Newsletter of the International Society forEvidence-Based Health Care
Newsletter 20, July 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 EBCP
- 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

Editor's choice

We've been assembling a special issue of the ISEHC newsletter based on the recent joint meeting in July in Sydney of the International Society of Shared Decision Making (ISDM) and ISEHC: so apologies we are a little late. This 4th ISEHC conference was a real milestone in the evolution of EBM. With over 320 participants attending, a very high standard of plenaries, and great research presentations, everyone enjoyed themselves while learning a lot from the exchange of ideas.

Some of the discussions are captured on the Twitter feed using the hashtag #ISDMISEHC. The conference co-chair, Professor Lyndal Trevena, also wrote a daily BMJ blog on as the conference proceeded. In her summary of Day 1 she suggested:

"Victor Montori from the Mayo Clinic started our meeting with a keynote address highlighting the importance of "context and circumstances" in caring for patients. Being a patient can be hard work and we need to try and ensure that our health teams minimise the burden we impose on them. Kindness and care can be lost in an overstretched work environment and there has been a lot of talk over the past two days about the need to support clinicians better."

After Victor's plenary, the burden of illness and kindness both became part of the language of discussions. Read Amanda McCullough's reflections in the editorial section to learn a little more of this (and Victor's arresting picture of a burdened patient). Day 2 was equally engaging but with some new themes, including overdiagnosis which had been little discussed in wither ISDM or ISEHC groups. Here is how Lyndal described it in her blog:

"Professor Alex Barratt from The University of Sydney started the day with a keynote address on over diagnosis which highlighted some of the methodological challenges of getting accurate evidence, the dilemmas of communicating and responding to uncertainty with individual patients, and the ethical issues this topic raises. She highlighted that breast cancer incidence and treatment has increased but is not linked to any substantial reduction in breast cancer mortality rates at a population level. This is clearly a very complex issue, and Alex suggested that trying to prevent too many more new tests being adopted before we have clear evidence that they improve the health of people and using a more transparent approach to present the evidence to patients might be the way forward."

Teaching was also a major theme of the conference – in particular how and when to teach shared decision making and EBM, both separately and together. Lyndal's mixed pessimism and optimism suggested:

"Today also resulted in some substantive discussions about teaching evidence based practice and shared decision making. Whilst many were quite demoralised about what was achievable through limited curriculum time and lack of role modelling from faculty, there was a beacon of hope from Hamburg in Germany where a sophisticated curriculum spirals through the medical undergraduate health psychology course. Impressively the student

feedback is very positive and the faculty has resourced the programme well to allow small group workshops and OSCE-style assessment. The group led by Martin Haerter will be monitoring whether these skills persist beyond graduation. Watch this space!"

Also see the articles in this newsletter by Tammy Hoffmann about her randomized trial of teaching shared decision making as part of courses in evidence-based practice. Dragan Ilic also held a busy and enthusiastic meeting of the ISEHC curriculum working group – see his summary in the newsletter, and also the abstract of his trial on blended learning. Another feature of the conference was the involvement of patient's and patient issues. This included a patient representative on the program committee, comments by patients at the end of some sessions, including the closing, and a special session on patient involvement. Lyndal noted:

"Perhaps the quote of the day came from Melissa Fox, one of our consumer discussants who was shocked to learn that shared decision making was not commonly included in communication skills courses saying "Isn't that what it's all about? What are they teaching instead?"

Good question, Melissa. As Tammy Hoffmann pointed out, it seems to fall between the evidence-based medicine teaching and the communication skills teaching.

So in all, this joint conference was a great success, and we look forward to the next one. As you will see in the Events section, 2017 will have a joint conference with the Cochrane Collaboration in Cape Town.

The 2016 ISEHC conference is still being finalised, and we hope to make an announcement shortly.

