



PREVENTING
OVERDIAGNOSIS

Winding back the harms of too much medicine

SEPTEMBER 1-3, 2015

CO-SPONSORED BY

NATIONAL CANCER INSTITUTE

Division of Cancer Prevention

UNIVERSITY OF OXFORD

Centre for Evidence-Based Medicine

NATCHER CONFERENCE CENTER

National Institutes of Health | Bethesda, Maryland USA

NOTICE OF PHOTOGRAPHY & FILMING

Preventing Overdiagnosis 2015 is being visually documented. By your attendance you acknowledge that you have been informed that you may be photographed and recorded during this event. Images taken will be treated as property of Preventing Overdiagnosis and may be used in the future for promotional purposes. These images may be used without limitation by any organisation approved by the Preventing Overdiagnosis scientific committee and edited prior to publication as seen fit for purpose.

Images will be available on the Internet, accessible to Internet users throughout the world including countries that may have less extensive data protection laws than partnering organisation countries.

All films will be securely stored on the University of Oxford servers. Please make yourself known at the registration desk if you wish to remain off camera.

Thank you for your cooperation.

CONFERENCE PARTNERS

The Dartmouth Institute

Bond University, Centre for Research in Evidence-Based Practice

The BMJ

Consumer Reports

University of Oxford, Centre for Evidence-Based Medicine

The views expressed in these materials or by presenters or participants at the event do not necessarily reflect the official policies of the U.S. Department of Health and Human Services, the National Institutes of Health, the National Cancer Institute, or any NIH component.

TABLE OF CONTENTS

WELCOME

2015 Scientific Committee

4

KEYNOTES BIOS

6

PROGRAMME

16

KEYNOTE ABSTRACTS

32

WORKSHOP ABSTRACTS

34

SEMINAR ABSTRACTS

48

PANEL SESSION ABSTRACTS

61

POSTERS

66

NOTES

67

MAPS

WELCOME

We are pleased to welcome you to the 3rd Preventing Overdiagnosis conference, held in Bethesda, Maryland on the campus of the US National Institutes of Health. The meeting co-sponsors, the U.S. National Cancer Institute and the Centre for Evidence-Based Medicine at the University of Oxford, as well as our conference partners, the Dartmouth Institute for Health Policy and Clinical Practice, The BMJ, Bond University and Consumer Reports, hope this meeting will both inform and inspire.

This annual conference draws a spectrum of health professionals and scientists together to go over the most appropriate methods of identifying overdiagnosis and determining the necessary research directions to reach needed answers. The Preventing Overdiagnosis meeting is a manifestation of the importance of gathering investigators from a wide range of fields and disciplines to talk about what is known regarding the natural history of diagnosed conditions; what the driving factors are; what the consequences of overdiagnosis are; to the extent known, how to mitigate the consequences; and how to counsel patients about both the benefits and harms of screening and diagnostic testing. The conference received an overwhelming response to the call for abstracts, attracting an impressive amount of quality science from across the globe.

Delegates will convene to share research, opinions and ideas across more than 150 presentations, posters, workshops and seminars all focusing on the issues of overdiagnosis, what is driving it and what can be done about it. We will spend three full days discussing major areas of concern: the description, definitions and consequences of overdiagnosis (day 1); analytic approaches and identification of causes of overdiagnosis (day 2); and interventions to decrease overdiagnosis or mitigate harms.

As co-chairs of the conference planning committee, we hope that you enjoy the conference and we are looking forward to working with you to prevent overdiagnosis.

Barry Kramer, Director, Division of Cancer Prevention, National Cancer Institute,
National Institutes of Health, US Department of Health and Human Services

Lisa Schwartz and Steve Woloshin, Co-Directors, Center for Medicine and the Media
The Dartmouth Institute for Health Policy and Clinical Practice

2015 SCIENTIFIC COMMITTEE

Alexandra Barratt - University of Sydney

Otis Brawley - American Cancer Society

John Brodersen - University of Copenhagen

Jenny Doust - Bond University

Lisa Gill - Consumer Reports

Paul Glasziou - Bond University

Russ Harris - University of North Carolina

Iona Heath - Royal College of General Practitioners

Carl Heneghan - Centre for Evidence-Based Medicine, University of Oxford

David Henry - University of Toronto

David Klemperer - Regensburg University of Applied Sciences

Barry Kramer - National Cancer Institute, Division of Cancer Prevention

Ray Moynihan - Bond University

Lisa Schwartz - The Dartmouth Institute

Timothy Wilt - US Department of Veterans Affairs

Steve Woloshin - The Dartmouth Institute

EVENT COORDINATOR

Ruth Davis, Centre for Evidence-Based Medicine, University of Oxford, UK

Kathy Marshall, National Cancer Institute, US

KEYNOTE BIOS

KEYNOTE SESSION

1

Tuesday, September 1st

9:10 - 9:30

Otis Brawley, MD, MACP, Chief Medical and Scientific Officer, Executive Vice President, Research. American Cancer Society

As the chief medical and scientific officer and executive vice president of the American Cancer Society, Otis Webb Brawley, MD, is responsible for promoting the goals of cancer prevention, early detection, and quality treatment through cancer research and education. He champions efforts to decrease smoking, improve diet, detect cancer at the earliest stage, and provide the critical support cancer patients need. He also guides efforts to enhance and focus the research program, upgrade the Society's advocacy capacity, and concentrate community cancer control efforts in areas where they will be most effective. Further, as an acknowledged global leader in the field of health disparities research, Dr. Brawley is a key leader in the Society's work to eliminate disparities in access to quality cancer care.

Dr. Brawley currently serves as professor of hematology, oncology, medicine and epidemiology at Emory University. He is also a medical consultant to the Cable News Network (CNN). From April of 2001 to November of 2007, he was medical director of the Georgia Cancer Center for Excellence at Grady Memorial Hospital in Atlanta, and deputy director for cancer control at the Winship Cancer Institute at Emory University. He has also previously served as a member of the Society's Prostate Cancer Committee, co-chaired the U.S. Surgeon General's Task Force on Cancer Health Disparities, and filled a variety of positions at the National Cancer Institute (NCI), most recently serving as Assistant Director.

Currently, Dr. Brawley is a member of the Centers for Disease Control and Prevention Advisory Committee on Breast Cancer in Young Women. He was a member of the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection and Control Advisory Committee. He served as a member of the Food and Drug Administration Oncologic Drug Advisory Committee and Chaired the NIH Consensus



Panel on the Treatment of Sickle Cell Disease.

He is listed by Castle Connolly as one of America's Top Doctors for Cancer. Among numerous other awards, he was a Georgia Cancer Coalition Scholar and received the Key to St. Bernard Parish for his work in the U.S. Public Health Service in the aftermath of Hurricane Katrina.

Dr. Brawley is a graduate of University of Chicago, Pritzker School of Medicine. He completed a residency in internal medicine at University Hospitals of Cleveland, Case-Western Reserve University, and a fellowship in medical oncology at the National Cancer Institute.

9:30 - 9:50

Virginia A. Moyer, MD, MPH, Vice President for Maintenance of Certification and Quality, American Board of Pediatrics

Dr. Moyer graduated from Baylor College of Medicine in 1977, and trained in Pediatrics at Children's National Medical Center in Washington DC. She later obtained her MPH degree from the University of Texas School of Public Health. Dr. Moyer practiced general pediatrics in Houston in the 1980s, and subsequently joined the faculty at the University of Texas at Houston, where she was Director of Community and General Pediatrics, and Associate Director of the Center for Evidence Based Medicine and Clinical Research. She returned to Baylor in 2006, where she was Professor of Pediatrics and the inaugural Chief Quality Officer at Texas Children's Hospital, and was Deputy Editor of Pediatrics and Associate Editor of Evidence Based Child Health: A Cochrane Journal. Dr. Moyer has particular interests in teaching clinical epidemiology, studying the use of diagnostic tests in clinical care, and is a federally funded patient



KEYNOTE BIOS

safety researcher. She is past chair of the United States Preventive Services Task Force, is a member of the Evidence Based Medicine Working Group and the International Advisory Board for the Cochrane Collaboration Child Health Field, and is Chair of the Board of Directors of the Portfolio Program, ABMS. Dr. Moyer is author of more than 140 scientific articles and chapters and is Editor of the book Evidence Based Pediatrics and Child Health. In 2004, Dr. Moyer received the Leonard Tow Humanism in Medicine award at the University of Texas, and in 2006 was inducted into the University of Texas Academy of Health Science Education. She was named by Time Magazine as a “person who mattered” in 2011.

9:50 - 10:10

Alan Schwarz, Reporter, New York Times

Alan Schwarz is a National Correspondent for The New York Times who focuses on matters of public health. His four-year series of more than 100 articles on the seriousness of sports-related concussions was a finalist for the 2010 Pulitzer Prize for Public Service, and has been generally credited with revolutionizing the care of concussions in sports worldwide. From 2012 to 2014 he wrote another series about the misdiagnosis of and misuse of medications for Attention Deficit Hyperactivity Disorder, primarily in children.



10:10 - 10:30

PANEL DISCUSSION

KEYNOTE SESSION

2

Wednesday, September 2nd

9:30 - 9:50

Laura Esserman, MD, MBA, Director, Carol Franc Buck Breast Care Center, Professor, Departments of Surgery and Radiology, and Affiliate Faculty, Institute for Health Policy Studies, University of California - San Francisco

Laura Esserman is a surgeon and breast cancer oncology specialist practicing at the UCSF Carol Franc Buck Breast Care Center where she has also held the position of Director since 1996. She co-leads the Breast Oncology Program, the largest of the UCSF Helen Diller Comprehensive Cancer Center's multidisciplinary programs. The program is comprised of 69 faculty members who represent 16 academic specialties and is internationally recognized and well-established with major initiatives in epidemiology, genetics, biology, therapeutics, and clinical cancer care. She is a professor of Surgery & Radiology at UCSF and faculty at the UCSF Helen Diller Family Comprehensive Cancer Center where she founded the program in Translational Informatics. As part of this program, her research has focused on bioinformatics, medical and clinical informatics, systems integration, and clinical care delivery.



9:50 - 10:10

Hyeong Sik Ahn, MD, PhD, Korea University School of Medicine

A health services researcher at the Korea University School of Medicine. He graduated with a degree in medicine from the Seoul National University in 1985. He completed his post graduate training and was board certified in Preventive Medicine in 1990. He then received a PhD in preventive medicine from the Seoul National University in 1995. He had worked in Korea



KEYNOTE BIOS

University as a professor and chairman of the Department of Preventive Medicine since 1996. He has been working on evidence based medicine and is a leader on a variety projects for health policy issue. He totally published 50 papers on international and Korean refereed journals, which have been cited over 400 times, and is the author of several books. His research has been supported by grants from the following sources: Ministry of Health and Welfare, Korean government, Academic Institute in Korea, and National Insurance Cooperation. He also worked on development of academic organization on his research field including Cochrane Korea. He is currently appointed as director Institute for Evidence based Medicine, also Dean of School of Public Health, Korea University

10:10 - 10:30

Cindy Pearson, Executive Director of the National Women's Health Network.

Founded in 1975, the Network was the first feminist health group to utilize a national membership in support of D.C.-based health activism. The Network's goal is to bring the voices of women everywhere decisions are being made that affect women's health. The Network testifies before Congress and the FDA, speaks out at scientific meetings, publicizes issues through the media, networks individual activists and other local and national groups working on women's health, and mobilizes its constituency to influence decisions made by federal regulatory agencies. The Network is a co-founder of Raising Women's Voices for the Health Care We Need, a national initiative working to make sure women's voices are heard and women's concerns are addressed in health care reform.

In addition to representing the Network in the media and to the government, Cindy has served on the Boards of the Reproductive Health Technologies Project, the National Action Plan on Breast Cancer, the Campaign for Women's Health, the D.C. Women's Council on AIDS, and the Advisory Board of Our





Bodies Ourselves. In recognition of the NWHN's leading role in advocating for the creation of the NIH Office of Research on Women's Health and providing guidance thereafter, Cindy was presented with the Keystone Award for Advocacy for Women's Health Research on the 20th anniversary of the Office. NWHN recently received the Grassroots Activism Award from the National Breast Cancer Coalition for its role in reducing breast cancer rates significantly for the first time in U.S. history by ensuring that women had the information they needed to avoid unnecessary exposure to drugs that would have caused it.

