

Newsletter of the International Society for Evidence-Based Health Care

Newsletter 18, January 2015

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

Our apologies for the late newsletter. The CREBP team has been up to our ears in grant submissions. Last year's ISEHC conference in Taipei was fantastic: hundreds of delegates, and a great program that showcased the continuing evolution of EBM. In that vein, the editorial is a summary of my opening plenary on "Six Proposals for the Future of EBM". A vote at the end suggested an interest in all of them. But we will certainly see lots of shared decision making at the forthcoming joint ISDM and ISEHC conference in Sydney (details at the back of the newsletter) which has had 452 abstract submissions!

I hope many of you have already posted comments/letters in PubMedCommons? This is a great NLM initiative which overcomes the time and space constraints journals place on letters about specific articles. Now the NLM is extending this idea to include Journal Club presentations posted on PubMed (but also set up as a collection), again improving visibility of comment on published research. Melissa Vaught has written an article and instructions in this issue – please sign up! And Melissa's colleague at the NLM, Hilda Bastian has another great statistical cartoon and blog – this time on composite outcomes in trials. In teaching, we have two important things. First, is the EU-UNITY program for online teaching of EBM which the authors have kindly made freely available, and Dragan Ilic in Melbourne has kindly hosted – see the article for details and URLs. Second, there is a systematic review on teaching of EBM to medical trainees.

In one of the most important articles published last year, Tammy Hoffmann and Chris Del Mar reviewed 35 studies of how well patient's expectations of benefits and harms matched the actual benefits and harms found in trials. They didn't match: patients mostly overestimated benefits and underestimated harms, which goes a long way to explaining why we have such an epidemic of overtreatment. And it also helps illustrate the need for better patient information and shared decision making. The article received a lot of media commentaries (including the New York Times) and a couple are appended to the abstract.

Sadly, we are about to lose DARE, the Database of Reviews of Effects, but Sarah Thorning and John Rathbone tell you about some other options. Less sadly is the huge range of EBM events this. EvidenceLive is in Oxford next month, then we have the joint ISEHC-ISDM meeting in Sydney, the always delightful Sicily EBHC Conference, the 3rd PreventingOverdiagnosis conference, an EQUATOR meeting focused on the Waste in Research (based on the Lancet series), and the annual Cochrane meeting. I hope you can make at least one or two of these – they will all be great.

Paul Glasziou
Twitter: @PaulGlasziou

Six proposals for EBM's future

Paul Glasziou, Centre for Research in Evidence-Based Practice, Bond University
Gordon Guyatt coined the term EBM over 20 years ago, and it has had a remarkable global influence. But EBM is not a static set of concepts set in stone tablets in the 1990's; it is a young and evolving discipline. The fundamental concept of EBM - using the best available research evidence to aid clinical care – may have changed little, but what is best and how to apply the concepts in practice continue to develop. The 3rd ISEHC conference in Taiwan, November 2014, marked another step in the evolution of evidence-based health care. On the opening plenary, I suggested 6 areas where EBM's future attention was needed.

1. Don't skip "step 0", but foster doubt, uncertainty and honesty

The "traditional" steps of EBM we teach students are: Ask, Acquire, Appraise and Apply. However, Dr Ian Scott – a physician in Brisbane – has suggested the most important step precedes these: recognizing our uncertainties. Without this "Step 0" we cannot begin the other steps. Beginners often ask detailed convoluted questions. But with experience of uncertainty we ask more basic questions about our everyday tests and treatments, and about the advice and information we are deluged by. However, we currently understand little of this step of recognizing our basic uncertainties. At McMaster Sackett often exposed disagreement about clinical signs to raise the uncertainty about what is "correct". Others simply reward students for saying "I don't know", instead of treating ignorance as an admission of failure.

Both are excellent ideas, but, compared with the other steps of EBM, we have few ideas and almost no research on how best to do "step 0". We need to do much more.

2. Beware overdiagnosis: our definitions are as important as our tests

For much of the brief history of EBM we have taken diagnostic definitions for granted, using them as a starting point to study prognosis or treatment. However, definitions of disease often move over time: either incidentally - through improved technology such as spiral CT scans for pulmonary embolism - or through deliberate changes - such as the lowering of thresholds for diseases like diabetes, hypertension or osteoporosis.

