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EDITOR'S CHOICE

Attention, please

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The *BMJ* has long been at the forefront of drawing attention to the harms of overdiagnosis and disease mongering, and in doing so has often run up against various vested interests and awareness-raising organisations. Perhaps the trickiest areas lie in the behavioural disorders, where doctors (and patients) have to make judgments between what is an unfortunate but normal part of life and what is debilitating and socially disruptive behaviour that may be amenable to treatment. It is possibly here—with conditions such as attention-deficit/hyperactivity disorder (ADHD)—that the perils of medicalisation are at their greatest.

As Rae Thomas and colleagues write in the latest article in our "Too much medicine" campaign (doi:10.1136/bmj.f6172), prevalence and prescribing rates for ADHD have risen sharply over the past decade "partly in response to concerns about underdiagnosis and undertreatment." But whereas doctors have become better at recognising, diagnosing, and treating children with the disorder, 86% of children who receive a diagnosis have, according to recent data, only "mild or moderate" disorder, and some are said to have ADHD without fulfilling any of the diagnostic criteria.

Subjectivity, of course, plays a part in mental health diagnoses (doi:10.1136/bmj.f6622 and doi:10.1136/bmj.f6621), which is why they are so vulnerable to overdiagnosis. In the case of ADHD, when does being inattentive, disorganised, easily distracted, restless, and persistently interrupting (to give some of the defined symptoms) become a medical disorder? But formal diagnostic criteria have also been increasing. As Thomas and colleagues point out, the criteria in the *International Classification of Diseases, 10th revision* (ICD-10) are more restrictive and "result in smaller prevalence rates than ADHD diagnosed using DSM [*Diagnostic and Statistical Manual of Mental Disorders*] criteria. However, most practitioners use DSM."

Moreover, the criteria as set out in successive editions of DSM have been widening. "These show a significant increase in ADHD prevalence between each version of DSM," say the authors, with prevalence "expected to rise further with the adoption of DSM-5, launched earlier this year."

Commercial influences have also played their part, as drug companies have used celebrities to raise awareness of ADHD, while 78% of those advising DSM-5 for ADHD and disruptive behaviour disorders disclosed links to pharma as a potential financial conflict of interest.

While Thomas and colleagues say that "severe cases of ADHD are obvious," it is in the mild and moderate cases where the bulk of diagnoses lie that the subjective opinions differ. In his letter this week, Sami Timimi goes further, and says that ADHD has no "objective data that can be used independently to support the validity of the diagnosis" and that (like autism) it relies on "ideologically driven ideas about how to classify heterogeneous presentations" (doi:10.1136/bmj.f6622). Meanwhile, those with the diagnosis continue to face the potential harms not only of overtreatment, but of diagnostic labels that see such children characterised as, to quote Thomas and colleagues, "lazier, less clever, and less caring."

It is perhaps in diagnosing and treating behavioural disorders that doctors need to be particularly mindful of the axiom "first do no harm." But this, writes Daniel K Sokol in his column this week (doi:10.1136/bmj.f6426), is a flawed dictum and should be updated to "first do no net harm." His argument is that doctors inflict harm all the time: the hope is that the benefits will outweigh the harms.

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