10:30 - 11:00

PANEL DISCUSSION

KEYNOTE BIOS

KEYNOTE SESSION

3

Thursday, September 3rd

9:00 - 9:20

Ned Calonge, MD, MPH, President and CEO of The Colorado Trust

The Colorado Trust is a private grant-making foundation dedicated to achieving health equity for all Coloradans. Dr Calonge is an Associate Professor of Family Medicine at the Colorado School of Medicine, University of Colorado, Denver, and an Associate Professor of Epidemiology at the Colorado School of Public Health. Nationally, he chairs the CDC's Evaluating Genomic Applications for Practice and Prevention (EGAPP) Working Group and the Agency for Healthcare Research and Quality's (AHRQ's) Electronic Data Methods (EDM) Forum Advisory Committee, and is a member of the CDC's Task Force on Community Preventive Services and of CDC's Breast and Cervical Cancer Early Detection and Control Advisory Committee. Dr Calonge serves on the Institute of Medicine's Board on Population Health and Public Health Practice as well as on the Roundtable on the Achievement of Health Equity and the Elimination of Health Disparities. He is a past Chair of the United States Preventive Services Task Force and is a past member of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. Prior to coming to The Trust, Dr Calonge was the Chief Medical Officer of the Colorado Department of Public Health and Environment. Dr. Calonge received his BA in Chemistry from The Colorado College, his MD from the University of Colorado and his MPH from the University of Washington, where he also completed his preventive medicine residency. He completed his family medicine residency at the Oregon Health Sciences University. He was elected to the Institute of Medicine in 2011.



9:20 - 9:40

John Brodersen, GP, PhD, Research associate professor, Associate Professor, University of Copenhagen, Department of Public Health, Research Unit and Section of General Practice

Dr Brodersen is general practitioner with over ten years experience in clinical practice. He has a PhD in public health and psychometrics and works as a professor in the area of prevention, medical screening and evidence-based medicine.

His research is focused on the field of development and validation of questionnaires to measure psychosocial consequences of medical screening. He has employed qualitative and quantitative methods for example developed patient reported outcomes measures qualitatively and validated those using Item Response Theory Rasch models to objectify subjective areas like psychosocial consequences. He has published widely in peer reviewed journals.

In relation to the areas of self-testing and screening Dr Brodersen expertise lies in areas of diagnostic test accuracy, overdiagnosis, informed consent and what the psychosocial consequences are for healthy people when they are tested. He also teaches nationally and internationally in evidence-based medicine.



KEYNOTE BIOS

9:40 - 10:00

Ina Kopp, Prof Dr med., Director of the German Association of the Scientific Medical Societies' Institute of Medical Knowledge-Management (AWMF-IMWi) at Philipps-University, Marburg.

AWMF-IMWi is the Clearinghouse of Clinical Practice Guidelines developed by the 156 specialty societies organized under the umbrella of AWMF. Dr Kopp serves as coordinator and consultant for CPG development and oversees the internet distribution of CPGs, related information and tools for guideline developers via the AWMF-website. She is vice chair of AWMF's Standing Commission for Clinical Practice Guidelines and represents AWMF in the National Programme for Disease Management Guidelines and in the Programme for Guidelines in Oncology in Germany. She is involved in several quality initiatives on the national level such as the National Project for Cross-Sectoral Quality in Health Care and the National Cancer Plan of the Federal Ministry of Health. She trained in general surgery (1995-2000) and internal medicine (2001-2002), received her MD and her professorship from the University of Marburg and did research work in the field of health services research and quality improvement. She is author or coauthor of 7 books and over 150 publications.



10:00 - 10:30

PANEL DISCUSSION

KEYNOTE SESSION

4

Thursday, September 3rd

1:30 - 2:00

Lisa M. Schwartz, MD, MS and Steven Woloshin, MD, MS,
The Dartmouth Institute

Lisa & Steve are general internists Professors of Medicine and Community & Family Medicine, and co-Directors of the Center for Medicine and the Media at the Dartmouth Institute for Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth (Lebanon, NH, USA). Their research addresses the excessive fear and hope created by exaggerations, and selective reporting in medical journals, advertising, and the health news. They have worked to improve communication of medical evidence to physicians, journalists and the public and are the co-founders of Informulary, Inc. (<http://www.informulary.com/>) a company that provides data about the benefits, harms and uncertainties of prescription drugs. Woloshin & Schwartz have co-authored 2 books: *Know Your Chances* and *Overdiagnosed*, and their essays have appeared in the *New York Times*, *Washington Post* and *LA Times*.



2:00 - 2:30

Ray Moynihan, PhD, Senior Research Fellow, Bond University

Ray is an internationally respected academic researcher, journalist and author. His critically acclaimed 2005 book "Selling Sickness: how the world's biggest pharmaceutical companies are turning us all into patients", was translated into 12 languages. Currently a Senior Research Fellow at Bond University's Centre for Research in Evidence-Based Practice, Ray has worked across radio, print, television and on-line, with time at ABC Four Corners and the Australian Financial Review. A former Harkness Fellow based at Harvard University, his academic research and commentary has been published in the *NEJM*, *Lancet*, *PLOS Medicine*, *MJA* and *The BMJ*.



PROGRAMME

DAY ONE

1

TUESDAY, SEPTEMBER 1ST

07:00 - 09:00

Registration

Natcher Building (Downstairs lobby)

09:00 - 09:10

Welcome – Barry Kramer

Ruth L Kirschstein Auditorium

09:10 - 10:30

Key Note Session 1 - Chair, Fiona Godlee

Ruth L Kirschstein Auditorium

09:10 - 09:30

Otis Brawley – Overdiagnosis: Pathologic Profiling!!!

09:30 - 09:50

Virginia Moyer – The Not-So-Well Child: Overdiagnosis in Pediatrics

09:50 - 10:10

Alan Schwarz – Rising ADHD Diagnosis Rates: What Does The Data Mean?

10:10 - 10:30

Discussion

10:30 - 11:00

Tea and Coffee Break with Poster Viewing

Upstairs lobby

11:00 - 12:30

Parallel Sessions

Session 1A

Ruth L Kirschstein Auditorium

Causes and Drivers of Overdiagnosis

Chair: Carl Heneghan

Abstract 0031 The early detection epidemic in health care – Bjørn Hoffman

Abstract 0087 Potential overtreatment of chronic diseases and associations with polypharmacy in nursing home patients: a cross-sectional survey – Rita McCracken

Abstract 0088 Benefits and harms of routine preoperative testing: comparative effectiveness review – Elisabeth Kato

Abstract 0091 Prevalence of incidental prostate cancer: a systematic review of autopsy studies – James Dickinson

Abstract 0115 Acute rheumatic fever and other post-streptococcal pharyngitis complications in North America in the 21st Century - do current guidelines lead to overdiagnosis and overtreatment? – Ian Johnston

Abstract 0124 Overdiagnosis, overtreatment and quaternary prevention in primary care – a qualitative study with general practitioners – Thomas Kühlein

Discussion – time permitting

Session 1B

Balcony A/B

Methodology for Measuring and Researching Overdiagnosis / Communicating About Overdiagnosis

Chair: Rae Thomas

Abstract 0003 Cardiac stress testing is associated with no benefit and significant overdiagnosis of coronary disease in emergency department patients with chest pain: a comparative effectiveness study – Andrew Foy

Abstract 0049 Why is it so hard to estimate how many people are overdiagnosed? – Ruth Etzioni

Abstract 0072 Balancing glycemic overtreatment and undertreatment for seniors: an out of range (OOR) population health safety measure – Leonard Pogach

Abstract 0025 Initiation of statin therapy for primary prevention according to gender and age: overprescribing in postmenopausal women with 'hypercholesterolemia'? – Helle Wallach-Kildemoes

Abstract 0102 Meta-analysis of overdetection in trials of mammography screening: an example of adjusting for unplanned cross-over in cancer screening trials – Gemma Jacklyn

Discussion – 15 minutes

Session 1C

Rm E1/E2

Prevalence of Overdiagnosis

Chair: John Brodersen

PROGRAMME

- Abstract 0008** Overdiagnosis of infant swallowing abnormalities by videofluoroscopic swallow studies – Eric Coon
- Abstract 0014** Breast cancer over-screening at an academic center in Latin America – Maria Salgado
- Abstract 0032** Size of breast cancers and level of overdiagnosis with breast screening in Denmark – Karsten Jørgensen
- Abstract 0037** Preoperative testing prior to low-risk surgical procedures – Kyle Kirkham
- Abstract 0053** Using a novel graphing approach to better understand the relationship between cancer statistics and changes in diagnosis patterns – Kathy Cronin
- Abstract 0062** A professional society's response to medical resource overuse – Cynthia D. Smith
- Discussion** – time permitting

11:00 - 12:30

Seminars

Rm F1 & F2

Rm A

Abstract 0150 Goldilocks optimal care: not doing too much or too little care, but just right – Linda Radler

Abstract 0122 Shared decision making interventions to address overdiagnosis and overtreatment: lessons learned – Kirsten McCaffery, Juan Brito, Jolyn Hersch, Mara Schonberg, Stacey Sheridan

11:00 - 12:30

Panel Session

Balcony C

ADHD Around the World: Problems and Solutions
Moderators: Allen Frances & Donna Manning
Panelists: Rae Thomas & C. Keith Conners

12:30 - 1:30

Lunch with Poster Viewing

Both lobbies

1:30 - 3:00

Parallel Sessions

Session 2A

Ruth L Kirschstein Auditorium

Causes and Drivers of Overdiagnosis & Consequences of Overdiagnosis

Chair: Carl Heneghan

Abstract 0159 Over-prescribed: an analysis of pre-participation sport physical exams – Gene Harkless

Abstract 0164 Overdiagnosis and the obesity epidemic: when cultural dogma trumps evidence-based medicine – Robert Gelfand

Abstract 0167 Risk perception, preferences and behaviors in prostate cancer screening: a system without negative feedback – Ozge Karanfil

Abstract 0026 Over investigation, over diagnosis and over treatment in the Middle East – Robin Davidson

Abstract 0125 Consequences of overdiagnosis – Lars Kristian Hebsgaard Jessen

Discussion – 15 minutes

Session 2B

Balcony A/B

Description of Problem (Qualitative and Quantitative) General

Chair: Iona Heath

Abstract 0054 Trends in prostate-specific antigen testing following 2012 USPSTF recommendation: retrospective longitudinal study - Mei Sing Ong

Abstract 0057 Race/ethnicity and Americans' perceptions and experiences of over- and under-use of care – Nancy Kressin

Abstract 0074 Competing priorities: a national survey of individuals with depression and clinicians who treat depression – Paul Barr

PROGRAMME

Abstract 0090 External validity of placebo-controlled trials of thromboprophylaxis for medical patients cited in clinical practice guidelines – Sami Morin, Ben Abdallah

Abstract 0104 Overdiagnosis of chronic obstructive pulmonary disease in the UK – Halima Buni

Abstract 0116 Assessment of benefit of ultrasound monitoring of adnexal masses <10 cm for ovarian cancer early detection – Betty Suh-Burgmann

Discussion – time permitting

Session 2C

Rm E1/E2

Prevalence of Overdiagnosis (Specific Conditions or General) & Policy or Intervention for Reducing/Preventing Overdiagnosis

Chair: Alexandra Barratt

Abstract 0096 What gain is worth a daily pill? A systematic review – Loai Albarqouni

Abstract 0107 Advancing overuse research: what did we learn in 2014? – Deborah Korenstein

Abstract 0126 Quantification of overdiagnosis in randomized trials of cancer screening: an overview of systematic reviews – Mikela Krag

Abstract 0131 Overuse of PET, CT and radionuclide bone scans in the staging of early prostate and breast cancer patients - measurement of ASCO's Choosing Wisely recommendations – Momoko Iwamoto

Abstract 0066 Preoperative laboratory testing prior to low-risk surgical procedures – Ciara Pendrith

Discussion – 15 minutes

1:30 - 3:00

Workshops

Rm A

Rm D

Abstract 0039 Overdiagnosis as an issue for life and living benefits insurance – Kevin Somerville & John Schoonbee

Abstract 0058 Quantifying overdiagnosis in cancer screening: evaluation of study designs – Dorien Ripping & Kevin ten Haaf

