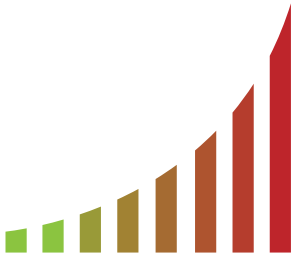

PREVENTING OVERDIAGNOSIS

Winding back the harms of too much medicine

DARTMOUTH COLLEGE | SEPTEMBER 10-12, 2013

STEERING COMMITTEE

Professor Paul Glasziou, Bond University, Australia

Dr. Lisa Schwartz, Professor, The Dartmouth Institute for Health Policy & Clinical Practice, United States

Dr. Steven Woloshin, Professor, The Dartmouth Institute for Health Policy & Clinical Practice, United States

Professor Alexandra Barratt, Sydney University, Australia

Professor Jenny Doust, Bond University, Australia

Professor David Henry, ICES, Canada

Dr. Iona Heath, President Royal College of General Practitioners, UK

Ray Moynihan, PhD student, author, Bond University, Australia

Dr. Barry Kramer, Director Division of Cancer Prevention, National Institute of Cancer, United States

Professor Virginia A. Moyer, Chair, US Preventive Services Task Force

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BMJ

BOND UNIVERSITY FACULTY OF HEALTH SCIENCES & MEDICINE

ConsumerReports

WELCOME

Greetings!

We are very pleased to welcome you to this special scientific gathering on overdiagnosis.

This conference began with a small planning meeting at Bond University in Australia in 2012, which then developed into an international partnership between Bond University, the Dartmouth Institute for Health Policy & Clinical Practice, the BMJ and Consumer Reports.

Our call for abstracts attracted a great deal of quality science, from 28 countries around the world. The conference features more than 150 presentations, posters and workshops – which will focus on what we know of the problem of overdiagnosis, what's driving it and what can be done about it – as well as a host of extraordinary plenary speakers and a special session featuring editors from leading medical journals. The BMJ is planning to publish a special theme issue, drawing from this conference, in early 2014.

To move the meeting agenda into solid plans and tangible outcomes afterwards, the conference also includes a series of strategic planning sessions – in the areas of research, education, communication and policy-making.

We hope that you enjoy the conference and are looking forward to working with you to prevent overdiagnosis.

Ray Moynihan, Paul Glasziou, Steven Woloshin, Lisa Schwartz

(On behalf of the steering committee)

CONFERENCE OVERVIEW

MONDAY, SEPTEMBER 9, 2013

START	END	EVENT	ROOM
5:00 PM	7:00 PM	**Registration**	*Pre-function area*
6:00 PM	8:30 PM	**Welcome Reception - Light Buffet & Cash bar**	*Ballroom*

TUESDAY SEPTEMBER 10, 2013

START	END	EVENT	ROOM
7:30 AM	9:30 AM	**Registration**	*Pre-function area*
7:30 AM	9:00 AM	**Breakfast**	*Pre-function area*
8:00 AM	9:00 AM	**Steering Committee**	*Washington*
10:00 AM	11:15 AM	**Opening Plenary**	*Moore Theater, Hopkins Center*
11:30 AM	1:00 PM	**Concurrent Sessions 1A - 1E**	
		1A	*Drake*
		1B	*Ballroom*
		1C	*Cummings 200, Thayer School*
		1D	*Hayward*
		1E Workshop	*Ford Sayre/Brewster*
1:00 PM	2:30 PM	**Lunch Break**	*Pre-function area*
1:00 PM	2:30 PM	**Poster Session - A**	*Lower Pre-function area*
2:30 PM	4:00 PM	**Concurrent Sessions 2A - 2D**	
		2A	*Drake*
		2B	*Ballroom*
		2C	*Ford Sayre/Brewster*
		2D Workshop	*Hayward*
4:00 PM	4:20 PM	**Tea & Coffee Break**	*Pre-function area*
4:30 PM	6:00 PM	**Concurrent Sessions 3A-3E**	
		3A	*Drake*
		3B	*Ballroom*
		3C	*Cummings 200, Thayer School*
		3D	*Ford Sayre/Brewster*
		3E Workshop	*Hayward*
5:00 PM	6:30 PM	**Dinner check in**	
6:15 PM	7:00 PM	**Cocktail Reception - Cash bar**	*Pre-function area*
7:00 PM	9:00 PM	**Welcome Dinner**	*Ballroom*

WEDNESDAY, SEPTEMBER 11, 2013

START	END	EVENT	ROOM
7:30 AM	9:30 AM	**Registration**	*Pre-function area*
7:30 AM	9:00 AM	**Breakfast**	*Pre-function area*
8:00 AM	9:00 AM	**Work Group Meetings:**	
		Research	*Washington*
		Education	*McFate*
		Communication	*Moosilauke*
		Policy	*Cardigan*
9:00 AM	10:00 AM	**Plenary Session**	*Moore Theater, Hopkins Center*
10:00 AM	10:30 AM	**Tea & Coffee Break**	*Pre-function area*
10:30 AM	12:00 PM	**Concurrent Sessions 4A - 4E**	
		4A	*Ford Sayre/Brewster*
		4B	*Ballroom*
		4C	*Cummings 200, Thayer School*
		4D Workshop	*Hayward*
		4E Workshop	*Drake*
12:00 PM	1:15 PM	**Lunch**	*Pre-function area*
12:00 PM	1:15 PM	**Poster Session - B**	*Lower Pre-function area*
1:15 PM	2:45 PM	**Concurrent Sessions 5A - 5E**	
		5A	*Ballroom*
		5B	*Hayward*
		5C	*Ford Sayre/Brewster*
		5D Workshop	*Cummings 200, Thayer School*
		5E Workshop	*Drake*
2:45 PM	3:00 PM	**Tea & Coffee Break**	*Pre-function area*
2:45 PM	4:00 PM	**Information/Registration desk open**	*Pre-function area*
3:00 PM		**Self-guided walking tours of the Dartmouth campus**	
		Dinner on your own	

