Co-sponsored by the World Health Organization

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Preventing Overdiagnosis 2018 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.
Welcome to Copenhagen and the sixth international Preventing Overdiagnosis Conference

This year co-sponsored by the World Health Organisation, together working towards making our health systems safe sustainable and successful well into the future.

Preventing Overdiagnosis 2018 will continue to 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. We offer a platform for delegates to learn how 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.

Overdiagnosis: what it is and what it isn’t, will be amongst the many topics discussed across three full days of knowledge sharing and debate designed to stimulate, provoke entertain and inspire.

Themes for 2018 include
  • De-implementation and the Challenge of Tackling Overdiagnosis at the Level of the Consultation
  • Turning Citizens Into Patients Unnecessarily
  • The Impact of Power Driven Overdiagnosis: The Role of Regulators & Health Authorities
  • Overdiagnosis 2.0 (Technology)
  • Psychiatry and Overdiagnosis
  • The Role of Risk Factors in Overdiagnosis

PODC 20-22 August 2018 has been approved for reimbursement from the Fund for General Practice with the following fees:

Self-chosen continuing education: 2 days lost working profit of 2,600 kr. And 2 days tuition fee of 2,400 kr. And max. 1,500 kr. In transport costs.

Course activity number 2018-0597. Refunds can be applied after August 22, 2018.

PLO is an organization that carries out the professional and financial interests of some 3400 GPs.

PODC2018 offers 18 hours of self-awarded CME credits.

Web: www.preventingoverdiagnosis.net
Twitter: @PreventingODx #PODC2018
## Day 1 – Monday August 20th

<table>
<thead>
<tr>
<th>Ground floor – Maersk Tower 07:30</th>
<th>Registration &amp; Coffee</th>
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</table>
| **Niels K. Jerne Auditorium 08:20 – 09:00** | **John Brodersen & Anders Beich** – Welcome / Introduction  
**Dr Francesca Racioppi** – WHO co-sponsor  
**Iona Heath** – Why are we so afraid to be normal |
| **Niels K. Jerne Auditorium 09:00 – 10:30** | **Keynote 1: De-implementation and the Challenge of Tackling Overdiagnosis at the Level of the Consultation**  
Chair – Julian Treadwell  
**Gisle Roksund** – A Clinical Perspective of Overdiagnosis  
**Tara Montgomery** – Citizens in Crisis: Rebuilding Trust to Prevent Overdiagnosis  
**Michael Baum** – Thinking, fast and slow-strategies for the de-implementation of the breast cancer screening programmes |
| **First floor – Maersk Tower 10:30 – 11:00** | **Break / Posters** |
Parallel Sessions: 11:00 – 12:30 (Choose one of the following six)

**Parallel Session 1: Deimplementation**
- Niels K. Jerne Auditorium
- Chair: Karsten Juhl Jørgensen
- Jacques Thivierge – Diagnosis: Industry’s royal road to manipulate modern medicine
- Ariane Plaisance – Shared decision making in goals-of-care conversations with elderly patients: concerns and limitations
- Carlos Martins – The effect of a test ordering software intervention on the prescription of unnecessary laboratory tests - a randomized controlled trial
- Joshua Zadro – Barriers and facilitators to adopting Choosing Wisely recommendations in physiotherapy
- Aleksi Varinen – Thyroid hormone treatment and hormone levels among fibromyalgia patients in a Finnish health center - are there indications of overuse?
- Leti van Bodegom-Vos – Barriers and facilitators for de-implementation of unnecessary MRI's and arthroscopic surgeries in patients aged 50+ years with degenerative knee complaints among orthopaedic surgeons

**Parallel Session 2: Other**
- Nielsine Nielsen Auditorium
- Chair: Alex Barratt
- Holli Loomans – Incidental detection of thyroid abnormalities on low-dose computed tomography in the National Lung Screening Trial
- Astridur Stefansdottir – What does “medicine” mean and why does it matter?
- Iain Maidment – MEMORABLE: MEdication Management in Older people: Realist Approaches Based on Literature and Evaluation
- Bjorn Hofmann – Back to basics: overdiagnosis is about wrongful diagnosis
- Tjin Kool – Volume and variation of low-value care practices in the Netherlands using health insurance claim data

**Parallel Session 3: Workshop**
- Meeting Room 1
- John Brodersen, Iona Heath, Gisle Roksund, Harald Sundby, Elisabeth Swensen
- The Difficult Art of Un-Doing

**Parallel Session 5: Seminar**
- Holst Auditorium
- Allen Shaughnessy – Moving Beyond Flexner: Evolving Medical Education to Stop Promoting Overdiagnosis

**Parallel Session 4: Seminar**
- Henrik Dam Auditorium
- Ricardo Quinonez – “Latest Evidence of Overdiagnosis in Pediatrics"

**Parallel Session 6: A Beginners Guide**
- Meeting Room 2
- PODC2018 Junior research Group – Introduction to Overdiagnosis: Session One

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**First floor – Maersk Tower**
12:30 – 13:30

**Lunch**
### Parallel Sessions: 13:30 – 15:00 (Choose one of the following five)

#### Parallel Session 1: Deimplementation
Niels K. Jerne Auditorium
Chair – Rachael Dodd

- **Joshua Zadro** – A Cochrane review of strategies to increase adoption of the Ottawa Ankle Rules and reduce unnecessary imaging
- **Natalie Armstrong** – The Risk Work of Overdiagnosis and Overtreatment
- **Bjarke Medici** – Changes in prescription routines for treating hypothyroidism between 2001 and 2015 - a population-based study of 929,684 primary care patients in Copenhagen
- **Tessa Rietbergen** – Barriers and facilitators associated with uptake of the Dutch Choosing Wisely recommendation regarding MRI and knee arthroscopy among orthopaedic patients with degenerative knee complaints
- **Rebecca Bradford-Duarte** – The Overdiagnosis of Chest Sepsis in Children: A Quality Improvement Project
- **Eva Verkerk** – Evaluating the five wise choices in wound care: are nurses and physicians choosing wisely?

#### Parallel Session 2: Turning citizens into patients
Nielsine Nielsen Auditorium
Chair - Barry Kramer

- **Ray Moynihan** – Use of regular feedback of ranked performance data to Family Medicine trainees in the Sultanate of Oman, to support a reduction in the overuse of resources
- **Rae Thomas** – Media coverage of the 2017 expanded definition of high blood pressure – and its risk of overdiagnosis: a cross sectional study
- **Anne Stiggelbout** – Women’s acceptance of overdetection in breast cancer screening: can we assess harm-benefit trade-offs?

#### Parallel Session 3: Workshop
Meeting Room 1

- **Eddy Lang** – PreventionPLUS: A Free Access Literature Awareness Portal That Surveills High Quality Research and Guidelines to Inform the Harms and Benefits of Screening and Prevention Strategies in Healthcare

#### Parallel Session 4: Seminar
Henrik Dam Auditorium

- **Maria del Rosario Perez** – Imaging asymptomatic people: a framework addressing clinical governance improvement and regulatory compliance

#### Parallel Session 5: A Beginners Guide
Meeting Room 2

- **PODC2018 Junior research Group** – Introduction to Overdiagnosis: Session Two

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### First floor – Maersk Tower
15:00 – 15:45

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<th>Niels K. Jerne Auditorium</th>
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<tr>
<td><strong>Keynote 2: Turning Citizens Into Patients Unnecessarily</strong></td>
<td>Chair – Iona Heath</td>
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<tr>
<td>Cécile Bour &amp; Jean Doubovetzky – Mammography screening in France: real advances and doublespeaking</td>
<td>Juan Pablo Brito – Patient-centred diagnosis</td>
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<td>Steve Woloshin &amp; Lisa Schwartz – Disease awareness campaigns: Invitations to overdiagnosis</td>
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17:30 – 19:30

- **17:30 Buses leave Panum Building** - **18:00 Town Hall welcome drinks**
Day 2 – Tuesday August 21st

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<tr>
<th>Ground floor – Maersk Tower 08:00 - 0900</th>
<th>First floor – Maersk Tower 08:00 - 0900</th>
<th>Research In Conversation Informal drop in breakfast session with coffee &amp; pastries</th>
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<tr>
<td><strong>Parallel Session 1: Deimplementation</strong></td>
<td><strong>Parallel Session 2: Turning citizens into patients</strong></td>
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<tr>
<td>Niels K. Jerne Auditorium</td>
<td>Nielsine Nielsen Auditorium</td>
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<tr>
<td>Chair – Gemma Jacklyn</td>
<td>Chair – Ray Moynihan</td>
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<tr>
<td>Alex Barratt – A collective approach to recommendations for de-implementation or reform of a national screening program. A case study from the French civic and scientific inquiry into breast cancer screening</td>
<td>Rachael Dodd – Opportunity to reduce overdiagnosis and overtreatment of cervical abnormalities: de-intensifying the Australian National Cervical Screening Program</td>
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<tr>
<td>Sweekriti Sharma – Clinician, patient and general public beliefs about diagnostic imaging for low back pain: A qualitative evidence synthesis</td>
<td>János Valéry Gyrícza – “People say it is dangerous”. Psychosocial Effects of Labelling People with Mild Hypertension: a Qualitative Study</td>
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<td>Kristen Pickles – Evaluating two decision aids for Australian men to support informed choice about prostate cancer screening</td>
<td>Stephanie Mathieson – Increasing prescription of opioid analgesics and neuropathic pain medicines for spinal pain in Australia</td>
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<td>Guylene Theriault – “Practicing Wisely”: a hands-on workshop to decrease overuse at the level of the consultation in primary care</td>
<td>Carlo Liverani – Human papillomavirus (HPV) infection of the anogenital tract detected through molecular tests leads to overtreatments and waste of resources</td>
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<td>Kristie Weir – Preventing overtreatment in older age by prioritising medicines</td>
<td>Jessica Malmqvist – Psychosocial consequences of participating in a national colorectal cancer screening programme</td>
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<td>Gustavo Machado – Design and rationale for an implementation trial to improve care for low back pain in emergency departments</td>
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<tr>
<td><strong>Parallel Session 3: Impact of power driven ODx</strong></td>
<td><strong>Parallel Session 4: Workshop</strong></td>
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<tr>
<td>Holst Auditorium</td>
<td>Meeting Room 1</td>
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<tr>
<td>Chair – Barry Kramer</td>
<td>Gloria Cordoba – Overdiagnosis and overtreatment of infectious diseases in general practice. How and where to break the endless loop?</td>
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<td>Chris Degeling – The introduction and demise of full body computed tomography (CT) scanning in Australia: implications for preventing overdiagnosis</td>
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<td>Jack O’Sullivan – Variation in diagnostic test requests and outcomes: a preliminary metric for OpenPathology.net</td>
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<td>Nicole Grössmann – Five years of EMA-approved systemic cancer therapies for solid tumours – a comparison of two thresholds for meaningful clinical benefit</td>
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<td>Julia Ledovskikh &amp; Vasiliy Vlassov – One year mortality from selected cancers: a dubious success of screening, Russia</td>
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<td>Adrian Traeger – Overdiagnosis of low back pain</td>
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<td>Ananta Dave – Physician stress and burnout- Cause or consequence of overdiagnosis?</td>
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<tr>
<td><strong>First floor – Maersk Tower 10:30 – 11:00</strong></td>
<td><strong>Break / Posters</strong></td>
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**First floor – Maersk Tower 10:30 – 11:00**

- Break / Posters
### Keynote 3: Impact of Power Driven Overdiagnosis: The Role of Regulators & Health Authorities

