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Does an interactive Summary of Findings table improve users’ understanding of and satisfaction with information about the benefits and harms of treatments? Protocol for a randomized trial

Moberg J et al.

IHC Working paper, 17. February 2017

Norwegian Institute of Public Health
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Jenny Moberg
Shaun Treweek
Gabriel Rada
Sarah Rosenbaum
Angela Morelli
Pablo Alonso-Coello
Claire Glenton
Simon Lewin
Jan Odgaard-Jensen
Andrew D Oxman

1. Global Health Unit, Norwegian Institute of Public Health, Oslo, Norway; 2. Health Services Research Unit, University of Aberdeen, Aberdeen, UK; 3. Epistemonikos Foundation, Santiago, Chile; 4. Internal Medicine Department and Evidence-Based Healthcare Program, Pontificia Universidad Católica de Chile, Santiago, Chile; 5. Infodesignlab, Oslo, Norway; 6. Iberoamerican Cochrane Center-CIBER Epidemiología y Salud Pública (CIBERESP), Biomedical Research Institute Sant Pau (IIB Sant Pau), Sant Antoni M(a) Claret 167, 08025, Barcelona, España; 7. Department of Clinical Epidemiology and Biostatistics, McMaster University, Hamilton, Canada

Jenny Moberg jmoberg@doctors.org.uk
Andrew D Oxman oxman@online.no

978-82-8082-809-5

Summary of findings, Evidence summaries, Understanding, Formatting, Randomized trial, Protocol, Evidence-based patient information


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Norwegian Institute of Public Health

February 2016
The development and evaluation of the interactive Summary of Findings table has received funding from the European Community's Seventh Framework Programme (FP7/2007-2013) under grant agreement no 258583 (DECIDE project).
Summary

**Background:** It is important that people understand the benefits and harms of the treatments about which they make decisions. Summary of Findings (SoF) tables were developed to be concise summaries of the key findings of systematic reviews that can be understood by all users of systematic reviews, with or without a research background. SoF tables have been shown to help readers of guidelines and systematic reviews better understand and extract the key findings from a review. However, many people still have difficulty understanding the numbers and some of the concepts in SoF tables, and static tables lack flexibility and are limited in terms of the amount and types of information they can include. We have therefore developed an interactive Summary of Findings table (iSoF) that provides both table producers and end users more flexibility, control and support for understanding.

**Objectives:** The primary objectives of this trial are to evaluate the following: the effects of iSoF tables compared to evidence-based patient information, and to static SoF tables on participants’ understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision; the effects of the initial iSoF table presentation on understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision; and which presentation participants prefer. The secondary objectives are to assess the reasons for participants’ preferences, their understanding of the balance of the benefits and harms, and their hypothetical decisions. We will also evaluate the above effects if we exclude people who would like their doctor or somebody else to make a decision for them from the comparisons, and whether the above effects vary across six different decision-making scenarios.

**Methods:** We will recruit members of the public to participate in the trial via the internet. We will randomly allocate participants to one of three topics, and give them a scenario involving making a hypothetical decision about whether or not to use a treatment. The three topics are antibiotics for acute otitis media, aspirin for primary prevention of coronary heart disease, and warfarin for atrial fibrillation. We will also be randomly allocate participants to see either evidence-based patient information, one of six initial presentations of an interactive SoF, or of a static SoF. We will ask participants to make a decision whether
or not to use the treatment, questions about their understanding of the balance between the benefits and harms, the sizes of effects, the certainty of the evidence; and whether they are satisfied that they have been adequately informed about the benefits and harms of the treatment. We will then show participants the alternative presentations for the same scenario and ask them again about whether they are satisfied that they were adequately informed. We will then ask whether they prefer just the standard patient information, an interactive SoF, or a static SoF; which initial presentation of the iSoF table they prefer; and the reasons for their preferences.

**Discussion:** This trial will provide information that will be useful for producers of patient information that is designed to inform people about treatments and help them make well-informed decisions about those treatments.
Background

Healthcare decisions are often taken by people with little or no research experience. This includes patients and their carers, the public, health professionals, guideline panel members, and healthcare policymakers. It is important that these people understand the likely outcomes, both benefits and harms, of the treatments about which they must make decisions or to which they may need to consent. This requires an understanding of the size of the effects, the certainty of the evidence for those effects, and the balance between the benefits and the harms.

