



**20–22 September 2016**

**BARCELONA**





# Agència de Qualitat i Avaluació Sanitàries de Catalunya

Preventing Overdiagnosis 2016 Conference Hosts

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HOLA I BENVINGUTS! HELLO AND WELCOME!

## to the 4th international conference on Preventing Overdiagnosis

We are delighted to welcome everyone to the conference here in Barcelona, and a warm thank you for coming. This year we have delegates attending from 30 countries, across all continents on earth. Overdiagnosis and overtreatment are challenges to all health systems around the world and this conference is a truly international collaborative event to address the important challenges facing all of us. Most of the conference will take place in English, but each day there will also be parallel sessions in Spanish. Together we will work to better understand the causes and consequences of overdiagnosis, and discuss a range of interventions to move forward with preventing it.

This year we'll have our first debate-style forum **Drawing the line between Health and Disease: who and how to define disease**. Don't miss this discussion of widening disease definitions as a key driver of overdiagnosis – and how things can and should be reformed.

We've also included new themes this year on **Genetics and genomic tests, and Ageing and deprescribing**. These topics feature in **New Frontiers** in overdiagnosis and overtreatment on Day 2. There is also a new theme on Cultural and existential drivers of overdiagnosis to keep our perspectives broad. On Day 3 we move forward **From Evidence to Action** amidst a plethora of parallel sessions on interventions to mitigate overdiagnosis.

We wouldn't be able to offer this conference without support from you the delegates and from our partners and associate partners – with very special thanks to our founding media-partner The BMJ – which has taken such a lead in publishing the science of too much medicine – and conference co-ordinator Ruth Davis.

Thanks also to the support of local Catalan & Spanish associate partners. We are especially grateful to the Agency for Health Quality and Assessment (AQuAS) of the Ministry of Health of the Government of Catalonia, an organization that is contributing to preventing overdiagnosis with its *Essencial* project to avoid low value clinical practices. Moreover, AQuAS has made huge contribution and put great effort into hosting this conference in Barcelona, a cosmopolitan city that you will enjoy so much that you will want to visit over and over again.

We very much hope you take advantage of this multi-disciplinary gathering to enjoy meeting each other and enjoy the science of this problem and its solutions. We are looking forward to meeting you. Together we will exchange our research on Preventing Overdiagnosis and work towards making our health systems safe, sustainable and successful, well into the future.

And speaking of the future, look out for the announcement of the venue for Preventing Overdiagnosis 2017.

Warmly,

**Scientific Program Co-chairs 2016: Dr Iona Heath, Professor Alex Barratt and Dr Ray Moynihan**

# PROGRAMME (DAY 1)

## Day 1 – Tuesday 20 September

<b>08:00</b>	<b>Registration – Entrance A</b>		
<b>Room 111/112</b> <b>08:45–09:00</b>	<b>Introduction</b> Toni Dedeu – Agency for Health Quality and Assessment of Catalonia (AQuAS)		
<b>Room 111/112</b> <b>09:00–10:30</b>	<b>Wider Perspectives on Overdiagnosis</b> CHAIR – Iona Heath Baruch Fischhoff – The Public Bulwark Nikola Biller Adorno – Overdiagnosis in the name of the patient – breaking the vicious circle Salvador Peiro – Talk title TBC		
<b>10:30–11:00</b>	<b>Break – FOYER</b>		
<b>11:00–12:40</b>	<b>Room 129</b> <b>Widening disease definitions that cause overdiagnosis</b> Oliver Senn: Appropriateness of bone density measurements in Switzerland: a cross-sectional study Benjamin Cook: Are Racial/Ethnic Disparities in Youth Psychotropic Medication Due to Overuse by Whites? The Relationship Between Psychological Impairment, Race/Ethnicity and Youth Psychotropic Medication Chisato Hamashima: Overdiagnosis on endoscopic screening for gastric cancer in Japan Robert Gelfand: Overdiagnosis of Overweight and Obesity: Cultural Dogma Trumps Evidence-Based Medicine Barbara Mintzes: Inadequate breast milk supply, a new epidemic? Bjørn Hofmann: The overdiagnosis of what? Barring the expansive conception of disease	<b>Room 130</b> <b>Genomics – unlimited potential for overdiagnosis? / Interventions to mitigate harms of overdiagnosis</b> Corine Mouton Dorey: Overdiagnosis and Big Data: An Ethical Perspective Pierre Massion: Molecular characterization for early stage lung adenocarcinoma Jodie Ingles: Impact of a positive hypertrophic cardiomyopathy gene result in asymptomatic family members: exploring potential for overdiagnosis due to genetic testing Per Henrik Zahl: Overdiagnosis of Clinically Irrelevant Cancers Henrik Vogt: Future screening: Predictive, preventive, personalized and participatory (P4) medicine meets a proactive quaternary (P4) prevention – an examination of visions and early results Gemma Jacklyn: Impact of extending screening mammography to older women: information to support informed choices	<b>Room 131</b> <b>Overuse and Economic consequences of overdiagnosis</b> Paul Levin: Penny Wise, Pound Foolish: The fifteen minute visit Claudia Wild: Appropriateness of MRI in Austria: identification of overuse Samanta Adomaviciute: Evaluation of the impact of Medical and Policy reviews in tackling overtreatment in musculoskeletal conditions using a predictive modelling approach Valentina Rapuano: Member Risk Model: a method to reduce over utilisation by predicting high cost claimants. Fátima Kang: Economic consequences of threatened preterm labor overdiagnosis Stephen Hall: Primary care physicians' over-utilization of medical tests and its association with cancer incidence and mortality

# PROGRAMME (DAY 1)

<p><b>11:00–12:40</b></p>	<p><b>Room 132</b></p> <p><b>Cultural and existential drivers of overdiagnosis/Other</b></p> <p><b>Pedro Pinto:</b> Attitudes of Portuguese women concerning breast cancer screening exams – A Population-Based Nationwide Cross-Sectional Study</p> <p><b>Chris Degeling:</b> Involving the Public in Preventing Overdiagnosis – community juries reason about the potential benefits and risks of PSA screening for prostate cancer</p> <p><b>Susann Schaffer:</b> Antibiotics for acute cough in general practice. Description of differences between high and low prescribers using claims data.</p> <p><b>Jack Bedeman:</b> Living on benefits: How cancer screening is portrayed in the UK national press Running title: 'Overdiagnosis coverage in the media'</p> <p><b>Phillipe Autier:</b> Mammography screening effectiveness and overdiagnosis in the Netherlands</p> <p><b>Yu Wang:</b> Reconsideration on General Health Checks in China: a Community-based Study from Beijing City on People's Understanding and Utilisation</p>	<p><b>Room 133</b></p> <p><b>Interventions to mitigate harms of overdiagnosis</b></p> <p><b>James Rickert:</b> An Innovative Patient-Centered Precertification and Data Collection Process for Total Joint Replacements</p> <p><b>Gaby Sroczynski:</b> Reducing Overtreatment associated with Overdiagnosis in Cervical Cancer Screening in Austria – A Decision-Analytic Benefit-Harm Analysis.</p> <p><b>Kathrin Schlößler:</b> A German Decision Aid to use within pre-screening discussions-A mixed methods study on patient and physician perspectives</p> <p><b>Ronen Bareket:</b> Schonberg index to Predict up to 9-year Mortality of Community-Dwelling Adults Aged 65 and Older - Validation for use with Electronic Medical Records in Israel</p> <p><b>John Hsu:</b> Reducing Use within Accountable Care Organizations</p> <p><b>Nikolai Mühlberger:</b> The benefit-harm balance of prostate cancer screening – A decision-analytic view on screening with and without active surveillance considering overdiagnosis and overtreatment</p>	<p><b>Room 134</b></p> <p><b>SPANISH Session</b></p> <p><b>Juan Víctor Ariel Franco:</b> Identification of medication discrepancies and potentially inadequate prescriptions in elderly adults with polypharmacy</p> <p><b>Mara Sempere Manuel:</b> Intervención para mejorar el uso de benzodicepinas en un departamento de salud</p> <p><b>Núria Molist:</b> Results of Application, a Patient-centered Prescription Model Assessing the Appropriateness of chronic Drug therapy in Older Patients</p> <p><b>Roser Vallès Fernández:</b> Deprescribir Farmácos que no Aportan Beneficio al Patient</p> <p><b>Marcella Marinelli:</b> Análisis de coste efectividad y de los daños causados por sobrediagnósticos de un programa de cribado de aneurismas de aorta abdominal</p> <p><b>Karla Salas Gama:</b> Analysis of the appropriateness of ambulatory prostate-specific antigen (PSA) test requests in a tertiary hospital in Barcelona.</p> <p><b>Carolina Requeijo Lorenzo:</b> Racionalización de la demanda de electroforesis de proteínas séricas</p>
<p><b>12:40–13:30</b></p>	<p><b>3 Minute Elevator Pitches – Room 111/112</b></p>		
<p><b>13:30–14:15</b></p>	<p><b>Lunch – Level 2 Room 211/212</b></p>		
<p><b>14:15–15:45</b></p>	<p><b>Workshop 1 – Room 129</b></p> <p><b>Barbara Dunn:</b> Overdiagnosis in Genetic Screening</p> <p><b>Seminar 1 – Room 132</b></p> <p><b>Saurabh Jha &amp; Suyash Mohan:</b> Overdiagnosis and Radiologists: Can the Arsonists become the Firefighters?</p>	<p><b>Workshop 2 – Room 130</b></p> <p><b>Ruth Etzioni:</b> Navigating your way through the methods minefield of cancer overdiagnosis – and emerging whole</p> <p><b>Seminar 2 – Room 133</b></p> <p><b>Gary Schwitzer:</b> Pernicious Promotion of Overdiagnosis: Public Relations News Releases</p>	<p><b>Workshop 3 – Room 131</b></p> <p><b>Corinna Schaefer:</b> Why is it so hard to understand? The challenge of communicating overdiagnosis to people facing screening decisions</p> <p><b>Seminar 3 – Room 134</b></p> <p><b>David Warriner:</b> Defining response and reducing harms from clinical therapies – lessons from cardiac resynchronization therapy</p>
<p><b>15:45–16:15</b></p>	<p><b>Break – FOYER</b></p>		
<p><b>Room 111/112</b> <b>16:15–17:30</b></p>	<p><b>Debate – Drawing the line between Health and Disease: who and how to define disease?</b></p> <p><b>CHAIR – Alex Barratt</b></p> <p><b>Paul Glasziou –</b> Centre for Research in Evidence-Based Practice, Bond University</p> <p><b>Mónica Cavagna Guerrero –</b> The Organisation of Consumers and Users</p> <p><b>Laragh Gollooly –</b> World Health Organization</p>		

# PROGRAMME (DAY 2)

## Day 2 – Wednesday 21 September

<b>08:00</b>	<b>Registration – Entrance A</b>			
<b>08:00–09:00</b>	<b>Breakfast Session Room 129</b> Helen MacDonald, BMJ Tips on Publishing on Overdiagnosis			
<b>Room 111/112</b>	<b>New Frontiers in Overdiagnosis</b>			
<b>09:15–10:15</b>	<b>CHAIR – Helen MacDonald</b> Chris Semsarian – Cardiac Genomics and the Potential for Overdiagnosis Carol Brayne – Dementia and ageing brains: the clash of evidence, belief and policy in diagnosis and capacity to benefit in our ageing populations.			
<b>10:15–10:45</b>	<b>Break – FOYER</b>			
<b>10:45–12:15</b>	<b>PANEL SESSION Room 111/112</b>  <b>Undiagnosing and Deprescribing: a special session on Ageing and Overdiagnosis</b>  <b>CHAIR – Carol Brayne</b>  David Le Couteur – University of Sydney  Anna Renom Guiteras – University Hospital Parc de Salut Mar  Tim Lambert – University of Sydney  Mirko Petrovic – Universiteit Gent	<b>Workshop 4 – Room 132</b>  <b>Kevin Somerville:</b> Overdiagnosis and overinvestigation as issues for life and living benefits insurance	<b>Workshop 5 – Room 133</b>  <b>Teppo Järvinen:</b> Fracturing a Frail Definition: A Cutting-Edge Social Media Movement to Dismantle an Overtreatment-Causing Definition	<b>Workshop 6 – Room 134 (SPANISH Session)</b>  <b>Juan Víctor Ariel Franco:</b> Sobrediagnóstico y toma de decisiones compartidas
<b>12:15–12:45</b>	<b>3 Minute Elevator Pitches – Room 111/112</b>			
<b>12:45–13:30</b>	<b>Lunch – LEVEL 2 Room 211/212</b>			