**Chair – Fiona Godlee**

- **Søren Brostrøm** – How can health authorities diminish and prevent overdiagnosis
- **Salvatore Vacarella** – “Evidence for thyroid cancer overdiagnosis: WHO views”
- **Paul Glasziou** – Impact of Power Driven Overdiagnosis: The Role of Regulators & Health Authorities

### First floor – Maersk Tower

- **12:30 – 14:00**: Lunch

### Parallel Sessions: 14:00 – 15:30 (Choose one of the following six)

#### Parallel Session 1: Other

**Niels K. Jerne Auditorium**

- **Chair – Kirsten Howard**
  - **Joshua Zadro** – Evaluating the content of Choosing Wisely recommendations and the prevalence of interdisciplinary finger pointing
  - **Bjorn Hofmann** – Overdiagnosis: a multi level problem
  - **Chisato Hamashima** – Systematic review of overdiagnosis in cervical cancer screening: How should we define overdiagnosis in cervical cancer screening?
  - **Nawras Azzam** – Primary health care education and Antibiotics overuse
  - **Emily McDonald** – The MedSafer pilot results: electronic deprescribing for hospitalized older adults with polypharmacy
  - **Lynette Reid** – On the relevance of definitions: three conceptually challenging issues in overdiagnosis

#### Parallel Session 2: Other

**Nielsine Nielsen Auditorium**

- **Chair – Steve Woloshin & Lisa Schwartz**
  - **Gemma Jacklyn** – Trends in stage-specific breast cancer incidence in New South Wales, Australia: insights from 25 years of screening mammography
  - **Andreea Badea** – To PET or not to PET?
  - **Alison Avenell** – Research misconduct can promote overtreatment. A multi-institutional case study from Japan, with implications for osteoporosis management with vitamin K
  - **Marc D. Ryser** – The Impact of Prognostic Estimates on Surgical Decision Making in the Setting of Severe Traumatic Brain Injury: A Survey of Neurosurgeons
  - **Tammy Clifford** – A critical interpretive synthesis of recommendations for De-intensification and de-IMPLEmentation from population Screening (DIMPLES)
  - **Ulrika Elmroth & Eva Arvidsson** – Quality Indicators aiming to help Primary Care in Sweden to balance between what to do and what not to

#### Parallel Session 3: Impact of power driven ODx

**Holst Auditorium**

- **Chair – Jack O’sullivan**
  - **Yu Wang** – Drivers of general health checks in China and the risk of overdiagnosis
  - **Christoffe Bjerre Haase** – The diagnostic “bubble“ - overdiagnosis revisited from economic perspective using osteoporosis as an example
  - **Christian Patrick Jauernik** – Systematic influences effect on participation rate in a fictional medical screening programme
  - **Marc Rhainds** – Antibiotics-impregnated calcium sulfate in surgery: A case of broader use of innovative medical practice
  - **Anna Tosteson** – Evaluation of Strategies to Prevent Overdiagnosis of Melanocytic Skin Lesion Biopsies: A Decision Analysis
  - **Alexander Spassov** – The impact of orthodontic treatment regulation in the German public health sector on the overuse of orthodontic services

#### Parallel Session 4: Workshop

**Henrik Dam Auditorium**

- **Julian Treadwell** – Engaging the grass roots and the Ivory towers

#### Parallel Session 5: Workshop

**Meeting Room 1**

- **James McCormack** – Reporting lab results: the cause of, and the solution to, the overdiagnosis problem

#### Parallel Session 6: Workshop

**Meeting Room 2**

- **Stefan Hjorleifsson** – Good doctoring: ‘Core writings’ as an antidote to medical overactivity
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<td>15:30 – 16:00</td>
<td>Maersk Tower</td>
<td>Break / Posters</td>
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| 16:00 – 17:30| Niels K. Jerne Auditorium | Keynote 4: Overdiagnosis 2.0 (Technology)  
Chair – Carl Heneghan  
Henrik Vogt – A new era of overdiagnosis: Big data and precision medicine  
Claus Ekstrøm – Big data: the inevitable statistical problem with overdiagnosis  
Johnny Kung – Engaging diverse communities on the benefits and implications of genetic diagnosis |
| 18:15        |                  | Boat trip and dinner party  
First boat leaves Ved Stranden at 18:15                                               |
| 18:15 – 18:30|                  | Boat trip                                                                                                                                      |
| 18:40 – 19:30| Niels K. Jerne Auditorium | Keynote 5: Psychiatry and Overdiagnosis  
Chair – Niels Saxtrup  
Allen Frances – "Confusing Mad With Sad & Bad"  
Anders Petersen – Psychiatry and overdiagnosis: a sociological perspective  
Olga Runciman – Patient/citizen perspective - “stickiness” of psychiatric diagnoses: once you have it, you often cannot “unhave it” - Overdiagnosis of mental health conditions in everyday practice |
| 19:30        |                  | Dinner Party - Toldboden                                                                                                                       |

Day 3 – Wednesday August 22nd

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<tr>
<td>08:00 – 09:30</td>
<td>Maersk Tower</td>
<td>Registration</td>
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</table>
| 08:00 – 09:30| Niels K. Jerne Auditorium | Research In Conversation  
Informal drop in breakfast session with coffee & pastries |
| 09:30 – 11:00| Niels K. Jerne Auditorium | Keynote 5: Psychiatry and Overdiagnosis  
Chair – Niels Saxtrup  
Allen Frances – "Confusing Mad With Sad & Bad"  
Anders Petersen – Psychiatry and overdiagnosis: a sociological perspective  
Olga Runciman – Patient/citizen perspective - “stickiness” of psychiatric diagnoses: once you have it, you often cannot “unhave it” - Overdiagnosis of mental health conditions in everyday practice |
| 11:00 – 11:30| Niels K. Jerne Auditorium | Break / Posters                                                                                                                                |

**Parallel Sessions: 08:00 – 09:30 (Choose one of the following three)**

- **Parallel Session 1: Workshop**  
  **Meeting Room 1**  
  **Johann Agust Sigurdsson** – Policy and practice in the European countries regarding overdiagnosis and quaternary prevention

- **Parallel Session 2: Workshop**  
  **Holst Auditorium**  
  **Frederik Martiny** – How do we engage new health care providers (students and new practitioners) in initiatives to reduce overdiagnosis?

- **Parallel Session 3: Seminar**  
  **Nielsine Nielsen Auditorium**  
  **Anne Møller** – Definition of multimorbidity and risk of overdiagnosis

**Niels K. Jerne Auditorium 09:30 – 11:00**  
Keynote 5: Psychiatry and Overdiagnosis  
Chair – Niels Saxtrup  
Allen Frances – "Confusing Mad With Sad & Bad"  
Anders Petersen – Psychiatry and overdiagnosis: a sociological perspective  
Olga Runciman – Patient/citizen perspective - “stickiness” of psychiatric diagnoses: once you have it, you often cannot “unhave it” - Overdiagnosis of mental health conditions in everyday practice
**Parallel Sessions: 11:30 – 13:00 (Choose one of the following six)**

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<td>Niels K. Jerne Auditorium</td>
<td>Nielsine Nielsen Auditorium</td>
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<tr>
<td>Chair – Karsten Juhl Jørgensen</td>
<td>Chair – Tara Montgomery</td>
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<tr>
<td><strong>Macedo Gustavo</strong> – The STARS Back Pain App - using real time emergency department data to address overdiagnosis</td>
<td><strong>Mette Kjer Kaltoft</strong> – Mono-critical thresholds are a likely source of over-testing and over-treatment</td>
</tr>
<tr>
<td><strong>Alexandra Barratt</strong> – Impact of Full-Field Digital Mammography versus Film-Screen Mammography: Systematic Review</td>
<td><strong>Eddy Lang</strong> – Decision Support and Knowledge Translation Tools to Highlight the Benefits and Harms of Screening: An Analysis of Online Access and Dissemination of the Canadian Task Force for Preventive Healthcare Resources</td>
</tr>
<tr>
<td><strong>Milan Mrekaj</strong> – Innovative approaches to proactively identify members with special medical needs</td>
<td><strong>James Dickinson</strong> – Loss of insurability: an inadequately elucidated harm of screening and overdiagnosis</td>
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<tr>
<td><strong>Mary O’Keeffe</strong> – Do nudge-type interventions change clinician treatment, screening, and testing behaviours?: a systematic review</td>
<td><strong>Tessa Copp</strong> – Challenges and uncertainties regarding Polycystic Ovary Syndrome (PCOS) and the potential for overdiagnosis: Clinicians’ views and experiences</td>
</tr>
<tr>
<td><strong>Mono-criterial thresholds are a likely source of over-testing and over-treatment</strong></td>
<td><strong>Fran Quattri</strong> – Pharmacovigilance and participatory medicine through social media – we are still not there</td>
</tr>
<tr>
<td><strong>Eddy Lang</strong> – Decision Support and Knowledge Translation Tools to Highlight the Benefits and Harms of Screening: An Analysis of Online Access and Dissemination of the Canadian Task Force for Preventive Healthcare Resources</td>
<td><strong>Jette Nygaard Jensen</strong> – Reducing inappropriate antibiotic use among infants through an educational intervention targeting new parents</td>
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<tr>
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<th>Parallel Session 4: The role of risk factors &amp; impact of power driven ODx</th>
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<tr>
<td>Henrik Dam Auditorium</td>
<td>Holst Auditorium</td>
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<tr>
<td>Chair – Carl Heneghan</td>
<td>Chair – Ray Moynihan</td>
</tr>
<tr>
<td><strong>Ian Maidment on behalf of the MEDREV Team</strong> – MEDREV: feasibility study of a pharmacy de-prescribing and health psychology intervention to improve care for people with dementia with BPSD in care homes</td>
<td><strong>Katy Bell</strong> – Incremental benefits and harms of the 2017 American College of Cardiology/American Heart Association High Blood Pressure Guideline</td>
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<td><strong>Timo Beeker</strong> – Psychiatrization of Society: A Wake-up Call for Debate</td>
<td><strong>Danielle Durham</strong> – Cause of death among lung cancer patients in the National Lung Screening Trial: Competing causes of death as a hallmark of overdiagnosis</td>
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<tr>
<td><strong>Brooke Levis</strong> – Overestimation of depression prevalence in meta-analyses via the inclusion of primary studies that assessed depression using screening tools or rating scales rather than validated diagnostic interviews</td>
<td><strong>Roshini Kulanthaivelu</strong> – Overinvestigation in the elderly? The role of guidelines on emergency intracranial imaging: Experience from a DGH</td>
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<td><strong>Rae Thomas</strong> – Applying the Checklist for Modifying the Definition of Disease to Attention Deficit/Hyperactivity Disorder (ADHD) age of onset criterion (AOC)</td>
<td><strong>Alison Avenell</strong> – Is there really an epidemic of vitamin D deficiency? An investigation of the evidence base for vitamin D supplementation</td>
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<tr>
<td><strong>Charlotte Lunde</strong> – Drug treatment of ADHD in children and adolescents – tenuous scientific basis</td>
<td><strong>Jamie Falk</strong> – The Impact of a Regulatory Nudge on the Overuse of Low Dose Codeine in Manitoba, Canada</td>
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<td><strong>Huib van Dis</strong> – Study doping: Prevalence of psychostimulants use among university students in the Netherlands</td>
<td><strong>Gillian Parker</strong> – The use of theories and frameworks to understand and address the reduction of low-value healthcare practices: a scoping review</td>
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<tr>
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<tr>
<td><strong>Niall McLaren</strong> – Overdiagnosis of depression: Clinical, Practical &amp; Cost implications</td>
<td><strong>Eva Verkerk</strong> – Why is it so hard to stop overuse?</td>
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**PROGRAMME**
First floor – Maersk Tower
13:00 – 14:00

Lunch

Parallel Sessions: 14:00 – 15:30 (Choose one of the following five)

