

Additional file 2. Basis for the recommendations, caveats and risk mitigation

Recommendation	Research evidence	How this can affect use of the information and decision-making	Caveats and risk mitigation
Make it easy for your target audience to quickly determine the relevance of the information, and to find the key messages.			
<p>1. Clearly state the problem and the options (interventions) that you address, using language that is familiar to your target audience – so that people can determine if the information is relevant to them.</p>	<p>People commonly use search engines to find health information, they often do not go beyond the first results page, and they examine and abandon pages quickly.¹⁻⁴ People quickly make judgments about the potential relevance of information before considering the quality of the information; and relevance and ease of access can affect judgements about the trustworthiness or credibility of information.^{2,5-7}</p>	<p>The harder it is to find information and the longer it takes people to assess its relevance, the less likely it is that it will be used. Making it possible to quickly determine whether the information addresses a problem (or risk) and options (interventions) that are relevant, can increase the likelihood that people in your target audience will use it. People are most likely to seek information that is relevant to specific problems or concerns that they have or specific interventions that they are considering.</p>	<p>The more likely it is that people will find and use your information, the more important it is to ensure that it is informed by the best available evidence and that it is usable and useful. Many decision-makers are unlikely to use Boolean operators when searching, and are likely to search using a single search term.^{1,8} It may be important to consider how people in your target audience are likely to search for information and what terms they are likely to use; and to include multiple terms, when relevant. It may also be important to consider ways of increasing the ranking of your information by search engines, such as Google. For users who are directed to your website, it is important to ensure that information is easy to find using the website's search function.^{3,9}</p>
<p>2. Present key messages up front, using language that is appropriate for your audience and make it easy for those who are interested to dig deeper and find information that is more detailed.</p>	<p>Too much text contributes to the rejection and mistrust of websites, and reduces the likelihood that information will be used; people examine and abandon online information quickly; and much online health information has a readability level that is inappropriate for general public use.^{2,10,11} Decision-makers want and are more likely to read short, clear summaries with brief key messages rather than large blocks of text, and layered information, beginning with a concise summary through to detailed information and links to systematic reviews, caters for varying needs, time demands, and expertise.^{5,12-25}</p>	<p>The more quickly that people find and understand the key messages, the more likely it is that they will use the information. Poor readability can reduce the likelihood of information being used and can result in misunderstanding and misinformation.</p>	<p>Repetition of information in more than one layer can be off-putting and should be minimised.</p>

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3. Report all potentially important benefits and harms, including outcomes for which no evidence was found – so that there is no ambiguity about what was found for each outcome that was considered.	It is frequently ambiguous whether unreported outcomes - particularly harms - were considered and no evidence was found or they were not considered; and outcomes are frequently reported selectively. ²⁶⁻³⁶	Reporting all of the potentially important benefits and harms that were considered, including ones for which little or no evidence was found, can reduce ambiguity and misleading reporting of key findings.	How important outcomes are to people varies. Patients, health professionals, policymakers, and researchers may have different views about which outcomes are important. It may be important to engage people in your target audience (or the people affected by a decision) in making judgements about the relative importance of outcomes. If there are many outcomes, this can be overwhelming. It may be desirable to report the most important outcomes in the top layer (summary information) and other important outcomes in other layers.
For each outcome, help your target audience to understand the size of the effect and how sure we can be about that; and avoid presentations that are misleading.			
4. Explicitly assess and report the certainty of the evidence.	Several factors affect the certainty (or quality) of the evidence for estimates of effect, and the certainty of the evidence can vary from very low to high. ³⁷⁻⁴⁴	The certainty of the evidence can affect the decisions that people make. Assuming the purpose is to inform people rather than to persuade them, it is necessary to include information about the certainty of the evidence. Not doing so can be misleading. Unsystematic and nonexplicit assessments of the certainty of the evidence also can be misleading.	Assessments of the certainty of the evidence requires judgements. The underlying judgements and the basis for those judgements should be available. Uncertainty might sometimes be misunderstood or misused as an excuse for not taking appropriate actions, particularly for health system and public health interventions. ⁴⁵ Clear explanations of what is meant by different levels of certainty should be provided (e.g. as scroll-overs); and care should be taken not to imply that uncertainty about effects necessarily means that an intervention should not be used.
5. Use language and numerical formats that are consistent and easy to understand	Verbal expressions of uncertainty or probability often mean different things to different people and some verbal expressions may be easier to understand than others. ⁴⁶⁻⁵² Inconsistent use of language increases the risk of spin and verbal descriptions that are inconsistent with the evidence. ^{53,54} Use of consistent language that has been tested can improve the understanding, usability, and usefulness of information about intervention effects. ^{55,56}	Using consistent language with well-defined meanings can help reduce the risk of misunderstandings and misleading descriptions of the certainty of the evidence and the size of the effects.	Overly rigid application of consistent descriptions can result in awkward sentences that are difficult to understand. The language that is used to describe the certainty of the evidence and the size of the effects should be chosen carefully and, ideally, tested.

