Overdiagnosis:
a Japanese Knotweed in our clinical realm?

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How and why are we overusing our specialist language?

Another view.

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Richard Smith's recent review[1] of Suzanne O'Sullivan's *The Age of Diagnosis: Sickness, Health and Why Medicine Has Gone Too Far* does credit to this seminal, provocatively substantial yet very readable book. He conveys well O'Sullivan's evidence for the massive increase in often 'new' diagnoses that are often simultaneously both unprovable and irrefutable, and then lacking in any useful therapeutic benefit. This trend, she says, is unsustainable and often harmful.

Both O'Sullivan's book and Smith's review make powerful arguments for the existence of, and the price we pay for, the overuse – the mission creep – of diagnoses and their inseparable medical model. The following response briefly elaborates and adds to their very cogent arguments. For concision these additional ideas are merely outlined here in note form.

Historical perspectives

- Until Medicine's more modern era (say late 1960s) diagnoses dealt almost entirely with *current* and evident (ie objectively observable) symptomatic disease – they attempted to define only what is actually there and happening *now*. Diagnoses were mostly applied to the evidently ailing.
- But due largely to advances in screening-technology we now expect medical practice, additionally, to predict or prevent possible *future* illnesses, to command what *may be*. Hence the expansion of diagnoses of possible future morbidity, eg hypertension, subclinical hypothyroidism, hypercholesterolemia, prediabetes, cervical dyskaryosis.
- Such 'risk-factor diagnosis' has expanded even more rapidly with the development of genetic testing.

The subjective and the objective

- So until this modern era, medical practice was mostly confined to actual physical ailments. The exception – psychiatry – then generally dealt with gross and severe breakdowns, not more nuanced dysfunctions of behaviour, appetite, mood and impulse (BAMI) as is the case now.
- The medical model and its diagnoses work best when the subjective (the patient's experience) can be seamlessly sewn together with the objective (the medical examination and subsequent third-party visualisations, tissue and fluid investigations etc). The more sources for such congruent accounts and evidence, the more useful and reliable a diagnosis has been proven to be. This makes subjectively sourced diagnoses particularly capricious and problematic. This is a fundamental caveat, often now disregarded.
- Meanwhile we are dazzled by the dramatic success, accumulating over recent decades, of technology-based scientific medicine in tackling many serious physical illnesses. Because of this our modern era has inaptly presumed that this same approach can be effectively applied to a much wider range of problems – in particular those that are essentially experiential, ie where there is clearly subjective dis-ease, but not objective disease.
- Such dis-ease is real enough, extremely common, and probably has always presented to healers and doctors. But important questions arise: is the language of biodeterminism – diagnoses – our wisest choice here? If not, what is?

A cultural perspective

- Such initiatives to designate, pack and code all our discrepant or distressing experience is akin to much else in our industrialised lives. Almost everything we

now use or consume is delegated and processed in these ways.

– This experts-can-fix-it view of complex human problems is inextricably linked to the increasingly effective market-reach of capitalism and its corporatisation. Big Pharma's massive growth and power now depends very much on generating, then vaunting, an increased number of complaints and patients that are putatively treatable. These can then be boosted by lowering the diagnostic thresholds to include the mild, the masked, the subclinical and the atypical.

– These commercial and corporate factors may similarly account for the massive proliferation of specialists and their institutions – they all must make more diagnoses and treat more patients to ensure professional credibility, survival and expansion. Why else is it that almost all proliferating specialists and specialisms will claim that *their* expertise and practice are under-recognised, undervalued, underused and underfunded? Can they all be correct? How do we decide?

Reference

1. Richard Smith. 'The diagnosis explosion: an important new book tries to understand what's happening'. *BMJ*, 16 April 2025.

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