EvidenceLive
University of Oxford  June 18–20 2018
Actively Disseminating and Translating
Evidence to Drive Innovation in Healthcare
Welcome back for **Evidence Live 2018**

Generating Better Evidence for Better Healthcare.

Jointly hosted by the Centre for Evidence-Based Medicine (CEBM) at the Nuffield Department of Primary Care Health Sciences, University of Oxford and The British Medical Journal (BMJ).

Evidence Live offers a platform that encourages debate on the current status and future directions of Evidence-Based Medicine. This annual conference provides a line-up of world leading speakers whose remit is to stimulate, provoke, entertain and inspire.

The 2018 conference will focus on Dissemination, Translation and Innovation, with leading speakers who actively disseminate and translate evidence to drive innovation, creating unique initiatives that will enhance your ability to communicate, translate and exchange information to make a real difference in health care.

This year we are introducing a new Question Time session on Monday afternoon where Research Integrity is under the spotlight. The audience will hear from an advocate in clinical, academic and animal research, setting the scene and generating questions for the bigger debate. Audience questions will be collected throughout the day at the registration desk and via twitter #ELQuestionTime. Questions will be filtered to ensure an appropriate balance of debate.

We hope that you will join us at the Radcliffe Primary Care building for drinks after the session and continue the discussion.

EL2018 Conference Committee

Notice of photography and filming

Evidence live 2018 is being visually documented. By attending you acknowledge that you have been informed that you may be caught on camera during this event. Images taken may be used in the future for promotional purposes. These images may be used without limitation by any organisation approved by CEBM & The BMJ and edited prior to publication as seen fit for purpose. Images will be available on the internet accessible to internet users throughout the world including countries that may have less extensive data protection than partnering countries. All images will be securely stored on University of Oxford servers. Please make yourself known at registration if you wish to remain off camera.

For updates: www.evidencelive.org or follow us on @EvidenceLive #EvidenceLive
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<td>Tara Lamont – Ways of making evidence used and useful in a world of information overload</td>
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### Oral Sessions

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- **David Nunan** – Session Chair
  - **Wei Wang** – The application of EBM Club in standardized resident training in China
  - **Julie Mclellan** – Restricted meta-analyses versus full meta-analyses: threshold number of studies based on study sample size
  - **Vivienne C Bachelet** – Being part of advanced research to instill a working knowledge of critical appraisal and research methods in a group of medical students as an educational objective – the experience of one professor in a state university in Chile
  - **Niamh O'Rourke** – Building capability, leadership and a home for Evidence based Medicine in Ireland
  - **Antonino Cartabellotta** - Teaching of Evidence-based Medicine in Italian medical schools: a systematic analysis of courses and syllabi

- **Veronica Williams** – Session Chair
  - **Kiron Koshy** – The Academic Surgical Collaborative: A three-year review of a Trainee Research Collaborative
  - **Simon Kolstoe** – What can ethics committees do to promote the REWARD statement and reduce research waste?
  - **Barbara Nusbaumer-Streit** – Increased risks for false-positive or false-negative findings are common in outcomes graded as high certainty of evidence
  - **Arsenio Paez** – IDEAL - Physio: A new tool guiding innovation and evaluation of complex interventions and enacting the EBM-Manifesto in Physiotherapy
  - **Janet Martin** – How Fragile is the Evidence Base? A Meta-Epidemiologic Study of the Fragility Index Derived from 374 Randomized Trials
  - **Franz Porzsolt** – The assessment of two different dimensions “efficacy” and “effectiveness” requires two different tools the Randomized Controlled Trial (RCT) and the Pragmatic Controlled Trial (PCT)

- **Peter Gill** – Session Chair
  - **Alexandra Freeman** – The effects of communicating uncertainty about facts and numbers
  - **Kristian A. Espinosa** – Effect Of Early Surgery In Elderly Patients With A Hip Fracture: Systematic Review And Meta-Analysis
  - **Chiara Arienti** – The effectiveness of Student 4 Best Evidence as a tool to improve Evidence-Based Practice competencies in undergraduate health professional students: a pilot study
  - **Antonia Panayi** – Disclosing the results of clinical trials: how is the pharmaceutical industry doing?
  - **Rossella Salandra** – Impact of bias (detection) on follow-on research: evidence from the medical literature

- **Annette Pluddemann** – Session Chair
  - **Laura Downie** – Transforming evidence-based practice with CrowdCARE: Crowdsourcing Critical Appraisal of Research Evidence
  - **Anna Noel-Storr** – Cochrane Crowd: new ways of working together to produce health evidence
  - **Lorainne Tudor Car** – Digital education for guidelines adoption and adherence: preliminary findings from a systematic review
  - **Farhad Shokraneh** – Gallstone, snake venom and witchcraft for schizophrenia: the challenges of classifying schizophrenia trials
  - **Linda Nyanchoka** - Methods for Identifying and Displaying Research Gaps