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6. Present both numbers and words, and include summary of findings tables.	Words may be easier to understand than numbers, and words used to express probabilities are often ordered consistently, but their interpretation is highly variable and may result in inappropriate perceptions and decisions. ^{47-49,51,57} Numbers are more accurate, but many people have poor numeracy skills and may have problems understanding effect estimates. ^{50,51,58} People differ in their preferences for words, numbers, or both. ⁴⁷ Combinations of words and quantitative presentations are likely to have advantages over quantitative presentations alone as this can help to interpret and ensure understanding of numbers. ⁵¹ Summary of findings tables are perceived as understandable and useful, and they can improve how quickly people find key information, understanding, accurate perceptions of effects, and choices. ^{13,56,59-61}	Presenting both numbers and words and including summary of findings tables can help to ensure correct understanding of effect estimates and may improve decision-making.	Words alone may be sufficient for communicating vague or very uncertain effects. ⁴⁸ Some people may be put-off by numbers or overwhelmed by summary of findings tables. One strategy for mitigating this risk is to partially hide the tables (e.g. by only showing the top of the table or a thumbnail image), so that they can be quickly accessed by those who want that information, while not putting off those who do not. Another strategy is to use interactive summary of findings tables , which enable users to modify what information is displayed.
7. Report absolute effects.	A relative effect may give readers the impression that a difference is more important than it actually is when the likelihood of the outcome is small to begin with. ^{62,63}	Absolute effects generally are less likely to be misleading than relative effects and are easier to understand and use when making a decision.	For some target audiences it may be desirable to report both absolute and relative effects. Absolute effects may be difficult to calculate or interpret for some outcomes. In those cases, it may be best not to report an absolute effect. Consideration should be given to providing help with interpreting such effect estimates, when needed.
8. Avoid misleading presentations and interpretations of effects.			
<ul style="list-style-type: none"> Help your audience to avoid misinterpreting continuous outcome measures. 	Important continuous outcome measures, such as pain or quality of life, are easily misinterpreted and it is often difficult to make sense of them. ^{29,64-66}	Interpretation of continuous outcome measures is challenging. Careful reporting and explanations may help your target audience to make sense of them and to avoid misinterpreting them.	Although guidance is available for reporting continuous outcome measures, ⁶⁴ alternative presentations all have merits and limitations.
<ul style="list-style-type: none"> Explicitly assess and report the credibility of subgroup effects. 	Most differential effects suggested by subgroup results are likely to be due to the play of chance and are unlikely to reflect true differences. ⁶⁷	Using explicit criteria to make judgements about the credibility of subgroup effects can help to avoid misleading presentations. ⁶⁸⁻⁷¹	Assessments of the credibility of subgroup effects requires judgements. The underlying judgements and the basis for those judgements should be available.