THURSDAY, SEPTEMBER 12, 2013

START	END	EVENT	ROOM
7:30 AM	9:00 AM	**Breakfast**	*Pre-function area*
8:00 AM	9:00 AM	**Medical Journal Editors Panel**	*Hayward*
9:00 AM	10:00 AM	**Plenary Session**	*Ballroom*
10:00 AM	10:30 AM	**Tea & Coffee Break**	*Pre-function area*
10:30 AM	11:30 AM	**Concurrent Sessions 6A- 6E**	
		6A Workshop	*Ballroom*
		6B Final Work Group Meeting: Research	*Ford Sayre*
		6C Final Work Group Meeting: Education	*Drake*
		6D Final Work Group Meeting: Communication	*Cummings 200, Thayer School*
		6E Final Work Group Meeting: Policy	*Brewster*
11:45 AM	12:30 PM	**Closing Plenary**	*Ballroom*

KEYNOTE SPEAKERS

Virginia Moyer, Chair, United States Preventive Services Task Force

Lisa Schwartz & Steven Woloshin, Professors of Medicine, Dartmouth Institute for Health Policy & Clinical Practice, co-authors *Overdiagnosed*

Jim Guest, President and CEO, Consumer Reports

Otis Brawley, author *How We do Harm*, Chief Medical Officer, American Cancer Society

Peter Gøtzsche, Director, Nordic Cochrane Centre

Allen Frances, Chair DSM IV Task Force, author Saving Normal

Barry Kramer, Director, Division of Cancer Prevention, National Cancer Institute

Iona Heath, former president, Royal College of General Practitioners

Fiona Godlee, Editor in Chief, BMJ

Deborah Grady, Deputy Editor, JAMA Internal Medicine and Editor for Less is More Series

Deborah Cotton, Deputy Editor, Annals of Internal Medicine

CONFERENCE PROGRAM

MONDAY, SEPTEMBER 9, 2013

5:00 – 7:00 PM	Registration	*Pre-function area*
6:00 – 8:30 PM	Welcome Reception - Light Buffet & Cash bar	BALLROOM

TUESDAY, SEPTEMBER 10, 2013

7:30 – 9:30	Registration	*Pre-function area*
7:30 – 9:00	Breakfast	*Pre-function area*
8:00 – 9:00	Steering Committee	*Washington Room*

10:00 – 11:15	OPENING PLENARY	MOORE THEATER, HOPKINS CENTER
10:00 – 10:15	Welcome Ceremony *Wiley "Chip" Souba, Vice President for Health Affairs, Dartmouth College, Dean, Geisel School of Medicine; Elliott S. Fisher, Director of The Dartmouth Institute for Health Policy & Clinical Practice; Elizabeth Loder, BMJ*	
10:15 – 11:15	What is Overdiagnosis and What's Driving It? ***Chair: Ray Moynihan, Bond University*** Lisa Schwartz and Steven Woloshin (Dartmouth professors, co-authors Overdiagnosed); Otis Brawley (author, How we do harm, Chief Medical Officer, American Cancer Society)	

11:30 – 1:00	CONCURRENT SESSION 1A — DRAKE
	Defining Overdiagnosis ***Chair: Iona Heath***
11:30 – 11:45	**Abstract #77** Conceptual challenges lurking behind the problems with measuring overdiagnosis: towards a more robust definition of overdiagnosis – *B Hofmann*
11:45 – Noon	**Abstract #119** Overdiagnosis and overtreatment over time: historical perspective of a very modern problem – *SA Martin*
Noon – 12:15	**Abstract #111** Overdiagnosis: the roots of the problem – *CJ Wright*
12:15 – 12:30	**Abstract #154** Refining the concepts of overdiagnosis, medicalization, and disease mongering – *DB Menkes*
12:30 – 1:00	**General questions and discussion**

11:30 – 1:00	CONCURRENT SESSION 1B — BALLROOM
	Expanding Disease Definitions and Medicalization ***Chair: Jenny Doust***
11:30 – 11:45	**Abstract #70** What is a disease? Perspectives of the public, health professionals, and legislators in the Finnish Disease (FIND) Survey – *KAO Tikkinen*
11:45 – Noon	**Abstract #33** Expanding disease definitions and expert panel ties to industry: a cross sectional study of common conditions in the United States – *R Moynihan*
Noon – 12:15	**Abstract #91** World-wide prevalence of attention-deficit hyperactivity disorder (ADHD): a systematic review and meta-analyses – *R Thomas*
12:15 – 12:30	**Abstract #42** Medicalization of social problems – *W Schneider*
12:30 – 12:45	**Abstract #150** Gestational diabetes – expert opinion or independent review? – *T Cundy*
12:45 – 1:00	**General questions and discussion**

11:30 – 1:00 CONCURRENT SESSION 1C CUMMINGS 200, THAYER SCHOOL

Risk as Disease

Chair: Alan Cassels

11:30 – 11:45 **Abstract #126**
Does inclusion of total cholesterol in mortality risk algorithms lead to overestimation of risk? Ten years prospective data from the Norwegian Hunt 2 Study – *H Petursson et al*

11:45 – Noon **Abstract #81**
Implementation of the European guidelines for management of arterial hypertension might destabilize the Norwegian Healthcare System – modelling study based on the Hunt 2 population – *JA Sigurdsson*

Noon – 12:15 **Abstract #97**
FRAX®, the fragile WHO fracture prediction tool: Who made WHO, WHO made you? – *TLN Järvinen*

12:15 – 12:30 **Abstract #155**
Performance of the UKPDS Risk Engine in a UK cohort of patients with Type 2 Diabetes: a validation study – *C Bannister*

12:30 – 12:45 **Abstract #96**
Measurement variability and frequency testing and their impact on overdiagnosis – *A Hayen*

12:45 – 1:00 **General questions and discussion**

11:30 – 1:00 CONCURRENT SESSION 1D HAYWARD

What's Driving Overdiagnosis?