"Overdiagnosis" has been low on the EBM radar, but has grown to be one of the largest problems facing medicine[1]. As one example, take the 3-fold growth in the incidence of thyroid cancer in the USA, Australia and other countries. Is that radiation or diet? Probably neither; more probably it is an epidemic of diagnosis, not an epidemic of cancer. Thyroid cancer mortality is unchanged. Even more dramatic is the 15-fold increase in thyroid cancer in South Korea[2] which arose from the ease with which it was added to national screening programs. Though less dramatic most cancers have seen substantial rises in incidence which appear to be overdiagnosis rather than true increases. Many other diseases have seen changes in definitions, with most expanding. A recent analysis of guidelines which changed 14 disease definitions found 10 widened and only 1 narrowed the definition[3].

This Overdiagnosis causes problems with interpretation of our evidence about the prognosis and treatment of diseases, as the spectrum has been changed and sometimes dramatically. However, Overdiagnosis is such a threat to the sustainability of medicine, that it is a worthy EBM topic in its own right.

3. It is the patient's decision: practice and teach Shared Decision Making alongside EBM

EBM has always expressed sympathy with the ideas of shared decision making. For example the Sackett textbook definition is: "Evidence-based medicine is the integration of best research evidence with clinical expertise and patient values". But the step of sharing decision making gets much less attention than searching skills or critical appraisal in our EBM textbooks and teaching. We need to be much more explicit about the "how to" and teach, as part of the steps of EBM, both generic shared decision making ("options talk" and "decision talk") and the use of decision aids. A small step is to incorporate SDM into tutorials on critical appraisal. For example, after doing a critical appraisal I often end with students doing a role play of explaining its meaning: one plays doctor, one plays patient; then we have feedback using "Pendleton rules" – from the "doctor" then the "patient" then everyone else; we then swap roles and do again. A similar process could also be done to allow practice with using a decision aid. Taking SDM more seriously is not only a good thing in itself, but would also help overcome the common misconception of EBM as a rigid discipline which is not patients centred[4].

4. Take non-drug interventions as seriously as pharmaceuticals

If a drug which reduced hospital re-admissions for patients with chronic airways disease by 70%; or cut invasive melanoma rates by 50%; or prevented 50% of malaria cases; or prevented 50% of breech births we would clamour for access. But these non-drug treatments are neglected: exercise ("pulmonary rehabilitation"), daily sunscreen, insecticide-impregnated bed nets, and external cephalic version (turning the baby via the mother's abdominal wall). We neglect them partly because they are not available in a single place, equivalent to a pharmacopoeia[5]. To avoid this availability bias, those working in EBM need to put more effort into non-drug interventions than drug interventions to redress our imbalance. The Royal Australian College of General Practitioners has pilot a Handbook of NonDrug Interventions - www.racgp.org.au/HANDI - but a global effort is needed to extend this to other disciplines and countries.

5. Build clinical practice "laboratories" to study translation and uptake

Courses in EBM usually spend most time on the theory and skills, but very little – or none – on how to integrate these skills into bedside care. However, the clinical practice of EBM tends to go unrecorded, remaining out of public view and discussion, which limits the exchange and evolution of methods. We need to better record, evaluate and teach the different ways of "doing" EBM in the clinical setting. In a series of interviews at the CEBM in Oxford, I talked with a dozen leading EBM practitioners in different clinical disciplines. They had very

different ways of going about EBM in paediatric oncology, perinatal medicine, surgery, emergency medicine, and general practice. Of course, there are necessary differences, but we may also learn and adapt by finding out the processes of others. We need to treat the methods for the efficient and effective bedside practice of EBM as seriously as we treat the methods for doing a systematic review. To do this, we will need “EBM laboratories” where we can readily observe, record, and analyse process of using evidence in practice.