1:30 - 3:00

Seminars

Balcony C

Rm F1/F2

Abstract 0105 Symposium: understanding overdiagnosis, medical overuse and avoidable care: a consensus-derived research agenda – Daniel Morgan, Aaron Leppin & Shanon Brownlee

Abstract 0052 Potential examples of pediatric overdiagnosis – Eric Coon

3:00 - 3:30

Tea and Coffee Break with Poster Viewing

Upstairs lobby

3:30 - 5:00

Parallel Session

Session 3A

Rm F1/ F2

Description of Problem (Qualitative and Quantitative) General

Chair: Jack O'Sullivan

Abstract 0128 Obtaining informed consent by invitations to cervical screening – John Brodersen & Karsten Juhl Jørgensen

Abstract 0140 Veterans' identification of important factors in lung cancer screening decision making – Sarah Lillie

Abstract 0152 Treatment preferences for active surveillance vs active treatment among men with low risk prostate cancer – Kathryn Taylor

Abstract 0163 When do changes in cancer survival mean progress? – Hyunsoon Cho

Abstract 0147 The direct and derived costs of lung cancer CT screening in a Danish setting – Manja Dahl Jensen

Discussion – 15 minutes

PROGRAMME

3:30 - 5:00

Workshop

Rm D

Abstract 0144 Choosing Wisely and maximizing value: lessons from the US Veterans Health Administration Healthcare System – Nancy Kressin, Linda Kinsinger, Timothy Wilt & David Aron

3:30 - 5:00

Seminar

Balcony A/B

Abstract 0035 The role of the media in promoting or preventing overdiagnosis – Gary Schwitzer

DAY TWO

2

WEDNESDAY, SEPTEMBER 2ND

07:30 - 09:30

Registration

Natcher Building (Downstairs lobby)

09:30 - 11:00

Key Note Session 2 - Chair, Barry Kramer

Ruth L Kirschstein Auditorium

09:30 - 09:50 Laura Esserman – Understanding the basis of overdiagnosis should drive solutions to mitigate harm

09:50 - 10:10 Hyeong Sik Ahn – Korea Thyroid Cancer Epidemic and Afterwards

10:10 - 10:30 Cynthia Pearson – Overdiagnosis and Women's Health: Challenges and Opportunities

10:30 - 11:00 Discussion

11:00 - 11:30

Tea and Coffee Break with Poster Viewing

Upstairs lobby

11:30 - 1:00

Parallel Sessions

Session 4A

Ruth L Kirschstein Auditorium

Causes and Drivers of Overdiagnosis

Chair: David Henry

Abstract 0022 Selective cutoff reporting in studies of diagnostic test accuracy of depression screening tools: comparing traditional meta-analysis to individual patient data meta-analysis – Brooke Levis

Abstract 0136 Perceptions and attitudes of primary care physicians toward overdiagnosis and unnecessary care – Cari Almazán

Abstract 0146 Political foundations of overdiagnosis: transformations in modeling and measuring illness at the National Institute of Mental Health – Herschel Nachlis

Abstract 0165 Dynamics of routine health screening: why is screening so common for some diseases when evidence is so uncertain? – Ozge Karanfil

Abstract 0064 A diagnostic discovery: transforming low back and neck pain care – Ronald Donelson

Discussion – 15 minutes

Session 4B

Balcony A/B

Causes and Drivers of Overdiagnosis

Chair: Iona Heath

Abstract 0002 Recognizing intervention bias in the practice of medicine – Andrew Foy

Abstract 0046 New PR tactics promoting drugs for “female sexual dysfunction” – Leonore Tiefer

Abstract 0095 Intensive monitoring after resection of primary colorectal cancer advances diagnosis of liver and lung metastases but does not improve survival – Tom Treasure

Abstract 0103 Is there over screening for cancer in patients with limited estimated life expectancy? A cross sectional study in Israel – Ronen Bareket

PROGRAMME

Abstract 0145 Race/ethnicity and overuse of care: result from a systematic review of the literature – Nancy Kressin

Discussion – 15 minutes

Session 4C

Rm F1/F2

Policy or Interventions for Reducing/Preventing Overdiagnosis (Interventions)

Chair: David Klemperer

Abstract 0030 A checklist for modifying disease definition: a method to reduce overdiagnosis – Ina Kopp

Abstract 0112 Reducing overdiagnosis by obtaining second opinions: the potential population impact of alternative breast pathology reading strategies – Anna Tosteson

Abstract 0141 Establishment of the Israeli Society for the Reduction of Overdiagnosis – Anat Gaver

Abstract 0168 Challenging the selling of sickness: a partnership model of professionals and advocates for a new social health movement – Kim Witczak

Abstract 0123 Comparison of the 2009 and 2013 appropriate use criteria for single photon emission computed tomography (SPECT) at a Canadian academic hospital – Kareem Morant

Abstract 0015 The overdiagnosis of Attention Deficit Hyperactivity Disorder: an ideological perspective or cause for concern? – Sheelah Mills

Discussion – time permitting

11:30 - 1:00

Workshop

Rm A

Abstract 0070 Choosing Wisely: is it wise enough? Criticisms (and solutions) for the campaign – Jessica Otte & James Rickert

11:30 - 1:00

Seminars

Balcony C

Rm D

Abstract 0034 ADHD overdiagnosis in Louisiana, a child and adolescent psychiatrist's perspective – Kristopher Kaliebe

Abstract 0013 Symposium: shortfalls in clinical decision making that contribute to overdiagnosis and overtreatment – Daniel Morgan, Aaron Leppin, Deborah Korenstein & Cynthia D Smith

11:30 - 1:00

Panel Session

Rm E1 & E2

Communicating About Overdiagnosis

Moderator: Ray Moynihan

Panelists: Kirsten McCaffery, Steven Woloshin & Lisa Schwartz, Lisa Gill & Jolyn Hersch

1:00 - 2:30

Lunch with Poster Viewing

Both lobbies

2:30 - 4:00

Parallel Sessions

Session 5A

Ruth L Kirschstein Auditorium

Causes and Drivers of Overdiagnosis, Consequences of Overdiagnosis (Interventions)

Chair: David Henry

Abstract 0027 Small renal masses discovered on low-dose CT scans of the thorax in the National Lung Screening Trial (NLST) – Barbara Dunn & Paul Pinsky

Abstract 0099 Going beyond limited evidence: an approach for guideline panels to help reduce overdiagnosis by providing additional guidance - William M Garneau

Abstract 0106 Practices to question in 2014 – Sanket Dhruva

PROGRAMME

Abstract 0161 Active surveillance of prostate cancer detected by population based screening – Michael Leapman

Abstract 0082 The overuse and misuse of musculoskeletal imaging: the initiating step to overdiagnosis, overtreatment and unnecessary management – Paul Levin

Abstract 0143 Understanding the nature of PSA (prostate specific antigen) prevents overdiagnosis – Juerg Kuoni

Discussion – time permitting

Session 5B

Balcony A/B

Methodology for Measuring and Researching Overdiagnosis & Communicating About Overdiagnosis (Interventions)

Chair: Alexandra Barratt

Abstract 0059 Can a single question be used to facilitate shared decision making for lung cancer screening? – Tanner Caverly

Abstract 0098 Influence of information about risks, lack of benefits, and expert recommendations on uptake of cancer screening tests – Laura Scherer

Abstract 0133 Should we require informed consent forms for risk factor treatment? – John Yudkin

Abstract 0148 Wikipedia in medical school classrooms: crowdsourcing public health communication through medical education – Lane Rasberry

Abstract 0009 Is the origin of unwarranted variation in the primary health doctor's office? (variations at a local municipal level in rural Norway) – Hans Johan Bredablik

Discussion – 15 minutes

Session 5C

Rm E1/E2

Policy or Intervention for Reducing/Preventing Overdiagnosis (Interventions)

Chair: David Klemperer

Abstract 0042 A patient-centered Choosing Wisely list for orthopedics – James Rickert

Abstract 0048 Integrating decision aids in guidelines: an approach to reduce overtreatment? – Corinna Schaefer

Abstract 0060 An alternative to diagnosis-based practice in pediatric mental health –
Kristopher Kaliebe

Abstract 0076 A model for delivering high value care to improve patient outcomes – Amir
Qaseem

Abstract 0156 Is there an App for that? Assessing a web-based tool (MedStopper) as a
decision-aid in “deprescribing” – Allan Cassels

Discussion – 15 minutes

2:30 - 4:00

Workshops

Rm G

Abstract 0075 Think before you “Pink:”
launching a social movement to re-
design cancer screening campaigns
– Ronald Adler & Stephen Martin

Rm D

Abstract 0121 What constitutes
adequately informed choice in
the context of overdiagnosis: a
methodological workshop to explore
expert preferences – Kirsten Howard,
Kirsten McCaffery, Alex Barratt, Jolyn
Hersch & Michael Pignone

4:00 - 5:30

Seminars

Rm A

Abstract 0041 Inflection point: two decades in the making of the MemorialCare
overdiagnosis case study - Barry Arbuckle & Lorellen Green

Rm F1/F2

Abstract 0004 Shared decision making in regard to cardiac stress testing could reduce
overdiagnosis of coronary disease in low-risk emergency department patients with
chest pain: a multicenter randomized vignette study – Andrew Foy

PROGRAMME

Balcony C

Abstract 0071 A precise mechanical diagnosis: the foundation for superior triple aim outcomes for low back and neck pain care – Ronald Donelson

4:00 - 5:30

Poster Session with Tea and Coffee Break

Upstairs lobby

7:00 - 12:00

Dinner Dance

Hyatt Regency Crystal Ballroom

DAY THREE

2

THURSDAY, SEPTEMBER 3RD

07:00 - 09:00

Registration

Natcher Building (Downstairs lobby)

09:00 - 10:30

Key Note Session 3 - Chair, Carl Heneghan

Ruth L Kirschstein Auditorium

09:00 - 09:20

Ned Calonge – The challenge of communicating overdiagnosis

09:20 - 09:40

John Brodersen – What are the Harmful Consequences of Overdiagnosis in Medical Screening?

9:40 - 10:00

Ina Kopp – Can Clinical Guidelines Protect from Overuse?

10:00 - 10:30

Discussion

10:30 - 11:00

Tea and Coffee Break with Poster Viewing

Upstairs lobby

11:00 - 12:30

Parallel Sessions

Session 6A

Ruth L Kirschstein Auditorium

Communicating & Methodology for Measuring and Researching Overdiagnosis

Chair: Timothy Wilt

Abstract 0011 Overdiagnosis or real patient benefit: how to evaluate new diagnostics that challenge existing disease definitions – Joris de Groot

Abstract 0028 W(h)ither expertise: Choosing Wisely in brain imaging – Peter Whitehouse

Abstract 0040 Tackling overtreatment in musculoskeletal condition area in UK private settings – Milan Mrekaj

Abstract 0081 Can interval cancer rates be used to monitor overdiagnosis from new technologies in breast cancer screening? – Alexandra Barratt

Discussion – 15 minutes

Session 6B

Balcony A/B

Policy or Intervention for Reducing/Preventing Overdiagnosis

Chair: Russ Harris

Abstract 0045 Reducing inappropriate PSA-based prostate cancer screening in men ≥ 75 years old with a highly specific computerized clinical decision support tool – Jeremy Shelton

Abstract 0050 Evaluating the evidence for Choosing Wisely in primary care using the strength of recommendation taxonomy (SORT) – Kenneth Lin

Abstract 0051 Too much routine follow-up – Stephen Hall

Abstract 0056 Addressing overtreatment of ductal carcinoma in situ (DCIS): a qualitative study of how terminology affects women's concern and treatment preferences – Brooke Nickle

Abstract 0111 Long term SSRI antidepressant use: effective care or overtreatment? RCT of maintenance SSRI treatment versus discontinuation – Dee Mangin

PROGRAMME

Abstract 0113 The role of guided referrals on reducing inappropriate diagnosis and treatment: a policymaker's guide to profiling providers based on quality & cost – Ayodele Kazeem

Discussion – time permitting

Session 6C

Rm E1/E2

Policy and Intervention for Reducing/Preventing Overdiagnosis

Chair: John Brodersen

Abstract 0114 Using deliberative methods to guide implementation of lung cancer screening: exploring perceptions and understanding of overdiagnosis – Daniel Reuland

Abstract 0117 Reducing unnecessary prostate cancer screening in older men – Violeta Rabrenovich & Ronald Loo

