BMJ

BMJ 2012;344:e4293 doi: 10.1136/bmj.e4293 (Published 25 June 2012)

LETTERS

PREVENTING OVERDIAGNOSIS

We can learn from disciplines outside medicine

Louisa Polak *general practitioner and research student*[1 2]

[1]North Hill Medical Group, Colchester CO1 1DZ, UK; [2]London School of Hygiene and Tropical Medicine, London, UK

Moynihan and colleagues have omitted three issues from their article on preventing overdiagnosis.[1]

Firstly, who decides where the balance of harms and benefits tips into overdiagnosis? For taxpayers, some screening and preventive treatments may be the most cost effective use of NHS resources. For patients, preference depends on the values they ascribe—for example, to reducing risk of fractures versus risk of side effects of treatment for osteoporosis—it is simplistic to talk of "net harm." It also depends on the probability of these outcomes; combining this with values produces what game theorists call expected utility—the rational basis for such decisions and a concept that should have been central to the article.

Secondly, the two situations often medicalised are current mild problems and increased risk of future disease, and the article's analysis of future risk was confusing. Among many examples: screening programmes mostly attempt to "prevent genuine illness," although they may be a poor use of resources; and statements like "a substantial proportion . . . will never progress" seem to imply a wish for a crystal ball so we can treat only those certain to benefit.

Thirdly, no references come from the social science literature, which has considered these matters in depth for decades. For example, Armstrong described how "surveillance medicine" created new diagnoses (starting well before the middle of the 20th century),[2] Davison and colleagues wrote of lay understanding of the paradox that preventive measures can save lives in a group yet harm individuals,[3] and Conrad identified the changing drivers of medicalisation.[4]

I hope that next year's conference will include speakers from disciplines outside medicine, so that rather than trying to reinvent the wheel, doctors can focus on how to tackle the problem of medicalisation in public health and clinical practice.

Competing interests: None declared.

1 Moynihan R, Doust J, Henry D. Preventing overdiagnosis: how to stop harming the healthy. *BMJ* 2012;344:e3502. (29 May.)
2 Armstrong D. Political anatomy of the body. Cambridge University Press, 1983.
3 Davison C, Davey Smith G, Frankel S. Lay epidemiology and the prevention paradox: the implications of coronary candidacy for health education. *Sociol Health Illness* 1991;13:1-20.
4 Conrad P. The shifting engines of medicalization. *J Health Soc Behav* 2005;46:3-14.

Cite this as: *BMJ* 2012;344:e4293

© BMJ Publishing Group Ltd 2012

louisa.polak@lshtm.ac.uk

For personal use only: See rights and reprints http://www.bmj.com/permissions Subscribe: http://www.bmj.com/subscribe

BMJ: first published as 10.1136/bmj.e4293 on 25 June 2012. Downloaded from http://www.bmj.com/ on 13 March 2024 by guest. Protected by copyright.