

Newsletter of the International Society for Evidence-Based Health Care

Newsletter 8, July 2012

Mission

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

Vision

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

Key objectives of the Society

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



Evidence-Based Clinical Practice Office
McMaster University, Canada



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Editorials

International Society for Evidence-Based Health Care Inaugural Conference, New Delhi, October 2013.

'Incredible India' says the advertisement. Equally incredible has been the response for the first conference of the ISEHC: 128 abstracts submitted from 20 countries; half a dozen proposed pre-conference workshops, and a terrific suite of keynote speakers paying their own travel costs. For such a young society – founded in 2010 – this is a wonderful boost.

New Delhi is also a most appropriate initial venue for several reasons. First, an aim of the Society was to help support EBM development in less developed countries, so keeping cost low was important. Second, India is the second most populated country in the world and in need of EBM to help better use scarce medical manpower and resources. Finally, the Society was initiated at the surgery of Dr. Kameshwar Prasad, a neurologist in New Delhi who has beaten the EBM drum, written the low-cost textbook, but been frustrated by the slow response.

On the day prior (6th October) to the two day main conference, there will be a series of pre-conference workshops:

Wksp1- Evidence-Based Medicine curriculum for UG/PG

Wksp2- Bringing Evidence to Healthcare Professionals

Wksp3- Evidence-Based Practice for Allied Health

Wksp4- Evidence-Based Practice for Allied Health

Wksp5- An Evidence Based Framework

Wksp6- Evidence-Based Dentistry

Wksp7- From Evidence to Action

Wksp 8 - Evidence-Based Medicine

As well as several keynotes and 2 parallel streams plus posters. We are looking forward to the event, and given its success, we are planning the 2013 meeting already – probably Europe. See many of you there!! But if you can't make it, we hope to publish abstracts on the website and some full articles in this Newsletter.

And planning is underway for the 2013 conference, which will be announced in the next ISEHC Newsletter.



As if there's not enough for us to remember, we're supposed to remember endless acronyms for trials too now. There's even a [wiki to help us](#) keep them straight and a call for a [register of trial acronyms](#) to reduce multiple use of all the words ending in T! Somewhere along the line this became marketing: not much equipoise in [ACHIEVE](#), [MIRACLE](#) or [PROMISE](#), eh? A [study](#) has classified this as a form of coercion. If you're irritated by the next outbreak of trial acronymania or [acronymesis](#) you come across, you're not alone!

Title: Statistically funny - commenting on the science of unbiased health research with cartoons

Author: Hilda Bastian

Background: The comedic possibilities of clinical epidemiology are known to be limitless

Methods: A new cartoon every week or two in Blogger, a Google application which can be followed

Results: Can be found at <http://statistically-funny.blogspot.com/>

Conclusions: Systematic reviewers do it robustly, but more cartoons are needed

Teaching & Practice Tips

Do you know good short videos on EBM topics?

Good short videos can be useful for teaching EBM either directly or as a source of ideas, so we would like to collect as many as possible and will put up links on the ISEHC website. To get you thinking about this, here are some examples we have come across all available for free on YouTube:

The CEBM in Oxford has made available some short videos from their 3 day workshop which are freely viewable at www.cebm.net and on YouTube at



A Clinical Introduction to a Pre-Clinical Course in Biostatistics

Evidence-Based Medicine in Practice - Diagnostic Tests #1
Evidence-Based Medicine in Practice - Appraisal of Clinical

Trials #1

http://www.youtube.com/user/cebmed?feature=results_main



Sensitivity and Specificity. A 2 minute tutorial teaching sensitivity vs. specificity, including SPIN and SNOUT mnemonics from HelpHippo.

Sensitivity Specificity: Easy
Epidemiology Difference Spin

Snout Test

<http://www.youtube.com/watch?v=LCndoLgoPVk>



Accuracy versus Precision. A 1 minute HelpHippo tutorial giving a Mnemonic for remembering the difference of accurate vs precise: accuRIGHT or pREPEATable? Accuracy Precision Epidemiology

Tutorial | Accurate vs Precise

<http://www.youtube.com/watch?v=BR59TT2zF38>



A nine year old tests therapeutic touch.