### Panel Session, Lecture Theatre One

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<td>Shelley Jofre, Jet Schtouten , Kath Sansom and Deb Cohen</td>
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Seminar Room 2 | **Educating patients / Improving the dissemination of evidence**  
Seminar Room 3 |
|            | Please see previous page | **Amy Rogers** – Can cluster randomisation of prescribing policy be used to efficiently generate drug safety and effectiveness data within the NHS? Pilot data from the EVIDENCE study  
**Ranin Soliman** – Using Data to Improve Care and Health Outcomes in Resource-limited Settings: Reflections from Knowledge to Wisdom and Implications at Children’s Cancer Hospital 57357 – Egypt  
**David Osser** - Advantages and Disadvantages of Using Algorithms for Selecting Psychopharmacology Treatment | **Bruce Hugman** – Tribalism and binary thinking are crippling public discourse: truth lies bleeding  
**Mona Ghannad** – Misrepresentation and Overinterpretation in Evaluations of Biomarkers in Ovarian Cancer: A Systematic Review |
| 13:00 – 14:15 | **Lunch** | |
| 14:15 – 15:45 | **Workshops & Seminars** | |
| 14:15 – 15:45 | **Enhanced dissemination of evidence syntheses to support emerging new models of care**  
Alison Turner, Rod Sheaff & Paul Wilson | **Key Concepts for teaching critical thinking and critical appraisal**  
Andy Oxman & Iain Chalmers | **Catalogue of Bias**  
David Nunan & Carl Heneghan |
| Seminar Room 1 | Seminar Room 2 | Seminar Room 3 |
| 15:45 – 16:00 | **Tea & Coffee Break** | |
| 16:00 | **Closing Keynote, Lecture Theatre One**  
Dissemination of Cochrane Reviews: Maximising Research Impact to Improve Healthcare  
David Tovey with Fiona Godlee | |
| 16:30 | **Safe Journey Home** | |

**PROGRAMME** • For the latest updates go to: evidencelive.org
Monday June 18th 13:00  Lecture theatre 1
Research & Dissemination
CHAIR: Helen MacDonald

What are the next steps in enabling dissemination of clinical trial results?: WHO’s perspective
Vasee Moorthy

While the many compelling reasons for requiring reporting of clinical trials results are well known, compliance, policy and legislative development remains incomplete. In this talk Dr Moorthy will summarise WHO’s work in bringing research funders together to develop policies that require registration and results disclosure, and discusses possible next steps with other stakeholders in the clinical trial ecosystem.

Ways of making evidence used and useful in a world of information overload
Tara Lamont

Evidence does not speak for itself. Effort is needed by researchers to make sense of their findings in ways that are meaningful to wider audiences. That means understanding who the audience is and the context in which they work and live. We can learn from experts in communication, marketing and persuasion. There is also some evidence about what works in terms of formats of research-based outputs which are most likely to be taken up by decision-makers. I will talk about the work of the NIHR Dissemination Centre in packaging up evidence and framing findings for non-academic audiences. Our experience over the last three years has made us think about principles of good dissemination, which I will describe in terms of who, what, how and when. I will share our experience and pointers from a wide range of sources and examples of research which has had reach and impact for service audiences.

Monday June 18th 15:45  Lecture theatre 1
Research Integrity – Question Time
CHAIR: Fiona Godlee

Emily Sena, Peter Wilmshurst, Trish Groves and Aseem Malhotra

This session will cover integrity in clinical, academic and animal research. The audience will hear from an advocate in each sector setting the scene and generating questions for the bigger debate. Audience questions will be collected throughout the day at the registration desk and via twitter #ELQuestionTime. These will be filtered by the session chair Fiona Godlee to ensure an appropriate balance of debate.

Tuesday June 19th 11:00  Lecture theatre 1
Science and Informing the Public
CHAIR: Helen MacDonald

We don’t live in a post-truth society
Tracey Brown

In 2016 the Oxford English Dictionary made ‘post-truth’ word of the year. Across Europe, conferences have sprung up among health research and regulatory bodies disturbed about how to operate in a world of Facebook filter bubbles and alternative facts. Despite all their appeals to greater public engagement, people in
public life actually appear to be losing faith with the public. Amid this anxiety, we’re in danger of seeing only memes that reinforce the idea that people aren’t interested in evidence, that they just hear what they are already disposed to hear, that there is no scope for persuasion or challenge and factual credibility counts for nothing. This would be wrong. In fact, 2016, or 2017 or 2018, could just as easily be called the year of truth seeking – a year in which thousands of people sought truth about all manner of things in the natural and social world, from heart surgery outcomes to clinical trial reports and police statistics. Working with the public reminds us that scientific evidence is a tool of empowerment and accountability, not something people should swallow for their own good; and working with the public expands our social imagination about how to communicate and collaborate more effectively. It forces us to ask: Are we grappling alongside people, to ask testable questions, to define terms, to crunch the numbers? How can we truly embark on that together, with the public and in the public interest?

Teaching children to assess the trustworthiness of claims and make informed health choices

Andy Oxman

Claims about what might improve or harm our health are everywhere. Many of these claims are unreliable and many people are unable to distinguish reliable from unreliable claims. This leads to poorly informed choices, unnecessary suffering, and waste. The Informed Health Choices Project aims to address this problem by teaching children and adolescents to think critically about health claims and choices so that, as they grow older, they can make informed personal choices and contribute to informed health policy decisions. In this presentation I will describe work that we have done up to now and plans for future work.

100% safe, 100% bull – why are the public still being misled?

Margaret McCartney

It’s clear that despite the upring of evidence based medicine, the teaching of children about science, and the holding to account of newspapers and journalists has huge potential to ensure that the public get better information about what works and what doesn’t. But we need to look in the mirror. We know that the press releases sent out by researchers and research institutions can be as hyped and misleading as any commercial company. We know that our regulatory systems have large gaps allowing non evidence based medicine and interventions to be promoted to the public. But is the medical establishment part of the problem or capable of solving it?

Tuesday June 19th 17:30 Lecture theatre 1
Finding the truth through medical journalism
CHAIR: Carl Heneghan

Shelley Jofre

Shelley Jofre is Editor of BBC Scotland’s investigations unit. She previously worked for 15 years as a Correspondent on Panorama, and developed a particular focus on evaluating the risks versus benefits of SSRI antidepressants.

Shelley’s award-winning films about Seroxat resulted in the antidepressant being contraindicated in under-18s and prompted an overhaul of the Yellow Card Reporting System, allowing patients for the first time to report adverse effects directly to the regulator.

Without a medical background, Shelley unravelled the truth about the now-notorious Study 329. That clinical trial – which had been peer-reviewed and published in a respected US medical journal - stated Seroxat was “safe and effective” in the paediatric population. Shelley’s investigation revealed the opposite to be the case; the trial showed no benefit in depressed children but significant harms.