**Parallel Session 1: Deimplementation**
Niels K. Jerne Auditorium
Chair – Karsten Juul Jørgensen
Ronald Adler – De-Implementing Unconsidered Cancer Screening: Primum non Nocere
Sergio Minue – Overdiagnosis and error in general practice: the need of a new approach
William Baughman – The Imaging Learning Network (ILN): a healthcare provider-industry collaboration to reduce inappropriate imaging through clinical decision support
Simone Diniz – Screening and breast cancer mortality and in São Paulo State, Brazil: an ecological analysis
William Peagam – Reducing over investigation in suspected PE

**Parallel Session 2: Turning citizens into patients / Psychiatry & ODx**
Nielsine Nielsen Auditorium
Chair – Niels Saxtrup
Tessa Copp – Under- versus overdiagnosis: Exploring the benefits and harms of a PCOS label and its impact on women’s psychosocial wellbeing, lifestyle and behaviour
Jacob Bülow – Sarcopenia: A case study in how the phenomenon of overdiagnosis is generated
Christiana Naaktgeboren – Widening Disease Definitions in Gestational Diabetes: an evaluation of changing guidelines
Kimberly Gibbons – The evaluation of a breast cancer screening decision aid in the community setting
Kimberly Turner – Defining Overdiagnosis of Mental Health Disorders: Secondary Analysis of an Overdiagnosis Scoping Review

**Parallel Session 3: Other**
Henrik Dam Auditorium
Chair – Barry Kramer
Joshua Zadro – Overdiagnosis, overtreatment and low-value care in physiotherapy: a scoping review
Frederic Grannis – A Tale of Two Studies: Diagnostic algorithms and clinical practice guidelines minimize overdiagnosis and overtreatment and maximize survival in lung cancer screening
Kirsten Howard – Preferences for papillary thyroid cancer management and the impact of terminology: a discrete choice experiment
Katy Bell – Can We Detect Overdiagnosis Early? Exploring indicators of possible overdiagnosis outside cancer screening contexts
Janessa Griffith – Evaluation of a Choosing Wisely Canada initiative to reduce unnecessary radiology and laboratory testing in the emergency department
Marc D. Ryser – Natural History of Ductal Carcinoma in Situ in the Absence of Locoregional Treatment

**Parallel Session 4: The role of risk factors**
Holst Auditorium
Chair – Carl Heneghan
Paula Byrne – Statins for the primary prevention of cardiovascular disease: a simulation of eligibility, costs, patient preferences and number-needed-to-treat in the context of changing clinical guidelines
Bram Vrijsen – Physicians’ perceptions of inappropriate laboratory testing in clinically admitted patients
Adrian Traeger – No benefit of additional care for ‘high-risk’ patients with acute low back pain: The PREVENT randomized, placebo-controlled trial
Lorna Gibson – Risk factors associated with potentially serious incidental findings and with serious final diagnoses on multimodal imaging in the UK Biobank Imaging Study
Carlos Brotons – Are we overestimating or underestimating cardiovascular events risk? The impact of using the American, British and European guidelines on cardiovascular risk assessment

**Parallel Session 5: Seminar**
Meeting Room 2
Jessica Malmqvist – What is the relationship between deviations, abnormalities, risk factors, pathologies and overdiagnosis?
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<td>15:30 – 16:00</td>
<td>First floor – Maersk Tower</td>
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<td>16:00 – 17:30</td>
<td>Niels K. Jerne Auditorium</td>
<td><strong>Keynote 6: Overdiagnosis in Risk Prevention: Cardiovascular</strong></td>
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<td><strong>Hálfdán Pétursson</strong> – The tsunami of overdiagnosis in cardiovascular risk in general practice</td>
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<td><strong>Torben Jørgensen</strong> – General health check to prevent cardiovascular diseases (CVD)</td>
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<td><strong>Paul Whelton</strong> – The 2017 American College of Cardiology/American Heart Association Blood Pressure Guideline: Major Recommendations, Rationale, and Clinical Implications.</td>
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<td><strong>Closing Comments – John Brodersen</strong></td>
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<td><strong>Intro to PODC 2019 – Ray Moynihan</strong></td>
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PREVENTING OVERDIAGNOSIS

5-7 December 2019 SYDNEY

SAVE THE DATE

KEYNOTES:
BMJ Editor-in-chief, Dr Fiona Godlee
Low-value care world expert, Prof Adam Elshaug

More to come...

preventingoverdiagnosis.net
PREVENTING OVERDIAGNOSIS 2018
WELCOME TO COPENHAGEN

Monday August 20th

Enjoy a drink and snack courtesy of the Municipality of Copenhagen whilst watching a short dance display from the children at Tivoli ballet school.

Buses leave from the front of the Panum Building at 17:30
PREVENTING OVERDIAGNOSIS 2018
BOAT TRIP DINNER & DISCO

Tuesday August 21st

Enjoy a 60 minute tour along the water to Nordre Toldbod for drinks, dinner & dancing at Toldboden and the best view in Copenhagen

The first boat leaves from Ved Stranden parking bays 4 & 5 at 18:15
Copenhagen is well served by Kastrup International Airport, just 15 minutes to the city centre Nørreport Station. The metro station is located in extension of Terminal 3. The Metro runs at 4–6 minute intervals during the day and evening hours and at 15–20 minute intervals at night. A single ticket is approx 36DKK.

Taxis can be taken from Terminal 1 & 3 and can cost between 250 – 300 DKK.
**08:20 Monday August 20th**

**Why are we so afraid to be normal?**

Iona Heath

Or, to turn the question upside down, why are we so keen to rush to diagnosis? What is a diagnosis and who decides? What is normal and whose normal is normal? Why do we treat diagnoses as if they are more real than the experience of patients; why have we allowed our notion of diseases to become separated from our understanding of illness and suffering; why do we put so much trust in numbers rather than the details of symptoms? And how does all this relate to neoliberal economics and its resultant politics? Perhaps these are all aspects of the same question.

Healthcare professionals have been complicit in the erosion of normal. Is there now a role for the robust defence of its importance?

**Iona Heath** was a general practitioner in inner-city London for 35 years and is a past President of the UK Royal College of General Practitioners (RCGP). She has held several roles in the RCGP including chair of the Ethics Committee, the International Committee, and the Health Inequalities Standing Group. She chaired the BMJ Ethics Committee 2004 to 2009 and wrote a regular column for the BMJ from 2005 to 2013. She is a co-chairmember of the Scientific Committee for the 2017-2018 Preventing Overdiagnosis conference.

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**09:00 Monday August 20th**

**De-implementation and the Challenge of Tackling Overdiagnosis at the Level of the Consultation**

Chair – Julian Treadwell

**A Clinical Perspective of Overdiagnosis**

**Gisle Roksund** is a specialist in general and social medicine. He has previously been a district doctor in Ulvik and Granvin, municipal councilor in Siljan, and health manager in Skien. He is now general practitioner at Klosterhagen Medical Center in Skien, and is head of the Norwegian Association for General Medicine.

MD, general practitioner in Skien, Norway and former chair of both Norwegian College of General Practice and Nordic Federation of General Practice. Gisle will describe and discuss the problems of overdiagnosis from the clinical general practitioners point of view and present actions the Norwegian college of General Practice has taken to meet the different challenges. He will give some examples of the different types of overdiagnosis met in clinical work, such as avoidable overdiagnosis, system driven overdiagnosis, profit driven overdiagnosis, disease mongering and overdiagnosis driven by fear.

Actions need to be taken at several levels.

**Citizens in Crisis: Rebuilding Trust to Prevent Overdiagnosis**

**Tara Montgomery** as a patient- and family-centered care advocate and consumer health strategist, Tara convenes and partners with diverse stakeholders across health, media, and consumer organizations to implement culture change in healthcare. As founder of the consulting practice Civic Health Partners, she collaborates with health system leaders to explore the intersections of health, technology, education, policy, and communications and discover solutions that integrate empathy and evidence.

During her 14 years with Consumer Reports, Tara led the Health Impact team, developed strategies to advance high value care for
Thinking, fast and slow—strategies for the de-implementation of the breast cancer screening programmes

Michael Baum, Professor Emeritus of Surgery and visiting Professor of Medical Humanities in University College London (UCL), is a British surgical oncologist who specialises in breast cancer treatment. He is also known for his contributions to the evaluation and support of patient quality of life. He has been Professor of Surgery in King's College London, the Royal Marsden Hospital and UCL. He is a notable critic of alternative medicine.

In 2007, Baum received the St Gallen lifetime achievement award for the treatment of breast cancer.

Baum's team was the first to demonstrate the effectiveness of adjuvant tamoxifen for early breast cancer, which has contributed to the 30 per cent reduction in breast cancer mortality and its efficacy in the prevention of breast cancer in susceptible women. Since then, while at UCL, he was responsible for the largest-ever international cancer trial (ATAC – Arimidex, Tamoxifen, Alone or in Combination), which in record time showed anastrozole to be better than tamoxifen.

“Thinking, fast and slow” is the title of the book by the Nobel laureate, Daniel Kahneman.

This book describes two systems of thought. System 1 is always ticking away in the background and provides effortless intuitive solution to problems. System 2 must be switched on to provide rational solutions to complex problems that make greater demands on cerebral activity. Take this example: A bat and a ball costs $1.10, the bat costs one dollar more than the ball. How much does the ball cost? Your system 1 answer will be wrong.

Breast cancer is a complex problem and the “catch it early save a life” mantra is a simple intuitive answer that is wrong. To understand why it is wrong you must energies your brain into type 2 thinking, that is too much effort for most lay people and politicians, however compelling the data. I would like to offer two solutions to the problem.

First I will present a new data set from a RCT of whole breast radiation (WBRT) v single shot intraoperative radiotherapy (IORT) [1] 60% of cases in this study were screen detected. There was no
difference in cause specific mortality but a significant excess of deaths from the complications of WBRT. These observations confirmed my predictions. [2] These data are so striking as to give pause for thought. Secondly, to reduce the effort of type 2 thinking, I have developed an analogy to weather forecasting. The failure of the breast screening experiment is the fact that disease is a chaotic system. The weather forecast is accurate because it applies the laws of chaos theory. We learn about this every time we watch the weather forecast on the news. Such familiarity can be easily transcribed to a better understanding of breast cancer.


15:45 Monday August 20th

Turning Citizens Into Patients Unnecessarily

Chair – Iona Heath

Mammography screening in France: real advances and doublespeaking

Cécile Bour, after completing a bachelor’s degree, Dr Bour began medical studies at the University of Strasbourg. Specialising in medical imaging and radiodiagnostics in Reims and Besançon.

Participating for a little over twenty years in organized screening in the Metz region, Dr Bour became second reader, but resigned from the departmental association, being less and less convinced of its merits.

Cartoon Illustrator of two medical comics “burn-out” for the League against Cancer and “enlightened hypnosis* for the Aquitaine Douleur Group, Bordeaux. Illustrator and editor on the medical expression site: http://exmed.org/ held by Dr. François-Marie Michaut.

Jean Doubovetzky, General Practitioner and Senior Editor for the Prescrire Journal, obtained his baccalaureate degree in 1975. Parallel to his medical studies he also obtained a certificate of higher studies in general medical psychology and a diploma in emergency medicine and oxylogy. Subsequently studying tropical medicine and applied epidemiology.

Dr Doubovetzky’s medical practice is centered on the care of refugees. He also teaches as a lecturer at the Faculty of Medicine of Toulouse, speaking at medical training evenings on vaccinations and the proper use of antibiotics. He is an expert lecturer at local, regional or national continuing medical education seminars funded by the Fonds de formation professionnelle professionnelle des médecins.

