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SESSIONE I:
EVIDENCE BASED MEDICINE e Medicina d'Urgenza

Ruolo della Cochrane Collaboration nel fornire evidenze

Vittorio Demicheli
Cochrane Vaccines Field

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Is an international organisation that aims to help people make well-informed decisions about healthcare by preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions

È un'organizzazione internazionale il cui scopo è aiutare le persone a prendere decisioni ben informate sull'assistenza sanitaria preparando, favorendo e mantenendo l'accessibilità di revisioni sistematiche sugli effetti degli interventi sanitari

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- **ispirata all'attività di Archie Cochrane**
- **organizzazione internazionale, multidisciplinare, fondata sul volontariato e la collaborazione**
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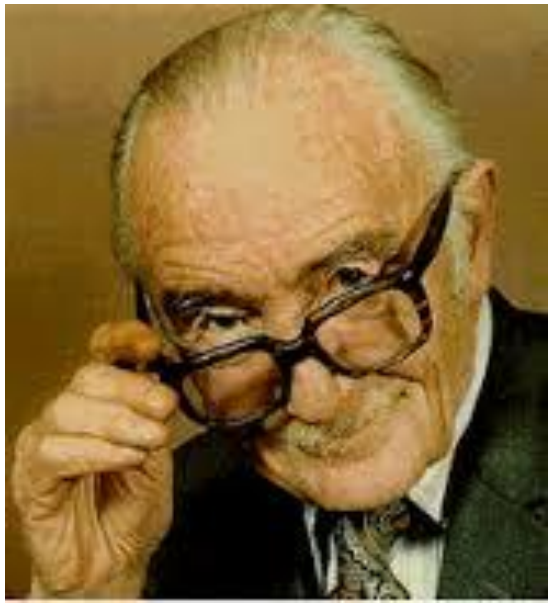

"Society should privilege interventions which are proved to be effective and efficient"

(Rock Carling Lecture - March 20, 1972)

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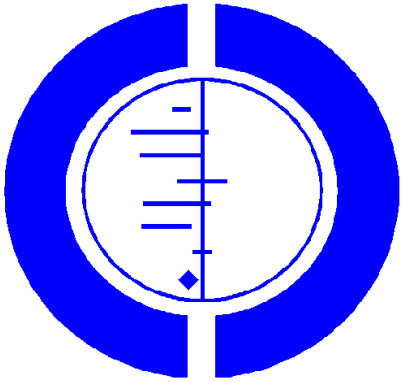
2	Building on the enthusiasm of individuals	by involving, supporting and training people of different skills and backgrounds.
3	Avoiding duplication of effort	by good management, co-ordination and effective internal communications to maximise economy of effort.
4	Minimising bias	through a variety of approaches such as scientific rigour, ensuring broad participation, and avoiding conflicts of interest.
5	Keeping up-to-date	by a commitment to ensure that Cochrane Systematic Reviews are maintained through identification and incorporation of new evidence.
6	Striving for relevance	by promoting the assessment of health questions using outcomes that matter to people making choices in health and health care.
7	Promoting access	by wide dissemination of our outputs, taking advantage of strategic alliances, and by promoting appropriate access models and delivery solutions to meet the needs of users worldwide.
8	Ensuring quality	by applying advances in methodology, developing systems for quality improvement, and being open and responsive to criticism.
9	Continuity	by ensuring that responsibility for reviews, editorial processes and key functions is maintained and renewed.
10	Enabling wide participation	in our work by reducing barriers to contributing and by encouraging diversity.



Il logo della Collaborazione Cochrane illustra una revisione sistematica di dati di 7 RCT che confrontano un trattamento sanitario con un placebo. Il “rombo” rappresenta i risultati combinati

lo scopo della Collaborazione Cochrane è quello di raccogliere, valutare criticamente e diffondere le informazioni relative all'efficacia degli interventi sanitari

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Central Executive Team Cochrane contributors Evidence-based health care