Abstract 0130 Avoiding low-value practices: implementation of ESSENCIAL project in Catalonia – Cari Almazán

Abstract 0134 Active surveillance as a possible management strategy for ductal carcinoma in situ: a computational risk analysis – Marc D. Ryser

Abstract 0149 Guidelines, benefit design, and cancer screening: combining levers for reducing overuse? – John Hsu

Abstract 0015 The overdiagnosis of Attention Deficit Hyperactivity Disorder: an ideological perspective or cause for concern? – Sheelah Mills

Discussion – time permitting

11:00 - 12:30

Workshop

Rm A

Abstract 0138 Overdiagnosis in general practice: a position paper from the Norwegian College of General Practice; The causes of overdiagnosis and how it can be limited – Gisle Roksund Elisabeth Swensen, Morten Laudal, Per Øystein Opdal & John Brodersen

11:00 - 12:30	<p>Seminar</p> <p style="text-align: right;">Rm D</p> <p>Abstract 0133 Should we require informed consent forms for risk factor treatment? – John Yudkin</p>				
11:00 - 12:30	<p>Panel Sessions</p> <p style="text-align: center;">Balcony C Rm G</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>The Role and Limitations of Statistical Modeling in Estimating Overdiagnosis in Screening Programs</p> <p>Moderator: Barry Kramer</p> <p>Panelists: Michael leFevre, Doug Owens & Stuart Baker</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Lessons Learned: The Choosing Wisely Program as a Model to Reduce Overuse in Medicine</p> <p>Moderator: Lisa Gill</p> <p>Panelists: TBC</p> </td> </tr> </table>	<p>The Role and Limitations of Statistical Modeling in Estimating Overdiagnosis in Screening Programs</p> <p>Moderator: Barry Kramer</p> <p>Panelists: Michael leFevre, Doug Owens & Stuart Baker</p>	<p>Lessons Learned: The Choosing Wisely Program as a Model to Reduce Overuse in Medicine</p> <p>Moderator: Lisa Gill</p> <p>Panelists: TBC</p>		
<p>The Role and Limitations of Statistical Modeling in Estimating Overdiagnosis in Screening Programs</p> <p>Moderator: Barry Kramer</p> <p>Panelists: Michael leFevre, Doug Owens & Stuart Baker</p>	<p>Lessons Learned: The Choosing Wisely Program as a Model to Reduce Overuse in Medicine</p> <p>Moderator: Lisa Gill</p> <p>Panelists: TBC</p>				
12:30 - 1:30	<p>Lunch with Poster Viewing Both lobbies</p>				
1:30 - 2:30	<p>Key Note Session 4 - Co Chairs, Fiona Godlee & Barry Kramer Ruth L Kirschstein Auditorium</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 20%;">09:10 - 09:30</td> <td>Steve Woloshin & Lisa Schwartz – Low Regulation: Allowing Disease Awareness Campaigns to Fuel Overdiagnosis</td> </tr> <tr> <td>09:30 - 09:50</td> <td>Ray Moynihan – Preventing Overdiagnosis: Where to from Here?</td> </tr> </table>	09:10 - 09:30	Steve Woloshin & Lisa Schwartz – Low Regulation: Allowing Disease Awareness Campaigns to Fuel Overdiagnosis	09:30 - 09:50	Ray Moynihan – Preventing Overdiagnosis: Where to from Here?
09:10 - 09:30	Steve Woloshin & Lisa Schwartz – Low Regulation: Allowing Disease Awareness Campaigns to Fuel Overdiagnosis				
09:30 - 09:50	Ray Moynihan – Preventing Overdiagnosis: Where to from Here?				
3:00 - 3:30	<p>Safe Journey Home Home</p>				

KEYNOTE ABSTRACTS

KENOTE SESSION

1

Tuesday, September 1st

Chair: Fiona Godlee

09:10 - 10:30

Otis Brawley - Overdiagnosis: Pathologic Profiling!!!

Overdiagnosis is the diagnosis of “disease” that would not cause symptoms or death during a patient’s lifetime. It is a side effect of efforts to screen and detect disease early. Overdiagnosis exists in a number of diseases, but it is an especially important issue in cancer medicine. Even though discussed for decades, the existence of cancer overdiagnosis is not widely known nor its importance widely accepted in the medical community. For many, it is a difficult concept as the decades old common mantra has been, “all cancers are bad” and “the best way to deal with cancer is find it early and cut it out.”

It is perhaps easier to accept the existence of overdiagnosis in cancer when one realizes the evolution of cancer medicine over the past 175 years. In the mid-19th century, European physicians developed most of the pathologic techniques done to this day. They were the first pathologists. They did biopsies, examined specimens under a microscope and described the microscopic appearance or profile of malignancy. They did autopsies on people who clearly died of cancer. A number of imaging technologies have been developed since publication of the original histologic definitions of cancer. Indeed, in just the past fifty to sixty years, we have had the introduction of ultrasound, more advanced Xray mammography, computerized tomography (CT) and Magnetic Resonance Imaging (MRI). Stereotactic biopsy technology has also improved tremendously. Today, it is not uncommon to identify, biopsy, and examine a 5 mm breast lesion.

Many of these small lesions fulfill the 175 year old criteria for malignancy and are labeled “cancer.” Many assume in this “pathologic profiling” that because the biopsy looks like a lesion that has killed, it must be a dangerous cancer that if left alone will kill. The true question is, “are these small lesions that look like something that killed, genetically or genomically programmed to grow, spread and kill?” Despite our tremendous advances in technology, we still use a mid-19th century definition of cancer. We need a 21st century definition of cancer that will incorporate both histology and genomics and appreciate the varying biologic behaviors of tissues that fulfill the profile of malignancy.

Virginia A. Moyer - The Not-So-Well Child: Overdiagnosis in Pediatrics

While overdiagnosis in adult medicine has become widely recognized, particularly in relationship to cancer screening, it has been less well described in children. However, overdiagnosis does occur in pediatrics, perhaps most notably with common conditions such as ADHD, urinary tract infection, food allergy, and possibly even with some cancer screening. It is clear that substantial numbers of children may not benefit from commonly pursued diagnoses. The American Academy of Pediatrics joined the Choosing Wisely campaign in 2013 with “Five things physicians and patients should question” and a year later added “Five more things...” Increasing recognition of this problem in pediatrics has the potential to meet our pledge to “first do no harm”.

Alan Schwarz - Rising ADHD Diagnosis Rates: What Does The Data Mean?

Government data show that 15 percent of American children get diagnosed with ADHD; in some Southern states, almost 1 in 3 boys receive the diagnosis. A vast majority of them are prescribed stimulant medications like Adderall or Concerta. As the rates continue to rise, what are the forces behind them?

KEYNOTE ABSTRACTS

KENOTE SESSION

2

Wednesday, September 2nd

Chair: Barry Kramer

09:30 - 11:00

Cindy Pearson - Overdiagnosis and women's health: challenges and opportunities

Women are uniquely vulnerable to overdiagnosis because their reproductive and sexual experiences are perceived as different, deficient, and needing treatment. In this presentation, I will argue that the biological underpinning of efforts to diagnose women's reproductive and sexual functioning as disordered is often weak; and that unconscious sexism plays an important role in the overdiagnosis of women. I will discuss in detail the creation of female sexual dysfunction (a disease created and marketed by pharmaceutical interests), present alternative ways of understanding low libido, and describe the tactics used by astroturf NGOs and industry to persuade the FDA to approve a libido pill for women. Approval of a drug for female sexual dysfunction, without adequate evidence of safety and effectiveness, could harm the health of as many as 68 million women, the potential number of customers created by the promotion of FSD as a medical condition. I will compare the relentless push for medical treatments of female sexual dysfunction to earlier examples of overdiagnosis in women, such as postmenopausal estrogen "deficiency", osteopenia, and premenstrual dysphoric disorder. The successful challenging of these earlier paradigms by feminist health activists contains valuable lessons for the movement to reduce overdiagnosis.

Decline in surgery is primarily not the result of more conservative surgical practice (e.g. active surveillance), rather it is the result of less screening – and less diagnosis.

There is evidence that the changes mainly reflect patient choice, not physician recommendation. This case give an example to approach to medical care phenomenon and to to encourage doctors to find their voice when faced with medical trends that run counter to their patients' interests.

Hyeong Sik Ahn - Korea Thyroid Cancer Epidemic and Afterwards

In Korea, the national cancer screening service was implemented from 1999. This government program provided free screening for breast, cervical, colon, gastric and hepatic cancers. Many hospitals also market comprehensive health check-up programs that include thyroid cancer screening, in addition to more technologically intensive exams such as MRI, PET-CT. In these programmes, many providers chose to offer ultrasonography screening as an inexpensive add-on exam.

Thyroid cancer incidence rose slowly during the 1990s, then rapidly following the turn of the century. In 2011 the rate of thyroid cancer diagnosis was 15 times that observed in 1993. Although the incidence in females is roughly 5 times that of males, the relative increase was similar in the two sexes. The entire increase is attributable to the detection of papillary thyroid cancer. And despite the dramatic increase in incidence, thyroid cancer mortality remains stable.

Thyroid cancer incidence varies across Korea's 16 administrative regions – variation that can be explained by regional screening penetration. There was a strong correlation between the proportion of the population screened in a region and the regional incidence of thyroid cancer. Significant correlations also existed in each of eight age-sex groupings

In March of 2014, 8 physicians formed the Physician Coalition for Prevention of Overdiagnosis of Thyroid Cancer. The coalition sent an open letter to government health authorities and various media outlets highlighting that Korean thyroid cancer incidence was extraordinarily high and proposing that ultrasound screening be discouraged

Subsequently, there has been marked decline in thyroid surgery after a decade of explosive growth. Compared to over 48,000 thyroid cancer surgeries in previous year, about 34,000 surgeries occurred – a reduction of 35%. Preliminary estimates from insurance claims suggest a similar 30% reduction in thyroid cancer incidence. Thus the decline in surgery is primarily not the result of more conservative surgical practice (e.g. active surveillance), rather it is the result of less screening – and less diagnosis.

Laura Esserman - Understanding the Basis for OverDiagnosis Can Drive Solutions to Mitigate Harm

Over the past 4 decades, our understanding of and treatment approaches to breast cancer have changed dramatically. The spectrum of tumor types diagnosed have also changed, particularly with the advent of population screening and public awareness campaigns. Molecular tools have enabled more precise characterization of tumor types. While more early stage molecularly low risk tumors are being identified, higher risk and more aggressive biology also persists. Unfortunately, these aggressive tumors can have adverse outcomes even when detected as stage 1, and some can present as clinical cancers in between normal screens. Our approach to early detection has to evolve as our understanding of breast cancer biology evolves. We need to develop better tools to identify indolent tumors at the time of diagnosis, refine our targets for screening, and as well, our thresholds for biopsy. Screening has generated a great deal of controversy and there is no consensus on guidelines. Rather than argue about data generated prior to the advent of systemic therapies (endocrine and chemotherapies), we should initiate modern trials of screening that help us to continue to improve our approach to screening. We have an unprecedented opportunity to advance the field if we incorporate our current understanding of breast cancer biology, advances in risk assessment, and imaging technology to learn who is at risk for what kind of cancer and adjust accordingly. The WISDOM trial (Women Informed to Screen Depending On Measure of risk), funded by PCORI (Patient Centered Outcomes Research Institute) was designed as just such a modern trial, and will open in 2015. The goal is to improve our approach to screening and to test a personalized (risk based) vs. annual screening approach and learn if the personalized approach is as safe, preferred by women, less morbid, facilitates adoption of prevention.

KEYNOTE ABSTRACTS

KENOTE SESSION

3

Thursday, September 3rd

Chair: Carl Heneghan

09:00 - 10:30

Ned Calonge - The challenge of communicating overdiagnosis

Overdiagnosis in cancer is conceptually straightforward: there is a spectrum of disease progression such that a given cancer, detected by screening or case finding, may grow slowly and never become symptomatic, require treatment or shorten the life of the individual. However, the real-world narrative for cases of overdiagnosis creates a kind of high-level, personalized length-time bias, reinforcing a non-evidence-based belief in the benefit of screening for both patient and provider. The narrative that "screening saved my life," which certainly supports fundraising efforts by advocacy groups, is become a cultural norm. And, as the patient did not die, this outcome--while having no relationship to early detection and treatment--supports the screening decision, and is difficult to challenge. To address overdiagnosis, we need to develop strategies to bring the harms of overdiagnosis into the decision-making process for screening for both providers and patients. Visual tools and info-graphics may offer some potential for informing decisions. If feasible, developing narratives and putting a face on overdiagnosis could be very powerful.