Chair: Elizabeth Loder, BMJ

11:30 – 11:45 **Abstract #35**
A systematic evaluation of factors contributing to over-investigations and overdiagnosis – *M Parmar*

11:45 – Noon **Abstract #56**
What drives the activities of specialist physicians under fee for service? – *D Henry*

Noon – 12:15 **Abstract #26**
Proposed financial reward for early diagnosis of Dementia: A recipe for overdiagnosis – *I Campbell-Taylor*

12:15 – 12:30 **Abstract #69**
Overdiagnosis or real clinical benefit: the challenge in evaluating new sensitive diagnostic tests or biomarkers – *J de Groot*

12:30 – 12:45 **Abstract #62**
Patient's reasons for pursuing diagnosis of harmless and untreatable diseases: insights on overdiagnosis – *SL Sheridan*

12:45 – 1:00 **General questions and discussion**

11:30 – 1:00 **CONCURRENT SESSION 1E** **FORD SAYRE/BREWSTER**

Workshop – Screening: Assessing the Harms

Abstract #158

Assessing harms of screening: psychosocial consequences, healthcare costs and rates of overdiagnosis, false-positive and false-negative

J Brodersen, B Heleno,* JF Rasmussen,* M Johansson,# S Reventlow,* V Siersma**

**The Research Unit and Section of General Practice, Department of Public Health, Faculty of Health Sciences, University of Copenhagen; #Department of Public Health and Community Medicine, Institute of Medicine, The Sahlgrenska Academy, University of Gothenburg.*

To reduce mortality many healthy screening participants will be overdiagnosed and hundreds will inevitably receive false-positive screening results. These healthy participants may experience physical and psychosocial harm. In this workshop, we will explore methodological challenges in assessing psychosocial consequences of screening, healthcare costs associated with screening, and assessment of the accuracy of screening programs.

Methods for development and validation of psychosocial measures in three cancer screening programmes (breast, cervical, lung) and in abdominal aorta aneurism screening will be presented. In addition, we will present methods for the analysis of these psychosocial measures over time. Those with most psychosocial harm, i.e. those with positive screening results, will have a tendency not to answer the questionnaires. Hence, longitudinal analysis needs to take into account the differential dropout. We will present published and unpublished results from longitudinal surveys on psychosocial consequences in lung and breast cancer screening that illustrate these challenges. Research about harms of screening should include qualitative research. The methodology and results from a 12-year follow-up qualitative study including women from a population study who have had a bone scan examination will be presented.

At present, one of seven randomized low dose computerised tomography (CT) screening trials for lung cancer show reduced overall and lung cancer-specific mortality; the six remaining trials have not reported their mortality data. In addition, it is unclear whether CT-screening is cost-effective. A registry study of the population in the Danish lung cancer CT-screening trial (DLCST) investigated the healthcare costs in both the primary and secondary healthcare sector. The data collection in the registry study, the methods and the results from the comparison between: 1) the randomized screening group and control group, and 2) each of the diagnostic groups (true-positives, false-positives and true-negatives) and the control group will be presented.

Participant misclassification underlies the two major harms of screening (false-positives and overdiagnosis). In CT-screening for lung cancer it has been suggested that increasing the cut-off would reduce the number of false-positives for a small number of false-negatives. Data from the DLCST were used to explore the consequences of different choices of cut-offs. Generally, the choice of an optimum cut-off point depends on the test characteristics, incidence of disease, assumptions about overdiagnosis and utility of the different outcomes of the test.

1:00 – 2:30 **Lunch Break** *Pre-function area*

1:00 – 2:30 **Poster Session A with Poster Presenters** *Lower Pre-function area*

2:30 – 4:00 CONCURRENT SESSION 2A — DRAKE

Screening and Overdiagnosis – General

Chair: Tim Wilt

2:30 – 2:45 **Abstract #92**
How frequently are harms reported in cancer screening trials? A literature review – *B Heleno*

2:45 – 3:00 **Abstract #82**
Quantifying and monitoring overdiagnosis in cancer screening: A systematic review of methods – *J Carter*

3:00 – 3:15 **Abstract #132**
Overuse of colorectal cancer screening in the Veterans Health Administration – *AA Powell*

3:15 – 3:30 **Abstract #124**
Diagnostic uncertainty as a result of newborn screening for cystic fibrosis: a qualitative exploration of family experience – *R Hayeems et al.*

3:30 – 3:45 **Abstract #144**
Changing screening policies to reduce overdiagnosis – *J Dickinson*

3:45 – 4:00 **General questions and discussion**

2:30 – 4:00 CONCURRENT SESSION 2B — BALLROOM

Breast and Prostate Cancer Screening

Chair: Virginia Moyer

2:30 – 2:45 **Abstract #73**
Screening for prostate cancer – *P Dahm*

2:45 – 3:00 **Abstract #63**
How do primary care physicians weigh recommendations to stop PSA screening and patients' requests to be screened? – *MB Vu*

3:00 – 3:15 **Abstract #103**
Comparison of the burden of overdiagnosis in screening for breast cancer and cervical cancer in a nationwide screening programme, a modelling approach – *PA van Luijt*

3:15 – 3:30 **Abstract #110**
Overdiagnosis in breast cancer screening – Dutch incidence data show a compensatory decline – *NT van Ravesteyn*

3:30 – 3:45 **Abstract #128**
Impact of computer-aided mammography dissemination on early-stage breast cancer treatment rates in the Medicare population – JJ Fenton et al

3:45 – 4:00 **General questions and discussion**

2:30 – 4:00 CONCURRENT SESSION 2C — FORD SAYRE/BREWSTER

Mental Disorders

Chair: Allen Frances

2:30 – 2:45 **Abstract #45**
Re-analysis of the United States Preventative Services Task Force systematic review on screening for depression in primary care – *B Thombs*

2:45 – 3:00 **Abstract #121**
The implications of overdiagnosis for treatment: a comparison of clinical practice guidelines for the treatment of depression – *L Cosgrove*

3:00 – 3:15 **Abstract #20**
Off-label use of atypical antipsychotic medications in Canterbury, New Zealand – *E Monasterio*

3:15 – 3:30 **Abstract #80**
Mental Health care without diagnosis: best practices – *S Harper*

3:30 – 4:00 **General questions and discussion**

2:30 – 4:00 CONCURRENT SESSION 2D — HAYWARD

Workshop – How is Wikipedia Health Information Useful?

