PREVENTING OVERDIAGNOSIS
Winding back the harms of too much medicine

17–19 August 2017
QUEBEC CITY
Notice of photography and filming

Preventing Overdiagnosis 2017 is being visually documented. By attending you acknowledge that you have been informed that you may be caught on camera during this event. Images taken will be treated as the property of Preventing Overdiagnosis and may be used in the future for promotional purposes. These images may be used without limitation by any organisation approved by the PODC Committee and edited prior to publication as seen fit for purpose. Images will be available on the internet accessible to internet users throughout the world including countries that may have less extensive data protection than partnering countries. All films and images will be securely stored on University of Oxford servers. Please make yourself known at registration if you wish to remain off camera.
to Quebec City and the 5th international conference on Preventing Overdiagnosis: Towards Responsible Global Solutions

Preventing Overdiagnosis 2017 will cover how physicians, researchers and patients can implement solutions to the problems of overdiagnosis and overuse in the healthcare system using evidence available and that currently being generated. Delegates will learn to avoid waste, use best practice when communicating and engaging with patients and the public, and achieve a better understanding of the benefits of shared decision making within the constraints of modern practice.

This year’s session topics have been set to meet with the conference learning objectives:
- Facilitate a movement toward responsible global solutions for preventing overdiagnosis and overuse.
- Implement solutions to the problems of overdiagnosis and overuse in the healthcare system using evidence available and that currently being generated.
- Use best practice when communicating and engaging with patients and the public.
- Share the benefits of shared decision making within the constraints of modern practice.

Moving from Evidence to Action
- Identify factors contributing to Overdiagnosis and Over Medication at the level of the health care system, the clinical practice and the public domain.
- Choose best practices to address Overdiagnosis and Over Medication at the level of the health care system, the clinical practice and the public domain.

Engaging with Citizens, Patients and the Public
- Choose best practices in engaging citizens, patients and the public in addressing Overdiagnosis and Over Medication.

Communicating about Overdiagnosis
- Apply best practices in communicating with policy makers, clinicians, citizens, patients and the public about Overdiagnosis and Over Medication.

Overuse, Overmedicalisation & Overdiagnosis
- Adapt evidence based strategies to address Overdiagnosis and Over Medication in local context.
- Apply best practices to address Overdiagnosis and Over Medication at the level of the health care system, the clinical practice and the public domain.

19.5 CME Credits have been awarded to Preventing Overdiagnosis 2017

The Office of the Vice-Dean of Education and Professional Development from the Faculty of Medicine at Université Laval is supported by the Collège des Médecins du Québec, the Committee on Accreditation of Canadian Medical Schools (CACMS) and the Accreditation Council for Continuing Medical Education (ACCME) in the United States and is authorized by these regulatory authorities to offer activities in medical education.

The Office of the Vice-Dean of Education and Professional Development from the Faculty of Medicine at Université Laval will acknowledge Category 1 credits (1 credit for each hour of learning) as defined as Royal College of Physicians and Surgeons of Canada (RCPSC) Maintenance of Certification (MOC) Accredited Section 1 activity credits and as a group-learning activity as defined by the College of Family Physicians of Canada to medical participants of the 5th International Preventing Overdiagnosis Conference.

The Office of the Vice-Dean of Education and Professional Development from the Faculty of Medicine at Université Laval will also acknowledge UECs (Unités d’éducation continue) (0.1 UECs for each hour of learning) in continued education for other participants of the 5th International Preventing Overdiagnosis Conference.
## Day 1 – Thursday August 17th

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>08:00</td>
<td>Registration</td>
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| Room 306AB 08:30 – 09:00 | Welcome / Introduction  
Gaétan Barrette, Quebec Health Minister |
| Room 306AB 09:00 – 10:30 | Moving from Evidence to Action  
CHAIR – Steve Woloshin & Lisa Schwartz  
Barry Kramer – Overdiagnosis: The Clash of Science and Intuition  
Stacy Carter – Counterintuitive harms, social movements, and moral challenges  
Normand Laberge – Healthcare overuse; Time for action...  
Patient/ Citizen Representative – Alies Maybee |
| Room 307A | Overuse & Over Medicalisation  
CHAIR – John Brodersen  
Chisato Hamashima – Rapid dissemination of H. pylori eradication for chronic gastritis among asymptomatic people  
Geoff Porter – The Increasing Incidence of Thyroid Cancer: A Pan-Canadian Analysis  
Stephen Hall – The excessive costs of routine medical tests when ordered by physicians who are higher (over) testers  
Janet Squires – Overuse of contralateral prophylactic mastectomy: A growing concern in over-aggressive treatment of breast cancer patients  
Sayeeda Amber Sayed – Frequency of Pap testing in women aged 10–29 years in Alberta, Canada: A case of over screening? |
| Room 307B | Moving from Evidence to Action  
CHAIR – Holly Witteman  
Chris Degeling – Influencing Health Policy through Public Deliberation: Lessons learned from two decades of Citizens’/Community Juries  
Paula Riganti – Motivating factors influencing women on performing mammograms for breast cancer screening  
Sian Taylor-Philips – Do methods of evidence review affect policy-makers decisions of whether to implement new screening programmes?  
Milan Mrekaj – Demonstrating the value of direct access to musculoskeletal care in the UK private setting  
Robin Holtedahl – Experience with reducing the volume of knee arthroscopies in patients with degenerative meniscal tears and osteoarthritis  
Natalie Armstrong – System change to mitigate overdiagnosis and overtreatment: How can we ensure ‘just enough medicine’? |
| Room 308A | Overuse & Over Medicalisation (FRENCH)  
CHAIR – Guylène Thériault  
Antoine Lapointe – Calcium, magnesium and phosphorus dosage: Impacts and relevance in the Emergency Department  
Gilles Mignon – A review of medications to be excluded from care. The experience of the magazine Prescrire in France  
Marc Rhainds – Prenatal ultrasound in normal pregnancy: the bridge between health technology assessment guidance and local medical perspective  
Manon Niquette – Facebook pharmaceutical advertising to mothers and the risk of acetaminophen overdose in small children |
<p>| Room 308B | Workshop – Tom Perry &amp; Emily McDonald, Deprescribing: the solution to irrational polypharmacy |
| Room 309A | Workshop – Barbara Dunn, Overdiagnosis in Genetic Screening: Clinical Implications |
| Room 309B | Workshop – Gordon Schiff, Balancing Diagnostic Errors with Conservative Diagnosis: Developing a New Paradigm for More Appropriate Diagnosis |</p>
<table>
<thead>
<tr>
<th>Room 306AB</th>
<th>12:30 – 13:00</th>
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<tr>
<th>ESPACE URBAN</th>
<th>13:00 – 14:00</th>
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<tr>
<th>Parallel Sessions</th>
<th>14:00 – 15:30</th>
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| Room 307A | **Overuse & Over Medicalisation**  
CHAIR – Steve Woloshin & Lisa Schwartz  
**Shaun Peter Qureshi** – New doctors’ perceptions of inappropriate investigations and treatment for dying patients – a qualitative medical education study of Scottish doctors  
**Ingvild M Rosenlund** – The extent, regional variation and impact of gynaecologist payment models in unwarranted pelvic examinations: A nationwide cross sectional study  
**Zachary Bouck** – Measuring the frequency and variation of unnecessary care across Canada  
**Martin Gariépy** – Measuring overuse of Head CTs for Pediatric mTBI patients in two Canadian Emergency Departments (phase I of the Wiki Head CT Patient Decision Aid Study)  
**Maria Eugenia Santiago Cadelago** – Consequences of prostate cancer screening in asymptomatic men enrolled in a private Health Insurance Plan In Buenos Aires, Argentina |
| Room 307B | **Overuse & Over Medicalisation**  
CHAIR – Yu Wang  
**Moriah Ellen** – Nurses’ perceptions on the overuse of health services in health systems: A qualitative study  
**Kevin McGeehan** – Factors associated with the initiation of testosterone replacement therapy among men participating in the 45 and Up study  
**James Rickert** – Preliminary Results of An Innovative Patient Centered Preauthorization and Data Collection Program for Total Joint Replacement  
**Albert Prats-Urbe** – Use and misuse of PSA testing for prostate cancer screening in Catalonia  
**Niall McLaren** – Overdiagnosis in Psychiatry: the looming catastrophe |
| Room 308A | **Moving from Evidence into Action**  
CHAIR – Barry Kramer  
**Rachel Farber** – Examination of the Practice Shift from Plain Film Mammography to Digital Mammography  
**Anat Gaver** – Implementing tools/measures for reduction of overdiagnosis and overtreatment in clinical guidelines – a position paper  
**Karsten Juhl Jørgensen** – A Framework for determining when screening interventions should be de-intensiﬁed or de-implemented  
**Imran Sajid** – Clinical Commissioning Strategies to Reduce Diagnostic Over-requesting and Improve Interpretation of Musculoskeletal Imaging and Laboratory Pathology: Tools to de-bias clinicians and patients; what works and what doesn’t in practice  
**Martin Scherer** – Guideline for “Protection against Over- and Underuse of Healthcare” of the German College of General Practitioners and Family Physicians (DEGAM)  
**Marlene Azar** – Trial and Meta-analysis Characteristics Associated with Data Contribution in Individual Patient Data Meta-Analyses of Randomized Controlled Trials |
| Room 308B | **Engaging with citizens, patients and the public**  
CHAIR – Navjoyt Ladher  
**Chris Degeling** – Should mammography screening programs continue to invite women aged 70–74 to participate? – A report on two community juries of Australian women in the target age group  
**John W Osterman** – Overdiagnosis and Public Health: Inventing an Epidemic in Moldy Montreal Schools  
**Nikesh Parekh** – Medication-related problems: A qualitative exploration of the older person’s lived experience  
**Johanna Caro Mendivelso** – Low-value clinical practices from the perspective of patients. A qualitative study  
**Rae Thomas** – Case Finding for Dementia in Primary Care: What a Community Jury thinks Australian General Practice Physicians Should Do |

| Room 309A | **Workshop**  
John Abramson, Report From Inside the Statin Wars: The best--but inadequate--evidence about whether low risk people benefit from statin therapy, and the resistance to robust scientific debate |
| Room 309B | **Seminar**  
Brooke Nickel, Applying a research framework for medical overuse – examples from research in thyroid cancer |
**Day Two – Friday August 18th**

**Hall 310**

08:00 Registration

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**Room 306AB**

08:30 – 10:00 Tackling the defensive practice argument

**CHAIR** – Guylène Thériault

- Audrey Parayre
- Dr Lorraine LeGrand Westfall
- Michel T. Giroux

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**Parallel Sessions**

10:30 – 12:00

- **Room 307A**
  - Overuse & Over Medicalisation
  - **CHAIR** – France Légaré
  - Geneviève Rail – Overdiagnosis and the construction of “at-risk” girls: HPV vaccination campaigns as rescue missions
  - Edeltraut Kröger – Health impacts and characteristics of deprescribing interventions in older adults – a systematic review
  - Dana Sumilo – How many tonsillectomies are necessary? An eleven year retrospective cohort study of indications and eligibility for childhood tonsillectomy in UK primary care
  - Wieteke van Dijk – “Dear neurologist, that’s not my spine. That’s a model on a table.” How contextual factors contribute to decision making
  - Megan Evans – Marketing as Medicine: Developing Disease to Produce Profit