Lyndal Trevena – Co Chair ISDM – blogs on reflections per day
For all the blogs by Lyndal Trevena go to
http://blogs.bmj.com/bmj/2015/07/23/lyndal-trevena-final-reflections-as-the-isdmisehc-conference-in-sydney-concludes/

Victor Montori's reflections
The Keynote Speaker from Monday, Victor Montori – Professor of Medicine at Mayo Clinic, provided his reflections after ISDM ISEHC 2015: The Triumph of the Patient.
http://shareddecisions.mayoclinic.org/discussion/reflections-after-the-2015-sydney-isdm-isech-conference-the-triumph-of-the-patient

Best Oral and Best Poster Awards

This year we awarded two prizes. The inaugural David Sackett Memorial Prize for best oral paper by a young researcher which was won by Mr Logan Trenaman from Vancouver, Canada for his cost-effectiveness analysis of a decision aid for knee arthroplasty. The Best Poster Prize went to Siritree Suttajit, a young researcher from Thailand who was attending her first international conference with two colleagues, all of whom had received assisted places from the organising committee and it was the first time that all three had been outside Thailand. They had measured shared decision-making implementation in several hospitals and presented their work clearly and beautifully. Congratulations to the team!

Paul Glasziou
Twitter: @PaulGlasziou

An example of clinician-led evidence-based practice from the ISDMISEHC

Rae Thomas

A sustainable evidence-based practice model from the New South Wales Speech Pathology Network.

After 10 years, the EBP Network for Speech Pathologists in New South Wales Australia is still going strong. At the recent combined ISDMISEHC Conference Melissa Brunner, Melissa Parkin and Pip Taylor discussed the development and sustainability of the EBP Network.

Established by clinicians for clinicians in 2002 and steered by a nine member committee, there are currently over 200 members and 11 different clinical groups with rotating clinical leads that contribute to the Network. The Network conducts EBP training several times a year, has mentoring for new members, an "academic link member" in each clinical group, and conducts structured journal clubs several times a year.

The clinical groups set goals for topic appraisals derived from relevant clinical questions that arise from within the team. First, searches are conducted to find the relevant research for each question. Then several original papers are critically appraised using the Network's standardised forms, collated and then appraised as a specific topic area. Due to the challenges of distance, meetings are flexible in their modality. Groups have between 10 and 20 active members and meet on average six times a year via face-to-face, teleconference, Skype or webex.

The Network hosts an annual EBP showcase where clinical groups have the opportunity to present findings from their topic appraisals and disseminate information to the wider group.

A small pilot study conducted by the Network showed 75% of EBP Network members read research articles more than once per month compared with only 37% of non-members.

For more information, access to standardised forms and showcase evidence-based topics, visit http://nswspeechpathologyebp.com/

#ISDMISEHC – Care, kindness, solidarity

Amanda McCullough

Care. Kindness. Solidarity. Three words that sum up many of the twitter (and non-twitter) discussions from the #ISDMISEHC conference. The twittersphere was buzzing with 140 character bites of wisdom from presenters and listeners alike.

Victor Montori (@vmontori) set the stage for the kind, person-centred focus of the conference when he showed the image below in his opening plenary, and advocated that the look in this woman's eyes was enough to show

that we needed to do better when applying evidence to healthcare. He also proposed a new term for evidence-based medicine — medicine.

Over the following days, Trish Groves (@trished) described the BMJ's efforts to include patients in all aspects of the research process, including as peer reviewers. The "People's Research Institute" (@PCORI) encouraged us to involve patients in all aspects of research from idea generation to funding applications, development of protocols and dissemination. Karen Carey (@Tonic_Karen) from the National Health and Medical Research Council of Australia gave us insight into how the consumer panels rates grant applications. A lively twitter debate took place on #MedicalUncertainty as Kirsten McCaffrey (@KirstenMcCaffer) discussed its implications for shared decision making. And, Alexandra Barrett enlighted us about #overdiagnosis - more is not necessarily better.

How to bring shared decision making and evidence-based healthcare together was a key focus of many of the sessions. Tammy Hoffmann (@Tammy_Hoffmann) offered insights into how to teach it. Researchers from the Preference Lab in Dartmouth and Thomas Agoritsas suggested tools we can use to bring evidence to our patients (options grids, MAGIC). And, Sharon Straus offered us useful advice: don't use the 'It seemed like a good idea at the time' principle and learn to say 'No' nicely. But, Chirk Jenn Ng described something that I personally hadn't thought of in great enough detail - the importance of context, particularly across cultures and languages. He included alternative therapies in a decision aid because it was culturally appropriate - not something many evidence based practitioners might consider.