Watch a video about the aims of and thinking around the *Strategy to 2020*

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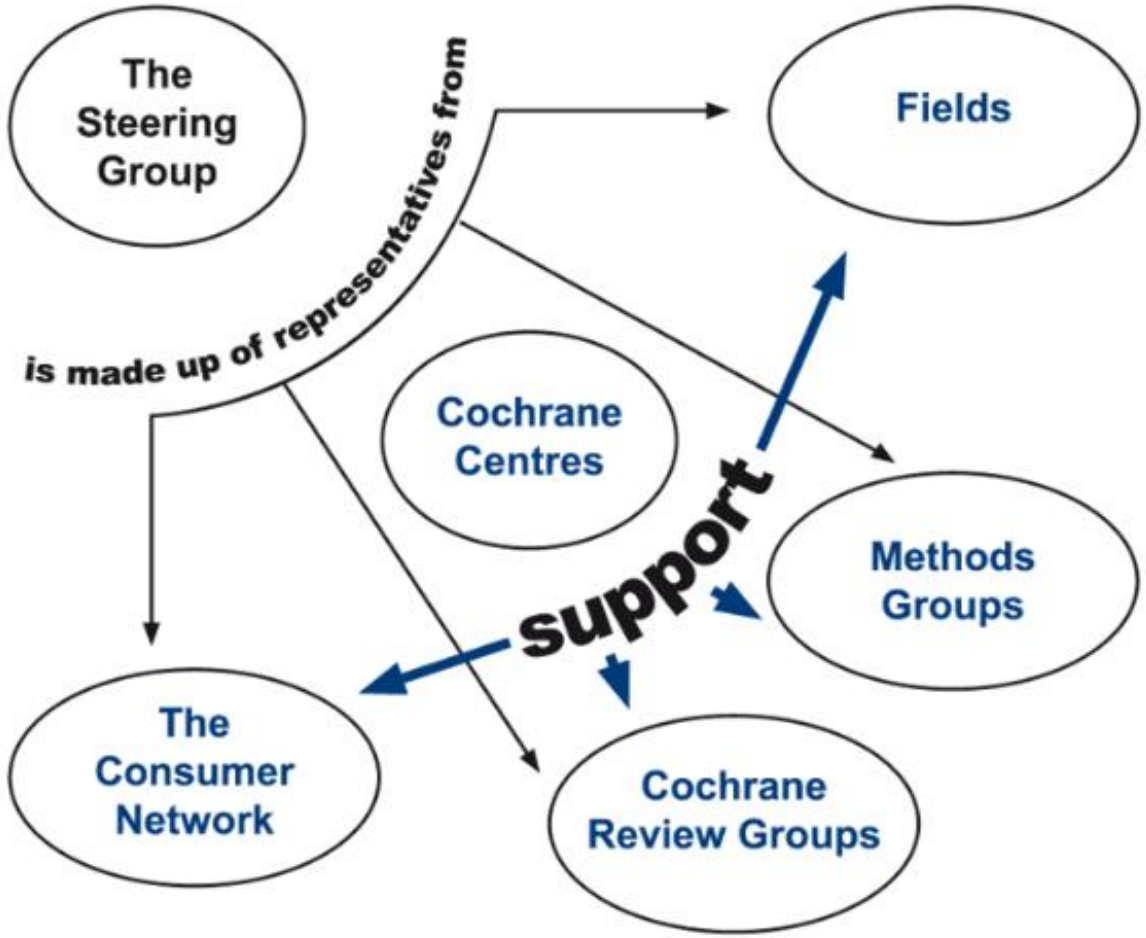
- **The production of high-quality evidence;**
- **On making Cochrane evidence accessible and useful to everyone, everywhere in the world; and**
- **On making Cochrane the 'home of evidence' to enable informed decision making.**

The fourth goal, which underpins and supports the other three, centres around:

- **Building an organisation that is effective and sustainable in a rapidly evolving and increasingly complex healthcare and publishing environment.**

Structure of the Collaboration's groups



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- **31000** operatori sanitari, ricercatori e rappresentanti di associazioni di pazienti
- **100** Paesi del mondo

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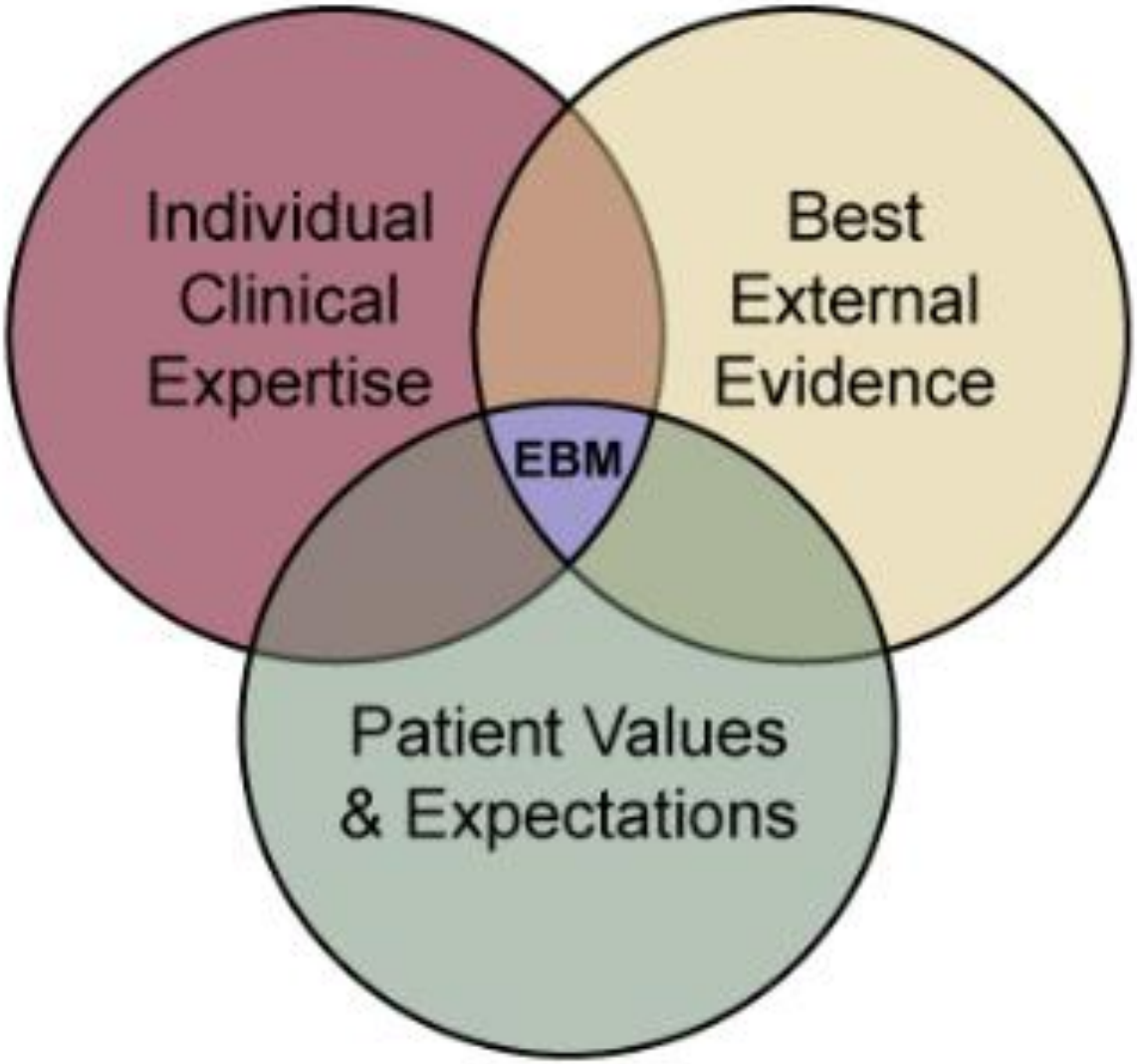
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REVISIONI SISTEMATICHE