- **Room 307B**
  - Moving from Evidence into Action
  - **CHAIR** – Toni Dedeu
  - Ora Paltiel – Examining the utilization of CT or PET-CT for routine surveillance of asymptomatic lymphoma patients in remission in Israel; evidence-based groundwork for a “choosing wisely” recommendation
  - Fred Arthur – The Failure of the PSA Test. Implications and Opportunities
  - Christopher Rauscher – Polypharmacy Risk Reduction in BC- Practical Experience of Moving From Contemplation to Action
  - Milan Mrekaj – Effectiveness of conservative treatment for musculoskeletal conditions
  - Ora Paltiel – Use of National Quality Indicators to Reduce Under- and Overdiagnosis of Cervical Cancer in Israel

- **Room 308A**
  - Communicating Overdiagnosis
  - **CHAIR** – Karsten Juul Jørgensen
  - Fabien Gagnon – Overdiagnosis of Psychiatric Disability: Best practice, Advocacy, “Complaisance”, Fraud or Ignorance?
  - Dennis Fechtelpeter – Development and pilot testing of a short film explaining overdiagnosis
  - Brenda Wilson – First do no harm? The importance of communicating overdiagnosis in guideline recommendations: Approach of the Canadian Task Force on Preventive Health Care
  - Nancy Schoenborn – Older adults’ preferences for how to explain cancer screening cessation – results from a national survey using best-worst scaling
  - Samara Noble – Could disease labelling have positive effects? An experimental study exploring the effect of the Chronic Fatigue Syndrome label on social support
  - Jolyn Hersch – 2-Year Follow-Up in a Breast Screening Decision Aid RCT: Retention of Overdetection Knowledge and Other Decision Making Effects
## PROGRAMME

### Parallel Sessions 10:30 – 12:00

| Room 308B | Seminar – Marc Rhainds, Patient expectations and engagement: a challenge in overdiagnosis and overuse |
| Room 309B | Seminar – Corinna Schaefer, How to strengthen trustworthiness of “choosing wisely” – recommendations – best practice examples from Germany and Austria |

### Parallel Sessions 12:00 – 13:30

| Room 306AB | Plenary Debate – Journal Editors: The role of journals in Preventing Overdiagnosis  
CHAIR – Navjoyt Ladher |
| Room 307A | Workshop – Karen Born, Fostering Undergraduate Medical Student Leadership in Resource Stewardship: Choosing Wisely Canada STARS |
| Room 307B | Workshop – Andrew Foy, A Mixed Methods Study of an Enhanced Decision Aid for Emergency Department Patients with Low-Risk Chest Pain |

### ESPACE URBAN 13:30 – 14:30

- Lunch

### Parallel Sessions 14:30 – 16:00

| Room 307A | Overuse & Over Medicalisation  
CHAIR – Annie LeBlanc  
Krista Margeson – Reducing polypharmacy in the frail elderly: an improvement project in a rural long-term care facility  
Jack William O’Sullivan – Assessing how appropriately diagnostic tests are used in primary care: a systematic review and meta-analysis  
Lorna Gibson – Impact of detecting potentially serious incidental findings during multi-modal imaging: experience from Uk Biobank  
Minna Johansson – Screening for malignant melanoma – results from a Cochrane review  
Francois Rousseau – Using per-capita clinical laboratory expenses to compare appropriate use of laboratory tests  
Monique Pappadis – Perceptions of Overdiagnosis of Breast Cancer among a Tri-ethnic Sample of Women 70 Years of Age and Older |
| Room 307B | Communicating Overdiagnosis  
CHAIR – Marie Dominique Beaulieu  
Jolyn Hersch – How Information About Overdetection Changes Breast Screening Decisions: Mediation Analysis Within a Randomised Controlled Trial  
Ronald Adler – Cancer overdiagnosis explained: A simple graphical model  
Ashley Houston – Perspectives on Discontinuing Breast Cancer Screening Among Older Women  
Dagmar Luehmann – Prioritizing Recommendations for the guideline "Protection against Over- and Underuse of Healthcare" by the German College of General Practice and Family Medicine (DEGAM) – Methodological Considerations  
France Légaré – Decisional conflict screening for a diversity of primary care decisions. Are we SURE yet? |

| Room 308A | Workshop – Edeltraut Kröger, Polypharmacy and Deprescribing |
| Room 308B | Workshop – Nick Zhygan, John Jose Nunez, Alexandra Bite, Olivia Margie & Vincent Wong, Choosing Wisely: one person at a time |

| Room 309A | Seminar – David Warriner, How to Choose Wisely – What makes a successful campaign to reduce too much medicine |
| Room 309B | Seminar – Pamela Marcus, Discussing our disagreements: what is the definition of cancer overdiagnosis? |

### Hall 310 16:00 – 16:15

- Break / Posters

### Room 306AB 16:15 – 17:45

- Communicating about Overdiagnosis  
CHAIR – Stacy Carter  
France Légaré – Shared decision making in the context of overdiagnosis and overtreatment  
André Picard – The challenges and opportunities of communicating overdiagnosis to a wide public audience  
Rita Redberg – Communicating overdiagnosis to health professionals – via the vehicle of a medical journal  
Patient/Citizen Representative – André Gaudreau

### 18:00 – 20:00

- QMA Cocktail Reception at the Palais Montcalm
### Day Three – Saturday August 19th

<table>
<thead>
<tr>
<th>Hall 310 08:00</th>
<th>Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room 306AB 09:00 – 10:30</td>
<td>Overuse, Overmedicalisation &amp; Overdiagnosis&lt;br&gt;CHAIR – John Brodersen&lt;br&gt;Wendy Levinson – Choosing Wisely: From an Idea to an International Movement&lt;br&gt;Vinay Prasad – Medical reversal: Why 46% of what we do is wrong&lt;br&gt;Vikas Saini – Defining the Right Care Requires a New Science&lt;br&gt;Patient/Citizen Representative – Mathieu Bouchard</td>
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<tr>
<td>Hall 310 10:30 – 11:00</td>
<td>Break / Posters</td>
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<tr>
<td>Parallel Sessions 11:00 – 12:30</td>
<td>Room 307A&lt;br&gt;Overuse &amp; Over Medicalisation&lt;br&gt;CHAIR – Yu Wang&lt;br&gt;Ignacio Ricci – Colonoscopy overuse in colorectal cancer screening and associated factors in Argentina: A retrospective cohort study&lt;br&gt;Abdou Elhendy – Overdiagnosis of coronary artery disease by stress echocardiography. Identification of variables associated with a false positive stress test&lt;br&gt;Laura Llobet i Vila – Facing a dilemma in elderly complex and vulnerable patients: to stop or not to stop prevention?&lt;br&gt;Tristan Rainville – Analytical Approaches in Phase III Clinical Trials of Direct Oral Anticoagulants: A Systematic Review&lt;br&gt;Simon Berthelot – A time-driven activity-based costing study to estimate the cost of diagnostic tests ordered in the emergency department</td>
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<td>Room 307B</td>
<td>Room 308A&lt;br&gt;Other&lt;br&gt;CHAIR – Jack O’Sullivan&lt;br&gt;Brooke Levis – Overdiagnosis of major depression based on lay-administered fully structured diagnostic interviews&lt;br&gt;Simon Décary – Diagnostic validity of combining history elements and physical examination tests for symptomatic knee meniscal tears&lt;br&gt;Tessa Copp – Polycystic ovary syndrome controversy: are expanding disease definitions unnecessarily labelling women with PCOS?&lt;br&gt;Rami Rahal – Avoidable diagnostic breast imaging and biopsy investigations: Impact of rising abnormal screening mammography rates&lt;br&gt;Cindy Gauvreau – The comparative impacts of cervical cancer screening guidelines on the overdiagnosis of pre-cancerous lesions in Canada</td>
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<td>Room 308B</td>
<td>Workshop – Eva Verkerk, Less is really more: how to reduce low-value care</td>
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<td>Room 309A</td>
<td>Room 309B&lt;br&gt;Workshop – Katy Bell, Diagnostic test measurement variability – relevance to overdiagnosis&lt;br&gt;Seminar – John Brodersen, Imaging asymptomatic people: are we doing more good than harm?</td>
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<tr>
<td>Room 306AB 12:30 – 13:00</td>
<td>Room 307A 14:00 – 15:15</td>
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<td>Room 307A</td>
<td>Overuse &amp; Over Medicalisation</td>
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<td>CHAIR – Navjoyt Ladher</td>
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<tr>
<td>Laurence Simard-Émond</td>
<td>Endometrial biopsy in an outpatient gynaecological setting: overinvestigation</td>
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<tr>
<td>Rebecca Francois</td>
<td>Adaptation and Validation of the Multi-dimensional Measure of Informed Choice for Cardiopulmonary Resuscitation and Mechanical Ventilation for Elderly Patients in a French Canadian Population</td>
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<tr>
<td>Gemma Jacklyn</td>
<td>Overdiagnosis in Australia due to screening mammography for breast cancer</td>
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<tr>
<td>Eva Verkerk</td>
<td>Identifying and reducing low-value care: development of a typology</td>
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<td>Prajakta Adsul</td>
<td>Using colposcopy to calculate screening performance measures of VIA in Indian cervical cancer screening programs: potential for overtreatment?</td>
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<td>Christiana Naaktgeboren</td>
<td>Interventions to reduce unnecessary laboratory test utilization in hospital practice – A narrative review</td>
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<td>Room 307B</td>
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<td>CHAIR – Guylène Thériault</td>
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<td>B.E.L. Vrijen</td>
<td>The positive side of overdiagnosis: does an immediate comprehensive panel of laboratory tests in outpatient care improve patient outcomes?</td>
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<td>Kevin Jenniskens</td>
<td>Lost in terminology: towards a typology for dissecting overdiagnosis</td>
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<td>Susan Weller</td>
<td>Understanding motivations of older women to continue or discontinue breast cancer screening</td>
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<td>Pamela Marcus</td>
<td>Serendipitous detection of pancreas cancer during lung cancer screening with low-dose computed tomography</td>
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<td>Danielle Durham</td>
<td>Awareness of overdiagnosis in cancer screening among post-doctoral students enrolled in a cancer screening course</td>
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<td>Room 309A</td>
<td>Room 308B Engaging/ Comm &amp; Other (FRENCH)</td>
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<td>Room 309B</td>
<td>Room 308A Engaging/ Comm &amp; Other (FRENCH)</td>
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<tr>
<td>Room 308B</td>
<td>Workshop – Teppo Jarvinen, #ShowMoreSpine: a grassroots campaign to tackle the widening of disease definitions – lessons learned and what’s next</td>
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<tr>
<td>Room 309A</td>
<td>Seminar – Natalie Armstrong, Realising the value of social science theory and methods for researching overdiagnosis and overtreatment</td>
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<tr>
<td>Room 309B</td>
<td>Seminar – Brenda Wilson, Precision medicine and preventing overdiagnosis: concordance or paradox?</td>
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<thead>
<tr>
<th>Room 306AB 15:15 – 16:00</th>
<th>Closing Keynote</th>
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<tbody>
<tr>
<td>CHAIR – Hugo Viens</td>
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<tr>
<td>Karsten Juhl Jørgensen</td>
<td>How to determine when to stop screening</td>
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<td>Thomas Lemke</td>
<td>Experiences with explaining overdiagnosis to the general public: screening healthy people, absolute versus relative risks, how this affected people’s perception of health interventions</td>
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<tr>
<td>John Brodersen</td>
<td>Introducing the 6th Preventing Overdiagnosis conference in Copenhagen, Denmark: 20 – 22 August 2018</td>
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| Hall 310 16:00 | Coffee – safe journey home |
Québec City is well served by Jean-Lesage International Airport, just 20 minutes from the Convention Centre. Public transit services are within easy reach to access downtown or any other location in town. Taxi rates are between $35–$40.