Her investigative work exposed the prevalence of ghost-writing in medical journals and the payments made by drug companies to Key Opinion Leaders (KOLs) to try to influence clinicians to prescribe medicines where there evidence base is at best uncertain, at worst negative.
Kath Sansom

I've been a regional newspaper journalist since 1990, with a passion for human interest stories and a mission to take jargon-heavy documents and turn them into plain English. For 28 years this has involved planning agendas at local councils, court reporting, fund raising stories, inquests, animal rescues. Disgruntled local resident associations, the bread and butter of any regional newspaper across the country. I love being part of a local community and being their voice for the good, the bad and the ugly - the lows and the highs of every day life.

So it is with this background that I was unwittingly thrown into the murky world of medical corruption and digging out the problem with pelvic mesh implants - then writing about it.

I didn't mean to get involved, I certainly didn't set out to found Sling The Mesh, and had no idea it would become the biggest global support network for mesh injured women, and some men who have hernia mesh, at a staggering 6,000 members.

I just happened to make the fatal mistake of trusting my surgeon and signing up for what I was told was a simple, 20 minute, gold standard fix for stress incontinence - suffered thanks to two babies and a passion for high impact exercise.

From superfit mum to compromised by daily pain and a surgeon who belittled my suffering, I was shocked to say the least. Three years later I am still shocked as I learn more about the shambolic medical device regulation system that means Ikea flat pack furniture gets more safety checks than a permanently implanted device. Compare that to drugs that take an average of 10 years to get to market yet permanent devices can be passed with a cursory nod of equivalence.

Shocked that the science journals are full of all sorts of mischief. Who knew? I certainly didn't until this. With trials that are short term, some p-hacked, research that uses quality of life surveys deliberately designed to not capture suffering, surgeons who only look at efficacy and not risks to life quality. Add in research leaders who have conflicts with industry, trial cohorts of as low as 58 to "prove" devices are safe. Abstracts that don't reflect the truth contained within the paper but to a busy medic would show a positive spin. It came as a real shock.

Next came the jargon. All sorts of terms, references and every day science lingo to turn into plain English to make stories palatable to readers.

My aim continues to be to help empower women in the campaign with knowledge so they are confident to stand up and fight. Because with knowledge comes much power.

Deb Cohen

Deborah Cohen is an award-winning freelance medically qualified journalist. During her medical training in Manchester and Rennes, she soon realized that she had a tendency to question what she was told – which doesn't always go down well in medical training - so intercalated in journalism. This was a liberating experience that encouraged questioning of authority, freedom of thought and creativity - all of which may be lacking in medical training.

After qualifying, Deborah edited various sections of The BMJ before becoming the first investigations editor of a medical journal. She has written about many medical, research and scientific issues including drug and medical device regulation, access to preclinical and clinical data, cost of medicines, research integrity and conflicts of interest.

Deborah has conducted data driven stories collaboratively with international media and the Centre of Evidence Based Medicine, which they’ve dubbed ‘investigative epidemiology’. This combines journalism with epidemiology using prespecified protocols and systematic review for robustness. The journalism provides a social and political context to explain the research data. The output has been published in medical journals and underpinned programmes on BBC’s Newsnight, Panorama, File on 4, and also Channel 4 News and Dispatches.

Jet Schouten

Jet Schouten is a journalist with Radar, a Dutch Consumer television programme, where she uncovered the scandal of mesh approval in Europe.
Dissemination and application of research results to inform decision making

Peter Davidson

I will discuss the issues people have when dealing with health research evidence and how independent disseminating groups can help with this. On the one hand, there is too much research for anyone to handle, with much of it unreliable and irrelevant. On the other hand, people using, delivering or managing health services are very keen to use research evidence, particularly to help with some of their trickiest problems. Managers seem more comfortable than researchers in dealing with imperfect or ‘good-enough’ research; is this a reasonable approach and can groups who critically appraise and disseminate research help? I will talk about our approaches to selecting research for dissemination and how to present its implications, reliability and relevance to audiences who are often more accustomed, in the UK at least, to reading guidelines than research results.

"That sounds interesting... but what are you actually working on?"

Ben Goldacre

It is vitally important that we invest in clinical trials and other primary research. But that is not enough on its own. All too often, dissemination and implementation are regarded as bolt-ons, poor cousins, or even hobbies. This talk will aim to address that shortcoming.

David Tovey with Fiona Godlee

Paradigms around evidence synthesis are changing and Cochrane needs to adapt to the changes to ensure its sustainability. There are two main elements to the changes: the first relates to the content that evidence users need to inform decision making, and the second to the emerging science of knowledge translation. In short, we need to ensure that we produce the right evidence and ensure that is delivered, in the right form, at the right time to the key decision makers.

In the talk, David Tovey will describe Cochrane’s new content development and knowledge translation strategies and explain why it is important they are closely aligned and what they aim to achieve. Each starts with a deep understanding of the needs of end users through active engagement and meaningful dialogue. This leads to thorough appreciation of the relevant question, which in itself guides the choice of data sources and methods. Finally, to achieve optimal impact and improve health care, the evidence needs to be packaged and delivered in ways that evidence users can access and use.
Elisabeth Cresta & Caroline Day: Interactive workshop: Dissemination and communication through social media with Fight the Fads (Sem 1)

Social media has revolutionised the way in which we communicate. This has provided an unprecedented opportunity to share ideas and generate conversation around emerging health research. However, it has increased the circulation of misleading health messages from less than credible sources leaving the public confused. So now more than ever there is a need for scientists and researchers to embrace social media to share evidence-based information to the combat the misleading messages around health and disease. Unfortunately, many researchers and scientists still shy away from social media.