# PROGRAMME (DAY 2)

<p><b>13:30–15:00</b></p>	<p><b>Room 129</b></p> <p><b>Widening disease definitions that cause overdiagnosis</b></p> <p><b>Samuel Finnikin:</b> A THIN database investigation into cardiovascular risk scoring and the prescribing of statins in UK General Practice</p> <p><b>Peter Whitehouse:</b> Amyloid PET Scans: another expensive imaging test we don't need?</p> <p><b>Dawnelle Topstad:</b> An escalating thyroid cancer epidemic in Canada from over-diagnosis: national data analysis from 1992–2013</p> <p><b>Barbara Mintzes:</b> Pharmaceutical industry-funded education on overdiagnosed conditions</p> <p><b>Tessa Copp:</b> Impact of the Polycystic Ovary Syndrome (PCOS) disease label on medical decision making and psychosocial outcomes</p> <p><b>Brett Thombs:</b> There is not evidence that “screening” with self-report questionnaires for presently experienced health problems and symptoms improves health: a review of randomized controlled trials included in major screening guidelines and recommendations</p>	<p><b>Room 130</b></p> <p><b>Ageing: overdiagnosis, dediagnostics and deprescribing</b></p> <p><b>Caterina Vicens:</b> Evaluation of a multifactorial intervention to reduce the consumption of benzodiazepines in primary care. A randomized cluster clinical trial</p> <p><b>Kristen Anderson:</b> Why we fail to act – perspectives of general practitioners and consultant pharmacists on deprescribing in primary care</p> <p><b>Jesse Jansen:</b> Reducing inappropriate use of multiple medicines (polypharmacy) in older people: pilot study of a communication tool to support decision making</p> <p><b>Johanna Caro Mendivelso:</b> Impact of ESSENCIAL recommendations in primary care</p> <p><b>Kristie Weir:</b> Shared decision making about multiple medicines: the attitudes and experiences of healthy and frail older adults and their companions</p> <p><b>Eric Geijteman:</b> Opinions of physicians on discontinuation of medications at the end of life: a questionnaire study</p>	<p><b>Room 131</b></p> <p><b>Interventions to mitigate harms of overdiagnosis</b></p> <p><b>Minna Johansson:</b> Methodological challenges in quantifying overdiagnosis in organized screening for abdominal aortic aneurysm using Swedish registry data</p> <p><b>Rachelle Buchbinder:</b> Consumer information about knee arthroscopy: a review of written patient information provided by clinicians or easily accessible via the internet in Australia</p> <p><b>Chris Degeling:</b> Shared decision making and PSA screening for prostate cancer: all care, but whose responsibility?</p> <p><b>Jolyn Hersch:</b> 12-month follow-up effects of over-detection information in a breast screening decision aid trial</p> <p><b>Eric Coon:</b> Trends of head CT imaging, detection of intracranial bleeding and skull fractures, and outcomes in pediatric isolated head injury</p> <p><b>Moriah Ellen:</b> Addressing ‘waste’ in health systems through disinvestment: a critical interpretive synthesis</p>	<p><b>Room 132</b></p> <p><b>Interventions to mitigate harms of overdiagnosis</b></p> <p><b>Simon Deblois:</b> A systematic review of the interventions aiming at reducing the overuse of diagnostic imaging in the emergency department and inpatient settings when a pulmonary embolism is suspected</p> <p><b>Hadeel Nimaa:</b> Overtreatment of polyps in low risk groups</p> <p><b>Lorette Stammen:</b> Training physicians to provide high-value, cost-conscious care</p> <p><b>Aaron Lear:</b> Does following guidelines for patients admitted to hospital with low risk chest pain lead to unnecessary stress testing and coronary angiography?</p> <p><b>Marleine Azar:</b> Transparency of outcome reporting and trial registration of randomized controlled trials of non-regulated health interventions</p>
	<p><b>Workshop 7 – Room 133</b></p> <p><b>Wynne Norton:</b> De-Implementation: Exploring Multi-Level Strategies for Reducing Overdiagnosis and Overtreatment</p>		<p><b>Workshop 8 – Room 134</b></p> <p>(SPANISH Session)</p> <p><b>Beatriz Gonzalez:</b> Iatrogenics by SESPAS*</p>	
<p><b>15:00–15:30</b></p>	<p><b>Break – FOYER</b></p>			

# PROGRAMME (DAY 2)

15:30–17:15	<p><b>Room 129</b></p> <p><b>Widening disease definitions that cause overdiagnosis</b></p> <p><b>Eric Coon:</b> Overdiagnosis of coronary artery abnormalities among children with Kawasaki Disease</p> <p><b>Cristina Colis:</b> Actors and factors influencing treatment with drugs for attention deficit and hyperactivity disorder (ADHD)</p> <p><b>Rae Thomas:</b> Overdiagnosis of osteoporosis? Views of Australian women in community focus groups</p> <p><b>Jenny Doust:</b> Are we overdiagnosing myocardial infarction?</p> <p><b>Kuniyoshi Hayashi:</b> Measurement error of HbA<sub>1c</sub> for screening diabetes among healthy Japanese adults</p> <p><b>Joan Escarrabill:</b> Variability in home respiratory therapies in Catalonia</p>	<p><b>Room 130</b></p> <p><b>Interventions to mitigate harms of overdiagnosis</b></p> <p><b>Montserrat Rue:</b> Towards a better paradigm for breast cancer screening: establishing risk-based strategies and informing women and health professionals about benefits and harms</p> <p><b>Ian Scott:</b> Underuse of risk assessment and overuse of CTPA in patients with suspected pulmonary thromboembolism</p> <p><b>Ian Scott:</b> Unnecessary hospitalization and investigation of low risk patients presenting to hospital with chest pain</p> <p><b>Merce Obach:</b> QPI tool: an intervention in primary care to enhance prescription quality</p> <p><b>Charlotte Lunde:</b> The making of a patient: an analysis of a neuropaediatric patient's case (informed consent given)</p> <p><b>Donatella Sghedoni:</b> "Doing more does not mean doing better" Project: Italian Diabetologists' Association (AMD) take the opportunity to promote overdiagnosis and overtreatment</p>	<p><b>Room 131</b></p> <p><b>Interventions to mitigate harms of overdiagnosis</b></p> <p><b>Brooke Nickel:</b> Words do matter: a systematic review on how different terminology for the same condition influences treatment decision making</p> <p><b>Carlo Liverani:</b> Inappropriate use of HPV testing among Italian gynecologists</p> <p><b>Dennis Fechtelpeter:</b> A decision aid for mammography screening in Germany – development of information about overdiagnosis</p> <p><b>Gari Blumberg:</b> Who chooses laboratory tests? The physician or the computer?</p> <p><b>Uri Goldberg:</b> Two year sustainability of an educational intervention to reduce unnecessary stress ulcer prophylaxis</p> <p><b>Timothy Wilt:</b> Clinical guidelines and recommendations from the American College of Physicians: their role in improving health care value and reducing overdiagnosis</p> <p><b>Niklas Bobrovitz:</b> Interventions to reduce unscheduled hospital admissions among adults: an overview of systemic reviews.</p>	<p><b>Room 132</b></p> <p><b>Hot topics in overdiagnosis: cancer screening and end of life care</b></p> <p><b>Sian Taylor-Phillips:</b> Evaluating potential overdiagnosis in population screening programmes: systematic review comparing evidence review methods in 15 countries</p> <p><b>Jason Oke:</b> Estimates of excess cancer incidence and cancer deaths avoided in Great Britain from 1980–2012: the potential for overdiagnosis</p> <p><b>Jaume Galceran:</b> Estimation of the effect of prostate-specific antigen (PSA) test on prostate cancer incidence, survival and prevalence in Tarragona, Spain</p> <p><b>Cinzia Colombo:</b> Four citizen juries on screenings in Italy: an effective method to inform health-care policy decisions. The experiences on prostate cancer and cystic fibrosis carrier screening</p> <p><b>Pamela Marcus:</b> Cancer overdiagnosis: discussing our disagreements</p> <p><b>Philippe Autier:</b> Effectiveness of lung cancer screening with low-dose computed tomography: a systematic review and meta-analysis</p>
	<p><b>Workshop 9 – Room 133</b></p> <p><b>Amitava Banerjee:</b> Big data-part of the problem of over-diagnosis or part of the solution?</p>		<p><b>Seminar 4 – Room 134</b></p> <p><b>James McCormack, Paul Glasziou, Richard Lehman, Alan Cassels &amp; John Yudkin:</b> How clinical practice guidelines for chronic disease prevention could reduce overdiagnosis instead of promoting overdiagnosis</p>	
20:00	SOCIAL			

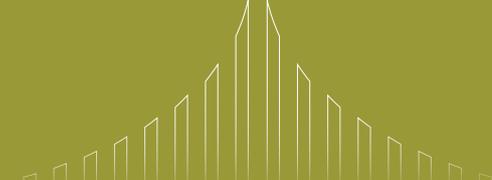
## Day 3 – Thursday 22 September

<b>08:00</b>	<b>Registration – Entrance A</b>		
<b>Room 111/112</b> <b>09:00–10:30</b>	<p><b>Moving from Evidence to Action</b>  <b>CHAIR – Steve Woloshin &amp; Lisa Schwartz</b>  <b>Cari Almazan</b> – How to avoid unnecessary interventions in primary care  <b>William C Black</b> – New radiologic reporting and management guidelines for screening and incidental detection  <b>Catherine Calderwood</b> – Realising Realistic Medicine to address over-diagnosis                      Followed by 30 min panel and audience discussion about interventions</p>		
<b>10:30–11:00</b>	<b>Break – FOYER</b>		
<b>11:00–12:30</b>	<p><b>Room 129</b>  <b>Widening disease definitions that cause overdiagnosis</b>  <b>Jarno Rutanen:</b> Differences in disease definition across medical specialties  <b>Paula Byrne:</b> Who is prescribed statins and why? Cross sectional analysis of cardiovascular risk and socio-demographic factors influencing statin prescription from The Irish Longitudinal Study on Ageing  <b>Teresa Leonardo Alves:</b> Exposure to disease awareness campaigns in printed and online media in Latvia  <b>Kevin Jenniskens:</b> Methodological challenges for overdiagnosis: what's out there?  <b>Cynthia Feltner:</b> Quantifying overdiagnosis in serologic screening for genital herpes: barriers and future research needs  <b>Kari Tikkinen:</b> The concept of psychiatric disease: public, health professional, and legislator perspectives</p>	<p><b>Room 130</b>  <b>Socio-cultural and existential drivers of over diagnosis</b>  <b>Minna Johansson:</b> “Informed choice” in a time of too much medicine - no panacea for ethical dilemmas  <b>Carl Tagesson:</b> Fear of the dark: tendency to overuse CT-imaging of the aorta in search for an explanation of unclear chest pain  <b>Brooke Nickel:</b> Stories of overdiagnosis: men’s experiences of choosing not to have surgery for prostate cancer  <b>Carlos Zegarra:</b> Attitudes, perceptions and awareness concerning quaternary prevention among family doctors working in the Social Security system, Peru  <b>Vincent Doria-Rose:</b> The US PROSPR Research Network: a Platform for Studying Overdiagnosis in the Community Setting  <b>Agnish Nayak:</b> What is the evidence for legacy effects of statins? A systematic review</p>	<p><b>Room 131</b>  <b>Socio-cultural and existential drivers of over diagnosis</b>  <b>Paul Glasziou:</b> Prevalence of differentiated thyroid cancer in autopsy studies over six decades: a meta-analysis  <b>Elizabeth Thomas:</b> Prevalence of incidental breast cancer and precursor lesions in autopsy studies: a systematic review  <b>Ian Scott:</b> The elephants in the room – the role of cognitive biases in overdiagnosis and overtreatment  <b>Astridur Stefansdottir:</b> Why are fat people the focus of medical attention?  <b>Beth Tarini:</b> Chronic fatigue or myalig encephalomyelitis – how disease labels affect perceived need for treatment</p>

# PROGRAMME (DAY 3)

<p><b>11:00–12:30</b></p>	<p><b>Room 132</b></p> <p><b>Interventions to mitigate harms of Overdiagnosis</b></p> <p><b>David Henry:</b> Impact of delisting diagnostic imaging studies for uncomplicated low back pain in Ontario</p> <p><b>Dan Reuland:</b> Effects of a lung cancer screening decision aid on overdiagnosis knowledge and screening intent in primary care patients</p> <p><b>Donatella Sghedoni:</b> “Doing more does not mean do better” Project: some ambiguities may not prevent overdiagnosis and overtreatment</p> <p><b>Stuart Hogarth:</b> Overdiagnosis and the progress of diagnostic reform</p> <p><b>Anne Katrine Bie:</b> Why do some colorectal cancer screening participants choose not to undergo colonoscopy following a positive test result?</p> <p><b>Luca Iaboli:</b> Doctor G: a graphic medicine project promoting statistical literacy to contrast overdiagnosis</p> <p><b>Monika Nothacker:</b> Gemeinsam Klug Entscheiden. Choosing wisely – together. An initiative of the Association of the Medical Scientific Societies (AWMF) and its member societies in Germany</p>	<p><b>Room 133</b></p> <p><b>Interventions to mitigate harms of Overdiagnosis</b></p> <p><b>Natalie Armstrong:</b> Trial participation as a strategy to avoid over-diagnosis</p> <p><b>Stephen Hall:</b> What are the indications for and the implications of ordering a diagnostic neck ultrasound examination?</p> <p><b>Christiana Naaktgeboren:</b> Preventing overdiagnosis through the de-implementation of low-value diagnostic tests: a systematic review</p> <p><b>Jeffrey Kullgren:</b> Commitment to Choosing Wisely is a low cost, scalable strategy that can decrease clinician ordering of services that can lead to overdiagnosis</p> <p><b>Jayant Vaidya:</b> The TARGIT trial and the chance confirmation of the hazards of over-diagnosis when screening for breast cancer</p> <p><b>Anat Gaver:</b> The Israeli Society for the Reduction of Overdiagnosis (ISROD) – Foundation and Challenges</p>	<p><b>Room 134</b></p> <p><b>SPANISH Session</b></p> <p><b>Oscar Garcia Gimeno:</b> Promoción del Right Care en un Centro de Atención Primaria</p> <p><b>Mercè Marzo:</b> Oportunidades para aumentar el valor de nuestras intervenciones: Recomendaciones NO HACER de semFYC</p> <p><b>Jacobo Mendioroz:</b> Diagnostic quality standards: reducing overdiagnosis in primary health care</p> <p><b>Jacobo Mendioroz:</b> Prescription quality standards (PQS): reducing overtreatment in primary health care</p> <p><b>Roser Vallès Fernández:</b> implementación del proyecto esencial en atención primaria: un proyecto multidisciplinar</p> <p><b>Antonio Sánchez Hidalgo:</b> Objective criteria for ordering cardiac stress tests to reduce overdiagnosis of ischemic heart disease</p> <p><b>Marcella Marinelli:</b> Atlas de variaciones de la práctica clínica: ¿una herramienta para identificar posible sobre o infra-tratamiento? El caso de las artroplastias en Catalunya</p>
<p><b>12:30–13:10</b></p>	<p><b>3 Minute Elevator Pitches – Room 111/112</b></p>		
<p><b>13:00–13:45</b></p>	<p><b>Lunch – LEVEL 2 Room 211/212</b></p>		