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<td>418 653-7777</td>
<td>418 651-2727</td>
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For other transport links please refer to YQB taxis-and-public-transportation.
The Québec Medical Association invites all participants of the Preventing Overdiagnosis 2017 Conference to a cocktail that will take place at the Palais Montcalm, which is only a 5-minute walk from the Quebec City Convention Center. The Palais Montcalm is renowned for the beauty of its architecture and its ideal location in the heart of Old Quebec.

Want to go out for dinner after the cocktail? Check out the promotions offered by the following restaurants. More information on www.preventingoverdiagnosis.net or in the participant kit.
Cancer Overdiagnosis: A Clash of Science and Intuition

Leading global authority on overdiagnosis in cancer, Dr Barry Kramer is Director of Cancer Prevention at the US National Cancer Institute. Cancer screening has been promulgated to the health professions, policymakers, and public for nearly a century—often referred to as the most important tool in a "war on cancer." The concept of early detection has strong intuitive appeal to healthcare providers and patients alike. In some cases, randomized trials have confirmed benefits, at least in reduction of cancer-specific mortality. However, the magnitude of benefits has rarely matched original expectations. In some cases, studies show no benefit at all. Moreover, the enthusiasm for screening has weathered increasing evidence of important harms, particularly cancer overdiagnosis, in a clash of intuition with science. Can science overtake intuition? Much of the effort has been devoted to describing the magnitude of overdiagnosis and its consequences. As important as that effort has been, that accumulated evidence provides a path for research on interventions. This talk will cover possible strategies we can use in the clinical setting and in the laboratory to preserve screening benefits (when they are present) and mitigate harms.

You may find these links useful for background:

Advances in healthcare have produced enormous benefits for society. Healthcare spending has risen by over 70% in the last few decades while life expectancy has increased by about 1 year every 4 years in the same period. As a result, for the first time ever, there are now more people aged 65 and over than there are under age 5 in the world. With the costs associated with ageing of the population, healthcare demand will or is undermining public finances. Cost pressures have become the dominant issue in all advance economy and all payors are moving towards cost containment measures to achieve operational efficiency. This could seriously damage some of the advances in life expectancy. In addition, overuse of healthcare resources is now impeding on education and the economy which in turn is having a negative effect on population health and well-being. It is obvious that overuse in healthcare exists and is costing significant amount of money and wasting significant resources. As there is enough evidence showing there is overuse in healthcare, it is becoming critical to act and act now. Communicate, educate and engage are the three steps recommended for change and are fully applicable for the issue of overuse, overmedication and overdiagnosis.

16:00 Thursday August 17th

Engaging with Citizens, Patients and the Public

Chair – Barry Kramer

A future where we are all patients

Celebrated advocate with an international reputation, **Fran Visco** is president of the National Breast Cancer Coalition in the United States, and is a former member of the US President’s Cancer Panel.

In breast cancer, over the past 40 years, the public has been inundated with the message that early detection saves lives. That message has been spread worldwide through hundreds of millions of dollars of marketing campaigns by non-profit organizations, industry, government and academia. More recently, the science of genomics has been marketed as a breakthrough for cancer and is most often touted in the area of early detection. The newest sound bite involves the idea of liquid biopsy that can identify abnormalities that may lead to cancer before a tumor has formed. Little emphasis is placed on the very real possibility that everyone will have an abnormality that will of course be deemed to require intervention. There is little discussion of the necessity to focus on early detection of lethal cancer. We are on the way to every individual becoming a patient thereby creating a vast market for researchers, medical device and drug companies and NGO’s. The National Breast Cancer Coalition has worked to rebut these approaches in the advocacy community through science education for lay advocates who are involved with a constituency, in addition to programs that teach advocates how to understand and communicate about evidence based decision making. NBCC works to educate scientists and policy makers about the problems of over diagnosis and overtreatment through public policy programs such as the Department of Defense Peer Reviewed Research Program. A legislative approach to combating Government persistence on the message of screening and early detection includes opposition to Congressional bills seeking to undermine the USPSTF and advancement of the CDC Breast and Cervical Cancer Treatment Act, which was in part intended to educate policy makers that just finding cancer is not a solution.

Welcome to the revolution: the growing international movement for healthcare consumer involvement in research

As Consumer Network Coordinator for Cochrane **Richard Morley** has extensive experience of public engagement and partnership working in the voluntary, public and education sectors. Richard co-chairs the Department of Health Sciences Patient and Public Involvement Committee, is a James Lind Alliance Adviser.

A revolution has begun. A growing global network of institutions and individuals is promoting consumer (patients, caregivers or family members) involvement and engagement in research, with the aim of changing health policy and practice and giving healthcare consumers powerful tools to support their health care decisions, including addressing over-diagnosis and overtreatment.

This presentation will draw on the Richard Morley’s experience of involvement with the James Lind Alliance (JLA) and Cochrane. The JLA is a non-profit-making initiative that brings together patients, carers and healthcare professionals in Priority Setting Partnerships (PSPs) to identify and prioritise unanswered questions about the effects
of treatments for future research. Established in the UK in 2004 it is becoming increasingly international in nature. Cochrane is a global independent network of researchers, professionals, patients, carers, and people interested in health and the largest international producer of systematic reviews involving 37,000 contributors from more than 130 countries including an active and growing network of over 1,500 healthcare consumers. Both organisations share a philosophy of making evidence-based medicine relevant, and a commitment to involving consumers in their work.

Healthcare consumers live in a world where access to health services is increasingly commodified, and where independent, high quality evidence competes to be heard and understood. The movement to engage and involve people in research is vitally important, ensuring that evidence is relevant, accessible, and gives people the tools they need to make decisions about their health, including addressing issues of over-diagnosis and over treatment.

As this movement spreads, there is an imperative to be reflective and self-critical, to pay attention to the theory of involvement, to ensure that the practice of involvement and engagement is itself evidence-based, and to seize opportunities for collaboration to make this a truly global and effective movement.

Welcome to the revolution!

Truth, Belief and Evidence in Health Choices: it’s a matter of trust

Carolyn Canfield, independent citizen-patient and honorable lecturer in the Department of Family Practice at the University of British Columbia

Medical hierarchy has long admonished that the best patient is the obedient one. With competing and inconsistent medical advice coming from all sides, who are we patients supposed to believe? How familiar are variants of the escape in “If you were me, doc, what would you do?”

Learning what care is appropriate and what is excessive and possibly harmful is fraught with a tangle of confusing claims and interpretations. If the experts can’t agree, how do I choose what’s best for me and my family?

A toxic mix of commercial agendas and science ignorance fuels lethal propaganda like the antivaxxers. Celebrities debate pseudo science as if facts were at play. Exposés of faked and incomplete research findings shake our confidence in so-called evidence. Corporate gifts and payouts seem intended to bribe medical students and practicing clinicians who defend their sacred impartiality.

In this cacophony of competing voices, all claiming authority on the patient’s best interest, confusion and doubt run rampant. Overwhelmed, many of us, escape the noise to find comfort in what we want to hear.

What is truth, what is belief and what is evidence? And then, what motivates us to act?

08:30 Thursday August 18th
Tackling the defensive practice argument
Chair – Guylène Thériault

Audrey Ferron Parayre
Assistant professor, Faculty of Law, University of Ottawa

Dr Lorraine Legrand Westfall
Director, Regional Affairs and Chief Privacy Officer, Canadian Medical Protective Association

Michel T. Giroux
Lawyer and medical ethicist

When the issue of reducing overdiagnosis and overuse is discussed with physicians, many of them are afraid of not following guidelines from medical specialities, even when they are aware of contradicting evidence. Physicians very often report that they engage in defensive practices out of fear of becoming the subject of a malpractice lawsuit. Three experts will address this issue from a legal and ethical point of view. More precisely, they will reflect on this issue using information about the code of ethics, the judicial process and shared decision making while remembering us that the goal of care is the well-being of the patients.
**16:15 Thursday August 18th**

**Communicating about Overdiagnosis**

Chair – Stacy Carter

Patient/ Citizen Representative – André Gaudreau

**Shared decision making in the context of overdiagnosis and overtreatment**

**Dr France Légaré.** Professor at the Université Laval, France is a leading global authority on Shared-Decision Making.

Taking action about a health issue begins with a decision. Shared decision making (SDM) is a process whereby patients and clinicians relate to and influence each other to make healthcare choices informed by best evidence and by what matters to the patient. For many people, the clinical consultation is the point in their interaction with the health and social care system when they receive diagnoses, learn about health and social issues, and consider steps to maintain or improve their health. While patient engagement in their own health care is far broader than what happens during a consultation, this interaction offers a unique opportunity to engage patients in decisions that will impact their health. In SDM, patient autonomy is optional rather than mandatory. SDM improves patients’ and providers’ healthcare experiences and leads to improved healthcare processes, patient outcomes, and health costs. SDM reduces overuse of ineffective tests and treatments while it increases uptake of effective ones. It thus plays an important role in reducing harms and increasing patient safety. SDM is best practice for informed consent, and when combined with outcomes research, a promising strategy for reducing unwarranted regional variation.

For these reasons and because it is considered an ethical imperative, SDM appears in policy and legislation in many countries. It is a key component of most healthcare reform policies to emerge in the past few years, such as the Triple Aim approach and is fundamental to the Organisation for Economic Co-operation and Development (OECD)’s People at the Centre adopted as a priority by 42 nations for achieving high-value health systems and policies. This presentation will briefly summarize what SDM is and is not, discuss some of the myths about SDM and highlight few initiatives that have relied upon SDM approaches to tackle overdiagnosis and overtreatment in health and social care domains.

Writing for Canada’s Globe and Mail, **André Picard** is one of the world’s most influential health reporters, and a much sought-after public speaker.

**Rita Redberg** is a Professor at the University of California, San Francisco, and the respected editor of one of the world’s leading medical journals, JAMA Internal Medicine, which features the ground-breaking series, Less is More.

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**09:00 Friday August 19th**

**Overuse, Overmedicalisation & Overdiagnosis**

Chair – John Brodersen

Patient/ Citizen Representative – Mathieu Bouchard

**Choosing Wisely: From an Idea to an International Movement**

**Dr Wendy Levinson.** Professor of Medicine and Past Chair of the Department of Medicine at the University of Toronto. Wendy is a national and international expert in the field of physician-patient communication, studying topics including the disclosure of medical errors to patients and informed decision making.

