

Newsletter of the International Society for Evidence-Based Health Care

Newsletter 14, January 2014

Mission

The mission of the International Society for Evidence-Based Health Care is to develop and encourage research in evidence-based health care and to promote and provide professional and public education in the field.

Vision

The society is inspired by a vision to be a world-wide platform for interaction and collaboration among practitioners, teachers, researchers and the public to promote EBHC. The intent is to provide support to frontline clinicians making day-to-day decisions, and to those who have to develop curricula and teach EBHC.

Key objectives of the Society

- To develop and promote professional and public education regarding EBHC
- To develop, promote, and coordinate international programs through national/international collaboration
- To develop educational materials for facilitating workshops to promote EBHC
- To assist with and encourage EBHC-related programs when requested by an individual national/regional organization
- To advise and guide on fundraising skills in order that national foundations and societies are enabled to finance a greater level and range of activities
- To participate in, and promote programs for national, regional and international workshops regarding EBHC
- To foster the development of an international communications system for individuals and organizations working in EBHC-related areas
- To improve the evidence systems within which health care workers practice.



Evidence-Based Clinical Practice Office
McMaster University, Canada



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Editorials

Editors Choice

ISEHC is on a success path and is growing rapidly. After two successful conferences the society is becoming an increasingly established player in the EBHC field.

In this issue, we include a short report from the second ISEHC Conference last year and a few conference abstracts on different ways to integrate evidence-based practice into education.

The conference also discussed views of the future and recognised the move to increasingly high-tech solutions such as smart phones and push services. Along those lines, we present two new digital resources in this issue: a Flipboard magazine to keep up-to-date with EBHC-related news articles and a new website for students interested in sharing knowledge on evidence-based healthcare.

Do single-centre trials in critical care medicine provide the same estimates of treatment effects than multi-centre trials? According to a systematic review by Susanne Unverzagt and colleagues, single-centre trials tend to provide larger estimates of treatment effects and should be used with caution for decision making.

Belinda Burford and colleagues encourage authors of systematic reviews of complex interventions to assess the applicability of their findings. This could further enhance the utility of reviews for decision making.

Finally, the EBM events to bear in mind for this year are the G-I-N Conference in Melbourne in August, the Preventing Overdiagnosis Conference in Oxford in September and the 3rd ISEHC Conference in Taiwan in November.

Hope to see you there.

Paul Glasziou

Evidence-Based Medicine – An Oral History

Evidence-based medicine (EBM) is a relatively young field. Although its roots go back to the 1960s, Gordon Guyatt only coined the term EBM in 1991. Since then, much innovation in practicing and teaching medicine has been achieved, not least through the worldwide Cochrane Collaboration.

JAMA and the *BMJ* recently invited six pioneers of the EBM movement to participate in an oral history event and filming. The six individuals shared their personal perspectives on the origins, present and future of EBM, along with personal reflections of clinical and patient encounters and shared decision making in the context of EBM.

The six EBM leaders were:

- Iain Chalmers, MBBS, DSc, coordinating editor, The James Lind Library and Testing Treatments Interactive
- Kay Dickersin, MA, PhD, director, John Hopkins Centre for Clinical Trials and director of the US Cochrane Centre
- Paul Glasziou, FRACGP, PhD, general practitioner, clinical researcher, and former director of Oxford University's Centre for Evidence-Based Medicine
- Muir Gray, CBE, DSc, MD, FCLIP, director, Better Value Healthcare
- Gordon Guyatt, BSc, MD, MSc, FRCPC, distinguished professor of medicine and clinical epidemiology and biostatistics, McMaster University
- Drummond Rennie, MD, FRCP, former contributing deputy director, *JAMA*, and adjunct professor of medicine, P.R. Lee Institute for Health Policy Studies, University of California, San Francisco.
- David L. Sackett, OC, FRSC, MD, MDHC, FRCP, director, Trout Research and Education Centre at Irish Lake
- Richard Smith, MBChB, CBE, FMedSci, FRCPE, FRCGP, director, UnitedHealth Chronic Disease Initiative and former editor, *BMJ*

The video of the event is available for free, alongside interviews with other EBM leaders, on the following website:

<http://ebm.jamanetwork.com/index.html>

An editorial written by Richard Smith and Drummond Rennie has been published by *JAMA* and *BMJ*.