GRADE (Grading of Recommendations Assessment, Development and Evaluation) Summary of Findings (SoF) tables are intended for a broad audience, including end users of systematic reviews and guidelines. They provide a concise summary of the key information that is needed by someone making a decision and, in the context of a guideline, provide a summary of the key information underlying a recommendation. We have previously reported on the design of a static SoF table, and shown that users of systematic reviews found these tables useful and understandable and that a SoF table, compared to a systematic review without a SoF table, improves understanding of key findings and reduces the time taken to extract key information. Subsequent studies have compared alternative presentations for static SoF tables. However, SoF tables are too inflexible for a broad range of users: many people have difficulty understanding the numbers and some of the concepts, while other people want more information than the current tables include.

As part of the DECIDE project (Developing and Evaluating Communication Strategies to Support Informed Decisions and Practice Based on Evidence), we have developed interactive SoF (iSoF) tables. We have iteratively developed these tables in response to extensive feedback from producers and users of SoF tables, user testing with patients, the general public, healthcare professionals and healthcare policymakers, and advice from international experts. Like static SoF tables, iSoF tables present the key messages from a systematic review in a concise format, including the most important outcomes (benefits and harms), the size of the effects, and the certainty of the evidence. In addition, iSoF tables offer a layered presentation of this information enabling the producer to present a simple table, tailored to the target audience. At the same time, it enables the
user to drill down for more information, or quickly access explanations and alternative presentations of information. The iSoF table incorporates plain language statements, which encourage the use of standardized language to describe effect sizes and the certainty of the evidence, in order to improve correct understanding of summaries of the findings of a systematic review.8 Users can also select different baseline risks for each outcome for which this is relevant, rather than being confronted with several different estimates for different baseline risks or several different tables, as is necessary with static SoF tables. The impact of an intervention on each outcome can be viewed in one or all of the following ways in iSoF tables: in plain language, as absolute effects, and as relative effects. Absolute effects can be presented as numbers (natural frequencies and differences), described in text, or visualised. The iSoF table also includes explanations of terms and concepts within the table and footnotes presented as scroll overs. iSoF tables can be presented in different languages and can be linked to from other documents and websites, such as patient information leaflets, tools for shared decision-making, online articles, recommendations, and policy briefs.

Most people (including clinicians) without research training or experience, have similar levels of health numeracy, regardless of their level of education,9 and they often are not comfortable interpreting statistical information.6 Well-designed information can compensate for lack of numeracy skills, for example by easing cognitive load, making computation simpler, and filling in background knowledge the user does not have.9 While consumers may prefer plain language summaries, and plain language summaries help them understand the findings of systematic reviews,8 the addition of numerical information can facilitate a better understanding and improve decision-making.10 However, even with the inclusion of all this information (the size of the effect, the certainty of the evidence, and plain language statements for each important outcome), comprehension may still be a problem for many people.8 The way information about the effects of healthcare treatments is presented affects how people perceive the information, and has an impact on their decisions.1,10,11,12,13,14 From user testing of iSoF tables, we have consistently observed that there is wide variation in how much information people like to see in the initial display.
Overview of the trial

We will carry out an internet-based parallel randomized trial to evaluate whether iSoF tables improve understanding and decision-making compared to standard evidence-based patient information without a SoF table (no SoF), and compared to static SoF tables (SoF). We will compare six initial presentations of the iSoF (Figures 1 – 6). We will present information on three different topics: antibiotics for acute otitis media in children; aspirin for primary prevention of coronary heart disease; and warfarin for atrial fibrillation. We looked for diverse topics with at least two different risk groups - one acute condition, one primary prevention, and one secondary prevention - that we anticipate will be easily understood, for which it will be easy for participants to imagine themselves in their assigned scenario, and for which there are recent good quality reviews with clear benefits and harms shown in dichotomous outcomes. For each topic we will include two hypothetical decision-making scenarios (making a total of six scenarios): one in which the participant’s baseline risk is low and one in which it is high.