This workshop will provide insight into how to utilise social media to disseminate your evidence-based research. The workshop will be run by Fight the Fads. Fight the Fads is an online nutrition platform run by two soon to be registered dietitians from Kings College London. Since 2016 Fight the Fads have been using social media to address and correct nutritional misinformation in the media using evidence based science.

The aim of this workshop is to provide a step-by-step guide on how to campaign through social media to disseminate evidence based research. The workshop will cover topics including:

- Where to start
- Content creation
- Increasing engagement
- Online networking and creating conversation

Barbara Osimani: Philosophy of Evidence: Dimension of Evidence and Criteria for Standards Improvement (Sem 2)

Objective: The "reproducibility crisis" revealed the need for a deep reflection on current approaches to evidence evaluation and their reliability (Begley and Ellis, 2012; Ioannidis, 2005, Prinz et al(2011). Hidden moderators (Hanin, 2017), publication bias and low power have been identified as possible sources for such results (Etz and Vandekerckhove, 2016; Marsman et al. 2017). Instead, some understand the failure of replication simply as a result of random error (Stanley et al. 2014; Senn 2002). Finally, others suggested to adopt a more comprehensive view to the analysis of evidence (Andrew Gelman, 2015; Marsman et al. 2017).

Philosophy of Science and Epistemology can fruitfully complement Statistical knowledge, Epidemiology, and Medical Methodology in analyzing medical evidence from different perspectives. The roundtable intends to offer such an opportunity and to examine the interaction of different dimensions of evidence, such as consistency, reliability, variety with respect to methodology, context of enquiry, and theory.

Methods: Develop a platform for discussing issues arising from the algorithmic approach developed in the EBM and proposals for improvements coming from within EBM and from methodologists and philosophers. These concern how reliability could be broken down in different dimensions, on how context-sensitivity of causation could be exploited for discovery and scientific understanding, and on how theories of causation and knowledge may contribute to improve the concept of evidence developed within the EBM paradigm.

These questions will be analysed from the perspective of philosophers of science and epistemologists: Rani Anjum, Vincenzo Crupi, Bennett Holman, Barbara Osimani, Ben Smart as well as scientists: Jeff Aronson, Ralph Edwards, Marie Lindquist,
Elena Rocca. The interaction of both sides may greatly contribute to the debate for several reasons; mainly for the complementary expertise and views developed within various philosophical areas and scientific methodology with respect to evidence at different stages of the scientific enquiry.

**Result:** The following questions will be examined both in the presentations and in the discussion time: What is the nature of medical evidence? 2) What is the “best evidence” for what aim and under what conditions? This implies a cost-benefit analysis of evidential standards for different purposes both in terms of information value, as well as in terms of (opportunity) costs at the individual and public level (e.g. Evidence for hypothesis generation vs. evidence for decision); 3) What is the specific informative contribution of evidence from “big-data”, with respect to standard epidemiological and clinical evidence or to simulations? 4) What is the right trade off between replication and robustness analysis? Under which circumstances? 5) What is the role of expert opinion in making sense of such an amount of heterogeneous data? 6) Impact of regulatory frames on the development of evidential standards and vice-versa; 7) Is a grand-unified theory of evidence possible?

**Conclusions:** Philosophers of science have examined how the choice of scientific methods reveal the implicit philosophical assumptions about the nature of causation. Furthermore, specific domains of causal assessment, such as pharmacovigilance, can be better characterised as contexts of discovery and hypothesis generation, rather than of hypothesis testing and justification, therefore, evidence in these contexts work differently.

More generally, the roundtable presents a comprehensive approach to evidence evaluation, which takes also "higher-order" dimensions of evidence into account and discusses the nature of evidence and the role of evidence standards at its roots.

**David Nunan:** From 10 essential papers for EBM to 10 essential paper on bias (Sem 3)

Join David Nunan as he walks you through the 10 papers selected (and some of the ‘nearly made it’) as essential for folk starting out on an evidence-based journey, hoping to raise discussion and debate along the way. We’d also like to kick start what would make your top 10 and why for the essential papers on bias.

**Marie Lindquist & Jeffrey Aronson:** History of Hierarchies (Sem 1)

**Hierarchy, n. ... Rule or dominion in holy things**

... *Oxford English Dictionary online*

In 1979 the Canadian Task Force on the Periodic Health Examination, of which David Sackett was a member, ranked effectiveness of interventions according to the quality of different sources of evidence, briefly summarized here:

1. randomized controlled trials;
2. historical and geographical comparisons and dramatic results in uncontrolled studies;
3. opinions of respected authorities.

Since then many others have proposed rankings (so-called hierarchies) of evidence. Typically, these are headed by randomized controlled trials and systematic reviews of such trials (i.e. the best evidence), followed by observational studies, with case series and case reports at the foot. Early rankings also included expert opinion, placed at the foot, a category error, since opinions are not evidence and can be excellent, if based on high-quality evidence.

It was subsequently recognized that the forms of evidence at each level of such rankings can be of variable quality, and more flexible versions, such as GRADE and the Oxford CEBM Levels of Evidence, were developed. However, the latter includes “mechanism-based reasoning” at the lowest level, another category error, since reasoning is not evidence and mechanistic evidence is of a different kind to outcome evidence from clinical studies. These systems represent improvements on the original hierarchies, but, despite their flexibility, they remain hierarchical.

Nevertheless, it is widely recognized that there can be problems with the types of evidence that are commonly ranked high on the list and that different forms of evidence can be useful in different circumstances. For this reason, I have proposed that the hierarchical approach is misleading, and that instead all types of evidence should be regarded as being of equal potential value, depending on the question being asked and the ability of the research technique to elicit a satisfactory answer. This leads to the concept of a wheel of evidence and teleoanalysis, in which different forms of evidence, including, for example, animal data and mechanistic information, can be adduced and when possible combined.