# PROGRAMME (DAY 3)



<p><b>13:45–15:15</b></p>	<p><b>Room 129</b></p> <p><b>Overuse and Economic consequences of overdiagnosis</b></p> <p><b>William Hrushesky:</b> Mammographic Screening for Breast Cancer and PSA Testing for Prostate Cancer: Damaging and Wasteful Symmetry</p> <p><b>Jessica Malmqvist:</b> Costs of the Danish national colorectal cancer screening programme</p> <p><b>Fiona Miller:</b> Informally regulated innovation systems: Challenges for responsible innovation in diagnostics</p> <p><b>Lindy Willmott:</b> Reasons doctors provide 'futile' treatment at the end of life: a qualitative study</p> <p><b>Willian Hrushesky:</b> Over-treatment of Overdiagnosed Ductal Carcinoma in Situ (DCIS): Less is More</p>	<p><b>Workshop 10 – Room 130</b></p> <p><b>Molecular and Cellular Characterization of Screen-Detected Lesions</b></p> <p><b>Jim Brooks:</b> Cancer screening and the Challenges of Over-diagnosis and Over-treatment</p> <p><b>Laura Esserman:</b> Unlocking the Mystery of Overdiagnosis: Implication for Early Detection</p> <p><b>Sudhir Srivastava:</b> Research Directions to Understanding Overdiagnosis: Biology of Screen-detected vs Symptom-detected Cancer</p>	<p><b>Seminar 5 – Room 131</b></p> <p><b>Jessica Otte:</b> Around the world in 80 names: Exploring global variation in terminology pertaining to 'preventing overdiagnosis'</p>	<p><b>Seminar 6 – Room132</b></p> <p><b>Martin Whitely:</b> The rise and fall of ADHD in Perth Western Australia – lessons learned in isolation</p>
<p><b>Room 111/112</b> <b>15:15–16:00</b></p>	<p><b>CHAIR – Paul Glasziou</b></p> <p><b>Carl Heneghan:</b> Journey to understanding overdiagnosis and too much medicine</p> <p><b>Hugo Veins:</b> Overdiagnosis and the medical profession; Time for a new social contract</p> <p><b>Closing remarks</b></p>			
<p><b>16:00</b></p>	<p><b>Networking coffee – Safe journey home – FOYER</b></p>			

# HOW TO GET TO AND FROM CCIB



## **TO AND FROM THE AIRPORT**

The international airport, Aeroport del Prat, is located 13 km south-west of Barcelona and 20 km from the CCIB.

The highway C-31 directly connects the airport with Barcelona. To enter the city, the most direct routes to the city center are Avinguda Diagonal and Gran Via and also Ronda de Dalt and Ronda Litoral, which surround the city.

## **AEROBUS**

The bus service between the airport and the center of Barcelona (Plaça Catalunya) runs from 6:00 to 1:00 (to Barcelona) and from 5:30 to 0:15 (to the airport) every day.

The bus frequency is one every 10–12 minutes and the journey time is around 30 minutes.

## **TAXI**

The taxi ride takes about 20 minutes. The rates change depending on the schedule.

There is a large taxi rank directly outside the airport and also on Pl de Llevant to the rear of the convention centre

**Baruch Fischhoff** is Howard Heinz University Professor, Department of Engineering and Public Policy and Department of Social and Decision Sciences, Carnegie Mellon University, where he heads the Decision Sciences major. A graduate of the Detroit Public Schools, he holds a BS (mathematics, psychology) from Wayne State University and a PhD (psychology) from the Hebrew University of Jerusalem. He is a member of the National Academy of Medicine and has served on many NAS/NRC/IOM committees. He is past President of the Society for Judgment and Decision Making and of the Society for Risk Analysis. He chaired the Food and Drug Administration Risk Communication Advisory Committee and has been a member of the Eugene Commission on the Rights of Women, the Department of Homeland Security Science and Technology Advisory Committee and the Environmental Protection Agency Scientific Advisory Board, where he chaired the Homeland Security Advisory Committee. His books include *Acceptable Risk, Risk: A Very Short Introduction, Judgment and Decision Making, A Two-State Solution in the Middle East, Counting Civilian Casualties, and Communicating Risks and Benefits*. He co-chaired two National Academy Sackler Colloquia on the Science of Science Communication, with associated special issues of the Proceedings of the National Academy of Sciences. A recent review is Fischhoff, B. (2015). The realities of risk-cost-benefit analysis. *Science*, 350(6260), 527. <http://dx.doi.org/10.1126/science.aaa6516>

[www.cmu.edu/dietrich/sds/people/faculty/baruch-fischhoff.html](http://www.cmu.edu/dietrich/sds/people/faculty/baruch-fischhoff.html)

**Dr Nikola Biller-Andorno** directs the Institute of Biomedical Ethics and History of Medicine, University of Zurich, Switzerland, which serves as WHO Collaborating Centre for Bioethics. She co-leads the PhD program “Biomedical Ethics and Law” and serves a member of the Central Ethics Committee of the Swiss Academy of Medical Sciences and as Vice-President of the Clinical Ethics Committee of the University Hospital Zurich. She is also a member of the Research Ethics Committee of the Federal Institute of Technology Zurich, and an expert adviser

to the Swiss Medical Board, an HTA agency providing clinical and cost effectiveness analyses of diagnostic and therapeutic interventions. From 2009 to 2011 she acted as President of the International Association of Bioethics. Most recently, she has been a Commonwealth Fund Harkness Fellow (2012–13), a Safra Network Fellow (2013–14) and a Visiting Professor of Biomedical Ethics (2012–14) at Harvard.

**Salvador Peiro** Specialist Medical in Preventive Medicine and Public Health. He directs the Research Area in Health Services of FISABIO|SALUT PUBLICA (Conselleria de Sanitat de la Generalitat Valenciana), he is the President of the Foundation Research Institute in Health Services (IISS), Associate Researcher of Aragonés Institute of Health Sciences and Associate Researcher of Centre for Research in Health and Economics (CRES).

**Professor Chris Semsarian**, MBBS PhD MPH FAHMS FRACP FCSANZ FAHA FHRS is a cardiologist with a specific research focus in the genetic basis of cardiovascular disease. He trained at the University of Sydney, Royal Prince Alfred Hospital, and Harvard Medical School. A focus area of his research is in the investigation and prevention of sudden cardiac death in the young, particularly amongst children and young adults. Prof Semsarian has an established research program which is at the interface of basic science, clinical research and public health, with the ultimate goal to prevent the complications of genetic heart diseases in our community. A recent area of interest is in assessing the benefits and harms of cardiac genetic testing, and in screening athletes to prevent sudden death.

He has published over 180 peer-reviewed scientific publications, in the highest-ranking cardiovascular and general medical journals. He has also been the primary supervisor of over 30 PhD, honours, and medical honours students since 2003, and is an active member of the mentoring program at the University of Sydney.



### Current Appointments

Professor of Medicine, University of Sydney  
Cardiologist, Royal Prince Alfred Hospital (RPAH), Sydney  
Head, Molecular Cardiology Program, Centenary Institute, Sydney  
NHMRC Practitioner Fellow  
Associate Dean of Research Integrity, University of Sydney

### Qualifications

1989 MBBS at University of Sydney  
1996 FRACP (Cardiology)  
1999 PhD in Molecular Cardiology, University of Sydney  
2005 FCSANZ (Fellow of Cardiac Society of Australia & NZ)  
2009 FAHA (Fellow of American Heart Association)  
2013 FHRS (Fellow of Heart Rhythm Society USA)  
2014 MPH at University of Sydney  
2015 FAHMS (Fellow of Australian Academy of Health and Medical Sciences)

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**Carol Brayne** is a Professor of Public Health Medicine and Director of the Cambridge Institute of Public Health in the University of Cambridge. She is a medically qualified epidemiologist and public health academic. Her main research has been longitudinal studies of older people following changes over time with a public health perspective and focus on the brain. She is lead principal investigator in the MRC CFA Studies and other population based studies and has played a lead role in teaching and training in epidemiology and public health at Cambridge University. She is a Fellow of the Academy of Medical Sciences and a NIHR Senior Investigator.

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**Cari Almazan**, MD, specialist in Preventive Medicine and Public Health. She began as researcher in healthcare planning in the Catalan Minister of Health. She moved to the former Agency for Health Quality and Assessment of Catalonia (AQuAS) contributing in its creation and was responsible of the Health Technology Assessment Area. With over 20 years' experience at the health sector, developing and recommending strategies and policies about the introduction, diffusion, planning and evaluation of medical and surgical procedures, imaging diagnostic technologies and telemedicine, using health technology assessment tools in these areas. She has been involved in several ICT European Projects and she has taught Health Technology Assessment in the Open University of Catalonia. Currently she is responsible of the new Person-centred care Area of the AQuAS and Head of the 'Project Essencial. Adding value to the clinical practice'.

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**William C Black**, MD, is a Professor of Radiology and of Community and Family Medicine at Dartmouth Hitchcock Medical Center (DHMC) and member of The Dartmouth Institute. His clinical area of expertise is chest radiology and he has research interests in screening, incidental detection and overdiagnosis. As the site Principal Investigator at DHMC and a member of the Executive Committee, Dr Black played a major role in the design, execution, and analysis of the National Lung Screening Trial (NLST). He led the cost-effectiveness analysis related to lung cancer screening in the NLST and was a consultant to the Lung Group of the Cancer Intervention and Surveillance Network (CISNET), which modeled the effects of alternative strategies of lung cancer screening on the US population for the US Preventive Services Task Force. Dr Black currently serves on several American College of Radiology committees related to lung cancer screening and incidental detection and leads the lung cancer screening program at DHMC.

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**Catherine Calderwood**, MA Cantab, MBChB FRCOG FRCP Edin, qualified from Cambridge and Glasgow universities. As a junior doctor she worked in medical specialities in Glasgow Royal infirmary and at the Royal Infirmary of Edinburgh before completing her specialist training in obstetrics and gynaecology and maternal medicine in SE Scotland and St Thomas' Hospital London.

She became a medical adviser to Scottish Government in 2010 and has been instrumental in the work in reducing stillbirths and neonatal deaths in Scotland and in reducing avoidable harm in maternity services. More recently her role expanded to include major trauma services and the introduction of robotic surgery for prostate cancer to Scotland. Until her recent appointment as CMO Catherine was also the National Clinical Director for maternity and women's health for NHS England.

She continues work as an obstetrician, seeing pregnant women in a regular antenatal clinic at the Royal Infirmary in Edinburgh. Her research interests include thromboembolic disease in pregnancy and she is an investigator on the AFFIRM study which is examining whether increasing focus on the importance of movements of babies in the womb will help further reduce stillbirths across the UK and Ireland.

Catherine launched her first annual report as Chief Medical Officer for Scotland in January 2016 which focuses on 'Realistic Medicine' and challenges modern medicine to rethink priorities. It has been universally well received amongst doctors, nurses, pharmacists, paramedics and AHPs and read across the world. It also recognizes the importance of valuing and supporting staff as vital to improving outcomes for the people in our care. Catherine believes that these improved outcomes must also include what the priorities are for that person (formerly known as a patient) and their family. She regularly blogs at [blogs.scotland.gov.uk/cmo/](https://blogs.scotland.gov.uk/cmo/) and you can follow her on Twitter @ [cathcalderwood1](https://twitter.com/cathcalderwood1)

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**Carl Heneghan**, BM, BCH, MA, MRCP, DPhil, Professor of Evidence-Based medicine is a clinical epidemiologist and his work focuses on changing healthcare both nationally and internationally for the better. He has extensive experience in systematic reviews and quantitative methodologies focusing on both communicable and Non Communicable (NCD) diseases. He has also led groundbreaking work, which notably includes the tamiflu systematic reviews, and he is Director of a World Health Organization Collaboration Centre in Self Care.

Carl's work also includes investigating the evidence base for drug and device regulation, advising governments on the regulatory and evidence requirements for devices and drugs, as well undertaking a number of evidence-based projects in the public interest. He is also a founder of the AllTrials campaign and has chaired WHO guidelines on self-care and CVD risk and he is a PI on 4 multi-centre RCTs and chairs two NIHR trial steering committees. His work focuses on evaluating practice based interventions and in 2013 and 2015 he was voted by the HSJ as one of the top 100 NHS clinical leaders.

Carl is Director of the Centre for Evidence-Based Medicine (CEBM), which is dedicated to the practice, teaching and dissemination of high quality evidence-based medicine, and is a global leader in applied healthcare research and evaluation. CEBM devotes a large proportion of its time to capacity building work through outreach teaching and training activities – making EBM accessible to a wide range of healthcare professionals.