Impiego di metodi espliciti per identificare, localizzare, procurare e analizzare dati pubblicati o meno sugli effetti di un intervento sanitario allo scopo di minimizzare i bias e generalizzare le conclusioni

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24 hours | **7 days** | 30 days | 3 months

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1. Vaccines to prevent influenza in healthy adults (1132)
2. Presión positiva al final de la expiración (PEEP) durante la anestesia para la prevención de la mortalidad y las complicaciones pulmonares posoperatorias | Resúmenes Cochrane (316)
3. Rééducation après fracture de la cheville chez l'adulte | Résumés Cochrane (228)
4. Exercise for depression (202)
5. Les antibiotiques pour prévenir les complications après des extractions de dent | Résumés Cochrane (181)
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14. Traitements topiques pour le lichen scléreux génital | Résumés Cochrane (116)
15. Speech and language therapy interventions for children with primary speech and language delay or disorder (109)
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18. Combinations of topical fluoride (toothpastes, mouthrinses, gels, varnishes) versus single topical fluoride for preventing dental caries in children and adolescents (100)

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About The Cochrane Library

Cochrane Reviews are published in *The Cochrane Library* – an online collection of databases that brings together in one place rigorous and up-to-date research on the effectiveness of healthcare treatments and interventions, as well as methodology and diagnostic tests.

There are over 5,000 Cochrane Reviews currently available in *The Cochrane Library*.

This is an incredible figure since each review takes hundreds of hours and a whole team of people to produce. Over 2,000 protocols for Cochrane Reviews are also available, providing an explicit description of the research methods and objectives for Cochrane Reviews in progress.

'ISI Impact Factor' is an internationally recognised tool for ranking, evaluating and comparing journals in all subject areas. The 2012 Impact Factor for the CDSR was announced as 5.785. The CDSR is ranked 11 of 151 journals in the "Medicine, General & Internal" category of the Journal Citation Reports® (JCR).

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Issue 11 of 12, November 2014

(Updated Daily) | Contents

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- Child health (1759)
- Complementary & alternative medicine (598)
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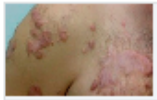
- Dentistry & oral health (161)
- Developmental, psychosocial & learning problems (126)

SPECIAL COLLECTIONS


Malaria diagnosis and treatment


Malaria prevention and control


World No Tobacco Day


Cochrane Evidence Aid: resources for burns

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EDITORIALS

#CochraneTech: technology and the future of systematic reviews

Julian Elliott, Ida Sim, Jessica Thomas, Nancy Owens, Gordon Dooley, Jacob Riis, Byron Wallace, James Thomas, Anna Noel-Storr, Gabriel Rada, Caroline Struthers, Tracey Howe, Harriet MacLehose, Linn Brandt, Ilkka Kunnamo & Chris Mavergames

A clearer view of evidence in treating macular degeneration: off-label policies and independent research