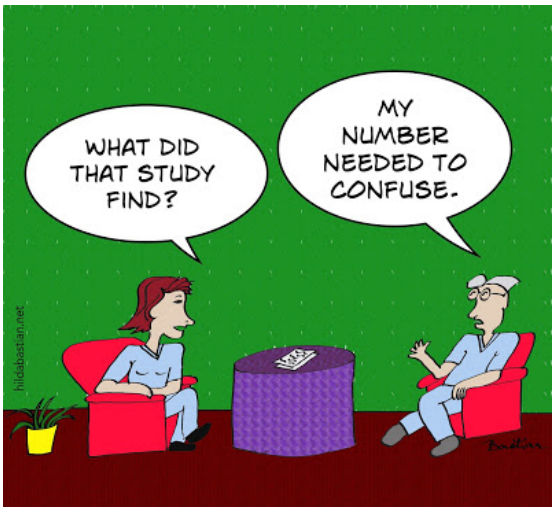
Finally, Health Consumers NSW (@HCNSW) closed the ISDMISEHC show - with a fitting summary that can act as a guiding principle for evidence-based healthcare and shared decision making going forward - Care. Kindness. Solidarity.

For more information: see post-conference reflections from Victor Montori (http://tinyurl.com/p28ryp9) and Lyndal Trevana (@LyndalTrevena)

http://tinyurl.com/pfgk2b8. Click here for an overview of the twitter feed from the conference: http://tinyurl.com/oq9hd8w

ARR OR NNT? What's Your Number Needed to Confuse

Hilda Bastian



*I used to think numbers are completely objective. Words, on the other hand, can clearly stretch out, or squeeze, people's perceptions of size. "OMG that spider is **HUGE**!" "Where? What - **that** little thing?"*

Yes, numbers can be more objective than words. Take adverse effects of health care: if you use the word "common" or "rare", people won't get as accurate an impression as if you use numbers.

But that doesn't mean numbers are completely objective. Or even that numbers are always better than words. Numbers get a bit elastic in our minds, too.

We're mostly good at sizing up the kinds of quantities that we encounter in real life. For example, it's pretty easy to imagine a group of 20 people going to the movies. We can conceive pretty clearly what it means if 18 say they were on the edge of the seats the whole time.

There's an evolutionary theory about this, called ecological rationality. The idea is, our ability to reason with quantities developed in response to the quantities around us that we frequently need to mentally process.

.... 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

EBP curriculum design and teaching: how is it best done?

Dragan Ilic

Craig Mellis and Dragan Ilic facilitated a special interest group (SIG) session at the recent ISDM/ISEBHC conference in Sydney, Australia. The SIG session focused on three key areas of EBP curriculum design and teaching which included; (i) which aspects are critical to teaching EBP, (ii) effectiveness of different modes of teaching, and (iii) assessing competency in EBP.

The five steps of EBP were identified as essential to teaching EBP, but a robust discussion was had in terms of when certain steps should be implemented, or emphasised, within the curriculum setting. A variety of methods for teaching were discussed, including didactic, blended, flipped, clinically integrated and online. The SIG attendees

shared their experiences with each of the mentioned techniques, highlighting pragmatic strengths and limitations of each method. The session concluded with a discussion on current assessment techniques in EBP teaching. The majority of assessment was based on multiple choice questions (MCQs), objective structured clinical examinations (OSCEs) and critical appraisals.

The session concluded by asking attendees to share information about their EBP curricula. Below is an example of information provided about EBP curricula. We thank all those who attended the SIG and look forward to further developing our understanding of how to better teach EBP.

What are the main learning objectives of your course?
The objectives are threefold;
1) To find, select, appraise and apply clinically relevant research that answers clinical questions
2) To identify, examine and assess evidence for risk management; treatments, prognostic, diagnostic, and phenomenological questions
3) To be able to explain information to assist patients make shared decisions

Is EBP in your curriculum as a 'stand-alone course' or is it integrated in the rest of the curriculum?
The course is integrated with the result of the medical curriculum, across lectures, tutorials and other bed-side teaching opportunities.

What are the main teaching strategies of your EBP course (e.g. lectures, PBL, blended…)?
Main teaching strategies include lectures and tutorials, simulated patients for shared decision making.

Please describe any barriers encountered when implementing the EBP curriculum in your course.
Several key barriers are encountered, most significantly a lack of role models in the clinical setting and some lack of expertise mong the other teaching staff (and curriculum-setters). The latter due to the integrated nature of the course.

