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Overdiagnosis: A necessary part of the learning curve towards excellence

Dear Editor

Doust and Glasziou¹ have highlighted their valid concerns that greater expectations have led to increasing numbers of people who are diagnosed with 'illnesses' that that would never have caused them harm, and are exposed to treatments where the risks outweigh the benefits. There is one good example of this is in paediatrics that needs to be brought to the fore. This is the concept of screening the urine of infants at 6 months of age for the presence of catecholamines, which are markers of neuroblastoma, developed by Japanese researchers.^{2,3} The intention at that time was laudable in view of the high mortality associated with neuroblastoma diagnosed at the later stages of the disease. It made sense, then, to screen infants early (6 months) for the early stages of the disease, as 40% of neuroblastomas are diagnosed in infancy.^{2,3} However, it was not known then whether this approach would reduce the mortality rate for neuroblastoma. While the initial results of his study appeared promising, methodological limitations, lack of controls and lack of population-based studies exposed the need for more acceptable studies. This led to a North American study of neuroblastoma in which screening was performed at 3 weeks and 6 months of age in Quebec, Canada. The study found a substantial increase in cases of neuroblastoma in infants (<1 year) but no reduction in cases diagnosed at older ages, no decrease in the incidence of advanced-stage neuroblastoma and no reduction in late-stage disease and disease with unfavourable prognostic features or mortality.^{4,5} This culminated in a large-scale study reported in the *New England Journal of Medicine*⁶ that revealed no benefit of screening and indicated that it may cause definite harm. This led to the abandonment of screening for neuroblastoma worldwide.

Doctors and patients have benefited from this experience, which was an essential part of

the learning curve that led to improved overall understanding of neuroblastoma and now propels us towards greater challenges ahead. This leads us to the next issue of whether diagnosis of a potentially 'harmless during life-time condition' should be kept from the patient. This raises professional and ethical issues on patients' rights to know about their illnesses and whether doctors are empowered to keep secrets from their patients at the doctors' own discretion? In addition, what is the certainty that the diagnosis of innocent/harmless is absolutely correct? What if the diagnosis proves wrong? Who takes responsibility for this? Distinguishing between innocent and malignant may require tests for which proper informed consent is necessary. Patients have a right to know and to be kept informed at all times, unless they are of diminished capacity, in which case, the legal guardian exercises that right.

What is necessary is not secrecy but proper counselling. Patients need to understand the condition(s) they have and to take responsibility for their own healthcare with the guidance and assistance of doctor(s), nurses, relatives and friends. Doctors' practice and decisions need to be evidence-based; doctors should ensure that no unwarranted treatment is advocated for conditions that are 'potentially harmless during a patient's life-time'. It is the doctor's responsibility to ensure patients are not exposed to treatments where the risks outweigh the benefits through proper and adequate counselling.

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Revalidation

Dear Editor

I read the timely article, 'Revalidation-a personal reflection', by Paresch Dawda (*AFP*, November 2013) with interest.¹ The article highlights the rigorous, disciplined, time-consuming and costly process required for successful revalidation and thus being able to practice medicine.

I began my career as a registered medical practitioner way back in 1959, long before continuing professional development (CPD) and revalidation were considered necessary, and I remain in practice to date.^{2–5} It was clear right from the beginning that a career in medicine required a lifelong ability to learn, assimilate and adapt to an ever-changing healthcare environment in order to practise. Career progress rested on one's capacity for hard work, long hours dedicated to patients, and learning towards improving the quality of patient care.

Medical licensing procedure has changed for the better since the introduction of the Medical Board of Australia.² With the rapidly changing healthcare environment in Australia, as elsewhere, one may expect further changes. Revalidation is focused on the individual and not much on the healthcare system in which one has to work. To be meaningful, revalidation should embrace the entire healthcare system, as highlighted by the author. Healthcare in Australia, where itemised fee-for-service medicine allowing patients to see a doctor

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of their choosing, is considerably different from that in the NHS in the UK.

Revalidation should not be at the expense of the actual time needed for patient care. A practising doctor anywhere in the world will be judged by the outcome of work regardless of the length and breadth of his qualifications and a valid licence.

If revalidation improves patient outcome as it is expected to do then it should be implemented. A practising doctor must be able to navigate through an increasingly complex healthcare team and process without losing focus on patients and not doing any harm, with the knowledge that there is always more to learn and that none of us is perfect.

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Reply

Dear Editor

Dr Bhattacharyya's letter raised three related but pertinent issues relevant to revalidation: first, professionalism in medicine requires a commitment to lifelong learning; second an acknowledgement that in the past, licensing procedures have changed in response to a changing healthcare environment; and third, the implication that a market environment will regulate doctors who provide poorer outcomes of care; facilitated through consumers exercising choice enabled by an itemised fee for service system in Australia.

I completely agree that professionalism is fundamental. However, the healthcare landscape

is very dynamic and continues to change across the world and a redefining of professionalism has been called for.¹ This redefining stated 'the profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal'.¹ This is against the grain of placing the responsibility for regulation onto patients through their right to exercise choice. Other countries with a fee-for-service model have adopted a form of revalidation or recertification.

The data from revalidation in the UK to date shows 1.3% of doctors had their revalidation deferred because of concerns and seven out of eight of those have not previously been the subject of concerns raised with the General Medical Council.² It has been said 'revalidation provides an opportunity for promoting the new professionalism'.³ Although in the UK revalidation may have caused confusion and cynicism among some doctors, there is consensus that it offers possible benefits, particularly the developmental potential for doctors.⁴ That is not to say the process adopted in the UK or elsewhere is the right process for Australia. As concluded by Breen in a recent article 'revalidation as part of renewal of medical registration in Australia needs to be debated widely among the Medical Board of Australia and members of the medical profession in Australia'.⁵

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Diagnosis and management of zoonoses

Dear Editor

The recent report, 'Diagnosis and management of zoonoses' (*AFP* March 2014) is very interesting.¹ Gunaratnam et al developed a new algorithm with emphasis on risk factors such as such as 'non-household contact with animals, excluding other possible causes of fever'.¹ Indeed, the tool can be useful for diagnosis and management of zoonoses. However, there are some concerns on the algorithm. The risk factors might not be seen in many zoonoses and patients might not give an accurate history. Subclinical infection and asymptomatic case are common in many zoonoses.² The use of the algorithm might result in either under- or overdiagnosis. In fact, the awareness of the family practitioner to the possibility of occurrence of zoonosis is very important in early diagnosis and management of the infected case. Practitioners should have continuous medical education to update knowledge on zoonosis.³

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Letters to the Editor

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