

EDITOR'S CHOICE

Overtreatment, over here

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How much of what we offer to patients is unnecessary? Worse still, how much harm do we do to individuals and society through overtreatment? In the 30 years since Ivan Illich wrote his seminal and, at the time, shocking book *Medical Nemesis*, the idea that medicine can do clinical and societal harm as well as good has become commonplace. But are we doing enough to bring medicine's harmful hubris under control?

The answer, in the United States at least, is no. Earlier this year, concerned individuals from a range of backgrounds met in Cambridge, Massachusetts, to explore the problem of overtreatment. As Sharon Brownlee explains in a video on bmj.com, her starting point for concern—and the inspiration for her book on overtreatment in America—was the realisation that, alone among developed nations, America's per capita spending was rising sharply while life expectancy was not. The problem is complex and the list of potential contributing factors long. As Jeanne Lenzer reports (doi:10.1136/bmj.e6230), reasons for overtreatment identified at the meeting include fear of malpractice lawsuits, supply driven demand, knowledge gaps, biased research, profit seeking, patient demand, financial conflicts of guideline writers, failure to fully inform patients of the potential harms of elective treatments, and the way American physicians are paid by a fee for service.

Are other parts of the world similarly affected? Growing evidence of practice variation in other developed countries suggests that they are, though possibly to a lesser extent. As Margaret McCartney writes in an accompanying commentary (doi:10.1136/bmj.e6617), England and Wales benefit from the National Institute for Health and Clinical Excellence (NICE), which insulates them against some of medicine's excesses. But

she warns that the GP contract and non-evidence based awareness campaigns are fuelling polypharmacy and overdiagnosis. The latest health service changes have, she says, "given permission for the dissolution of the NHS into a mere brand."

Nigel Crisp, in his essay this week (doi:10.1136/bmj.e6177), also holds up the NHS as a small beacon of light. As its former chief executive officer, he points out that the NHS is not "a mere health insurance system" but one in which patients' and doctors' interests are largely aligned within a framework of shared values and expectations. But even with the NHS, the United Kingdom has failed—as have all countries, he says—to give people a truly central role in improving health and shaping healthcare delivery. He calls for a new intellectual framework that challenges the dominant economic mindset and our over-reliance on the views of professionals. "The doctor doesn't always know best," he says.

Neither the meeting in Massachusetts nor Crisp in his essay provide easy, or indeed any, solutions. Further meetings and research are planned. But if overtreatment is in part due to a failure to place the patient's perspectives and interests at the centre of everything we do, perhaps there's one simple phrase that could help. Speaking at the International Forum on Quality and Safety earlier this year, Maureen Bisognano, chief executive officer of the Institute for Healthcare Improvement, suggested that instead of asking your next patient "What's the matter?" you could ask "What matters to you?"

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