

OBSERVATIONS

REALITY CHECK

Science of overdiagnosis to be served up with a good dose of humility

The Preventing Overdiagnosis international scientific conference gets under way next month

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The Preventing Overdiagnosis conference (www.preventingoverdiagnosis.net) is close to capacity and may have to close registrations even before it opens its doors in a couple of weeks. It's pleasing that so many people will gather within the grounds of Dartmouth College's picturesque campus in New England to share the science of this problem and its potential solutions.

The meeting is hosted by the Dartmouth Institute for Health Policy and Clinical Practice, in partnership with the *BMJ*, the influential US consumer organisation Consumer Reports, and Bond University in Australia. It will feature more than 90 presentations, with participants from almost 20 nations. The twin aims are to share what we know about overdiagnosis and how we might best respond to it. And as we sit down to try to work out how to wind back the harms of too much medicine safely and fairly, if there's an overarching theme, let it be humility... for there are no simple quick fixes and no panaceas. As interest in this field grows, it's worth restating that there are myriad benefits of a medical diagnosis. An appropriate diagnosis can open the door to effective management and well targeted treatment that can extend life and ameliorate suffering. Disease definitions and standardised diagnostic criteria enable reliable evaluation of treatments and a common language among researchers. Giving a label to bewildering or debilitating symptoms can help bring understanding and a great sense of relief to people. A diagnosis from a doctor can be a way for

society to say that it cares enough about that suffering to label and treat it; medicalisation can pave the way to de-stigmatisation, recognition, and resources.

However, almost weekly in the world's top medical journals there's fresh evidence or debate about overdiagnosis and overtreatment. In recent months we've seen concern about the overtreatment of mild hypertension in *JAMA Internal Medicine*¹ and recommendations in *JAMA* for combating the overdiagnosis of cancer,² covered last week in Douglas Kamerow's *BMJ* column.³ The *BMJ*'s new Analysis series on overdiagnosis (part of its Too Much Medicine campaign (bmj.com/too-much-medicine)) kicked off recently with an article on the overdiagnosis of pulmonary embolism⁴ and followed with a piece on the controversy around "chronic kidney disease,"⁵ where the boundaries of the "disease" have been set so wide that some experts have observed that "like a fishing trawler it catches many more innocent subjects than it should."⁶ In *PLOS Medicine* last week I and a team of researchers published a study looking at a range of common conditions in which we observed that definitions were often broadened or diagnostic thresholds lowered by panels of experts with financial ties to drug companies that stood to gain from such expansion.⁷ We didn't identify any causal link—but our findings augment the debate on the nature of overdiagnosis and reinforce questions about whether the current processes of disease definition need reform.

The Preventing Overdiagnosis conference will feature workshops on the philosophical underpinnings of how we define disease and how we define "normal." Others will look at how to reduce overdiagnosis in emergency medicine and general practice. Concurrent scientific sessions cover a wide array of topics, with many presentations focusing on the potential harms of screening and how to communicate them. Breast and prostate cancer are the subjects of several presentations, but a number of other conditions are covered, such as attention-deficit/hyperactivity disorder, osteoporosis, depression, asthma, and thyroid cancer. There are also sessions on how healthcare managers are responding to overdiagnosis inside hospitals and health systems and presentations on the role of financial incentives such as fees for services—part of the

exploration of the many drivers of medical excess. Strategic planning sessions will close the conference, looking forward to further research, education, effective communication about overdiagnosis with professionals and the public, and policy reform, cognisant of the many activities already under way in this burgeoning field.⁸

While much ground will be covered in Dartmouth, other parts of the field warrant more digging. The coming tsunami of routine genetic testing for disease predisposition clearly carries huge risks of overdiagnosis. Making links between the problem of too much medicine and the way excess more generally is driving unhealthy climate change is another potentially fruitful area for debate and investigation.

Confronting truisms that “more is better,” that “newer is best,” and that early detection is always desirable is a complex challenge, and discussions on these issues will doubtless continue in conferences, seminars, workshops, and media across the globe.

In some ways this growing concern about medical excess feels like something new, but surely it is part of a very long discussion about how to minimise any harm caused when doctors try to heal. Let’s hope that we can keep that conversation going with a large dose of humility, a sprinkling of hope, and even, at times, a dash of humour.

Competing interests: I am one of the organisers of the Preventing Overdiagnosis conference, and a member of the conference’s scientific committee.

Those who wish to can follow conference events on Twitter (#PODC2013). The *BMJ* plans to publish a special theme issue in early 2014, aiming to capture the best from the conference floor and beyond.

Provenance and peer review: Commissioned, not peer reviewed.

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