Giulio Formoso, Anna Maria Marata, Nicola Magrini & Lisa Bero

When trial authors write Cochrane Reviews: competing

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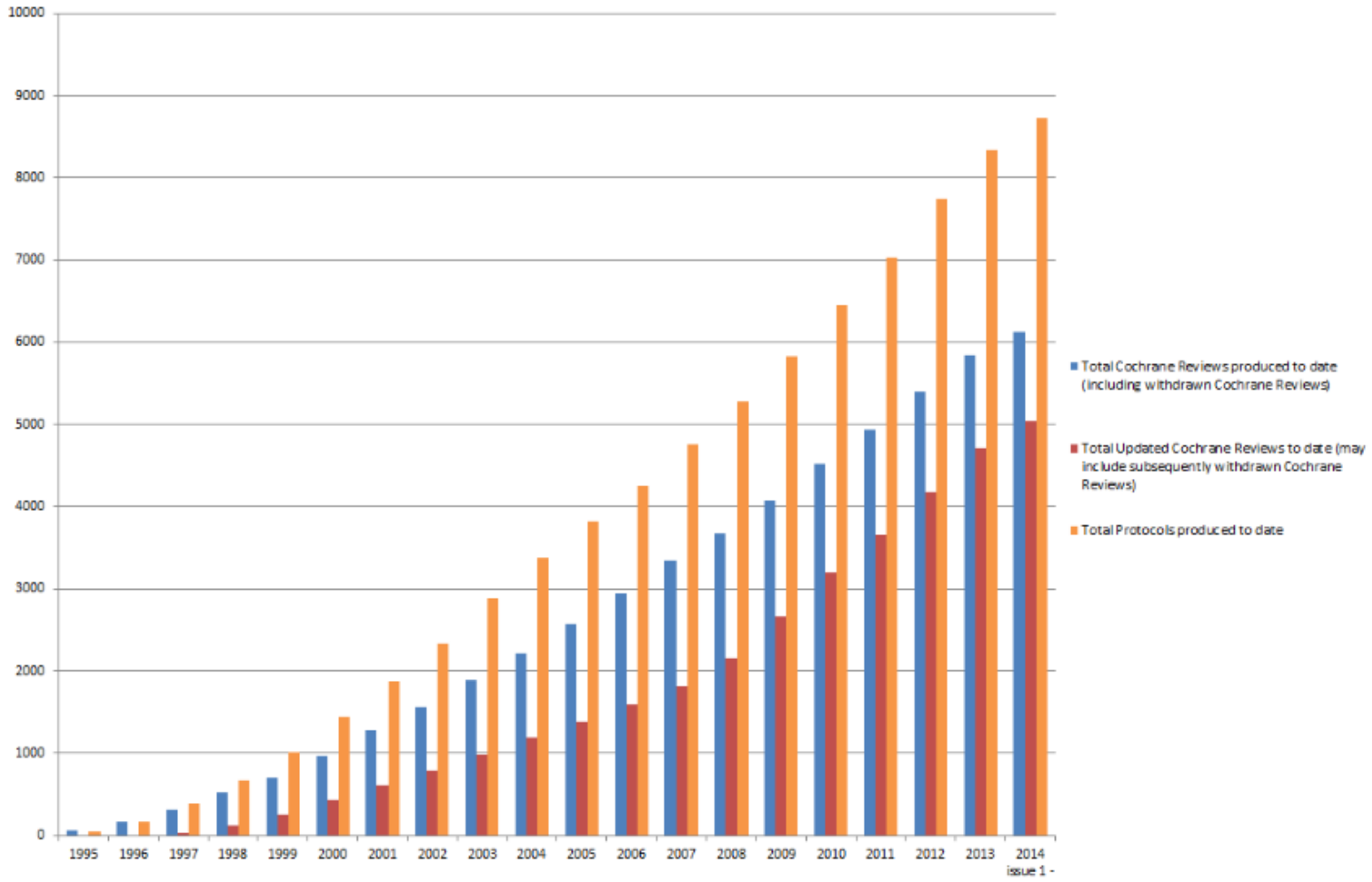
Cochrane Database of Systematic Reviews: total Cochrane Reviews and Protocols



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COCHRANE CENTRAL REGISTER OF CONTROLLED TRIALS (CENTRAL)

Search for trials **Issue 10 of 12, October 2014**

Link to Known Issues regarding CENTRAL

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Methods Studies **Issue 4 of 4, Oct 2012**

Technology Assessments **Issue 4 of 4 Oct 2014**

Economic Evaluations

Cochrane Groups **Issue 10 of 12, Oct 2014**

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Title, Abstract, Keywords | * | Go | Save

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All Results (904080)

- Cochrane Reviews (6156)
  - All
  - Review
  - Protocol
- Other Reviews (32932)
- Trials (818236)
- Methods Studies (15764)
- Technology Assessments (14267)
- Economic Evaluations (16644)
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Cochrane Database of Systematic Reviews : Issue 10 of 12, October 2014

Issue *updated daily* throughout month

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An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes

Gerd Flodgren , Martin P Eccles , Sasha Shepperd , Anthony Scott , Elena Parmelli and Fiona R Beyer

Online Publication Date: July 2011

Review | Ov

All Results (904080)

- (•) Cochrane Reviews (6156)
  - ( ) All
  - (•) Review
  - ( ) Protocol
- ( ) Other Reviews (32932)
- ( ) Trials (818236)
- ( ) Methods Studies (15764)
- ( ) Technology Assessments (14267)
- ( ) Economic Evaluations (16644)
- ( ) Cochrane Groups (81)

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Documentazione e ricerca per i professionisti della salute

Benvenuto Demicheli Vittorio **Cambia password**

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07 ottobre 2014
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Il Pensiero Scientifico Editore segnala un interessante articolo su questo tema.