<http://jama.jamanetwork.com/article.aspx?articleid=1817042>

What's so good about "early", anyway? Hilda Bastian



EVERY DAY GERTRUD WAS MORE CONVINCED THE BENEFITS OF BEING AN EARLY BIRD HAD BEEN WILDLY EXAGGERATED

"Early." It's one of those words like "new" and "fast," isn't it? As though they are inherently good, and their opposites - "late," "old" and "slow" - are somehow bad.

Believing in the value and virtue of being an early bird has deep roots in our cultural consciousness. It goes back at least as far as ancient Athens. Aristotle's treatise on household economics said that early rising was both virtuous and beneficial: "It is likewise well to rise before daybreak; for this contributes to health, wealth and wisdom."

But just as Gertrud came to suspect the benefits for her of being early weren't all they were cracked up to be, earliness isn't always better in other areas either. The "get in early!" assumption has an in-built tendency to lead us astray when it comes to detection of diseases and conditions. And even most physicians – just the people we often rely on to inform us - don't understand enough about the pitfalls that lead us to jump to conclusions about early detection too, well...early.

.... continued at <http://statistically-funny.blogspot.com.au/2013/12/whats-so-good-about-early-anyway.html>

Further reading: Earlier is not necessarily better p.5

Teaching & Practice Tips

Public Engagement Exercise: The Chocolate Trial

Used to great success at various outreach events, the Chocolate Trial is a public engagement exercise to make it easier for patients and public to understand the steps and jargon involved in a clinical study.

Visitors to the stand are taken through the stages of a clinical trial, comparing a standard treatment (generic chocolate) to a new treatment (more expensive chocolate or differently flavoured chocolate) to determine which one is better (more satisfying).

Visitors will be given a participant information sheet and learn about eligibility, consent, randomisation and blinding. They will provide feedback on their given chocolate and learn about the reporting of study results.

The following documentation was developed by Danielle Neal, Communications and PPI Officer at North West London Diabetes Local Research Network and is available for download from the National Institute for Health Research website:

http://www.crncc.nihr.ac.uk/about_us/ccrn/nwlondon/Patient%20and%20Public%20Involvement/1%20work%20for%20the%20NHS

- The Chocolate Trial – Guide: this acts as the study protocol and contains all the information on how to conduct the study and what materials you will need
- Participant Information Sheet: the equivalent of the patient information sheet that allows participants to decide whether they want to take part in the study.
- Feedback slips: to be completed by participants after the study is complete
- Randomised clinical trial process: a document that breaks down the essential stages and vocabulary of the study, for use when discussing research with participants.

All documents are free and can be tailored to local requirements.

Information provided by NIHR.

Testing Treatments Book Chapter: Earlier is Not Necessarily Better

'Testing Treatments' is a comprehensive guide about evidence-based medicine that urges everyone to get involved in improving current research and future treatment. The book and the associated website outline practical steps that patients and health professionals can take together to do this.

The second edition of the book includes a thought-provoking account of screening, explaining how early diagnosis is not always better. Below is a summary of the respective book chapter. A PDF of the book is freely available for download from the Testing Treatments website (www.testingtreatments.org).

Many types of screening are of no, or uncertain, benefit. Two heavily contested examples are mammography screening for early breast cancer detection and prostate-specific antigen (PSA) testing for early prostate cancer diagnosis. Both tests may detect cancers that would otherwise never have become apparent or harmful in a patient's lifetime.

A systematic review of all available evidence found that if 2,000 women are screened regularly for 10 years, one will benefit from screening and avoid dying from breast cancer. But at the same time, 10 healthy women will become 'cancer patients' and receive unnecessary treatments. Moreover, 200 out of 2,000 women screened will have a false alarm, causing unnecessary anxiety and further tests.

