



*"... we are prone to underestimating what we don't know."*

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## A call for inaction

No joke: with GP workload pressures mounting ever higher, even those in charge doubt their ability to handle the expected workforce crisis.<sup>1</sup> And yet everywhere around us, if we look for it, is evidence that the old aphorism 'If in doubt, do nothing' is being widely ignored.

Surely a key element of managing with declining resources should be to do less? There is plenty of evidence to support the notion that this would be entirely reasonable. Let me give you some examples that I have found.

A recent study highlighted that the adoption of the GOLD guidelines has led directly to a big increase in COPD diagnosis (from 13% to 22%).<sup>2</sup> Yet there is no evidence that this increase has a medical advantage sufficient to compensate for its known downsides such as the risk of excess cardiovascular deaths caused by medication for the condition.

An editorial in this Journal in July questioned whether the drive towards ever lower HbA1c targets is a good thing for patients with type 2 diabetes.<sup>3</sup> The author pointed to evidence of increased mortality in those with results <7.5%, and to uncertainty as to whether there is a net benefit for over 50 year olds of aiming for <9%.

Most shockingly for me, a recent meta-analysis of research on blood pressure management for those with type 2 diabetes and chronic kidney disease concluded 'No blood pressure-lowering strategy prolonged survival.'<sup>4</sup> This is an important negative finding, implying that blood pressure control can only be of value for limiting morbidity in these patients. How much polypharmacy is justified by that goal is certainly questionable.

Anyway, these are some examples but there are more: their power is in showing the gaps in our knowledge. Psychologists already know we are prone to underestimating what we don't know.<sup>5</sup> This tendency is exacerbated by the ways information is manipulated by those with vested interests, a point not simply demonstrated but the following should help.

One-third of randomised controlled trials of glucose-lowering drugs published in the 20 years up to 2013 were published by 1% of authors in the field, according to a recent

study.<sup>6</sup> A linked editorial<sup>7</sup> highlighted the distorting effect of this on the evidence base, the strength of commercial influence involved, and that it is not limited to diabetes research.

Another recent study on cardiovascular devices found that, of trials submitted as evidence to the US Food and Drug Administration (FDA), less than one-quarter of the research had been published and in a form that reliably matched what had been submitted.<sup>8</sup> A linked editorial noted that most FDA and European Medicines Agency (EMA) submissions are not publicly available and so such discrepancies are mostly hidden.<sup>9</sup> It noted case law evidence however, such as the 2012 GlaxoSmithKline case brought by the FDA in relation to Avandia that led to a fine of over \$242 million being levied, of companies' selective reporting even of safety data.

Further evidence that the drug companies' efforts to influence behaviour is not limited simply to managing what is published and in what form, is provided in a recent study on the overdiagnosis and treatment of osteoporosis.<sup>10</sup>

So, there is plenty of evidence that doing less may be better, or at least no worse, across a range of conditions. And evidence too of the extent to which what is not known is being systematically hidden or downplayed.

It is time for an authoritative, national, primary care-focused guidance group. And its task should be to promote evidence-based inaction. Seriously.

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DOI: 10.3399/bjgp15X686653

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