She is presently the Chair of Choosing Wisely Canada, a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures. She also chairs and is coordinating the international collaborative of the Choosing Wisely campaigns in nearly 20 countries worldwide. In 2015, Dr. Levinson was appointed an Officer of the Order of Canada for her work.

Choosing Wisely Canada is a campaign to help clinicians and patients engage in conversations about unnecessary tests, treatments and procedures. This presentation will describe the Choosing Wisely Canada campaign and how Choosing Wisely has spread to over 20 countries worldwide. It will also present strategies to implement Choosing wisely in medical education and clinical practice, and the emerging evidence of campaign impact on changing clinical practice.
Objectives:
1. To describe the Choosing Wisely® campaign in Canada and internationally
2. To share strategies to implement Choosing Wisely in medical education and practice
3. To present the evidence of impact

Medical reversal: Why 46% of what we do is wrong

Brilliant and engaging, Dr Vinay Prasad is the author of the recently published “Ending Medical Reversal” and Assistant Professor at the Oregon Health and Sciences University.

Medical reversal occurs when a widespread medical practice is found to be no better or worse than a prior or lesser standard of care.

Famous examples of medical reversal include stenting for stable angina and routine hormone therapy for post-menopausal women. Reversal is common, and carries clear harms. Higher upfront standards of evidence would lower the rates of reversal.

Defining the Right Care Requires a New Science

A cardiologist with a background in philosophy, Dr Vikas Saini is President of the Lown Institute, a major driver of the Right Care Alliance, and key author of a recent Lancet series on overuse.

The problems of overdiagnosis and overtreatment are gaining increasing recognition worldwide, but there is a fundamental limitation in our current paradigm.

Current debates around the proper diagnostic and treatment thresholds revolve around the Bayesian statistics of sensitivity, specificity and pre-test probabilities. While knowledge about the discriminative accuracy of diagnostic tests, and well as knowledge about rates of clinical efficacy of specific treatments may continuously improve as more studies are done, there will always be residual uncertainty about what we know, as well as uncertainty about the right care for the individual patient relative to the mass statistics of RCT’s. Are these so-called grey zones impossible to resolve? Perhaps not.

The starting point of overdiagnosis is defining what diagnosis is – the gnosology or naming of an illness. Historically, such definitions of illness were functional.

Before the advent of modern techniques of measurement and imaging, silent pulmonary embolus was not detected, and effectively, did not exist outside of an autopsy. The elucidation of disease mechanisms and the more recent radical improvements in anatomic and molecular laboratory examinations have created a situation where the impact on human life of conditions called illnesses is harder and harder to distinguish from normal variance. In these grey zones, many sterile debates occur.

What we need is a new science for defining and naming disease, based on the outcomes that matter: all-cause mortality and whatever functional status that makes life worth living. Seeking unity in the midst of such complexity is a daunting challenge, but not insurmountable. We have examples from the world of mathematics, complexity theory and network science to help us. Such an approach might illuminate scale-free networks that simplify our task of identifying and delivering the right care far more often than we currently do.

15:15 Friday August 19th
Closing Keynote
Chair – Hugo Viens

How to determine when to scale back or stop screening, implement changes, and monitor its effects

On behalf of the screening re-assessment collaborating group: Karsten Juhl Jørgensen, MD, DrMedSci, Deputy Director, The Nordic Cochrane Centre, Copenhagen, Denmark.

The balance between benefits and harms of screening interventions may change over time. This can be caused by changes in disease prevalence; development of new effective
and safer treatments; recognition of previously overlooked harms including opportunity costs, emergence of data that contradict previous conclusions about efficacy etc. While there are established principles for the introduction of screening, there is a need for a framework for standardised, periodic, and independent re-assessment of screening interventions in current use to determine if, how, and when to scale back, alter, or stop screening. Evidence integrated into this framework may lead to a recommendation for de-intensification or de-implementation, for which practical guidance is also needed. Our project will lead to four manuscripts, each addressing important steps in the process.

Our first manuscript will explain the need for and outline a framework for re-assessment of current screening practises. The conceptual basis will be GRADE- and USPSTF principles for assessing benefits and harms of interventions. We will emphasise the importance of pre-specification of acceptable levels of benefits and harms, having independent panel members with diverse skill sets, and including citizen representatives. Our vision is that re-assessment and its conclusions have three components. Each will be discussed in its own manuscript.

Component 1 is reassessment. Our manuscript will recommend a re-assessment standardisation process that includes setting up outcomes table, monitoring procedures for established screening practises, and evaluations whether initial recommendations to offer screening interventions met established criteria. Component 2 is establishment of “red flags” which mark critical warning signs of lack of net benefit. We will identify these flags based on a review of historical examples of screening interventions that have been de-intensified or de-implemented. These flags will be classified according to the PICO-format. Component 3 is implementation and monitoring the impact on patient-relevant benefits and harms. De-implementation and de-intensification of screening may not be well-received even when scientifically well-founded. Our manuscript will explore formal guidance on practical implementation of recommended changes, as well as monitoring procedures to assess their impact.

Experiences with explaining overdiagnosis to the general public: screening healthy people, absolute versus relative risks, how this affected people’s perception of health interventions

Thomas Lemke

Making prime time broadcast television about a complex subject like overdiagnosis requires more than just a bunch of “talking heads”, explaining to the viewers what it is about. It is very different from producing an article or a book about the subject. The big challenge is to make a very abstract subject comprehensible for ordinary people through moving images and also make the audience relate to the subject matter emotionally in order to make them keep watching the program. Last summer The Danish Broadcasting Corporation, DR (The Danish equivalent to the BBC), aired a series of three programs about the subject in prime time with an average viewing share of 27 % of all Danes who watched television at that moment. For those not familiar with viewing shares this is an unusually high share for a documentary program of this sort. The relatively high viewing share was probably due to the use of elements in the programs from the reality genre and even talent shows like The X Factor and The Voice. The use of voting séances in the programs in combination with giving the cast a chance of taking preventive examinations themselves on camera, made people face the sort of dilemmas that our modern health care system puts us in in an engaging and exiting manner that made people wonder “what would I do?”

Introducing the 6th Preventing Overdiagnosis conference in Copenhagen, Denmark: 20–22 August 2018

Professor John Brodersen works as an associate research professor in the area of medical screening at University of Copenhagen, Department of Public Health, Research Unit and Section of General Practice. In relation to the area of self testing and screening Dr. Brodersen expertise lies in areas of sensitivity, specificity, predictive values, overdiagnosis, informed consent and what the psychosocial consequences are for healthy people when they are tested. He also teaches nationally and internationally in evidence-based medicine.
Results
1. organize a complex drug list by indications;
2. identify harmful drugs that should be stopped, and communicate how to stop them;
3. identify drugs that appear beneficial and should be continued;
4. group drugs for which indication or evidence are unclear and plan a logical review;
5. provide patients with a simple deprescribing plan that they and other clinicians can understand and follow;
6. communicate to students, clinical colleagues and public why skilled deprescribing is important for better health and survival of affordable health care systems.

Conclusions
1. Practical deprescribing improves public health and professional satisfaction;
2. Deprescribers should share their insights and experience with colleagues and learners including: doctors, pharmacists, nurse practitioners, nurses, patients, and the general public.

Objectives: Pontificating about deprescribing is easy; but "drugectomy" can be daunting in practice. Guidelines and pharmacoagnosia make complex polypharmacy seem "normal". Sophisticated approaches to deprescribing are inefficient, condemning patients to ongoing drug harms. Experimental evidence for any approach is underwhelming.

Effective action requires a simplified logical approach. Deprescribing must become the inevitable corollary of prescribing. Clinicians need self-confidence to apply real evidence to patient goals, prevent drug harms, and preserve affordability.

Three recent cases demonstrate how simple clinical logic and evidence facilitate deprescribing. We will help participants identify 5 drugs and indications that are most often harmful to the patient. Participants will share with the workshop their tricks for teaching effective medication review and deprescribing.

Method: Apply clinical experience, knowledge of clinical pharmacology, and critical appraisal of evidence to 3 video-illustrated cases. Demonstrate how clinical and pharmacological logic can answer for each drug:
1. is there an indication?
2. does its clinical pharmacology inform a decision to stop/continue?
3. is this patient benefiting (for symptoms)?
4. is this patient being harmed?
5. if intended for prevention, what is the probability of "success"?
6. is the cost worthwhile?
7. does it pass a common sense test?

Participants may follow with worksheets and review cases in advance or discuss after workshop, or bring their own cases.
Method: The 1.5 hour workshop includes a moderator (organizer: geneticist/oncologist), two invited speakers (a genetic counselor and medical geneticist) and two panel discussants (organizers: oncologist/epidemiologist and primary care physician). The workshop will address the following topics:

1. Review of cancer genetic testing for inherited cancer syndromes, possible test results and potential for overdiagnosis and overtreatment.
2. Discussion of evidence on patient over-interpretation of VUS results and resultant use of health care resources.
3. Proposals on the primary care physician's role in risk assessment and genetic testing, communication and management of cancer risk, and responsibility in avoiding overdiagnosis and overtreatment.

Results: Workshop attendees will achieve greater understanding of how to interpret genomic abnormalities associated with cancer, associated risk of disease, how genetic information affects individuals' health or well-being and how primary care providers can provide excellence in caring for their patients at increased risk.

Conclusions: With greater use of genome sequencing in the clinical setting, primary care providers need to be well equipped to anticipate patient responses, be familiar with high-risk management strategies, and enter into collaboration with genetic counselors and other specialty providers. The primary care provider's role in cancer genetic counseling, risk assessment, communication and clinical management will be explored in the context of cancer genomics testing outcomes as a source of overdiagnosis.

WORKSHOP – ROOM 309B
Balancing Diagnostic Errors with Conservative Diagnosis: Developing a New Paradigm for More Appropriate Diagnosis

11:00 Thursday August 17th

Gordon Schiff1, Sara Myers1, Lynn Volk3, David Eidelman3, Stephen Martin4
1Brigham and Women's Hospital, Boston, MA, USA, 2Partners HealthCare, Boston, MA, USA, 3McGill University, Montreal, Canada, Canada, 4University of Massachusetts, Worcester, MA, USA

Objectives: The US National Academy of Medicine (IOM/NAM) report has focused worldwide attention on diagnostic errors and delays. However, there is a need for a more dialectical understanding of diagnosis that goes beyond merely balancing tradeoffs between diagnosis errors/delays (under-diagnosis) and over-diagnosis/wasteful over-testing. Some diagnoses are being pursued and treated beyond beneficial effect with interventions causing harm outweighing benefits; yet other diagnoses that would help relieve suffering are missed. We have developed a new conservative diagnosis paradigm that attendees will engage by working through the concepts of conservative diagnosis and providing input into a white paper detailing these principles.

Method: Preliminary principles were modeled from previously published Principles of Conservative Prescribing. A series of focused meetings were held to collect expert opinion and formulate basic concepts for more conservative, careful, appropriate diagnosis. Primary care and specialty physicians were convened and feedback was gathered at several national conferences including the Lown Road to Right Care, Society to Improve Diagnosis in Medicine Conference, and Diagnostic Error in Medicine Conferences.

