

association between BSA and GDM/OGTT separately by the body mass index groups.

Results A lower BSA predicted an increased risk for GDM and pathological OGTT among the underweight ($b = -2.69$, $SE = 0.25$, $p < 0.001$; $b = -2.66$, $SE = 0.23$, $p < 0.001$, respectively) pregnant women, and normal weight ($b = -0.30$, $SE = 0.10$, $p = 0.002$; $b = -0.67$, $SE = 0.09$, $p < 0.001$, respectively) pregnant women; and pathological OGTT among the overweight ($b = -0.31$, $SE = 0.10$, $p = 0.001$) pregnant women. Within the obese class II or greater, a higher BSA predicted a higher risk for GDM ($b = 0.74$, $SE = 0.12$, $p < 0.001$) and pathological OGTT ($b = 0.79$, $SE = 0.13$, $p < 0.001$). Maternal smoking predicted a significantly higher risk of GDM and pathological OGTTs in almost all body mass index groups.

Conclusions This study showed that in comparison to women with a higher BSA, underweight and normal weight pregnant women with a smaller BSA may be more susceptible to GDM and have a pathological OGTT.

4 CLINICAL SKILLS FOR AVOIDING OVERDIAGNOSIS

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This workshop will focus on clinical skills for helping patients without over-diagnosing in a society where patients are increasingly framed as consumers and there is an escalating and unsustainable demand for healthcare.

Medical knowledge is usually conceived as intrinsically good and desirable, while at the same time being value neutral, i.e. pertaining to facts that have nothing to do with value judgments and political governance.

In the workshop we will explore an alternative approach, emphasizing the relational aspects of medical knowledge as it is negotiated in clinical encounters and in society. We suggest that in many situations a functional conception of illness and medical care is preferable to an essentialist and descriptive one. Thus, it can often be more useful to ask: 'how can we improve the functional capacity of this person?' rather than 'how can we prove whether the patient has this or that disease?'

Our main clinical example will be a well-trained young man who consults with his doctor because his fitness device has alerted him that some of his training sessions are sub-optimal. We will seek ways to increase the patient's ability to deal with life challenges with less recourse to medical diagnoses and treatment. The workshop will offer short training sessions and demonstrations, while we also reflect upon the reframing of the ethical demands in medical care.

Objectives Promote clinical skills emphasizing functional ability and individual values.

Method Demonstrations, group discussions, exercise in triads, plenum discussions.

Results Promote clinical skills and ability to judge when a descriptive approach is relevant, and when a functional approach is more applicable.

Conclusions Clinical medicine needs an ethical demand that promotes functional ability in addition to disease diagnosis and treatment.

5 PRACTICE VARIATION REVISITED – THE CONTRIBUTION OF PRIMARY CARE

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Practice variation is often explained as originating from supply-driven services in hospitals and secondary care. This presentation will have studies from primary care as its point of departure.

I will present results related to PSA-testing, tonsillectomy, referral to psychiatric specialist care, use of specialist care, variation in diagnostic labelling, and use of resources at the primary care level. I will discuss the concept of unwanted or unexplained variation and identify factors that can explain the variation. Factors related to sociodemographics and morbidity are known and accepted as source of explained variation. Our research has also examined how resource allocation in health care in the municipalities contributes to practice variation. Relative inequality at the municipality level contributes to psychiatric morbidity and explains variation.

Finally, I will discuss the phenomenon of overdiagnosis in a historical perspective. I start with Michael Balint and the post-second-world-war psychosocial turn in medicine. The family was the important unity in this era. It was taken over by the risk society era where the individual was the focus of medical interest. Balint acknowledged 'infantile regression' as a common human experience of suffering. How can we promote his concept of 'maturation' in our current society to enable realistic expectations to health care?.

Objectives Present research from primary health care in Norway with focus on practice variation.

Method Oral presentation of own research.

Results Practice variation is evident also at the primary care level. Some of the variation is random and unexplained. However, we find some factors at the primary care level that can explain practice variation.

Conclusions Practice variation is mostly unexplained. Diseases are not objective phenomena, but seem also to originate as a product of the doctor-patient interaction. 'Maturation' - is that a responsibility for the clinician?.

6 GLOBAL BURDEN OF DISEASE 2017 ESTIMATES FOR MAJOR DEPRESSIVE DISORDER: A CRITICAL APPRAISAL OF THE EPIDEMIOLOGICAL EVIDENCE

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Objectives To critically appraise the quality of the studies underpinning the GBD 2017 estimates for MDD with respect to i) the GBD 2017 inclusion criteria and ii) population coverage.

Methods Of 431 studies underpinning the GBD 2017 estimates, 400 were retrieved. Country-level samples used in multi-country studies were disaggregated to give 467 country-

level studies. Each study was critically appraised with respect to the four GBD 2017 inclusion criteria: representativeness, study method and sample, diagnostic criteria and publication from 1980 onwards. Population coverage was calculated by country, by region and in total.