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**Dr Hugo Viens**, Vice-president of the Quebec Medical Association. A 1998 graduate of the Université de Montréal, Dr. Hugo Viens work as medical director for Clinique Dix30 as a specialist in orthopedic surgery. Dr. Viens joined the board of the QMA as a director in 2014.

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09:00 – Tuesday 20 September

## The Public Bulwark

**Baruch Fischhoff**

Carnegie Mellon University

If people understood the relevant medical evidence, then they could make informed decisions about whether to undergo medical treatments and, indeed, whether to become patients at all. One barrier to people making such decisions, and defending themselves against overdiagnosis, is the difficulty of understanding complex, uncertain medical evidence. A second barrier is the meme, sometimes traced to behavioral research, that treats lay people as incapable of such understanding. A third barrier lies in the incentives to believe that meme, in order to deny people information and subject them to paternalistic manipulation. A fourth barrier resides in the weak scientific foundations of many health communications, reinforcing perceptions of lay competence, by holding lay people responsible for professionals' failure to fulfill their duty to inform them. Overcoming these barriers requires modest resources and strong leadership.

## Overdiagnosis in the name of the patient – breaking the vicious circle

**Nikola Biller-Andorno**

Zürich, Switzerland

The ethical relevance of preventing overdiagnosis (OD) is quickly established: First, OD is a waste of precious (public) resources; second, it can hurt the patient, even severely so. Tackling the issue is not as straightforward. Multiple factors contribute to maintaining or even reinforcing OD, among them ever more sensitive tests, defensive medicine, a business approach to health care and – supposedly – patient expectations. Complying with patient preferences is a popular legitimation for continuing with unnecessary tests. This argument from patient autonomy is highly problematic: Patient preferences are frequently misdiagnosed, and they cannot make up for the lack of a convincing indication. Patients, on the other hand, tend to rely

on their providers' recommendation, again reinforcing OD. The talk will present some approaches that might break this vicious circle, focusing on “guidelines for guidelines”, an attempt to reduce conflicts of interest in the development of clinical guidelines.

**Salvador Peiro**

Centre for Research in Health and Economics, University Pompeu Fabra

09:15 – Wednesday 21 September

## Cardiac Genomics and the Potential for Overdiagnosis

**Professor Chris Semsarian MBBS PhD MPH**

University of Sydney

Cardiac genetic testing is a beneficial process in the diagnosis and management of patients with inherited heart diseases. Identification of a disease-causing gene mutation can inform diagnosis, treatment, prognosis, and family screening in at-risk people. The rise of next generation sequencing genetic testing approaches, including large panels of “cardiac” genes (up to 200 gene panels), whole exome sequencing (the entire coding region) and whole genome sequencing (the entire genome). Many of these “cardiac” genes have insufficient evidence to be disease-related. This expansion of cardiac genetic testing, and specifically, the rapid increase in the number of genes being tested, has created the potential to overdiagnose so-called “gene carriers” for cardiac disease, and may cause more harm than benefit.

## Dementia and ageing brains: the clash of evidence, belief and policy in diagnosis and capacity to benefit in our ageing populations

**Professor Carol Brayne**

Institute of Public Health, University of Cambridge

Dementia and ageing brains: the clash of evidence, belief and policy in diagnosis and capacity to benefit in our ageing populations.

Dementia has emerged as a hot topic for research and politicians in recent years. This talk will examine the background evidence base on dementia and cognitive decline from a population and public health perspective. This has provided the numbers for the drive in awareness. I will explore how the evidence base relates to the national and global rhetoric and efforts related to primary, secondary and tertiary prevalence of dementia.

09:00 – Thursday 22 September

## How to avoid unnecessary interventions in primary care

**Cari Almazán Sáez, MD**

Agency for Health Quality and Assessment of Catalonia (AQuAS)

In recent years, there has been a growing interest in reducing unnecessary care of healthcare services, related to overdiagnosis, overtreatment, overuse, which the harm outweigh the benefits, resulting in physical, psychological and financial impacts to patients. In 2013 in Catalonia the Essencial Project was launched with the aim to elaborate recommendations to avoid low-value practices commonly used in our healthcare services identified by healthcare professionals. This presentation will explain how is being the implementation of Essencial Project in Primary Care, which recommendations have been selected by GP to implement, how GP approached these low-value practices in their clinical practice, what are they proposal to avoid them and what are the lessons learnt of this experience.

## New radiologic reporting and management guidelines for screening and incidental detection

**William C Black, MD**

The Dartmouth Institute for Health Policy and Clinical Practice

Over the past several decades, technological advances in radiology and its increased use have led to increases in overdiagnosis, through both screening and incidental detection. However, major efforts are underway to reduce the burden of

overdiagnosis through improved reporting and management. For example, the American College of Radiology (ACR) has developed a reporting system for lung cancer screening, Lung-RADS, which substantially reduces the potential for the false positive results and overdiagnosis observed in the National Lung Screening Trial. In addition, the ACR has sponsored a series of white papers on the reporting and management of incidental findings on CT of the chest, abdomen and pelvis. Compliance with these reporting and management guidelines could be facilitated with clinical decision support, better financial incentives and a change in culture.

## Realising Realistic Medicine to address over-diagnosis

**Dr Catherine Calderwood**

Chief Medical Officer, Scotland

In my first Annual Report since becoming Chief Medical Officer (CMO) for Scotland, I asked the following questions of clinicians in Scotland if we can practice Realistic Medicine by:

- ▲ changing our style of shared decision-making?
- ▲ building a personalised approach to care?
- ▲ reducing harm and waste?
- ▲ reducing unnecessary variation in practice and outcomes?
- ▲ managing risk better? and
- ▲ becoming improvers and innovators?

The response to me asking the profession I lead has been overwhelmingly positive across the globe on social media and the Realistic Medicine movement been accepted not only by clinicians but practitioners across health and social care who want to embrace its philosophy. The feedback has helped me understand what professionalism and excellence looks like in the future and how we can all realise Realistic Medicine in the future.

15:15 – Thursday 22 September

## **Journey to understanding overdiagnosis and too much medicine**

**Carl Heneghan**

Centre for Evidence-Based Medicine, University of Oxford

What happens when you are invited to screening, what information would you want and what would you want that information to look like? Answers to these questions are essential to understanding the problems of overdiagnosis and too much medicine. Yet, the concepts of diagnosis and screening are so poorly understood by the public, clinicians and health professionals alike that it prevents practical strategies to reduce low value testing and treatments.

Carl Heneghan, Professor of Evidence-Based Medicine at the University of Oxford, is at an age where invites to screening have become part of his routine part of his life. He has spent the last year asking questions about the sort of evidence that informs routines glaucoma testing, health screening, depression screening and many more tests that he has been invited to; providing insights into why we test so much for these common problems – often without knowing why- and the consequences that have led to overtreatment for ineffective treatments.

Carl has been teaching and researching diagnosis at the Centre for Evidence-Based Medicine for over twenty years and has an active interest in improving the public understanding of EBM, which is woefully inadequate when it comes to understanding diagnostic testing.

## **Overdiagnosis and the medical profession: Time for a new social contract**

**Dr Hugo Viens Chair POD 2017**

QMA president-elect

Effective healthcare has become an essential element of civilized society. As healthcare has advanced, it has transformed from an artisanal practice to a major part of every developed country's gross domestic product. During this transition, healthcare has come to be viewed as a fundamental human right. As professionals, we doctors have a moral and social obligation to make sure healthcare services are provided not only to the benefit of patients but also serves the best interest of society. We, therefore, must act in order to guarantee the quality and availability of healthcare services which demands that we tackle the overdiagnosis challenge. In Quebec evidence has prompted actions and produced positive results in winding back the harm from too much medicine. POD 2017 will be the occasion to share experiences and learn from colleagues about solutions and concrete actions that have proved to be successful.



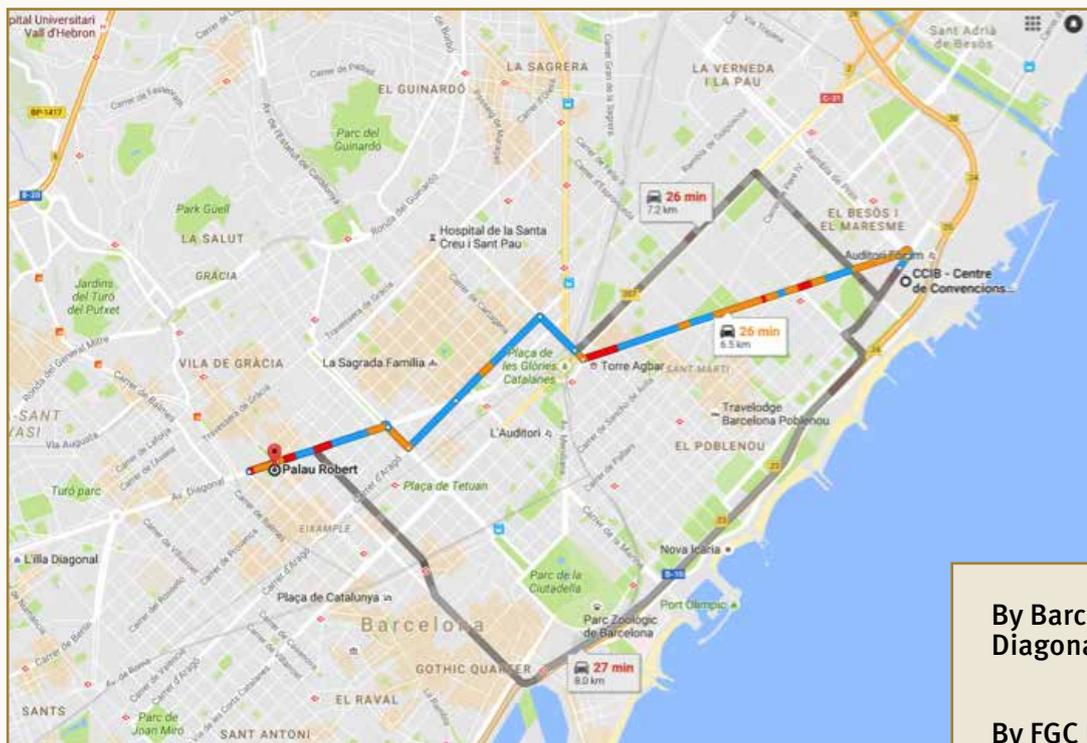
## **Preventing Overdiagnosis 2016 Hosts Agency for Health Quality and Assessment of Catalonia (AQuAS) Invite you to drinks and tapas in Barcelona's Palau Robert**

20:00–22:00 – Wednesday 21 September



Barcelona's Palau Robert is an exhibition center run by the Government of Catalonia. The centre is housed in a neoclassical building at the junction of Avinguda Diagonal and Passeig de Gràcia, two of the most important thoroughfares in the Catalan capital. The building also houses a Tourism Office, where qualified staff provide information about the whole of Catalonia.

Activities organized by the Palau Robert also take place in the Cotxeres building, one room for exhibitions, the other for cultural and social events and functions. Between these two buildings is the peaceful, leafy Garden, an invitation to take a break from the bustling city all around.



By Barcelona Underground:  
Diagonal (3 line and 5 line)

By FGC Underground:  
Provença (6 line and 7 line)

By bus: [www.tmb.cat](http://www.tmb.cat)

14:15 – Tuesday 20 September – Room 129

## Overdiagnosis in Genetic Screening

**Stephen Taplin, Barbara Dunn, Barry Kramer**  
NIH, NCI, Rockville, MD, USA

**Abstract:** As genome wide analysis becomes clinically viable there is growing concern that individuals may face information whose meaning is at best ambiguous. The question this raises is whether healthy people become unhealthy in the face of information that has no immediate consequences. Even when the meaning is relatively clear, as in established deleterious BRCA1 and BRCA2 mutations, there remains about a 45% chance that a carrier will not get breast cancer. Within this workshop we will explore how genetic information is reaching people, how it is being translated into cancer risk estimations, how perceptions of genetic risk relate to those of cancer risk, and whether these estimates result in genetic overdiagnosis. Attendees will leave with a better understanding of the growing number of genomic abnormalities associated with breast cancer, their associated risk of disease, and what we know about the effects of the information on individual's health, in the broadest sense.

### Objectives:

1. Attendees will gain a better understanding of the growing number of genomic abnormalities associated with breast cancer.
2. Attendees will acquire knowledge of the levels of risk of disease associated with specific gene mutations, including VUS/variants of unknown significance and their implications for developing cancer.
3. Attendees will develop a deeper understanding of the effects of genetic information on an individual's health, in the broadest sense: on life areas including, but not exclusive to, breadth of genetic knowledge, psychological impact, follow-up medical interventions, financial and social effects.

**Method:** This genetics/genomics-focused workshop is relevant to the larger field of Overdiagnosis; genetic testing leads to a spectrum of sequelae, all connected to "risk" of developing actual disease. Genetic/genomic testing is increasingly common.

This topic relates to the larger concerns of overdiagnosis because of the interdigitation of genetic/genomic testing with direct disease-oriented screening modalities. Breast cancer is a useful model disease for genetic testing in relation to overdiagnosis because of the extensive knowledge base that exists in this area. Genetic/genomic testing is of interest to all parties concerned with the impact of overdiagnosis on an individual's health in the broadest sense.