6. Invest long-term in automating evidence synthesis

The costs of gene sequencing have dropped dramatically in the last decade: more than 50% per year. This dramatic drop in cost was not chance, but a serious investment in doing sequencing faster, better, and cheaper. By contrast, the costs of evidence synthesis have been increasing as we have increased the rigour of the process. That cost is inhibiting the use and uptake of evidence in practice, with our information landscape littered with out-of-date systematic reviews. We need to dramatically speed up the processes through standardising, streamline, and – most importantly – automating many of the dozen or so steps in doing a systematic review or other evidence synthesis[6]. It will take time and resources to achieve this – maybe reducing the time by 50% per year – but we need to ignore some of the specific review alligators and start draining the process swamp. Without this automation, we will fall further behind with reviews and updates. And that will mean such reviews are seen as less relevant to practice. If I had my time again, I would have started on these sooner. But as a wise ecologist once

said: the best time to plant a tree is 50 years ago, the second best time is today.

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Bringing your Journal Club discussions to PubMed

Melissa Vaught

Around the world, the journal club is a cornerstone engagement with the scholarly literature. Whether in face-to-face meetings or on social media platforms, researchers,

physicians, and trainees gather to debate and converse about publications. Participants share their views on methods and interpretations of results. They discuss how publications fit into a broader context or might inform their own research or practice.

In short, the journal club can represent a major intellectual investment – and a long-standing form of post-publication evaluation.

Yet often, the analyses and ideas don't travel far beyond core participants. Digital records and virtual journal clubs can help deliver the discourse to others. Still, wouldn't it be fantastic if more of us could see what these groups have to say?

That's the goal of PubMed Commons Journals Clubs.

For more than a year now, [PubMed Commons](#) has provided a forum for many scientists, clinicians, and others to share opinions and information about citations in biomedicine and health. With the introduction of [PubMed Commons Journal Clubs](#), we hope to connect more journal club discussions to PubMed citations. These accounts will allow journal clubs to establish their own identity on PubMed Commons and post comments to any PubMed record. These comments can highlight key points and questions, as well as provide links, for example, to contextual literature or more extensive discussions

The Centre for Research in Evidence-Based Practice (CREBP) Journal Club at Bond University is one of our first PubMed Commons Journal Clubs. For instance, they covered a long-term follow-up trial on the recurrence of

acute otitis media after antibiotic treatment. They posted a comment to [PubMed Commons](#), including a link to their webpage where more notes from their discussion were available. A reader of the comment can learn more about the CREBP Journal Club by clicking on their name and following the link to their [PubMed Commons Journal Club profile page](#).

As more PubMed Commons Journal Clubs join, we'll be looking at ways we can actively support networking with other groups and researchers.

PubMed Commons Journal Club accounts are currently open to journal clubs discussing literature for research, graduate and postgraduate education, or continuing professional education. A PubMed Commons member who participates in the journal club serves as guarantor, responsible under the [PubMed Commons Guidelines](#). For more information or to apply for a Journal Club account, email pubmed.common@ncbi.nlm.nih.gov.

A portion of this was adapted from PubMed Commons Blog "Introducing PubMed Commons Journal Clubs". Read more at: <http://pubmedcommonsblog.ncbi.nlm.nih.gov/2014/12/17/introducing-pubmed-commons-journal-clubs/>

Let's Play Outcome Mash-Up – A Clinical Trial Shortcut Classic!

Hilda Bastian

AN EARLY PROTOTYPE FOR GENERATING CLINICAL TRIAL OUTCOME SHORTCUTS.



Deciphering trial outcomes can be a tricky business. As if many measures aren't hard enough to make sense of on their own, they are often combined in a complex maneuver called a composite endpoint (CEP) or composite outcome.

The composite is treated as a single outcome. And journalists often phrase these outcomes in ways that give the impression that each of the separate components has improved.

Here's an example from the [New York Times](#), reporting on the results of a major trial from the last American Heart Association conference:

"There were 6.4% fewer cardiac events - heart disease deaths, heart attacks, strokes, bypass surgeries, stent insertions and hospitalization for severe chest pain..."