Training health professional students in Shared Decision Making, as part of EBP

Tammy Hoffmann

At the recent ISEHC-ISDM Conference, there were a number of presentations that discussed the results of shared decision making (SDM) training initiatives or discussed SDM implementation activities and concluded that SDM training was needed. Most discussion on SDM training was centred on training practicing health professionals.

During the second day's plenary session, I gave a presentation titled "Starting early: teaching SDM skills, as part of EBP, to health professional students". In this presentation, some of the main topics that I discussed included:

- **Why training student health professionals in SDM skills is a good idea**.

  - Reasons include: so that clinicians graduate not just aware, but also with some experience of SDM, before establishing clinical habits, patient interaction patterns, and attitudes to these; lack of role modelling of SDM skills from clinicians so skills are unlikely to be observed once working clinically; lack of training in SDM skills is one of the barriers to its implementation, yet opportunities to receive SDM skill training as continuing professional development are limited.
- Despite the overlap and relevance of SDM to two areas (evidence-based practice and patient communication), **teaching of these skills seems to fall between the two**, with neither routinely covering the topic.
  - Much of the skill focus of EBP teaching is on finding and appraising evidence and shared decision making is often not covered under the umbrella of communication skills.
- **Why and how teaching SDM fits logically as part of EBP teaching**
  - expanding upon the broader discussion that is presented in: Hoffmann TC, Montori VM, Del Mar C. The connection between evidence-based medicine and shared decision making. *JAMA*. 2014;312(13):1295–1296.
- The methods and results of **a study that evaluated teaching SDM as part of the 'fourth step' of EBP**. A modified abstract of the paper that describes this randomised trial appears below.

Many of the trial materials (intervention slides, script of the modelled role-play; clinical scenarios used for student role-plays; marking matrix) are available. Please email me for a copy of these: thoffmann@bond.edu.au.

On a final note, there are few randomised trials in medical education and ironically, not many in the area of evidence-based practice teaching other than those that largely focus on critical appraisal. It would be terrific if this intervention and an evaluation of it could be replicated in different countries and settings so that the evidence base for teaching SDM skills to health professional students can be expanded (currently, this is the only randomised trial ever done on this topic!). If any departments/ universities are interested in doing this, we'd be very interested to hear from you and explain what is involved.

Modified abstract of paper: Hoffmann T, Bennett S, Tomsett C, Del Mar C. Brief training of student clinicians in shared decision making: a single-blind randomised controlled trial. J Gen Int Med 2014;29:844–849.

Background: Shared decision making (SDM) is a crucial component of evidence-based practice, but a lack of training in the "how to" of it is a major barrier to its uptake.
Objective: To evaluate the effectiveness of a brief intervention for facilitating SDM skills in clinicians and student clinicians.
Design: Multi-centre randomized controlled trial.
Participants: 107 medical students, physiotherapy or occupational therapy students undertaking a compulsory course in evidence-based practice as part of their undergraduate or postgraduate degree from two Australian universities.
Intervention: The 1 hour small-group intervention consisted of a presentation of the

stages of SDM, some strategies for each implementing each step, and a facilitated critique of a pre-recorded 12 minute modelled role-play which demonstrated some of these strategies and . Both groups were provided with a chapter about SDM skills from the course EBP textbook (Hoffmann T, Tooth L. Talking with patients about evidence. In: Hoffmann T, Bennett S, Del Mar C, eds. *Evidence-based practice across the health professions*. 2nd ed. Sydney: Elsevier; 2013:328–352).

Main measures: The primary outcome was skills in shared decision making and communicating evidence [Observing Patient Involvement (OPTION) scale, items from the Assessing Communication about Evidence and Patient Preferences (ACEPP) Tool], rated by a blinded assessor from videorecorded role-plays. Secondary outcomes: confidence in these skills and attitudes towards patient-centred communication (Patient Practitioner Orientation Scale (PPOS)).

Key results: Of participants, 95 % (102) completed the primary outcome measures. Two weeks post-intervention, intervention group participants scored significantly higher on the OPTION scale (adjusted group difference = 18.9, 95 % CI 12.4 to 25.4), ACEPP items (difference = 0.9, 95 % CI 0.5 to 1.3), confidence measure (difference = 13.1, 95 % CI 8.5 to 17.7), and the PPOS sharing subscale (difference = 0.2, 95 % CI 0.1 to 0.5). There was no significant difference for the PPOS caring subscale.