***Lane Rasberry**, Wikipedian in Residence at Consumer Reports*

Wikipedia is one of the world's most popular websites. To what extent does its popularity apply to the field of health, and why would anyone go to Wikipedia for health information? Join this session for a one-hour introduction to Wikipedia, which includes a tour of the health-related Wiki entries, and a case study of the content on overdiagnosis. In the last half hour, people who need coffee are excused while those interested folks with laptops can join a short, hands-on workshop to learn practically how to determine what it would mean to use Wikipedia as a health communication platform.

Here is a breakdown of the session:

20-25 minutes

1. General description of Wikipedia platform
2. Anatomy of a Wikipedia article – look at article and point out key features (overdiagnosis article)
3. General description of health content on Wikipedia
4. Overview of health content traffic statistics (example - overdiagnosis article)
5. The pitch – "You can edit Wikipedia"
6. Push back – Dissuade people for whom Wikipedia would not be helpful. Give practical reasons why people should not edit Wikipedia to excuse the people who cannot go further.
7. Case study - overdiagnosis article – rather thorough review
8. Review of talk – explain, "You can check article traffic, you can repeat what I did to the overdiagnosis article"

35 minutes: Questions and live demonstrations based on questions

5 minutes: Excuse people who do not wish to participate in workshop

25 minutes: *Offer assistance in doing 2-3 Wikipedia exercises, including the following:*

1. Checking article traffic
2. Generating a citation from a book or article
3. Adding content which I have prepared for them to a live article
4. Posting a comment to a help board

4:00 – 4:20 **Tea and Coffee Break** *Pre-function area*

4:30 – 6:00 **CONCURRENT SESSION 3A** **DRAKE**

Overdiagnosis and Overtreatment – Elderly, End of Life Care
Chair: Shannon Brownlee

4:30 – 4:45 **Abstract #74**
Prevalence of polipharmacy among elderly patients in a healthcare centre – *S Guerrero*

4:45 – 5:00 **Abstract #19**
Overtreatment fuelled by over-optimism and terror management at the end-of-life (EOL): the crossroads of health services and psychology – *P Duberstein*

5:00 – 5:15 **Abstract #109**
Overdiagnosing disease, undervaluing living? Investigating during end-of-life care – *A Ratneswaren*

5:15 – 5:30 **Abstract #90**
Endoscopy for elderly patients with Upper Gastrointestinal Haemorrhage: what value does it add? – *A Duggan*

5:30 – 5:45 **Abstract #48**
Overuse of endoscopic examinations for asymptomatic persons – *C Hamashima*

5:45 – 6:00 **General questions and discussion**

4:30 – 6:00 **CONCURRENT SESSION 3B** **BALLROOM**

Breast and Prostate Cancer Screening
Chair: Jim Dickinson

4:30 – 4:45 **Abstract #101**
QALY modelling for the Norwegian Breast Cancer Screening Program: net harms are inevitable – *PH Zahl*

4:45 – 5:00 **Abstract #129**
Overdiagnosis of breast cancer risk: different models, different predicted risk – *EM Ozanne et al*

5:00 – 5:15 **Abstract #7**
PSA-testing and prostatic cancer in different counties in Norway – variation and overdiagnosis – H Breidablik

5:15 – 5:30 **Abstract #104**
Use of MRI as part of breast cancer diagnostic assessment in a population based sample – *ST Hawley*

5:30 – 5:45 **General questions and discussion**

4:30 – 6:00 CONCURRENT SESSION 3C CUMMINGS 200, THAYER SCHOOL

Examples of Overdiagnosis

Chair: Gerd Antes

4:30 – 4:45 **Abstract #146**
Evidence of overtesting for Vitamin D in Australia: an analysis of 4.5 yr of Medicare Benefits Schedule (MBS) data – *K Bilinski*

4:45 – 5:00 **Abstract #6**
Overdiagnosis of Gonorrhoea in treatment guidelines for Pelvic Inflammatory Disease (PID) – A recipe for resistance? – *D Barlow*

5:00 – 5:15 **Abstract #156**
Thyroid cancer overdiagnosis: current status of the problem in the United States – *L Davies*

5:15 – 5:30 **Abstract #57**
Asthma diagnosis revised: overdiagnosis revealed by metacholine bronchial challenge – *E Heffler*

5:30 – 5:45 **Abstract #24**
Overdiagnosis due to improper assessment and management of Oropharyngeal Dysphagia – *J Furstoss*

5:45 – 6:00 **General questions and discussion**

4:30 – 6:00 CONCURRENT SESSION 3D FORD SAYRE/BREWSTER

Examples of Overdiagnosis II

Chair: Dee Mangin

4:30 – 4:45 **Abstract #29**
Helicobacter pylori – friend or foe? – *S Malnick*

4:45 – 5:00 **Abstract #28**
Do emergency department patients receive a diagnosis? A study of the prevalence of diagnosis at ED discharge in a nationally-representative sample – *L Wen*

5:00 – 5:15 **Abstract #59**
Characteristics of screen detected Bronchioloalveolar Carcinoma in the NLST – *P Pinsky*

5:15 – 5:30 **Abstract #58**
Understanding primary care in Argentina: a survey about primary care physicians' view on their practice – *M Florencia Grande-Ratti*

5:30 – 6:00 **General questions and discussion**

4:30 – 6:00 | **CONCURRENT SESSION 3E** | **HAYWARD**

Workshop – How Should We Define Normal?

AG Fraser, *Wales Heart Research Institute, Cardiff University, Cardiff, U.K.*

Many diagnoses that previously were based on qualitative judgments or categorical discriminations are now made using quantitative criteria. With the increasing precision of measurements, subclinical relationships with risk factors and premorbid disease become apparent so that a continuous spectrum emerges from absolute health to established pathology. Diagnosis now involves making a decision about which point along this spectrum should be taken as the partition between health and disease. When there is no consensus about how this should be performed, clinical diagnosis can become arbitrary and therefore inconsistent between physicians and institutions.