*That individual statement sounds like the drug reduced deaths, bypasses, stents, and hospitalization for unstable angina, doesn't it? But it didn't. The modest effect was on non-fatal heart attacks and stroke only.**

CEPs are increasingly common: by 2007, [well over a third](#) of cardiovascular trials were using them. CEPs are a clinical trial shortcut because you need fewer people and less time to hit a jackpot. A trial's main pile of chips is riding on its pre-specified [primary outcome](#): the one that answers the trial's central, most important question.

The primary outcome determines the size and length of the trial, too. For example, if the most important outcome for a chronic disease treatment is to increase the length of people's lives, you would need a lot of people to get enough events to count (the event in this case would be death). And it would take years to get enough of those events to see if there's anything other than a dramatic, sudden difference.

But if you combine it with one or more other outcomes - like non-fatal heart attacks and strokes - you'll get enough events much more quickly. Put in lots, and you're really hedging your bets.

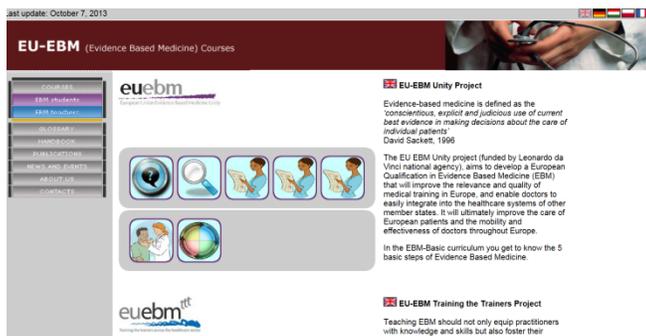
.... continued at <http://statistically-funny.blogspot.com.au/search?updated-min=2015-01-01T00:00:00-05:00&updated-max=2016-01-01T00:00:00-05:00&max-results=1>

Teaching & Practice Tips

EU-EBM website

The EU-EBM website has recently been relocated to the following URL:

<http://www.ebm-unity.med.monash.edu/>.



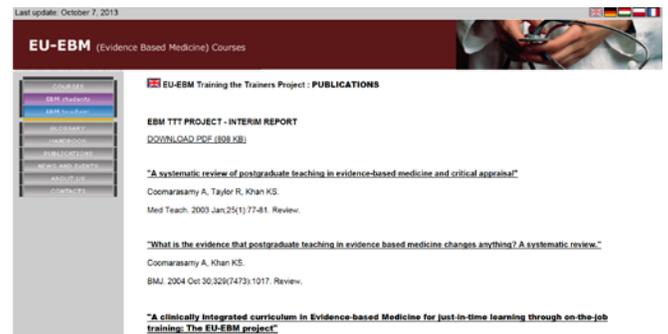
The EU-EBM website provides courses for users wishing to learn about the EBM process, as well as a train the trainers program for those wishing to teach EBM.

The EBM users course provides five interactive modules on defining clinical questions; searching the evidence, appraising the evidence (including trial methodology and biostatistics), application of the evidence and implementation of the evidence into practice. The EBM 'train the trainers' course provides six interactive modules on how to teach EBM including modules on different teaching strategies and assessment.

Learning modules incorporate audio-visual media, as well as tools and examples of EBM teaching and learning. The EU EBM Unity project was originally funded by the Leonardo

da Vinci national agency and has resulted in a number of publications since its initial launch

(<http://www.ebm-unity.med.monash.edu/publications.html>).



Methods of teaching medical trainees evidence-based medicine: a systematic review

Ilic D, Maloney S

Medical Education 2014; 48: 124–135

ABSTRACT:

Context: The principles of evidence-based medicine (EBM) provide clinicians with the ability to identify, source, appraise and integrate research evidence into medical decision making. Despite the mantra of EBM encouraging the use of evidence to inform practice, there appears little evidence available on how best to teach EBM to medical trainees. A systematic review was performed to identify what type of educational method is most effective at increasing medical trainees' competency in EBM.

Methods: A systematic review of randomised controlled trials (RCTs) was performed. Electronic searches were performed across three databases. Two reviewers independently searched, extracted and reviewed the articles.

The quality of each study was assessed using the Cochrane Collaboration's risk of bias assessment tool.

Results: In total, 177 citations were returned, from which 14 studies were RCTs and examined for full text. Nine of the studies met the inclusion criteria and were included in this review. Learner competency in EBM increased post-intervention across all studies.