Objectives

The primary objectives of this trial are to evaluate:

• The effects of iSoF tables compared to evidence-based patient information (no SoF) and to static SoF tables on participants’ understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision
• The effects of the initial iSoF table presentation on understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision
• Which presentation participants prefer

Secondary objectives are to assess:

• The reasons for participants’ preferences, their understanding of the balance of the benefits and harms, and their hypothetical decisions
• All of the above effects when people who would like their doctor or somebody else to make a decision for them are excluded from the comparisons
• Whether the above effects vary across the six decision-making scenarios.
Participants

The participants in this trial will be members of the general public (anyone who uses the internet). We have developed iSoF tables for a range of users including patients, the general public, healthcare professionals and healthcare policymakers. User testing during development of the iSoF table and previous research suggest that users without a research background have a similar understanding of the concepts in SoF tables.\(^9\)

We will recruit participants from the SHARE online database of over 80,000 people in Scotland who are interested in participating in trials ([www.registerforshare.org](http://www.registerforshare.org)). We will place an invitation on the SHARE homepage and in the SHARE newsletter, and we will email members with information explaining the trial and giving a link that people can click on if they are interested in participating. Participants will be able to participate anywhere they choose, provided they have an internet connection and a laptop or desktop computer. All of the data will be collected by software built into the trial website ([http://isof-trial.epistemonikos.org/#/](http://isof-trial.epistemonikos.org/#/)). Before participants see their assigned scenario, we will ask some background questions (for details, see below in section about background information, data collection and data management). Anybody who wishes to participate can do so but we will include and analyse data according to the following inclusion and exclusion criteria:

**Inclusion criteria**

- Over 18 years of age

**Exclusion criteria**

- Familiarity with GRADE SoF tables (assessed by asking participants)
- Previous participation in the trial
- Research training or experience equivalent to an MSc or PhD

**Information for participants**

After clicking on the link to the trial website, participants will see a screen with information explaining that we are carrying out a trial of different ways of presenting information to inform decisions about treatments. We will tell them that if they consent to participate in the study, we will:

- Ask them for some basic background information
- Give them a scenario in which they will be asked to make a hypothetical decision whether to use a treatment for a condition they or someone they care for has.
• Show them information about the treatment, based on the best available research, presented in different ways
• Ask them to make decision about whether or not to use the treatment, and some questions about the information they are shown
• Show them the different ways of presenting the information and ask them which one they prefer

Participants will be asked to consent to participate after reading the participant information. We will reassure them that we are testing the presentations and not them, and that there are no right or wrong answers. We will ask them to complete all the questions, but will inform them that they are free to stop if they wish. We will give them an estimate of the time it is likely to take them to complete the task (15 minutes).

We will inform participants that the results of the trial will be reported on the SHARE website in early 2016, and that they can contact us directly if they would like to ask questions or receive a report of the results.
Interventions

For each of the three topics, we will show participants a scenario with a hypothetical baseline risk, and we will ask them to make a hypothetical decision about whether or not to use a treatment. Participants will be allocated to one of 13 presentations (six iSoF presentations, patient information with no SoF, 6 SoF presentations):

• An iSoF with one of the following initial presentations:
  o The bottom line
    
    *Fig. 1 iSoF table bottom line*

  o A table with plain language statements and the certainty of the evidence
    
    *Fig. 2 iSoF table with plain language statements and certainty of the evidence*
o A table with absolute effects and the certainty of the evidence

*Fig. 3 iSoF table with absolute effects and certainty of the evidence*

![Image of iSoF table with absolute effects and certainty of the evidence]

o A table with plain language statements, absolute effects and the certainty of the evidence

*Fig. 4 iSoF table with plain language statements, absolute effects and certainty of the evidence*

![Image of iSoF table with plain language statements, absolute effects and certainty of the evidence]
- A table with the absolute effects, a visual overview of the effects, and the certainty of the evidence
  
  *Fig. 5* iSoF table with absolute effects, visual overview and certainty of the evidence

- A table with plain language statements, absolute effects, relative effects and the certainty of the evidence