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<ul style="list-style-type: none"> Avoid confusing “statistically significant” with “important”, or a “lack of evidence” with a “lack of effect”. 	<p>Whether or not an effect is “statistically significant” is frequently confused with whether an effect is important.⁷²⁻⁷⁷</p>	<p>Considering the precision of effect estimates when making judgements about the certainty of the evidence,^{78,79} and not reporting effects as “statistically significant” or “statistically non-significant” can reduce the chances of misleading your target audience.</p>	<p>Although confidence intervals are more informative than p-values, confidence intervals can also be misinterpreted.⁸⁰⁻⁸³ There are pros and cons to reporting confidence intervals and little evidence to support a recommendation either to include them or exclude them, or how to present and explain them, if they are included. Deciding whether and how to report confidence intervals may depend on the target audience.</p>
Help your target audience to put information about the effects of interventions in context, and to understand why the information is trustworthy.			
<p>9. Provide relevant background information, help people weigh the advantages against the disadvantages of interventions, and provide a sufficient description of the interventions.</p>	<p>Absolute effects may vary widely across subgroups with different baseline risks.⁸⁴⁻⁸⁷ How much people value different outcomes also can vary widely.⁸⁸⁻⁹⁰ Interventions are frequently inadequately described in trial reports and in systematic reviews.^{91,92} Other factors besides treatment effects and the certainty of the evidence can affect people’s decisions.⁹³⁻⁹⁹</p>	<p>Differences in baseline risk, differences in values, and other factors, including costs, acceptability, and feasibility can affect decisions. It may not be possible or appropriate to provide all this information outside of the context of guidelines or recommendations. Nonetheless, decision-makers may find it helpful to have potentially important considerations flagged,¹⁵ and doing so may reduce the risk of other important factors not receiving appropriate consideration. If a decision is made to use an intervention, decision-makers cannot implement it if it is not adequately described.</p>	<p>When additional information is provided, care should be taken to ensure that it is trustworthy.</p>
<p>10. Tell your audience how the information was prepared, what it is based on, the last search date, who prepared it and whether the people who prepared the information had conflicts of interest.</p>	<p>This information is often lacking or difficult to find.¹⁰⁰ Information from reputable sources often is not based on systematic reviews, not clear, incomplete, and misleading.¹⁰⁰⁻¹⁰² Information may become out-of-date if new research evidence has been reported since it was prepared.¹⁰³⁻¹¹⁰ Conflicts of interest are common, frequently are not disclosed, and can lead to biased reporting.¹¹¹⁻¹²¹</p>	<p>The source of information about the effects of treatments does not alone provide a reliable basis for judging how reliable the information is. Empowering people to make well-informed decisions about interventions requires that they have access to trustworthy information and that they are able to assess the trustworthiness of information based on how it was prepared, when it was prepared, and the extent to which conflicts of interest may have distorted the information.</p>	<p>This information should be up-to-date, easy for the target audience to understand, and easy to find.</p>

References

1. Eysenbach G, Powell J, Kuss O, Sa ER. Empirical studies assessing the quality of health information for consumers on the world wide web: a systematic review. *JAMA* 2002; 287:2691-700.
2. Toms EG, Latter C. How consumers search for health information. *Health Informatics J* 2007; 13:223-35.
3. Samuel HW, Zaiane OR, Zaiane JR. Findability in health information websites. Proceedings of 2012 IEEE-EMBS International Conference on Biomedical and Health Informatics 2012; 10.1109/BHI.2012.6211681.
4. Branscum P, Hayes L, Wallace L. Direct observation of searching for online health information: a systematic review of current evidence. *Am J Health Stud* 2016; 31: 222-32
5. Sorian R, Baugh T. Power of information: closing the gap between research and policy. *Health Aff* 2002; 21:264-73.
6. Zhang Y. Consumer health information searching process in real life settings. *Proc Am Soc Info Sci Tech* 2012; 49:1-10.
7. Sbaffi L, Rowley J. Trust and credibility in web-based health information: a review and agenda for future research. *J Med Internet Res* 2017; 19:e218.
8. Rosenbaum SE, Glenton C, Cracknell J. User experiences of evidence-based online resources for health professionals: User testing of *The Cochrane Library*. *BMC Med Inform Decis Mak* 2008; 8:34.
9. Oxman AD, Paulsen EJ. Who can you trust? A review of free online sources of "trustworthy" information about treatment effects for patients and the public. *BMC Med Inform Decis Mak* 2019; 19:35.
10. Mcinnes 2011. McinnesN, Haglund BJ. Readability of online health information: implications for health literacy. *Inform Health Soc Care* 2011; 36:173-89.
11. Daraz L, Morrow AS, Ponce OJ, Farah W, Katabi A, Majzoub A, et al. Readability of online health information: a meta-narrative systematic review. *Am J Med Qual* 2018; 33:487-92.
12. Lavis JN, Davies H, Oxman AD, Denis JL, Golden-Biddle K, Ferlie E. Towards systematic reviews that inform health care management and policy-making. *J Health Serv Res Policy* 2005; 10 Suppl 1:35-48.
13. Rosenbaum SE, Glenton C, Oxman AD. Summary of Findings tables improved understanding and rapid retrieval of key information in Cochrane Reviews. *J Clin Epidemiol* 2010; 63:620-6.
14. Rosenbaum SE, Glenton C, Wiysonge CS, Abalos E, Mignini L, Young T, et al. Evidence summaries tailored for health policymakers in low and middle-income countries. *WHO Bull* 2011; 89:54-61.
15. Opiyo N, Shepperd S, Musila N, Allen E, Nyamai R, Fretheim A, et al. Comparison of alternative evidence summary and presentation formats in clinical guideline development: a mixed-method study. *PLoS One* 2013; 8:e55067.