**Tuesday 19th June 09:00 - 10:30**

**Marie Lindquist & Jeffrey Aronson:** History of Hierarchies (Sem 1)

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Roman Kislov: The art of compromise: Co-production of evidence in applied health research (Sem 2)

Objectives: Co-production approaches, variously referred to as integrated knowledge translation, participatory research and co-design, provide an alternative to the traditional ‘push’ and ‘pull’ modes of translating research evidence into better healthcare. Despite the growing importance of the impact agenda and the proliferation of collaborative research partnerships, awareness about the practical realities of co-production remains low. This interactive workshop, drawing on the ongoing programme of research conducted by the workshop organisers as well as on their personal experiences, will address the following learning objectives:

1. To explore different definitions and types of co-production in applied health research;
2. To examine tensions and compromises involved in co-production;
3. To discuss the implications of the co-production for the focus and outputs of research as well as for the structure and function of the research team;
4. To analyse the factors influencing the processes and outcomes of co-production;
5. To share personal experiences of co-production.

Method: The workshop will be delivered by an experienced team comprised of the Director of a large-scale co-production programme, an editor of Implementation Science and two researchers involved in studying co-production as part of the NIHR CLAHRC-funded research project. By combining experiential and empirical evidence, the workshop will provide both practical tips about how to make co-production work and a more critical exploration of its limitations and unintended consequences. The time will be split equally between the didactic component, summarising the existing research on co-production, and the interactive component, where workshop participants will work together in small groups, reflecting on the information presented and sharing their own experiences. We will facilitate a participatory group exercise, which will produce an outline of key practical steps involved in co-designing applied health research proposals with practitioners and/or service users. Microsoft PowerPoint sides, flip charts and post-it notes will be used during the workshop.

Results: We aim to show that although co-production approaches may differ depending on the stage(s) of the research process in which they are deployed as well as on the type of stakeholders involved, all of them require a number of compromises directly affecting the collaborators. Contrasting the expectations of healthcare practitioners with the researchers’ way(s) of doing things, we categorise these compromises into three broad groups: (1) complementing ‘research’ by ‘non-research activities’, such as implementation, improvement and education; (2) opening up the research team to include project managers, practitioners, and service users as well as to bring together researchers espousing different epistemological and methodological paradigms; and (3) adapting to a practice-driven agenda and embracing impact as an essential component of evaluation and research. We will also discuss the ‘dark side’ of co-production, alerting the workshops participants to its potential limitations, and suggest possible ways to address these in practice.

Conclusions: By uncovering the tensions and complexities involved in co-production of evidence, our workshop will touch upon a number of broader topical issues currently facing the community of researchers involved in evidence-based healthcare. How to strike the balance between the production of high-quality evidence and its implementation in actual practice? Does participation in practice-driven research projects represent a ‘career suicide’ for early-career researchers or an opportunity to develop a unique and exciting career trajectory? How to foster the cadre of implementation-savvy researchers and research-savvy practitioners? This interactive workshop will aim to represent multiple perspectives and facilitate constructive dialogue between them.

Heather Murray: Knowledge translation in the digital world: Using Wikipedia as an EBM teaching platform (Sem 3)

Learning outcomes for participants:

1. Understand structure of Wikipedia pages and process for editing and adding citations
2. Examine Wikipedia-based assignments used in two different medical schools for different learner populations (pre-clerkship and clerkship students)
3. Identify barriers and supports that would enhance feasibility for adoption in participant environments and for targeted groups of learners
4. Plan student assessment that evaluates both EBM whole task capability and critical thinking for a variety of learner types and level
**Background:** With more than 220M page views per day, Wikipedia is the ultimate knowledge translation platform, providing unbiased, structured and rigorously-sourced medical information free to the world. Based on the instructors’ experience teaching Wikipedia editing courses to medical students at Queen’s University and the University of California, San Francisco (UCSF), editing Wikipedia pages allows learners to improve Wikipedia, improve communication skills, and build critical appraisal skills while practicing Evidence-Based Medicine (EBM). Participants in this workshop will learn how to design and implement Wikipedia-based EBM exercises for a broad range of learner types and training levels.

**Resources:** Participants will need to bring laptops or tablets for hands-on activities within Wikipedia. Instructors will distribute assignment and assessment materials from the Wikipedia-based longitudinal EBM exercises at Queen’s University and at UCSF. We will actively collaborate to scale these resources to ensure suitability for learners across the continuum of medical education. Finally, we will troubleshoot potential challenges and brainstorm solutions for regional implementation of these exercises.

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**Ben Goldacre & EBM Data Lab: Producing Data-driven Tools (Lec 2)**

**Objectives:** EBM DataLab is a team that aims to produce tools from data, rather than just academic publications. We have a multidisciplinary approach that combines the skills of software engineers, clinicians and academics. In this workshop we will give an overview covering how to make effective interactive services driven by data, through:

1. Providing an overview of the software and services which can be used to create your own data-driven tools.
2. Demonstrating examples from the work of the EBM DataLab.
3. Providing an opportunity for attendees to discuss their own ideas or experiences related to data-driven tools.

**Method:** In this session you will learn the very basics about a range of useful software and services including Python, pandas and iPython notebooks, GitHub, Google Analytics, Google Sheets, Google Forms, API’s (for Scopus, PubMed, and Web of Science), SQL databases such as BigQuery and Postgres, and graphical tools such as Tableau and d3. We will demonstrate the creative use of these tools with worked examples from our recent output including the Retractobot, various trials trackers, OpenPrescribing long term trends, the Drug Tariff explorer, and more.

**Results:** Attendees should leave this workshop with a better grasp of how to identify user needs, select the appropriate software or services for the job, design tools to be deliverable and impactful, manage the development cycle from prototyping to launch, and carry out the basic process of user testing.