Approaches adopted in different branches of medicine include:

- Using "hypercontrols" – e.g. in genome-wide analyses of polymorphisms
- Using reference ranges derived from healthy individuals who have no risk factors – leading to a high prevalence of abnormality in asymptomatic subjects
- Using confidence intervals derived from normative population samples – including all individuals, with disease defined as >2 or >3 standard deviations from the mean
- Defining healthy limits by clinical outcomes – e.g. as used to establish normal values for ambulatory blood pressure

Alternative concepts include deriving statistical models (or 'atlases') from large population studies and using information technology to implement clinical decision tools that adjust for risk factors and pre-test probability to give an individualized z-score. Different definitions may be appropriate in different circumstances, depending on the availability of effective treatment early in the natural history of a disease.

This workshop will explore these alternative approaches and seek consensus on common principles.

5:00 – 6:30	**Dinner Check In**	
6:15 – 7:00	**Cocktail Reception - Cash bar**	*Pre-function area*
7:00 – 9:00	**Welcome Dinner**	*Ballroom*

WEDNESDAY, SEPTEMBER 11, 2013

7:30 – 9:30	**Registration**	*Pre-function area*
7:30 – 9:00	**Breakfast**	*Pre-function area*
8:00 – 9:00	WORK GROUP MEETINGS (Steering Committee – BYO Breakfast) **Research** **Education** **Communication** **Policy**	 *Washington* *McFate* *Moosilauke* *Cardigan*
9:00 – 10:00	PLENARY: WHAT CAN WE DO ABOUT OVERDIAGNOSIS? ***Chair: Fiona Godlee, Editor in Chief BMJ*** Virginia Moyer (Chair, US Preventive Services Task Force); Barry Kramer (National Cancer Institute, Dir. Div. Cancer Prevention): Jim Guest (President, CEO, Consumer Reports)	MOORE THEATER, HOPKINS CENTER
10:00 – 10:30	**Tea and Coffee Break**	*Pre-function area*
10:30 – NOON	CONCURRENT SESSION 4A Communicating about Overdiagnosis ***Chair: Lisa Gill***	FORD SAYRE/BREWSTER
10:30 – 10:45	**Abstract #88** Women's views on overdiagnosis in breast cancer screening: a qualitative study – *K McCaffery*	
10:45 – 11:00	**Abstract #89** Overdiagnosis in breast cancer screening: communicating effectively with women – *J Hersch*	
11:00 – 11:15	**Abstract #86** Model of outcomes of screening mammography: information to support informed choices – *G Jacklyn*	
11:15 – 11:30	**Abstract #125** Communicating with patients about overdiagnosis: development of a pamphlet to improve understanding of the benefits and harms of prostate cancer screening, and to address patient concerns about discontinuation – *MR Partin et al*	
11:30 – 11:45	**Abstract # 115** Impact of performance management on utilization of screening among veterans – *SD Saini*	
11:45 – Noon	**General questions and discussion**	

10:30 – NOON	CONCURRENT SESSION 4B	BALLROOM
	Health Systems Responding to Overdiagnosis ***Chair: James McCormack***	
10:30 – 10:45	**Abstract #8** Overcoming overtreatment in thyroid cancer – *JP Brito*	
10:45 – 11:00	**Abstract #3** Do physician searches for clinical information help to avoid unnecessary diagnostic tests, treatments or specialist referrals? – *R Grad*	
11:00 – 11:15	**Abstract #108** Diagnosing overtreatment and how to stop it – *M Hoffmann*	
11:15 – 11:30	**Abstract #127** Ontario's approach to evaluating the appropriateness of routine procedures and tests – *BR McCurdy et al*	
11:30 – 11:45	**Abstract #51** Financial impact of a national program to influence acute low back pain management in general practice – *R Lindner*	
11:45 – Noon	**General questions and discussion**	

10:30 – NOON	CONCURRENT SESSION 4C	CUMMINGS 200, THAYER SCHOOL
	Preventing Overtesting and Overtreatment – Initiatives ***Chair: David Henry***	
10:30 – 10:45	**Abstract #136** 'Goldilocks' cancer screening – not too little ... not too much – *A Compton-Phillips; L Radler*	
10:45 – 11:00	**Abstract #137** Success in appropriate diagnosis and management of lower back pain – *F Alamshaw et al*	
11:00 – 11:15	**Abstract #65** Clinical review and audit – a commissioner's approach to managing unwarranted variations in rates of abdominal hysterectomy – *A Bentley*	
11:15 – 11:30	**Abstract #75** Veterans health administration activities to reduce overuse of cancer screening tests – *LS Kinsinger*	
11:30 – 11:45	**Abstract #122** Review of performance measurement as an approach to targeting overdiagnosis: high yield prospects for measure development – *D Pamnani et al*	
11:45 – Noon	**General questions and discussion**	

10:30 – NOON

CONCURRENT SESSION 4D

HAYWARD

Workshop – Screening: Assessing the Harms

Abstract #159
Promoting awareness of the potential harms of screening: an approach to reducing overuse and overdiagnosis

Presenters: R Harris, MD, MPH; C Barclay, MPH; and S Sheridan, MD, MPH. Presenters have been leaders or organizers of workshops on: research methods and preventive care (UNC MD-MPH Program); communicating benefits and harms of screening (SGIM); critical appraisal of medical literature (UNC medical students and residents); and, appropriate use of clinical preventive services (UNC Research Center for Excellence in Clinical Preventive Services).

Background: One approach to increasing awareness of overdiagnosis emphasizes the financial cost of intensive testing and screening. The public, however, is skeptical about reducing even low-value testing "simply to save money." An alternative approach, focusing on how intensive testing and screening exposes people to unnecessary harms, has been impeded by the lack of a clear understanding and taxonomy of these potential harms, and of a robust literature exploring them.