For prostate cancer, a blood test exists that measures elevated levels of the enzyme PSA, which is indicative of prostate cancer. However, there is no clear cut-off for the test and more importantly, the test does not distinguish between fast-growing cancers that may be life threatening, and slow-growing cancers that may never cause any trouble to the patient. In addition, PSA, unlike

the name suggests, is not specific. Non-cancerous prostate tumours, infections and even some over-the-counter painkillers can cause raised PSA levels.

One in five men with clinically significant cancers will have normal PSA levels. On the other hand, a 2010 systematic review found no evidence that PSA screening had an impact on either the rate of death from cancer or the overall death rate.

At the very least, men should be educated about the fact that the test cannot tell them whether they have a life-threatening cancer but that it could lead them through a series of tests and treatments that could be unnecessary.

Diagnosing a disease earlier does not automatically make patients live longer – they often merely live for a longer time with the disease, or with the knowledge that they may develop a disease. The latter is especially true for genetic testing – a screening test that, not so long ago, was more or less confined to generally rare, single-gene disorders such as the childhood-onset muscle-wasting disease Duchenne muscular dystrophy. However, most diseases cannot be attributed to a single faulty gene, but depend on how risk variants in several genes interact with one another and with environmental factors. Despite this complexity, the media and promoters of direct-to-consumer genetic testing praise the supposed virtue and simplicity of genetic risk profiling. However, the result may well make you anxious and decision-making difficult, and may have wider implications too – on members of your family, for example.

There are other cases where screening may detect diseases earlier, but not early enough. Some cancers, for example lung cancer, spread in the body before the patient has any symptoms and before any tests can detect the presence of the cancer. Traditionally, attempts to detect this cancer early involved chest X-rays. Recently, a large randomised trial involving over 50,000 current and former heavy smokers compared chest X-ray screening with screening by a special type of computer tomography (CT) scan called a spiral CT. Spiral CT diagnosed lung cancers at an even earlier stage than did chest X-rays, and in a small proportion of patients this was sufficiently early for treatment to be of benefit (346 deaths from lung cancer in the spiral CT group vs 425 in the chest X-

ray group). But this beneficial outcome came at the expense of a large proportion of people wrongly labelled with lung cancer. Overall, for every 1,000 heavy smokers who had three annual X-rays or scans, over eight years of follow-up, three fewer died of lung cancer. But 13 still died of lung cancer despite earlier detection and 233 received a false-positive result that required further investigation.

People invited for screening need sufficient and balanced information about the test being offered. This should include possible harms, consequences, limitations and potential benefits – so that they can make an informed choice.

Screening should not happen unless:

- The condition being screened for is important in terms of public health – for example, it is serious and/or affects large numbers of people
- There is a recognizable early stage of the condition
- There is an effective and acceptable treatment for the condition, so screening is likely to make a difference to its outcome
- There is a valid and reliable test for the condition that is acceptable to people being offered screening
- The screening programme is of good quality and cost-effective in the setting in which it is to be offered
- The information provided to people is unbiased; based on good evidence; and clear about possible harms (eg. overdiagnosis leading to over-treatment) as well as potential benefits
- The invitation for screening is not coercive – that is, it indicates it is reasonable to decline
- The chance of physical or psychological harm to those offered screening is likely to be less than the chance of benefit
- There are adequate facilities for the diagnosis and treatment of abnormalities detected by screening

Reference

Imogen Evans, Hazel Thornton, Iain Chalmers and Paul Glasziou. Testing Treatments – Better Health for Better Healthcare. 2nd ed. Pinter & Martin, 2011.

Research & Reviews

Assessing the applicability of findings in systematic reviews of complex interventions can enhance the utility of reviews for decision making

Belinda Burford, Simon Lewin, Vivian Welch, Eva Rehfuss, Elizabeth Waters

Assessment of applicability is an essential part of the systematic review process. In the context of systematic reviews of the effects of interventions, applicability is an assessment of whether the findings of a review can be applied in a particular context or population. For more complex interventions, assessing applicability can be challenging because of greater diversity of, and interactions within and between, the intended population, intervention components, comparison conditions, and outcomes as well as a range of further considerations related to intervention context and theoretical basis. We recommend that review authors plan and conduct analyses to explain variations in effect and answer questions about mechanisms of action and influence of different settings, contexts, and populations. We also recommend that review authors provide rich descriptions of the setting, implementation details, resource use, and contexts of included studies and assess applicability for at least one target population, setting, and context. This should facilitate applicability assessments by end users. Consensus on terminology is needed and guidance should be developed for the synthesis of implementation information within reviews as well as the documentation of applicability judgments by review authors.

