COVID-19: has EBM been replaced by hype-based medicine?

Margaret McCartney
Fulton Street Medical Centre, Glasgow, UK
Correspondence to mgtmmccartney@gmail.com

When Donald Trump said that he had a ‘good feeling’ about hydroxychloroquine in the treatment of COVID-19, I had a bad feeling. In the midst of a pandemic, we are in a period of instability, which brings the potential of benefit—a loosening of bureaucratic restrictions—and risks—again, a loosening of bureaucratic restrictions. The situation is dramatic and understandably frightening. Emotions are high. No one is safe. Because we are in the middle of a pandemic, the argument goes, we cannot wait for trials. We feel compelled to do something.1 We cannot allow people to die before randomised controlled trials are reported: we are urged to do something visibly and quickly than not. Of the influenza pandemic that followed the First World War, the panic was so great that the public would not suffer for the additional care which is given it.2

In EBM, the argument goes, we cannot wait for trials. But quantity is not quality. Out of the many interventions tested for Ebola, during the outbreak of 2014, only one (a triple monoclonal antibody cocktail) was investigated in a randomised controlled trial, leading to the conclusion that the ‘tragedy of not discovering new therapies during an outbreak cannot be repeated’.3 4 Preprints may be widely shared and direct practice, but the speed of production may not be matched by critical analysis and the need for replication. Despite the lack of evidence for effective peer review it is not clear what happens when we do without it altogether.5 Yet, despite all the challenges of the Ebola outbreak, it was demonstrated that it is possible to conduct a randomised controlled trial in the context of a major public health emergency. Bravo, therefore, for the PRINCIPLE (Platform Randomised trial of INterventions against COVID-19) study,6 RECOVERY (Randomised Evaluation of COVid-19 Therapy) and REMAP-CAP (A Randomised, Embedded, Multi-factorial, Adaptive Platform Trial for Community- Acquired Pneumonia) trials (https://www.recoverytrial.net/), now underway, that is adaptive, agile and based on rigorous scientific principles.7 8

But we also need to know about non-drug interventions. An impassioned debate is currently taking place about whether the public should be compelled to wear cloth face masks. There are no trials of cloth mask use in the general population. A common argument is that trials would be too slow and we cannot wait. The distress caused by a pandemic creates an urge to act before evidence is understandable. But corona will likely be with us a long time, and it is too important not to know what is, and is not, most effective against it. Knowledge about effective and ineffective interventions allows us to rely on useful measures and dismiss those which are not. A pragmatic, real-world randomised trial of delivering face masks and education on their use in one geographical population versus another ‘usual care’ group would be possible, especially with the use of smartphone technology monitoring for suspected or known cases. Research assessing and comparing behaviours of people choosing to use masks in public spaces such as transport systems is possible. All interventions in medicine have some sort of potential hazard. We do not know if people wearing masks will behave in ways which makes them accrue higher risks through a false sense of security, that changes society as a result. Reliance on a non-evidenced intervention may do harm to the population when it does not work yet is assumed to do so. We will only fully know the benefits and harms through high-quality research. It would be of grave concern if research into non-drug interventions was treated as second class. We must ensure that we continue to interrogate the uncertainties of COVID-19, review the totality of research to ensure we are not missing important data, register and report trials, and press for better, not necessarily more, research. Pandemics may feel frightening, but even more frightening is annexing the scientific method in dealing with it.

Competing interests None declared. Refer to the online supplementary files to view the ICMJE form(s).

Provenance and peer review Commissioned; externally peer reviewed.

This article is made freely available for use in accordance with BMJ’s website terms and conditions for the duration of the covid-19 pandemic or until otherwise determined by BMJ.
DTB FORUM

You may use, download and print the article for any lawful, non-commercial purpose (including text and data mining) provided that all copyright notices and trade marks are retained.

© Author(s) (or their employer(s)) 2020. No commercial re-use. See rights and permissions. Published by BMJ.

References


DOI: 10.1136/dtb.2020.000029