This is a 5:30 video on investigation of therapeutic touch by Emily Rosa, who at the age of 9 set up a blinded study of therapeutic touch

practitioners to determine whether they could detect whether her hand was over theirs - they couldn't! She became the youngest JAMA author ever! This might provide trigger material for group discussion or use as part of a lecture:

STOSSEL TESTING THERAPEUTIC TOUCH
<http://www.youtube.com/watch?v=mNoRxCRJ-Y0>

If you have other suggestions please contact cerueti@bond.edu.au.

Evidence Based Medicine Meets Shared Decision Making

(Interview done by Paul Glasziou at the Evidence 2010 conference, Victor is from the Mayo Clinic)

Professor Victor Montori is a diabetologist and health services researcher. He is the lead investigator of the Knowledge and Evaluation Research Unit and a Professor of Medicine at Mayo Clinic in Rochester, Minnesota, USA. He serves as Director of the Healthcare Delivery Research Program at the Mayo Clinic Center for the Science of Healthcare Delivery. Victor is interested in patient-centered healthcare delivery and outcomes for patients with chronic disease, in the corruption of evidence.

Paul: Could you tell us about the setting that you work in?

Victor: Yes Paul – I work at the Mayo Clinic in the referral endocrinology practice, I am an endocrinologist most of my practice is type2 diabetes although I follow some complex patients with type1 diabetes as well. I also have an important part of my practice, a teaching clinic which is mostly focused on criston metabolic problems which basically means diabetic and lipid problems and in that clinic I interact with trainees with different levels of training from medical students, very few, to endocrinology trainees and endocrinology fellows.

Paul: *You are obviously an advocate of EBM. Can you tell us how EBM works in your clinic and in your team?*

Victor: I tried to imbed it as part of a routine conversation, as part of a routine practice, I frequently make it nowadays an issue that is separate or worthy of a remark that is outside of routine so when possible I try to role model for both my patients and my trainees that this is how I do it rather than having to label it explicitly, so for instance that takes the shape of for instance a patient coming with cholesterol problems and the trainees telling me about the guidelines and how they will be using guidelines to treat this patient and I would ask them, well that's good but the guidelines are based on this way of thinking about the evidence so the way I think about it is I look at the studies and I would mention a few of the studies and I would describe each of them very briefly and say from those studies I gather that its talking cholesterol medicine that makes a difference it's not aiming at an ideal goal so I have a problem with the guideline you may want to go back and have a look at that and see if you have a problem with the guideline or whether you just follow it blindly and will make statements like that that are somewhat challenging have to say not many of the trainees don't bother looking at it up again and don't follow up but some do and those that do begin to have some degree of critical thinking of the guidelines which in the case of diabetes and cholesterol are quite strongly enforced. I bring it as a resistance movement sort of thing, I wonder if you have looked I have looked and this is what I have found and so I practice this other way. The other part of getting it into practice is when we have to explain it to patients and I have developed a number of tools that help me explain the magnitude of benefit for patients for the different treatments that we offer or the kinds of treatments that are available for example diabetes drugs and I use them in my practice quite routinely not only to demonstrate their use to the trainees but also with my patients as part of my routine care when the opportunity arises so that's another way I make evidence come alive during my consultation by showing patients what is the magnitude of the benefit and what is the degree of uncertainty that that benefit may play out in their lives or not.

Paul: *So you are an advocate of shared decision making.*

Victor: Yes and I have found that to be just an integral part of EBP, not for every decision of course because some these are fundamentally technical and there seems to be a right answer. Apparently there is a right answer but the patient needs to be on board to execute and accrue the benefit in a safe way they better know what they are getting into or you get into problems of non adherence to therapy then partial benefit or just

exposure to harm and cause without any positive tradeoffs.

Paul: *How do you find the patients react to evidence and the numbers?*

Victor: I don't know whether it's the setting in which I work or what but I find that the majority of the patients engage and that's consistent with the evidence as it turns out that most patients will engage in sharing of information not everyone appears to be interested in participating all through the process or even taking responsibility of making the final decision but I just work with them empathically so I give them as much as they would want to take and if they become uncomfortable I problem solve with them and make a decision with them I won't abandon them I won't say it's your problem but I will work with them and try to invite them to engage to the extent at which they are comfortable and often I am surprised that it is often all the way they really want to have a say and their say is often what we eventually execute I would not execute options that I am not comfortable in following through so we end up executing what we both agree is the thing to do and which is often a very informed guess. Some patients will consider looking at the numbers as gambling and they will reject that other people find it disturbing to talk about heart attacks or death and they prefer to avoid it but I can remember their faces they are very few, the majority of the patients do engage.

