## Practising sound medicine in the absence of evidence

The commentary by Harriet MacMillan and Nadine Wathen[1] illustrates some of the problems that may arise in using only an evidence-based approach to guide clinical decision-making, rather than balancing existing evidence with clinical judgement. Although it was perhaps not the authors' intention, we are concerned that the message that physicians may take from this article is that they should not screen for abuse because evidence for such an intervention is inadequate.

There is a marked paucity of research in this field, particularly given the pervasiveness of abuse and the injuries and deaths it causes. If we are to use only those interventions for which significant (statistically or otherwise) research has been done, then we may be systematically excluding interventions for which there has been less academic interest and consequently less published research on which to base recommendations.

The suggestion to screen people with signs and symptoms of "potential abuse"[2] is confusing. Although research has been done on the prevalence of various signs and symptoms in people who have been abused,[3] the predictive value of signs and symptoms has not been high,[4,5] which suggests that they are not sensitive indicators of abuse. This, coupled with the high prevalence of abuse, justifies universal screening: if, as the authors state, it is appropriate to screen people exhibiting signs and symptoms, then it should be appropriate to screen everyone.

Finally, it appears that the authors did not consider that the act of disclosing to a health care provider an experience of abuse may be a positive outcome in and of itself, if the disclosure is beneficial psychologically.

Given the apparent lack of harm in screening patients for abuse and its potential benefits, which have yet to be adequately investigated, we feel that this intervention should continue to be widely used until further research demonstrates that it is inappropriate or unnecessary.

**Fiona Kouyoumdjian**
**Vanessa L. Cardy**
Medical Students
Dalhousie University
Halifax, NS

### References

1. MacMillan HL, Wathen CN. Violence against women: integrating the evidence into clinical practice [editorial]. *CMAJ* 2003;169(6):570-1.
2. Wathen CN, MacMillan HL, with the Canadian Task Force on Preventive Health Care. Prevention of violence against women. Recommendation statement from the Canadian Task Force on Preventive Health Care. *CMAJ* 2003;169(6):582-4.
3. McCauley J, Kern DE, Kolodner K, Dill L, Schroeder AF, DeChant HK, et al. The "battering syndrome": prevalence and clinical characteristics of domestic violence in primary care internal medicine practices. *Ann Intern Med* 1995; 123(10):737-46.
4. Wasson JH, Jette AM, Anderson J, Johnson DJ, Nelson EC, Kilo CM. Routine, single-item screening to identify abusive relationships in women. *J Fam Pract* 2000;49(11):1017-22.
5. Saunders DG, Hamberger LK, Hovey M. Indicators of woman abuse based on a chart review at a family practice center. *Arch Fam Med* 1993;2 (5):537-43.

DOI:10.1053/cmaj.1031733

### [The authors respond:]

We agree with Fiona Kouyoumdjian and Vanessa Cardy that in the face of uncertain evidence, clinical context and clinician experience will ultimately determine the course of care. Unfortunately, Kouyoumdjian and Cardy seem to have misunderstood a key point of our commentary[1] and the accompanying recommendations of the Canadian Task Force on Preventive Health Care.[2] We do not recommend that clinicians "screen people with signs and symptoms of 'potential abuse'"; rather, good clinical care demands accurate diagnosis and appropriate treatment when a woman presents with injuries or other manifestations consistent with abuse. The difficulty in recommending universal screening — that is, routine assessment of all women presenting for any medical concern — is the lack of evidence regarding appropriate treatment interventions.[3]

Kouyoumdjian and Cardy further state that there is an "apparent lack of harm in screening patients for abuse" and that the act of disclosing abuse "may be a positive outcome in and of itself." In fact, a range of potential harms may result from screening, including the possibility of psychological distress (as opposed to the benefit assumed by Kouyoumdjian and Cardy) when a woman is asked to disclose abuse when she is not ready to do so;[4] the raising of false hope that screening can help, when in fact it may not; and the potential of exposing the woman to further violence. The lack of evaluation of the potential harms of screening is a major problem in this field. No intervention is completely without harm or cost, whether it be opportunity cost (e.g., the clinical time required for screening that could be spent on other problems) or a specific risk associated with the intervention or its sequelae (e.g., adverse reaction to a vaccine). It is essential that screening be evaluated to determine whether it does more good than harm, rather than simply assuming that it has benefit. As outlined in our commentary,[1] we are fortunate that various organizations, including the US Centers for Disease Control and Prevention and the Ontario