  *Fig. 6* iSoF table with plain language statements, absolute effects, relative effects and certainty of the evidence
• Evidence-based patient information with no SoF table

Fig. 7 Standard evidence-based patient information with no SoF table

Fig. 8 SoF table with one of the 6 initial presentations: plain language statements, absolute effects, relative effects and certainty of the evidence
**Allocation of interventions**

We will randomly allocate participants to one of three different topics, and to one of two baseline risks for each topic (see Fig. 10 below). We will then randomize participants to one of the 13 different presentations listed above. We will use block randomization with blocks of six for the first randomization, and blocks of 13 for the second randomization to ensure equal numbers of participants in all comparison groups for all scenarios. Participants allocated to see an iSoF table will see the information for their hypothetical baseline risk displayed in the table, with information for the other baseline risk available by clicking on the other radio button. See Fig. 9 below:

![Image of iSoF table]

**Fig. 9 iSoF table showing baseline risk buttons: information for low-risk population displayed**

The static SoFs will have information about both baseline risks displayed. The allocations will be according to an algorithm built into the software of the trial website. The allocation will be concealed from the participants and from the investigators.
Recruit participants

Randomize to one of 3 topics, and one of 2 baseline risks for each

Topic 1 Scenarios
Randomize to 1 of 13 presentations of iSoF, no SoF, or static SoF
iSoF with corresponding baseline risk displayed
Bottom-line text
PLS
Absolute effects
PLS and Absolute effect
Absolute effect and visual overview
Whole table (without visualisation)

Topic 2 Scenarios
Same as for topic 1 using information for topic 2
Static
Bottom-line text
PLS
Absolute effect
PLS and Absolute effect
Absolute effect and visual overview
Whole table

Topic 3 Scenarios
Same as for topic 1 using information for topic 3
No SoF
Outcome measures

Primary outcomes
The primary outcomes we will measure are participants’ understanding of and satisfaction with information about the benefits and harms for the treatment choice to which they are allocated and their preferences for the different presentations.

Understanding of the benefits and harms, and of the certainty of the evidence
We will measure their understanding of the size of the effect for the primary benefit and harm and the certainty of the evidence for each of those effects, for example:

![Image of a question about understanding benefits and harms with a scale from 0 to 100.](image)

Satisfaction with the adequacy of the information about the benefits and harms
We will measure participants’ satisfaction with being adequately informed about the benefits and harms of the treatment:

Do you agree or disagree with the following statement?

*I am satisfied that I have been adequately informed about the benefits and harms of the treatment.*

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree
**Presentation preferences**

We will measure participants’ preferences for an iSoF versus patient information with no SoF versus a static SoF using the following questions:

Which presentation(s) or combination of presentations do you prefer? Please tick the options below: you can choose more than one presentation.

Which presentation(s) or combination of presentations do you least prefer? Please tick the options below: you can choose more than one presentation.

We will measure participants’ preferences for the initial presentation using a five point scale:

*Look at the images below and then indicate your preference(s) by ticking below. You can enlarge the images by clicking on them as many times as you would like. These are just images and do not have interactive functionality.*

*Please indicate the reason(s) for your preference(s) by ticking below. If you click on ‘other’, it would be helpful if you give your reason(s) in the free text box that appears.*
Secondary outcomes

In addition to the primary outcomes above, we will measure the following secondary outcomes:

- Reasons for the participants’ preferences for an iSoF versus patient information with no SoF, a static SoF, a combination iSoF plus patient information, and a combination of static SoF plus patient information.

- Reasons for the participants’ preferences for the initial iSoF presentation:

- Use of interactive functions in the iSoF

- The trial website will automatically record participants’ use of interactive functions to view different presentations of treatment effects. We will
record whether people click on interactive functions, how much, and which functions they click on. We will use these data to find out the extent to which participants used the interactive functions of the iSoF.

• Understanding of the balance of the benefits and harms; for example:

From the information you have been given, do you think the benefits of taking antibiotics for a middle ear infection outweigh the harms?
- Yes, the benefits clearly outweigh the harms
- The benefits slightly outweigh the harms
- The benefits and harms are closely balanced
- The harms slightly outweigh the benefits
- The harms clearly outweigh the benefits

• Participants’ hypothetical decision; for example:

In this scenario, and based on the information you have been shown, would you give your child antibiotics?
- Yes
- No

Blinding

The participants will not be aware of the details of the comparisons in this trial, and will not know what the participants randomized to other presentations of information are seeing. The investigators will not be present when participants carry out the trial session. Analysis of the data will be done without knowing the allocation of the participants.