14:15 – Tuesday 20 September – Room 130

## Navigating your way through the methods minefield of cancer overdiagnosis – and emerging whole

**Ruth Etzioni<sup>1</sup>, Eric Feuer<sup>2</sup>, John Wong<sup>3</sup>**

<sup>1</sup>Fred Hutchinson Cancer Research Center, Seattle, WA, USA,  
<sup>2</sup>National Cancer Institute, Bethesda, MD, USA, <sup>3</sup>Tufts University, Boston, MA, USA

**Abstract:** The objective of this tutorial-style workshop is to bring together different perspectives on the problem of estimating overdiagnosis in cancer screening studies - and to find ways to reconcile them based on an in-depth understanding of how they work.

We propose three presentations accompanied by a facilitated discussion. All presentations will be grounded in real data and will provide examples of different study designs and estimation approaches.

The first presentation will use an allegorical device to bring the complicated concepts of overdiagnosis estimation down to earth and to explain how cancer incidence trends capture information about the extent of overdiagnosis. The first presenter (Dr Eric Feuer) is an international expert in cancer surveillance modeling and is the founder and scientific leader of the Cancer Intervention and Surveillance Modeling Network.

The second presentation will review the methods used for cancer overdiagnosis estimation. This presentation will systematically investigate the validity of excess-incidence and model-based approaches under different study designs. A key feature of this presentation will be a side-by-side comparison of excess-

incidence and model-based results in several screening trial and population studies. The second presenter (Dr Ruth Etzioni) is a statistician and cancer modeler who has published on overdiagnosis estimation in breast and prostate cancer and on methodology for estimating overdiagnosis.

The third presentation will consider patient decision making and specifically the roles of evidence and values when incorporating information about overdiagnosis in practice. The third presenter (Dr John Wong) is chief of the Division of Clinical Decision Making at Tufts Medical Center and is an expert in patient decision making.

The third presenter will then lead a facilitated discussion among audience members and the presenters with the objective being to advance towards a consensus around best practices for developing and disseminating cancer overdiagnosis estimates.

### Objectives:

1. To provide insight into the complexities of overdiagnosis estimation in cancer
2. To achieve an understanding of the reasons for variability in published estimates.
3. To educate about different approaches to estimating overdiagnosis and why/when they generate biased results.
4. To consider how patients use information about overdiagnosis and how to help them integrate this information with values and preferences in clinical decision making around cancer screening.
5. To generate a consensus about types of studies and study features that are adequate for valid estimation of overdiagnosis.
6. To facilitate dialogue and collaboration and reduce polarization in the field.

**Method:** This workshop will be of interest to all conference participants who seek to understand how overdiagnosis estimates are derived in the context of cancer screening. It will appeal particularly to those who are puzzled over the heterogeneity in published estimates and wish to reconcile them. Although we will discuss study designs/methods, the workshop is not technical and is designed to be at a level that

will be accessible to the clinical audience. Many examples of published estimates will be provided and discussed. We expect that investigators across a wide range of disciplines will find value in this workshop.

14:15 – Tuesday 20 September – Room 131

## Why is it so hard to understand? The challenge of communicating overdiagnosis to people facing screening decisions

Corinna Schaefer<sup>1</sup>, Denis Fechtelpeter<sup>2</sup>, Rachel Sommer<sup>3</sup>,  
Monika Nothacker<sup>4</sup>

<sup>1</sup>German Agency for Quality in Medicine, Berlin, Germany, <sup>2</sup>Institute for Quality and Efficiency in Health Care, Cologne, Germany, <sup>3</sup>Department of Medical Psychology, University Medical Center Hamburg-Eppendorf, Hamburg, Germany, <sup>4</sup>Association of the German Scientific Medical Societies, Düsseldorf, Germany

**Abstract:** There is international consensus that overdiagnosis represents a considerable harm of screening and should be communicated to people facing health care decisions. However, evidence about how to best communicate overdiagnosis and about potential barriers to its understanding is lacking. Trials investigating the effect of decision aids containing information about overdiagnosis show only modest or no influence on the intention to get screened, thus suggesting that either the harm from overdiagnosis is not considered as relevant as the benefit, that the information is not sufficiently understood or that the concept itself is not accepted. Additionally, other factors than the provided information may play a dominant role.

In this workshop, facilitators will report experiences with conception, reception and evaluation of information about overdiagnosis, based on qualitative research and a systematic search and synthesis of qualitative studies.

In a moderated group discussion, participants will develop a framework of different factors representing barriers to understanding.

In small group breakouts, participants will elaborate on possible communication strategies to address these factors.

## Short Presentations:

- ▲ “This is no decision aid; it makes decision difficult!” – What we know about people’s understanding of overdiagnosis.
- ▲ Development of a decision aid for mammography-screening: How do potential users understand and perceive the information about overdiagnosis?
- ▲ Overdiagnosis – communication strategies of physicians and possible influences of existing health care conditions

**Objectives:** This workshop aims at identifying factors that complicate communication and understanding of overdiagnosis and at discussing possible solutions. These factors may include: practical issues like difficulties to differentiate between false positive results and overdiagnosis; cognitive challenges in understanding the abstract concept of “overdiagnosis” which cannot be experienced and thus not reported; counterintuitive information; people’s preconceptions of, expectations towards and beliefs in prevention and health care interventions; suspicion that any recommendation against an intervention may not be evidence- but cost-driven. Physicians’ communication strategies may be influenced by their own perception of harms and benefits, contextual factors of the health care system and “culture”.

**Method:** Physicians, Patients and other health care providers will gain awareness of specific challenges when communicating overdiagnosis and of barriers to its understanding for patients. By discussing possible communication strategies along a framework, attendees will identify tools to overcome these perceived difficulties.

10:45 – Wednesday 21 September – Room 132

## Overdiagnosis and overinvestigation as issues for life and living benefits insurance

Kevin Somerville DM, John Schoonbee MD, Swiss Re

Insurance mitigates the consequences of a quantifiable untoward event happening and has a major social role. Life and living benefits (disability, critical illness) insurance include an initial risk assessment of an application for an insurance policy (underwriting) and also the ascertainment

of the validity or otherwise of an insurance claim (claims management), particularly relating to living benefits. Overdiagnosis and overinvestigation have the potential to affect both the underwriting stage as well as claims assessment.

At the time of underwriting, information about the health of applicants for such insurance is an integral part of matching the price paid for insurance cover to the risk of an insured event. This information may already be part of the medical record and, if so, is asked for and used by underwriters and medical advisors for risk selection. An applicant may already have had numerous screening tests with abnormal or incidental findings of uncertain relevance and the risk assessor has to make sense of these. In addition, supplementary insurance medical screening, which can range from an independent medical examination to an investigation such as a blood test or medical imaging, may be requested. The tests asked for vary by age, sex, level of sum assured, as well as the type of insurance. The collated medical data is used to allocate the applicant to an insured lives risk pool. Supplementary medical screening carries with it a risk of both overinvestigation and/or overdiagnosis and hence the possibility of labelling an insurance applicant as a having a “disease”.

By contrast, a living benefits claim is based upon a medical diagnosis which is typically provided by the claimant’s medical practitioner and/or consultant. Life and living benefits insurance policies are typically long term (sometimes whole of life) and priced for using the current incidence of a condition based on contemporary definitions of disease. A change in the definition of disease will affect this process. Such a change, usually a widening of the definition, will also affect risk assessment. Overzealous screening can also detect clinically irrelevant disease which can lead to unpriced for claims

The seminar will explore the potential effects of overdiagnosis on insurance risk assessment and claims management. It will have particular reference to the effect of screening on the underwriting of life insurance and the effect of the changing definitions of diseases such as myocardial infarction and stroke/transient ischaemic attack on critical illness claims

## Workshop Fracturing a Frail Definition: A Cutting-Edge Social Media Movement to Dismantle an Overtreatment-Causing Definition

Teppo Järvinen<sup>1</sup>, Alan Cassels<sup>2</sup>, Roope Kalske<sup>1</sup>, Ajay Puri<sup>3</sup>, Malcolm Willett<sup>4</sup>

<sup>1</sup>University of Helsinki, Helsinki, Finland, <sup>2</sup>University of Victoria, Victoria, British Columbia, Canada, <sup>3</sup>Changemakers Vancouver, Vancouver, British Columbia, Canada, <sup>4</sup>Willett Ink, London, UK

**Abstract:** Current clinical practice guidelines on the management of osteoporosis and “fragility fractures” are premised on the idea of secondary prevention where those with a fracture are automatically considered candidates for drug therapy<sup>1-3</sup>. Advocates of this treatment strategy argue that “a vertebral compression fracture signals a patient at high risk of subsequent fractures who should be managed appropriately. Vertebral fractures have debilitating consequences and even increase the risk of death.<sup>1</sup>” This is all true.

But what is a “vertebral fracture”?

Given that vertebral “fractures” are the pillars of the fragility fracture burden - representing roughly half of the overall burden, how we define them has huge consequences. Being a “bone fracture”, it comes as no surprise that the diagnosis is primarily based on x-rays<sup>4</sup>. However, what is surprising is that there are a range of different criteria for classifying a change in an x-ray as a “fracture”. Depending on the criteria chosen, the prevalence of vertebral fractures can vary as much as from 3% to 90% in the same elderly population<sup>5</sup>. Because at least two-thirds of people with x-ray changes diagnosed as “vertebral fractures” are asymptomatic<sup>6</sup>, the prevailing osteoporosis guidelines risk labelling the majority of otherwise asymptomatic older people as sick. Since vertebral fractures are said to increase mortality and morbidity, then they become the ultimate argument for pharmacological intervention. However, the occurrence of vertebral fractures is a poor predictor of future back pain or functional status of the spine<sup>7-8</sup> and the fracture preventing efficacy of bone-targeted pharmacotherapy is meagre – at best – on vertebral fractures and there is no evidence to suggest that drugs have an effect on mortality<sup>9-10</sup>.

**Objectives:** The objective of this workshop is to showcase how a vague disease definition has penetrated into routine practice, despite being irrational and unhelpful, and how we are winding back medical excess through an approach of launching an innovative campaign in social media.

### Method

The workshop will consist of the following interactive presentations:

1. Vertebral Fracture: A classic case of a disease definition that leads to overdiagnosis and overtreatment (Järvinen & Kalske)
2. #OsteoPledge: A People-Powered Approach to Wind Back Overdiagnosis Through A Social Movement (Cassels & Puri)
3. How to Use An Animation To Convey An Important Social Message (Willett)  
Premier of An Animation: “Let’s Show More Spine In How We Define Vertebral Fractures”
4. Launch of The Campaign (Järvinen, Cassels & Puri)

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10:45 – Wednesday 21 September – Room 134

## Sobrediagnóstico y Toma de Decisiones Compartidas

Juan Victor Ariel Franco<sup>1, 2</sup>, Karín Kopitowski<sup>1, 2</sup>, Sergio Terrasa<sup>1, 2</sup>

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### Contenidos del Taller

- ▲ Introducción a la toma de decisiones compartidas (TDC). Principio de autonomía. Visión poblacional vs visión individual. Consentimiento informado.
- ▲ TDC en procesos donde puede estar involucrado sobrediagnóstico y sobretratamiento.
- ▲ Instrumentos en los cuales apoyarse para la TDC (herramientas genéricas para cualquier problema de salud y “decision aids” específicas)
- ▲ Conceptualizar junto a los participantes las barreras y facilitadores del uso de las TDC en los escenarios clínicos mencionados.
- ▲ Reconocer el proceso de TDC como Herramienta comunicacional a nivel individual del concepto de sobrediagnóstico.
- ▲ Identificar oportunidades de investigación en la temática.

### Taller

- ▲ Presentación de los conceptos en una mini conferencia y trabajo en pequeños grupos con casos clínicos.
- ▲ Los casos clínicos involucran diferentes escenarios: pre-screening, pre-test confirmatorio, pre-tratamiento.
- ▲ Puesta en común de lo trabajado en los grupos pequeños.

El taller plantea el uso de las TDC para asistir a la toma de decisiones en salud explicitando aspectos relacionados con los potenciales beneficios y potenciales riesgos incluyendo el sobrediagnóstico y sobretratamiento. Es de interés para todos aquellos que están interesados en adquirir herramientas que ayudan a la comunicación individual del concepto de sobrediagnóstico.

13:30 – Wednesday 21 September – Room 133

## De-Implementation: Exploring Multi-Level Strategies for Reducing Overdiagnosis and Overtreatment

Wynne Norton, Barry Kramer

National Cancer Institute, Rockville, MD, USA

**Abstract:** A product of overdiagnosis and resulting overtreatment (herein referred to as overuse) is low-value, harmful, and ineffective healthcare. It is all-too-common in healthcare settings and delivery systems. While considerable effort has been made to describe, characterize and understand drivers of overuse, comparatively little work has focused on identifying and testing multi-level strategies (e.g., patient-, provider-, organization-, and societal-levels) needed to curb the drivers. Moreover, strategies needed to curb overuse are likely different from those needed to facilitate adoption of new practices, given that reducing or stopping established practice is often more difficult than starting new practice. Using a thematic focus on interventions to mitigate harms of overdiagnosis, the proposed workshop seeks to address this knowledge gap by exploring the range of multi-level strategies needed to prevent or curb overuse and identifying next steps needed to advance the state-of-the-science.

The workshop will include two presentations, an open, group-based discussion, and identification of next steps. One presentation will illustrate the multi-level issues involved in overuse through several case study descriptions; the other presentation will introduce a new, social-ecological framework for conceptualizing multi-level drivers of and strategies for reducing overuse. Participants will have the opportunity to ask questions and provide feedback during the discussion period. Organizers will close the workshop by suggesting next steps to advance the field.

**Objectives:** The learning objectives of this workshop are three-fold: (1) to discuss multi-level barriers towards de-implementation; (2) to explore potential de-implementation strategies; and (3) to identify the role of different stakeholder groups (e.g., patients, providers, policymakers, etc.) in advancing the science and practice of de-implementation.