Results: Practice and policy domains that serve as the foundation for Principles of Conservative Diagnosis include: 1) the need to develop a new model for patient "caring" that avoids equating more testing with taking patients' concerns seriously; 2) creating a new science of clinical uncertainty; 3) rethinking common symptoms, especially nonspecific symptoms seen in primary care; 4) (re)prioritizing diagnoses based on treatment imperatives and effectiveness; 5) taming time to facilitate more time with patients and watchful waiting; 6) better appreciating test limitations; 7) leveraging continuity relationships; 8) incorporating diagnostic safety lessons; anticipating "don't miss diagnoses" and pitfalls; 9) new approaches for timely cancer diagnosis; 10) transforming role of specialists and EDs from current status of promoters of non-conservative diagnosis; 11) prospective guidelines for common problems; and 12) understanding, overcoming fragmentation, lack of coordination as drivers of suboptimal diagnosis.

Conclusions: A linear view of striking a balance between missed/delayed diagnosis with overdiagnosis and over-testing needs to be replaced with a more dialectical approach focusing on more appropriate diagnostics based combining fundamentals of good
diagnosis (careful exam, listening to patient, avoiding known biases, understanding test limitations) with the critical approaches based on the precautionary principle, primary care principles, key patient safety lessons, and healthy skepticism of market-oriented medicine. It must enhance patients' role in co-producing diagnoses, appreciate/minimize patient/provider anxieties, and identify when early definitive diagnosis actually represents the optimal conservative strategy.

**WORKSHOP – ROOM 309A**

*Report From Inside the Statin Wars: The best but inadequate evidence about whether low risk people benefit from statin therapy, and the resistance to robust scientific debate*

14:00 Thursday August 17th

John Abramson¹, Harriet Rosenberg², James Wright³
¹Harvard Medical School, Boston, MA, USA, ²York University, Toronto, ON, Canada, ³University of British Columbia, Vancouver, BC, Canada

The aims of this workshop are:
- Present the data from statin clinical trials, and CTT meta-analyses
- Explain the process by which clinical trial data become "scientific evidence," the opportunities for commercial bias to distort the information available to healthcare professionals, and lead to potential overdiagnosis and over-treatment for CVD prevention
- Present our re-analysis of the 2012 CTT meta-analysis published in BMJ, showing no overall benefit for people with < 20% 10-year risk of CVD
- Show the limitations of the CTT meta-analyses
- Share the “pushback” that ensued when CTT conclusions were challenged

**Objectives:**
- Understand how the prevention of heart disease and stroke in low risk people has become medicalized
- Understand the pros and cons of statin therapy for people at low risk of CVD
- Understand the challenges to clinical trial data integrity and the corruption of what healthcare providers are presented as "scientific evidence."
- Understand the resistance to open scientific debate about matters of urgent importance to public health

**Method:** We will review the quality of data from statin trials, CTT meta-analyses, Cochrane reviews, and guidelines. The CTT data (most complete available) will be critically reviewed. We will provide a narrative discussion of the process by which we came to write the 2013 BMJ article and the reaction that followed.

**Results:** Statins are now recommended for one half of all Americans between the ages of 40 and 75, two thirds of whom are not at high risk of cardiovascular disease. We identify three categories of problems with the data upon which these recommendations rely. First, statins do not confer a significant reduction in mortality in people who are not at high risk of CVD. The absolute reduction in non-fatal heart attacks and strokes is 1.5% over 5 years, at best. Second, the underlying data from clinical trials has still not been made available for independent analysis so all recommendations are unverified–including those included in guidelines. Third, open scientific discussion of these issues has become impossible. Although the demand for retraction of our 2013 BMJ article showing no net benefit of statins for low-risk people was unanimously rejected by an external panel, which upheld our findings, we are still being accused in the media by members of the CTT of being “worse than Andrew Wakefield.” We will share our experience challenging the presumptive statin authorities, which has been informative, time and energy consuming, intermittently harrowing, and uplifting.

**Conclusions:** Statin therapy for low risk (<20% 10-year CVD risk) has limited if any positive impact on overall health. Healthcare providers should engage low risk people for whom guidelines recommend statin therapy in a process of informed shared decision. The data from statin trials remains non-transparent, despite numerous requests for data sharing. Doctors cannot act in the best interest of their patients when they are dependent (directly or indirectly) on commercial sources for their information.
Applying a research framework for medical overuse – examples from research in thyroid cancer

14:00 Thursday August 17th

Brooke Nickel¹, Juan P Brito¹,²
¹Wiser Healthcare, School of Public Health, University of Sydney, NSW, Australia, ²Division of Endocrinology, Diabetes, Metabolism & Nutrition, Mayo Clinic, Rochester, MN, USA

Objectives: Overdiagnosis and overtreatment leads to potential harms to patients and health care systems. Morgan et al. proposed a research framework for medical overuse (BMJ 2015) with the goal of coordinating research to improve the understanding of the problem and find effective solutions. Thyroid cancer provides an example of where there is overdiagnosis and overtreatment occurring where a research framework could be successfully implemented.

Method: We applied elements of the available research agenda to establish a research network of collaborators to design qualitative and quantitative research projects to curtail overdiagnosis and overtreatment of thyroid cancer.

Results
1. Assess the extent of overdiagnosis and overtreatment
We will describe the epidemiology of thyroid cancer in the United States and South Korea, and assess the extent to which overdiagnosis explains the increased incidence.
2. Understand the drivers of overdiagnosis and overtreatment
We will share our findings of two population-based studies that elucidated the drivers of thyroid cancer overdiagnosis.
3. Capture the perception of patients and clinicians
We will discuss our findings from two qualitative interview studies.
4. Test interventions
We will present results from decision aid and terminology intervention studies as potential strategies to reduce overtreatment of thyroid cancer.

Conclusions: Using examples from our research in thyroid cancer, we will present and discuss how the application of a research framework guided projects to understand and curtail the overdiagnosis and overtreatment in thyroid cancer. The thyroid cancer case could be seen as example to follow for other research groups addressing conditions in need to reduce aggressive diagnostic and treatment responses to low risk disease.
in medicine and may contribute to overdiagnosis and subsequent inappropriate treatment. Three HTA case studies will be presented by the panel to open the discussion with the audience about patient engagement’s role in preventing over diagnosis and overuse. The first case on the overuse of ultrasounds in normal pregnancy highlights the consultation process to document pregnant women’s perceptions and beliefs and possible knowledge transfer strategies in relation with recommendations to cease routine third-trimester ultrasounds. The second case illustrates direct patient participation in the assessment of alternative interventions to restraint and seclusion among adults in short-term hospital wards and long-term care facilities. The third case addresses the assessment of prostate cancer treatment options and a shift in paradigms and mindset among medical leaders to support patient involvement and shared decision-making processes to prevent overuse of invasive treatments. Discussions will focus on strategies on how to include patients’ perspective in HTA processes, including barriers and facilitators to patient engagement and communication issues related to patient expectations.

**Conclusions:** HTA of diagnostic and treatment modalities in tertiary care hospitals should involve the perspectives of all decision-makers, including those of patients, in order to curb the trend of overdiagnosis and overuse.

**SEMINAR – ROOM 309A**


10:30 Friday August 18th

Leonore Tiefer¹, Alan Cassels², Kim Witczak³, Barbara Mintzes⁴, Brenda LeFrancois⁵, Fernand Turcotte⁶, John Abramson⁷, Jacques Thivierge⁸, Abby Lippman⁹

¹NYU school of medicine, NY, NY, USA, ²University of Victoria, Victoria, BC, Canada, ³Woody Matters, Minneapolis, MN, USA, ⁴University of Sydney, Sydney, Australia, ⁵Memorial University of Newfoundland, St. John’s, NL, Canada, ⁶Universite Laval, Montreal, Quebec, Canada, ⁷Harvard Medical School, Boston, MA, USA, ⁸Universitaire, Montreal, Quebec, Canada, ⁹McGill University, Montreal, Quebec, Canada

**Objectives:** This panel will introduce Biojest, an activist listserv, to the larger audience of biomedical researchers, media, and scholars. Biojest provides a communication model to the wider activist community.

**Method:** Biojest members rarely meet in person, but since many are located in Canada, Preventing Overdiagnosis 2017 offered an opportunity to put our heads together. The list was surveyed and volunteers accepted for this panel. The moderator is also a long-term member

**Results:** Seven longterm Biojest members will discuss how they use Biojest in their research, activism, scholarship and clinical work. One member will discuss the founding of the list, how participants join, and how the focus has changed over the years. We will conclude with a discussion of the generalizability of our model.

**Conclusions:** Biojest is an international critical health listserv founded by Canadian feminist health activists in 1998. Over the years, it has expanded to include researchers, clinicians, advocates, and scholars of many disciplines. It is a unique resource because of the diversity, high quality, and passion of its members.

**SEMINAR – ROOM 309B**

How to strengthen trustworthiness of „choosing wisely“-recommendations – best practice examples from Germany and Austria

10:30 Friday August 18th

Corinna Schaefer¹, Andrea Siebenhofer²,³, Monika Nothacker⁴, David Klemperer⁵

¹German Agency for Quality in Medicine, Berlin, Germany, ²Institute of General Practice and Evidence-based Health Services Research, University of Graz, Graz, Austria, ³Ostbayerische Technische Hochschule Regensburg, Fakultät Angewandte Sozial- und Gesundheitswissenschaften, Regensburg, Germany, ⁴Institute of General Practice, Goethe University, Frankfurt am Main, Germany, ⁵AWMF-Institute for Medical Knowledge Management, Marburg, Germany

**Objectives:** To present and discuss an approach to harmonize the development of high quality guidelines and Choosing Wisely recommendations
The Choosing Wisely Initiative encourages medical societies worldwide to develop Top-5-Lists of medical interventions that are overused and should be avoided in order to reduce waste and improve quality of health care. However, trustworthiness and methodological soundness of some of these recommendations have been questioned recently, based on the fact that the evidence base was either not systematically assessed or the search and assessment was poorly reported.

On the other hand, high quality guidelines and recommendations exist, which have undergone a rigorous and evidence-based development process in multidisciplinary panels, but their implementation and acceptance remains unclear.

The German Association of the Scientific Medical Societies (AWMF) has launched its campaign "Gemeinsam klug entscheiden (GKE)" ("Choosing wisely together") in order to bridge the gap between high quality guidelines and choosing wisely recommendations, to assure consistency between the respective recommendations and trustworthiness of both, guidelines and choosing wisely recommendations. A multidisciplinary panel has developed a manual for deriving GKE recommendations from high quality guidelines or other reliable sources of evidence. It is actually being piloted for 4 evidence-based guidelines.

The Austrian initiative, led by Austrian Universities and the Austrian Cochrane group together with a stepwise involvement of the Austrian medical societies, launched its campaign "Gemeinsam gut entscheiden (GGE)" ("Choosing well together") in March 2017. Current US top five list recommendations found to be sufficiently trustworthy will be provided to the executive boards of different medical societies who will in turn, through a transparent delphi process, choose the most relevant recommendations in terms of expected clinical impact, expected improvement in quality of supply, relevance for the Austrian health system etc. Existing patient information will be sought and adopted for the Austrian system where possible. Dissemination will primarily be achieved by the medical societies.