However, no difference in learner outcomes was identified across a variety of educational modes, including lecture versus online, direct versus self-directed, multidisciplinary versus discipline-specific groups, lecture versus active small group facilitated learning.

Conclusions: The body of evidence available to guide educators on how to teach EBM to medical trainees is small, albeit of a good quality. The major limitation in assessing risk of bias was the inability to blind participants to an educational intervention and lack of clarity regarding certain aspects within studies.

Further evidence, and transparency in design, is required to guide the development and implementation of educational strategies in EBM, including modes of teaching and the timing of delivering EBM content within the broader medical curriculum. Further research is required to determine the effects of timing, content and length of EBM courses and teaching methods.

Research & Reviews

Scientific hypotheses can be tested by comparing the effects of one treatment over many diseases in a systematic review

Chen YF, Hemming K, Chilton PJ, Gupta KK, Altman DG, Lilford RJ

J Clin Epidemiol 2014; **67**(12): 1309-19.

ABSTRACT:

Objectives: To describe the use of systematic reviews or overviews (systematic reviews of systematic reviews) to synthesize quantitative evidence of intervention effects across multiple indications (multiple-indication reviews) and to highlight issues pertaining to such reviews.

Study Design and Setting: MEDLINE was searched from 2003 to January 2014. We selected multiple-indication reviews of interventions of allopathic medicine that included evidence from randomized controlled trials. We categorized the subject areas evaluated by these reviews and examined their methodology. Utilities and caveats of multiple-indication reviews are illustrated with examples drawn from published literature.

Results: We retrieved 52 multiple-indication reviews covering a wide range of interventions. The method has been used to detect unintended effects, improve precision by pooling results across indications, and examine scientific hypotheses across disease classes.

Conclusion: Systematic reviews of interventions are typically used to evaluate the effects of treatments, one indication at a time. Here, we argue that, with due attention to methodological caveats, much can be learned by comparing the effects of a given treatment across many related indications.

COMMENTARY:

This very informative and interesting paper highlights the utilities and caveats in the use of multiple-indication reviews. Producers of systematic reviews should consider using this kind of reviews instead of, or in addition to, reviews focusing on a single indication. Important information that we cannot get with traditional methods (single-indication reviews) can be achieved if this methodology is followed. For example, multiple-indication reviews are very useful in the fight against antibiotic resistance. Providing Health Care Professionals and patients with comprehensive information about the risk of adverse effects and the benefit-harm trade-off may reduce their desire for use of antibiotics.

Chen et al identified three uses of multiple-indication reviews. However, one might argue that the use of this kind of review can be broadly categorised as either:

- To get a better estimate of the effectiveness or harms
E.g. What are the adverse effects of amoxicillin? (P I C H1, H2, ...)*
- To examine heterogeneity across indications or interventions
E.g., When are prophylactic antibiotics effective? (P1, P2, P3, ... I C O1),

E.g., What is the optimum timing of prophylactic antibiotics before any surgery? (P I1 I2 I3, ... C O1)*

(PICO notation: P* = any disease; P1 P2 P3 = set of disease, I1 I2 I3 = set of interventions, C = comparison, O1 = outcome, H = harm)
When undertaking a multiple-indication review much attention has to be paid to the methodological caveats such as 'overlapping' of included reviews; the extra level of complexity (potential heterogeneity in the contributing systematic reviews, in addition to heterogeneity in the primary trials); potential confounders (e.g. methodological quality of included studies and reviews) and risk of bias (e.g. different duration or dose of tested treatment or different control groups). Some of these methodological challenges can be dealt with in the designing of the review and some should be taken into account in the analytical approach. 'Overlapping' can be circumvented if only the data from the original trials are included in the multiple-indication review. However, if the multiple-indication review is based on results from systematic reviews one needs to take account of the potential 'overlapping' of included studies and software routines to conduct these reviews - especially a 2-step frequentist approach - would be desirable.

Patients' Expectations of the Benefits and Harms of Treatments, Screening, and Tests. A Systematic Review

Hoffmann T, Del Mar C

JAMA Intern Med. 2015;175(2):274-286.