A founder of ARÉSIP (Association for Research on Health Events and their Personal Impacts) which aims to achieve methodical studies on the health knowledge of non-professionals in France, and to make the results accessible to all via a website, modeled on healthtalkonline.org and youthhealthtalk.org. In 2015, he collaborated on the development of the independent Cancer-Rose group brochure on breast cancer screening.

In spite of the controversy about mammographic screening, from the 2000s as well as whistle-blowers, French politicians generalize its organization in 2004.

Heath authorities and cancer control associations depreciate the question of overdiagnosis and distort information for women.

The Prescrire journal and independent associations are the only source of balanced information for professionals as well as the public, until 2016, when an independent national inquiry on breast cancer screening is organized. Its report concludes that organized screening should be stopped or radically transformed.
Patient centered diagnosis

Juan Pablo Brito is an endocrinologist, health care researcher, medical director of the Mayo Clinic Shared Decision Making National Resource Center and principal investigator in the Knowledge and Evaluation Research Unit (KER). Thyroid cancer is the most common cancer in young adults, and the fastest growing cancer in older Americans. Dr. Brito uses the tools of meta-analysis, large database analysis and shared decision-making to examine multiple dimensions of health care quality for patients with thyroid cancer. He is also interested in the evidence-based development of clinical practice guidelines and clinical decision-making for diagnostic tests.

The function of diagnosis is to help clinicians and patients determine the patient’s health problem and formulate a plan of treatment which fits with both the clinical and personal situation of the patient. While diagnosis is central to the practice of medicine, diagnostic processes can fail when clinicians do not recognize the patient’s situation or choose the wrong test to address it. Overdiagnosis might occur as a consequence of these breakdowns in the diagnostic process. Patient centered diagnosis ensures that the diagnostic process contributes to the resolution of a patient’s problematic situation, in a way that makes sense intellectually (it aligns with what is known and the likely unknown along with the appropriate sequencing of the investigation), practically (it can reasonably be done), and emotionally (it responds to the emotional needs of the patient and clinician). This process could be aided by instruments that help clinician and patient, i) contextualize the diagnostic process for example, with an ICAN discussion aid (The Instrument for Patient Capacity Assessment) and , ii) co-create the plan of tests with a diagnostic reconciliation tool. This process has the potential to reduce overdiagnosis at the encounter level.

Disease awareness campaigns: Invitations to overdiagnosis

Steven Woloshin & Lisa Schwartz are co-directors of the Center for Medicine and Media at The Dartmouth Institute and general internists. Both have worked together to improve the communication of medical evidence to physicians, journalists, policymakers, and the public to help them see through excessive fear and hope created by exaggerated and selective reporting in medical journals, advertising, and the news.

Their research themes include: medicine in the media, the science of effective risk communication, prescription drugs, overdiagnosis, and the marketing of medicine. Woloshin and Schwartz’s seminal work helped to establish the field of health–related numeracy. They created the “drug facts box”, drug–benefit and harm–data summaries shown in clinical trials to improve consumer decision–making. The FDA’s Risk Communication Advisory Committee unanimously endorsed the box and Congress directed FDA to consider it (S.3507 Affordable Care Act). While the FDA has not yet implemented boxes, they replicated Woloshin and Schwartz’s findings, acknowledged to Congress that boxes influenced their Guidelines and created the Trials Snapshots website with drug box content. Based on their work developing “risk charts” the National Cancer Institute created the Know Your Chances website.

Both are frequent contributors to major media outlets, including The Washington Post and The New York Times and co–authored two books: Know Your Chances and Overdiagnosed. For more than a decade, Woloshin and Schwartz have led the “Medicine in the Media” workshop with the NIH, teaching over 500 health journalists how to interpret and report medical research. In announcing that Woloshin and Schwartz received the 2017 McGovern Award from the American Medical Writers Association, President Lori Alexander said, “These two physicians are my heroes because of their commitment to improving the quality of messages directed at lay audiences.”

Steve Woloshin & Lisa Schwartz are founding members of the Steering Committee for Preventing Overdiagnosis, , Advisory Board members of AllTrials, and collaborators in Informed Health Choices (improving critical thinking skills in schools).
Drs. Lisa Schwartz and Steven Woloshin, pioneering researchers in overdiagnosis and founding-organizers of Preventing Overdiagnosis, are Professors of Medicine and co-Directors of the Center for Medicine and the Media at the Dartmouth Institute for Health Policy and Clinical Practice and co-authors of Know Your Chances and Overdiagnosed.

Awareness campaigns can improve health by teaching the public about a serious disease and beneficial actions they might take: recognizing symptoms, reducing risky behaviors, or undergoing screening, diagnosis and treatment. Ironically, campaigns can actually worsen health by creating too much fear about disease and too much hope about interventions. Or by serving as a gateway to overdiagnosis – where the harms of diagnosis and treatment outweigh benefit. Harmful campaigns turn questionable risk factors (e.g., prediabetes) or even ordinary experience (e.g., chronic dry eye disease) into disease. They also create public health norms for behaviors that are arguably individual choices – for example, creating the expectation that a responsible woman does not weigh benefits and harms, but just gets a mammogram.

Campaigns funded by pharmaceutical companies exist in a grey zone between public health messages and marketing. These inherently conflicted campaigns sell diseases to sell drugs. They are found around the world, often appearing before drug approval to prime the market, and are essentially unregulated. In the US, unlike drug advertising, there is no requirement for “fair balance”: awareness campaigns can assert treatment benefits without noting harms. Nor do scientific standards exists for the ubiquitous symptom quizzes and checklists which encourage self-diagnosis and prompt subsequent consultations (“ask your doctor about…”).

In this talk, we look at the evolution of disease awareness campaigns, highlight common strategies used to stimulate citizens to undergo screening, diagnosis and treatment, review the limited evidence about campaign effects, and consider the future as they expand into social media.
of new diagnostic and screening practices are known to vary substantially across countries/regions and have been shown to be associated with the risk of detection of benign and malignant thyroid diseases. The average national figures on TC overdiagnosis can therefore hide marked regional inequalities, depending on the local medical practices. The clinical and human burden of TC overdiagnosis is heavy, especially on young women. The large majority (over 90%) of patients receiving a TC diagnosis undergo total thyroidectomy and often other harmful and lifelong treatments. Besides, there are also large economic costs associated with thyroid cancer overdiagnosis. Since there is evidence of harm but not benefit from the intense scrutiny of the thyroid, overdiagnosis and overtreatment of TC should be urgently addressed. This presentation will review existing evidence about thyroid cancer overdiagnosis and discuss possible approaches to prevent unnecessary harm due to overdiagnosis from the WHO perspective.

Impact of Power Driven Overdiagnosis: The Role of Regulators & Health Authorities

Paul Glasziou, is Professor of Evidence-Based Medicine at Bond University and a part-time General Practitioner. He is currently the Director of the Centre for Research in Evidence-Based Practice at Bond University and previously the Director of the Centre for Evidence-Based Medicine in Oxford from 2003–2010.

His key interests include identifying and removing the barriers to using high quality research in everyday clinical practice and more specifically on improving the clinical impact of publications by reducing the more than $85 Billion annual loss from unpublished and unusable research (Chalmers, Glasziou, Lancet 2009).

Much of the growth in overdiagnosis has occurred by stealth. For example thyroid cancer incidence has steadily grown 3-fold - in the USA, Australia, and elsewhere – while the mortality has not changed. This increase can be explained by our overuse of improved diagnostic tools, such as imaging. Similar overdiagnosis “epidemics” have also occurred with more deliberate screening, such as breast and prostate cancers. But perhaps the largest growth has been in the disorders where we have changed the definition by moving the fuzzy dividing line between normal and abnormal, for condition such hypertension, diabetes, osteopenia, and obesity, where small changes in the boundaries have greatly expanded the proportion of the population labelled.

Changes are need at both health policy and clinical levels. The policy changes needed include both the “who” and “how” of changing disease definitions. Currently there are minimal agreed standards on the constitution of panels adding or altering the definitions of diseases, nor are there clear criteria for when it is reasonable to change disease definitions. We should be particularly careful not to label risk factors as diseases, for example by talking with patients about raised blood pressure not “hypertension”; “reduced bone thickness” not “osteoporosis”; “reduced kidney function” not “chronic kidney disease” as these labels alter patients expectations and choices. For guidelines, there are some specific strategies that may be helpful before, during, and after investigation. To minimize the chances of over-detection and incidentalomas, investigation and screening should be very selective and targeted. We also need to improve sharing the information and consequences of options with the patient – shared decision making.

16:00 Tuesday August 21st

Overdiagnosis 2.0 (Technology)

Chair – Carl Heneghan

A new era of overdiagnosis: Big data and precision medicine

Henrik Vogt is a Medical Doctor working at the General Practice Research Unit at the Institute of Community Medicine, NTNU who has also studied History of Science. Henrik’s Ph.D investigates what the up and coming field of Systems Medicine will mean for Primary Care.

With a purposefully broad and generalist educational background Henrik’s knowledge is a combination of a primarily scientific education (Medicine), a humanistic one (History and some Philosophy) and a pragmatic communicational one (Journalism).

Academically interested in why doctors think the way they do, and how this affects their practice (and vice versa). Also interested in the degree to which and how the theoretical foundations of medicine can incorporate both the natural scientific and humanistic worldviews...
in a comprehensive manner. In his own Ph.D project Henrik employs his own broad, educational background within the fields of General Practice and Community Medicine, which offer and need the most comprehensive (or “holistic”) and generalist approach to human beings and their health. This project is anchored to the needs of primary care doctors and their patients leading to investigate theoretical questions of special interest to them.

Henrik writes popular science articles and commentaries in the lay press in addition to part time work in a primary care practice. Read more at https://ntnu.edu/employees/henrik.vogt

We are entering a new era of screening and overdiagnosis. Driven by new technologies, a new medicine is emerging, based on genomics and other big data of unprecedented volume and variety. This is often called precision medicine or personalised medicine. One of its main promises is a revolution in individualized disease prevention, and to further increase medicine’s focus on the apparently, risk factors and early detection of disease. Such big data-based precision medicine will entail a massive, new form of screening ("screening version 2.0"). Medical screening has previously typically involved testing of one or a few variables, at a limited set of time-points on a select group of individuals. By contrast, screening 2.0 will be directed at everyone through ubiquitous technologies that bypass previous screening constraints, and, in terms of measurements, it will be both multi-level (from the molecular to the social), multi-dimensional (many variables), highly detailed (high resolution), and longitudinal (showing dynamic bodily changes over time). Drawing on examples from the first studies that explore such screening, this talk explains how the strategy is likely to aggravate overdiagnosis. Crucially, screening 2.0 will increase the sensitivity of testing, detecting whatever conditions are defined as abnormal or of unknown significance. Each human body will be made "transparent", and "everything" will be detected. At the same time, only a limited amount of these findings will actually lead to clinically manifest disease. It is explained how we cannot expect precision medicine to be precise enough to predict just which of the myriad of abnormalities will - and will not - manifest clinically, a situation which leads to a tsunami of overdiagnosis. Those working to prevent overdiagnosis should preemptively make big data screening a top priority, and those working to further personalised or precision medicine should recognize overdiagnosis as a key problem.

Big data: the inevitable statistical problem with overdiagnosis

Claus Ekstrøm, Professor, Department of Biostatistics at University of Copenhagen. Primary research interests within the fields of bioinformatics, statistical genetics, and genetic epidemiology. In particular, research has been centered on methods for linkage analysis and quantitative traits, linkage analysis and heterogeneity, analysis of genomewide association studies, environmental statistics, genetic marker error detection, and statistical models for genetic analysis of quantitative and qualitative traits measured on complex human families. Bioinformatics-related research involves functional data analysis, analysis of microarray experiments, image analysis of microarray scans, and integrated analysis of gene expression and metabolic profile data.