Results Only 262/467 (56.10%) of studies reported specifically on MDD and more than a third did not use DSM or ICD criteria: 94/467 (20.13%) did not specify any diagnostic criteria and 68/467 (14.56%) relied on self-reported depression for diagnosis. Overall, 107/195 (54.87%) of countries were covered by at least one prevalence study. Population coverage varied by region from only 6.28/100,000 in the SEARO region compared with 7617.09/100,000 in the PAHO region. Regional estimates of coverage were distorted by overrepresentation of some countries, for example respondents from the USA accounted for 90.61% of PAHO region respondents despite the USA only making up approximately a third of the total PAHO population and similarly, Vietnamese respondents accounted for 73.60% of WPRO region respondents although Vietnam only makes up 5% of the total WPRO population. Less than half of studies (221/467, 47.32%) were nationally representative. The majority of studies (400/467; 85.63%) provided sufficient information to assess the quality of the study; 10 did not report on the age group and 57 did not report response rates. Only 62/467 (13.28%) of studies were from 2011-2017.

Conclusions Studies that do not use diagnostic criteria or report specifically on MDD were included in the GBD 2017 estimates for MDD. Self-reported estimates of depression are known to inflate estimates and the lack of specific data of on MDD may have led to the inclusion of cases that would not meet diagnostic criteria for MDD. The estimates were also based on incomplete country and population coverage and there was a lack of nationally representative studies. Given these critical flaws in the data, underpinning the GBD 2017 estimates they are not uniformly reliable and, as such, may have only limited value in international policymaking. At country level policymakers should interpret the estimates with caution, as reliance on poor quality data will lead to the misallocation of resources in prioritising disease conditions and health services.

7 PREVENTING OVERMEDICALISATION AMONG PEOPLE WITH CHRONIC DISEASE: A QUALITATIVE STUDY OF PEOPLE LIVING WITH HIV

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Objectives People with chronic disease are at risk of overmedicalisation including overdiagnosis because of their frequent contact with the health care system. People living with HIV (PLWH) have benefited from exceptional efficacy of antiretrovirals with minimal toxicities so that many screening and testing strategies for HIV related conditions can be implemented. In developed countries the population of PLWH is aging and multimorbidity remains prevalent requiring shared care between HIV specialists and primary care providers. We explored consumer perspectives on overmedicalisation within a qualitative study of shared care among PLWH.

Method Thirteen semi-structured interviews with PLWH from Northern NSW were conducted by four medical student researchers in February and March 2022. The interview schedule covered access, communication, co-ordination and value within a shared care model. The interviews were coded for concepts related to value and overmedicalisation using NVivo. Latent inductive thematic analysis with a constructivist approach was performed and themes were developed in discussion with experienced qualitative researchers and HIV specialists and social workers.

Results Participants valued holistic, patient-centred care and identified the predominant harm of overmedicalisation as treatment and investigation burden, often driven by poor co-ordination. Overdiagnosis was infrequently recognised meaning health anxiety, consumer expectations and desire for action have the potential to drive future overdiagnosis. However high levels of trust, strong primary care provider relationships and health literacy were potential braking forces on overdiagnosis.

Conclusions Consumer education for PLWH and others with chronic disease may play a critical role in addressing potential overdiagnosis drivers such as patient anxiety and desire for action. Trust and engagement with primary care providers was varied, but has the potential to reduce overmedicalisation. Perspectives from other levels of the healthcare system and other chronic diseases should be sought to comprehensively understand overmedicalisation in chronic disease care.

8 DEVELOPING A TRUSTING RELATIONSHIP AT THE FIRST ENCOUNTER TO HELP MINIMIZE OVERTESTING AND OVERDIAGNOSIS

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Narrative Summary: Patients often seek urgent evaluations for acute flares of chronic conditions (e.g. functional abdominal pain, migraine headache), and often see physicians they have never met. This interactive workshop will allow participants to share challenges and gain skills in their abilities to rapidly establish trusting therapeutic relationships and provide appropriate, evidence-based care, using a structured framework for categorizing and evaluating symptoms. We will outline essential steps for patients to understand and accept the biopsychosocial aspects of chronic conditions, to be confident that the evaluation has been adequate to rule out other organic conditions while minimizing unnecessary testing, to accept the limitations of therapy and incremental improvements of symptoms, and to engage in effective self-management. We will encourage all participants to share challenges, stories, and their own best practices in similar settings, and learn from one another.

Background Mayo Clinic, best known as a tertiary care center, also provides primary care to a local population of over 140,000 patients. We have found that patients frequently seek urgent evaluations (including testing) for what are often acute flares of chronic conditions (irritable bowel syndrome, atypical chest pain, migraine headache, etc.). These diagnoses have sometimes not been made at all or at least have not been fully understood by the patient, and continuity is lacking. Consequently, patients are often given appointments with physicians with whom they are barely, if at all, acquainted,