ABSTRACT:

Importance: Unrealistic patient expectations of the benefits and harms of interventions can influence decision making and may be contributing to increasing intervention uptake and health care costs.

Objective: To systematically review all studies that have quantitatively assessed patients' expectations of the benefits and/or harms of any treatment, test, or screening test.

Evidence Review: A comprehensive search strategy was used in 4 databases (MEDLINE, Embase, Cumulative Index to Nursing and Allied Health Literature, PsycINFO) up to June 2013, with no language or study type restriction. We also ran cited reference searches of included studies and contacted experts and study authors. Two researchers independently evaluated methodological quality and extracted participants' estimates of benefit and harms and authors' contemporaneous estimates.

Findings: Of the 15 343 records screened, 36 articles (from 35 studies) involving a total of 27 323 patients were eligible. Fourteen studies focused on a screen, 15 on treatment, 3 a test, and 3 on treatment and screening. More studies assessed only benefit expectations (22 [63%]) than benefit and harm expectations (10

[29%]) or only harm (3 [8%]). Fifty-four outcomes (across 32 studies) assessed benefit expectations: of the 34 outcomes with overestimation data available, the majority of participants overestimated benefit for 22 (65%) of them. For 17 benefit expectation outcomes, we could not calculate the proportion of participants who overestimated or underestimated, although for 15 (88%) of these, study authors concluded that participants overestimated benefits. Expectations of harm were assessed by 27 outcomes (across 13 studies): underestimation data were available for 15 outcomes and the majority of participants underestimated harm for 10 (67%) of these. A correct estimation by at least 50% of participants only occurred for 2 outcomes about benefit expectations and 2 outcomes about harm expectations.

Conclusions and Relevance: The majority of participants overestimated intervention benefit and underestimated harm. Clinicians should discuss accurate and balanced information about intervention benefits and harms with patients, providing the opportunity to develop realistic expectations and make informed decisions.

This article has attracted a lot of media attention.

The Conversation, 23 December 2014

Great expectations: our naive optimism about medical care

"It might do me some good and it won't hurt to give it a go."

How often have you heard a phrase like this?



Most people overestimate the benefits and underestimate the harms of medical intervention. [Barbara M./Flickr, CC BY](#)

Most people have naïve optimism about medical care. That's the finding of a systematic review of all available research on common medical treatments we published today in the journal JAMA Internal Medicine.

To read the full article online, go to:
<https://theconversation.com/great-expectations-our-naive-optimism-about-medical-care-33845>

Health Report, ABC Radio, 9 February 2015

Assoc. Prof. T. Hoffmann and Prof. C. Del Mar was interviewed by Dr. Norman Swan from the Health Report on ABC Radio on their published paper.

For more information and to listen to the interview, go to:
<http://www.abc.net.au/radionational/programs/healthreport/patients27-expectations-of-the-benefits-and-harms-of-treatment/6072402>

Resources & Reviews

Where can you go to find systematic reviews now funding for DARE has ceased?

Sarah Thorning and John Rathbone

[Database of Reviews of Effects \(DARE\)](#) was a reliable source for finding systematic reviews. In addition to their weekly comprehensive search of multiple databases using a sensitive filter for finding systematic reviews, they tracked websites of organisations that produced systematic reviews and hand searched some high impact journals. However with cessation of funding the last records were added at the end of 2014. The statement on the [Centre for Reviews and Dissemination \(CRD\)](#) website suggests this archive will remain – but for how long? This raises the question of where do you go now to find systematic reviews?

Other sources indexing systematic reviews exist but are they as comprehensive as DARE? You could try [Epistemonikos](#) which has a simple to use search interface for finding systematic reviews and links to the primary studies used in those reviews. Epistemonikos provides a [list of the sources](#) they use to build the database and this appears to be quite comprehensive. [PubMed Health](#) specialises in clinical effectiveness reviews and links to the systematic reviews of a number of [information partners](#) as well as to PubMed records. [Trip](#) is a search engine with the option of filtering searches to identify systematic reviews. The filter works by linking to specific systematic

review websites rather than filtering by type of article. Currently these three sources could probably be seen as the most comprehensive replacements for DARE.