J Clin Epidemiol 2013 Nov; 66 (11):1251-61.

Notes from the 2013 ISEHC Conference, October 30 – November 2, Sicily, Italy

The 2013 EBHC International Joint Conference was held on October 30-November 2 in Taormina, Sicily, and was a great success.

For this second annual conference, ISEHC teamed up with the EBHC Teachers and Developers Conference hosted by GIMBE Foundation, which turned out to be a perfect match. The commonality between the two organizations is, of course, the basic principle that evidence should inform all healthcare decisions at all levels: patients, healthcare professionals, healthcare educators, and policy makers.

The conference attracted 159 participants from 30 countries. Some key take home messages from the conference were Gordon Guyatt's new *First principle of EBM: Systematic summaries of the best available evidence should guide patient management decisions*, Brian Haynes' presentation and emphasis of the value of pre-appraised evidence to facilitate clinical decision making, and Paul Glasziou's presentation, via link from Australia, on digestion of evidence and the use of YouTube in medicine.

Other interesting highlights and outcomes of the conference were the initiation of an EBHC MOOC (Massive Open Online Course), a funding appeal/proposal for the implementation of evidence-based practice (EBP) in developing countries, and a proposal on how to integrate shared decision making in EBP education.

Views of the future were shared and included the move to increasingly high-tech solutions for EBHC such as smart phones, integrated EMR's, and push services.

All speaker presentations and a full abstract book can be accessed via www.ebhc.org. A few abstracts are featured in this newsletter.

The 3rd ISEHC Conference will be held in Taipei on November 6-9, 2014. It will be jointly hosted by the Taipei Medical University and Taiwan Evidence-Based Medicine Association (TEBMA).

Abstract submissions and workshop proposals can be submitted between February 15 and April 30.

For details and abstract submission see the conference website: <http://www.isehc2014.tw/>

Selected Abstracts from the 2013 ISEHC Conference, Sicily

Implementing Evidence-Based Practice through EBP Champions

Fathimath Shifaza – Australia

BACKGROUND: Evidence-Based Practice (EBP) is a problem-solving approach that integrates the best available evidence from well-designed studies with clinical expertise, patient assessment, and patients' preference. EBP has been accepted as a process that reduces practice variation and is consistent regardless of the clinician, hospital or geographical location (Davis and Cordiner, 2008). It is fundamentally about reducing the uncertainty in clinical care, in order to achieve efficient and effective service delivery (Courtney and McCutcheon, 2010). Major healthcare organizations are emphasizing the importance of EBP in developing countries. It is an area that needs to be strengthened in developing countries. To date there are many practices that are based on past experience, tradition, trial and error and untested theories in the Maldives.

AIMS: Broadly, the aim of this study is to explore the implementation of EBP into clinical practice in the Maldives health care system, using Evidence-Based Champions. The specific aim for this study is to develop nurses as EBP champions and investigate the usefulness of EBP champions in implementing EBP.

METHODS: This study explores the phenomena of the Evidence-Based Champion model which aims to produce clinical leaders from a variety of backgrounds, who could implement EBP in the Maldives through an action research. It discusses the process that was undertaken to prepare EBP champions and their roles in implementing EBP. Clinicians working in five public healthcare facilities

