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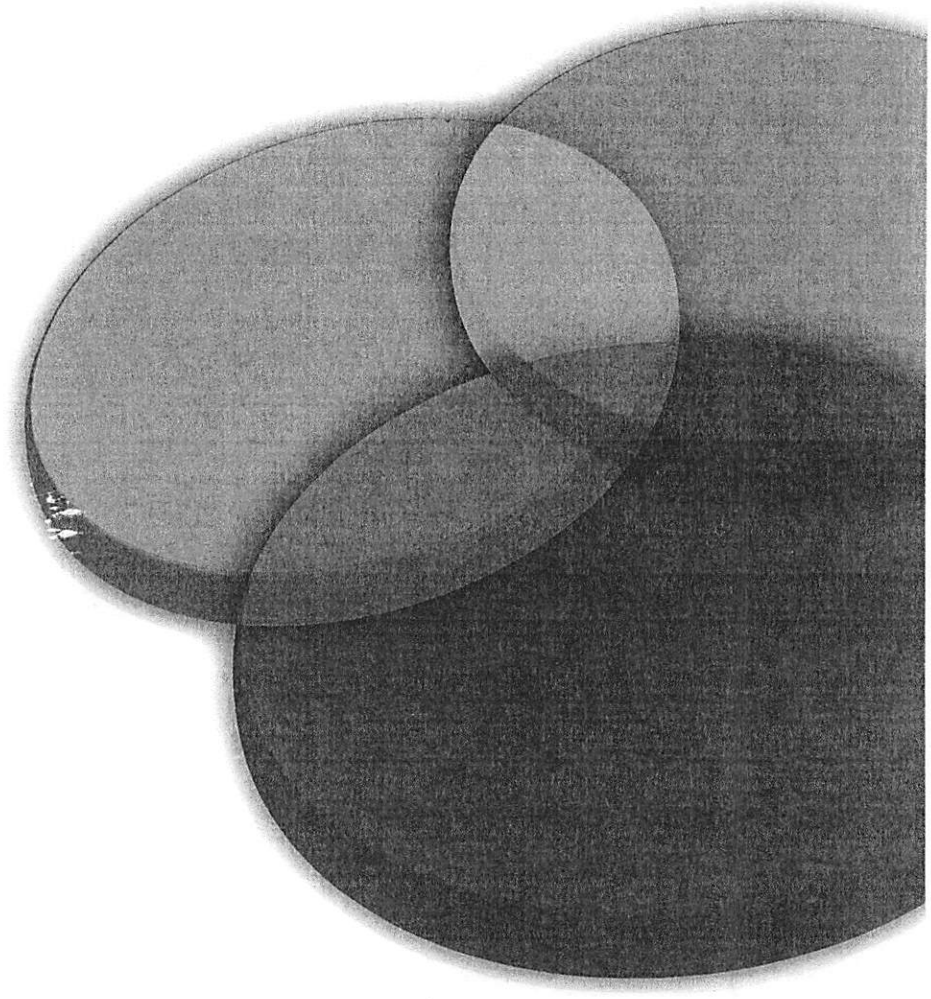
EVIDENCE-BASED MEDICINE

EXPERTISE VALUES EVIDENCE



Preventing Overdiagnosis Abstracts December 2019, Sydney, Australia

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in the case of an elderly patient with mild decline of kidney function. Further exploration of why GPs might think this type of patient doesn't have a clinical problem with their kidneys needs to be explored.

76 USE OF SCREENING RESEARCH TO BOOST OVERDIAGNOSIS: THE MYPEBS TRIAL

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In 2016, a French independent review proposed that the Organized Breast Cancer Screening program should be

- stopped
  or
- stopped as existing today and re–organized after a complete revision.

The first proposition was immediately dismissed by the French authorities. At first sight, the second recommendation seems to be fulfilled by the MyPeBS randomized clinical trial, to be launched in 7 European countries in 2019. Its promoters presented it as seeking to know whether screening tests based on 'individual risks of cancer are as efficient or better than standard screening tests'. They already announced that its results will serve as a basis to organize a new screening in France (and possibly in other countries).

MyPeBS will compare two groups.

Women from the 'standard group' will be screened according to the usual screening program in their geographical area: mammography screening every 1 to 3 years, from the age of 45 or 50. Following a complex process, women from the 'individual risk group' will be divided into four risk subgroups. Low-risk will lead to no screening; moderate risk to mammography screening every two years; high-risk to annual mammography and very high-risk to an additional MRI scan every year. After four years, every woman will undergo mammography screening.