16. Ellen ME, Lavis JN, Wilson MG, Grimshaw J, Haynes RB, Ouimet M, et al. Health system decision makers' feedback on summaries and tools supporting the use of systematic reviews: a qualitative study. *Evid Policy* 2014; 10:337-59.
17. Kristiansen A, Brandt L, Alonso-Coello P, Agoritsas T, Akl EA, Conboy T, et al. Development of a novel, multilayered presentation format for clinical practice guidelines. *Chest* 2015; 147:754-63.
18. Brennan SE, Cumpston M, Misso ML, McDonald S, Murphy MJ, Green SE. Design and formative evaluation of the Policy Liaison Initiative: a long-term knowledge translation strategy to encourage and support the use of Cochrane systematic reviews for informing health policy. *Evid Policy* 2016; 12:25-52.
19. Petkovic J, Welch V, Jacob MH, Yoganathan M, Ayala AP, Cunningham H, et al. The effectiveness of evidence summaries on health policymakers and health system managers use of evidence from systematic reviews: a systematic review. *Implement Sci* 2016; 11:162.
20. Tricco AC, Cardoso R, Thomas SM, Motiwala S, Sullivan S, Kealey MR, Hemmelgarn B, et al. Barriers and facilitators to uptake of systematic reviews by policy makers and health care managers: a scoping review. *Implement Sci* 2016; 11:4.
21. Mijumbi RM, Rosenbaum SE, Oxman AD, Lavis JN, Sewankambo NK. Policymaker experiences with rapid response briefs to address health- system and technology questions in Uganda. *Health Res Policy Syst* 2017; 15:37.
22. Brandt L, Vandvik PO, Alonso-Coello P, Akl EA, Thornton J, Rigau D, et al. Multilayered and digitally structured presentation formats of trustworthy recommendations: a combined survey and randomised trial. *BMJ Open* 2017; 7:e011569.
23. Busert LK, Mütsch M, Kien C, Flatz A, Griebler U, Wildner M, et al. Facilitating evidence uptake: development and user testing of a systematic review summary format to inform public health decision-making in German-speaking countries. *Health Res Policy Syst* 2018; 16:59.
24. Marquez C, Johnson AM, Jassemi S, Park J, Moore JE, Blaine C, et al. Enhancing the uptake of systematic reviews of effects: what is the best format for health care managers and policy-makers? A mixed-methods study. *Implement Sci* 2018; 13:84.
25. Petkovic J, Welch V, Jacob MH, Yoganathan M, Ayala AP, Cunningham H, et al. Do evidence summaries increase health policy-makers' use of evidence from systematic reviews? *Campbell Syst Rev* 2018:8.
26. Ernst E, Pittler MH. Assessment of therapeutic safety in systematic reviews: literature review. *BMJ* 2001; 323:546.
27. Silagy CA, Middleton P, Hopewell S. Publishing protocols of systematic reviews: comparing what was done to what was planned. *JAMA* 2002; 287:2831-4.
28. Oxman A. Summaries of findings in Cochrane reviews. *Cochrane Collaboration Methods Groups Newsletter* 2004; 8:8.
29. Glenton C, Underland V, Kho M, Pennick V, Oxman AD. Summaries of findings, descriptions of interventions, and information about adverse effects would make reviews more informative. *J Clin Epidemiol* 2006; 59:770-8.