**Conclusions:** Simple yet engaging presentation of data that allows people to act on it can be a critical step in disseminating evidence and improving quality of care. Live updating dynamic tools can keep information at the cutting-edge and provide a platform that provides real and enduring value to users. There are great resources available that can allow researchers to quickly and efficiently turn their findings into public-facing tools. We hope this workshop will empower attendees to begin presenting and sharing their data in new and effective ways in order to promote positive change in their respective fields.

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**Tuesday 19th June 14:00 - 15:30**

**Roger Shinton, Richard Thompson & Peter Wilmshurst: Evidence, Missing Evidence, Alteplase and Stroke (Sem 1)**

Since the 1980s debate has continued to develop over the possible role of thrombolytic drugs to treat stroke patients. This worldwide debate has often exhibited more heat than light. The infrastructure to facilitate a balanced and engaged discussion in the UK has been eroded due to a complex range of reasons. We aim to present some key facets relating to the evidence behind the treatment, particularly examining the alteplase story. Our hope is to promote a measured discussion on the way forward in this, and perhaps other, contentious areas of medical science.

**David Colquhoun: False positive risk: a solution to the problem of p-values (Sem 2)**

It is a truth universally acknowledged that some areas of science suffer from a surfeit of false positives.

It is still widely believed that the p-value is the probability that your results occurred by chance. This is simply wrong. It confuses the p-value with
the false positive risk (FPR).

By a false positive, I mean that you claim that an effect exists when in fact the results could easily have occurred by chance. The false positive risk (FPR) is the probability that a "significant" result is nothing more than chance.

The aim of this work is to investigate what can be said about the FPR in order to provide a better method of expressing the strength of the evidence than is provided by p values.

The aim is to answer the following question. If you observe a ‘significant’ p-value after doing a single unbiased experiment, what is the probability that your result is a false positive?

It is assumed that we wish to test a null hypothesis that the true effect size is zero against the alternative that it is not zero. Student's t test for two independent samples are used as an example. Both simulations and exact calculations are used to assess false positive risks.

In order to calculate the false positive risk, you need Bayes’ theorem. That involves the prior probability that your hypothesis is true, i.e. the probability that there is a real effect there before the experiment is done. You hardly ever have a value for this, so what can be done? There are two possibilities.

First, you can say that a prior probability bigger than 0.5 is hardly ever justified, so you can calculate a minimum FPR based on the assumption of a prior of 0.5. If you observe p = 0.05 then the FPR is at least 26%. If the hypothesis was implausible, with a prior of 0.1, then then the FPR would be a disastrous 76%.

Second, since you don’t know the prior, you can calculate it as the value that would be needed to reduce the FPR to 0.05 (that is what most people still think that the p value tells you). If you observe p = 0.05 in a well-powered experiment then you would need to assume a prior of 0.87 in order to achieve an FPR of 0.05. You would have to assume that you were almost (87%) certain that there was a real effect before you did the experiment.

Evidently the evidence provided by the usual standard for “statistical significance” is weak. Even observing p = 0.005 would not be strong evidence for an implausible hypothesis: for a prior probability of 0.1 it would give a minimum FPR of 24%.

It’s suggested that FPR, or the prior needed to achieve an FPR of 0.05, are a better measures of evidence than p-values.

In practice, decisions depend on the relative costs (in money and in reputation) that result from wrongly claiming a real effect when there is none, and by failing to detect a real effect when there is one.

Evidence Aid: How can knowledge translation of robust evidence engage humanitarian practitioners in evidence-based decision making, and influence guidelines and standards (Sem 3)

With more than US$27.3 billion spent in 2016 on international humanitarian aid, the use of evidence is critical if funding is to be used effectively. Since Evidence Aid (www.evidenceaid.org) was established in 2004, >1.6 billion people have been affected by disasters globally, with the estimated total cost of damages totalling over US$1.3 trillion for the period to 2013. Despite this enormous burden and the real and pressing need to alleviate it, robust evidence of the effects of interventions in humanitarian response remains hard to find. Where robust evidence exists, it is often difficult to access, is scattered across the academic literature, making it difficult for aid organisations to find and use. We will use this parallel session to explore how evidence can be translated in different ways which make it easier to find and use, ensuring decision-making can be as evidence-based as possible.

Objectives:

- To provide examples of knowledge translation that highlight the access to robust evidence to inform decisions and choices in different humanitarian disasters and emergencies, demonstrating why evidence matters wherever the emergency is in the world
- Share examples of the difficulty in conducting research in emergencies and consequent dependence on indirect evidence, ‘low quality’ research, expert opinion and ‘gut feeling’
- Show some of the challenges in interpreting and translating evidence from a more routine setting when applying it to a disaster or other emergency.
- Discuss why some interventions are applied despite a lack of evidence
- Raise the profile of the use of robust evidence in the humanitarian sector
- Showcase the development and role of Evidence Aid, Emergency Nutrition Network, Oxfam and the ReBuild programme

Description: After introducing Evidence Aid, Marie McGrath (Emergency Nutrition Network: ENN), a collaborator on the ‘Nutrition in Emergencies’ collection will present it, discussing how this could contribute to decision-making in malnutrition management. She will
present ENNs role in fast-tracking nutrition evidence development and dissemination to influence and learn from practice, as well as presenting examples of relevant global initiatives. The session continues with a presentation from the ReBuild programme describing their experience of translation of health systems research evidence to support long-term positive outcomes in protracted crises. Next Oxfam will discuss the Humanitarian Evidence Programme - a consortia of funders who funded several systematic reviews, and the challenges they faced with getting the evidence that was found into practice. During this session there will be a fully interactive discussion session which will explore different ways of translating evidence to ensure effective and efficient decisions and best use of funds.

Concluding comments: By bringing together those who generate the necessary evidence with those who need and want to use it, we will explore the notion of how to improve outcomes for billions of the world’s most vulnerable people. This session will highlight how translation of evidence has the capacity to help agencies access and use evidence in different ways. We need to ensure that knowledge translation is appropriate for and accessible to the humanitarian sector for them to be able to use it in the best ways that they can.

