EDITOR'S CHOICE

Preventing overdiagnosis

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Last week's BMJ Group Improving Health Awards gathered an inspiring cast of finalists and produced 12 worthy winners (doi:10.1136/bmj.e3773). Among them was Bernard Lown, who won our Lifetime Achievement award (see interview on bmj.com at <http://bit.ly/K6t9Vg>). As well as his international achievements as a cardiologist, inventor, and peace activist, Lown has recently given his support to efforts to prevent unnecessary medical treatment, as Elizabeth Loder recently reported (<http://bit.ly/KPYfKz>).

Concern about the harms and costs of overtreatment is gaining momentum. So too is concern about arguably the most important driver of overtreatment, overdiagnosis. As Ray Moynihan and colleagues explain (doi:10.1136/bmj.e3502), there's growing confidence that overdiagnosis is actively harmful. New technologies mean that ever more sensitive tests can detect "abnormalities" and "incidentalomas," while widening definitions of disease and falling treatment thresholds capture more and more previously unmedicalised people in their net. The result is that people at ever lower risks are given permanent medical labels and lifelong treatments that will benefit only a few of them.

Moynihan and colleagues are keen to point out that concern about overdiagnosis doesn't preclude concern about people missing out on much needed healthcare. On the contrary, resources wasted on unnecessary care can be much better spent treating genuine illness, they say.

Other authors this week pick up the theme. Responding to Des Spence's recent column on "psychiatric oligarchs medicalising normality," (BMJ 2012;344 e3135) Sami Timimi describes an evidence based campaign against the latest *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) (doi:10.1136/bmj.e3534), while Parashar Ramanuj writes that "our masters

now seek to reduce even normal human experience to mere collections of symptoms" (doi:10.1136/bmj.e3545).

And in his broadside against the activities of the drug industry in the developing world, John Yudkin sees overdiagnosis of diabetes as one of the barriers to appropriate care (doi:10.1136/bmj.e3018). Successive reductions in diagnostic thresholds and the creation of the condition of so-called pre-diabetes have both added to the likely harm of overenthusiastic glycaemic control, he says. "The numbers who will fail to benefit from glucose lowering are likely to be even larger in a lower risk population—such as one diagnosed by screening or at a lower diagnostic threshold."

Yudkin points the finger firmly at the drug industry as probably "the sole beneficiary" of this state of affairs. Moynihan and colleagues spread the blame more widely. They see a mixture of commercial and professional vested interests, legal incentives, and a fixed cultural belief in the merits of early detection.

So how do we move from concern to concerted action to prevent overdiagnosis? We need to understand more about the causes if we are to begin proposing solutions. To this end, the BMJ is supporting the international conference on preventing overdiagnosis hosted by Dartmouth Institute for Health Policy and Practice in the United States in September 2013 (www.preventingoverdiagnosis.net). Between then and now, a series of educational articles will explore the potential for overdiagnosis in specific conditions, and a call for research papers will follow later this year. We hope those of you working in the field will join us in this important endeavour.

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