Glossary

Blinding (masking): in an experimental study, refers to whether patients, clinicians providing an intervention, people assessing outcomes, and/or data analysts were aware or unaware of the group to which patients were assigned. In the methods section of *Evidence-Based Nursing* abstracts of treatment studies, the study is identified as blinded, with specification of who was blinded; unblinded, if all parties were aware of patients' group assignments; or unclear if the authors did not report or provide us with an indication of who was aware or unaware of patients' group assignments.

Concealment of randomisation: concealment of randomisation is specified in the methods section of *Evidence-Based Nursing* abstracts of treatment studies as follows: *allocation concealed* (deemed to have taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, central randomisation; sequentially numbered, opaque, sealed envelopes; sealed envelopes from a closed bag; numbered or coded bottles or containers; drugs prepared by the pharmacy; or other descriptions that contain elements convincing of concealment]); *allocation not concealed* (deemed to have not taken adequate measures to conceal allocation to study group assignments from those responsible for assessing patients for entry in the trial [ie, no concealment procedure was undertaken, sealed envelopes that were not opaque or were not sequentially numbered, or other descriptions that contained elements not convincing of concealment]); *unclear allocation concealment* (the authors did not report or provide a description of an allocation concealment approach that allowed for the classification as concealed or not concealed).

Confidence interval (CI): quantifies the uncertainty in measurement; usually reported as 95% CI, which is the range of values within which we can be 95% sure that the true value for the whole population lies.

Fixed-effects model[1]: gives a summary estimate of the magnitude of effect in meta-analysis. It takes into account within-study variation but not between-study variation and hence is usually not used if there is significant heterogeneity.

Inception cohort: a defined, representative sample of patients is assembled for a study at a common (ideally early) point in their disease or condition and followed up over time.

Hazard ratio[2]: the weighted relative risk over the entire study period; often reported in the context of survival analysis

Heterogeneity[1]: the degree to which the effect estimates of individual studies in a meta-analysis differ significantly.

Intention-to-treat analysis (ITT): all patients are analysed in the groups to which they were randomised, even if they failed to complete the intervention or received the wrong intervention.

Number needed to harm (NNH)[3]: number of patients who, if they received the experimental treatment, would lead to 1 additional person being harmed compared with patients who receive the control treatment; this is calculated as 1/absolute risk increase (rounded to the next whole number), accompanied by the 95% confidence interval.

Number needed to treat (NNT): number of patients who need to be treated to prevent 1 additional negative event (or to promote 1 additional positive event); this is calculated as 1/absolute risk reduction (rounded to the next whole number), accompanied by the 95% confidence interval.

Participatory action research: action oriented research in which the researchers and participants are partners in developing the question, intervention, and evaluation.

Power[4]: the ability of a study to detect an actual effect or difference between groups; it has to do with the adequacy of sample size. Before a study begins, researchers often calculate the number of participants required to detect a difference between 2 groups. If a study has insufficient power (ie, sample size is too small), actual differences between groups may not be detected.

Random-effects model[1]: gives a summary estimate of the magnitude of effect in meta-analysis. It takes into account both within-study and between-study variance and gives a wider confidence interval to the estimate than a fixed-effects model if there is significant between-study variation.

Relative benefit increase (RBI): the proportional increase in the rates of good events between experimental and control participants; it is reported as a percentage (%).

Relative risk (RR): proportion of patients experiencing an outcome in the treated (or exposed) group divided by the proportion experiencing the outcome in the control (or unexposed) group.

Relative risk increase (RRI): the proportional increase in bad outcomes between experimental and control participants; it is reported as a percentage (%).

Relative risk reduction (RRR): the proportional reduction in bad outcomes between experimental and control participants; it is reported as a percentage (%).

Weighted mean difference[1]: in a meta-analysis, used to combine outcomes measured on continuous scales (eg, height), assuming that all trials measured the outcome on the same scale; the mean, standard deviation and sample size of each group are known, and weight given to each trial is determined by the precision of its estimate of effect.

1. **Higgins JPT,** Green S, editors. Cochrane handbook for systematic reviews of interventions. Version 4.2.6 (updated September 2006). In: *Cochrane Library*. Chichester, UK: John Wiley & Sons Ltd.
2. **Guyatt G,** Rennie D, editors. *Users' guides to the medical literature. A manual for evidence-based clinical practice*. Chicago: American Medical Association, 2002.
3. **Sackett DL,** Haynes RB, Guyatt GH, *et al*. *Clinical epidemiology: basic science for clinical medicine*. Second edition. Boston: Little, Brown and Company, 1991.
4. **Dawson-Saunders B,** Trapp RG. *Basic and clinical biostatistics*. Norwalk: Appleton and Lange, 1994.