John Brodersen - What are the harmful consequences of overdiagnosis in medical screening?

Medical screening leads inevitably to over-detection of either of the precursors that are screened for and/or the actual targeted disease. The harmful consequences of this type of overdiagnosis is accordingly overexamination, overtreatment and thereby overuse. In addition, the harmful consequences can in theory be categorised into at least eight different domains: 1) financial strain; 2) hassles/inconvenience; 3) medical costs; 4) opportunity costs; 5) physical harms; 6) psychological harms; 7) work-related costs and 8) societal costs. However, do we have empirical evidence that supports this theoretical categorisation and what kind of evidence is missing? In this lecture, I will talk about the limitations and strengths of the existing empirical evidence, plus what kind of research is needed, about the harmful consequences of overdiagnosis in medical screening.

Ina Kopp - Can Clinical Guidelines Protect from Overuse?

NO ABSTRACT SUBMITTED

KEYNOTE ABSTRACTS

KENOTE SESSION

4

Thursday, September 3rd

Co-Chairs: Fiona Godlee and Barry Kramer

1:30 - 2:30

Steve Woloshin & Lisa Schwartz - Low R[egulation]: Allowing disease awareness campaigns to fuel overdiagnosis
NO ABSTRACT SUBMITTED

Ray Moynihan - Preventing Overdiagnosis - where to from here?

Launched in 2012, we've now held three international scientific conferences called Preventing Overdiagnosis, at Dartmouth, Oxford and this year at the NIH. The conference is produced free of all industry funding by a partnership including academic units, a major consumer organisation and one of the world's leading medical journals, which is concurrently running a series on expanding definitions of disease and the risk of overdiagnosis. A number of national meetings on overdiagnosis are also taking place. This presentation will examine the strengths and limitations of what we have and haven't achieved in the past few years, and what options we might consider collectively exploring in the future. New cures for aging may also be covered. At times candid, at times tedious, this presentation is certainly one to consider missing if you're tired of talking about overdiagnosis.

WORKSHOP ABSTRACTS

WORKSHOPS

1

Tuesday, September 1st

1:30 - 3:00

Abstract 0039 Overdiagnosis as an issue for life and living benefits insurance

Kevin Somerville, John Schoonbee

Overdiagnosis has the potential to affect both the risk assessment process and decision at the time of insurance application and the outcome and frequency of life and living benefits insurance claims. Information about the health of applicants for life and living benefits insurance is an integral part of matching the price to the risk of an insured event. This information may already be part of the medical record and is used by underwriters and medical advisors for risk selection. However, 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 requested vary by age, sex, level of sum assured, as well as the type of insurance applied for. The collated medical data is used to allocate the applicant to one of a number of insured lives risk pools, the number of which varies according to market norms. However, there is a risk for overdiagnosis and hence the possibility of labelling an insurance applicant as a having a "disease".

By contrast, for insured lives a living benefits claim is based upon a medical diagnosis which is typically provided by the claimant's medical practitioner and/or consultant. In addition, such insurance policies are typically long term (sometimes whole of life) and priced for using the current incidence of a condition based on extant contemporary definitions of disease.

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

WORKSHOP ABSTRACTS

1:30 - 3:00

Abstract 0058 Quantifying overdiagnosis in cancer screening: evaluation of study designs

Theodora Maria Ripping, Nicolien Thea van Ravesteyn, Kevin ten Haaf

Objectives: To evaluate and apply existing study designs to estimate overdiagnosis in cancer screening in order to gain insight in the potential biases and weaknesses of different methodologies and to provide researchers with guidance to obtain a reliable estimate of overdiagnosis in cancer screening.

Methods: We conducted a systematic review in PubMed to identify primary research studies quantifying overdiagnosis in breast cancer screening. Studies were grouped by design and evaluated on the data required, assumptions made, and risk of bias and confounding. Furthermore, we used four different study designs to calculate overdiagnosis from breast cancer screening in the Netherlands, in order to illustrate strengths and weaknesses of these approaches.

Results: All studies were divided into two groups: 1) observational studies and trials and 2) modeling studies. In observational studies and trials, the main challenges are to obtain the breast cancer incidence from a comparable non-screened population and to adjust the breast cancer incidence of the screened population for early detection. We identified five different approaches to obtain the breast cancer incidence in a non-screened population: observed in the control arm of a trial, extrapolation of pre-screening trends, non-attenders, control region, adjusted for the effect of screening. Furthermore, we identified three approaches to adjust for lead time: compensatory drop, lead time adjustment, early versus late stage cancers. In modeling studies, the main challenge and uncertainty are related to the development of the model, model assumptions and inputs, and how well the model is validated.

Conclusion: Each study design has its own strengths and drawbacks, which should be taken into consideration when estimating overdiagnosis. We conclude with recommendations on the selection and execution of study designs to guide researchers estimating overdiagnosis in cancer screening.

WORKSHOP ABSTRACTS

3:30 - 5:00

Abstract 0144 Choosing Wisely and Maximizing Value: Lessons from the US Veterans Health Administration Healthcare System

Nancy Kressin, Timothy Wilt, Linda Kinsinger, Mark McConnell, Melissa Partin, Daniel Morgan, David Aron, Leonard Pogach, Eve Kerr

Objectives: The US Department of Veterans Affairs (VA) is the nation's largest integrated healthcare system. Recently, the VA adopted a "Blueprint for Excellence", emphasizing the importance of value in VA care, and of providing evidence-based care to patients who can benefit, while refraining from providing harmful or low value practices. Similarly, the American Board of Internal Medicine Foundation's "Choosing Wisely" campaign emphasizes the importance of identifying and reducing the use of low-value and potentially harmful services. VA clinicians, operations leaders, and researchers are now working together to "Choose Wisely" and maximize the value of VA care.

Methods: We will describe the concepts and definitions of value, overuse, and overtreatment, suggesting a framework for evaluating screening, diagnosis and treatment "intensity", which facilitates assessments of the balance between intensity and value (optimizing benefits for incremental harms and costs). In some situations more intensity is needed, while in others lower intensity is better value. We will describe a perspective for appropriately balancing benefits with harms and costs that accompany an intervention (but are often unrecognized/reported/assessed). Presenters will describe ongoing VA efforts to maximize value, using case studies to exemplify the issues in conducting such work, including successes from and barriers to such efforts.

Results: The VA has initiated efforts to reduce overuse of PSA testing and is now developing an approach to maximizing the value of lung cancer screening. A Choosing Wisely/Hypoglycemia Safety Initiative aims to reduce the percentage of high risk diabetes patients receiving over-intensive treatment, which has resulted in a notable 8% reduction in patients at high risk.

Conclusions: There are many successes of and barriers to maximizing value in a large healthcare system like VA; we will share suggestions for others who seek to do so in their own systems and invite discussion.

11:30 - 1:00

Abstract 0070 Choosing Wisely: Is it wise enough? Criticisms (and solutions) for the campaign

Jessica A Otte & Dr James Rickert

Objectives: Choosing Wisely is an initiative, now propagating globally, that offers a practical starting point to preventing delivery of inappropriate care. While promising, significant criticisms of the campaign exist. The aim of this session is to identify and categorize these limitations, develop possible solutions, and transmit those to the campaign* in order to improve it and shape its future.

* via Choosing Wisely Canada, which has been tasked with coordination of the international campaign

Methods:

1. Literature review for known criticisms of the Choosing Wisely campaign
2. Facilitated discussion of key limitations and how they might be categorized
3. Development of possible responses in areas for improvement

Results: The Choosing Wisely (CW) campaign represents one of the first, broadest reaching, and most tangible approaches to preventing overtesting and overtreatment internationally. It also offers a public platform to promote engaging patients in shared decision-making. However, it is limited in ways that include:

Communication

- Not reaching patients and physicians who need CW-type support
- Often not written in patient-centered language; no patient input in phrasing recommendations

Motivation

- Concern that it is about rationing or austerity

WORKSHOP ABSTRACTS

- Concern that wide acceptance of lists will limit a provider's practice autonomy

Recommendations chosen

- Variable quality of evidence behind the statements
- Ineffectual statements, some do not challenge the status quo or pertain to interventions that stop being used pre-CW
- Not patient-centered
 - No patient-created list
 - Recommendations often not directed toward patients, only apply to physician, or are not likely to arise in provider-patient encounters (some items cannot be discussed, eg. while patient is under anesthesia)
- No proof of efficacy, unclear plan for measurement
- Lack of advocacy to change important drivers of overdiagnosis and overtreatment
- No discussion of physician conflicts of interest
- No approach to care given in the wrong setting (Emergency/clinic/hospital/home) or by the wrong provider (GP/specialist/pharmacist/nurse, etc)

Conclusions: Choosing Wisely represents a place to start in the global movement towards preventing overdiagnosis and avoiding harmful, unnecessary care. However, there are significant areas for improvement; addressing these may improve support for the campaign as well as its reach and effectiveness.

2:30 - 4:00

Abstract 0075 Think before you “Pink:” Launching a Social Movement to Re-Design Cancer Screening Campaigns

Ronald Adler, Stephen Martin

Realities of cancer screening do not match cervical cancer screening’s success. For other cancers, benefits are less than thought, while harms are greater than imagined. Chief among these is overdiagnosis, the Achilles’ Heel of screening, which always identifies more indolent conditions. The prevalence of overdiagnosis of cancers is approximately 1-in-2 for prostate, 1-in-3 for breast, and 1-in-5 for lung. Meanwhile, policymakers, patients, and clinicians cling to the reassuring myth that early diagnosis is always beneficial.

Relying on clinicians to communicate this is problematic because many hold similar misconceptions. Even should they clarify their misconceptions, a problem of scale remains. When the environment is filled with messages uncritically promoting cancer screening, individual clinicians cannot move patients toward a mindset where they can make considered, well-informed decisions. The clinical conversation is further distorted by truncated informed consent and incentives that reward clinicians for screening rates, not whether they engaged patients in shared decision-making (SDM).

We seek to galvanize a social movement. We need a campaign that moves people to a neutral position from which they can make balanced judgments regarding cancer screening tests. Such a campaign would communicate that:

- Cancers are heterogeneous, ranging from harmless to lethal.
- Cancer screening causes harm (false alarms, finding indolent cancers).
- Benefits of cancer screening are less than most people believe.
- Cancer screening should occur only after well-informed SDM.

In this workshop we will share communication strategies that articulate these concepts in clear ways. These include illuminating analogies plus presentation of

WORKSHOP ABSTRACTS

data as pictograms, natural frequencies, number needed to screen/harm, and ARR. Participants will contribute their expertise and ideas to develop a strategy to re-educate clinicians, the public, and policy-makers. We look to establish a coalition to promote and disseminate these messages. This call to action requires skills and strategies employed in other successful social movements.

Abstract 0121 What constitutes adequately informed choice in the context of overdiagnosis: a methodological workshop to explore expert preferences

Kirsten Howard, Kirsten McCaffery, Alex Barratt, Jolyn Hersch, Michael Pignone

Background: It is generally accepted that informed choice requires adequate knowledge, and intentions/decisions consistent with one's attitudes. An ideal measure of informed choice would appropriately weight these components. This workshop focuses on knowledge.

Frameworks in screening outline the types of knowledge individuals require, including conceptual and numerical components. Scoring varies some use competency-based approaches, others report mean/median scores. However, a number of uncertainties remain, eg: 1) optimal weighting of conceptual and numerical knowledge to ensure someone is 'adequately informed'; 2) the relative importance of various aspects of knowledge (How much weight should be placed on understanding benefits compared to harms?); 3) acceptable uncertainty in numerical responses (how wrong can a number be and still indicate adequate understanding) and whether this varies with content (eg, benefit versus harm).

There is no formal theory telling us the optimal weighting of various aspects of knowledge. We propose a novel approach using discrete choice experiments (DCE) to examine expert judgements as to whether a hypothetical individual is adequately informed. We will thereby develop a weighting algorithm for how experts value various aspects of knowledge.