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PERIODICI ELETTRONICI

Intervention Review

Helicopter emergency medical services for adults with major trauma

Samuel M Galvagno Jr[1,*], Stephen Thomas[2], Christopher Stephens[3], Elliott R Haut[4], Jon M Hirshon[5], Douglas Floccare[6], Peter Pronovost[7]

Database Title
The Cochrane Library

Editorial Group: Cochrane Injuries Group

Published Online: 28 MAR 2013

Assessed as up-to-date: 24 JAN 2012

DOI: 10.1002/14651858.CD009228.pub2

Abstract

Jump to...

Background

Although helicopters are presently an integral part of trauma systems in most developed nations, previous reviews and studies to date have raised questions about which groups of traumatically injured patients derive the greatest benefit.

Objectives

The purpose of this review is to determine if helicopter emergency medical services transport (HEMS) is associated with improved morbidity and mortality, compared to ground emergency medical services transport (GEMS), for adults with major trauma. The primary outcome was survival to hospital discharge. Secondary outcomes were quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs).

Search methods

Searches were run in CENTRAL, MEDLINE, EMBASE, CINAHL (EBSCOhost), SCI-EXPANDED, CPCI-S, and ZETOC in January 2012. Relevant websites were also searched, including controlled trials registers, HSRProj, the World Health Organization (WHO) ICTRP, and OpenSIGLE. Searches were not restricted by date, language, or publication status. Attempts were made to contact authors in the case of missing data.

Selection criteria

Eligible trials included randomised controlled trials (RCTs) and non-randomised intervention studies. Non-randomised studies (NRS), including controlled trials and cohort studies, were also evaluated. Each study was required to have a GEMS comparison group. An injury severity score (ISS) > 15 or an equivalent marker for injury severity was required. Only adults aged 16 years or older were included.

Data collection and analysis

Three review authors independently extracted data and assessed the risk of bias of included studies. The Downs and Black quality assessment tool was applied for NRS. The results were analysed in a narrative review, and with studies grouped by methodology and injury type. A predefined subgroup was comprised of four additional studies that examined the role of HEMS versus GEMS for inter-facility transfer. Summary of findings tables were constructed in accordance with the GRADE Working Group criteria.

Main results

Twenty-five studies met the entry criteria for this review. Four additional studies met the criteria for a separate, predefined subgroup analysis of patients transferred to trauma centres by HEMS or GEMS. All studies were non-randomised studies; no RCTs were found. Survival at hospital discharge was the primary outcome. Data from 163,748 people from 21 of the 25 studies included in the primary analysis were available to calculate unadjusted mortality. Overall, considerable heterogeneity was observed and an accurate estimate of overall effect could not be determined. Based on the unadjusted mortality data from five trials that focused on traumatic brain injury, there was no decreased risk of death with HEMS (relative risk (RR) 1.02; 95% CI 0.85 to 1.23). Nine studies used multivariate regression to adjust for confounding, the five largest indicated a statistically significant increased odds of survival associated with HEMS. All Trauma-Related Injury Severity Score (TRISS)-based studies indicated improved survival in the HEMS group as compared to the Major Trauma Outcomes Study (MTOS) cohort; some studies showed survival benefits in both the HEMS and GEMS groups as compared to MTOS. No studies were found to evaluate the secondary outcome of morbidity as assessed by QALYs and DALYs. All four studies suggested a positive benefit when HEMS was used to transfer patients to higher level trauma centres. Overall, the quality of the included studies was very low as assessed by the GRADE Working Group criteria.

Authors' conclusions

Due to the methodological weakness of the available literature, and the considerable heterogeneity of effects and study methodologies, an accurate composite estimate of the benefit of HEMS could not be determined. Although five of the nine multivariate regression studies indicated improved survival associated with HEMS, the remainder did not. All were subject to a low quality of evidence as assessed by the GRADE Working Group criteria due to their non-randomised design. Similarly, TRISS-based studies, which all demonstrated improved survival, cannot be considered strong evidence because of their methodology, which did not randomize the use of HEMS. The question of which elements of HEMS may be beneficial for patients has not been fully answered. The results from this review provide motivation for future work in this area. This includes an ongoing need for diligent reporting of research methods, which is imperative for transparency and to maximise the potential utility of results. Large, multicentre studies are warranted as these will help produce more robust estimates of treatment effects. Future work in this area should also examine the costs and safety of HEMS, since multiple contextual determinants must be considered when evaluating the effects of HEMS for adults with major trauma.

Plain language summary

Jump to...