30. Parmelli E, Liberati A, D'Amico R. Reporting of outcomes in systematic reviews: comparison of protocols and published systematic reviews. 15th Cochrane Colloquium, Sao Paulo, 23–27 October 2007. https://ac.els-cdn.com/S0277953607000160/1-s2.0-S0277953607000160-main.pdf?_tid=a479d5e3-2bb5-420f-9734-0876eda08545&acdnat=1552063075_2ac0d4acdcd7f8cb8c6c67653f13f090
31. Kirkam JJ, Altman DG, Williamson PR. Bias due to changes in specified outcomes during the systematic review process. *PLoS One* 2010; 5:e9810.
32. Kinciski M. Publication bias in recent meta-analyses. *PLoS One* 2013; 8:e81823.
33. Norris SL, Moher D, Reeves BC, Shea B, Loke Y, Garner S, et al. Issues relating to selective reporting when including non-randomized studies in systematic reviews on the effects of healthcare interventions. *Res Synth Methods* 2013; 4:36-47.
34. Page MJ, McKenzie JE, Kirkham J, Dwan K, Kramer S, Green S, et al. Bias due to selective inclusion and reporting of outcomes and analyses in systematic reviews of randomised trials of healthcare interventions. *Cochrane Database Syst Rev* 2014; MR000035.
35. Pandis N, Fleming PS, Worthington H, Dwan K, Salanti G. Discrepancies in outcome reporting exist between protocols and published oral health Cochrane systematic reviews. *PLoS One* 2015; 10:e0137667.
36. Zorzela L, Loke YK, Ioannidis JP, Golder S, Santaguida P, Altman DG, et al. PRISMA harms checklist: improving harms reporting in systematic reviews. *BMJ* 2016; 352:i157.
37. Balshem H, Helfand M, Schunemann H, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines 3. Rating the quality of evidence – introduction. *J Clin Epidemiol* 2011; 64:401-6.
38. Guyatt GH, Oxman AD, Vist G, Kunz R, Brozek J, Alonso-Coello P, et al. GRADE guidelines 4. Rating the quality of evidence - study limitations (risk of bias). *J Clin Epidemiol* 2011; 64:407-15.
39. Guyatt GH, Oxman AD, Montori V, Vist G, Kunz R, Brozek J, et al. GRADE guidelines - 5. Rating the quality of evidence - publication bias. *J Clin Epidemiol* 2011; 64:1277-82.
40. Guyatt GH, Oxman AD, Kunz R, Brozek J, Alonso-Coello P, Devereaux PJ, et al. GRADE guidelines 6. Rating the quality of evidence – imprecision. *J Clin Epidemiol* 2011; 64:1283-93.
41. Guyatt GH, Oxman AD, Kunz R, Woodcock J, Brozek J, Helfand M, et al. GRADE guidelines 7. Rating the quality of evidence – inconsistency. *J Clin Epidemiol* 2011; 64:1294-302.
42. Guyatt GH, Oxman AD, Kunz R, Woodcock J, Brozek J, Helfand M, et al. GRADE guidelines 8. Rating the quality of evidence – indirectness. *J Clin Epidemiol* 2011; 64:1303-10.
43. Guyatt GH, Oxman AD, Sultan S, Glasziou P, Alonso-Coello P, Atkins D, et al. GRADE guidelines 9. Rating up the quality of evidence. *J Clin Epidemiol* 2011; 64:1311-6.
44. Guyatt GH, Oxman AD, Sultan S, Glasziou P, Alonso-Coello P, Atkins D, et al. GRADE guidelines: 11. Making an overall rating of quality of evidence for a single outcome and for all outcomes. *J Clin Epidemiol* 2013; 66:151-7.
45. Schunemann 2006. Schünemann HJ, Fretheim A, Oxman AD. Improving the Use of Research Evidence in Guideline Development: 9. Grading evidence and recommendations. *Health Res Policy Syst* 2006; 4:21.

46. Mazur DJ, Hickam DH. Patients' interpretations of probability terms. *J Gen Intern Med* 1991; 6:237-40.
47. Wills CE, Holmes-Rovner M. Patient comprehension of information for shared treatment decision making: state of the art and future directions. *Patient Educ Couns* 2003; 50:285-90.
48. Burkell J. What are the chances? Evaluating risk and benefit information in consumer health materials. *J Med Libr Assoc* 2004; 92:200-8.
49. Knapp P, Raynor DK, Berry DC. Comparison of two methods of presenting risk information to patients about the side effects of medicines. *Qual Saf Health Care* 2004; 13:176-80.
50. Trevena LJ, Davey HM, Barratt A, Butow P, Caldwell P. A systematic review on communicating with patients about evidence. *J Eval Clin Pract* 2006; 12:13-23.
51. Lipkus IM. Numeric, verbal, and visual formats of conveying health risks: suggested best practices and future recommendations. *Med Decis Making* 2007; 27:696-713.
52. Visschers VHM, Meertens RM, Passchier WWF, de Vries NK. Probability information in risk communication: a review of the research literature. *Risk Anal* 2009; 29:267-87.
53. Hewitt CE, Mitchell N, Torgerson DJ. Listen to the data when results are not significant. *BMJ* 2008; 336:23-5.
54. Boutron I, Dutton S, Ravaud P, Altman DG. Reporting and interpretation of randomized controlled trials with statistically nonsignificant results for primary outcomes. *JAMA* 2010; 303:2058-64.
55. Glenton C, Santesso N, Rosenbaum S, Nilsen ES, Rader T, Ciapponi A, et al. Presenting the results of Cochrane Systematic Reviews to a consumer audience: a qualitative study. *Med Decis Making* 2010; 30:566-77.
56. Santesso N, Rader T, Nilsen ES, Glenton C, Rosenbaum S, Ciapponi A, et al. A summary to communicate evidence from systematic reviews to the public improved understanding and accessibility of information: a randomized controlled trial. *J Clin Epidemiol* 2015; 68:182-90.
57. Kong A, Barnett GO, Mosteller F, Youtz C. How medical professionals evaluate expressions of probability. *New Engl J Med* 1986; 315:740-4.
58. Schwartz LM, Woloshin S, Black WC, Welch HG. The role of numeracy in understanding the benefit of screening mammography. *Ann Intern Med* 1997; 127:966-72.
59. Rosenbaum SE, Glenton C, Nylund HK, Oxman AD. User testing and stakeholder feedback contributed to the development of understandable and useful Summary of Findings tables for Cochrane Reviews. *J Clin Epidemiol* 2010; 63:607-19.
60. Schwartz LM, Woloshin S, Welch HG. Using a drug facts box to communicate drug benefits and harms: two randomized trials. *Ann Intern Med* 2009; 150:516-27.
61. Brandt L, Vandvik PO, Alonso-Coello P, Akl EA, Thornton J, Rigau D, et al. Multilayered and digitally structured presentation formats of trustworthy recommendations: a combined survey and randomised trial. *BMJ Open* 2017; 7:e011569.
62. Akl EA, Oxman AD, Herrin J, Vist GE, Terrenato I, Sperati F, et al. Using alternative statistical formats for presenting risks and risk reductions. *Cochrane Database Syst Rev* 2011; CD006776.