(hospitals and clinics) were invited to participate in this study. Flyers and information sheets outlining the project were distributed in the wards. Fourteen clinicians volunteered to become EBP champions in their clinical areas. The training for EBP champions involved attendance of a two-day introductory workshop that focused on the concepts and principles of EBP. The main aim of this training was to enhance the EBP champions' competencies for the EBP process, knowledge, skills and attitude towards EBP. The training consisted of the following components: history of EBP, steps involved in EBP, importance of critical appraisal, and developing skills for database searching. During the training, EBP champions were paired up and instructed to conduct an EBP project. All EBP champions were provided with a list of websites and databases that support EBP. EBP champions' activities were monitored over the course of one year to investigate the role of the EBP champion and how they have contributed to effective implementation of EBP. The following things were examined: 1) the types of work that was carried out; 2) any practice changes; 3) the facilitators and barriers faced by the champions. Data were obtained through semi-structured focus group interviews and from web-based activities where the champions shared their experiences and problems. Content analysis was used to analyse discussions with focus groups and web-based data as content analysis is flexible and allows clear identification of prominent themes. This analysis was informed by the framework of Krippendorff (1980) and was processed using the qualitative analysis software NVivo9.

RESULTS: Analysis revealed that the EBP champions engaged in seven core activities. These include educating the general public, educating nurses and disseminating knowledge, implementing projects, auditing, developing guidelines, and facilitating practice change and leadership activities. Sixteen guidelines and four major practices have been changed over the course of one year.

LIMITS: Limitations occur for all studies and for this study they included researchers being away from the research site, which affects communication. However, to overcome this, online communication was used. The other limitation is that the research cannot be generalized. Action research does not require generalization, however, it can be adapted to a research setting.

CONCLUSIONS: This study aimed to achieve a better understanding of the role of EBP champions in the implementation of EBP. Implementation of EBP champions in the Maldives healthcare system has been an additional boost to the implementation of EBP in the country. It provided an opportunity for clinicians to gain an understanding of EBP and identify areas of concern. It attempts to offer new insights of EBP champions and implementation of EBP. This study might serve as a model for similar healthcare organisations interested in implementing EBP through champions.

Evaluating the Impact of an Intensive Education Workshop on Evidence-Informed Decision Making Knowledge, Skills and Behaviours: a Mixed Methods Study.

Jennifer Yost – Canada

BACKGROUND: Health professionals require a unique set of knowledge and skills in order to meet increasing expectations to use research evidence to inform practice and policy decisions. They need to be able to find, access and interpret the best available research and apply the evidence, along with information about patient preferences, clinical expertise, and the clinical context and resources to such decisions.

AIMS: This study evaluated the impact of a five-day intensive educational workshop on evidence informed decision making (EIDM) knowledge, skills and behaviours.

METHODS: An explanatory mixed methods, longitudinal study design was implemented among a convenience sample of various healthcare professionals attending the workshop (N=51). EIDM knowledge, skills and behaviours were quantitatively measured at baseline and at six months follow-up, with EIDM knowledge and skills measured additionally immediately following the educational workshop (post-test measurement). EIDM knowledge and skills were measured using a researcher developed questionnaire consisting of 18 open-ended and multiple-choice format questions. EIDM behaviours were measured using the EBP Implementation Scale (developed by Bernadette Melnyk and Ellen Fineout-Overholt)

which asks 18 scaled items about how often in the past eight weeks a range of EIDM behaviours were performed. Change in EIDM knowledge and skills was determined using repeated measures analysis of variance (ANOVA) and paired t-tests were performed to determine change in EIDM behaviours. The relationships between EIDM knowledge and skills and EIDM behaviour was explored using Pearson's correlation. To determine participants' preferences for continuing education, data were collected using quantitative surveys (post-test measurement) and qualitative (individual telephone interviews after six-month follow-up) methods.

RESULTS: EIDM knowledge and skills increased significantly from baseline to immediately following the intervention [5.6, 95% CI (3.7, 7.4), P 0.000] and from baseline to six-month follow-up [3.7, 95% CI (2.1, 5.3), P 0.000], with a significant decrease from immediately following the intervention to six-month follow-up [-1.9, 95% CI (-3.5, -0.3), P 0.018]. EIDM behaviours increased, but not significantly, from baseline to six-month follow-up [1.7, 95% CI (-0.3, 3.8), P 0.095]. At baseline and six-month follow-up, there was a weak, non-significant positive correlation between EIDM knowledge and skills and EIDM behaviours ($r=0.29$, P 0.069 and $r=0.24$, P 0.136, respectively). Participants indicated a willingness to participate in continuing education that was evident immediately following the week-long workshop and six months after the workshop. Preferences for the time and frequency of online continuing education strategies, however, appeared to shift during this timeframe.