Conclusions: This brief intervention was effective in improving student clinicians' ability, attitude towards, and confidence in shared decision making facilitation. Following further testing of the longer-term effects of this intervention, incorporation of this brief intervention into evidence-based practice courses and workshops should be considered, so that student clinicians graduate with these important skills, which are typically neglected in clinician training.

Research & Reviews

A randomised controlled trial of a blended learning education intervention for teaching evidence-based medicine

Ilic D, Nordin RB, Glasziou P, Tilson JK, Villanueva E.

BMC Med Educ, 15:39

Abstract

BACKGROUND:
Few studies have been performed to inform how best to teach evidence-based medicine (EBM) to medical trainees. Current evidence can only conclude that any form of teaching increases EBM competency, but cannot distinguish which form of teaching is most effective at increasing student competency in EBM. This study compared the effectiveness of a blended learning (BL) versus didactic learning (DL) approach of teaching EBM to medical students with respect to competency, self-efficacy, attitudes and behaviour toward EBM.

METHODS:
A mixed methods study consisting of a randomised controlled trial (RCT) and qualitative case study was performed with medical students undertaking their first clinical year of training in EBM. Students were randomly assigned to receive EBM teaching via either a BL approach or the incumbent DL approach. Competency in EBM was assessed using the Berlin questionnaire and the 'Assessing Competency in EBM' (ACE) tool. Students' self-efficacy, attitudes and behaviour was also assessed. A series of focus groups was also performed to contextualise the quantitative results.

RESULTS:
A total of 147 students completed the RCT, and a further 29 students participated in six focus group discussions. Students who received the BL approach to teaching EBM had significantly higher scores in 5 out of 6 behaviour domains, 3 out of 4 attitude domains and 10 out of 14 self-efficacy domains. Competency in EBM did not differ significantly between students receiving the BL approach versus those receiving the DL approach [Mean Difference (MD)=-0.68, (95% CI-1.71, 0.34), p=0.19]. No significant difference was observed between sites (p=0.89) or by student type (p=0.58). Focus group discussions suggested a strong student preference for teaching using a BL approach, which integrates lectures, online learning and small group activities.

CONCLUSIONS:
BL is no more effective than DL at increasing medical students' knowledge and skills in EBM, but was significantly more effective at increasing student attitudes toward EBM and self-reported use of EBM in clinical practice. Given the various learning styles preferred by students, a multifaceted approach (incorporating BL) may be best suited when teaching EBM to medical students. Further research on the cost-effectiveness of EBM teaching modalities is required.

David Sackett Memorial Prize Winner

The cost-effectiveness of a decision aid for patients considering total hip or knee arthroplasty: a randomized controlled trial

Mr Logan Trenaman[1,2,3], Dr Nick Bansback[1,2,3], Dr Stirling Bryan[1,2], Dr David Meltzer[4], Dr Peter Tugwell[5,6], Dr Geoff Dervin[5,6], Dr Gillian Hawker[7,8], Dr Dawn Stacey[5,6]

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Background
Despite the well documented benefits of patient decision aids, including increasing patient knowledge, reducing decisional conflict, and improving patient participation in decision-making, their uptake into routine clinical practice has been limited. One factor that may be limiting their uptake is the paucity of cost-effectiveness evidence.

Aim
To establish the cost-effectiveness of a decision aid (plus surgeon preference report) for patients considering total hip or knee arthroplasty.

Methods
The economic evaluation was undertaken using data from a randomized controlled trial with two years follow-up. 343 patients with osteoarthritis were recruited from two orthopedic screening clinics in Ottawa, Canada. Patients were randomized to either the control group (standard education materials) or decision aid plus surgeon preference report (intervention). The intervention was a decision aid and a one-page preference report that documented patients' clinical and decision data for the surgeon. Data were collected at baseline and every 6 months up to two years. Primary outcomes were health system costs and quality-adjusted life years (QALYs),with comparative results presented as an incremental cost-effectiveness ratio (ICER). Costs were calculated using self-report resource utilization from patient diaries (general practitioner, specialist, and rehabilitation visits, and prescription medications) by associated unit costs. QALYs were calculated using EQ-5D health utilities, derived from the Western Ontario and McMaster Osteoarthritis Index (WOMAC) scores.