Methods: We will use small groups to ascertain participants' views on types of information that should be included in a knowledge measure, based on literature and supplemented by discussion and a group ranking exercise. Discussions will consider scoring approaches and the tolerance for uncertainty that might be acceptable for different types of information: How wrong can a numerical estimate be and still be adequate? Should this differ by type of information? Should this be based on relative or absolute tolerance (eg, +/-10% of correct value or +/-10 people/1000)?

We will finish with a pilot DCE survey to assess feasibility of the methodology and inform development of a larger survey to be conducted after the conference.

WORKSHOP ABSTRACTS

WORKSHOP

3

Thursday, September 3rd

11:00 - 12:30

Abstract 0138 Overdiagnosis in general practice: A position paper from the Norwegian College of General Practice. The causes of overdiagnosis and how it can be limited

Gisle Roksund, Morten Laudal, Elisabeth Swensen, Per Øystein Opdal, John Brodersen

Testing of asymptomatic individuals in order to «prevent disease» or identify early diagnosis» is increasing in volume in general practice. The fear of hidden disease is flourishing among physicians, patients, politicians and health administrators. Privately run diagnostic and treatment services as well as private health insurance schemes are drivers of this trend.

Overdiagnosis is closely related to medicalization of the borders of normality and treatment of conditions that are either self-healing or untreatable. Overdiagnosis is linked to the false conception that it is an error not to diagnose at the first modest symptom which could be seen to indicate serious disease, but which in most cases is innocent and transitory.

The first imperative of medicine is not to harm. Overdiagnosis is harmful both to public health and to the individual. Public health deteriorates when resources are shifted away from the patients with chronic diseases and the poor to the well and the rich, while the individual is harmed by being defined as sick and perceiving herself as sick.

In 2001 the Norwegian College of General Practice stated the principle of «giving the most to those who have the greatest needs». This principle is just as important today. GPs must avoid diagnosis when there is none to be made. Treatment must be limited to cases where there is evidence that treatment will be effective. GPs must be guardians of a broad concept of normality.

With this background, the College decided to develop a position paper on overdiagnosis and overtreatment.

In this workshop the process of shaping the paper will be presented and discussed; including the history of the drivers of overdiagnosis in the Norwegian context, examples of overdiagnosis in (Norwegian) general practice, and finally proposals to limit overdiagnosis in the time to come.

SEMINAR ABSTRACTS

SEMINARS

1

Tuesday, September 1st

11:00 - 12:30

Abstract 0150 Goldilocks Optimal Care - Not doing too much or too little care, but just Right

Linda Radler

Background and Aim: Kaiser Permanente (KP) is an integrated care delivery system that provides clinical services to 10 million members in nine US states and the District of Columbia. Our mission is to provide high-quality and affordable health care. To improve the lives of the members we serve, we focus on ensuring reliable execution of the evidence-based screening, treatment and follow-up of care. As it is not only our patient's interests but our business interests to keep patients healthy, so we have a long tradition of promoting population health.

Methods: Founded as a health maintenance organization with a pre-paid, capitated business model, we have an obligation to our members/patients and to ourselves to provide the best available evidence-based care and to be smart stewards of our members. We have developed a universal process built on evidence/data based methodologies that include a change in management process with 1) communication planning, 2) report development/delivery, and 3) training/education for clinicians and patients. We measure 'value' that links practice variation and outcomes that matter to patients over cost of care to drive reduced overtesting and overdiagnosis. This presentation walks through the processes and methodologies used, including challenges/risks to ensuring the right level of testing is done, namely; dealing with varying and changing guidelines, educating members via shared decision making discussions, and measuring what matters to continuously improve. Data demonstrating reduction in unnecessary tests and downstream treatments will be shared that may include imaging, routine labs, CBCs, EKGs, head CTs, DEXA screens, specialty care visits, and antibiotic use, etc.

Results: By creating an overall repeatable process for monitoring the care to our patients, we see reduction of unnecessary testing and related overcare across KP regions. There is renewed culture toward greater communications and shared decision

SEMINAR ABSTRACTS

making with our patients; and a new definition of value where outcomes that matter to the patients over costs of services are driving significant improvements, including reductions in over diagnosis and unnecessary tests.

Abstract 0122 Shared Decision Making interventions to address overdiagnosis and overtreatment: lessons learned

Kirsten McCaffery, Stacy Carter, Juan Brito, Jolyn Hersch, Mara Schonberg, Stacey Sheridan

Background: With increasing concern about the harms of overdiagnosis, Shared Decision Making (SDM) has been put forward as a potential solution. This seminar comprises 5 brief presentations followed by discussion about when and how SDM is appropriate to tackle overdiagnosis and lessons learned from work to date.

SDM can address some, but not all, types of overdiagnosis. This talk will present a typology distinguishing three types of overdiagnosis (predatory, misdirected, and tragic) and then show that SDM methods are an appropriate response to some types of overdiagnosis but not others.

SDM for Thyroid Cancer: Why, When and How? This talk will present a population-based study that identifies the mechanism of detection of thyroid cancer and consider how SDM can be used as a solution to overdiagnosis. The initial prototype of a decision aid to help patients decide between surgery and active surveillance will be presented.

Psychosocial and decision process effects of information about overdiagnosis in a breast screening decision aid: This paper will present secondary results from a trial among 879 women randomized to 1 of 2 breast screening decision aids (1 including information about overdiagnosis). Outcomes presented include decision process variables, psychosocial outcomes, and acceptability.

Decision-making around mammography screening for women 75+: This talk will present

results from a pilot pretest-post-test trial of a decision aid on mammography screening for women 75+ that includes overdiagnosis as one of the risks of mammography screening.

Trial of alternate presentations of benefits/harms information for screening with varying potential for overdiagnosis and overtreatment: Results will be presented from a randomized trial of 775 US primary care patients exploring the differential effects of presenting benefits/harms information using words; numbers (absolute risks); numbers plus narratives; or numbers plus a framed presentation, on intent to be screened with 3

1:30 - 3:00

Abstract 0105 Symposium: Understanding Overdiagnosis, Medical Overuse and Avoidable Care: A Consensus-derived Research Agenda

Daniel Morgan, Aaron Leppin, Nancy Kressin, Sanket Dhruva, Les Levin, Bruce Landon, Mark Zezza, Harald Schmidt, Vikas Saini, Adam Elshaug

Objectives: To organize current overuse-related research in a framework and provide a research agenda to advance the field.

Methods: In December 2013, the Lown Institute convened a working group of clinicians and researchers in Boston, Massachusetts. The objective of this group was to develop a research agenda for advancing understanding related to the issue of medical overuse. A writing group formed to communicate this consensus-derived agenda.

Results: To date, accomplishments in the area of medical overuse include the refinement of terms such as overdiagnosis and overtreatment, the physician-led Choosing Wisely campaign, and development of medical journal sections focused on the topic of overuse. Research on overuse, however, remains poorly developed and uncoordinated. Critical areas warranting further development include: 1) increasing understanding of patient, provider and system level factors driving overuse, 2) describing and measuring the patient experience and population impact of

SEMINAR ABSTRACTS

overtreatment, 3) assessing the utility and value of tools intended to limit overuse, including the effects of Choosing Wisely and other initiatives aimed at curbing overuse, and 4) advancing the basic research infrastructure related to overuse by educating institutional review boards, addressing overuse in guidelines, and adopting standard terminology for search engines.

This symposium will present these results as:

1. Research accomplishments to date (D. Morgan)
2. Research Agenda items
 - a. Patient, provider, and system level factors driving overuse (A. Leppin)
 - b. Measuring the patient experience and population impact of overtreatment (S. Brownlee)
 - c. Assessing Choosing Wisely and other initiatives to limit overdiagnosis and overuse (S. Brownlee)
 - d. Necessary changes to the basic research infrastructure to limit overdiagnosis and overuse (D. Morgan)

Conclusions: Considerable momentum is building to understand overuse of medical care, but research efforts are uncoordinated. This symposium will engage the audience to consider methods to develop research that will improve understanding and more informed intervention.

Abstract 0052 Potential Examples of Pediatric Overdiagnosis

[Eric Coon](#), Ricardo Quinonez, Virginia Moyer, Alan Schroeder

Thanks to the efforts of leaders in overdiagnosis research and advocacy, many of whom attend the Preventing Overdiagnosis Conference, recognition of overdiagnosis for adult conditions has gained a great deal of traction over the last few years. However,

overdiagnosis has been less well described in children. Overdiagnosis of neuroblastoma from universal infant urinary catecholamine screening is the only proven example in children. Unfortunately, the idea that a correct diagnosis could be harmful is completely foreign to most pediatric providers and their patients and parents.

We recently authored the first publication to comprehensively define the problem of overdiagnosis in children, categorizing fifteen possible examples and laying out research strategies to further characterize and mitigate its influence. We propose to review the evidence for the 14 hypothesized examples (excluding neuroblastoma) of pediatric overdiagnosis: aspiration, attention deficit hyperactivity disorder, bacteremia, cholelithiasis, food allergy, gastroesophageal reflux, hyperbilirubinemia, hypercholesterolemia, hypoxemia, medium-chain acyl-coA dehydrogenase deficiency, obstructive sleep apnea, skull fracture, urinary tract infection, vesicoureteral reflux. With the exception of attention deficit hyperactivity disorder, the possibility that these conditions are being overdiagnosed had never before been discussed in the literature.

In addition to the above examples, we propose to discuss four harm domains and unique examples of each from pediatrics, our overdiagnosis prioritization scheme, and mitigation strategies. We would love the opportunity to critique our examples and discuss future collaboration on overdiagnosis research with experts and enthusiasts.

3:30 - 5:00

Abstract 0035 The role of the media in promoting or preventing overdiagnosis

Gary Schwitzer

Objectives: No discussion of preventing overdiagnosis is complete without consideration of the potential for news media to do good or harm. HealthNewsReview.org was created 10 years ago to analyze news stories about interventions and to provide feedback to journalists to guide improvement.

Methods: A team of reviewers has evaluated US news stories that include claims about

SEMINAR ABSTRACTS

interventions, applying as 10 standardized criteria (adopted from the Media Doctor Australia project, which as since ceased operation). The project has the largest dynamic database of such story reviews, providing clear data-driven lessons.

Results: Reviewers graded most of 2,000 stories unsatisfactory on five of 10 criteria. Stories that committed disease-mongering and promoted overdiagnosis sometimes covered life-threatening conditions such as Alzheimer's, cancer, cardiovascular diseases and diabetes. Sometimes, news consumers were driven to worry about non-life-threatening conditions such as low testosterone or "manopause," menopause, anti-aging, premature ejaculation, overactive bladder, "pre-colds," "runner's face," female sexual dysfunction, and underarm flab. Nearly all of these story examples encourage healthy consumers to become patients by seeking testing or treatment. Stories about screening tests have been perhaps the most troublesome, minimizing or ignoring the fact that all screening tests carry the potential for harm.

Conclusions: Our analysis demonstrates that interventions were usually portrayed positively; potential harms were minimized, and costs were ignored. In 2015, the project expanded its reviews, now critiquing health care-related news releases as well by journals, industry, academic medical centers and others. After a review is complete, we always send an email to the publishing organization, with a hyperlink to our review. This is the only such systematic feedback process for health care media messengers. Our reviews can help journalists and other writers improve their messages. But the project also educates news consumers about how to evaluate evidence and to understand that more is not always better.

11:30 - 1:00

Abstract 0034 ADHD Overdiagnosis in Louisiana, a Child and Adolescent Psychiatrist's Perspective

Kristopher Kaliebe

Objectives: To review data gathered by Louisiana's Department of Health and Hospitals ADHD Task Force. To examine Task Force recommendations for reducing ADHD over-diagnosis and over-treatment. To provide the perspective of a child and adolescent psychiatrist in Louisiana regarding barriers to more careful diagnosis and use of ADHD medications.

Methods: In 2014, the Louisiana State Legislature requested the Department of Health and Hospitals to study how best to ensure proper utilization of ADHD medications due to high and irregular rates of ADHD diagnosis and treatment. An ADHD Task Force of experts and stakeholders was created which reviewed data regarding ADHD diagnosis and treatment, convened a statewide symposium, and made a report providing recommendations to the legislature.

Results: The Louisiana ADHD Task Force February 2015 Report highlighted complex factors associated with ADHD diagnosis and treatment, including:

1. The majority of ADHD diagnosis and treatment was in primary care, with only 22% from psychiatrists.
2. Diagnosis rates have strong socio-economic, geographic and demographic influences. Yet unknown local factors are required to explain the data.
3. ADHD rates for boys within Medicaid statewide is 22%, with subpopulations over 30%.
4. Behavioral interventions and other therapies are rarely utilized, even in children below 6.

