

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 design 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 *blinded (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 design 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.

Conversation analysis:¹ examines the organization and structure of conversation, including all that is said.

Crossover trial: a method of comparing 2 interventions in which patients are switched to the alternative intervention after a specified period of time.

Data saturation (saturation, redundancy):² process of collecting data in a qualitative research study to the point where no new themes are generated.

Ethnography (ethnographic study):² an approach to inquiry that focuses on the culture or subculture of a group of people, with an effort to understand the world view of those under study.

Ethnomethodology: an approach to inquiry that focuses on the way people make sense of their everyday lives.

Grounded theory:² an approach to collecting and analysing qualitative data with the aim of developing theories grounded in real world observations.

Hazard ratio:³ the weighted relative risk over the entire study period; often reported in the context of survival analysis.

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.

Nested case control study: a case control study done within a prospective cohort study.

Nominal group technique:⁴ a highly structured group process that provides an orderly procedure for obtaining qualitative information from specific groups who are closely associated with the area of interest.

Number needed to harm (NNH):⁵ 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.

Power:⁶ 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.

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) (risk ratio): 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 (%).

Receiver operating characteristic (ROC) curve:⁷ an analysis used to assess the clinical usefulness of a diagnostic or screening test. It yields a score that has the highest rates of both sensitivity and specificity with respect to a diagnosis – that is, a score that will give the maximum rate of accurate classifications.

Standardised mean difference:⁸ in a systematic review, a way of combining the results of studies that may have measured the outcome (eg, pain) in different ways, using different scales; effects are expressed as a standard value, with no units (difference between 2 means / estimate of within group standard deviation).

Weighted mean difference:⁸ 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.

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- 3 Guyatt G, Rennie D, editors. *Users' Guides to the Medical Literature. A manual for evidence-based clinical practice*. Chicago: American Medical Association, 2002.
- 4 Van de Ven AH, Delbecq AL. The nominal group as a research instrument for exploratory health studies. *Am J Public Health* 1972;62:337–43.
- 5 Sackett DL, Haynes RB, Guyatt GH, et al. *Clinical epidemiology: basic science for clinical medicine*. Second edition. Boston: Little, Brown and Company, 1991.
- 6 Dawson-Saunders B, Trapp RG. *Basic and clinical biostatistics*. Norwalk: Appleton and Lange, 1994.
- 7 Steer RA, Cavalieri TA, Leonard DM, et al. Use of the Beck Depression Inventory for Primary Care to screen for major depression disorders. *Gen Hosp Psychiatry* 1999;21:106–11.
- 8 Clarke M, Oxman AD, editors. Glossary. Cochrane reviewers' handbook 4.1.2 (updated March 2001). In: *Cochrane Library*, Oxford: Update Software. Updated quarterly.