Paul: *Can I come back to the issue of looking at the evidence behind the guidelines and trying to get your trainees and colleagues to look at that more explicitly is there a forum in your setting to do this is there a journal club for example?*

Victor: It is interesting how one gets busy I have tried all sorts of different formats and they have been successful when we had them but I am busy and I find I cannot host them anymore and I have not been able to produce a critical mass of teachers who will do it formally. I have been invited to journal clubs but I don't get invited a lot I think there are two reasons 1. Often the journal clubs are underwritten by pharmaceutical representatives and I don't support that and 2. Often my approach to the literature will not be necessarily as connected with the pathophysiology that endocrinologists seem to enjoy so much and trainees may find that less helpful perhaps in having that sort of interpersonal professional skills that are necessary to hang out with other endocrinologists in fact if you think about endocrinology it's a challenging field in that's it's just like an internal medicine physician but one that knows a little bit more about the mechanism of

hormones so once you peel that off and say well it's just about the outcomes there is no reason for existence so it's a bit challenging culturally to discuss just the outcomes I find it much more effective, I don't have good proof of this but, I find it more effective to weave it into the same conversation so we are seeing a patient we are understanding the mechanism now, understand the treatment options now, understand the efficacy and now lets present the options to the patient now and so forth so it feels like it's the same flow of thought it's not something separate not something we do in a journal club not something we do in a conference room its something we do as part of our practice but its incomplete and relies heavily on the initiative of the different trainees and the fact that we may have a critical mass of people that provides those trainees with the same exposure it is changing as most training programs are finding themselves in a post evidence based medicine world where they think we've got the efficacy now, we've got the EBM now so let's work on quality improvement and safety and I find the trainees essentially assume they already know that stuff and they want to know about Root Cause Analysis and things like that but they don't really have a good grasp on evidence and incorporating it into practice.

Paul: *If I could give you a couple of wishes to change your setting that would improve the evidence based practice of your setting what would they be?*

Victor: There would be three things that I think of, two are global and not of my setting one the degree of corruption of the evidence base the introduction of bias into research, the introduction of spin into the research and the product of publication bias I think the corruption of research and its examination is a big challenge for evidence based practitioners. The second is also global and that is the corruption of health care itself to the extent that health care practices aim to improve outcomes that are not those of the patient, such as economic outcomes, to an extent that they become entrepreneurial and for profit and I find that difficult to bring that back to be about the patient so the corruption of health care delivery is another global challenge for evidence practitioners and in my local setting I wish I could rewind the tape a little bit and force people to think back about their quality improvement and standardisation processes to ask them have you look at the underlying evidence is it robust enough that you are putting all this effort and resource in making this happen, this post EBM world has come to soon or at least has come at the exclusion of further exploration of the underlying principles of evidence based practice.

Paul: *So can I just clarify this as it's an important point are you saying that quality improvement initiatives and*

standardization initiatives within your setting, you think have proceeded without a careful look at the evidence

Victor: The people who are running those processes they themselves, I don't think have the necessary skills to carefully look at the underlying evidence and they don't recruit people that have those skills and as we are training the health professionals who are going to be leading the way we are assuming that they got EBM skills some time in medical school but what is new is the skills of quality improvement and so let focus on training them there so what we are creating is a group of people that do a lot of good standardisation but whether they are standardising on good practices is what worries me.

Paul: *Thank you very much Victor for your time*

Research & Reviews

Editor's Note: *The following commentary arose from a series of journal clubs we are running looking at whether we can be more efficient at doing systematic reviews. However, the technique suggested is likely to be of interest to those doing rapid searches to answer clinical questions in real time.*

Sampson M, Shojania KG, McGowan J, Daniel R, Rader T, Iansavichene AE, Ji J, Ansari MT, Moher D. J Clin Epidemiol. 2008 Aug;61(8):755-62. Surveillance search techniques identified the need to update systematic reviews.

OBJECTIVE: This article reports on literature surveillance methods to identify new evidence eligible for updating systematic reviews.

STUDY DESIGN AND SETTING: Five surveillance search approaches are tested in the context of identifying studies that would signal major or invalidating new evidence for existing systematic reviews of health care interventions. Recall for each search approach was assessed as proportion of a composite yield of relevant studies across all search approaches that were identified by that approach. Screening burden was the number of studies that would need to be reviewed to identify the evidence that would necessitate updating.