Outcomes of the workshop may include (but not be limited to) a peer-reviewed manuscript, a follow-up think tank, and/or a priority-setting research agenda.

**Method:** We encourage all types of stakeholder representatives to participate in this interactive workshop, including patients, citizen/consumer advocates, health professionals, policymakers, and funding agency representatives, among others. The objectives and subsequent outcomes of this workshop will be best achieved by having diverse perspectives on the drivers of and potential solutions to overdiagnosis and overtreatment.

13:30 – Wednesday 21 September – Room 134

## IATROGENICS

**Organized by:** **SESPAS** (Spanish Association of Public Health and Healthcare Administration) and **OMC** (Spanish Medical Association)

### Who?

SESPAS is a confederation of 12 public health associations in Spain (currently around 4.000 members), created in 1985. It takes part of the European Public Health Association (EUPHA). The goals of SESPAS are to contribute to the scientific advance in public health from a multidisciplinary perspective, to contribute to professional development of public health practitioners, to provide advice in health policies and to do advocacy for health. SESPAS's scientific journal is *Gaceta Sanitaria*, included in the JCR.

OMC is the official organization representing physicians in Spain, as a federation of all the territorial professional associations, organizations of compulsory affiliation to practice medicine. It has around 250.000 members.

SESPAS and OMC signed an agreement to collaborate to analyze iatrogeny as a health problem in Spain. After creating a specific working group, some activities have already been done, including a public presentation in a national conference on iatrogeny (Madrid, April 8th).

### What?

We understand by iatrogeny “the harmful effects generated by healers by the administration of medical and surgical treatments,

the activities of prevention, diagnosis and screening, as well as those caused by products and healthcare devices and even the development of public health actions. Although people tend to identify iatrogenic effects with errors or negligence of health professionals, the concept is broader and goes far beyond, including those effects due to overdiagnosis, prescribing unnecessary and lacking evidence treatments, improper functioning of the health system and public health services, medicalization of everyday life and social and cultural factors that create exaggerated expectations about the real possibilities of medicine and public health in preventing disease and postponing death.

### How?

The activities of the working group aims to (re)define an expanded field of iatrogenesis, to promote research and action on its causes, and to bring awareness to the public, both professional and general, about the paths to reduce the huge burden of harm imposed by inappropriate health practices.

To do this we are aware of the need of collaborative actions with other institutions, initiatives and potential partners to increase a sharing understanding of the problems related with iatrogenics and promote and launch campaigns and initiatives to cope with it. In this sense our presence in a forum aimed to “winding back the harms of too much medicine” is seen as an opportunity to share and interchange views and projects with different kind of peoples and institutions with similar concerns and aims

Our intention is to present and debate the first document of the working group, a position paper, integrating the different concerns, fields, and views about iatrogenics, and focusing in actions and strategies to address this problem.

Given the topic and the institutions involved, the presentation will attract the attention of the press, as it was the case of the presentation at the national conference on iatrogeny ([www.gacetamedica.com/noticias-medicina/2016-04-08/politica/el-15-de-los-sanitarios-estan-involucrados-cada-ano-en-al-menos-un-evento-adverso/pagina.aspx?idart=976102](http://www.gacetamedica.com/noticias-medicina/2016-04-08/politica/el-15-de-los-sanitarios-estan-involucrados-cada-ano-en-al-menos-un-evento-adverso/pagina.aspx?idart=976102)).

15:30 – Wednesday 21 September – Room 133

## Big data-part of the problem of over-diagnosis or part of the solution?

**Amitava Banerjee**

Farr Institute of Health Informatics Research, University College London, London, UK

**Format:** Introduction to big data, problem of overdiagnosis and learning health systems: whole group together (15 mins)

First brainstorming in small groups (5–12 people per group and ideally 4 groups): How can we use linked data in real-time to reduce overdiagnosis? (20 mins)

Reporting back to whole group: 2 minutes for each group (4 groups) and discussion

(15 mins)

Second brainstorming in small groups (5–12 people per group): Work through one specific example of using linked data in a learning health system to reduce overdiagnosis (25 mins)

Presentation to whole group: 2 minutes for each group (4 groups) and summary/wrap-up session (15 mins)

**Total duration of workshop: 90 mins**

### CONTENT

#### Presentation

**Purpose:** How can big data worsen overdiagnosis? How can a learning health system help?

**Plan:** Interactive presentation/discussion

#### Breakout session (1)

**Purpose:** How can we use linked data in real-time to reduce overdiagnosis?

**Plan:** Participants will discuss potential avenues where linked data can be used in real-time (rather than retrospectively) in order to reduce overdiagnosis. Ideas during the break-out session for each of the 3–4 groups will be recorded on a flipchart. (20 mins)

#### Breakout session (2)

**Purpose:** Work through one specific example of using linked data in a learning health system to reduce overdiagnosis

**Plan:** Again breaking out into the same group, participants are invited to concentrate on one of the potential uses of linked data research and to develop a research and implementation plan. (25 mins)

### PROCEDURE

An introductory presentation/discussion will set the scene, by defining big data and how current models may worsen the problem of overdiagnosis. Introducing the concept of the “learning health system”, we will provide examples of how linked data research facilitates this model and can reduce overdiagnosis.

Breaking into small groups, participants will discuss potential avenues where linked data can be used in real-time (rather than retrospectively) in order to improve healthcare and reduce overdiagnosis. Ideas during the break-out session for each group will be recorded on a flipchart.

Each group will briefly report back their discussions to the whole group to stimulate further debate regarding possible uses of linked data at the bedside.

Again breaking out into the same group, participants will concentrate on one of the potential uses of linked data research and develop a research and implementation plan.

Each group will present the pathway to translation for their specific example to the whole group. A wrap-up session will summarise preceding discussions

### Objectives:

1. To understand how big data can influence healthcare delivery
2. To discuss how current paradigms of translation in big data do not necessarily translate to improvements in patient care and may exacerbate the problem of overdiagnosis
3. To consider ways in which current models of linked data research could be used to directly influence healthcare in a learning health system
4. To develop specific examples of how such linked data can work in real-time to reduce overdiagnosis

**Method:** Learning health systems (LHS) coordinate, integrate and feedback between research, teaching and healthcare delivery, three areas which are interlinked in concept, but often divided in practice. Linked electronic health records and improvements in data science offer opportunities to implement LHS at scale. The translational potential of bioinformatics has been widely discussed, but to-date, has mostly been restricted to genomics, drug life cycle and novel avenues of research, with less emphasis on reducing overdiagnosis and quality improvement of healthcare delivery. However, linked electronic record research has largely been retrospective and has not sufficiently translated to the bedside in order to influence daily patient care.

The target audience of the workshop is bioinformatics researchers, clinicians, data scientists and informaticians, public health professionals and policymakers interested in tackling overdiagnosis. This workshop is consistent and integral to the main theme of the conference, which is to explore and avoid overdiagnosis in healthcare. Moreover, the central aim of this workshop, which is to stimulate participants to consider how big data can be used to reduce overdiagnosis, is aligned with several sub-themes of the conference, including, “Big data”, “Widening disease definitions that cause overdiagnosis” and “Genomics and the potential for overdiagnosis”.

This workshop involves small group work and two break-out sessions, which groups must report back to the overall group. Even during the initial presentation, discussion and interaction is encouraged, and in fact necessary to the success of the workshop. The well-defined activities during the break-out sessions will allow a wide range of participants to explore the translational impact of linked data research for patient care. Participants will have the opportunity to hear and provide feedback on the ideas of other groups.

13:45 – Thursday 22 September – Room 130

## Molecular and Cellular Characterization of Screen-Detected Lesions

Sudhir Srivastava<sup>1</sup>, James Brooks<sup>2</sup>, Laura Esserman<sup>3</sup>

<sup>1</sup>NIH, NCI, Rockville, MD, USA, <sup>2</sup>Stanford University, Stanford, CA, USA, <sup>3</sup>University of California, San Francisco, CA, USA

**Abstract:** Currently, one of the most challenging problems in oncology is predicting more precisely whether lesions that are detected by sensitive screening tests are indolent (hence, not requiring extensive treatment) or progressive and potentially life-threatening. Currently, there are no efforts that systematically address the issue of differentiating indolent from progressive lesions using all components of the tumor including its microenvironment. Such efforts are likely to define molecular features distinguishing early, non-progressing lesions from those with progressive potential, as well as features distinguishing non-symptomatic, screen-detected cancers from rapidly growing, symptomatic interval cancers. Such studies may provide opportunities for the development of novel biomarkers for molecular diagnosis and prognostic evaluation, for prevention and therapeutic intervention, and provide the potential of improving imaging modalities to discriminate between non-aggressive and malignant tumors. In 2015, the National Cancer Institute established a Consortium on Molecular and Cellular Characterization Laboratories (MCL) of Screen-detected Lesions to identify cellular and molecular characteristics that distinguish progressive from non-progressive lesions.

**Objectives:** In 2015, the National Cancer Institute established a Consortium on Molecular and Cellular Characterization Laboratories (MCL) of Screen-detected Lesions to identify cellular and molecular characteristics that distinguish progressive from non-progressive lesions.

Investigators in the consortium are employing genomic, proteomic, epigenomic and structural imaging approaches to characterize tissues, tumor cells, and the tumor microenvironment (including endothelial and immune cells, fibroblasts, and the extracellular matrix), growth factors, and cytokines.

**Method:** It is hoped that the battery of molecular profiles will help determine both the cellular and molecular phenotypes of early lesions, to assess the degree to which the behavior of these lesions is predictable or stochastic, and to allow better prediction of the fate of such lesions.

The session will highlight progress made to date and provide opportunity to interact with other investigators working on the overdiagnosis of cancer.

14:15 – Tuesday 20 September – Room 132

## Overdiagnosis and Radiologists: Can the Arsonists become the Firefighters?

Saurabh Jha, Suyash Mohan

University of Pennsylvania, Philadelphia, USA

**Abstract:** Increasingly it is imaging, not pathology, which defines diseases. Radiologists are implicated in overdiagnosis. This session will explain the epistemological basis of overdiagnosis giving several examples in imaging including pulmonary embolism, brain aneurysms, substrates for sudden cardiac death and incidentally discovered thyroid lesions. We will emphasize trade-offs in the face of imperfect information and how and why we have chosen to err. The session will be interactive, not didactic, because we wish to learn from the audience as much as we wish to explain. While we will offer prescriptions, these will not be magic bullet solutions, but difficult trade-offs.

### Objectives

1. Explain the trade-offs inherent in defining disease.
2. Understand why improved technology leads to overdiagnosis.
3. Explain the challenges in using evidence to reduce overdiagnosis.
4. Derive pragmatic solutions to the problem of overdiagnosis in radiology with audience participation

**Method:** Radiologists are involved in overdiagnosis. While this is known the perspective of the radiologist is seldom heard. To understand why overdiagnosis occurs we must understand the incentive system which encourages overdiagnosis, and also the nature of information and knowledge (epistemology).

This session will be of use to epidemiologists, physicians and journalists. We want a lively discussion and pragmatic solutions.

14:15 – Tuesday 20 September – Room 133

## Defining response and reducing harms from clinical therapies – lessons from cardiac resynchronisation therapy

David Warriner

Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK

Cardiac resynchronization therapy (CRT) is a recent adjunct in the treatment of end stage heart failure. However, devices cost between £3500-12500, associated with significant risk of immediate complications e.g. death, pneumothorax, bleeding and up to a third of patients don't derive benefit, termed non-responders. Much research has been conducted to attempt to define and predict response and so prevent patients from being exposed to such harms, if they will not derive benefit. Furthermore, there can be ongoing morbidity with device malfunction, infection, lead displacement following "successful" implantation. But how is response to such a therapy best defined, is it improvements in cardiac remodeling, symptoms, biomarkers, admissions, mortality or quality of life? Response in which domains and to what extent do is acceptable to mitigate such risks? In early studies, up to a third of patients felt better with the device switched off, does this mean they have responded? Yet, in clinic, this is often all that is used to assess response and many trials have used only single variables to define such response.

Presentation on the concept, benefits and harms of CRT and how response is currently defined.

Discussion on the challenges of defining response to any therapy, such as variable physiological state, inter-observer variability in measurements, motivation in exercise testing, mood affecting perceived quality of life etc. Then consideration of the wider issues surrounding defining response to a therapy, experiences from other specialties, are the general public aware of such nuances, how challenges should be communicated, cost implications, what potential harms in the absence of predicted benefit are acceptable?

## Aims

Consider how response to a medical therapy should be defined.

## Outcomes

- ▲ Introduction to CRT with potential benefits and harms
- ▲ Defining and measuring response in CRT.
- ▲ What is a meaningful response to such therapies.
- ▲ Lessons from other treatment modalities in heart failure, cardiology and beyond on defining response.
- ▲ Consider what % of potential response is acceptable, when the potential risks are also difficult to predict.

**Results:** For health care professionals, researchers, public, journalists and policy makers, as this seminar will discuss the key challenges in preventing overdiagnosis; role of industry, communication with patients, considering potential harms as well as benefits, how to measure if a patient is “better”, economic implications, lack of evidence, role of placebo and guideline creep.