Peter Ottegen & Alan Ehrlich: Putting it all together: from net effect estimate to the certainty of net benefit (Sem 4)

An evidence-based approach to clinical practice guidelines includes expressing the confidence that the desirable consequences outweigh the undesirable consequences for a particular recommendation. This is often done by expressing the strength of recommendation and the quality of evidence. The overall quality of evidence rating however is not the same thing as the confidence in the evidence that the summation of beneficial effects outweighs the summation of harmful effects. The objective of this year’s workshop is to extend the concepts of last year’s well-received workshop on determination of the net effect estimate and review how one can rate the certainty of net benefit.

Members of the GRADE Working Group struggling with how to convey the concept of Overall Certainty of Evidence for a concept when fully contextualized in the guideline development process came to realize that directly expressing Certainty of Net Benefit would be clearer and more useful for guideline users. The workshop facilitators have actively developed a protocol for determining the Certainty of Net Benefit and applied it to numerous examples. The concept is currently in development within the GRADE Working Group and is not current GRADE guidance.

Wednesday 20th June 14:00 - 15:30

Alison Turner, Rod Sheaff & Paul Wilson: Enhanced dissemination of evidence syntheses to support emerging new models of care (Sem 1)

This case study describes a programme of knowledge translation and mobilisation activities aimed to enhance the dissemination of five recent evidence syntheses to support emerging new models of care across England. The work aims to synthesize and articulate practical insights to prompt stakeholders to apply evidence from these studies to local NHS transformation programmes and decisions. The programme of activities was designed to enable the evidence to be spread widely (reaching decision makers, practitioners and public representatives across the health and care system) and in-depth (helping teams to act on our findings). We describe our approaches for targeting a diverse group of stakeholders, including NHS leaders developing Sustainability and Transformation Partnerships (STPs) and/or Accountable Care Systems (ACS) to improve coordination across different health services, and better coordinate these with social care, to maintain the quality and reduce the cost of all these services in aggregate.

Our aim was to combine critically reviewed evidence with practical experience of service improvement and transformation. A comprehensive synthesis of the literature [1] on knowledge mobilisation informed our approach to summarising the results across evidence syntheses, developing materials, communication, and disseminating these materials and key messages to stakeholders. The focus on increasing the impact of the evidence in the original studies upon health and health care guided the development and dissemination of communications materials. We leveraged team members’ and collaborators’ established networks and expertise in translating evidence into useable tools to support service improvement, stakeholder engagement in service redesign, and liaison across teams and stakeholder groups. We used an evaluation questionnaire to collect formative evidence about the impact of the dissemination, and about stakeholders’ perspectives and experiences of engaging with the project outputs. From this formative evaluation, we summarised practical recommendations for

This case study illustrated an approach to mobilising knowledge from different evidence syntheses with the view, from the outset, of maximising the impact of the evidence and of ensuring that research outputs are developed and disseminated ways that target the various stakeholders’ needs and interests. We encountered certain differences in the ways needed to disseminate research outputs to diverse groups of stakeholders with varying needs. The use of team members’ existing channels and networks among the relevant organisations increase the reach of the disseminated material and presented opportunities to identify alignment with these network’ existing priorities and engagement activities. Team members’ combined academic and practice-based expertise proved crucial in lending credibility and access to key influencers and target audiences. This case study presents a programme of evidence-informed knowledge translation and mobilisation, underpinned with pragmatic leveraging of researchers’ existing networks and relationships established during each respective project. Our formative evaluation and critical reflections on mobilising complex knowledge to inform the design and implementation of New Models of Care in the NHS has important lessons for accelerating the use of evidence to inform decisions about health and social care service design.

References:
1. Davies H et al. Mobilising knowledge to improve UK healthcare: learning from other countries and other sectors – a multimethod mapping study. Health Services and Delivery Research 2015;3.

Andy Oxman & Iain Chalmers: Key concepts for teaching critical thinking and critical appraisal (Sem 2)

Claims about the effects of “treatments” are in the mass media, advertisements and personal communication daily. Treatments include any intervention (action) intended to improve health. The ability to assess these claims and make informed choices depends on understanding and applying key concepts that are essential for making judgements about whether the basis for a claim is unreliable, whether comparisons are fair and reliable, and whether to take an action.

The Informed Health Choices project has developed educational resources for schoolchildren and their parents with the objective of improving their ability to assess claims about treatment effects. As our starting point, we developed a list of Key Concepts that people need to understand to assess these claims. The list currently includes 36 concepts and serves as a framework, or starting point, for teachers, journalists and other intermediaries for identifying and developing resources to help people to understand and apply the concepts.[1]

This workshop will be a structured discussion of the following questions: Are these concepts sensible and useful? To what extent are they applicable to interventions other than those directly relevant to health? How do these key concepts fit with other domains of critical appraisal and critical thinking; and how can we promote learning of these concepts?

The list of key concepts is reviewed annually to allow for revisions of existing concepts or identification and inclusion of additional concepts. This discussion will feed into this.

References:

David Nunan & Carl Heneghan: Catalogue of Bias (Sem 3)

David Nunan and Carl Heneghan from the Oxford Centre for Evidence-Based Medicine will be presenting the launch of a new website that catalogues the important biases affecting health and medical research. The website is in response to a call-to-arms raised nearly 40 years ago by the late David Sackett, where he called for ‘The continued development of an annotated catalog of bias. Each citation should include a useful definition, a referenced example illustrating the magnitude and direction of its effects, and a description of the appropriate preventive measures, if any. I volunteer for this task, would welcome collaboration, and would appreciate receiving nominations and examples of additional biases.’