**Short presentations:**

Choosing Wisely: assessment of current US top five list recommendations’ trustworthiness and a sample of application (A. Siebenhofer)

Harmonizing "Choosing Wisely" and guideline recommendations – the AWMF manual and its methodology (D. Klemperer)

**Best practice example:** Developing GKE recommendations in The German National Disease Management Guideline on low back pain (C. Schaefer)

In a moderated discussion, participants will explore the strengths and limitations of this approach and discuss if assuring consistency between sources of knowledge transfer and avoiding duplication of efforts may lead to improved implementation of relevant recommendations.

**WORKSHOP – ROOM 307A**

Fostering Undergraduate Medical Student Leadership in Resource Stewardship: Choosing Wisely Canada STARS

12:00 Friday August 18th

Karen Born¹, Bushra Khan³, Olivier Fortin², Brian Wong¹, Wendy Levinson¹

¹University of Toronto, Toronto, Ontario, Canada, ²Universite de Montreal, Montreal, Quebec, Canada, ³McMaster University, Hamilton, Ontario, Canada

**Objectives:** Resource stewardship is an essential competency for physicians, but is not required in undergraduate medical curricula in Canada. To address this, Choosing Wisely Canada launched Students and Trainees Advocating for Resource Stewardship (STARS).

**Workshop aims are:**

- To describe the need for resource stewardship content in undergraduate medical education
- To reflect on the role of grassroots, student leadership to influence curricular change
- To highlight examples and discuss learnings from STARS in their local and regional student–led advocacy

Outcomes are that attendees will gain tools and strategies to advocate for increased resource stewardship content in medical education.

**Method:** STARS was launched in November 2015, and is ongoing. To date, over 70 medical student leaders have been involved in leading STARS at their respective medical schools. Selected students learn about resource stewardship, fostering advocacy, gain
communication and leadership skill. A mixed methods evaluation six month following program launch was conducted to understand student efforts related to STARS, as well as key barriers and enablers.

**Results:** Evaluation findings will be highlighted. 27 of the 33 (82%) students from the first STARS cohort responded to the survey, representing all 17 Canadian medical schools; eleven of the 17 (65%) medical school Deans responded. Students facilitated a variety of activities, such as planned or implemented curricular change, interest groups, campaign weeks, publications, journals clubs, presentations and needs assessments.

For the workshop, two students will present on their experiences related to STARS. One student who led curricular change efforts will discuss key strategies, enablers and barriers. One student will describe regional efforts to develop a community of practice in Quebec.

**Conclusions:** The workshop will highlight evaluation findings from STARS, as well as local student experiences to provide attendees with tools, ideas and strategies to lead and/or support efforts to increase resource stewardship in undergraduate medical education.

**WORKSHOP – ROOM 307B**

**A Mixed Methods Study of an Enhanced Decision Aid for Emergency Department Patients with Low-Risk Chest Pain**

**12:00 Friday August 18th**

Andrew Foy, Ashley Bucher
Pennsylvania State University College of Medicine, Hershey, Pennsylvania, USA

**Objectives:** Despite being low-risk, cardiac stress testing is frequently recommended for those presenting to the ED with chest pain and no objective evidence of myocardial ischemia. We sought to use an explanatory mixed-methods design to assess correlation between real-life ED patients' intent to undergo cardiac stress testing and their general preference for receiving medical care after viewing an enhanced decision aid on the benefits and risks of cardiac stress testing.

**Method:** Participants included ED patients, without objective evidence of myocardial ischemia, who were being considered for cardiac stress testing prior to discharge. All participants watched a 6 minute informational video on the potential benefits and risks of cardiac stress testing, which included information on the low yield of testing, possible reduction in MI, high rate of false positive results, and possibility of receiving an unnecessary stent or experiencing a complication from an invasive test or procedure. After watching the video they participated in a semi-structured interview. Patients' intention to undergo stress testing was correlated with their score on the Medical Minimizer-Maximizer Scale (MMS). Directed and summative qualitative content analysis was performed on interviews.

Results: Twenty-three participants, aged 30 to 80 years (median, 55 years) of whom 65% were women were included in the study. There was no correlation between patients' intention to undergo cardiac stress testing and the MMS score. Two major themes and subthemes were identified in the qualitative study. 1) All patients gained information; however, information gain led to 2 major divergent conclusions. 1a.) Testing was low utility from the standpoint of not providing a clinical benefit or 1b.) Testing was high utility from the standpoint of providing reassurance. 2) Cost was important to most patients and was viewed with 2 divergent perspectives. 2a.) Cost was unjustified to those who viewed testing as low utility or 2b.) Cost was not a factor because it was "covered by the patient's insurance" for those who desired testing.

**Conclusions:** After viewing an enhanced decision aid, patients presenting to the ED with chest pain tended to reach 2 opposite conclusions. These findings highlight the subjective utility of medical testing to patients. It should not be assumed that all or the majority of patients desire testing for the sake of reassurance. Surprisingly, patients in neither group expressed concerns about false positive results or complications from unnecessary interventions. Also, patient’s intent to undergo testing was not correlated with MMS score.
WORKSHOP – ROOM 308A

Polypharmacy and Deprescribing

14:30  Friday August 18th

Edeltraut Kröger1,4, Barbara Farrell2,5, Caroline Sirois1,4, Cara Tannenbaum3

1Université Laval, Quebec City, Quebec, Canada, 2University of Ottawa, Ottawa, Ontario, Canada, 3Université de Montréal, Montreal, Quebec, Canada, 4Centre d’excellence sur le vieillissement de Québec, Quebec City, Quebec, Canada, 5Bruyère Research Institute and CT Lamont Primary Health Care Research Centre, Ottawa, Ontario, Canada

Objectives: Polypharmacy is common among seniors. Deprescribing is the planned, supervised process of dose reduction or stopping of medication that may be causing harm or no longer provide benefit.

Attendees will be able to:

1. Discuss research to precisely define ‘polypharmacy’ for clinical or research purposes and present timely information about its prevalence/incidence, risk factors and outcomes;
2. Discuss results from deprescribing trials, their focus, outcomes and limitations;
3. Use resources like screening tools and deprescribing guidelines, to facilitate deprescribing in clinical care and to engage patients in deprescribing conversations;
4. Contribute to the ongoing work of the Canadian Deprescribing Network.

Method: Presentation components will include ongoing work on the precise definitions of polypharmacy for clinical or research purposes and relevant Canadian statistics. Specific cases, where overdiagnosis may be involved, will be discussed.

The importance of deprescribing interventions will be related and an international overview of successful deprescribing trials and their outcomes will be presented.

The interactive component will comprise a pre–post questionnaire for attendees and focus on practice, using evidence–based deprescribing guidelines and related tools. Findings from trials examining patient communication/engagement in deprescribing will be presented and discussed.

An overview of the Canadian Deprescribing Network will highlight opportunities for collaboration.

Results: Attendees will be able to integrate information about polypharmacy and deprescribing to justify local initiatives and facilitate research plans. They will be able to use successful deprescribing interventions in practice or as models in other clinical contexts. They will have a better understanding of the role of public/patient engagement as a key factor to ensure integration of the deprescribing concept into routine health care.

Numerous initiatives are underway internationally regarding the issues around polypharmacy and deprescribing, and to develop deprescribing implementation processes. The Canadian Deprescribing Network is working towards this goal with the public, health care providers and researchers.

Conclusions: This workshop brings together Canadian researchers working on polypharmacy and deprescribing and leaders with the Canadian Deprescribing Network. It will highlight what is known about the need for deprescribing and how it can be achieved and integrated into routine health care successfully. Unresolved issues and how to scale up the deprescribing movement will also be discussed.

WORKSHOP – ROOM 308B

Choosing Wisely: one person at a time

14:30  Friday August 18th

Nick Zhygan1, John-Jose Nunez1, Alexandra Bite3, Tom Perry1

1University of British Columbia, Vancouver, BC, Canada, 2McMaster University, Hamilton, ON, Canada, 3University of Toronto, Toronto, ON, Canada

Objectives: Exemplary health care depends on wise choices. Conscientious intelligent individual decisions maximize patient benefits, minimize harms, and protect resources. But ingrained cultural and institutional prejudices can impede development of clinical wisdom. Hierarchical traditions perpetuate foolish or harmful practices that wilt in the face of logical challenge. For example, can it be essential to know by morning the "serum rhubarb" of a patient hospitalized overnight? Questioning can be difficult and intimidating. In Galen’s shadow, even William Harvey was circumspect when he proposed the circulation of blood.
The Choosing Wisely movement must face and overcome these barriers. We will explore how students and post-graduate trainees experience their attempts to implement a culture of choosing wisely in daily work. Are they supported or discouraged when they challenge unsound traditions and practices? How could we make it easier for them to improve how we practice as professions?

**Method:** Health science students, post-graduate trainees, and young professionals will log experiences from April–July 2017. We will use a standard online form to capture examples that illustrate a range of clinical decisions, whether explicit or implicit. Examples may include but will not be limited to official Choosing Wisely recommendations. Our survey may illuminate choices to undertake or forego a diagnostic test or monitoring intervention, to prescribe or deprescribe drugs, or to pursue or omit diagnostic or therapeutic procedures or surgery. We may consider how certain diagnoses (e.g. seizure disorder, depression, sepsis) are established, revised, or rescinded if unsubstantiated. We will ask participants to log difficulties or successes they encounter when attempting to use best practice evidence to guide their clinical judgment.

**Results:** Our workshop will present illustrative cases and themes revealed by the data. Attendees will learn interactively the problems faced by young health professionals who try to choose wisely on their own or to implement ideas from the Choosing Wisely movement. They should bring their own experiences to share. Insights from qualitative research and reflection may help trainees as well as experienced faculty to better foster a culture of critical thinking that protects patients and health care systems.

**Conclusions:** Good mentors inspire us by their knowledge and thinking, their humane attitudes, and their novel and challenging questions. The best are excited, not upset, by a question that is innovative. As health care providers, can we learn how to foster, rather than fear, logical and innovative questioning by young trainees? Might it be easier than we think to produce more leaders of continuous quality improvement?

**SEMINAR – ROOM 309A**

**How to Choose Wisely – What makes a successful campaign to reduce too much medicine**

14:30  Friday August 18th

David Warriner  
Academy of Medical Royal Colleges, London, UK

**Objectives:** Never before has the NHS faced such financial and organizational challenges, a result of an ageing and increasingly co-morbid population coupled with often unrealistic expectations of super-specialized and fragmented medical care. Not to mention over 80% of doctors admitting to having offered a test or treatment they knew would be of little benefit. How to square this circle? Enter the Choosing Wisely initiative, originating from the US in 2010, which has now spread to over 70 societies, involving over 1 million clinicians and 300 recommendations and in 2016, it was launched in the UK.