Results
The sample comprised 173 intervention and 169 control group patients. The typical patient was 66 years old, retired and living with someone. Results of the clinical trial (reported previously) indicate that the decision aid increased the proportion of patients making a 'good' decision (56.1% vs. 44.5%, relative risk 1.25 95% CI: 1.00- 1.56), and decreased the rate of arthroplasty (73.2% vs. 80.5%, relative risk 0.91 CI: 0.81-1.03). Over a 2 year period, patients in the decision aid arm used fewer resources resulting in a saving of $241 per patient ($9,124 vs. $9,365).The decision aid was also associated with improve quality of life, giving 0.05 additional QALYs (1.63 vs. 1.58). Consequently, the decision aid was the dominant strategy. Sub-group analysis by affected joint suggests decreased resource use in the decision aid group was primarily in those with knee, rather than hip, osteoarthritis.

Conclusion
The decision aid investigated in this trial is associated with both lower costs and more QALYs. Given there are over 100,000 arthroplasties performed in Canada each year, implementing a decision aid could have important health policy implications. Although our analysis did not consider the cost of delivering the intervention, the cost savings ($241) are unlikely to be offset by the cost of delivering the intervention (estimated to be ~$20). Future research will link trial with administrative data to allow for evaluation of the 5-year cost-effectiveness.

The frequency and nature of use of the speechBITE website: A growing phenomenon

Prof Leanne Togher[1,2,3], A/Prof Tricia McCabe[1], Dr Emma Power[1,2,3], Dr Natalie Munro[1], Ms Melissa Brunner[1], Ms Kate

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1 Speech Pathology, Faculty of Health Sciences, The University of Sydney, 2 NHMRC Centre of Research Excellence in Aphasia Rehabilitation, 3 NHMRC Centre of Research Excellence in Brain Recovery, 4 Royal College of Speech Language Therapists

Purpose
This paper describes the use and characteristics of the evidence based practice searchable database called speechBITE (www.speechbite.com). The paper will examine speech pathologists' frequency and nature of their use of speechBITE, and their perceptions and recommendations regarding using this resource.

Method
Speech-language pathologists were surveyed internationally about their use of the speechBITE website using an online survey comprising 10 questions regarding frequency and reasons for use, opinions regarding speechBITE's usefulness to their work, and its usefulness to the profession of speech pathology. There was also the option for participants to give additional comments. Web statistics using Google Analytics were also analysed from 2012-2014.

Results
Of the 725 respondents to the survey, 28% reported using speechBITE at least once a month, with 74% reporting they were searching for evidence to support clinical practice. speechBITE was reported to be useful to participants' work (72%) and useful to the profession (87%). Open-ended comments provided suggestions for improvements and underscored the need for freely available EBP resources. Web statistics showed a significant increase in the use of speechBITE over the past 3-year period.

Conclusions
EBP for speech pathologists remains a central goal underpinning clinical practice and the findings of this study support the continued need for free easily accessible resources.

Resources & Reviews

Looking for good quality systematic reviews?

Fran Wilkie

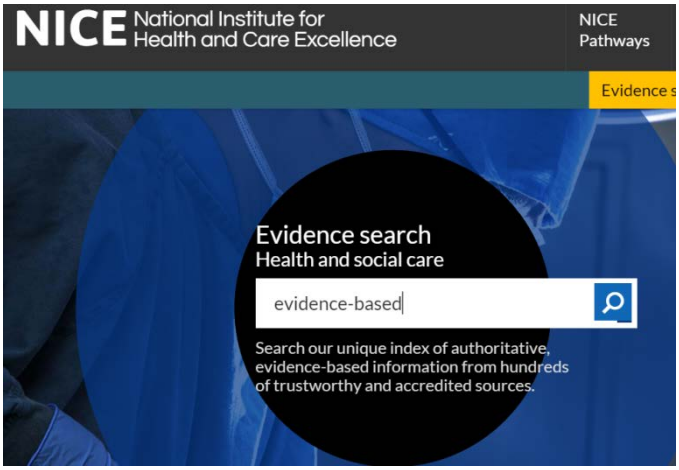
NICE Evidence Search allows you to search for systematic reviews from a range of sources all in one place (www.evidence.nhs.uk).