Aims and Content: In the first hour, three 10-minute presentations will each address a workshop objective, followed by 10 minutes of discussion.

1. Propose a taxonomy of the potential harms of screening (including overdiagnosis): a new way of organizing our thinking about harms
2. Summarize findings of a literature review on the published evidence about potential harms of screening, including gaps in the evidence
3. Present ideas for a collaborative action plan to increase awareness of the potential harms of screening among several audiences

In the second hour, break-out groups will meet for 30 minutes, with each beginning to outline an action plan to increase harms awareness among a target audience: 1) the public, 2) healthcare professionals, 3) policymakers, and 4) the media. The focus will be on concrete first steps that participants can make in their communities, with an eye toward collaboration and synthesis of these efforts at future meetings. We will then reconvene for a half hour of discussion about ideas from the small groups.

10:30 – NOON

CONCURRENT SESSION 4E

DRAKE

Workshop – Preventing Overdiagnosis and Back Pain

Abstract #160
Preventing overdiagnosis of back pain

Presenters: *T Corbin; A Indahl; J Lurie; J Rainville*

Back pain is the largest cause of disability in the United States for working-age consumers and the second largest cause of physician office visits[1]. The general category of low back pain is a complex mishmash of various conditions that produce pain in the back and/or radiating into the legs. When a patient presents at a primary care office with a new complaint of pure back pain, the prognosis for a quick recovery is good. The primary indicators of potential chronicity causing extended disability are psychosocial rather than physical signs.[2] These low-risk patients are easily identified in a brief physician visit.

Clinicians who consult with these patients have an obligation to educate and support patients without increasing their concerns. Although additional diagnostic tests such as MRI appear to be harmless, in fact the discussion of normal aging signs often raises concerns rather than reassures patients.[3] Any discussion of back injury with these patients is inappropriate because in most cases, back pain cannot be attributed to a specific event,[4] but is more likely a hereditary factor.[5]

If the patient prognosis can be modified by the physician for better or worse, what should they say to alleviate concerns without appearing to minimize the patient's complaint? In this workshop, leading back pain researchers will present the scientific evidence that back pain often has a favorable prognosis without diagnostic tests or therapy. They will share their individual strategies for brief discussions with back pain patients that maximize their chances of quick, recovery. The cost effectiveness of this approach will be discussed and extrapolated to the savings on a national level that would accrue if back pain is not overdiagnosed.

1. *Martin BI, Deyo RA, Mirza SK, et al. Expenditures and health status among adults with back and neck problems. JAMA 2008;299:656–64.*
2. *Hill JC, Dunn KM, Lewis M, et al. A primary care back pain screening tool: identifying patient subgroups for initial treatment. Arthritis Rheum 2008; 59: 632–41.*
3. *Chou R, Fu R, Carrino JA, Deyo RA. Imaging strategies for low back pain: systematic review and meta-analysis. Lancet 2009; 373: 463–72.*
4. *Carragee E, Alamin T, Cheng I, Franklin T, van den HE, Hurwitz E. Are first-time episodes of serious LBP associated with new MRI findings? Battie MC, Videman T, Levalahti E, Gill K, Kaprio J. Heritability of low back pain and the role of disc degeneration. Pain 2007; 131: 272–80.*

Noon – 1:15	**Lunch**	*Pre-function area*
Noon – 1:15	**Poster Session B with Poster Presenters**	*Lower Pre-function area*

1:15 – 2:45 CONCURRENT SESSION 5A — BALLROOM

Communicating about Overdiagnosis with Patients/Citizens

Chair: Kirsten McCaffery

1:15 – 1:30 **Abstract #46**
Cancer screening recommendations of the USPSTF: the impact of overdiagnosis on estimating benefits and harms – *TJ Wilt*

1:30 – 1:45 **Abstract #118**
Use of a prostate cancer screening patient decision aid reduces patient intent to be screened – *CD Brackett*

1:45 – 2:00 **Abstract #53**
Using a discrete choice experiment to communicate overdiagnosis in PSA screening – *MP Pignone*

2:00 – 2:15 **Abstract #116**
How do citizens balance the benefits and burdens of newborn screening? A public engagement survey – *F Miller*

2:15 – 2:30 **Abstract #149**
Terrorized by the polyp police: How well are consumers informed about the benefits and harms of colonoscopies and the uncertainties around colon polyps? – *A Cassels*

2:30 – 2:45 **General questions and discussion**

1:15 – 2:45	CONCURRENT SESSION 5B	HAYWARD
	Initiatives to Prevent Overdiagnosis ***Chair: TBC***	
1:15 – 1:30	**Abstract #83** Overdiagnosis.org: an evidence-based resource for patients and clinicians – *M Kadoch*	
1:30 – 1:45	**Abstract #72** Professional societies' top 5 lists for the choosing wisely initiative: evidence-based and sustainable? – *R Harris*	
1:45 – 2:00	**Abstract #16** Attending to our first obligation: the Do No Harm Project – *B Combs*	
2:00 – 2:15	**Abstract #14** The first International Days on Medical Independence (IDMI) – *P de Chazournes; A Cassels*	
2:15 – 2:30	**Abstract #37** Education – back to clinical thinking – *R Rahmani*	
2:30 – 2:45	**General questions and discussion**	

1:15 – 2:45	CONCURRENT SESSION 5C	FORD SAYRE/BREWSTER
	Policies and Interventions to Reduce Overdiagnosis ***Chair: Ray Moynihan***	
1:15 – 1:30	**Abstract #4** Reducing overdiagnosis by eliciting patients' preferences about acceptable regret of diagnostic testing – *B Djulbegovic*	
1:30 – 1:45	**Abstract #11** Analysis of clinical trial data by using evidence-based triage reduces overdiagnosis – *D Llewelyn*	
1:45 – 2:00	**Abstract #43** Proscribing hospital sponsorship of low-value testing by direct-to-consumer screening companies: a call to action – *E Wallace*	
2:00 – 2:15	**Abstract #60** Diagnosing and preventing overdiagnosis in Germany – *D Klemperer*	
2:15 – 2:30	**Abstract # 139** Child health supervision: Too many visits? Too much empty ritual – *GE Harkless*	
2:30 – 2:45	**General questions and discussion**	