Disease risk predictions play a huge part in disease diagnoses and general health care. Consequently, the availability of large-scale, complex data forms the basis of an enticing utopian dream of being able to predict everything about everyone – if only we have enough data. However, the vast majority of disease predictions is not perfect and each diagnosis bear the risk of overdiagnosis even if the sensitivity and specificity of the individual diagnoses is high.

With population-wide screening programmes that include more and more diseases we will inevitably end up with as a population where everyone becomes overdiagnosed of something. In this talk we will discuss the statistical issues with large-scale data availability and screening programmes and how these programmes will result in increased overdiagnosis. Overdiagnosis will influence and bias survival statistics and will make it difficult to infer the optimal treatments effect.
Engaging diverse communities on the benefits and implications of genetic diagnosis

Johnny Kung, Director of New Initiatives
Personal Genetics Education Project (pgEd) has the role of helping expand the reach of pgEd to underserved communities in Boston and beyond, to ensure that all communities are engaged in important conversations about the implications and benefits of genetic technologies. He is broadly interested in the legal, ethical and policy issues at the interface of genetics and society, and worked with pgEd on classroom workshops and publications during his graduate studies. Johnny received his H.B.Sc. in Biochemistry from University of Toronto, and his Ph.D. in Developmental and Regenerative Biology from Harvard University, with a secondary field of study in Science, Technology and Society, as well as a certificate in Human Biology and Translational Medicine. Before returning to pgEd, he was a science writer and project manager for Science Education videos at the Journal of Visualized Experiments.

Advances in genetic technologies hold promises to bring major health benefits through the diagnosis, treatment and prevention of disease. At the same time, these technologies have personal, social, ethical and policy implications that need to be tackled by each individual and the whole society. For example, how do we make sure that users understand the meaning and broader implications of results obtained from increasingly popular consumer genetics products or prenatal genetic tests? Will these technologies work for everyone in ethnically-diverse populations? And, particularly in countries without universal healthcare, will these technologies be available and affordable for all who want to make use of them?

The Personal Genetics Education Project of Harvard Medical School (pgEd.org) is an on-the-ground effort to raise awareness and include all communities in conversations about genetic technologies. Over the past 12 years, pgEd has worked to bring conversations about genetics into schools, youth groups, libraries, museums, communities of faith, Congressional briefings, and television and film. This presentation will highlight some of the issues that pgEd focuses on, as well as our experience in engaging diverse communities, including those with historically-justified distrust of the biomedical establishment. The goal is for everyone, regardless of socioeconomic or educational background, cultural or religious affiliation, and ethnic or personal identity, to be able to make informed decisions for themselves and their families, and to voice their opinions as societal participants.

09:00 Wednesday August 22nd
Psychiatry and Overdiagnosis
Chair – Niels Saxtrup

“Confusing Sad, Mad, and Bad”

Allen Frances is an American psychiatrist best known for chairing the task force that produced the fourth revision of Diagnostic and Statistical Manual (DSM-IV), that was published in 1994, and for his critique of the current version, DSM-5. He warns that the expanding boundary of psychiatry is causing a diagnostic inflation that is swallowing up normality and that the over-treatment of the “worried well” is distracting attention from the core mission of treating the more severely ill. DSM-5 takes a strong step towards biomedical model in defining disease in psychiatry. However, Frances has said that “psychiatric diagnosis still relies exclusively on fallible subjective judgments rather than objective biological tests”.

There is no clear boundary distinguishing mental illness from either normality or bad behavior. This has led to the cruel paradox that we over-treat the worried well, while neglecting and criminalizing the severely ill. Twenty percent of adults in the United States use psychiatric drugs that often have been prescribed carelessly and without clear indication. Meanwhile, care for the severely ill is terribly underfunded- leading to their neglect (250,000 are homeless) and criminalization (350,000 are in jail). Also troubling is the increasing trend toward medicalizing all sorts of bad behavior. The NRA succeeded in distracting attention from gun control by misleadingly asserting that mental illness is responsible for most gun violence. Rapists are committed to psychiatric hospitals as a form of unconstitutional preventive detention. Sex abusers hide behind fake “sex addiction.” And mental health professionals have been all too ready to mislabel Donald Trump as mentally ill rather than simply corrupt and incompetent. Experience teaches that any DSM disorder that can be misused will be misused. By widening the definition of mental disorders, DSM-5 has made our creeping medicalization of life even worse.
Psychiatry and overdiagnosis: a sociological perspective!

Anders Petersen is a sociologist and associate professor at Aalborg University. He is the author of the book ‘Performance Society’ and has together with Svend Brinkmann edited the anthology ‘Diagnoser’.

This year, in the ICD-11, WHO is going to add a new diagnosis to the list of diagnoses, namely “prolonged grief disorder”. The implementation of this new diagnostic grief category will not only provide a unique opportunity for studying the on-going changes in the human conception on grief specifically – and suffering and happiness more generally – but also for addressing the consequences of this diagnostic category, such as medicalization, individualization and overdiagnosis.

In this talk I will present a sociological framework, in which this can be addressed. I start by outlining the contours of a historical context that supports the emergence of “prolonged grief disorder”, namely the societal embedding of a diagnostic culture. Seen through this analytical prism, it is only “natural” and “rational” that a phenomenon such as grief – that to many people is perceived as a natural reaction to loss – becomes a diagnostic category and hence something socially ordered and institutionally manageable. I then proceed to broadening the analytical scope by placing the emergence of the grief diagnosis in a wider societal development, which I refer to as the performance society. The medicalization and individualisation of grief that is materialised in the diagnosis is also an indicator of the norms and social rules that are heralded in the performance society. The medicalization and individualisation of grief that is materialised in the diagnosis is also an indicator of the norms and social rules that are heralded in the performance society. That is, social rules and norms that stipulate a particular way of perceiving what a human being ought to be. This, I finally argue, will possibly pave the way for the overdiagnosis of grief!

“Patient/citizen perspective - “stickiness” of psychiatric diagnoses: once you have one, you often cannot “unhave it” - Overdiagnosis of mental health conditions in everyday practice

Olga Runciman is the first and only psychologist in private practice in Denmark to specialize in psychosis. She is an international trainer and speaker, writer, campaigner, and artist. She is a co-founder of the Danish Hearing Voices network. She is a board member for a variety of organizations including Intervoice, Mad in America, The Danish Psychosocial Rehabilitation Organization and others. She is currently finishing her three-year open dialog education as a family therapist.

Olga views mental distress from a post-psychiatric perspective and does not believe there is a correct way to frame madness. She believes in opening up spaces where other perspectives can assume a valid role and does not seek to find solutions within psychiatry. Instead, she advocates that we should be moving beyond psychiatry, encouraging an acceptance that not all human problems can be grasped in a modernist technological manner.

As a postpsychiatric psychologist, Olga has helped many people taper off or withdraw from their psychiatric drugs and has built up extensive everyday knowledge on how to best help people who wish to do this.

Why is it almost impossible to ‘get rid of’ a psychiatric diagnosis especially one of the more severe ones? What happens when you do get a diagnosis and it proves to be unhelpful or even detrimental to ones health and you don’t want it? How does stigma and discrimination play a role in the experience of psychiatric diagnoses? Finally how to shed a psychiatric diagnosis that won’t unstick it’s self.

As someone who has been a psychiatric nurse, a patient and now a psychologist I will illuminate some of the consequences of what a diagnosis can do. I will do that from the perspective of the professional working within the realm of the psychiatric system and it’s diagnoses, as well as through the eyes of someone who has survived the diagnosis of ‘schizophrenia’. Schizophrenia is still typically viewed as a chronic and incurable brain disease with potentially devastating consequences for the person so labeled.
This will be done through true stories interspersed with factual data highlighting some of the dilemmas and alternatives that can be found within psychiatry and its diagnostic system.

16:00 Wednesday August 22nd

Overdiagnosis in Risk Prevention: Cardiovascular

Chair – Paul Glasziou

The tsunami of overdiagnosis in cardiovascular risk in general practice

Hálfdán Pétursson is an Icelandic medical doctor employed as a researcher at the General Practice Research Unit. Department of Public Health and General Practice, NTNU. He received his PhD degree in 2012 and his research field is mainly cardiovascular risk factors and guidelines. Halfdan is also a specialist trainee in general practice/family medicine in Gothenburg, Sweden.

Cardiovascular disease (CVD) is the leading cause of death in the World and a major cause of disability and healthcare expenditure. Therefore preventive measures are of great interest and value to societies as well as individuals – and the market is gigantic for commercial actors. But most risk factors for CVD are gradient ones and not dichotomic, making it challenging to specify the most optimal cut-offs for initiating preventive treatment, opening for a continuous debate on the matter as CVD risk can never be eliminated completely. But lowering thresholds, as has been a major trend in recent decades, inevitably increases the risk of overdiagnosis and overtreatment. And while exposing an ever increasing proportion of the population to treatment associated risks the expected beneficial effects decrease, making the benefit:harms ratio questionable for many. A recent example of this threshold-lowering was presented by the American College of Cardiology and associated organisations in November with new guidelines on blood pressure management, redefining hypertension as blood pressure above 130/80 mmHg instead of the previously accepted 140/90 cut-off, supported by a very questionable evidence-base.

CVD risk-lowering treatment of individuals is primarily managed in primary care and is a considerable part of the work of general practitioners (GPs). Thus, lowering thresholds can vastly increase the workload of GPs, deprioritising other health issues, both on a population basis as well as on the individual level. How does that affect the quality and efficiency of the primary care?

The aim of the presentation is to explore the tsunami of overdiagnosis in cardiovascular risk as seen from the GP’s perspective.

General health check to prevent cardiovascular diseases (CVD)

Torben Jørgensen is a doctor with many years’ experience in public health. Since 1997 he has been Chief Physician at the Research Centre for Prevention and Health, Capital Region of Denmark, Glostrup Hospital, where the research mainly deals with population-based epidemiology, clinical epidemiology and preventive health care/health promotion. Since 2007 Torben Jørgensen has been a Clinical Professor in preventive health care and health promotion at the University of Copenhagen.

Attempt to prevent CVD is a long line from identification of risk factors, over personalised interventional studies to the present-day situation where we all are part of a giant screening programme for CVD risk leading to overdiagnosis.

In the late 60’ies health professionals felt rather confident in which risk factors caused CVD. This initiated large-scale population based randomised trials testing the effect of multifactorial intervention on an individual level. The first long term results published in the 80’ies showed no effect on CVD morbidity and mortality. Few studies have even shown a deleterious effect.

As the finding were contrary to expectations a long number of risk scores were developed to better identify persons at high risk. Today we have 70 risk scores specific aimed for CVD, but only two are tested in clinical trials showing no effect on reduction in risk for CVD.

Despite the evidence, many countries have introduced systematic screening in the form of health check of the general population. If the guidelines for CVD prevention from the European Society of Cardiology is used in the general population, it shows that nearly half of the population should be offered medical treatment to prevent CVD.
Today societies are filled with un-systematic screening tests for individual risk factors (e.g. measurement of cholesterol and blood pressure in supermarkets); and daily life is filled with technologies telling us, whether we fulfil the recommendations for a healthy life (e.g. hours slept, number of steps, calories burned). We are close to fulfilling the vision described by the author Jules Romains in “Dr. Knox”, where we all become patients.

But there are more rational ways to reduce the burden of CVD in society.

