EDITOR'S CHOICE

Too much medicine

Fiona Godlee *editor, BMJ*

There's a great deal to celebrate in medicine and healthcare, but it's also possible to have too much of a good thing. This week we launch our Too Much Medicine campaign (www.bmj.com/too-much-medicine). As explained in an editorial (doi:10.1136/bmj.f1271), the roots of the campaign go back at least a decade to a theme issue we published in 2002, guest edited by Ray Moynihan, called "Too much medicine?" You can find the entire issue on bmj.com (www.bmj.com/content/324/7342). Much of the content is as relevant now as it was controversial then.

Since then, the evidence of medical excess in rich countries has grown, with increasingly clear documentation of the harms and costs of unnecessary intervention. In the past few years the individuals and groups calling for moderation and scepticism have begun to coalesce into a loose movement, to which the *BMJ* is now signing up. Impressed by the "Less is more" initiative at *JAMA Internal Medicine*, led by its editor Rita Redberg, and by the Choosing Wisely initiative set up by the American Board of Internal Medicine Foundation (doi:10.1136/bmj.f1266), we want to explore the causes and potential remedies of overinvestigation, overdiagnosis, and overtreatment.

As our Editorial points out, this area is complex and under-researched: in many healthcare settings overtreatment and undertreatment coexist. "Because of this and other uncertainties, it will not be easy to communicate effectively about overdiagnosis with professionals and the public. The concept is unfamiliar and counterintuitive to many people." Our contribution will include partnering in an international scientific conference in September (preventingoverdiagnosis.net) and publishing a theme issue early next year.

This week's journal carries its own dose of cold water with which to douse medical enthusiasts. In an editorial, Edwin Gale

calls for a serious rethink about the use of GLP-1 agonists in diabetes because of strong evidence of increased rates of pancreatitis among patients taking these drugs (doi:10.1136/bmj.f1263). He asks why drug companies have been so slow to act on the signals and concludes that inviting drug companies to monitor the safety of their own products provides them with the strongest possible incentive for failing to do so. And in the Analysis section, Tom Treasure and Martin Utley question the benefits of surgical removal of pulmonary metastases. The evidence that this invasive procedure improves survival is weak, they say. They call for randomised trials rather than the dubious case series on which current practice is based (doi:10.1136/bmj.f824). One such innovative trial is now under way thanks to a previous *BMJ* paper from these authors.

Also this week, the *BMJ* speaks up for the Liverpool care pathway, which is under attack from the *Daily Mail* and others. We are emboldened to do so by a survey we undertook among palliative care doctors in the UK. As summarised by Krishna Chinthapalli, 91% of respondents thought that the pathway represented best practice for care of the dying patient (doi:10.1136/bmj.f1184). And when asked if they would want to be put on the pathway themselves if they were terminally ill, 90% said yes. This vote of confidence fits with views expressed at a conference in Edinburgh last week (doi:10.1136/bmj.f1303). Helping patients to die with dignity should be done with the same care and openness as anticipating and managing the birth of a child.

Cite this as: *BMJ* 2013;346:f1328

© BMJ Publishing Group Ltd 2013