RESULTS: Searches were tested in a cohort of 77 systematic reviews. No one method yielded consistently

high recall of relevant new evidence, so combinations of the strategies were examined. A search algorithm based on PubMed's related article search in combination with a subject searching using clinical queries was the most effective combination, retrieving all relevant new records in 68 cases. Screening burden was a median of 71 new records per review (inter-quartile range: 42-161).

CONCLUSION: Surveillance for emerging evidence that signals the need to update systematic reviews is feasible using a combination of subject searching and searching based on the PubMed's related article function.

COMMENTARY: How can we efficiently identify when an update of a systematic review is needed?

Sarah Thorning

The study by Sampson et al addresses the issue of efficient updating by looking at a previously used cohort of 100 systematic reviews that have been updated. The authors compared five search methods for identifying studies that would indicate the need to update a published systematic review. The search methods are intended to be more precise (returning smaller results sets) than the normal extensive search conducted for a systematic review. Efficient management of reviews is the goal so a comprehensive search would only be conducted if the surveillance search identified a need for an update. The authors list a set of signals that identify the need for a full update.

Three of the search strategies employed traditional "subject search" methods where a search strategy is developed using the PI (Population, Intervention) components of the PICO. Two of the subject searches were developed in MEDLINE (Ovid) and the third in CENTRAL (the Cochrane Library's database of randomised trials). The description of the methods for developing the search strategy for the "subject search" suggests that the search strategy is still a highly subjective method rather than a set method that anyone can follow. The search strategies were developed using Subject Headings (MeSH) if a good match was available, text words (natural language words) if a suitable MeSH term was not available or a combination of MeSH and text words if this was deemed the better alternative. Search features such as "focus" or "subheadings" were also employed to increase precision. This forms the basis of the "subject search" method.

Once the search strategy had been decided upon the methods for the "subject search" varied by either limiting a search using the optimized clinical queries for identifying "therapy" studies (method 1) or a combination of restricting the search to the core clinical journals and

limiting to the publication type RCT (method 2) or running the search in CENTRAL which had to be adapted as some of the features available in Medline (Ovid) are not available in CENTRAL (method 3). The other two methods do not employ a search strategy. Method 4 relies on the three largest and three most recent included studies in the published review and runs a search using MEDLINE's related article feature to retrieve further studies. These are then limited by date (entered into Medline after publication of review) and publication type (RCT). If the three largest and three most recent RCTs were the same or one or more of these articles were not indexed in Medline they were not replaced. Method 5 identified citing references either through Medline if it was a Cochrane Review or through Scopus for other reviews. The search results were then limited by date and publication type (RCT).

No single method performed sufficiently well on its own. However complete retrieval of all eligible RCTs for updating 68 out of the 77 systematic reviews used for this study were identified using a combination of related article RCT (method 4) and subject search with clinical query (method 1). For this particular set of reviews the combination of these two search methods retrieved a median of 71 articles for screening.

These results seem to suggest that it may be possible to employ search methods other than a full comprehensive search for review updates and that these methods might reduce the screening burden as they retrieve smaller more precise sets of records. However this study is complicated by the fact that it is a retrospective rather than a real time process and the main intent was to determine a method for identifying a trigger for when a review needed updating. More efficient search methods may perhaps work for some review updates and this is an idea worth exploring. The Cochrane Acute Respiratory Infections Group is looking at trialling this search method for some of its current updates. The records retrieved by the Sampson et al method will be compared with the set of records retrieved (and included in the review) using the traditional method.

PS A more complete description of the study is available in the full report:

Shojania KG, Sampson M, Ansari MT, Ji J, Garritty C, Rader T, Moher D. Updating Systematic Reviews. Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Sep.

Sarah is the Clinical Librarian for The Centre For Research in Evidence-Based Practice, Bond University, Gold Coast, Australia

Selected Abstracts

Methodologists and context experts disagreed regarding managing conflicts of interest of clinical practice guidelines panels

Akl EA, Karl R, Guyatt GH. J Clin Epidemiol. 2012 Jul;65(7):734-9. Epub 2012 May 5.