The 2017 American College of Cardiology/American Heart Association Blood Pressure Guideline: Major Recommendations, Rationale, and Clinical Implications

Paul Whelton MB, MD, MSc, is an Irish-born American physician and scientist who has made seminal contributions to hypertension and kidney disease epidemiology. He also mentored numerous public health leaders including the deans of the schools of public health at Johns Hopkins (Michael Klag) and Columbia (Linda Fried). He currently serves as the Show Chwan Health Care System Endowed Chair in Global Public Health and a Clinical Professor in the Department of Epidemiology at the Tulane University School of Public Health and Tropical Medicine. He is the founding director of the Welch Center for Prevention, Epidemiology, and Clinical Research at Johns Hopkins University.

The American College of Cardiology (ACC) and American Heart Association (AHA) sponsored an adult blood pressure (BP) clinical practice guideline, published in November 2017. No writing committee member had a relationship with companies producing BP products. The guideline provides 106 recommendations characterized by importance and quality of the supporting evidence.

BP measurement accuracy and averaging are emphasized, as is out-of-office readings. Normal BP remains the same as in previous US guidelines but what was previously designated as prehypertension is classified as elevated or stage 1 hypertension (SBP 130–139 mm Hg or DBP 80–89 mm Hg). Average SBP ≥140 mm Hg or DBP ≥90 mm Hg is classified as stage 2 hypertension. The rationale for stage 1 hypertension was based on CVD risk and nonpharmacological/pharmacological treatment trials. Nonpharmacological treatment is recommended as a core strategy, with addition of antihypertensive medication for the approximately 30% of U.S. adults with stage 1 hypertension at high risk for atherosclerotic CVD (ASCVD), for adults with hypertension and diabetes or chronic kidney disease, for older noninstitutionalized ambulatory adults with a SBP ≥130 mm Hg, and for adults with stage 2 hypertension.

BP control rather than choice of therapy should be the focus during drug treatment. Diuretics (especially the long-acting agents), calcium channel blockers (CCB), angiotensin converting enzyme inhibitors (ACEI), and angiotensin receptor blockers (ARB) are acceptable as first-line drugs but most adults should be treated with combination therapy, especially African Americans and adults with stage 2 hypertension.

The BP goal during treatment of hypertension is a SBP <130 mm Hg and DBP <80 mm Hg (SBP <130 mm Hg in older adults). Several strategies are recommended to improve control of hypertension.

Adoption of the 2017 ACC/AHA BP guideline should substantially improve health for US adults. The guideline does not replace the need for sound clinical judgement.
SEMINAR - Henrik Dam Auditorium

Latest Evidence of Overdiagnosis in Pediatrics
11:00 Monday 20th August

Ricardo Quinonez¹, Eric Coon²
¹Baylor College of Medicine - Texas Children's Hospital, Houston, USA. ²University of Utah School of Medicine - Primary Children's Hospital, Salt Lake City, USA

While the message of overutilization has gained timely momentum in pediatrics, an important but largely missing component of the dialogue is overdiagnosis. The most well-known examples of overdiagnosis exist in adults (ie prostate cancer) and indeed adult medicine has recently focused entire journal issues (BMJ) and conferences on the topic. Yet, overdiagnosis is equally widespread in pediatrics, but largely unappreciated. The authors of this potential lecture published the first comprehensive review of overdiagnosis in pediatrics (https://www.ncbi.nlm.nih.gov/pubmed/25287462). It plagues some of the most frequent inpatient pediatric conditions, including asthma, bacteremia, hypoxia, bacteriuria, reflux, and aspiration, to name a few. The primary aim of this lecture is to review the evidence suggesting overdiagnosis in pediatrics. In particular we would aim to review of the latest evidence since the publication of our comprehensive review that supports certain diagnosis in pediatrics as overdiagnosed. From hypoxemia to otitis media, randomized controlled trials and other study types will be reviewed that support that overdiagnosis in pediatrics is not only prevalent but likely understudied. A challenge to healthcare professionals who take care of children will be proposed to increase awareness and study of overdiagnosis in pediatrics.

SEMINAR - Holst Auditorium

Moving Beyond Flexner: Evolving Medical Education to Stop Promoting Overdiagnosis
11:00 Monday 20th August

Allen Shaughnessy¹, David Slawson²
¹Tufts University School of Medicine, Boston, USA. ²University of North Carolina Chapel Hill, Carolinas HealthCare System, Charlotte, USA

The current paradigm for making medical care decisions often leads to overdiagnosis, overtreatment, and profound wasting of resources. It was introduced with the overhaul of medical training in the United States and Canada following the report to The Carnegie Foundation by Abraham Flexner in 1910. This report ushered in a rational approach to medical care, with decisions made based on careful understanding of pathophysiology rather than on empirical observation.

An evidence-based medicine approach to decision making challenges this tradition, requiring decision making to be based on empirical research results of demonstrated clinical benefit rather than on pathophysiologic reasoning. As a result, evidence-based medicine requires a paradigm shift: Instead of relying on “what ought to work,” it requires identifying “what has been shown to work.” This reorientation requires clinicians to appreciate the role of probability in medicine. It is only with understanding and appreciating roles of uncertainty and probability that the various interventions that lead to overdiagnosis and overtreatment can be dropped from one’s practice. However, for many clinicians inculcated into bio-mechanical reasoning to make medical decisions, embracing outcomes-based, probabilistic thinking requires a transformation in their worldview.

In this seminar, we will discuss the concept that probabilistic thinking is required to embrace evidence-based medicine, with the goal of moving beyond Flexner to evolve education to stop overdiagnosis and overtreatment decisions at their root. After this brief introduction to the concepts, we will divide attendees into small groups to address five issues where embracing probabilistic thinking can address issues of overdiagnosis, overtreatment, and overuse, including: 1) “Action Gone Awry” (harming people with the best of intentions); 2) “Innocent Bystanders“ (people affected by false positive results); 3) “Creating the Worried Well” (the effect of labeling); 4) “The Butterfly Effect” (the unanticipated and unintended consequences of our actions); and, 5) “Out of Oz” (the lure of wishful thinking).
### WORKSHOP - Henrik Dam Auditorium

**The Difficult Art of Un-Doing**

**11:00 Monday 20th August**

*John Brodersen¹, Iona Heath², Gisle Roksund³, Harald Sundby⁴, Elisabeth Swensen³*

¹University of Copenhagen, Copenhagen, Denmark. ²Barts Health NHS Trust, London, United Kingdom. ³Norwegian College of General Practice, Oslo, Norway. ⁴Norwegian University of Science and Technology, Trondheim, Norway.

The evidence for overdiagnosis and overtreatment within medicine is growing: across disciplines and across the globe. Clinicians and their patients must now face the challenge of integrating this new knowledge into the realities of their everyday practice and the numerous decisions about investigation, labelling and treatment that have to be taken. While patients seek more involvement and more balanced information, professionals too often struggle with lack of confidence and lack of political and legal support in proceeding slowly and carefully. While winding back the harms of too much medicine is a noble cause, the very real fear of making mistakes continues to push doctors, and perhaps especially younger colleagues, towards acting precipitately and unthinkingly.

This symposium will offer a theoretical framework for the “de-implementation” of both screening and treatments that cause harm or do not improve outcomes for patients. We will present new thinking and a new vocabulary for a new practice. We will then describe clinical examples from everyday general practice to demonstrate how new knowledge on overdiagnosis/overtreatment can be integrated within shared decision-making in the consultation. Finally there will be an interactive role play on overdiagnosis/overtreatment, based on experiences from teaching and training medical students at the University of Trondheim, Norway.

### SEMINAR - Meeting Room Two

**Introduction to Overdiagnosis: Session One**

**11:00 Monday 20th August**

*Julian Treadwell¹, Gemma Jacklyn², Rae Thomas³*

¹University of Oxford, Oxford, United Kingdom. ²University of Sydney, Sydney, Australia. ³Bond University, Queensland, Australia.

The first of two sessions introducing the major themes and concepts in Preventing Overdiagnosis is aimed at clinicians, researchers and lay delegates who are new to the field. We will present a broad overview with plenty of time for questions and discussion to equip you for the rest of the conference and more in-depth exploration.

### WORKSHOP - Meeting Room One

**PreventionPLUS: A Free Access Literature Awareness Portal That Surveilles High Quality Research and Guidelines to Inform the Harms and Benefits of Screening and Prevention Strategies in Healthcare**

**13:30 Monday 20th August**

*Eddy Lang¹, Samantha Craigie²*

¹University of Calgary, Calgary, Canada. ²McMaster University, Hamilton, Canada.

**Aims:** The scientific literature that addresses both screening and preventive healthcare is growing at an increasingly unmanageable pace. Thousands of potentially relevant publications, including clinical practice guidelines of varying methodologic rigor, emerge annually. Clinicians, policymakers and guideline developers can be challenged when it comes to staying abreast of this literature including the science that informs the risk of false positive testing, overdiagnosis and the repercussions of these that manifest as overtreatment, as well as the role of shared-decision making to mitigate those risks. The Canadian Task Force for Preventive Healthcare in collaboration with the Health Information Research Unit at McMaster University has launched a free access, interactive and customizable literature awareness resource called Prevention Premium Literature Service or PreventionPLUS. PreventionPLUS screens over 120 journals for studies meeting pre-defined criteria and sends candidate articles.
to a cadre of peer reviewers who evaluate each paper for relevance and newsworthiness with an option to provide critical analysis. Relevant research can be delivered to any email inbox in line with user preferences for topic, frequency and study relevance thresholds. This workshop aims to introduce this resource to those in attendance highlighting its functionality and value as the prime resource for scientific evidence and guidelines that inform the harms and benefits of screening and prevention. Please note a device with internet access is needed to take full advantage of this workshop.

Outcomes: At the completion of this workshop participants will become familiar with the methodology and configuration features of the PreventionPLUS website. In addition, using a case-based approach, those in attendance will be able to search the PreventionPLUS database for research that addresses specific aspects of screening and prevention. These include resources that provide insight as to the risks of false positive screening tests and overdiagnosis for cancer and other conditions, and studies and reviews that facilitate shared decision-making, and evaluate the provision of patient decision aids.

SEMINAR - Holst Auditorium

Imaging asymptomatic people: a framework addressing clinical governance improvement and regulatory compliance

13:30 Monday 20th August

John Brodersen¹, Steve Ebdon-Jackson², Juergen Griebel³, Jim Malone⁴, Frederik Martiny⁵, Maria del Rosario Perez⁵

¹University of Copenhagen, Copenhagen, Denmark. ²Public Health England (PHE), Oxford, United Kingdom. ³German Federal Office of Radiation Protection (BfS), Munich, Germany. ⁴Trinity College, Dublin, Ireland. ⁵World Health Organization (WHO), Geneva, Switzerland

The role of medical imaging is recognized universally when considering the provision of high quality and safe healthcare. For a diagnostic imaging procedure to be justified, a net benefit must be ensured by assessing the total benefit for the individual against the individual detriment that the exposure might cause. Computed tomography (CT) is increasingly utilized for individual health assessment (IHA) of asymptomatic people in a number of areas such as coronary artery calcium scoring, investigation of coronary artery plaques, early detection of lung and colon cancers, and whole-body CT surveys. When CT is performed in asymptomatic people as part of opportunistic screening, such as in the case of IHA practices, consideration should be given to both radiological and non-radiological components of the benefit-to-harm balance. The latter includes overdiagnosis, false positives, false negatives, indeterminate and incidental findings, health economics and ethical dilemmas, among others. Screening has an intuitive appeal as it relies on the assumption that early detection will result in better treatment options and thereby improve the prognosis for the screening participants. On the other hand, harms and misconceptions about screening, like overdiagnosis or lead-time bias, are counterintuitive and unfamiliar concepts to many people. These may result in people placing a one-sided emphasis on the benefit of screening while downplaying the harms and physicians being unable to evaluate if a screening procedure is beneficial, harmful or inappropriate. There is a need to implement a robust clinical governance framework of IHA practice using CT, including a comprehensive regulatory dimension to ensure that these procedures are performed as part of good medical practice. WHO is developing a guidance document proposing a framework for enhancing justification and improving the clinical governance of these IHA practices. The objective of this seminar is to present a draft WHO guidance document proposing a framework for enhancing justification and improving the clinical governance of IHA practices using CT and to collect feedback from the audience. The scope and purpose of the project will be described, the key elements of a framework for justification and clinical governance of IHA practice using CT will be summarized, and the content/format of the document will be presented. The audience’s feedback collected during this seminar will be taken during the development of the proposed guidance material. The expected outcome will be a better-informed WHO policy guidance document more relevant to an increased range of stakeholders.
SEMINAR - Meeting Room Two

Introduction to Overdiagnosis: Session two

13:30 Monday 20th August

Julian Treadwell¹, Jack O’Sullivan¹, Gemma Jacklyn²
¹University of Oxford, Oxford, United Kingdom. ²University of Sydney, Sydney, Australia

The second of two sessions introducing the major themes and concepts in Preventing Overdiagnosis is aimed at clinicians, researchers and lay delegates who are new to the field. We will present a broad overview with plenty of time for questions and discussion to equip you for the rest of the conference and more in-depth exploration.