LIMITS: Participants represent a small convenience sample of health care professionals that were largely motivated and supported by their institution. Given that the researchers were unable to use possible workshop attendees who were wait-listed as a control group, it is possible that the significant increase in knowledge and skills from baseline to six-month follow-up could have been due to factors other than the EIDM workshop. In addition, participants could have received additional support following the EIDM workshop to promote EIDM knowledge and skills. Lastly, EIDM knowledge and skills were measured objectively but with a tool with undemonstrated reliability while EIDM behaviours were measured using a tool with documented validity and reliability, but were self-reported and not objectively measured.

CONCLUSIONS: An intensive educational workshop shows promise for increasing EIDM knowledge and skills. Increasing EIDM knowledge and skills may promote the capacity of health professionals to use research evidence when making practice and policy decisions and in turn lead to positive patient outcomes.

Evidence-Based Medicine Interactive eBook Learning Effect

Mao-Meng Tiao – Taiwan

BACKGROUND: Students often feel bored and cannot grasp the main points of learning “evidence-based medicine”.

AIMS: This study is initiated to help students formulate practical clinical questions.

METHODS: An e-book was designed via Adobe Flash Professional CS6. It includes an introduction to the basic concepts of evidence-based medicine, EBM databases, database literature search skills, critical appraisal methods, clinical application and effectiveness evaluation. At the outpatient clinic, the e-book and the skills of evidence-based medicine are presented to the students to formulate a question from a real life patient. Students then practice the five steps of evidence-based medicine to search and analyse the level of evidence of the article that they find and apply it clinically. Their skill is assessed by questionnaires, a five-point Likert item, both before and after class. Searched answers for the questions were later discussed based on a video recorded at the outpatient clinic.

RESULTS: A total of 30 students completed the questionnaire with video recording. The average satisfaction score of the students was 95.1 points (on a scale of 100). With the interaction of e-books, students feel that learning is improved. Database literature search skills scored from 2.5 to 4.1 (out of a possible five-point Likert item), critical appraisal from 2.3 to 4.2 and level of evidence from 2.7 to 4.4.

LIMITS: Too complex or too difficult cases are not suitable for the limited teaching time.

CONCLUSIONS: The integration of the e-book interactive mode into clinical cases can improve the skills of the students, raise interest in learning, and is clinically useful.

Resources & Reviews

EBHC Flipboard – Your Social News Magazine on Evidence-Based Health Care

Do you use Facebook or Twitter? Did you ever wish you could collate all those interesting links your friends and people you follow share with you in one place? The solution is Flipboard, a tablet and smartphone App that lets you create collections of content from your social media networks in the format of a digital magazine.

Once given permission to do so, Flipboard accesses your Twitter, Facebook, LinkedIn or Google+ accounts and aggregates shared links or posts. It also takes content and images from the respective URLs and tiles them in the style of a magazine or newspaper, which you can flip through using your touchscreen.

Flipboard allows you to create your own personalised magazines on topics that interest you. You can add content to those magazines by adding links you come across, for example, whilst browsing your Twitter feed. There is also a 'Flip it' applet for your internet browser, so that you can add stories whilst browsing from your laptop or desktop.

Your magazines can be private or shared with the public, allowing other readers to subscribe. You can invite contributors with similar interests to help fill the pages of a magazine too.

Paul Glasziou has created an EBHC magazine with news about evidence-based health care and Flipboard users are welcome to contribute. If you are interested, please drop Paul an e-mail (pglaszio@bond.edu.au) so that you can be added as a contributor.

To subscribe to the EBHC magazine, download Flipboard (www.flipboard.com) and install it on your tablet and/or smartphone, then search for "EBHC" among the available magazines.