14:15 – Tuesday 20 September – Room 134

## Pernicious Promotion of Overdiagnosis: Public Relations News Releases

### Gary Schwitzer

HealthNewsReview.org, University of Minnesota School of Public Health, Minneapolis, Minnesota, USA

**Abstract:** The general public may not be aware of how they are influenced by public relations messages about health care interventions. Journalists are bombarded by PR news (press) releases from government agencies, medical journals, academic medical centers, drug and device manufacturers, professional medical societies and others. Faced with story quotas and demands for high “click rates” on news websites, some journalists cave in to the pressure and fail to independently vet PR claims, and publish often biased and conflicted PR messages.

HealthNewsReview.org, the US-based media watchdog project that has been reviewing the quality of health care journalism for 10 years, has now begun to review PR news (press) releases as well. More than 200 such news releases have been systematically reviewed in the past 18 months.

Publisher Gary Schwitzer and reviewer Alan Cassels (and possibly other members of the review team attending the conference) will:

- ▲ Reflect on the literature concerning health care PR news releases;
- ▲ Demonstrate examples of some of the overdiagnosis messages seen in PR news releases;
- ▲ Discuss the impact they have had with their reviews, including one classic example that led to nationwide news coverage, a university’s internal investigation of a study and the admission of conflicts of interest, flawed conduct of research, and the absence of an appropriate press release oversight system;
- ▲ Encourage conference attendees to pursue similar watchdog projects in their own countries.

## Objectives

### Aims

1. Heighten awareness of the growing influence of health care public relations messages on journalists and on the general public, often on topics that encourage overdiagnosis.
2. Demonstrate the systematic, criteria-driven watchdog review processes of HealthNewsReview.org, the US-based project that will have reviewed more than 200 such PR news releases messages by the time of the conference (150 at the time of this submission).
3. Engage participants in a discussion of the kinds of PR messages they are aware of in their countries. (My aim is to be far more interactive with this proposed seminar than I was with the seminar at last year’s conference.)
4. Inspire participants to pursue watchdog projects similar to HealthNewsReview.org in their own countries.

## Outcomes

1. Attendees will gain a new grasp of the scope of the influence of PR news (press) releases messages on the general public and the harm that may be done by such messages.
2. Participants will understand how a 10-year-long project has undertaken systematic, criteria-driven reviews of media messages about health care interventions (including press releases), and how that project has interacted with those who disseminate such press releases.
3. Participants will learn that such watchdog efforts can have an impact on the improvement of the flow of information to the public.

## Method

This seminar will be of interest to:

- ▲ Clinicians, who may be unaware of the influence that PR news releases messages may have on their patients who come to the clinical encounter primed for overdiagnosis because of what they've read or heard;
- ▲ Journalists and communications professionals, who may not realize the harm that may be done to readers if biased, conflicted PR messages are not vetted;
- ▲ Patient advocates/educators, who need to understand the extent of the pernicious influence of inaccurate, imbalanced, incomplete PR news release messages;
- ▲ Representatives of government agencies, medical journals, academic medical centers, professional medical societies and others whose organizations disseminate health care PR news releases

15:30 – Wednesday 21 September – Room 134

## How clinical practice guidelines for chronic disease prevention could reduce overdiagnosis instead of promoting overdiagnosis

James McCormack<sup>1</sup>, Richard Lehman<sup>2</sup>, John Yudkin<sup>3</sup>, Alan Cassels<sup>4</sup>, Paul Glasziou<sup>5</sup>

<sup>1</sup>University of British Columbia, Vancouver, Canada, <sup>2</sup>Cochrane UK, Oxford, UK, <sup>3</sup>University College London, London, UK,

<sup>4</sup>University of Victoria, Victoria, Canada, <sup>5</sup>Bond University, QLD,

## Australia

**Abstract:** In theory, clinical practice guidelines (CPGs) for chronic disease prevention (glucose, blood pressure, lipids, and bone density) should provide clinicians with clinical recommendations/content based on a synopsis of the best available evidence. Interestingly, the evidence is quite clear many CPGs are not informed by a systematic review of the evidence. In addition, CPGs almost universally ignore patient values and preferences in their decision-making process. Unfortunately, some guideline writers have gone as far as saying that creating CPGs that provide information in a way that encourages shared decision making “would be incredibly labor intensive and would make the standards long and unwieldy”. This seminar will discuss the problem and hopefully come up with some solutions.

## Aims

- ▲ Explore and explain the important limitations of chronic disease prevention CPGs
- ▲ Discuss approaches and solutions for how to deal with the lack of a shared-decision making (SDM) process in CPGs
- ▲ Discuss and explore the strengths and limitations of available tools which help empower clinicians to do SDM
- ▲ Discuss what should be done about the limitations of CPGs

## Outcomes

- ▲ Develop a repository of the most useful tips/tools that inform clinicians/patients about the evidence surrounding chronic disease prevention
- ▲ Develop a plan to inform guideline writers about the need to have CPGs focus more on SDM rather than treatment thresholds

This seminar will be of interest to all clinicians who have struggled with applying chronic disease state guidelines in patient care settings and those who are interested in doing something about it.

13:45 – Thursday 22 September – Room 131

## Around the world in 80 names: Exploring global variation in terminology pertaining to ‘preventing overdiagnosis’

Jessica Otte<sup>1</sup>, Alan Cassels<sup>2</sup>

<sup>1</sup>The University of British Columbia, British Columbia, Canada,

<sup>2</sup>The University of Victoria, British Columbia, Canada

**Abstract:** The proposed format is a seminar with two leads (Jessica Otte and Alan Cassels). The session would entail a presentation of existing knowledge, using a map as an anchor for sharing information about the various names used for the campaign against overdiagnosis/overtreatment around the world. Following this, a facilitated discussion would be used to fill in the gaps from participants who may be aware of other campaigns and terminology. A discussion of the factors that have resulted in the diversity of names and concentration of initiatives will engage the participants.

[This work may be of use to the Preventing Overdiagnosis organizers who (at the close of last year’s conference) planned to seek consensus on a name for the international movement.]

**Objectives:** The focus of this session is to elaborate on regional differences in the dialogue and nomenclature of the movement around preventing overdiagnosis and confronting ‘too much’ medicine. Together we’ll discuss the possible factors behind this variation, attempt to answer the question of why certain regions are more or less represented, and explore why this matters.

### Method

1. Literature search for existing concepts and terminology that define and name the movement to prevent overdiagnosis
2. Use of a map tool to present regional efforts and nomenclature of the movement
3. Discussion amongst participants

**Results:** The discourse about inappropriate health care is happening all around the world. There are research projects and campaigns that tackle this issue in at least 25 countries, and the number is rapidly growing.

Independent groups have been coming to similar conclusions, creating solutions with variations in approach and terminology. Structures of health care delivery, academic strength in medical evidence and epistemology, socio-political climates, health literacy, and cultural traditions may be some of the factors that contribute to heterogeneity across geography.

**Conclusions:** Factors driving overdiagnosis are different from place to place, and so are the terms used to describe it and the solutions that are designed to tackle it. Further discussion can result in the development of a robust understanding of the factors behind regional variation in terms and approaches to preventing overdiagnosis.

13:45 – Thursday 22 September – Room 132

## The rise and fall of ADHD in Perth Western Australia – lessons learned in isolation

Martin Whitely

Murdoch University, Western Australia, Australia

**Abstract:** The world’s most isolated city, Perth, Western Australia (WA), has a unique history of rapidly rising and then falling ADHD child prescribing rates. In 2002 WA’s all age per capita rate was amongst the highest in the world, exceeding the US national average. The total number of Western Australian’s prescribed psycho-stimulants grew from 880 in 1989, to 18,715 in 2002.

This explosion in prescribing rates was created by a handful of paediatricians and psychiatrists who were very enthusiastic about marketing, diagnosing and treating ADHD. In 2003 politicians concerned about indiscriminate prescribing established a parliamentary inquiry and tightened prescribing accountability measures. A vigorous local debate followed and media coverage changed from emphasising ‘disease awareness’ to highlighting concerns about ‘over-diagnosis’. This changed environment eventually saw the ‘early retirement’ from treating ADHD of some notoriously heavy prescribers.

By 2010 WA's child prescribing rates had decreased by 50%. Over a similar timeframe there was a 51% decline in self-reported rates of teenage amphetamine abuse, supporting the assertion that giving teenagers prescription amphetamines facilitates amphetamine abuse.

Although ADHD critics were successful in driving down child prescribing rates, WA continues to have the highest (and rising) adult prescribing rates in Australia. WA also has Australia's highest incidence of adult amphetamine misuse, adding further evidence to the claim that rather than preventing drug misuse, ADHD prescribing fuels the problem.

Soon to be published WA research indicates that despite the decline many WA children are still being inappropriately diagnosed and medicated. The research found that WA children born in June, the last month of the school year were more likely (boys +52%, girls +75%) to take ADHD medication than children born in July. This provided further evidence that inappropriate, relative-age influenced ADHD diagnosis occurs in jurisdictions with higher (USA and Canada) or lower (WA and Taiwan) per-capita ADHD prescribing rates.

Earlier research, which reviewed data from a long term study into the wellbeing of 3,000 WA children, provided disturbing evidence on the safety and efficacy of stimulants. The two most significant findings of the research were that:

- ▲ Amongst children diagnosed ADHD, 'never medicated' children were 10.5 times less likely to fail academically than those who had been medicated.
- ▲ Exposure to stimulant medication is associated with increased diastolic blood pressure long after children have ceased treatment.

In summary Perth's ADHD history demonstrates both why it is important to tackle this contrived epidemic, and how it can be done.

**Objectives:** To review the history of, and effects of, ADHD child prescribing in Perth Western Australia in order to identify lessons applicable to tackling overdiagnosis and overtreatment in other jurisdictions.

**Method:** This would be an interactive seminar concentrating on reviewing advocacy that was at least partially successful in tackling ADHD overdiagnosis in one jurisdiction. It would be of interest and value to conference participants advocating against overdiagnosis of ADHD and other conditions in their own jurisdictions.

16:15 – Tuesday 20 September – Room 111/112

## Special plenary discussion addressing problem of expanding diseases

This year's conference will see the first Preventing Overdiagnosis plenary debate, taking place Tuesday afternoon at 16:15 in room 111/112 – titled “Drawing the line between Health and Disease: who and how to define disease?”

The discussion will cover the controversy surrounding expanding disease definitions, and the conflicts of interest of the expert panels which expand them.

The international panel will feature:

- ▲ Leading Spanish consumer advocate **Mónica Cavagna** – from the Health & Food Department at OCU – the influential Spanish consumer group with approximately 300 000 members
- ▲ **Laragh Gollogly** – from the World Health Organisation, who is Editor of one of the world's leading public health journals, the Bulletin of the World Health Organization
- ▲ **Paul Glasziou** – a Professor from Bond University in Australia, and member of the Guidelines International Network working group on overdiagnosis – tasked with reforming how disease definitions change, and who should change them
- ▲ The chair will be leading overdiagnosis researcher **Professor Alex Barratt** from the University of Sydney

The discussion will open with short presentations from each participant – and then a structured discussion with the whole panel – with time for audience interaction as well.

08:00 – Wednesday 21 September – Room 129

## Helen MacDonald: Tips on publishing on overdiagnosis

In recent years I have edited a series of articles on overdiagnosis in the BMJ, and a theme issue on too much medicine which included comment, research and analysis articles. These pieces have been well read and cited but have often proved tricky to write. If you would like to discover more about the series, think through an idea that you have, or listen to others do the same, come to the breakfast session and learn more.

10:45 – Wednesday 21 September – Room 111/112

## Undiagnosing and deprescribing: a special session on Ageing and Overdiagnosis

Ageing and overdiagnosis is the subject of a special new clinical session being organised by Professor David Le Couteur, one of the authors of recent paper on pre-dementia, which is part of the overdiagnosis series in The BMJ. Designed for doctors to share their tips and intelligence about how they practically deal with the problem of overdiagnosis with older people, Le Couteur says his session will feature “practicing clinicians describing their approaches to undiagnosis and deprescribing in polymedicated older people and those with mental health disorders.”

The session will feature Professor of Medicine **David Le Couteur** from the University of Sydney in Australia; **Dr Anna Renom Guiteras** Geriatrician and Researcher in geriatric pharmacotherapy from the University Hospital Parc de Salut Mar in Barcelona Spain; **Professor Tim Lambert**, Director Collaborative Centre for Cardiometabolic Health in Psychosis, Charles Perkins Centre, University of Sydney, Australia; and Professor of Geriatrics and Clinical Pharmacology. **Dr Mirko Petrovic**, researcher in geriatric pharmacotherapy, Universiteit Gent in Belgium.