Chair: Gemma Jacklyn

Session 2A: Expanding disease definitions and over treatment.
Julian Treadwell

Long term conditions like diabetes, chronic kidney disease and hypertension are all defined by thresholds decided by committees, often with conflicts of interest. This results in millions of people acquiring disease labels and often treatment which may be of low or no value to them and also risks harm.

We will discuss how this happens and how we might weigh up the benefits and risks for individuals.

Session 2B: Waste in test use - "Too much testing" Jack O’Sullivan

This session will describe what “too much testing” is and the strategies and challenges in trying to identify it. We will also discuss the drivers that lead to overtesting and its harms. Lastly, we will discuss incidentalomas – how often they occur and their eventual outcomes.

WORKSHOP - Meeting Room One

Overdiagnosis and overtreatment of infectious diseases in general practice. How and where to break the endless loop?

09:00 Tuesday 21st August

Gloria Cordoba¹, Sif Arnold¹, Malene Plejdrup Hansen², Julie Olesen¹, Maria Louise Veimer¹, Jette Nygaard³, Lars Bjerrum¹
¹University of Copenhagen, Copenhagen, Denmark. ²Aalborg University, Aalborg, Denmark. ³Herlev Hospital, Copenhagen, Denmark

Background: Uncertainty about the origin of symptoms is a frequent challenge faced by health professionals working in general practice. This uncertainty is caused by a complex interaction of factors related to the use and interpretation of diagnostic information triggering overdiagnosis and subsequently overprescription of antibiotics. Unnecessary use of antibiotics is the main driver for development of antimicrobial resistance; hence it is crucial to identify and understand the determinants for overdiagnosis if we are to curb the overprescription of antibiotics in patients seeking care in general practice.

Aim: To facilitate discussion and advance understanding of the determinants for overdiagnosis in patients seeking care in general practice with suspected respiratory and urinary tract infection.

Methodology: The didactic methods used in the workshop will be Case-based learning and the fish bowl technique to promote discussion and gradual participation of all attendees.

Program:

1. Lecture: Welcome and explanation of key concepts of the diagnostic process in respiratory and urinary tract infections in general practice – 15 minutes.

2. Clinical cases: this part will be divided into three sessions, in which a clinical case is presented, afterwards the fish-bowl technique is used to facilitate discussion – 60 minutes.

Two moderators will guide the discussion to secure that at least the following three key question are debated for each case:
What are the determinants of overdiagnosis or misdiagnosis in this case?

Can we find a solution?

Which knowledge is missing in order to find a solution to reduce overdiagnosis and the subsequent overtreatment?

Cases:
Diagnosis of urinary tract infections in the elderly
Diagnosis of acute lower respiratory tract infections
Diagnosis of sore throat as the main motive of consultation

Outcome: after this workshop the participants will be able to identify:

1. The challenges of the diagnostic process in the most common infectious diseases managed in general practice.
2. The drivers for overdiagnosis and subsequent overtreatment.
3. The potential solutions for reducing overdiagnosis.

SEMINAR – Henrik Dam Auditorium
Thyroid cancer screening: the impact of overdiagnosis in different scenarios
09:00 Tuesday 21st August

Salvatore Vaccarella¹, Filip Meheus¹, Andre Ibawi², Anssi Auvinen³, Juan Pablo Brito⁴, Seung Eun Jung⁵, Hyeong Sik Ahn⁶, Maria del Rosario Perez²
¹International Agency for Research on Cancer (IARC), Lyon, France.
²World Health Organization (WHO), Geneva, Switzerland.
³University of Tampere, Tampere, Finland.
⁴Mayo Clinic, Rochester, USA.
⁵Korean Society of Radiology (KSR), Seoul, Korea, Republic of.
⁶Korea University, Seoul, Korea, Republic of

Thyroid cancer is one of the most common cancers in young adults, and its incidence has drastically increased in the last years. Early detection of thyroid cancer reduces treatment morbidity and improves overall outcomes. Two distinct strategies can be used to detect cancer: either through early diagnosis of symptomatic cases or through opportunistic screening of populations without symptoms. Early diagnosis focuses on identifying symptomatic and clinically significant disease at an early stage. In contrast, cancer screening of asymptomatic populations is a more complex public health strategy aimed to identify unrecognized disease – a strategy that can cause harm, inappropriate health expenditures and inequities in health care. Opportunistic screening encompasses individual health assessments, case finding and spontaneous activities of surveillance.

The consequence of screening asymptomatic populations in thyroid cancer has been overdiagnosis, which is a public health concern in many high-income countries, and is emerging as a similar phenomenon in low- and middle-income countries. Despite accumulating evidence about overdiagnosis being a driving force for the observed increased incidence of thyroid cancer, the potential harms of overdiagnosis are not routinely considered in the development and implementation of policies and programmes on thyroid cancer screening.

This is also a concern regarding thyroid cancer screening in populations exposed to specific risk factors. The effect of mass screening using highly sensitive ultrasound technology on thyroid case finding (“screening effect”) has been reported in populations exposed to radioactive iodine following nuclear accidents.

Shared decision-making, a key component of integrated people-centred health care, is still not appropriately implemented and the discussions about the benefits and harms of thyroid cancer screening often do not consider overdiagnosis.

The purpose of this seminar is to review existing data and share country experiences regarding the magnitude and impact of overdiagnosis in different scenarios where thyroid cancer screening is implemented. The expected outcomes include the identification of research needs and possible approaches to prevent unnecessary harm due to overdiagnosis and overtreatment of thyroid cancer.
Julian Treadwell
Oxford University, Oxford, United Kingdom

Many of us – whether patients, clinicians or researchers – will be wishing to promote change in our health care systems to better address issues around overdiagnosis.

This needs engagement at all levels of the system and is challenging to achieve in this field, amid controversy and lack of funding.

How can we go about this? Can people at grassroots level make a difference? And how do we access and speak to those in power?

The UK Royal College of General Practitioners (RCGP) established a Standing Group on Overdiagnosis in 2014. A small group of enthusiasts has grown to a vibrant community of over 300 members including many GPs, but also specialists, researchers, lay members, international colleagues and senior figures in UK medical organisations. We have had successes, failures and frustrations but momentum continues to build.

Dr Julian Treadwell is Vice-Chair of this group and will facilitate this participatory workshop and present the story of the group so far.

Minna Johansson is a PhD student from Sweden working on overdiagnosis in screening programmes. She will introduce a discussion about strategies to handle sexism and personal attacks in a research context.

We would like to invite other PODC delegates to contribute to this session and tell their stories too, so that we can share lessons and experiences from different settings and build international connections.

If you would like to contribute to this session with a short informal presentation, please contact JT before or during the conference on email: julian.treadwell@phc.ox.ac.uk or twitter: @JulianTreadwell1

Or just come along on the day and join the discussion.

James McCormack¹, Jenny Doust², Catherine Bell³
¹University of British Columbia, Vancouver, Canada. ²Bond University, Gold Coast, Australia. ³University of Sydney, Sydney, Australia

Aims/background: Lab test results likely drive two-thirds to three-fourths of medical decisions. Unfortunately lab test reports rarely mention, or put into context, the analytic and biologic variation inherent with every result. This leads us in healthcare to, likely somewhat knowingly, sell preeminent precision even though we all know in our heart of hearts we can only deliver educated estimates.

Objectives: In this seminar we will

1. Outline the problem of lab test measurement and reporting and how it contributes to the overdiagnosis problem
2. Hopefully offer some useful tips and suggestions for how to deal with this extremely important and relevant healthcare conundrum

Methods: This seminar will introduce, via a series of brief presentations, the problem of lab value variation using examples of glucose, cholesterol, blood pressure, bone density and Vitamin D among others. We will then use interactive case studies to allow participants to learn and practice how to incorporate this issue into better shared-decision making with patients.

Conclusions: The problem with lab test variation is that it is not a fixable problem, it is only a knowable problem. Hopefully by the end of this session, participants will be armed with enough information to help them maneuver around this issue in an informed and practical manner.
**Good doctoring: ‘Core writings’ as an antidote to medical overactivity?**

14:00 Tuesday 21st August

Stefan Hjorleifsson¹,², Iona Heath³, Linn Getz⁴
¹University of Bergen, Bergen, Norway. ²Uni Health Research, Bergen, Norway. ³45 Canonbury Park South, N1 2JL, London, United Kingdom. ⁴Norwegian University of Science and Technology, Trondheim, Norway

**Background:** Rather than considering the state of medicine as a result of impersonal ‘scientific progress’, we must see ourselves as members of a reflective, responsible community in charge of continuously developing and re-thinking the field. And to counteract too much medicine, medical professionals need a fine blend of factual knowledge, critical reasoning skills, human sensitivity and courage.

A daunting challenge for future doctors will be to navigate an ocean of possibilities in terms of monitoring, testing, diagnoses and interventions. We believe competent adherence to a ‘less is more’ strategy can safeguard genuine medical needs and protect patients from excessive burdens of treatment, in a socially accountable manner (overall cost containment). However, this will not materialise simply from epidemiological analysis of harm accruing from medical overactivity. Good doctoring springs out of a complex maturation process which involves the breakdown of medical silo-thinking in favour of a generalist perspective where doctors interact with patients as whole persons in a wider context, zoom in on medical essentials, and deal compassionately and wisely with the fundamental uncertainties of human existence.

How can good, temperate doctoring be promoted? One answer might lie in stimulating, collective encounters with selected ‘core writings’ from the generalist medical literature. By core writings, we mean texts authored by professional role models who, from specific and recognizable perspectives, have identified viable principles of moderation and courage in solidarity with medicine’s moral mandate.

**Aim:** To explore the idea that well-tutored encounters with core generalist writings can help curb medical overactivity in an era of unprecedented belief in the powers of technology and overwhelming availability of medical (dis)information.

**Outcomes:** Raised awareness and moral purpose among participants to resist overuse in their different capacities as practitioners, policymakers, researchers, educators, etc.

**Format:** Brief plenary presentations focusing on how we currently use core generalist texts in Scandinavian general practice (family medicine) to nurture wisdom, moderation and courage. We will include examples from our own library that demonstrate what we believe characterises a core text and why we think it can have a significant, pedagogical impact. The main part of the workshop then involves discussions where participants share reflections, constructive critique and new ideas.