Helicopter emergency medical services for adults with major trauma

Trauma is a leading cause of death and disability worldwide and, since the 1970s, helicopters have been used to transport people with injuries to hospitals that specialise in trauma care. Helicopters offer several potential advantages, including faster transport to expert medical care and treatment en route to the hospital by providers who are specifically trained in trauma management. Twenty-five studies conducted internationally compared transport by helicopter emergency medical services to transport by ground emergency medical services (an ambulance), with both types of service aiming to improve either survival or disability for seriously injured patients. Some of these studies indicated some benefit of helicopter transport for survival after major trauma, but others did not. The studies were of varying sizes and different methods were used to determine if more patients survived when transported by helicopter versus ground ambulances. Some studies included helicopter teams that had specialised physicians on board whereas other helicopter crews were staffed by paramedics and nurses. Furthermore, patients transported by helicopter or ground emergency medical services had varying numbers and types of procedures en route to the trauma centre. The use of some of these procedures, such as the placement of a breathing tube, may have helped improve survival in some of the studies. Overall the quality of the included studies was low. Helicopter transport for some trauma patients may be beneficial for a variety of reasons and more research is required to determine what elements of helicopter transport help improve outcomes. The results from future research might help in better allocation of the helicopter transport resource with increased safety and decreased costs.

Résumé

Jump to...

Services médicaux d'urgence par hélicoptère pour les adultes présentant un traumatisme majeur

Lives saved by helicopter emergency medical services: an overview of literature (Structured abstract)

Centre for Reviews and Dissemination

Database of Abstracts of Reviews of Effects 2014 Issue 4

Original article:Ringburg AN, Thomas SH, Steyerberg EW, van Lieshout EM, Patka P, Schipper IB. Lives saved by helicopter emergency medical services: an overview of literature. Air Medical Journal.2009;28(6):298-302

CRD summary

This review concluded that there was a clear positive effect on survival associated with helicopter emergency medical services assistance. Possible language and publication bias, poor reporting and unclear reliability of the statistical methods used suggest the authors' conclusions may not be reliable

Intervention Review

Primary care professionals providing non-urgent care in hospital emergency departments

Jaspreet K Khangura[1,*], Gerd Flodgren[2], Rafael Perera[3], Brian H Rowe[4], Sasha Shepperd[5]

Editorial Group: Cochrane Effective Practice and Organisation of Care Group

Published Online: 14 NOV 2012

Assessed as up-to-date: 28 APR 2011

DOI: 10.1002/14651858.CD002097.pub3

Database Title

The Cochrane Library

Additional Information (Show All)

Abstract

Background

In many countries emergency departments (EDs) are facing an increase in demand for services, long-waits and severe crowding. One response to mitigate overcrowding has been to provide primary care services alongside or within hospital EDs for patients with non-urgent problems. It is not known, however, how this impacts the quality of patient care, the utilisation of hospital resources, or if it is cost-effective.

Objectives

To assess the effects of locating primary care professionals in the hospital ED to provide care for patients with non-urgent health problems, compared with care provided by regular Emergency Physicians (EPs),

Search methods

We searched the Cochrane Effective Practice and Organisation of Care (EPOC) Group Specialized register; Cochrane Central Register of Controlled Trials (The Cochrane library, 2011, Issue 4), MEDLINE (1950 to March 21 2012); EMBASE (1980 to April 28 2011); CINAHL (1980 to April 28 2011); PsychINFO (1967 to April 28 2011); Sociological Abstracts (1952 to April 28 2011); ASSIA (1987 to April 28 2011); SSSCI (1945 to April 28 2011); HMIC (1979 to April 28 2011), sources of unpublished literature, reference lists of included papers and relevant systematic reviews. We contacted experts in the field for any published or unpublished studies, and hand searched ED conference abstracts from the last three years.

Selection criteria

Randomised controlled trials, non-randomised studies, controlled before and after studies and interrupted time series studies that evaluated the effectiveness of introducing primary care professionals to hospital EDs to attend to non-urgent patients, as compared to the care provided by regular EPs.

Data collection and analysis

Two reviewers independently extracted data and assessed the risk of bias for each included study. We contacted authors of included studies to obtain additional data. Dichotomous outcomes are presented as risk ratios (RR) with 95% confidence intervals (CIs) and continuous outcomes are presented as mean differences (MD) with 95% CIs. Pooling was not possible due to heterogeneity.

Main results

Three non randomised controlled studies involving a total of 11 203 patients, 16 General Practioners (GPs), and 52 EPs, were included. These studies evaluated the effects of introducing GPs to provide care to patients with non-urgent problems in the ED, as compared to EPs for outcomes such as resource use. The quality of evidence for all outcomes in this review was low, primarily due to the non-randomised design of included studies.

The outcomes investigated were similar across studies; however there was high heterogeneity (I^2>86%). Differences across studies included the triage system used, the level of expertise and experience of the medical practitioners and type of hospital (urban teaching, suburban community hospital).

Two of the included studies report that GPs used significantly fewer healthcare resources than EPs, with fewer blood tests (RR 0.22; 95%CI: 0.14 to 0.33; N=4641; RR 0.35; 95%CI 0.29 to 0.42; N=4684), x-rays (RR 0.47; 95% CI 0.41 to 0.54; N=4641; RR 0.77 95% CI 0.72 to 0.83; N=4684), admissions to hospital (RR 0.33; 95% CI 0.19 to 0.58; N=4641; RR 0.45; 95% CI 0.36 to 0.56; N=4684) and referrals to specialists (RR 0.50; 95% CI 0.39 to 0.63; N=4641; RR 0.66; 95% CI 0.60 to 0.73; N=4684). One of the two studies reported no statistically significant difference in the number of prescriptions made by GPs compared with EPs, (RR 0.95 95% CI 0.88 to 1.03; N=4641), while the other showed that GPs prescribed significantly more medications than EPs (RR 1.45 95% CI 1.35 to 1.56; N=4684). The results from these two studies showed marginal cost savings from introducing GPs in hospital EDs.