This design is quite complex. In the 'individual risk group', mammography screening will begin at the age of 40, instead of 45 or 50 in the standard screening group. Screening programs organized in different countries will be, inaccurately, considered as identical. Paradoxically, in the individual risk group, young women with a low or moderate risk factors should undergo more mammography screenings than in the standard screening group. Conversely, some women over 50 will undergo fewer mammography screenings, and others, more. MyPeBS poses several problems: absence of non-screened group; risk evaluation methods not validated; heterogeneous groups; insufficient information given to participants.

The primary outcome is the incidence of advanced cancers. This doesn't seem a bad choice: advanced cancer incidence is linearly linked to breast cancer mortality. But the comparison methods are flawed. MyPeBS uses a non-inferiority design, with a 25% threshold. This means that if advanced cancer incidence (and breast cancer mortality) rises by less than 25%, the 'individual risk screening' will be considered 'non-inferior' to the standard screening. Now, for the Cochrane meta-analysis (and others), mammography screening seems to lower breast cancer mortality by 20%. So, even if the 'individual risk screening' does not perform better than no screening at all, it will be considered as non-inferior to the standard screening. Whatever the results, 'individual risk screening' will be considered a success.

When the results of a trial are known in advance, you cannot call it scientific trial: you have to call it marketing. And what does MyPeBS market? Screening from the age 40 (whatever the results of the AgeX trial) and extensive use of MRI scan for 'high risk women'. In other words: overdiagnosis and overtreatment.

Beware of rigged trials!

77 MEDICAL MAXIMIZING-MINIMIZING AND PATIENT PREFERENCES FOR HIGH AND LOW-BENEFIT CARE, PERCEIVED ACCEPTABILITY OF RECOMMENDATIONS AGAINST LOW-BENEFIT CARE, AND PATIENT SATISFACTION

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Objective The Medical Maximizer-Minimizer Scale (MMS) assesses patient preferences for active vs. passive approaches to healthcare and predicts healthcare utilization and patient preferences in a variety of healthcare contexts. In two surveys, our objective was to determine the utility of the MMS for predicting patient preferences for both high and low-benefit care, the acceptability of recommendations related to low-benefit care, and patient satisfaction with their physician.

Methods We conducted two online U.S. surveys, totaling 1,576 men and women age 18–84 (M=34; 52, both samples were majority White). The MMS was associated with the following outcomes: In Survey 1, participants indicated their medical preferences in 18 health scenarios that were constructed using medical expertise and Choosing Wisely® recommendations. In 8 scenarios the optimal approach was active intervention (e.g., colonoscopy at age 60) and in 10 scenarios an active intervention was *not*optimal (e.g., full body CT scan in an asymptomatic healthy person). In Survey 2, participants indicated (1) whether they think too much medicine is a problem, (2) the acceptability of recommendations to take a less aggressive approach to imaging for low back pain and colorectal cancer screening in older adults, (3) their satisfaction with their primary physician, and (4) their perception of whether their physician is a minimizer or maximizer.

Results In Survey 1, MMS scores were significantly correlated with medical preferences in 16/18 scenarios (rs=.16-.39, ps≤.001). Maximizers were more likely than minimizers to want to receive active medical intervention across the 8 scenarios in which action was appropriate (r=.35, p<.001) and across the 10 scenarios for which action was inappropriate (r=-.57, p<.001). In Survey 2, maximizers were less likely than minimizers to believe that too much medicine is a problem (r=-.37, p<.001), and were less likely to believe recommendations about back imagining and colorectal cancer screening are acceptable (rs=-.34, -.36 respectively, both ps<.001). Maximizers were slightly more satisfied with their primary physician than minimizers (r=.10, p=.007) but the perceived agreement between one's own MMS score and

usually absent, and quality assurance programmes are seldom in place.

Method WHO organized international workshops in 2014 (Munich), 2016 (Seoul), 2017 (Quebec) and 2018 (Copenhagen), and stakeholders' feedback was collected. The new International Radiation Basic Safety Standards (BSS) were considered in these deliberations. The BSS require that all radiological procedures on asymptomatic individuals, which are not part of approved health screening programmes, be justified by the practitioners involved, and that the individual presenting be informed of the expected potential benefits, potential harms and limitations. Based on these an international expert group published a paper identifying the issues and options open to policy makers and practitioners. The role of both health authorities and radiation regulators was addressed. Concerns included justification and appropriateness of procedures, safety, quality, process evaluation, optimization, protocols, staff education, training, performance, documentation, mechanisms for integrating the results into established care pathways, ethics and health economics issues, information on benefits, harms and other outcomes to citizens, patients and professionals.