OBJECTIVE: A new strategy to manage conflicts of interests (COIs) of a clinical guideline's panelists gives primary responsibility to a methodologist, puts equal emphasis on intellectual and financial COIs, and excludes panelists with primary conflicts from drafting or voting on recommendations. We explored the views of the methodologists and content experts regarding the new strategy.

STUDY DESIGN AND SETTING: Before the guidelines chapter panels initiated their work, we conducted semi-structured personal interviews with the methodologists and the lead content experts. We analyzed the data qualitatively.

RESULTS: Twenty-four panelists participated. The methodologists thought that the new strategy increased their responsibility and authority. The lead content experts perceived their role label as unfair and reflecting a demotion. Whereas methodologists were concerned about potential conflicts with content experts, the lead content experts were uncomfortable with the "extra surveillance" by the methodologists. Whereas methodologists believed that the changes ensure more rigorous evidence-based guidelines, some lead content experts were worried that methodologists' lack of content expertise and content expert attrition could hurt the quality of the guidelines.

CONCLUSIONS: The methodologists and lead content experts were uneasy regarding their counterpart's role. They disagreed about the potential effect of the new strategy on the quality of the guideline.

Informed consent documents do not encourage good-quality decision making

Brehaut JC, Carroll K, Elwyn G, Saginur R, Kimmelman J, Shojania K, Syrowatka A, Nguyen T, Hoe E, Fergusson D. J Clin Epidemiol. 2012 Jul;65(7):708-24.

OBJECTIVE: Informed consent for research has emphasized information provision over support to people making a difficult decision. We assessed the extent to which existing informed consent documents (ICDs) conform to the International Patient Decision Aid Standards for supporting decision making.

STUDY DESIGN AND SETTING: One hundred thirty-nine ICDs for trials registered with ClinicalTrials.gov were obtained from study investigators. Using a four-point scale, two raters assessed each ICD on 32 items.

RESULTS: Overall agreement between raters was 95.1% (linear weighted kappa-0.745). For 12 items focused on providing enough information, conformity was above 50% for three, and 0% for another four. For all eight items focused on how to present outcome probabilities, conformity was below 20%. For two items focused on clarifying and expressing values, conformity was below 10%. For two items focused on improving structured guidance, conformity was below 5%. For four items focused on using evidence, one item showed conformity of 74%; all others showed conformity below 5%. For four items focused on transparency, conformity was high (above 60% for two, above 80% for the others).

CONCLUSIONS: Existing ICDs do not meet most validated standards for encouraging good decision making. These standards make clear predictions about how one might improve ICDs ensure that research participants are fully informed.

GRADE guidelines 12. Preparing Summary of Findings tables-binary outcomes

Guyatt GH, Oxman AD, Santesso N, et al. J Clin Epidemiol. 2012 May 18.

Summary of Findings (SoF) tables present, for each of the seven (or fewer) most important outcomes, the following: the number of studies and number of participants; the confidence in effect estimates (quality of evidence); and the best estimates of relative and absolute effects. Potentially challenging choices in preparing SoF table include using direct evidence (which may have very few events) or indirect evidence (from a surrogate) as the best evidence for a treatment effect. If a surrogate is chosen, it must be labeled as substituting for the corresponding patient-important outcome. Another such choice is presenting evidence from low-quality randomized trials or high-quality observational studies. When in doubt, a reasonable approach is to present both sets of evidence; if the two bodies of evidence have similar quality but discrepant results, one would rate down further for inconsistency. For binary outcomes, relative risks (RRs) are the preferred measure of relative effect and, in most instances, are applied to the baseline or control group risks to generate absolute risks. Ideally, the baseline risks come from observational studies including representative patients and identifying easily measured prognostic factors that define groups at differing risk. In the absence of such studies, relevant randomized trials provide estimates of baseline risk. When confidence intervals (CIs) around the relative effect include no difference, one may simply state in the absolute risk column that results fail to show a difference, omit the point estimate and report only the CIs, or add a comment emphasizing the uncertainty associated with the point estimate.

Effect of editors' implementation of CONSORT guidelines on the reporting of abstracts in high impact medical journals: interrupted time series analysis

Hopewell S, Ravaud P, Baron G, Boutron I. BMJ. 2012 Jun22;344:e4178. doi: 10.1136/bmj.e4178.

OBJECTIVE: To investigate the effect of the CONSORT for Abstracts guidelines, and different editorial policies used by five leading general medical journals to implement the guidelines, on the reporting quality of abstracts of randomised trials.