# 3 MINUTE ELEVATOR PITCHES

## Day 1 – Tuesday 20 September

Room 111/112	3 minute Elevator Pitches
12:40–13:30	<p><b>Don Benjamin:</b> Exploring alternative cancer paradigms</p> <p><b>Gloria S Wright:</b> Eating children: childhood obesity, schooling, parenting and doctoring feeding a hungry diagnostic market.</p> <p><b>Jack O’Sullivan:</b> Written information for patients on the use of antibiotics in acute upper respiratory infections in primary care</p> <p><b>Enrico Heffler:</b> Slow Medicine approach promoted by the Italian Society of Allergy, Asthma and Clinical Immunology (SIAAIC): choosing wisely in Allergology</p> <p><b>Joan C Vilanova:</b> Multiparametric MRI: the new paradigm to avoid overdiagnosis &amp; overtreatment in prostate cancer</p> <p><b>Nicole Grössmann:</b> What do we actually know about novel cancer therapies at the time of approval?</p> <p><b>Alan Schroeder:</b> Defining a research agenda to identify and combat overdiagnosis in children</p> <p><b>Ingvild M. Rosenlund:</b> Routine deferred computed tomography for patients with suspected urolithiasis is low-value health care.</p> <p><b>Cristina Colls:</b> Evaluation of the main factors related to hip fracture in people over 64</p> <p><b>Alexandra Barratt:</b> Markers of overdiagnosis and overtreatment in routinely collected data: application to the potential for MRI to cause overdiagnosis and overtreatment of knee and hip pathology</p> <p><b>Shanay Daham:</b> The impact of a behavioural intervention on rates of inappropriate antibiotic prescribing.</p> <p><b>Jack Dowie:</b> Where does Overdiagnosis fit in a Multi-Criteria Decision Analysis?</p> <p><b>Stuart Hogarth:</b> Overdiagnosis and the political economy of diagnostic innovation - setting a new research agenda</p> <p><b>Violeta Rabrenovich:</b> Engaging Patients and Clinicians in Shared decision making process to mitigate unnecessary harm</p> <p><b>Luciana Garbayo:</b> On Successfully Implementing Medical Guidelines for Breast Cancer Screening: A Role for Agent-Based Simulation Analysis in Mitigating Overdiagnosis</p> <p><b>Kimberley Ivory:</b> Benign euphemism or malicious doublespeak? The role of language in “over diagnosis”</p>

## Day 2 – Wednesday 21 September

Room 111/112	3 minute Elevator Pitches
12.15–12:45	<p><b>Joana Fernandes:</b> Enfermedad poliquística renal autosómica dominante en niños: sobrediagnosticada?</p> <p><b>Alicia Quilez Cutillas:</b> Cómo influye el conocimiento sobre los beneficios y riesgos relacionados con el programa de cribado en la decisión de participar: Enfoque deliberativo</p> <p><b>Núria Molist:</b> A patient-centered prescription model assessing the appropriateness of chronic drug therapy in older patients</p> <p><b>Gemma Viñas:</b> Breast cancer mortality after a diagnosis of ductal carcinoma in situ from 1985 to 2013 in Girona province.</p> <p><b>Rosa Maria Vivanco Hidalgo:</b> Dyslipidemia, statin use and lipid profile in epilepsy patients and general population: EPIVASMAR-REGICOR comparative study</p> <p><b>Sebastian Calero:</b> Is there a correlation between the overdiagnosis of hypercholesterolemia and inappropriate statin's prescription in primary prevention?</p> <p><b>Naiara Parraza:</b> Sobrediagnóstico asociado a los programas poblacionales de cribado de cáncer en la Comunidad Autónoma del País Vasco</p> <p><b>Francisco Hernansanz:</b> Prevalence of attention deficit/hyperactivity disorder in children and influence of relative age and socioeconomic status on diagnosis and treatment.</p> <p><b>Fúlvio Nedel:</b> Atención primaria y cirugía de la próstata en el sur de Brasil</p> <p><b>Dimelza Osorio:</b> Encuesta para conocer el grado de acuerdo de los médicos con las recomendaciones locales para reducir prácticas de poco valor clínico, en un hospital de tercer nivel</p>

## Day 3 – Thursday 22 September

Room 111/112	3 minute Elevator Pitches
12:30–13:10	<p><b>Gwyn Carney:</b> The Balint Movement: Historical Solutions to Prevent Overdiagnosis</p> <p><b>Johanna Caro Mendivelso:</b> Drivers for low-value practices in primary care setting: a qualitative study.</p> <p><b>Vasily Vlassov:</b> Russia's experience with overdiagnosis during 'dispanserization'</p> <p><b>Hans Johan Breidablik:</b> Specialized health service in mental health care – allocation by patient's zip code?</p> <p><b>Jack O'Sullivan:</b> Practices of no net benefit</p> <p><b>Dylan Collins:</b> Total cardiovascular risk assessment in humanitarian medical settings: implications and improvements for statin therapy in the prevention of cardiovascular diseases</p> <p><b>Wouter Havinga:</b> Stop fever phobia to reduce antibiotic prescribing in children and unnecessary GP consultations and pediatric admissions.</p> <p><b>Enrico Heffler:</b> Mis-diagnosis of lower airway obstructive diseases (asthma and COPD) and under-utilization of spirometry in primary setting.</p> <p><b>Donatella Sghedoni:</b> The first appraisal of Choosing Wisely recommendations showed disappointing results. Here are some good reasons</p> <p><b>Helen Howson:</b> Prudent Initiative</p> <p><b>Ayodele Kazeem:</b> Identifying overutilization of diagnostics and the financial impact on patient pathway costs</p> <p><b>Nora Pashayan:</b> Integrating genomics into screening programme to reduce overdiagnosis</p>

BOARD NUMBER	First name	Last name	Title
1	Sachiko	<b>Ohde</b>	Choice of optimal parameter for blood pressure screening in healthy adults: Signal versus noise
2	Johanna	<b>Caro Mendivelso</b>	Drivers for low-value practices in primary care setting: a qualitative study
4	Caroline	<b>Morris</b>	RISK-Identification to Prevent Cardiovascular Disease – How do official versions of preventative care align with the everyday experiences of front-line clinicians and patients?
5	Rosa Maria	<b>Vivanco Hidalgo</b>	Dyslipidemia, statin use and lipid profile in epilepsy patients and general population: EPIVAS-MAR-REGICOR comparative study
6	Sebastian	<b>Calero</b>	Is there a correlation between the overdiagnosis of hypercholesterolemia and inappropriate statin's prescription in primary prevention?
7	Dylan	<b>Collins</b>	Total cardiovascular risk assessment in humanitarian medical settings: implications and improvements for statin therapy in the prevention of cardiovascular diseases
8	Naiara	<b>Parraza</b>	Sobrediagnóstico asociado a los programas poblacionales de cribado de cáncer en la Comunidad Autónoma del País Vasco
9	Francisco	<b>Hernansanz</b>	Prevalence of attention deficit/hyperactivity disorder in children and influence of relative age and socioeconomic status on diagnosis and treatment
10	Nora	<b>Pashayan</b>	Integrating genomics into screening programme to reduce overdiagnosis
12	Vasily	<b>Vlassov</b>	Russia's experience with overdiagnosis during 'dispanserization'
13	Ayodele	<b>Kazeem</b>	Identifying overutilization of diagnostics and the financial impact on patient pathway costs
13 <sup>a</sup>	Margarita	<b>Posso</b>	Double reading of mammograms in a breast cancer screening programme: costs and potential overdiagnosis
14	Sarah	<b>Brown</b>	Elderly care STOPP/START prescribing audit
15	Núria	<b>Molist</b>	A patient-centered prescription model assessing the appropriateness of chronic drug therapy in older patients
16	Jakob	<b>Blüdnikow</b>	Anticoagulants in ≥80 Year-Old Patients Assessed in an Emergency Department Setting – Too Much Medicine?
17	Cristina	<b>Colls</b>	Evaluation of the main factors related to hip fracture in people over 64
19	Anna Carol	<b>Perez Segarra</b>	"Essential Project" implementation in the San Rafael hospital
20	Érica	<b>Breslau</b>	De-implementation: Individualized cancer screening decisions as a way to achieve optimal care for older adults
21	Dimelza	<b>Osorio</b>	Utilización del Antígeno Prostático Específico (PSA) en el cribado de cáncer de próstata a nivel ambulatorio: atención primaria y la consulta externa.
23	Don	<b>Benjamin</b>	Exploring alternative cancer paradigms
24	Mie Sara	<b>Hestbech</b>	How does HPV vaccination status relate to risk perceptions and intention to participate in cervical screening? A survey study
25	Gwyn	<b>Carney</b>	The Balint Movement: Historical Solutions to Prevent Overdiagnosis
26	Laura	<b>Cámara Roca</b>	Se busca enfermedad para este fármaco. La Flibanserina y el Deseo Sexual Hipoactivo

27	Gloria S	<b>Wright</b>	Eating children: childhood obesity, schooling, parenting and doctoring feeding a hungry diagnostic market.
28	Ginny	<b>Russell</b>	What is the right level for a clinical cut point? The case of autism and ADHD
29	Luciano	<b>Duro</b>	Overscreening of lipid profile in a population based sampling: Exemple of study design
30	Hans Johan	<b>Breidablik</b>	Specialized health service in mental health care – allocation by patient's zip code?
31	Jack	<b>O'Sullivan</b>	Practices of no net benefit
32	Wouter	<b>Havinga</b>	Is the flu vaccine of any use or wasting public money?
33	Owen	<b>Dempsey</b>	“Who dies?” – A discourse analysis of the battle between the marketisation of genetic tests to predict cancer recurrence and its inadequate regulation by governmental expert health-economic appraisal in three advanced economies: the implications for over-diagnosis, over-treatment and the 'sacrifice' of publicly funded healthcare for voiceless 'others'
34	Tom	<b>Axelrod</b>	Overdoing in community medicine: a case report coping with a renal incidentaloma
35	Fúlvio	<b>Nedel</b>	Atención primaria y cirugía de la próstata en el sur de Brasil
36	Gabriel	<b>Eli</b>	Medicina Centrada en la Persona y las prácticas en Atención Primaria en el Curso de Medicina de la Universidade Federal de Santa Catarina, sur de Brasil
37	Wouter	<b>Havinga</b>	Stop fever phobia to reduce antibiotic prescribing in children and unnecessary GP consultations and pediatric admissions
38	Dimelza	<b>Osorio</b>	Encuesta para conocer el grado de acuerdo de los médicos con las recomendaciones locales para reducir prácticas de poco valor clínico, en un hospital de tercer nivel
39	Jack	<b>O'Sullivan</b>	Written information for patients on the use of antibiotics in acute upper respiratory infections in primary care
40	Enrico	<b>Heffler</b>	Slow Medicine approach promoted by the Italian Society of Allergy, Asthma and Clinical Immunology (SIAAIC): choosing wisely in Allergology
41	Joan C	<b>Vilanova</b>	Multiparametric MRI: the new paradigm to avoid overdiagnosis & overtreatment in prostate cancer
42	Ragnar	<b>Levi</b>	Using Journalistic Tools in a Long-Term Endeavour to Promote Critical Thinking
43	Petra	<b>Rosado Varela</b>	Women's perceptions of mammography screening. Using an informed consent in mammography screening: final results of a randomized trial in Spain
44	Joana	<b>Fernandes</b>	Enfermedad poliquística renal autosómica dominante en niños: sobrediagnosticada?
45	Alicia	<b>Quilez Cutillas</b>	Cómo influye el conocimiento sobre los beneficios y riesgos relacionados con el programa de cribado en la decisión de participar: Enfoque deliberativo
46	Marta	<b>Zwart</b>	The efficiency of the use of DXA in preventing osteoporotic fractures through a training intervention using a control group based on the FRAX tool with specific FRIDEX values
47	Margarita	<b>Posso</b>	Clinical recommendations of low-value diagnostic tests available in DianaHealth.com
48	Alex	<b>Ghanouni</b>	Information on 'overdiagnosis' in breast cancer screening on prominent United Kingdom- and Australia-oriented health websites
49	Esteve	<b>Llargués</b>	Uso adecuado de las pruebas diagnósticas: necesidad de aprendizaje temprano

50	Donatella	<b>Sghedoni</b>	The first appraisal of Choosing Wisely recommendations showed disappointing results Here are some good reasons
51	Gemma	<b>Viñas</b>	Breast cancer mortality after a diagnosis of ductal carcinoma in situ from 1985 to 2013 in Girona province
52	Shanay	<b>Daham</b>	The impact of a behavioural intervention on rates of inappropriate antibiotic prescribing
53	Jack	<b>Dowie</b>	Where does Overdiagnosis fit in a Multi-Criteria Decision Analysis?
54	Neus	<b>Gual</b>	Feasibility Study of motivational interviewing to improve rehabilitation in an Intermediate Care Hospital
55	Violeta	<b>Rabrenovich</b>	Engaging Patients and Clinicians in Shared decision making process to mitigate unnecessary harm
56	Luciana	<b>Garbayo</b>	On Successfully Implementing Medical Guidelines for Breast Cancer Screening: A Role for Agent-Based Simulation Analysis in Mitigating Overdiagnosis
57	Enrico	<b>Heffler</b>	Mis-diagnosis of lower airway obstructive diseases (asthma and COPD) and under-utilization of spirometry in primary setting
58	Giuseppe	<b>de Biase</b>	Surveillance of congenital malformations in Calabria
59	Nicole	<b>Grössmann</b>	What do we actually know about novel cancer therapies at the time of approval?
60	Ingvild M.	<b>Rosenlund</b>	Routine deferred computed tomography for patients with suspected urolithiasis is low-value health care
61	Roland	<b>Grad</b>	POEMs suggest new recommendations for the Choosing Wisely campaign
62	Alexandra	<b>Barratt</b>	Markers of overdiagnosis and overtreatment in routinely collected data: application to the potential for MRI to cause overdiagnosis and overtreatment of knee and hip pathology
63	Sara Eva	<b>Kaae Toft</b> (co-presenter)	The psychosocial consequences of receiving a false positive result in screening for colorectal cancer
64	Luis Carlos	<b>Saiz</b>	When distorted evidence-based medicine leads to overtreatment. The Improve-It trial case L
65	Luis Carlos	<b>Saiz</b>	Blood pressure targets and potential overtreatment in hypertensive patients with established cardiovascular disease L
66	Stuart	<b>Hogarth</b>	Overdiagnosis and the political economy of diagnostic innovation – setting a new research agenda
67	Helen	<b>Howson</b>	Prudent Initiative
68	Kimberley	<b>Ivory</b>	Benign euphemism or malicious doublespeak? The role of language in "overdiagnosis"

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