Words and numbers

Evidence-based medicine combines personal clinical experience and the best available clinical evidence. During the covid-19 pandemic in particular, some have turned their backs on this fruitful combination, shifting the emphasis towards their own experience, sometimes elevating it to the level of "expertise", and away from the best clinical evidence. This may be because, in recent decades, the evidence the medical world expects to see is too often based on an abundance of numbers and statistical analyses. To such a degree that others have disregarded the value of clinical experience, caught up in the idea that numbers and statistical tests are the sole guarantee of good evidence. But there is more to a person's health than numbers.

Numbers-based, quantitative data are useful, especially when evaluating the efficacy of an intervention. But they are not sufficient to assess every aspect of its harm-benefit balance. For example, in order to evaluate adverse effects, there is often a need to listen to and question patients, and put into words the harms they have experienced. It is one thing to quantify the incidence of an adverse effect. But it is another thing entirely to describe the adverse effect.

Qualitative data help us understand certain aspects of patients' lives that quantitative data cannot, or cannot adequately explain. There is no conflict whatsoever between quantitative and qualitative data: the two are complementary. They intertwine to form a solid body of evidence from which decisions can be made, based as much on critical analysis of certain numbers as on critical analysis of what patients say.

Qualitative data also provide insight into patients' points of view. Which sometimes differ from, but are often complementary to, healthcare professionals' views. And which can also be disconcerting, especially when expressed in poignant words (see "Difficulties encountered on discontinuing topical corticosteroids", *Prescrire Int* n° 230).

Evidence-based medicine is more than just numbers reported in randomised trials or meta-analyses. It also involves seeking out the evidence that best answers specific clinical questions. And in some cases, the best evidence is to be found in qualitative data, obtained by analysing what patients have to say. Provided we analyse their words critically and avoid the pitfalls that can result from bias within the data, or from our own preconceptions. The same provisos as apply when analysing quantitative data.

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