The third study (N=1878) failed to identify a significant difference in the number of blood tests ordered (RR 0.96; 95% CI 0.76 to 1.2), x-rays (RR 1.07; 95%CI 0.99 to 1.15), or admissions to hospital (RR 1.11; 95% CI 0.70 to 1.76), but reported a significantly greater number of referrals to specialists (RR 1.21; 95% CI 1.09 to 1.33) and prescriptions (RR 1.12; 95% CI 1.01 to 1.23) made by GPs as compared with EPs.

No data were reported on patient wait-times, length of hospital stay, or patient outcomes, including adverse effects or mortality.

Authors' conclusions

Overall, the evidence from the three included studies is weak, as results are disparate and neither safety nor patient outcomes have been examined. There is insufficient evidence upon which to draw conclusions for practice or policy regarding the effectiveness and safety of care provided to non-urgent patients by GPs versus EPs in the ED to mitigate problems of overcrowding, wait-times and patient flow.

Plain language summary

Jump to...

Does employing general practitioners to provide care for patients with non-urgent problems in emergency departments decrease resource use and costs?

An important portion of patients who attend hospital emergency departments (EDs) present with health problems that are classified as non-urgent. With many EDs experiencing long-waits and overcrowding, it has been suggested that providing primary care services in EDs for patients with non-urgent problems may be an efficient and cost-effective alternative to emergency care.

This review included three non-randomised studies, involving a total of 11 203 patients, 16 General Practitioners (GPs), and 52 Emergency Physicians (EPs), evaluating the effects of introducing GPs to provide care for patients with non-urgent problems in the ED, compared to EPs. The reported outcomes were similar across studies, however, pooling of the results was not feasible due to differences among the studies. Hence, we present the results as individual study risk ratios (RRs).

Two studies, involving 9325 patients and conducted at urban-teaching hospitals, demonstrated that GPs order less blood tests and x-rays and admit fewer patients to hospital. In addition, these studies demonstrated that EPs referred more patients and prescribed more medications than GPs. These two studies showed marginal cost savings of the intervention and provided limited evidence on patients' self-reported health outcomes.

A third study reported no differences between the two approaches with respect to blood tests, x-rays or hospitalizations. It did show that GPs referred more patients and prescribed more medications than EPs. This study involved fewer participants (1878), and used an unstructured triage system which may have led to misclassification of patients into urgent and non-urgent groups.

None of the included studies provided data on patient wait-times, length of hospital stay, adverse effects or mortality. Overall, the evidence is of very low quality, the safety has not been thoroughly examined and results are disparate. The evidence suggests that there is insufficient basis upon which to draw conclusions regarding the effectiveness and safety of care provided by GPs versus EPs for non-urgent patients in the ED.

Effectiveness of organizational interventions to reduce emergency department utilization: a systematic review (Structured abstract)

Centre for Reviews and Dissemination

Database of Abstracts of Reviews of Effects 2014 Issue 4

Original article:Flores-Mateo G, Violan-Fors C, Carrillo-Santisteve P, Peiro S, Argimon JM. Effectiveness of organizational interventions to reduce emergency department utilization: a systematic review. PLOS ONE.2012;7(5):e35903

CRD summary

This review examined the effectiveness of screening for domestic violence (DV) in the emergency department. The authors concluded that, owing to the paucity of research, there is insufficient evidence for or against DV screening. Although the review may be subject to a number of potential biases, the authors' conclusions appear balanced in light of the evidence presented.

Can primary care and community-based models of emergency care substitute for the hospital accident and emergency (A & E) department? (Structured abstract)

Centre for Reviews and Dissemination

Database of Abstracts of Reviews of Effects 2014 Issue 4

Original article:Roberts E, Mays N. Can primary care and community-based models of emergency care substitute for the hospital accident and emergency (A & E) department?. 1998;44(3):191-214.

Authors' conclusions

Emergency care provided by primary care or in the community can be used as an alternative to hospital AE care. Demand for hospital AE care may be reduced by broadening access to primary care and introducing user charges or other barriers for hospital AE attenders, but these interventions have not been costed. Employing GPs in hospital AE departments may be cost-effective. There was little evidence on telephone triage, minor injury units and GP out-of-hours cooperatives.

Advanced life support versus basic life support in the pre-hospital setting: a meta-analysis (Structured abstract)

Centre for Reviews and Dissemination

Database of Abstracts of Reviews of Effects 2014 Issue 4

Original article: Bakalos G, Mamali M, Komninos C, Koukou E, Tsantilas A, Tzima S, Rosenberg T. Advanced life support versus basic life support in the pre-hospital setting: a meta-analysis. *Resuscitation*.2011;**82**(9):1130-1137.