1:15 – 2:45

CONCURRENT SESSION 5D — CUMMINGS 200, THAYER SCHOOL

Workshop – Preventing Overdiagnosis in Emergency Department: PE as Example

Abstract #123

Preventing overdiagnosis in the Emergency Department: Lessons learned from the evaluation of patients with suspected pulmonary embolism

Presenters: *CR Carpenter; JD Schuur, AS Raja*

Pulmonary embolism (PE) mortality has remained steady for decades despite an increasing use of testing, mainly computerized tomography (CT). This increase has been associated with overdiagnosis of clinically inconsequential PEs. CT-related risks include contrast-induced nephropathy and long-term cancer risks related to radiation exposure. Despite a growing recognition of the risks associated with our current diagnostic and treatment paradigm, the number of PE CTs continues to increase each year in the United States. This workshop will review the reasons for overdiagnosis of PE and potential approaches to change this paradigm.

Over 60-minutes, this workshop aims to use PE evaluation in the emergency department (ED) as a case study for changing practices resulting in overdiagnosis in a stressful and highly variable clinical area. Panelists will present the 10-minute topics discussed below, followed by three concurrent 20-minute breakout groups, each focused on one aspect of reducing overdiagnosis in the ED: improving evidence uptake, use of technology, or use of policy. Each subgroup will then summarize their conclusions.

Dr. Carpenter will review the epidemiology and etiology of increased ED PE testing rates with an emphasis on CT, based upon his work developing an ongoing series in the leading peer-reviewed journal for emergency medicine.

Dr. Schuur will discuss system and policy efforts to reduce testing for PE based upon his work leading a CT appropriateness project across the 7 EDs of Partners Healthcare. He will share methods, challenges and successes from this effort. He has previously spoken nationally on quality measures with his work group's guideline for appropriate testing endorsed by the National Quality Forum.

Dr. Raja will discuss innovative strategies to change physician behavior using electronic decision support and accountability tools. He will use his NIH-funded work as actionable and pragmatic approaches for these challenges.

1:15 – 2:45

CONCURRENT SESSION 5E — DRAKE

Workshop – Interactive: How Should We Define Disease?

Abstract #39

Preventing overdiagnosis: ethical and philosophical considerations

WA Rogers; J Doust,# P Glasziou#*

**Macquarie University, Sydney, NSW, Australia; #Bond University, NSW, Australia*

Introduction: One of the barriers to preventing overdiagnosis is that there are no agreed criteria for defining disease. Without criteria for defining disease, it is difficult to claim that overdiagnosis is occurring. For example, the claim that chronic kidney disease (CKD) is overdiagnosed relies on assumptions about what a disease is, and the ways in which CKD maps onto these assumptions. The history of disease definition recognizes two broad approaches. The first is naturalist, in which

disease is defined in terms of objective or measurable departures from norms of species functioning. The second is normative, in which disease is defined in terms of states that are more or less disvalued by society. Both approaches have strengths and weaknesses, and neither seems wholly correct.

Aims and methods: The aim of this workshop is to investigate how we should define disease. Should we rely upon pathology or other apparently objective measures? If so, what is the "normal" against which these should be calibrated, given that increasingly sophisticated tests have broken down the distinction between normal and pathological? What weight, if any, should we give to the harms that ensue from particular physical or mental states, when defining disease?

In the first part of the workshop, Rogers will present various criteria used in the definition of disease, including departures from normal species functioning, statistical definitions, observable pathology, individual and social disutility and so forth.

The second part of the workshop will comprise two case studies, one on CKD by Doust, and one on prostate cancer by Glasziou. The case studies will examine how CKD and prostate cancer fit or do not fit with various criteria for defining disease. We will use the case studies to examine questions such as determining the reference population for "normal," whether apparently harmless abnormalities should count as disease; and whether or not the definition should alter depending upon the availability of beneficial remedies.

Format: Introduction and background to defining disease (W Rogers, 20 min, including discussion)

Case study 1: CKD (J Doust, 25 min, including group discussion)

Case study 2: Prostate cancer (P Glasziou, 25 min, including group discussion)

General discussion and wrap up (All, 20 min)

Potential outcomes

Potential outcomes include:

a) Discussion about what a definition of disease ought to be able to tell us;

b) Potential criteria for defining disease and justifications for these; and greater clarity about the extent to which the definition of disease plays a key role in overdiagnosis.

2:45 – 3:00	**Tea and Coffee Break**	*Pre-function area*
2:45 – 4:00	**Information/Registration Desk Open**	
From 3:00 on	**Self-guided Walking Tours of Dartmouth Campus**	
	Dinner on your own	

THURSDAY, SEPTEMBER 12, 2013

7:30 – 9:00 **Breakfast** *Pre-function area*

8:00 – 9:00 **MEDICAL JOURNAL EDITORS PANEL** **HAYWARD**

Chair: Dr Virginia Moyer, Chair, US Preventive Services Task Force

Fiona Godlee, BMJ; Deborah Grady, JAMA Internal Medicine; Deborah Cotton, Deputy Editor, Annals of Internal Medicine

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9:00 – 10:00 **PLENARY: WHAT WILL WE DO ABOUT OVERDIAGNOSIS?** **BALLROOM**

Chair: Fiona Godlee, Editor in Chief BMJ

Peter Gøtzsche (Dir. Nordic Cochrane Centre), Iona Heath (former pres. RCGP), Allen Frances (Task Force Chair DSM IV)

10:00 – 10:30 **Tea and Coffee Break** *Pre-function area*

10:30 – 11:30 **CONCURRENT SESSION 6A** **BALLROOM**

Workshop – Bad Guidelines and Overtreatment in Primary Care.
How Can We Access the Right Evidence to Practice More Patient-Centered Medicine

Abstract #18
How can primary care physicians avoid overdiagnosis and overtreatment in their daily practice? How could we improve our access to balanced evidence?