Examples of core generalist texts to curb medical overactivity include the writings of McCormick, Marmot, Tudor Hart, Greenhalgh, Gøtzsche, Malterud, Welch, Kirkengen and Gawande. However, our menu is still in the making, and new ideas are welcome. Please join in!

**Definition of multimorbidity and risk of overdiagnosis**

08:00 Wednesday 22nd August

Anne Møller, Tora Grauers Willadsen, Alexandra Brandt Ryborg Jönsson, Susanne Reventlow
Center for Research and Education in General Practice, Copenhagen, Denmark

The definition of multimorbidity has been discussed for several years, and research in this field is challenged by various definitions of multimorbidity. Inclusion of risk factors in the definition alongside more severe diseases is widely used, however, questioning the meaning of the concept of multimorbidity. Even though, both symptoms and severity are sometimes included in the broad definitions, the inclusion of risk factors could lead to overdiagnosis. Multimorbidity is rising, and there is a need to address the help to those most in need, but many of the current definitions increase the risk of targeting the wrong patients. Furthermore, diagnoses, including the diagnosis of multimorbidity, can have both positive and negative implications for a single patient. Some patients find identity in a diagnosis whereas others suffer from psychosocial side-effects of diagnoses.

In this seminar, we will introduce you to different definitions of
multimorbidity and risk of overdiagnosis in this field, and furthermore we will debate the positive and negative implications of diagnoses. Finally, we will invite you to a discussion about consequences of overdiagnosis working with multimorbidity in relation to patients, society, and future research.

**WORKSHOP - Meeting Room One**

**Policy and practice in the European countries regarding overdiagnosis and quaternary prevention**

08:00 Wednesday 22nd August

Johann Sigurdsson¹,², Mateja Bulc³, Seija Eskelinen⁴, Andrée Rochfort⁵, Anat Gaver⁶,⁷, Anna Stavdal⁸,⁹

¹Nordic Federation of General Practice, Reykjavik, Iceland. ²Dep of Public Health and Nursing. NTNU, Trondheim, Norway. ³EUROPREV Dpt of Family medicine, Medical Faculty of Ljubljana University and Ljubljana Community HealthCenter, Ljubljana, Slovenia. ⁴Self management department of Duodecim Medical Publications ltd. (Editor-in-Chief), Helsinki, Finland. ⁵EQuiP, Quality Improvement & Doctors Health in Practice Programme. Irish College of General Practitioners, Dublin, Ireland. ⁶The Israeli Society for the Prevention of Overdiagnosis and Overtreatment (ISROD), Tel Aviv, Israel. ⁷Dep of Family Medicine, Rabin Medical Center and Tel Aviv &Dan districts, Clalit Health Services, Tel Aviv, Israel. ⁸WONCA Europe (president), Oslo, Norway. ⁹Bolteløkka Legsenter, Oslo, Norway

**Objectives:** To get an overview on the policy and practice regarding overdiagnosis and related medical excess in our European countries. Secondly to analyse facilitating factors, barriers and possible actions taken on this matter such as avoidance of mitigation of harm from excessive or unnecessary health interventions

**Background:** It is generally agreed that problems related to "too much medicine", overdiagnosis and overtreatment are on the rise. Unwarranted medical activity leads to unnecessary waste of resources, more inequalities in healthcare and, at worst, direct harm to patients and healthy citizens. Examples include bacteria resistance from antibiotic overuse, over irradiation from excessive X-rays (over-investigation), complications from unnecessary procedures (overtreatment), mortality rise caused by polypharmacy and overtreatment at the intensive care units among terminal care patients. Therefore, health care stakeholders and others have taken initiatives to revert this evolution. Recently, the Nordic Countries and WONCA Europe, The World Organization of National Colleges and Academic bodies of family doctors in the European Region have agreed upon general position papers on this threat.

Methods and Learning issues: Presentations on an evaluation of overdiagnosis and overtreatment in different European countries, followed by critical case reports from selected countries.

**Questions to be discussed:**

- Is “too much medicine” an important part of doctors’ salaries?
- Does governmental initiatives to minimize overdiagnosis and overtreatment threaten the quality of health care?

Participants are invited to reflect on their own situation and challenged to indicate which actions can or cannot be taken.

**WORKSHOP - Meeting Room Two**

**How do we engage new health care providers (students and new practitioners) in initiatives to reduce overdiagnosis?**

08:00 Wednesday 22nd August

Frederik Martiny¹,², Julian Treadwell³,⁴, Anat Gaver⁵,⁶,⁷, James McCormack⁸

¹The Section of General Practice and the Research Unit for General Practice, Copenhagen, Denmark. ²The Research Unit for General Practice in Region Zealand, Soroe, Denmark. ³Royal College of General Practitioners Standing Group on Overdiagnosis, London, United Kingdom. ⁴Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, United Kingdom. ⁵the Israeli Society for the Prevention of Overdiagnosis and Overtreatment (ISROD), Tel Aviv, Israel. ⁶the Department of Family Medicine, Rabin Medical Center and Tel Aviv &Dan districts, Clalit Health Services, Tel Aviv, Israel. ⁷Sackler School of Medicine, Tel Aviv University, Tel Aviv, Israel. ⁸Faculty of Pharmaceutical Sciences, University of British Columbia, Vancouver, British Columbia, Canada

**Objectives:** Knowledge and understanding amongst health care providers is in many ways key to reducing the overdiagnosis problem. However, education about overdiagnosis and its causes is often scarce in health care curricula. At the same time, some of the drivers
of “too much medicine” (guidelines, fear of litigation, unwillingness to deviate from the norm) are ubiquitous in the clinical reality for young practitioners, as well as permeating much of the current healthcare education. Discussion and teaching about overdiagnosis thus risks conflicting with people’s preunderstanding of good clinical practice and/or the norm in the clinical setting where they practice. This may leave the impression that understanding the issues of overdiagnosis makes clinical practice more complicated and challenges existing practice. In the face of this challenge, the aim of this workshop is to explore ways to engage students and new practitioners in the prevention of overdiagnosis and reduce as much as possible the cognitive conflict.

**Our objectives are to identify:**

1. Ways to engage students and new practitioners in a concept that challenges prior beliefs about good clinical practice
2. Barriers for engaging people and how we might overcome these barriers
3. How the concepts of overdiagnosis should be integrated into healthcare curricula, and possibly be integrated into bed side education during clinical rotations
4. If we need a campaign or formal courses about overdiagnosis to change the status quo?

**Methods:** This workshop, will consist of 3–10 minute presentations from people with experience in engaging students and other health care providers about the problems of overdiagnosis. Participants will also be encouraged to share their own experiences and share ideas not covered in the presentations.

Following presentations, participants will be divided into small working groups. Each group will work on a unique aspects of the ideas that come up during presentations and the following debate. Subsequently each group will be encouraged to present their main conclusions for the other groups.

Both presentations and new ideas emerging during the workshop will be noted and shared with the participants following the workshop.

**Conclusions:** At the end of this session we want participants to share their take-home-messages, and have us all be inspired to go home, share their ideas, and the ideas of the group, and engage more people in reducing overdiagnosis.
SEMINAR - Meeting Room Two

Why is it so hard to stop overuse?

11:30 Wednesday 22nd August

Eva W Verkerk¹, R. Sacha Bhatia², Simone A van Dulmen¹, Rudolf B Kool¹
¹Radboud university medical center, Radboud Institute for Health Sciences, IQ healthcare, Nijmegen, Netherlands. ²Women's College Hospital Institute for Health Systems Solutions and Virtual Care, Women's College Hospital, Toronto, Canada

Objectives: Reducing low-value care improves quality of care and reduces waste of resources. However, achieving successful and sustainable de-implementation is a challenge as it is often hindered by several barriers. In addition, de-implementation strategies are often not tailored to the context and causes of the problem. These drivers of low-value care and barriers to de-implementation can be local or contextual, such as the organizational structure of a department, while others can be national or even global, such as patient and physician culture. We are eager to discuss the causes and solutions for this to set a global research agenda.

Aims:

• To discuss with participants why it is so hard to stop overuse
• To discuss the opportunities to tackle these barriers on a local, national and global level and set a global research agenda

Method: After an introduction on low-value care, Drs Verkerk will share the findings of a study on the drivers of low-value care in Canada, the US and the Netherlands. Next, Dr Bhatia will present his experiences with Choosing Wisely Canada the Echo-WISELY trial and why it was so hard to reduce inappropriate transthoracic echocardiograms. Dr Kool and Dr Van Dulmen will invite the participants to share their experiences with reducing overuse and will lead the discussion on the opportunities to tackle these barriers on a local, national and global level, to set a global research agenda.

Participants will:

• Gain insight in the drivers of low-value care and the barriers for de-implementation on local, national and global level, and how these interact

Conclusions: This seminar brings together the experiences of health care professionals, researchers and policy makers on reducing overuse. Together, we will discuss the problem with reducing overuse and the opportunities that we should seize on local, national and global level in order to improve the quality of care and reduce waste of resources.

SEMINAR - Meeting Room Two

What is the relationship between deviations, abnormalities, risk factors, pathologies and overdiagnosis?

14:00 Wednesday 22nd August

János Valery Gyuricza¹,², Jessica Malmqvist²,³, Frederik Martiny²,³, Anne Katrine Lykke Bie²,³, Sigrid Brisson Nielsen²,³, Manja Dahl Jensen²,³, John Brodersen²,³
¹Departamento de Medicina Preventiva da Faculdade de Medicina da Universidade de São Paulo, São Paulo, Brazil. ²Center for Research and Education in General Practice, Copenhagen, Denmark. ³The Research Unit for General Practice in Region Zealand, Copenhagen, Denmark

Disease definitions and treatment thresholds are often based on dichotomisation of continuous variables. Examples of these dilemmas are the definition of hypertension and the continuum of pathologies in polyps in colorectal cancer (CRC) screening. Continuous variables are a clinical dilemma since they make it difficult to determine when to diagnose and intervene. Dichotomisation requires per definition a threshold which results in an epidemiological dilemma: if the threshold is set too low, too many people are overdiagnosed and overtreated, whereas if the threshold is set too high, too many people are underdiagnosed and undertreated.

We will present empirical research on these dilemmas and then have a discussion on how to solve them. We will present research on the following dilemmas:
1. Increasing blood pressure levels are related to an increasing absolute risk of cardiovascular disease and mortality, and it is an oversimplification to determine who has hypertension based on a fixed threshold.

2. The threshold for an abnormal screening result partly determines the balance between benefits and harms in cancer screening. We will explore the implications fixed thresholds have for people using examples from CRC screening.

3. In CRC screening the detection and the definition of polyps as cancer precursors pose two dilemmas. These result in an increasing number of people being diagnostically labelled as a consequence of the spectrum of normality becoming narrower.

4. CRC screening consists of two parts: a faecal occult blood test and the following investigative colonoscopy. People who decline the colonoscopy after a positive faecal test find themselves in doubt, feeling healthy but with a positive result of screening.

5. With the increased use of PSA-blood tests the detection of low-grade prostate cancers has increased. Most of these low-grade cancers are indolent and will never cause harm by themselves, whereas there is a great diagnostic uncertainty when it comes to finding those few that will.

6. Citizen juries as a method for improving lay people’s understanding and eliciting their preferences in relation to harms and benefits of cancer screening. Cancer as a dichotomised variable as one of the most serious causes of harm.
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**POSTERS in Conversation**

Authors of Board Numbers 9 - 10 - 11 - 12 - 13 - 28 - 31 - 32 - 34 - 37 - 38 will be available for more indepth conversation over coffee and a pastry from 08:00 on Tuesday 21st & Wednesday 22nd.
Main themes:
- Core values
- Current challenges
- Changing practice