**Method:** Presentation on the history, development, delivery, challenges and lessons learned from the Choosing Wisely UK initiative, 1 year on. Discussion on the role of the AOMRC, as opposed to other organisations, in being chosen to lead on CWUK, the involvement of the other colleges and faculties in the process of defining (and refining) the recommendations, the role of the various CWUK steering groups, the launch, social media, public reception, measuring the impact and ongoing work and direction. Inviting debate on how other countries have developed their own, such as slow medicine or as a franchise of the Choosing Wisely brand.

**Results**

**Aims:** how to launch a national health campaign to reduce overdiagnosis and overtreatment

**Outcomes:**
- Introduction to CW and CWUK
- What makes a punchy recommendation to reduce waste and add value to patient care
How to maximize public involvement and involve patient representatives

Controversial recommendations and how to manage their inevitable fall out

How to reduce repetition in recommendations between specialties e.g. surgeons and anaesthetists and organisations e.g. Choosing Wisely and NICE

How to continue momentum following a successful launch

Can there be a choosing wisely approach to end of life care

Conclusions: For health care professionals, researchers, public, journalists and policy makers, as this seminar will discuss the key challenges in launching a national health campaign such as CWUK; specifically the role of the media, engaging stakeholders such as patients, public and doctors, considering unintended consequences and how to measure the impact of such a campaign. We will outline how to move from niche specialty and doctor focused recommendations to more generic patient and condition focused. Finally, how to embed the role of shared decision making and value based healthcare going forward.

SEMINAR – 309B

Discussing our disagreements: what is the definition of cancer overdiagnosis?

14:30 Friday August 18th

Pamela Marcus¹, Gemma Jacklyn⁴, Sian Taylor-Phillips³, Danielle Durham¹, Nora Pashayan²

¹National Cancer Institute, Bethesda, MD, USA, ²University College London, London, England, UK, ³University of Warwick, Coventry, England, UK, ⁴University of Sydney, Sydney, Australia

Objectives: Cancer overdiagnosis research is fraught with disagreement, even among those researchers who agree that some cancers are diagnosed and treated unnecessarily. At the 2016 Preventing Overdiagnosis meeting, we noted two factors at the root of these disagreements: there is no agreed-upon definition of what constitutes overdiagnosis and no agreement on how to determine the magnitude of overdiagnosis.

Method: A working group was formed after the 2016 meeting and now proposes a seminar for the 2017 Preventing Overdiagnosis meeting, one in which the differences in the meaning of cancer overdiagnosis can be discussed. The seminar will begin with a twenty-minute presentation by Dr. Marcus on reported areas of disagreement, including the role of screening and serendipitous detection in defining cancer overdiagnosis; whether overdiagnosed cancer must be indolent; and consideration of pre-invasive disease as overdiagnosed disease. A four-member panel (Drs Jacklyn and Taylor-Phillips, as well as two members to be determined) with a range of views on the definition of overdiagnosis then will address comments and questions from the audience, which will include adding their own thoughts on areas of disagreement. The seminar will close with thoughts from Dr. Pashayan.

Results: We expect the workshop to be highly interactive, with a lively and wide-reaching discussion. Audience members will be encouraged to participate and express their opinions, and Dr. Marcus and other members of the working group will ensure that equal opportunity be given to conflicting views and that interactions remain cordial.

Conclusions: We hope that attendees to the seminar will leave with a better understanding of the conflicting views of the meaning of cancer overdiagnosis, and have a better sense of what cancer overdiagnosis means to them.

WORKSHOP – ROOM 308B

Less is really more: how to reduce lowvalue care

11:00 Saturday August 19th

Eva Verkerk¹, Christiana Naaktgeboren², Simone Van Dulmen¹, Pauline Heus², Lotty Hooft², Tijn Kool¹

¹IQ healthcare, Radboud University Medical Center, Nijmegen, The Netherlands, ²Cochrane Netherlands, University Medical Center Utrecht, Utrecht, The Netherlands

Objectives: Reducing low-value care improves quality of care and reduces waste of resources. However, achieving successful and sustainable de-implementation is difficult as several cultural and contextual factors impede it. In this interactive workshop, participants
will receive the tools to start their own de-implementation project. We will share knowledge based on two systematic reviews of de-implementation studies, and our experience from the Dutch national program ‘To do or not to do? Reducing low-value care’. In this program we are reducing eight cases of low-value care across the Netherlands, in order to gain knowledge about the do's and don'ts in de-implementation.

**Aims:**
- To spread knowledge on what a de-implementation project entails and what steps one could follow
- To make participants aware of the difficulties they can encounter when designing and executing a de-implementation project and how to deal with them

**Method:** After an introduction on low-value care and the steps to de-implementation, participants will be assigned to groups of about four to five people. Each group will design a de-implementation project; examples will be made available, but cases may be brought in to this session. For each of the different stages of a de-implementation project the groups will receive a question or assignment to work on. The findings of each group will be discussed and we will conclude by sharing our own experiences.

**Outcomes:** Participants will gain insight in the following steps of the de-implementation process:
- Identifying and measuring low-value care in current practice;
- Analyzing reasons why low-value care persists and what potential barriers and facilitators to de-implementation may be;
- Developing a tailored de-implementation strategy keeping identified barriers and facilitators in mind;
- Executing a de-implementation strategy and evaluating its effectiveness
- Integrating changes in routine care to achieve sustainable de-implementation.

**Conclusions:** participants will go home with knowledge on designing and executing a de-implementation project, and are aware of accompanying challenges and their possible solutions.
Outcomes of the workshop for participants include:

1. Increased awareness of the impact of test measurement variability, and why this is more likely to result in overdiagnosis than underdiagnosis with repeat testing for asymptomatic conditions.
2. Identification of knowledge gaps and opportunity for further research on this topic.

**SEMINAR – ROOM 309B**

**Imaging asymptomatic people: are we doing more good than harm?**

11:00  Saturday August 19th

John Brodersen¹, Steve Ebdon Jackson², Juergen Griebel³, Eva G. Friberg⁴, Maria del Rosario Perez⁵

¹University of Copenhagen, Copenhagen, Denmark, ²Public Health England, Chilton, UK, ³Federal Office of Radiation Protection, Munich, Germany, ⁴Norwegian Radiation Protection Authority, Oslo, Norway, ⁵World Health Organization, Geneva, Switzerland

**Objectives:** To discuss the elements/requirements to be included in a framework of good governance of the use of computed tomography (CT) in asymptomatic people for individual health assessment (IHA).

**Method:** The sustainability, fairness, and equity of health systems are key factors to achieve universal health coverage. Both underuse and overuse of medical interventions represent barriers for strengthening health systems and ensuring the quality of health care. Advanced imaging technology has opened new horizons to medical diagnostics and improved patient care. However, a substantial fraction of procedures are unjustified and do not provide a net benefit. An area of special concern is the unnecessary use of computed tomography (CT) when clinical evaluation or other imaging modalities could provide an accurate diagnosis.

**Results:** While evidence-based imaging referral guidelines can assist decision-making process when choosing the best imaging procedure for patients with clinical signs and/or symptoms, there is mostly lack of evidence regarding the use of CT in asymptomatic individuals. When the latter is not performed as part of an approved population-screening program, it is often referred to as individual health assessment (IHA). IHA using CT is applied in many areas such as coronary artery calcium scoring, investigation of coronary artery plaques, detection of cancers of the lung or colon, and whole-body CT surveys. The justification of these IHA practices requires particular considerations, some of which go beyond the assessment of the risks associated to the exposure to ionizing radiation. Examples of such considerations are direct and indirect costs, ethical dilemmas, overdiagnosis / overtreatment, false positives, false negatives, indeterminate and incidental findings. Such matters are important and can divert funding from symptomatic individuals, thus challenging the key principle of fair and equitable healthcare services for those in need.

**Conclusions:** These and other considerations indicate that, in order to view some IHA as part of good medical practice, it would be necessary to establish a robust clinical governance framework, which includes regulatory dimensions. This seminar aims to discuss elements/requirements to be included in such a framework of good governance of IHA practices.

**WORKSHOP – ROOM 308B**

**#ShowMoreSpine: a grassroots campaign to tackle the widening of disease definitions – lessons learned and what’s next**

14:00  Saturday August 19th

Teppo Jarvinen¹, Roope Kalske¹, Alan Cassels², Malcolm Willett⁴, Ajay Puri³

¹University Helsinki, Helsinki, Finland, ²University of Victoria, Victoria, British Columbia, Canada, ³Independent consultant, Vancouver, BC, Canada, ⁴Malcolm Willett Art, London, UK

**Objectives:** We launched the #ShowMoreSpine campaign in Barcelona at the Preventing Overdiagnosis conference as a way to increase awareness of the problems of overly-widened disease definitions. We chose vertebral fractures as a case study where we believed patients’ interests were not being well-served, because of research which shows:

a) osteoporosis and vertebral fractures are clinical conditions where their definitions are not clearly defined, neither are the guidelines around how they are treated;
b) pharmacotherapy, ie: fracture preventing drugs, such as bisphosphonates are not as efficacious as claimed and come with rare but potentially serious harms; and,
c) vertebral fractures poorly predict future back pain or functional status of the spine.

Despite this growing body of research over the past several years we have seen little impact on guidelines or changing practice. Our campaign, aiming to raise awareness on this issue is entitled #ShowMoreSpine. We have seen some quick wins and growing support demonstrated by several thousand visits to our site, more than 100 subscribers to our newsletters, more than a dozen newsletters published (launched every two weeks in 2017), and more than 1500 views on our Youtube video interviews. Our mascot, Squidgy, a blue jellyfish, has been sighted around the world including in Vancouver, Helsinki, Montreal and New Dehli. We have seen two main achievements:

1. The World Health Organization clarified their position on the FRAX® tool for fracture prediction and has begun the process of retracting its support for it.
2. We have had meetings with the Finnish Osteoporosis Committee to discuss tightening up the clinical guidelines nationally.

We have learnt a lot to move the campaign forward and have three objectives of our workshop at PODC in Quebec: 1) to provide lessons learned of running this campaign, 2) gain feedback for #SMS 2.0 and 3) to support attendees and discuss creative and effective tactics to launch their own preventing overdiagnosis campaigns.

The workshop will consist of the following four components:

1. Vertebral Fracture: A classic case of a disease definition that leads to overdiagnosis and overtreatment (Järvinen & Kalske)
2. #ShowMoreSpine: A Campaign to Change Behaviour of Overdiagnosis and Overtreatment (Willett, Cassels & Puri)
3. Lessons learned: Challenges and Opportunities in Running a Campaign (Järvinen, Puri, Cassels)
4. Launch of SMS 2.0 and kickstarting others to create their own interactive campaigns (Järvinen)
for furthering our understandings of, and mitigating, overdiagnosis and overtreatment. Challenges such methodological approaches may help tackle are:

- Ensuring we fully understand when, how, and why overdiagnosis and overtreatment happen, including as an unintended consequence of efforts to improve care
- Development and evaluation of interventions seeking to mitigate overdiagnosis and overtreatment
- Scrutinising, and where necessary challenging, popular conceptualisations of overdiagnosis and overtreatment
- Understanding ideas like ‘value’ or ‘patient experience’ within established sociological theoretical frameworks

**Method:** A brief introduction will be followed by a small selection of case studies in order to set the scene and illustrate the ways in which social science theory and methods may be used to explore issues relevant to overdiagnosis and overtreatment. Facilitated group discussion will follow, seeking to achieve the following outcomes:

- Raising awareness of social science theory and methods, and starting to realise the value they may have for researching overdiagnosis and overtreatment
- Identifying future research agendas
- Building collaborations for future research
- Identifying and discussing methodological challenges posed by work in this area

### Objectives

1. To describe how the goals of precision medicine should be entirely consistent with the goal of preventing overdiagnosis
2. To illustrate how precision medicine interventions have the potential to do the opposite in practice, because of failure to attend to effective implementation
3. To facilitate discussion to identify strategies that ensure that emerging precision medicine technologies do not add to the problem of overdiagnosis, and help prevent it.