Students4BestEvidence – a New Network for Students Interested in Evidence-Based Healthcare

December 6, 2013 saw the official launch of a new website for students interested in evidence-based healthcare, www.students4bestevidence.net.

The website aims to serve as a platform where students in any healthcare discipline (and even non-healthcare disciplines) can post reviews of evidence-based online resources, discuss the latest evidence-based topics in a blog and share student tutorials on using evidence-based concepts.

All content is filtered using the five steps of evidence-based medicine: asking questions, searching for evidence, appraising research, acting on evidence and evaluating practice.

The website was developed through the UK Cochrane Centre after a Syrian medical student Norah contacted the Director with the idea just over a year ago.

However, it is a website by students for students, and the Cochrane Centre merely plays an administrative role. Several 'pioneers' produced a range of content for the website's soft launch in May 2013. By the end of the year, the community counted over 95 student members from around the world, from school age to university.

Students4BestEvidence collaborates with a series of organisations such as 'sense about science' and hopes to help introduce evidence-based healthcare into student education.

Single-Center Trials Tend to Provide Larger Treatment Effects than Multicenter Trials: a Systematic Review

Susanne Unverzagt, Roland Prondzinsky, Frank Peinemann

OBJECTIVES: To assess whether the reported trial characteristics are associated with treatment effects on all-cause mortality within critical care medicine.

STUDY DESIGN AND SETTING: We identified all eligible randomized controlled trials (RCTs) from Cochrane Reviews on patients with sepsis, septic shock, and cardiogenic shock. Risk of bias was judged on 12 trial characteristics, including the differentiation between single-center and multicenter trials. Hierarchical random-effects models quantified the impact of the risk of bias items on the reported effect estimates of mortality.

RESULTS: Twelve meta-analyses that involved 82 RCTs were selected and judged. Single-center trials estimated a significant larger treatment effect compared with multicenter trials (ratio of odds ratios, 0.64; 95% confidence interval: 0.47, 0.87). Treatment effect tended to be overestimated with selective reporting of preplanned end points. Biases in different trial characteristics are unlikely to operate independently and may have modified these associations.

CONCLUSION: The results of this study highlight a substantial difference in treatment effect estimates between single-center and multicenter trials. Therefore, we recommend that results from single-center trials should be cautiously used for decision making.

J Clin Epidemiol 2013 Nov; 66 (11):1271-80.

Workshops & Conferences

GIN 2014 Conference, Melbourne, Australia, 20-23 August 2014



Therapeutic Guidelines Ltd is delighted to extend a warm invitation on behalf of the Board of Trustees of the Guidelines International Network (G-I-N) and the Scientific Committee to attend the GIN 2014 Conference that will be held in Melbourne, Australia on 20-23 August 2014.

GIN is an international network that was established in 2002 to support collaboration between organisations and individuals that specialise in the development and implementation of guidelines for health professionals. The GIN 2014 conference theme is "Creation and Innovation: Guidelines in the Digital Age". We hope that you will take advantage of this opportunity to participate in the next GIN conference and look forward to welcoming you to Melbourne and the Land Down Under in 2014!

Dr Sue Phillips
President, GIN 2014 Conference

Important Dates:

Abstract Submission Opens

Registration Opens

Deadline for Abstract Submissions

Notification of Acceptance of Abstracts

End of Early Registration

Online Registration Closes

Conference

Professor Paul Glasziou
Chair, GIN 2014 Scientific Committee

11 November 2013

11 November 2013

Midnight* 28 February 2014

11 April 2014

16 May 2014

15 August 2014

20-23 August 2014

www.gin2014.com.au

SAVE THE DATE!