In honour of David’s memory and legacy, the CEBM have taken up where he left off. We are now ready to share the catalogue with the rest of the world for welcome feedback, discussion and further evolution.

We’ll also demonstrate how we write each catalogue entry and give you the opportunity to have a go too. Be warned, it’s not as easy as it looks!
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CONSIDER ATTENDING IF YOU...

Are committed to disseminating EBM principles through teaching

Enjoy learning and taking an active role in small group activities

Believe that teaching EBM should take a patient-centred approach

TEBM explores different educational models for teaching evidence-based practice and discusses the idea of pedagogy, curriculum design, development, and maintenance.

Personal development is encouraged with guidance and help in extending and advancing critical appraisal and teaching skills.

DESIGNED FOR ALL HEALTH CARE PROFESSIONALS
It is true that one can sometimes have too much of a good thing. In healthcare this has been referred to as "too much medicine", although because of potential confusion with "too much medication" a better term might be "too much healthcare".

**Overdiagnosis: what it is and what it isn't**

Broadly, overdiagnosis means making people patients unnecessarily, by identifying problems that were never going to cause harm or by medicalizing ordinary life experiences through expanded definitions of diseases.

Overdiagnosis has two major causes: overdetection and overdefinition of disease. While the forms of overdiagnosis differ, the consequences are the same: diagnoses that ultimately cause more harm than benefit. Confusion about what constitutes overdiagnosis undermines progress to a solution. We aim to draw boundaries around what overdiagnosis is and to exclude what it is not.

1. Ashley Duenas,
Does Personalised Genetic-Risk Information Impact Decision-Making for Colorectal Cancer Screening? A Systematic Literature Review

2. Mateusz Panasiuk,
Are manufacturers’ product claims supported by clinical evidence? An objective systematic evaluation of coronary stent product claims

3. Lorainne Tudor Car
Application of virtual reality in health professional education: an evidence synthesis-informed conceptual framework

4. Jamie Boisvenue
Using deliberative priority-setting to improve gestational diabetes education

5. Michal Rutkowski
Do robotic-supported prostatectomies provide superior clinical outcomes over traditional techniques? Application of a novel, quantitative approach for evaluating clinical evidence

6. Caroline De Brún
Community health: Public libraries and their role in health and well-being

7. Robin Haring
Does testosterone shorten life? Triangulation of a much-debated association

8. Chiara Arienti
Cochrane Rehabilitation E-Book: a knowledge translation project in rehabilitation

9. Vivienne C Bachelet
Living FRiendly Summary of the Body of Evidence using Epistemonikos (FRISBEEs) in Medwave – a Chilean experience of summarizing the existing body of evidence on a specific clinical question

10. Caroline De Brún
The HIFA LIS Project: Exploring the role of libraries in times of crisis

11. Cameron Brick
The basis of evidence-informed policymaking: communicating the potential impacts of policies

12. Melanie Walker
Wikipedia culture and usage: A survey of first year medical students to determine barriers and facilitators

13. Emma Carter
Key Concepts for Assessing Treatment Claims: A Blog Series by Students 4 Best Evidence
Making research evidence relevant, replicable and accessible

14. Rahul Mhaskar
Assessment of methodological quality of animal and human studies of a blockbuster immunotherapy drug Ipilimumab: a systematic review

15. Martin Keane
Barriers and facilitators to successful hospital mergers: a systematic review

16. Ramakrishnagupta Mudalagiri
Early detection of bowel problems in the community

17. Elizabeth Lynch
Implementation: the missing link in the stroke rehabilitation research pipeline

18. Monica Bawor
Trials and tribulations of establishing treatment effectiveness in addiction research

19. Denise Campbell-Scherer
A personalized approach to obesity consultations: patient perspective and impacts

20. Thu Van Nguyen
Methods of mobilizing collective intelligence through crowdsourcing in research: a scoping review

Better, usable and more accessible clinical guidelines

21. David Dobies
The Impact of Applying both a Critical Statistical and a Critical Clinical Appraisal to the Randomized Trials that form the Cardiology Revascularization Guidelines: Implications for Clinical Practice

22. Martin Downes
Imprecise evidence based guidelines and issues for decision-makers - an example of severe chronic plaque psoriasis in Australia

Increase the systematic use of existing evidence

23. Charmilie Chandrakumar
Therapeutic Nipple-sparing versus Skin-sparing Mastectomy: A Systematic Review

23a. Nav Persaud
Which medicines do we need? Development of an outcomes-based approach to essential medicines lists

24. Sohil Khan
Metabolic monitoring of youth prescribed antipsychotics: the evidence gap widens in failing to provide reasonable standard of physical healthcare

25. Georgia Richards
Factors and variation driving inappropriate opioid analgesic prescribing in the community: a systematic review protocol

26. Anna Cristina Åberg
The Swedish version of the Normalization Process Theory Measurement S-NoMAD: Translation, adaptation and pilot testing
Improve the use of information in the media

27. Alexandra Freeman
Improving the reporting of medical risks and benefits in the media: The Press Alert App

Tools and concepts that are basic and central to the teaching and practising of evidence-based medicine

30. Michael Pather
Evaluating the effect of the Practical Approach to Care Kit on teaching medical students primary care: Quasi-experimental study

32. Denise Campbell-Scherrer
Using human-centred design to better support primary care obesity management: 5As Team at Home

Translation of evidence into better care

29. Karolina Strzebonska
Do dose expansion cohorts impact surrogate benefit in pediatric Phase I trials in oncology?

33. Sadhvi Batra
Empirical evidence against placebo controls

34. Bosun Hong
A Nationwide Survey of the Attitudes of Doctors and Dentists in Training Towards the Use of Evidence-Based Practice

35. Peter Hoegen
EBP related self-efficacy among healthcare and social care professionals: a systematic review

36. Hanne Kaae Kristensen
Methods for teaching evidence-based practice: a scooping review
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