Dr J Treadwell; Dr I Heath, Royal College of General Practitioners

Introduction: Doctors might wish to practice in a more patient-centered way, testing and treating less, but work within cultural and regulatory frameworks strongly discourages this. Standard guidelines for practice and treatment steer us toward testing, diagnosing and treating our patient populations. The evidence to support an alternative course of action is difficult to access in a time-limited environment and tends not to be promoted by official bodies. We, therefore, have a dual problem of inadequate access to information and barriers to using it, if and when we find it.

Aims: To examine where and how we find our evidence base for daily practice, consider if it is adequate for our purposes and how we can improve on this.

Methods: Presentation looking at the nature of current commonly used guidelines followed by active discussion.

Results/Conclusion: To produce a summary statement commenting on the nature and quality of evidence presented to primary care doctors within guidelines, and to propose or design solutions to drive improvement

THURSDAY, SEPTEMBER 12, 2013

10:30 – 11:30	CONCURRENT SESSION 6B Final Work Group Meeting: Research	FORD SAYRE
10:30 – 11:30	CONCURRENT SESSION 6C Final Work Group Meeting: Education	DRAKE
10:30 – 11:30	CONCURRENT SESSION 6D Final Work Group Meeting: Communication	CUMMINGS 200, THAYER SCHOOL
10:30 – 11:30	CONCURRENT SESSION 6E Final Work Group Meeting: Policy	BREWSTER
11:45 – 12:30	CLOSING PLENARY: Finalize Conference Statement, and Planning *Chairs: Fiona Godlee and Paul Glasziou*	BALLROOM

POSTERS

#	POSTER TITLE	PRESENTER
3	Do physician searches for clinical information help to avoid unnecessary diagnostic tests, treatments or specialist referrals?	*R Grad*
5	Drivers for diagnosis of mental illness – an ethical analysis	*A Dave*
10	An approach to curb the over-ordering of AST, a diagnostically nonspecific enzyme	*G Cembrowski*
11	Analysis of clinical trial data by using evidence based triage reduces overdiagnosis	*D Llewelyn*
12	Diagnostic impressions supported by transparent clinical reasoning can reduce overdiagnosis	*D Llewelyn; co-presenter R Llewelyn*
13	The use of likelihood ratios to represent the usefulness of diagnostic findings can lead to overdiagnosis	*D Llewelyn; co-presenter I. Raburn*
22	Is there "a large reservoir" of overdiagnosed lung cancers?	*F Grannis Jr*
24	Overdiagnosis due to improper assessment and management of Oropharyngeal Dysphagia	*J Furstoss*
25	The driving forces behind overdiagnosis	*J Hernandez*
36	Computerized medical information systems to confront excessive diagnostic testing	*R Rahmani*
44	Deviations from the course of Evidence-Based Practice: Understanding social media contributions to overdiagnosis in the 21st century	*S Louvet*
49	Overdiagnosis and overtreatment of insomnia	*MR Peel*
50	Towards a definition of diagnostic futility	*B Hofmann*
55	The impact of the government limiting indications for imaging low back pain in Ontario	*D Henry*
64	Drivers of overdiagnosis in prostate cancer screening: An Australian GP perspective	*K Pickles*
66	A medical review process for Orthopaedic surgery – A commissioner's approach to managing unwarranted variation	*A Bentley*
67	Applying the medical evidence to funding policies – A commissioner's approach to managing unwarranted variation in rates of spinal surgery	*A Bentley*
71	Exploring decisions to withhold diagnostic investigations in Dutch Nursing Home Patients with a clinical suspicion of Venous Thromboembolism: A mixed method study	*H Schouten*
79	Reducing overdiagnosis on national level: Lessons learned from Germany	*C Schaefer*
84	The effects of replacing screening mammography with screening low-dose computed tomography in women	*M Kadoch*

#	POSTER TITLE	PRESENTER
85	Mitigating the harms of low-dose computed tomographic screening for lung cancer	*M Kadoch*
87	Communicating with physicians about overdiagnosis of prostate cancer: the promise of narrative communication techniques for addressing barriers to change	*MR Partin*
93	Withholding therapy and diagnostics at the end of life	*A van der Heide*
94	Use of private sector RWE in advancing understanding across countries about the role of inappropriate prescribing in driving antibiotic resistance	*M Aitken*
99	Who should define a disease?	*TLN Järvinen*
100	Our drugs kill us	*PC Gøtzsche*
102	Capsule endoscopy in the investigation of iron deficiency anemia and small bowel bleeding: does diagnosis alter management?	*A Duggan*
105	Healthcare costs of the Danish randomized controlled lung cancer CT-screening trial: a registry study	*JF Rasmussen*
106	Long term psychosocial consequences of false positive results in the Danish randomized controlled lung cancer screening trial: a cohort study	*JF Rasmussen*
112	The paradox of precision in diagnostic imaging	*AG Fraser*
117	Addressing bias in estimates of diagnostic accuracy of depression screening tools: a data registry for individual patient data meta-analyses	*B Levis*
133	A conceptual framework for understanding and reducing provider overuse of primary care services	*AA Powell*
134	Communication strategies to reduce overdiagnosis through a rational approach to cancer screening: a focus on PCPs	*R Adler*
135	Best care everywhere – appropriate Microhematura diagnostic work-up	*V Rabrenovich*
141	Benefits and harms of HPV primary screening for cervical cancer in Germany: estimates from a systematic decision-analysis	*U Siebert*
143	The extent of over-diagnosis caused by introduction of PSA screening in Australia	*J Dickinson; C Del Mar*
148	Personalized prostate cancer screening – a decision-analytic view on personalized benefit-harm balance	*U Siebert*
157	Management of incidentalomas found on radiologic imaging studies: discovery ways to stop the train before it leaves the station	*L Davies*
161	Clinical practice guidelines: why we can't trust guidelines and a proposal for change	*JL Lenzer*

THANK YOU

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