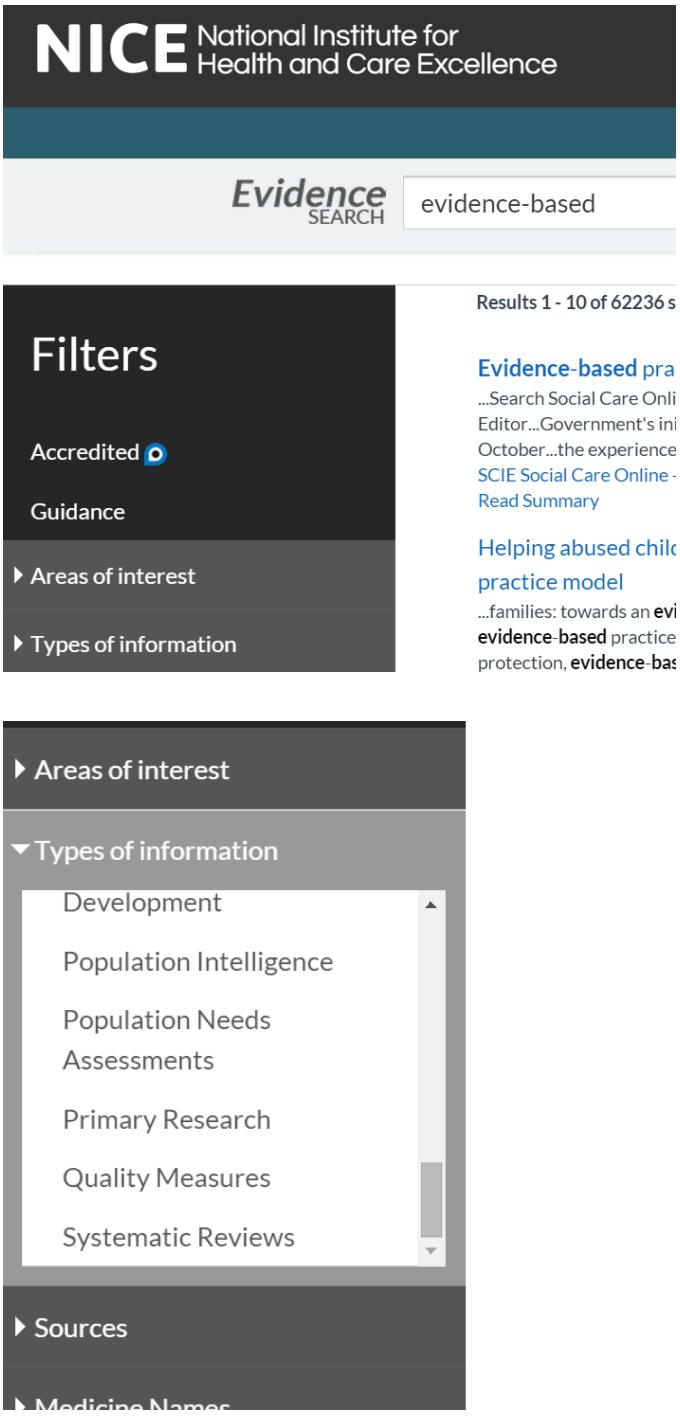
Evidence Search includes systematic reviews from Cochrane, DARE and other providers. Following the closure of the DARE service, systematic reviews published in PubMed from 1 January 2015 are now added to NICE Evidence Search, making Evidence Search a good place to start when looking for good quality systematic reviews.

Every week our information specialists search PubMed using the systematic review filter and apply criteria for selecting systematic reviews. A review is included if it is published by a journal which conforms to the preferred reporting items for systematic reviews and meta-analyses (PRISMA) standard. If not published by one of these journals, a

systematic review is deemed reliable if the abstract reports inclusion/exclusion criteria, confirms two or more sources have been searched, and incorporates a synthesis of included studies.

To find all included systematic reviews within Evidence Search, enter your search terms into the search engine, and then apply the 'Type of Information' filter *systematic reviews* to your results (click on the Type of Information filter on the left hand side of the screen, then scroll down and click on Systematic Reviews).





Workshops & Conferences

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**.

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

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.

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

http://www.preventingoverdiagnosis.net/

Cochrane Colloquium Vienna

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

Key dates:

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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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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