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Covid-19: Why we must temper urgency with diligence

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How should we balance the need for speed with our duty towards care and rigour? In the first days of the pandemic doctors who were faced with patients sick and dying from an unknown disease turned by necessity to existing drugs, those known to work against viral illness or to be potentially beneficial in multiorgan inflammatory disease. The list of these “repurposed” drugs is long, many with honourable records of safety and effectiveness in other conditions.

Almost all have fallen under scientific scrutiny. The Recovery trial, so impressively established in the very first days of the pandemic,¹ has given us one remarkable positive finding: that a cheap and widely available drug, dexamethasone, reduces mortality in critically ill patients.² Apart from this, and some emerging evidence of benefit from monoclonal antibodies, trials have almost all given existing drugs the thumbs down.³⁻⁴

In response to the science, most countries have seen these drugs falling out of use for covid-19.⁵ But not so in India. As the country suffers a terrible second wave,⁶⁻⁸ patients with mild covid are receiving a “cocktail of multiple ineffective drugs and unneeded investigations” at great cost and unnecessary harm, say Akshay Baheti and colleagues, while those with moderate or severe covid struggle to procure indicated drugs and oxygen, even on the black market.⁹

Further trials are under way,⁴ including the relaunched Solidarity trial, focusing on the immune response.¹⁰ And there is hope that the UK’s recently announced antiviral task force will fill the gap in preventive treatments.¹¹ But improved survival from covid has never been about drug treatments alone. Equally important are non-medical interventions: supportive and nursing care, and delaying ventilation.³ Nor should we forget the need for physical and mental rehabilitation for people who survive¹² and for long term and substantial investment in primary care.¹³⁻¹⁴

The pandemic has brought other tools into sharp relief: quality improvement¹⁵ and clinical guidelines. The paradox, say Dipender Gill and colleagues, is that the imperative for guidance is greatest when evidence is scarce.¹⁶ Could our guideline producers be bolder in the face of uncertainty? Will the plans of the UK National Institute for Health and Care Excellence for dynamic, modular, and living guidance be the answer?¹⁷

We travel in hope that our leaders will continue to invest in open and high quality science and that good regulation and clear guidance will enable clinicians and patients to follow it. In this and future pandemics we must temper urgency with diligence.

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