CRD summary

This review concluded that compared to basic life support, advanced life support in the pre-hospital setting can increase the chances of survival for non-traumatic cardiac arrest patients. Advanced life support for trauma patients was not associated with increased survival. The conclusions should be interpreted with caution due to concerns about study quality, the review reporting and heterogeneity

Preventive care in the emergency department. Screening and brief intervention for alcohol problems in the emergency department: a systematic review (Structured abstract)

Centre for Reviews and Dissemination
Database of Abstracts of Reviews of Effects 2014 Issue 4

Original article:D'Onofrio G, Degutis L C. Preventive care in the emergency department. Screening and brief intervention for alcohol problems in the emergency department: a systematic review. Academic Emergency Medicine.2002;9(6):627-638

Results of the review

Twenty-seven studies were included. Of these, 21 (n=6,244) were classified as RCTs and 6 (n=1,374) were cohort studies. Studies included in a previous report (see Other Publications of Related Interest) were also included. This gave a total of 30 RCTs and 9 cohort studies.

Of the 39 studies included, 32 showed a beneficial effect on one or more of the outcomes assessed: 12 showed a decrease in morbidity and mortality (the primary outcome), 29 showed a decrease in alcohol consumption, 4 showed a decrease in ED or out-patient visits and hospitalisations, 4 showed a decrease in social consequence, and 4 showed an increase in referrals. The authors did not report the number of studies that found either no benefit or a negative effect of the intervention. The effects on each outcomes reported in the individual trials were summarised in a table, but this was difficult to interpret.

Authors' conclusions

The review has demonstrated the efficacy of screening and brief intervention

Preventive care in the emergency department: screening for domestic violence in the emergency department (Structured abstract)

Centre for Reviews and Dissemination

Database of Abstracts of Reviews of Effects 2014 Issue 4

Original article:Anglin D, Sachs C. Preventive care in the emergency department: screening for domestic violence in the emergency department. Academic Emergency Medicine.2003;10(10):1118-1127.

CRD summary

This review examined the effectiveness of screening for domestic violence (DV) in the emergency department. The authors concluded that, owing to the paucity of research, there is insufficient evidence for or against DV screening. Although the review may be subject to a number of potential biases, the authors' conclusions appear balanced in light of the evidence presented.

JAMA The Journal of the American Medical Association

ARTICLE | November 4, 1992

Evidence-Based Medicine

A New Approach to Teaching the Practice of Medicine

Gordon Guyatt, MD, MSc; John Cairns, MD; David Churchill, MD, MSc; Deborah Cook, MD, MSc; Brian Haynes, MD, MSc, PhD; Jack Hirsh, MD; Jan Irvine, MD, MSc; Mark Levine, MD, MSc; Mitchell Levine, MD, MSc; Jim Nishikawa, MD; David Sackett, MD, MSc; Patrick Brill-Edwards, MD; Hertzel Gerstein, MD, MSc; Jim Gibson, MD; Roman Jaeschke, MD, MSc; Anthony Kerigan, MD, MSc; Alan Neville, MD; Akbar Panju, MD; Allan Detsky, MD, PhD; Murray Enkin, MD; Pamela Frid, MD; Martha Gerrity, MD; Andreas Laupacis, MD, MSc; Valerie Lawrence, MD; Joel Menard, MD; Virginia Moyer, MD; Cynthia Mulrow, MD; Paul Links, MD, MSc; Andrew Oxman, MD, MSc; Jack Sinclair, MD; Peter Tugwell, MD, MSc

JAMA. 1992;268(17):2420-2425. doi:10.1001/jama.1992.03490170092032.

JAMA The Journal of the American Medical Association

November 4, 1992, Vol 268, No. 17 >

Un nuovo paradigma?

Sapere in continua evoluzione, imparare il metodo

Fare solo ciò che dicono le revisioni sistematiche…

MD; Virginia Moyer, MD; Cynthia Mulrow, MD; Paul Links, MD, MSc; Andrew Oxman, MD, MSc; Jack Sinclair, MD; Peter Tugwell, MD, MSc

JAMA. 1992;268(17):2420-2425. doi:10.1001/jama.1992.03490170092032.

BMJ

BMJ 2014;348:g3725 doi: 10.1136/bmj.g3725 (Published 13 June 2014)

ANALYSIS

ESSAY

Evidence based medicine: a movement in crisis?

Trisha Greenhalgh and colleagues argue that, although evidence based medicine has had many benefits, it has also had some negative unintended consequences. They offer a preliminary agenda for the movement's renaissance, refocusing on providing useable evidence that can be combined with context and professional expertise so that individual patients get optimal treatment

BMJ

BMJ 2014;348:g3725 doi: 10.1136/bmj.g3725 (Published 13 June 2014)

Uso strumentale del termine

Iperproduzione di studi

Vantaggi terapeutici irrilevanti

Pazienti più vecchi e più complicati

All Results (904080)

- (•) Cochrane Reviews (6156)
  - ( ) All
  - (•) Review
  - ( ) Protocol
- ( ) Other Reviews (32932)
- ( ) Trials (818236)
- ( ) Methods Studies (15764)
- ( ) Technology Assessments (14267)
- ( ) Economic Evaluations (16644)
- ( ) Cochrane Groups (81)