, and Julie Parkes, of the Centre for Statistics in Medicine, both in Oxford, comment that "as is frequently the case in rapidly changing fields, events have passed this debate by" (page 203). The question, they maintain, is not so much whether to teach these skills, but how best to do it.

And that left us wondering what "evidence" is. We invited Olli Miettinen, of McGill University, to air what he has called his "frustrations with scientific evidence" (page 215). He begins at the root of the debate with the Greek word *gnosis*, "knowledge." An important word for physicians, it is part of our 3 fundamental activities: diagnosis (What condition does the patient have?), "etiognosis" (What caused it?) and prognosis (What does the future hold?). We agree with Miettinen when he says that part of the problem is that studies are designed to answer questions that have little relevance to physicians' encounters with specific patients.

Dr. Els Borst-Eilers, a physician-scientist and the Dutch minister of health, recently used the term "evidence-based rationing" to justify her government's diversion of money from the health care system to other areas such as education and housing. Stuart MacLeod and John Bienenstock, of McMaster University, remind us that governments are finding it useful to play the evidence card when they whack out chunks from health care budgets (page 213).