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PRACTICE GAPS

Identifying Biases

Physicians often do not implement the best evidence available when selecting therapy. In exploring this point, Eaglstein provides us with a valuable educational piece on a variety of biases that keep clinicians from instituting new therapies. He points out specific gaps that can result from these biases, including unnecessary recommendations that patients discontinue using retinoids in the perioperative period because of rare reports of altered wound healing. Data do not support these recommendations.

Eaglstein suggests that closing the gaps begins with education to better recognize biases. In residency training, the Accreditation Council for Graduate Medical Education is looking to stakeholders in dermatology to participate in the Milestone Project to define measurable markers of successful resident progress throughout training.¹ One competency area, practice-based learning and improvement, will propose milestones relating to the identification of biases encountered in the literature and in practice, including those mentioned by Eaglstein. Knowledge questions that identify biases corresponding to research-practice gap vignettes could be created as one measure of practice-based learning and improvement competency. In continuing medical education, a facilitator familiar with evidence and bias could lead discussion-based venues that would highlight various study results, use audience responses to identify research-practice gaps, and then

openly explore the biases that may be guiding practice. Continuing medical education venues that educate dermatologists about established medications as well as new medications should continue and should critically review the best available evidence to guide treatment selection.

Several additional barriers that were not discussed may also explain why dermatologists do not prescribe newer drugs. When providers attempt to prescribe new therapies for patients, treatment cost, prior authorization, justification letters, and insurance tier confusion all take considerable time and can be challenging to navigate. Furthermore, Eaglstein's article presumes that physicians read their journals well enough to know the latest evidence from trials, which may not be true. It identifies training as an inadequate and quickly outdated reference for future clinical decision making. Unfortunately, for some physicians, information from training remains an important resource for treatment selection. There is no requirement that a number of continuing medical education hours are to be spent confirming or learning appropriate therapeutic selection.

The final type of impactful bias is the relevant financial relationships of the authors. Nearly half of the RCTs published in dermatology include investigators who disclose a relevant financial relationship.² When reading a peer-reviewed article in the *Archives* that claims a therapy's success, the

reader should turn his or her attention to the authors' disclosure information, which is published with each article. Authors disclose relationships with industry that could potentially introduce bias into the results or conclusions that are presented in the article. Industry-sponsored studies are often of superior methodological design and more rigorous than other studies; however, such studies are more likely to report positive results than are those whose authors lack industry relationships. In his article, Eaglstein has declared his financial relationship with a pharmaceutical company; therefore, the reader is able to place his plea in context. Dermatologists are urged to think about how to eliminate biases against prescribing new therapies with the intention of improving patient care.

Erik J. Stratman, MD

Author Affiliation: Department of Dermatology, Marshfield Clinic, Marshfield, Wisconsin.

Correspondence: Dr Stratman, Department of Dermatology, Marshfield Clinic, 1000 N Oak Ave, Marshfield, WI 54449 (stratman.erik@marshfieldclinic.org).

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