DESIGN: Interrupted time series analysis.

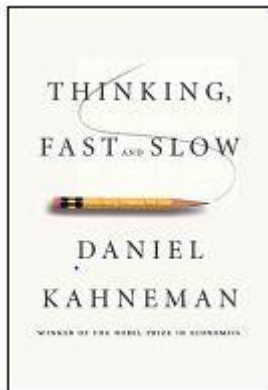
SAMPLE: We randomly selected up to 60 primary reports of randomised trials per journal per year from five high impact, general medical journals in 2006-09, if indexed in PubMed with an electronic abstract. We excluded reports that did not include an electronic abstract, and any secondary trial publications or economic analyses. We classified journals in three categories: those not mentioning the guidelines in their instructions to authors (JAMA and New England Journal of Medicine), those referring to the guidelines in their instructions to authors but with no specific policy to implement them (BMJ), and those referring to the guidelines in their instructions to authors with an active policy to implement them (Annals of Internal Medicine and Lancet). Two authors extracted data independently using the CONSORT for Abstracts checklist.

MAIN OUTCOME: Mean number of CONSORT items reported in selected abstracts, among nine items reported in fewer than 50% of the abstracts published across the five journals in 2006.

RESULTS: We assessed 955 reports of abstracts of randomised trials. Journals with an active policy to enforce the guidelines showed an immediate increase in the level of mean number of items reported (increase of 1.50 items; $P=0.0037$). At 23 months after publication of the guidelines, the mean number of items reported per abstract for the primary outcome was 5.41 of nine items, a 53% increase compared with the expected level estimated on the basis of pre-intervention trends. The change in level or trend did not increase in journals with no policy to enforce the guidelines (BMJ, JAMA, and New England Journal of Medicine).

CONCLUSION: Active implementation of the CONSORT for Abstracts guidelines by journals can lead to improvements in the reporting of abstracts of randomised trials.

Resources & Reviews



Thinking, Fast and Slow by Daniel Kahneman, Farrar, Straus and Giroux, 2011.

Reviewed by Rae Thomas

In 2002 the psychologist Daniel Kahneman won the Nobel Prize for (surprisingly) economics. The award was based on his work with fellow psychologist Amos Tversky in Prospect Theory and centred on how we make decisions, well and badly. Their work has influenced psychology, economics, medicine and a range of disciplines. Tversky died in 1996 but Kahneman continued his research, and in 2011 *Thinking, Fast and Slow* was published.

Few academics have synthesised a lifetime's worth of research so succinctly and powerfully. Not only is *Thinking, Fast and Slow* a compendium of Kahneman's research over 4 decades, it is also a showcase of other important and at times contradictory research focussed on how we think and why we choose one option over another. It is a must read for anyone interested in understanding or reviewing the principles behind the judgements and choices used to inform decisions. Working as a researcher within screening and evaluation I consider I have two primary tasks: 1) to conduct research and gather evidence and 2) communicate this to the public in an accessible and meaningful way. But communicating our research to the public, particularly evidence that defies popular views is challenging. We know that many individuals over-estimate their risk of both being diagnosed with, and dying from, breast or prostate cancer and that providing them with risk ratios and mortality statistics does not alter their decision to be screened. Clearly, our logical arguments and numbers are not enough to sway opinion. *Thinking, Fast and Slow*, raises (and for some re-familiarises) some important lessons we have learned about how people think.

For example, how might considering the mechanics of risk aversion (chapter 25) lead us to a clearer understanding of individual values in relation to universal screening? Or how might the anchoring effect (chapter 11) or availability heuristic (chapter 13) help us to

investigate new ways of presenting information? How might we adjust the way we communicate risk if we recognise that low probability events are more heavily weighted when relative frequencies (1 person out of 100,000 will be injured) versus risks (a 0.00001% chance of injury) are reported? Or what is the role of anticipated regret in deciding to be screened for breast cancer? Although both cognitive and social psychology have investigated these phenomenon, *Thinking, Fast and Slow* integrates these data in an engaging and unique way.

But, this book is not an easy bed-time read. *Thinking, Fast and Slow* synthesises and analyses hundreds of research projects in many domains. It is long and often requires thoughtful deliberation (and sometimes embarrassment when you get the example experiments wrong!). For best effect it requires underlining and reflection but is well worth the read.