Report recommendations included:

1. Promote the use of expert guidelines regarding ADHD diagnosis and treatment.

SEMINAR ABSTRACTS

2. Encourage practitioners to consider the effects of trauma and toxic stress as potentially mimicking ADHD.
3. Promote increased physical activity and reduced screen time.
4. Encourage educators to ensure classrooms are developmentally appropriate and to increase physical activity in school.

Conclusions: Louisiana displays a disorganized pattern of heavy ADHD medication use in the context of poor measures of childhood wellness and scholastic under-achievement. The ADHD Task Force has made a forceful assessment of the problem and developed a number of prudent recommendations.

Abstract 0013 Symposium: shortfalls in clinical decision making that contribute to overdiagnosis and overtreatment

Daniel Morgan, Aaron Leppin, Cynthia Smith, Deborah Korenstein

Objectives: To explore clinical decision-making factors that contribute to overuse and discuss ways to overcome them.

Methods: The session will begin with a brief introduction. Speakers will then address the problem of overdiagnosis from a variety of perspectives. They will facilitate interactive discussions around four themes:

Unawareness of the patient experience, focusing on patient interactions with healthcare, the notion of treatment burden and its contributors, and conceptual models that enhance understanding of patient context. (Aaron Leppin, MD. Mayo Clinic)

Failures in the patient-provider interaction, focusing on and demonstrating best practices in communication about not providing unnecessary care and the importance of not making assumptions about what patients want. Video will be used to promote discussion. (Cynthia (Daisy) Smith, MD. American College of Physicians)

Physician attitudes and beliefs that lead to overdiagnosis, focusing on provider psychology and the fears of uncertainty, inaction, and malpractice. Will also consider clinician misunderstanding of benefits and harms and issues related to common testing in low prevalence settings (Daniel Morgan MD MS, University of Maryland SOM)

The culture of medicine and the practice environment, exploring factors related to the broad culture of medicine and specific environmental characteristics such as payment models and microenvironments that lead to overdiagnosis. (Deborah Korenstein, MD. Memorial Sloan Kettering Cancer Center.)

After the four theme discussions, faculty will convene for a large-group panel discussion that will consider the interactions among the themes.

Results: Faculty and participants will work together to create a coherent and nuanced conceptual model of drivers of overdiagnosis.

Conclusions: At the end of the symposium, participants and faculty will draw conclusions about important next steps for minimizing overdiagnosis.

4:00 - 5:30

Abstract 0041 Inflection Point: Two Decades in the Making MemorialCare Overdiagnosis Case Study

David Law, Lorellen Green, Susan Melvin, Jim Leo, Peter Kim

Nearly two decades ago, MemorialCare Health System created the Physician Society in partnership with its physicians. The Society, 2,000 physicians strong, was created on the foundation of evidence-based medicine, when many physicians considered it “cookbook medicine.” Now 20 years later, we are just as dedicated to providing the best care for our patients. The Physician Society’s responsibility is to consider the evidence, understand the variances among different viewpoints, and make sound recommendations. With the move to population health and value-based payment, we need to choose resources wisely. For MemorialCare, having the Physician Society and its

SEMINAR ABSTRACTS

14 Best Practice Teams consider and evaluate the science behind overdiagnosis further builds on our mission to pursue best practice medicine.

A solid history of bold goals focused on improving quality and safety year after year, proved it was time to take that next BIG step. In 2013, as part of our quest to further MemorialCare in the new world of health care reform, physician leaders across the health system began launching initiatives focused on overdiagnosis. The concept of overdiagnosis lines up well with our movement from volume to value, and our dedication to population health; accomplishments we are achieving with less resources.

In constant pursuit of perfect care, our focus on overdiagnosis was quickly tested through: 1) advocacy trips to the federal and state governments, 2) building culture and knowledge through educational forums and “SuperMECs,” and 3) implementation of a tool to incorporate key Choosing Wisely alerts into our EMRs. Now we’re 18 months into this evolution of change and our results to date show progress. While not everyone is on the bus “yet,” traction is building. Learning from the Mayo’s “Start small, Go FAST and Think BIG” has taken us to the next level and shows great promise for our future focus.

Abstract 0004 Shared Decision Making in Regard to Cardiac Stress Testing Could Reduce Overdiagnosis of Coronary Disease in Low-Risk Emergency Department Patients with Chest Pain: A Multicenter Randomized Vignette Study

Andrew Foy, David Shi, Susie Sun, Christopher Sciamanna

Objectives: The use of cardiac stress testing has increased significantly over the last decade for low-risk patients presenting to the ED with chest pain. However, in this clinical setting, it has not been found to improve hard endpoints and evidence is emerging that it could lead to overdiagnosis of coronary disease. The aim of this study was to assess the impact of shared decision making (SDM) on patient’s desire to undergo cardiac stress testing.

Methods: This was a multi-site, randomized study using clinical vignette surveys. All participants received an identical question stem, which involved going to the ED

with chest pain and ruling out for an MI, and were randomized to either a standard recommendation based on current ACC/AHA guidelines or SDM. Patients in the SDM group were given additional information (155 words) including: 1) the likelihood of having a negative or positive test, 2) the expected rate of true and false positive test results, and 3) the uncertainty that if a blockage is ultimately found, coronary revascularization may not reduce the risk of dying or experiencing a heart attack in the future.

Results: A total of 742 patients were offered the chance to participate, 701 agreed, and 631 (85%) successfully completed the survey. The average age of the study group was 58, 62% were female, and 42% graduated college. Shared decision making led to a significant reduction in patients desire to undergo stress testing (36.5% vs 87.5%, $p < 0.0001$). On multivariate analysis, those in the SDM group were 94% less likely to choose stress testing. Age, gender, education status, tobacco use, and comorbid conditions did not impact patients desire to undergo stress testing.

Conclusions: SDM may reduce cardiac stress testing in low-risk patients with chest pain and thus, reduce overdiagnosis of coronary disease in this clinical setting.

Abstract 0071 A Precise Mechanical Diagnosis: The Foundation for Superior Triple Aim Outcomes for Low Back and Neck Pain Care

Ronald Donelson, Ezequiel Gherscovici

The inability to make a reliable diagnosis for most low back pain (LBP) and neck pain (NP) has been declared the fundamental source of error in identifying effective treatment. This has led to sky-rocketing costs. Consequently, international researchers have collectively determined the validation of subgroups to be the #1 LBP research priority.

Directional preference (DP) and pain centralization (PC) are two related clinical findings reliably elicited in most LBP and NP patients requiring a unique form of mechanical

SEMINAR ABSTRACTS

examination. When elicited, they reveal that the pain-source is mechanical and reversible, and how patients can successfully treat themselves. Well-documented, predictable, rapid, inexpensive recoveries also enable recurrence prevention. Reliability, observational cohort, randomized, and cost-comparison trials validate these findings.

It is well-documented that PC and DP can be elicited in 80-89% of acute and in 50% of chronic and radicular LBP and NP. With such predictably excellent outcomes for this very large subgroup, the greatest obstacle to their recovery is physicians' failure to provide this unique examination early in their care, resulting in widespread inadequate diagnoses. The exceptional insights this examination provides has propelled it to becoming of primary importance within numerous LBP classification systems.

Unfortunately, current clinical guidelines only inform how to treat the "average" patient with these non-specific symptoms, while the reliability and validity of this mechanical exam enables individualized, predictably-effective care.

Four studies of lumbar disc surgery candidates who were finally provided the opportunity to undergo this examination: 50% reported the ability to rapidly and fully recover without surgery using treatment directly guided by the exam findings. Most would otherwise have undergone unnecessary, risky, and expensive surgery.

This symposium will introduce and demonstrate this mechanical paradigm, its extensive role in comprehensive spinal care, and the extensive evidence validating its high-value based on Triple Aim Outcomes.

11:00 - 12:30

Abstract 0133 Should We Require Informed Consent Forms for Risk Factor Treatment?

John Yudkin

Medical interventions are diverse, ranging from surgery to prescribing. The decision-making process requires the patient's assessing the balance of benefit and 'disutility,' comprising risks of the procedure, false-positive screening tests, or side effects of drugs and treatment inconvenience. For each, the physician needs the patient's consent. This could be the signed consent form preceding surgery, or verbal consent, usually assumed, for prescribing for symptomatic acute illness.

People are increasingly being prescribed drugs for preventing complications of non-communicable disease. The person may be asymptomatic, although at increased future risk, but is initiated on a drug, maybe for life. Similarly, asymptomatic people with type 2 diabetes may be started on insulin because glycemic control is poorer than recommended in guidelines. Studies suggest that physicians, as well as patients, may have grossly exaggerated perceptions of benefits, with information often presented solely as relative risk reduction ("25% fewer heart attacks").

A recent landmark case in the UK Supreme Court has considered the information provided by an obstetrician to a pregnant woman with diabetes about possible risks of a vaginal delivery. The court overturned the principle of the doctor deciding the optimal course, saying that the woman should have been provided with all the information necessary for her to make a choice, with the process carefully documented.

Similar considerations are likely to apply to benefits and risks of screening, investigations and prescribing – particularly when considering interventions intended for both individual and public health benefit - as well as to surgical interventions. Providing precise estimates for these will require improvements in knowledge, communication skills, and shared decision-making tools, and careful documentation of the consultation content. For initiating long-term drug treatment, introduction of a signed informed consent form might be considered. This will undoubtedly demand major changes in medical education, information tools and health service provision.

PANEL SESSION ABSTRACTS

PANEL SESSION

1

Tuesday, September 1st

11:00 - 12:30

ADHD around the world: Problems and solutions

Moderators: Allen Frances, Professor Emeritus and former Chair, Dept of Psychiatry, Duke University. Chair DSM IV Task Force & Donna Manning

Panelists: Rae Thomas, PhD, Grad Dip Couns Psych, BEd, Senior Research Fellow
Faculty of Health Sciences and Medicine Bond university

C Keith Connors , Professor Emeritus of Medical Psychology in the Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine

Iona Heath, former GP and president of the Royal College of General Practitioners from 2009 to 2012

Abstract: ADHD around the world: Problems and solutions Diagnostic patterns in the US often spread quickly around the world. The rate of ADHD diagnosis has more than doubled in the US during the past 20 years and is increasing at a lesser, but still substantial rate, throughout the developed world. Some of the increase is appropriate, reflecting the diagnosis of previously missed cases. Some reflects the misuse of the diagnosis as justification to give a truly non-ADHD child medications that might improve their behavior and academic performance. Much of that has been ascribed to aggressive marketing of the disorder by pharmaceutical companies and their growing menu of drugs to treat it. In this session, we will look at international efforts to appropriately diagnose and treat the disease while limiting overdiagnosis and overtreatment.

11:30 - 1:00

Communicating about overdiagnosis

Moderator: Ray Moynihan, Bond University

Panelists: Kirsten McCaffery, University of Sydney, Australia. Kirsten has carried out leading research in the area of overdiagnosis communication and is leading the writing of an article arising from discussions about communication and overdiagnosis at the 2014 Preventing Overdiagnosis conference.

Lisa Schwartz and Steve Woloshin, The Dartmouth Institute for Health Policy and clinical practice, USA. Steve and Lisa are internationally recognised as leading researchers in the field of communicating about overdiagnosis and too much medicine.

Lisa Gill, Consumer Reports, USA. The highly influential Consumer Reports is engaged both with Choosing Wisely and Preventing Overdiagnosis. Lisa Gill and colleagues have taken a strong interest in how to communicate about the often counter-intuitive subject of overdiagnosis and are currently engaged in translating an overdiagnosis series in The BMJ into lay language.

Jolyn Hersch, Sydney University, Australia. Jolyn has recently published in The Lancet the results of a randomized evaluation of information for women about overdiagnosis of breast cancer, based on previously published qualitative work.

Abstract: Objectives: The workshop will have the twin aims of developing key principles relevant to communicating about overdiagnosis as well as proposals for improving/ extending communication to different audiences, whether they be professionals, policymakers or the public. Methods: The first half of the workshop will feature short presentations from a panel of researchers and consumer advocates with specialist experience in the area of communicating about overdiagnosis and related topics. The second half will involve a structured interactive discussion with panel and workshop participants, focussing on developing key principles and proposals for more effective communication. Results and Conclusions: The aim is to further develop key principles and proposals for communicating more effectively about overdiagnosis.