63. Woloshin S, Schwartz LM. Communicating data about the benefits and harms of treatment: a randomized trial. *Ann Intern Med* 2011; 155:87-96.
64. Guyatt GH, Thorlund K, Oxman AD, Walter SD, Patrick D, Furukawa TA, et al. GRADE guidelines: 13. Preparing Summary of Findings tables and evidence profiles - continuous outcomes. *J Clin Epidemiol* 2013; 66:173-83.
65. Guyatt GH, Juniper EF, Walter SD, Griffith LE, Goldstein RS. Interpreting treatment effects in randomised trials. *BMJ* 1998; 316:690-3.
66. Mayer M. Continuous outcome measures: conundrums and conversions contributing to clinical application. *BMJ Evid Based Med* 2019; pii:bmjebm-2018-111136.
67. Sun X, Briel M, Busse JW, et al. Credibility of claims of subgroup effects in randomised controlled trials: systematic review. *BMJ* 2012; 344:doi:10.1136/bmj.e155.
68. Sun X, Ioannidis JP, Agoritsas T, Alba AC, Guyatt G. How to use a subgroup analysis: users' guide to the medical literature. *JAMA* 2014; 311:405-11.
69. Sun X, Briel M, Walter SD, Guyatt GH. Is a subgroup effect believable? Updating criteria to evaluate the credibility of subgroup analyses. *BMJ* 2010; 340:850-4.
70. Oxman AD, Guyatt GH. A consumer's guide to subgroup analyses. *Ann Intern Med* 1992; 116:78-84.
71. Oxman AD. Subgroup analyses: the devil is in the interpretation. *BMJ* 2012; 344:e2022.
72. Freiman JA, Chalmers TC, Smith H Jr, Kuebler RR. The importance of beta, the type II error and sample size in the design and interpretation of the randomized control trial. Survey of 71 "negative" trials. *N Engl J Med* 1978; 299:690-4.
73. Sterne JAC, Davey Smith G. Sifting the evidence—what's wrong with significance tests? *BMJ* 2001; 322:226-31.
74. Alderson P, Chalmers I: Survey of claims of no effect in abstracts of Cochrane reviews. *BMJ* 2003, 326:475.
75. Hauer E. The harm done by tests of significance. *Accid Anal Prev* 2004; 36:495-500.
76. Cummings P, Koepsell TD. P values vs estimates of association with confidence intervals. *Arch Pediatr Adolesc Med* 2010; 164:193-6.
77. Gates S, Ealing E. Reporting and interpretation of results from clinical trials that did not claim a treatment difference; survey of four general medical journals. *OSF Preprints* 2018; doi:10.31219/osf.io/725sz
78. Altman DG, Bland JM. Absence of evidence is not evidence of absence. *BMJ* 1995; 311:485.
79. Cochrane Effective Practice and Organisation of Care (EPOC). Results should not be reported as statistically significant or statistically non-significant. EPOC Resources for review authors, 2017. <http://epoc.cochrane.org/resources/epoc-resources-review-authors>.
80. Canal GY, Gutiérrez RB. The confidence intervals: a difficult matter, even for experts. In: Data and context in statistics education: Towards an evidence-based society, Proceedings of the Eighth International Conference on Teaching Statistics. Ljubljana, Slovenia. Voorburg, The

Netherlands: International Statistical Institute 2010.