Results Structured definitions and descriptions of CT-IHA practices have been developed, described and compared with more formal radiation screening programmes. In addition, these definitions/descriptions are reviewed in the context of more widespread screening activities in medicine and public health. The considerations involved go beyond radiation-induced cancer risks, and the obvious radiation related legal and good practice requirements. They include public health, ethics, over-diagnosis, over-treatment, false positives, false negatives, indeterminate results and incidental findings, among others. A framework is presented to assist policy development by health authorities, radiation protection regulators, and other relevant stakeholders. It provides for improving clinical governance and regulatory compliance. Notable uncertainties are involved in treating both benefits and harms as well as in the overall experience of persons in receipt of CT-IHA, and these are addressed. This paper summarizes the structure and content of the new WHO document.

19 GUIDELINES AND MINDLINES IN FAMILY MEDICINE

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Objectives Family doctors make diagnoses and manage problems in unique ways, however we rarely discuss openly how we think.

Gabbay and Lemay have described 'mindlines' as the internal processes doctors use to reach their decisions.

Guidelines are a welcome help in working with patients as they offer professional, evidence-based and equal treatment for all patients, but too often reveal shortcomings in multimorbidity, in elderly, representing the majority of our visits, and especially in patients with less serious illnesses. At that time, the equipment can only be based on physicians' healthy wisdom, experience, ingenuity and the needs of the patient to avoid overdiagnosis and overtreatment.

Fighting overdiagnosis and overtreatment is difficult, because these concepts are difficult to master and to explain, and because professionals and people are eager to believe in healing.

'Make believe' is powerful and this is why it is important to take lessons from the best makers of beliefs, whether we have or not religious feelings.

In the French or English translations of the Holy Gospels, Jesus' healings are depicted in a way that 'make believe' supernatural miracles. How does this happen? History, linguistics, archaeology, exegesis and medicine combine to help us understand what may have really happened, and provide lessons for contemporary contexts.

Shift in the meaning of the words Let's talk about the blind man. In Aramaic language, there is no word meaning 'not being able to perceive things with the eyes', implying the idea of a definitive state. The only existing word means 'any serious impairment of sight', even of short duration. Jesus' treatment is precisely described: saliva, a plaster of clay and washings with clear water. At that time, all around the Mediterranean Sea, this happens to have been the standard care for purulent conjunctivitis. In the same way, deafness referred to impaired hearing, but may have been a simple cerumen cap. 'Lepers' only suffered from skin diseases that made them 'unclean' for the Torah, possibly eczema or psoriasis.

In modern times, we see the same phenomena when mere risk factors are widely considered as serious illnesses, and when the media say that mammography screening lower 'mortality' instead of 'breast cancer mortality', making the benefit absolute.

Shrinking time Most Jesus' healing stories give a sensation of immediateness: healing seems to happen in a few minutes. There are strong reasons to believe that quite often, it took several days or weeks to complete. For instance, when the ten lepers go to see the priests in Jerusalem to be declared 'clean again', from the border between Galilea and Samaria, it must have taken 5 to 12 days. But when you read the story, you think it only took a few hours. When expressing benefits and harms from cardiovascular or cancer prevention, time scale should always be stated.

Forgetting natural history of disease When he sees the so-called lepers, Jesus only tell them that they are 'clean'. He doesn't heal them. When he sees Jairus' daughter, he says 'She is not dead but asleep'. He corrects a false diagnosis of death, he does not resurrect her.

The same mental misperceptions are at play when breast cancer 'survivors' speak of themselves as 'saved' by screening.

The patients' sins In the Bible, when the patient is healed, God must be praised. When he is not, the cause lies in his own sins. Ask people about their responsibility in the onset of their cancer, or myocardial infarction, or diabetes: is it really different nowadays?

Conclusion To fight 'the harms of too much medicine', we need to master communication skills and tools and learn from the best.

20 MAKE BELIEVE AND MEDICINE: LESSONS FROM THE FOUR HOLY GOSPELS

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