Being at "high risk" of ill health has become a disease in its own right

Doctors as 'risk-illiterate' as patients; this undermines preventive medicine efforts

Classifying an individual as being at "high risk" of developing a particular condition/disease has become a disease in its own right, and is turning the healthy into the sick, argues an expert in an editorial published online in the ***British Journal of Sports Medicine.***

And doctors are as bad as patients at understanding what is meant by high risk and the anticipated benefit of any preventive treatment, says Professor Teppo Järvinen, of the Department of Orthopaedics and Trauma, Helsinki University Hospital, in Finland.

This 'risk-illiteracy' undermines preventive medicine and the ability of patients to take charge of their own health, he suggests.

Professor Järvinen gives several examples of the way in which the concept of high risk has skewed the perception of ill health.

Around 10 years ago, the threshold for treatment of high blood pressure in the European guidelines on cardiovascular disease classified most adult Norwegians—among the healthiest populations in the world—as being at high risk.

If these guidelines had been put into practice, "the focus on hypertension would have drained the entire primary healthcare budget," points out Professor Järvinen.

Similarly, the recent US National Osteoporosis Foundation guidance on the threshold for the treatment of brittle bone disease, stipulates that treatment should be offered to all those whose 10 year probability of sustaining a hip fracture is 3%.

On this basis, he argues, almost three out of four white women over the age of 65 in the US and over 90% of those over the age of 75 would be recommended drug treatment.

And it doesn't stop there. "The new cholesterol guideline similarly colonises virtually the entire elderly population in the realm of the 'sick'," he points out.

But faith in doctors to work out who most needs treatment might be misplaced, he suggests.

"If we assume doctors are truly more competent in making value judgments about the lives of their patients than the patients sitting in front of them, should we not have proof that doctors can do the job?" he asks.

"Sadly despite medical education and clinical experience, doctors do not seem to possess the required skill," he writes.

Furthermore, there's a mismatch in perception of the trigger threshold for treatment, he says. Patients tend to think that to qualify for preventive treatment the reduction in absolute risk needs to be large—in the region of 20%-50%.

But doctors "began prescribing enthusiastically when an osteoporosis drug was shown to increase the probability of avoiding a hip fracture from 97.9% to 98.9%," he says, possibly because it was framed as a 50% reduction in relative risk to make the benefit seem more impressive.

And sometimes the effort required for prevention consumes vastly more resource than the treatment of the condition it is designed to stave off, he says.

"Despite laudable efforts to improve the communication and comprehension of both the concept of risk and the anticipated treatment benefit, risk-illiteracy of the gravest magnitude still affects both doctors and patients," he writes.

"But without accurate and common comprehension of these key aspects, there is no basis for shared decisions. And without shared decision-making, pharmacological primary intervention becomes a tyranny of eminence," he concludes.