https://www.stat.auckland.ac.nz/~iase/publications/icots8/ICOTS8_C143_CANAL.pdf

81. Foster C. Confidence Trick: The interpretation of confidence intervals. *Can J Sci Math Technol Educ* 2014; 14:23-34.
82. Greenland S, Senn SJ, Rothman KJ, Carlin JB, Poole C, Goodman SN, et al. Statistical tests, P values, confidence intervals, and power: a guide to misinterpretations. *Eur J Epidemiol* 2016; 31:337-50.
83. Hoekstra R, Morey RD, Rouder JN, Wagenmakers EJ. Robust misinterpretation of confidence intervals. *Psychon Bull Rev* 2014; 21:1157-64.
84. Schmid CH, Lau J, McIntosh MW, Cappelleri JC. An empirical study of the effect of the control rate as a predictor of treatment efficacy in meta-analysis of clinical trials. *Stat Med* 1998; 17:1923-42.
85. Engels EA, Schmid CH, Terrin N, Olkin I, Lau J. Heterogeneity and statistical significance in meta-analysis: an empirical study of 125 meta-analyses. *Stat Med* 2000; 19:1707-28.
86. Deeks JJ. Issues in the selection of a summary statistic for meta-analysis of clinical trials with binary outcomes. *Stat Med* 2002; 21:1575-600.
87. Furukawa TA, Guyatt GH, Griffith LE. Can we individualize the 'number needed to treat'? An empirical study of summary effect measures in meta-analyses. *Int J Epidemiol* 2002; 31:72-6.
88. Schünemann HJ, Fretheim A, Oxman AD. Improving the use of research evidence in guideline development: 10. Integrating values and consumer involvement. *Health Res Policy Syst* 2006; 4:22.
89. Krahn M, Naglie G. The next step in guideline development: incorporating patient preferences. *JAMA* 2008; 300:436-8.
90. MacLean S, Mulla S, Akl EA, Jankowski M, Vandvik PO, Ebrahim S, et al. Patient values and preferences in decision making for antithrombotic therapy: a systematic review: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. *Chest* 2012; 141(2 Suppl):e1S-e23S.
91. Hoffmann TC, Eructi C, Glasziou PP. Poor description of non-pharmacological interventions: analysis of consecutive sample of randomised trials. *BMJ* 2013; 347:f3755.
92. Hoffmann TC, Walker MF, Langhorne P, Eames S, Thomas E, Glasziou P. What's in a name? The challenge of describing interventions in systematic reviews: analysis of a random sample of reviews of non-pharmacological stroke interventions. *BMJ Open* 2015; 5:e009051.
93. Alonso-Coello P, Schünemann HJ, Moberg J, Brignardello-Petersen R, Akl E, Davoli M, et al. GRADE Evidence to Decision (EtD) frameworks: A systematic and transparent approach to making well-informed healthcare choices. 1. Introduction. *BMJ* 2016; 353:i2016.
94. Alonso-Coello P, Oxman AD, Moberg J, Brignardello-Petersen R, Akl e, Davoli M, et al. GRADE Evidence to Decision (EtD) frameworks: 2. Clinical practice guidelines. *BMJ* 2016; 353:i2089.
95. Parmelli E, Amato L, Oxman AD, Alonso-Coello P, Brunetti M, Moberg J, et al. GRADE Evidence to Decision (EtD) framework for coverage decisions. *Int J Technol Assess Health Care* 2017; 33:176-82.
96. Rosenbaum SE, Moberg J, Glenton C, Schünemann HJ, Lewin S, Akl E, et al. Developing Evidence to Decision frameworks and an interactive Evidence to Decision tool for making and using decisions and recommendations in health care. *Global Challenges* 2018; 10.1002/gch2.201700081.

