COVID-19: has EBM been replaced by hype-based medicine?

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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—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 act. The inference is that the slow-footed are effectively killing family, colleagues, friends. It is usually easier and more popular to do something visibly and quickly than not. Of which is given it’.2

We feel compelled to do something.1 We are in the middle of a pandemic, the ‘last resort’ wrongly assumes that benefit and death on a wide scale’.4 The ‘general health’, 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. And indeed the planning that 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.

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.

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