Post-recruitment retention strategies

We do not anticipate participant retention to be a big problem because the trial is completed within one session. It is possible that people may find the tables overwhelming or difficult to understand. We will reassure them that it may take some time for them to find their way around the table, but that they can quit at any time. We will aim to minimize the burden by limiting the number of questions. We will inform participants how far they have progressed as they move through the questions. We will ask participants who wish to quit to click on a quit button. If they click ‘quit’ we will ask them to indicate why with the following options. They will be told that they can choose more than one option.
Background information, data collection and data management

We will collect the following descriptive information about the participants before they are shown their scenario:

Information about you
First we need some information about you. Please answer the following questions by ticking the boxes and click NEXT at the bottom of the page when you are ready to move on.

How old are you?*
- Under 18
- 18 to 30
- 31 to 50
- 51 to 70
- 71+

Are you male/female?*
- Male
- Female

What is your level of education?*
- Secondary school (up to S4)
- High school (Highers)
- University degree or other further education
- Higher degree (masters, PhD)

Do you have health research training or experience (equivalent to a MSc or PhD)?*
- Yes
- No

Are you a health professional (nurse, doctor, physiotherapist etc)?*
- Yes
- No

Are you familiar with GRADE Summary of Findings tables?*
- Yes
- No, but I know what they are
- I’m not sure what they are
- No

In addition, we will ask participants the following questions regarding whether participants would want to know about the size of the effects and the certainty of the evidence, and their preferences for making a decision:
Participants’ answers to all of the questions will be recorded directly into a database. Data collection will be built into the software of the trial website and entered directly into a statistical programme for the analysis.

**Analysis**

All eligible participants will be included in the analysis for all of the outcome questions that they have completed, even if they quit before answering all of the questions. We will conduct the following analyses.

**iSoF versus no SoF, and iSoF versus SoF**

For the size of the effect for the primary benefit and harm and the certainty of the evidence for each of those effects, each answer will be coded as correct or incorrect. We will conduct three comparisons for seven outcome measures using Pearson’s chi square with a Bonferroni correction for multiple comparisons. The seven outcomes are the proportions of correct answers for each of the four questions about participants’ understanding of the benefits and harms, the proportions of participants who prefer and least prefer each of the presentations, and participants’ categorical responses to the question about whether they are satisfied that they were adequately informed about the benefits and harms of the treatment. The three comparisons are:

- iSoF versus standard evidence-based patient information with no SoF
- iSoF versus static SoF
  - We will conduct two comparisons of the iSoF versus SoF:
    - iSoF versus static SoFs that include the absolute effects
    - iSoF versus static SoFs that do not include the absolute effects (plain language statements alone) and the bottom line
Comparison of initial presentations in interactive SoF tables

We will conduct a logistic regression analysis comparing the six alternative initial presentations in interactive SoF tables for seven outcomes. The seven outcomes are the proportions of correct answers for each of the four questions about participants’ understanding of the benefits and harms, participants’ categorical responses regarding their preferences for each of the presentations, and participants’ categorical responses to the question about whether they are satisfied that they were adequately informed about the benefits and harms of the treatment.

Subgroup analyses and sensitivity analyses

We will conduct one subgroup analysis and one sensitivity analysis. In the subgroup analysis, we will exclude people who would prefer for someone who understands the benefits and harms and the underlying evidence to make the decision for them. We hypothesize that people who do not want to make their own decisions are more likely to prefer a patient information without an iSoF or SoF, less likely to feel inadequately informed, and less likely to understand effect sizes and certainty of the evidence. Consequently, if these hypotheses are correct, excluding them will provide a better estimate of the effects of the different presentations for people who want to make their own decisions than the overall estimates. We will conduct tests for an interaction for these analyses and use published guidelines to interpret the results of this subgroup analysis.\textsuperscript{15,16}

In the sensitivity analysis, we will examine whether the effects are consistent for the main comparisons and outcomes across the six different scenarios (three different treatments, with a high or low baseline risk for each treatment). We hypothesize that there will not be important differences in effects across the different scenarios. If we find important differences, this will weaken our conclusions about the overall effect for any comparison and outcome where we find an important difference; i.e. a difference that is unlikely to have occurred by chance and that would lead to a different conclusion about which presentation was best.