PANEL SESSION ABSTRACTS

PANEL SESSIONS

3

Thursday, September 3rd

11:30 - 1:00

The Role and Limitations of Statistical Models for Estimation of Overdiagnosis

Moderator: Barry Kramer, Director NCI Division of Cancer Prevention

Panelists: Michael L LeFevre, MD, MSPH, Future of Family Medicine Professor and Vice Chair, Family & Community Medicine, University of Missouri, is the Future of Family Medicine Professor and Vice Chair of Family and Community Medicine at the University of Missouri, Columbia. As Medical Director for the Department of Family Medicine, he has administrative oversight of family medicine, urgent care and quick care practices in eight locations with over 150,000 annual visits. He teaches residents and medical students in the inpatient and outpatient settings and maintains an active practice across the full breadth of family medicine including inpatient work and, through 2012, obstetrics. He served as Chief Medical Information Officer for MU Health Care and directed the implementation of the electronic medical record across the system from 2002 through 2012. Much of his academic effort has been in the area of evidence based medicine and clinical policies, and he currently serves as the immediate past chair of the United States Preventive Services Task Force after having completed a decade of work on the Task Force in April 2015, serving as co-vice chair for three years and chair for a year. He was also a member of the Joint National Conference on Prevention, Detection and Treatment of Hypertension (JNC 8). He was elected to the Institute of Medicine in 2011. He has received numerous awards, including the University of Missouri School of Medicine Medical Alumni Association 2013 Citation of Merit and the University of Missouri 2013 Faculty-Alumni Award. He has BSEE, MD and MSPH. degrees from the University of Missouri and has been on faculty there since 1984.

Stuart Baker, was the first recipient of the distinguished alum award from the Department of Biostatistics at the Harvard School of Public Health. Dr Baker is also a fellow of the American Statistical Association. Dr Baker's research contributions includes the paired availability design for historical controls, latent class instrumental variables, relative utility curves for evaluating prognostic markers, benefit functions for evaluating predictive markers, the swirls and ripples approach for classifying microarray data, identifying biologically relevant models in time series microarray data, a biomarker

pipeline to evaluate markers for the early detection of cancer, estimation of cumulative false positive rates in cancer screening, the leave-one-out method for evaluating surrogate endpoints, the latent class twin method for estimating genetic susceptibility, periodic cancer screening evaluation based on a few screens at various ages, and commentaries on paradigm instability in theories of carcinogenesis.

Douglas K. Owens MD MS is the Henry J. Kaiser, Jr. Professor, and Director of the Center for Health Policy (CHP) in the Freeman Spogli Institute for International Studies (FSI) and of the Center for Primary Care and Outcomes Research (PCOR) in the Department of Medicine and School of Medicine at Stanford. He is a general internist and Associate Director of the Center for Innovation to Implementation, a health services research center of excellence, at the VA Palo Alto Health Care System. Owens is a Professor of Medicine and, by courtesy, Professor of Health Research and Policy, and Professor of Management Science and Engineering, at Stanford University; he is also a Senior Fellow at FSI.

Abstract: Statistical models are frequently used in the medical literature to estimate cancer overdiagnosis, and have increasingly been incorporated into the deliberations of the US Preventive Services Task Force. Proponents of their use point out the limitations of clinical trials and observational evidence in providing precise estimates of overdiagnosis, including: insufficient duration of follow-up in clinical trials, as well as crossover (contamination) in screening practice during and after the trial; and drifts in population incidence trends and risk factors. They therefore argue that modeling is a necessity in formulating health policy. Skeptics point out that these very limitations of trials and population-based ecologic studies are also the Achilles heel of statistical models, since the models require assumptions about unobserved (and even unobservable) subclinical biological processes, as well as temporal projections that may extend decades beyond the observed evidence. Dynamic biological processes that interact and follow exponential relationships are drivers of statistical chaos. Models that attempt to adjust for lead time bias may also lead to underestimates of overdiagnosis. Speakers in this workshop will each give a perspective on the use and limitations of statistical models for estimation of overdiagnosis when there are substantial gaps in the empiric evidence.

PANEL SESSION ABSTRACTS

Lessons Learned: The Choosing Wisely Program as a Model to Reduce Overuse in Medicine

Moderator: Lisa Gill, Consumer Reports, who has experience in translating Choosing Wisely and Preventing Overdiagnosis materials to a lay audience and working with medical specialty societies and clinicians to develop their materials.

Panelists: Three medical society representatives Those societies could include, for example: American Society of Clinical Oncology (ASCO), American Academy of Family Physicians, Society of Hospital Medicine, or American Academy of Ophthalmology.

Abstract: Objectives: To aid physicians, medical societies, health systems and consumers in understanding how the Choosing Wisely topics are developed and distributed via medical societies, and how that approach could be applied to preventing overdiagnosis. **Methods:** The first half of the workshop will feature short presentations from a panel of medical society representatives who will discuss the success and challenges of the development of the Choosing Wisely program, as well as: a) how their societies selected their topics, particularly in areas of medical overuse; b) how those were implemented into medical practice; c) if and how metrics were developed to measure success; d) how will they be updated or amended. The second half will involve a structured and dynamic discussion with panel and workshop participants, focusing on translating lessons learned into key takeaways for participants on how to begin a campaign in their own medical practices or professional societies. **Results and Conclusions:** The aim is to gain a deeper and more nuanced understanding of how to apply lessons learned from the development and implementation of Choosing Wisely program in order to inform the preventing overdiagnosis effort.

POSTERS

Author _____

Gustavo Gusso - University of São Paulo

Johanna Trimble - Patients for Patient Safety,
Canada

Sudhir Srivastava - National Cancer Institute

Deborah Korenstein - Memorial Sloan Kettering
Cancer Center

Ana Royuel - CIBERESP

Roland Grad - McGill University

Chisato Hamashima - National Cancer Center

Peter Whitehouse - Case Western Reserve University

Sarah Temkin - National Cancer Institute

Sahru Keiser - Breast Cancer Action

Title _____

Four prevention fields and overdiagnosis: A complex
conceptual framework

Is Your Mom on Drugs? Ours was. Here's What We Did
About it

Gene expression profiling to identify novel biomarkers
that predict risk of recurrence among breast cancer
patients

Internal Medicine resident attitudes toward
unnecessary testing

Evidence-based recommendations about ionizing
radiation diagnostics tests in the Emergency
Department

POEMs Reveal Candidate Clinical Topics for the
Choosing Wisely™ Campaign

Oversupply of CT and MRI equipment, but
undersupply of mammography equipment in Japan

From ethical, social and legal Issues to responsible
innovation in developing early diagnostic markers for
Alzheimer's disease

Endometrial Cancer Overtreatment in the United
States

Should I Get A Mammogram? Understanding the
Harms and Benefits of Routine Breast Cancer
Screening

POSTERS

<u>Author</u>	<u>Title</u>
Kato Mikiro - Mito Kyodo General Hospital	Over-testing by routine pre-procedure coagulation screening for patients undergoing gastrointestinal endoscopy
Rachel Thompson - Dartmouth College	Too much medicine? Perceptions of overtreatment among 13,033 maternity care consumers in Queensland, Australia
Brandon Combs - University of Colorado School of Medicine	A Qualitative Evaluation of the Do No Harm Project Subtitle: "Once you start thinking about this you see a lot more harms than before:"
Eva Koeller - Minneapolis VA Medical Center	Taxonomy of Health Care Overuse Literature & Minneapolis VA High Value Care (HiVAC) Initiative
Tulia Manso - University of Copenhagen	Long-term psychosocial consequences in women diagnosed with carcinoma in situ of the breast and invasive breast cancer via screening mammography
Natalie Armstrong - University of Leicester	'Leave no stone unturned' or 'enough is enough'? Approaches to the use of a diagnostic tool of uncertain clinical utility.
Pedram Kazemi-Esfarjani - Alumnus Faculty of Health Sciences, University of Copenhagen	State Sponsored Psychiatric Overdiagnosis in 21 Century as A Tool of Oppression of Healthy Perceived Political Dissidents in Europe and Beyond.
Paul Levin - Montefiore Medical Center	Improving health care and preventing over diagnosis and over treatment: Ban the fifteen minute rule
Melissa Stiles - University of Wisconsin-Madison	A Program to Promote Cost of Care Education for Medical Students

POSTERS

Author _____

Sachiko Ohde - Center for Clinical Epidemiology

Dennis Fechtelpeter - Institute for Quality and Efficiency in Health Care (IQWiG)

Agnes van der Heide - Erasmus MC

Robin Davidson - Sultan Qaboos University

Annika Viniol - Philipps University Marburg

Ananta Dave - NHS UK

Colleen Barclay - The University of North Carolina at Chapel Hill

Marian McDonagh - Oregon Health & Science University

Stephanie Taylor - Universit of South Florida

Stephen Van Den Eeden - Kaiser Permanente Northern California

Title _____

The optimal screening interval for detecting type2 diabetes among Japanese healthy population.

Describing overdiagnosis in patient information - challenges in the case of mammography screening

Usefulness of the "surprise question" to avoid overtreatment in the last phase of life

Over Prescribing by Family Medicine Trainees - comparing the Sultanate of Oman and the UK

Excessive thyroid hormone intake: not much diagnosis and overtherapy

'I need to be mentally ill'- Drivers for (increased) diagnosis of mental illness in the UK

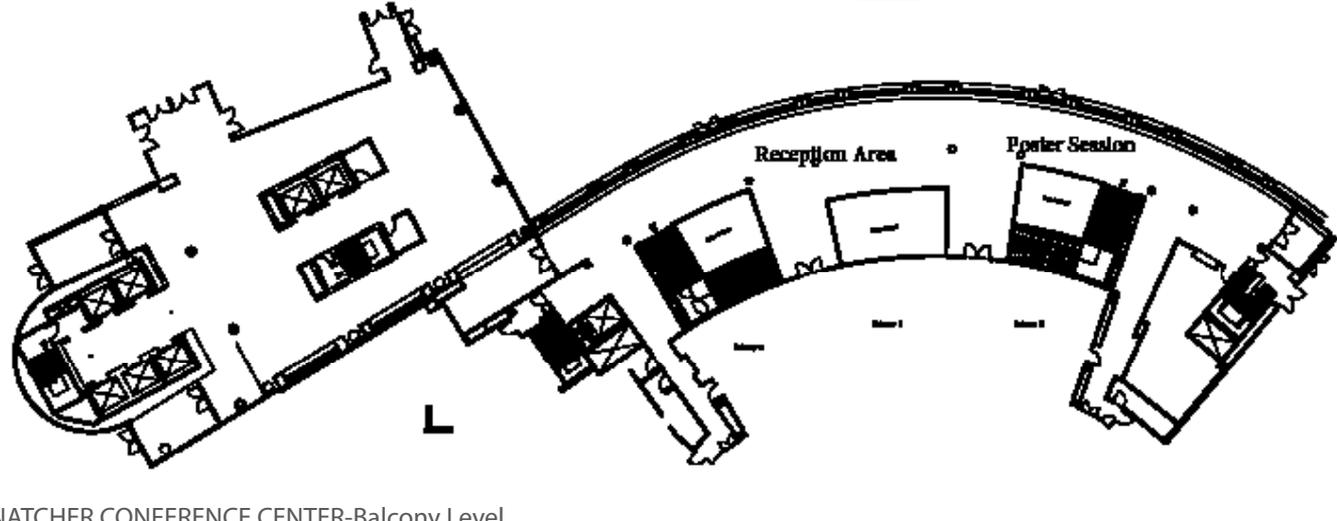
Choosing Wisely: Progress in Use of Evidence to Develop Top 5 Lists?

Point-of-care diagnostic tests as a tool to reduce unnecessary antibiotic prescribing for acute respiratory tract infections in primary care settings: a systematic review.

Dispersion of care in the hospital: How many providers are involved in the care of each patient?

Predictors of Men with Low Risk Prostate Cancer Choosing Active Therapy vs. Active Surveillance: 2004-2010 at Kaiser Permanente Northern California

NATCHER CONFERENCE CENTER-First Floor Level



NATCHER CONFERENCE CENTER-Balcony Level

NATCHER CONFERENCE CENTER-P2 Level