Rae Thomas is a Senior Research Fellow, Centre for Research in Evidence-Based Practice



FIRST INTERNATIONAL CONFERENCE on
EVIDENCE BASED HEALTHCARE (October 6-8, 2012)

BMJ



Welcome to ISEHCON 2012

All India Institute of Medical Sciences, Clinical Epidemiology Unit, in continuance of its pursuit for excellence in healthcare, is organizing "Pre-Conference Workshops & International Conference on EVIDENCE-BASED HEALTHCARE" from October 6th - 8th 2012 at India International Centre, New Delhi, India. Approximately 300 experts and delegates from diverse fields are expected to participate in this mega event from across the globe.

Highlights

- Inaugural Conference of the International Society for Evidence-Based Healthcare.
- First event of its kind in the country.
- Focusing on issues discussed never before.
- Over 300 experts and delegates from across the globe.
- Renowned national and international speakers.
- It will provide an opportunity to interact with many Evidence Based Healthcare enthusiasts around the world.

Objectives

- To provide a platform for interaction to those implementing Evidence-Based Healthcare around the world in their settings/country.
- To bring together world class experts with the Indian participants, educationists and policy-makers to promote healthcare that is shown to be effective, efficient and affordable through research.

Aim

To promote Evidence Based Healthcare globally and meet the need for an International Conference to bring the people interested in the area of EBHC around the world.

Design

1. Interactive Platform
2. Case Studies
3. Group Work
4. Poster Presentation

The Faculty members: Dr. Gordon Guyatt, Dr. Paul Glasziou, Dr. Victor M. Montori,
Dr. Ken N Kuo, Dr. Luz M. Letelier, Dr. Tony Dans, Dr. Mujtaba Quadri,
Dr. Kameshwar Prasad

You can register at <http://www.isehcon2012.com/registration.html> or contact

Organizing Committee
"ISEHCON 2012"

Clinical Epidemiology Unit, Room No-91, Near Examination Section,
All India Institute of Medical Sciences, Ansari Nagar, New Delhi-110029, India
Tel: +91-11-26594436/26588434 e-mail: isehcon2012@gmail.com

March 25-26 2013 Oxford

The annual Evidence Live conference is unlike any other event in healthcare. It brings together leading speakers in evidence-based medicine from all over the world, from the fields of research, clinical practice & commissioning. Evidence Live is the place for learning about the latest advances in evidence-based healthcare and finding out how they can be best applied in clinical practice.



At the Evidence Live conference researchers, clinicians and professionals, working with evidence at different stages in the healthcare chain, learn about important issues in healthcare. The programme is designed to showcase the most innovative ideas, processes and best practices that form the foundations of an evidence-based approach.

General enquiries, venue and travel

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10-12 September 2013

The Preventing Overdiagnosis conference will take place on 10-12 September 2013 in the United States, hosted by The Dartmouth Institute for Health Policy and Clinical Practice, in partnership with one of the world's most respected medical journals, the BMJ, the leading New-York based consumer organisation Consumer Reports, and Bond University. A call for papers will be issued later in 2012.

If you are interested in attending or want to receive more information about the conference, please sign up for updates at

http://www.preventingoverdiagnosis.net/?page_id=21.



International Conference
6th International Conference for EBHC Teacher and Developers
Taormina (Italy), 30th October - 2nd November 2013

Abstract Submission & Registration

Open

30 October 2012

Very Early Registration deadline

31 December 2012

Abstract Submissions deadline

31 March 2013

Notification of Abstract Acceptance

30 April 2013

Early Registration deadline

31 May 2012

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7th International Shared Decision Making Conference



June 16-19 2013
www.isdm2013.org

GLOBALIZING
SDM
.....
PACIENTES
@ the CENTRE
of HEALTHCARE

Between June 16 and June 19 of 2013 we will be meeting in Lima, Perú to push for a patient revolution. Researchers, patients, clinicians, and policymakers will get together to discuss how to globalize patient-centered care in general and shared decision making in particular, globalizing it to people, practices, healthcare environments, and countries, in which these practices are not common, considered feasible, or accepted.

To accomplish our goals we will set several inspiring keynote addresses and thought provoking panels, offer plenty of time for dialogue and networking, training courses for newbies and experts, and a rich social calendar to make more colleagues, collaborators and friends.

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