Other resources include, the [Cochrane Library](#) for healthcare reviews, [Campbell Collaboration](#) for reviews of social interventions and the [EPPI Centre](#) who produce reviews covering both healthcare and social topics. Databases such as the freely available PubMed or subscription based Embase, CINAHL and PsycInfo may be searched in combination with the programs own inbuilt filters or limits for reviews.

Alternatively you could combine your topic search with one of the validated systematic review filters described on the [InterTASC Information Specialists Sub-Group \(ISSG\)](#) search filters resource.

And see [Prospero](#) – for prospectively registered reviews!

Workshops & Conferences



On behalf of the International Society for Evidence Based Health Care (ISEHC) and the International Shared Decision-Making (ISDM) group we warmly invite you to attend the joint ISDM/ISEHC Conference in Sydney, 2015.

This will be a landmark event in the evolution of both evidence-based health care and shared decision making, which have much to contribute to each other and to better care for patients. This is an important opportunity for you to enjoy the fellowship of like-minded colleagues as well as enjoying the many pleasures of Sydney.

Key dates:

Abstract submissions deadline: Closed
Notification of abstract acceptance: March 2015
Early bird registration closes: 17 April 2015

Conference dates: 19-22 July 2015

For more information, visit our website at: <http://www.isdm-isehc2015.org/>

7th EBHC International Conference, Sicily,

28th – 31st October 2015

We are delighted to invite you to the **7th International Conference of EBHC Teachers & Developers** hosted by GIMBE Foundation. Built on 6 previous highly successful meetings, the Conference is an excellent opportunity to network with worldwide EBHC teachers and developers in the wonderful frame of **Taormina, the pearl of the Mediterranean Sea**.



Key dates:

31 March 2015: Abstract submissions deadline
30 April 2015: Notification of abstract acceptance
31 May 2015: Early registration deadline
30 September 2015: Cancellation refund deadline

For more information, visit our website at <http://www.ebhc.org/>



equator
network

**Research Waste / EQUATOR Conference 2015,
Edinburgh, UK - 28-30 September 2015**

Venue: John McIntyre Conference Centre, Edinburgh, UK

Conference aims

- (1) Review the progress made by research regulators, academic institutions, researchers, funders, and publishers against Research Waste series recommendations
- (2) Presentations and posters on problems and potential solutions aimed at making research production more efficient and better reported
- (3) Develop a consensus statement and action plan for making progress against Research Waste series recommendations

Local organising committee: Judi Clarke, Rustam Al-Shahi Salman, Malcolm Macleod

Programme committee: EQUATOR: Doug Altman, Philippe Ravaud, David Moher, Ana Marusic, Iveta Simera WASTE: Paul Glasziou, Iain Chalmers, Rustam Al-Shahi Salman, Malcolm Macleod, John Ioannidis, An-Wen Chan

Conference website: <http://researchwaste.net/research-wasteequator-conference/>

Contact: To register your interest in the conference and to receive more information when it becomes available please email: Ms Judi Clarke (Judi.Clarke@ed.ac.uk)

Third Preventing Overdiagnosis Conference

Following the sell-out 2014 conference, we are pleased to announce a third Preventing Overdiagnosis conference in the State of Washington DC, US September 1st – 3rd 2015.

POD2015 is hosted by the National Institutes of Health, National Cancer Institute.



Registration and Call for Abstracts are open.

Deadline for abstract submission: March 31st 2015

Sign up to the mailing list and receive notifications or visit their website for more information.

<http://www.preventingoverdiagnosis.net/>



Filtering the information overload for better decisions
3rd - 7th October 2015



Key dates:

11 February 2015	Open call for abstracts and workshops
11 March 2015	Early registration opens
25 March 2015 (11am, CET)	Abstracts and workshop submission deadline
13 May 2015	Abstract and workshop notification
22 July 2015 (11am, CEST)	Early registration closes
26 August 2015	Workshop and meeting sign-up Registration cancellation deadline
9 September 2015	Registration closes

Website:

<https://colloquium.cochrane.org/>

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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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