2015

Joint ISEHC & International Shared Decision Making Conference

Sydney, Australia

Second Preventing Overdiagnosis Conference, September 15-17, 2014, Oxford, UK



Following the extraordinary success of the 2013 conference, the second Preventing Overdiagnosis conference will be hosted by the Centre for Evidence-Based Medicine, Department of Primary Care Health Sciences, University of Oxford, Oxford UK. **Abstract submission and early bird registration are now open**, with limited places for a fee currently set at £345. **Abstracts close March 27.**

Abstracts are sought for short oral scientific presentations or posters on the problem of overdiagnosis and potential solutions. Abstract themes can relate to any of the conference sub-themes including: the prevalence of overdiagnosis, methods for researching and measuring the problem, its causes or consequences, policy interventions and communication strategies. Work on defining overdiagnosis, and placing the problem within historical and cultural contexts is also welcome. While the conference is primarily a scientific gathering, abstract submissions from policy makers, citizen or consumer representatives are also welcome, as are proposals for workshops, (around 90 minutes).

A number of workshops have already been proposed including: Methods for measuring incidence, prevalence and over-diagnosis in cancer screening; Nailing the definition of overdiagnosis; Methods for communicating about overdiagnosis; Revealing and measuring harms of screening other than overdiagnosis.

Keynote Speakers

Jack Wennberg - pioneer and leading researcher of unwarranted variation in the healthcare industry. Founder of the Dartmouth Institute of Health Care Policy and Research at Dartmouth Medical School, United States and author of *Tracking Medicine*; a book which connects the problem of unwarranted variation to over-"and mis"-diagnosis.

Linn Getz - MD, Professor, Department of Public Health and General Practice, Norwegian University of Science and Technology, Trondheim, Norway.

Alex Barratt - Professor of Epidemiology, University of Sydney, School of Public Health, Australia.

Margaret McCartney - GP in Glasgow, Scotland, and writer for a range of media, newspapers and journals including the *British Medical Journal*, and BBC Radio 4's *Inside Health*.

Sir John Burn - former head of the Institute of Human Genetics, current Genetics Lead for the National Institute of Health Research and medical director of a new start-up planning to produce hand-held DNA testing devices.

Iona Heath - former president Royal College of General Practitioners, London, England.

Barry Kramer - National Cancer Institute, United States (Panel chair)

Fiona Godlee - Editor-in-chief *BMJ* (chair)



The 3rd International Society for Evidence-based Health Care Conference will be held in the NTUH International Convention Center

Theme - Knowledge Translation and Decision Making for Better Health: Challenge of Globalization.

November 6-9, 2014, Taipei, Taiwan

Hosted by the Taiwan Evidence-Based Medicine Association (TEBMA) in cooperation with Center for Evidence-Based Medicine, Taipei Medical University

ISEHC is on a success path and is growing rapidly. After two successful conferences the society is becoming an increasingly established player in the EBHC field. It is soon time to turn our focus on the 3rd ISEHC conference in Taipei November 6-9, 2014. Abstract submissions and workshop proposals can be submitted between February 15 and April 30. For details and abstract submission see the conference website: www.isehc2014.tw/

Important Dates

Abstract Submission Starts	February 15, 2014
Abstract Submission Deadline	April 30, 2014
Notification of Abstract Review Results	June 30, 2014
Registration Deadline of Accepted Abstracts	July 31, 2014
Proposal of Workshop/Symposium/Panel/Forum Submission Starts	February 15, 2014
Proposal Submission Deadline	March 31, 2014
Notification of Proposal of Workshop/Symposium/Panel/Forum	April 15, 2014
Registration Deadline of Accepted Proposals	May 15, 2014
Registration Starts	February 15, 2014
Very Early Registration Deadline	March 31, 2014
Early Registration Deadline	July 31, 2014
Regular Registration Deadline	September 30, 2014

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MAILING LIST

We would like to keep our mailing list as up to date as possible. If you are planning to move, have moved, or know someone who once received the newsletter who has moved, please e-mail maddock@mcmaster.ca or write your new address here and send to Deborah Maddock, CE&B, HSC 2C12, McMaster University Health Sciences Centre, 1280 Main Street West, Hamilton, ON L8S 4K1, Canada. Thank you!

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SIGN UP A COLLEAGUE!

If you would like to encourage a colleague to attend the workshop next year, please e-mail maddock@mcmaster.ca or write the address here and send to Deborah Maddock, CE&B, HSC 2C12, McMaster University Health Sciences Centre, 1280 Main Street West, Hamilton, ON L8S 4K1, Canada. Thank you!

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