**Method:** Precision medicine is “an emerging approach for disease treatment and prevention that takes into account individual variability in environment, lifestyle, and genes for each person”,1 with the term sometimes being used interchangeably with ‘personalized’ or ‘stratified’ medicine. In order to increase capacity and strengthen expertise in the rigorous evaluation and translation of precision medicine approaches in the Canadian health system, Genome Canada established in 2016 the Precision Medicine Policy Network (PMPN).2 The PMPN brings together experts in multiple disciplines and areas working in the ‘-omics’ field, including law, ethics, economics, epidemiology, molecular genomics, and social science.

In this seminar, we will explore whether precision medicine will, in practice, be more likely to prevent or promote overdiagnosis. Two short presentations will illustrate (a) how the paradigm of precision medicine – in which patient stratification should become increasingly accurate – should be entirely consistent with the goal of preventing overdiagnosis; and (b) how, in practice, precision medicine may be applied inappropriately, paradoxically promoting overdiagnosis and over-intervention.

We will facilitate discussion on perceptions of precision medicine (particularly its apparent ‘exceptionalism’), and on how to engage the implementation science community in promoting evidence-based implementation of these emerging technologies.
## ELEVATOR PITCHES 12:30 August 17th

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<thead>
<tr>
<th>Name</th>
<th>BN</th>
<th>Title</th>
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<tbody>
<tr>
<td>Gilles Mignot</td>
<td>05</td>
<td>Medicines to be removed from care: securing the market is too slow.</td>
</tr>
<tr>
<td>Roland Grad</td>
<td>21</td>
<td>The POEMs of 2016 most consistent with principles of the Choosing Wisely campaign</td>
</tr>
<tr>
<td>Ahmad Sidiqi</td>
<td>22</td>
<td>Evaluating Canadian medical students’ interest and preparedness in learning and practicing high-value care and resource stewardship: A survey of student perceptions</td>
</tr>
<tr>
<td>Luciana Garbayo</td>
<td>25</td>
<td>On Conceiving and Re-Conceiving Overdiagnosis: From Ostensive, to Explicative and Stipulative Definitions and their Applications in Breast Cancer Research and Medical Care</td>
</tr>
<tr>
<td>Abi Sriharan</td>
<td>11</td>
<td>Neuroscience of Behavioral Change</td>
</tr>
<tr>
<td>Paul Hill</td>
<td>28</td>
<td>Mutual Failure: Costs/Harms of Extra-Spinal Overdiagnosis from Joint Clinician &amp; Radiologist Non-compliance with Societal Guidelines for MRIs of the Lumbar Spine</td>
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## ELEVATOR PITCHES 12:30 August 19th

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<th>Name</th>
<th>BN</th>
<th>Title</th>
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<tbody>
<tr>
<td>Ndeye Thiab Diouf</td>
<td>35</td>
<td>Teaching Shared Decision Making to Family Medicine Residents: A Descriptive Study of a Web-Based Tutorial</td>
</tr>
<tr>
<td>Sian Taylor-Phillips</td>
<td>42</td>
<td>Evaluating changes to screening programmes</td>
</tr>
<tr>
<td>Frederik Martiny</td>
<td>44</td>
<td>Physical harm of colorectal cancer screening – a systematic review</td>
</tr>
<tr>
<td>Michael Akadiri</td>
<td>34</td>
<td>The hidden dangers of the Surviving Sepsis Campaign: a hospital-based Quality Improvement Project (QIP) designed to quantify the extent of chest sepsis overdiagnosis and an intervention to alter clinicians’ behaviour in order to observe a reduction in antibiotic over-use.</td>
</tr>
<tr>
<td>David Klemperer</td>
<td>40</td>
<td>Reducing unwarranted variation in the use of left cardiac catheter on patients with chest pain and coronary heart disease. Design of the “Kardio-Studie”</td>
</tr>
<tr>
<td>Anne Kearney</td>
<td>08</td>
<td>Overdiagnosis is a significant harm in population-based mammography screening</td>
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</tbody>
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The Québec Medical Association (QMA) takes positions on key healthcare issues and the future of the medical profession in order to help improve the practice of medicine for the benefit of the population.

As the host of the 5th Preventing Overdiagnosis Conference and as an important player in the Québec health system, the QMA has set itself apart with a series of reflection projects and actions to address overdiagnosis and medical professionalism.

1st Quebec symposium on overdiagnosis in April 2014

Multiple conferences and training opportunities for physicians

Launch of the Practising Wisely: Reducing Unnecessary Testing and Treatment training program in French in collaboration with the Québec College of Family Physicians

Establishment of the Choosing Wisely Québec network

Get involved with us!

Take one of our medical leadership training courses

Come out and meet us in your region during our tour on the theme of medical professionalism

Above all, be sure to join the QMA by visiting www.amq.ca
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<thead>
<tr>
<th>Name</th>
<th>BN</th>
<th>Title</th>
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</thead>
<tbody>
<tr>
<td>Aline Vidal</td>
<td>BN 01</td>
<td>Facing overdiagnosis in Primary Health Care in Brazil – a report of the experience of graduate medical students</td>
</tr>
<tr>
<td>Cheng Yu-Ling</td>
<td>BN 02</td>
<td>Enhance nursing isolation measures during taking care of patients with drug-resistant strains.</td>
</tr>
<tr>
<td>David Warriner</td>
<td>BN 03</td>
<td>Choosing Wisely UK: lessons learned in launching a national Choosing Wisely initiative</td>
</tr>
<tr>
<td>Sheila Feit</td>
<td>BN 04</td>
<td>Clinical decision support tools as pathways to avoid care overuse</td>
</tr>
<tr>
<td>Guylène Thériault</td>
<td>BN 06</td>
<td>FROM UNDERSTANDING TO TAKING ACTION: EDUCATION AND ENGAGEMENT OF PHYSICIANS IN QUEBEC</td>
</tr>
<tr>
<td>Samanta Adomaviciute</td>
<td>BN 07</td>
<td>Shared decision making in a private healthcare sector</td>
</tr>
<tr>
<td>Godefroy Hardy St-Pierre</td>
<td>BN 09</td>
<td>La pertinence clinique en action: analyse stratégique de l'expérience du CHU de Québec</td>
</tr>
<tr>
<td>Shiva Nagaratnam</td>
<td>BN 10</td>
<td>Management of CKD in Primary Care Setting: A perspective from Northeast Ohio</td>
</tr>
<tr>
<td>Wen-Hsuan Hou</td>
<td>BN 12</td>
<td>Rasch analysis of the 9-item Shared Decision Making Questionnaire in women with breast cancer</td>
</tr>
<tr>
<td>Sheila Feit</td>
<td>BN 13</td>
<td>Shared decision-making and overuse of care</td>
</tr>
<tr>
<td>Sheila Feit</td>
<td>BN 14</td>
<td>Overtreatment vs. undertreatment: The REACH-VET initiative and optimized allocation of care</td>
</tr>
<tr>
<td>Caroline Morris</td>
<td>BN 16</td>
<td>Unexpected harms of preventative care: findings from an ethnography of CVD prevention in general practice</td>
</tr>
<tr>
<td>Brianne Wood</td>
<td>BN 17</td>
<td>&quot;They should be asking us&quot;: a decisional needs assessment for women considering cervical cancer screening</td>
</tr>
<tr>
<td>Samira Abbasgholizadeh Rahimi</td>
<td>BN 18</td>
<td>A Theory-Based Web Survey to Identify Health Professionals' Intention to use a Decision Aid for Down Syndrome Screening</td>
</tr>
<tr>
<td>Jean-Simon Létourneau</td>
<td>BN 19</td>
<td>Adaptation of DECISION+, a training program in shared decision making on the use of antibiotics for acute respiratory infections in primary care, to the context of Emergency Department: a mixed methods study</td>
</tr>
<tr>
<td>Diana Stewart Hoover</td>
<td>BN 20</td>
<td>Preferences for Communicating about Breast Cancer Screening among Racially/Ethnically Diverse Older Women</td>
</tr>
<tr>
<td>Wilber Deck</td>
<td>BN 23</td>
<td>Overdiagnosis is a misnomer, and it is overcounting</td>
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<tr>
<td>Albert Prats-Uribe</td>
<td>BN 24</td>
<td>Chronic Kidney Disease in the elderly: beyond the glomerular filtrate ratio.</td>
</tr>
<tr>
<td>Vanessa Fillion</td>
<td>BN 26</td>
<td>Study of in situ cancers in the Quebec Breast Screening Program between 2002 and 2012</td>
</tr>
<tr>
<td>Ebtisam Elghblawi</td>
<td>BN 27</td>
<td>Under the theme of Overuse and Overmedicalistion and overdiagnosis. Title: Establishing a rapport and gaining trust</td>
</tr>
<tr>
<td>Sarah Tremaine</td>
<td>BN 29</td>
<td>Ethical Responses to Over Diagnosis of Papillary Thyroid Microcarcinoma</td>
</tr>
<tr>
<td>Nicolas Gillot</td>
<td>BN 30</td>
<td>Projet d'amélioration de la qualité des soins pour diminuer le recours aux examens barytés de déglutition chez l'adulte présentant une dysphagie oro-pharyngée et hospitalisé en soins aigus à l'hôpital de Hull (CISSSO)</td>
</tr>
<tr>
<td>Martin Bussières</td>
<td>BN 31</td>
<td>Magnetic resonance imaging in the diagnosis of acute shoulder disorders: overuse or misuse?</td>
</tr>
<tr>
<td>Martin Gariepy</td>
<td>BN 32</td>
<td>Measuring Overuse of Head CTs for Pediatric mTBI Patients in Two Canadian Emergency Departments (Phase I of the Wiki Head CT Patient Decision Aid Study)</td>
</tr>
<tr>
<td>Shahrzad Shidfar</td>
<td>BN 33</td>
<td>Misdiagnosis, overdiagnosis and overtreatment of catheter associated urinary tract infection (CAUTI) in acute care hospitals: A No win situation</td>
</tr>
<tr>
<td>Hugues Vaillancourt</td>
<td>BN 36</td>
<td>An epistemological perspective to tackle challenges of overdiagnosis and overtreatment</td>
</tr>
<tr>
<td>Emily Ward</td>
<td>BN 37</td>
<td>Are multidisciplinary medication reviews in acute care the key to reducing polypharmacy in the elderly?</td>
</tr>
<tr>
<td>Bettina Engel</td>
<td>BN 38</td>
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