97. Moberg J, Oxman AD, Rosenbaum S, Schünemann H, Guyatt G, Flottorp S, et al. GRADE Evidence to Decision (EtD) frameworks for health system and public health decisions. *Health Res Policy Syst* 2018; 16:45.
98. Morgan RL, Kelley L, Guyatt GH, Johnson A, Lavis JN. Decision-making frameworks and considerations for informing coverage decisions for healthcare interventions: a critical interpretive synthesis. *J Clin Epidemiol* 2018; 94:143-50.
99. Rehfues EA, Stratil JM, Scheel IB, Portela A, Norris SL, Baltussen R. The WHO-INTEGRATE evidence to decision framework version 1.0: integrating WHO norms and values and a complexity perspective. *BMJ Glob Health* 2019; 4(Suppl 1):e000844.
100. Oxman AD, Paulsen EJ. Who can you trust? A review of free online sources of "trustworthy" information about treatment effects for patients and the public. *BMC Med Inform Decis Mak* 2019; 19:35.
101. Glenton C, Paulsen E, Oxman AD. Portals to Wonderland? Health portals lead confusing information about the effects of health care. *BMC Med Inform Decis Mak* 2005; 5:7.
102. Coulter A, Entwistle V, Gilbert D. Sharing decisions with patients: is the information good enough? *BMJ* 1999; 318:318-22.
103. Shekelle P, Eccles MP, Grimshaw JM, Woolf SH. When should clinical guidelines be updated? *BMJ* 2001; 323:155-7.
104. Gartlehner G, West SL, Lohr KN, Kahwati L, Johnson JG, Harris RP, et al. Assessing the need to update prevention guidelines: a comparison of two methods. *Int J Qual Health Care* 2004; 16:399-406. N
105. Moher D, Tsertsvadze A, Tricco A, Eccles M, Grimshaw J, Sampson M, et al. When and how to update systematic reviews. *Cochrane Database Syst Rev* 2008; MR000023.
106. Peterson K, McDonagh MS, Fu R. Decisions to update comparative drug effectiveness reviews vary based on type of new evidence. *J Clin Epidemiol* 2011; 64:977-84.
107. Chung M, Newberry SJ, Ansari MT, Yu WW, Wu H, Lee J, et al. Two methods provide similar signals for the need to update systematic reviews. *J Clin Epidemiol* 2012; 65:660-8.
108. Pattanittum P, Laopaiboon M, Moher D, Lumbiganon P, Ngamjarus C. A comparison of statistical methods for identifying out-of-date systematic reviews. *PLoS One* 2012; 7:e48894.
109. Beller EM, Chen JK, Wang UL, Glasziou PP. Are systematic reviews up-to-date at the time of publication? *Syst Rev* 2013; 2:36.
110. Bashir R, Surian D, Dunn AG. Time-to-update of systematic reviews relative to the availability of new evidence. *Syst Rev* 2018; 7:195.
111. Bekelman JE, Li Y, Gross CP. Scope and impact of financial conflicts of interest in biomedical research: a systematic review. *JAMA* 2003; 289:454-65.
112. Jørgensen AW, Maric KL, Tendal B, Faurshou A, Gøtzsche PC. Industry-supported meta-analyses compared with meta-analyses with non-profit or no support: differences in methodological quality and conclusions. *BMC Med Res Methodol* 2008; 8:60.
113. Akl EA, El-Hachem P, Abou-Haidar H, Neumann I, Schünemann HJ, Guyatt GH. Considering intellectual, in addition to financial, conflicts of interest proved important in a clinical practice guideline: a descriptive study. *J Clin Epidemiol* 2014; 67:1222-8.
114. Dunn AG, Arachi D, Hudgins J, Tsafnat G, Coiera E, Bourgeois FT. Financial conflicts of interest and conclusions about neuraminidase inhibitors for influenza: an analysis of systematic reviews. *Ann Intern Med* 2014; 161:513-8.

115. Forsyth SR, Odierna DH, Krauth D, Bero LA. Conflicts of interest and critiques of the use of systematic reviews in policymaking: an analysis of opinion articles. *Syst Rev* 2014; 3:122.
116. Viswanathan M, Carey TS, Belinson SE, Berliner E, Chang SM, Graham E, et al. A proposed approach may help systematic reviews retain needed expertise while minimizing bias from nonfinancial conflicts of interest. *J Clin Epidemiol* 2014; 67:1229-38.
117. Hakoum MB, Anouti S, Al-Gibbawi M, Abou-Jaoude EA, Hasbani DJ, Lopes LC, et al. Reporting of financial and non-financial conflicts of interest by authors of systematic reviews: a methodological survey. *BMJ Open* 2016; 6:e011997.
118. Lieb K, von der Osten-Sacken J, Stoffers-Winterling J, Reiss N, Barth J. Conflicts of interest and spin in reviews of psychological therapies: a systematic review. *BMJ Open* 2016; 6:e010606.
119. Mandrioli D, Kearns CE, Bero LA. Relationship between research outcomes and risk of bias, study sponsorship, and author financial conflicts of interest in reviews of the effects of artificially sweetened beverages on weight outcomes: a systematic review of reviews. *PLoS One* 2016; 11:e0162198.
120. Lundh A, Lexchin J, Mintzes B, Schroll JB, Bero L. Industry sponsorship and research outcome. *Cochrane Database Syst Rev* 2017; MR000033.
121. Hansen C, Lundh A, Rasmussen K, Gøtzsche PC, Hróbjartsson A. The influence of industry funding and other financial conflicts of interest on the outcomes and quality of systematic reviews. In: Peer Review Congress 2017. <https://peerreviewcongress.org/prc17-0222>