Secondary outcomes and descriptive analyses

We will compare participants’ understanding of the balance of the benefits and harms and their decisions for iSoF versus no SoF, iSoF versus SoF, and across the six initial presentations, as described above. We will consider answers about the balance of the benefits and harms correct if they are consistent with the data, and with the recommendation made in the patient information (otitis media) or by the guideline panels (aspirin and warfarin).
We will report the following descriptive information for the participants in each group: age, sex, level of education, health professional (yes/no), know what SoF tables are (yes/no), whether they would want to know about the size of effects and the certainty of the evidence, and their preference for decision making.

We will report the reasons for participants’ preferences descriptively for each of the presentations, and we will report whether participants opened and closed columns and used other functions in the iSoF descriptively. We will report on differences between risk groups in their answers to the questions about the balance of the benefits and harms, and whether their answer to this question is consistent with their decision.

**Missing data**

Because participants must answer all of the questions in the online questionnaire before continuing to the next page, we do not anticipate any missing data up until completion of the study or the point at which participants choose to quit.

**Sample size**

We have calculated the sample size taking into consideration the findings of a pilot study in which there was a 4% completion rate in response to 1900 recruitment emails.

In the pilot study about 50% (29-67%) of the static SoF group answered the questions about effect sizes and certainty of the evidence correctly. To detect a 10% difference (60% in the iSoF group, assuming 80% power and an alpha of 0.05) with the Bonferroni correction for multiple comparisons, we estimate that we would need a maximum of 750 participants per group for the seven primary outcomes. Based on these estimates, and on the completion rate in the pilot, we decided it is not feasible for us to get a large enough sample size to detect a 10% difference between the initial presentations of the iSoF.

A sample size of 3200 participants (800 in the patient information group and 1200 in each of the groups, iSoF and SoF groups, with 200 in each initial presentation group), gives us at least 80% power to detect a 10% difference between iSoF and no SoF, and between the iSoF and static SoF for the seven primary outcomes, and at least 80% power to detect a 20% difference among the initial presentations for the same outcomes.

With a response rate of 4%, we therefore would need to send 70,000 invitations. There are 48,000 people on the SHARE register who are accessible by email. We will therefore send recruitment emails to all of these people, and aim
with the aid of reminders to increase the response rate to 7%, in order to obtain 3200 completed questionnaires.

**Ethical considerations**

All participants will be asked to consent to taking part in the trial after receiving the participant information.

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**Better information for better health choices**

*A trial of different ways of presenting information to inform decisions about treatments*

Hello!

Thanks for taking an interest in our trial.

This trial is testing different ways of showing information from research about treatments. It is part of the DECIDE project. The DECIDE project ([www.decide-collaboration.eu](http://www.decide-collaboration.eu)) is working to find ways to present information about treatments to all the people involved in making healthcare decisions, including patients and their families, healthcare managers, doctors, nurses and other health professionals. This is an important part of providing high quality health care. DECIDE is funded in part by the European Commission under the Seventh Framework Programme.

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**Consent**

*Have a look at the information below and click on Consent at the bottom of the page if you are happy to take part in the trial.*

1. **Background to the trial**

We all need to make decisions about our health and treatments. Information about treatments is sometimes confusing or hard to understand. To make it easier to understand for people making a decision about a treatment, we would like members of the public to test some different ways health research information can be presented.

Taking part in the study won’t lead to an immediate benefit for you personally. However, it will help organisations that produce health information improve the way they do this. This may be helpful to you in the future when you, or others, are making real decisions about treatments that affect you.

Click [here](#) for more information about this trial.

2. **What we want you to do**

You are in charge and you can stop at any time. If you stop please click on QUIT in the bottom left hand corner.

You can take as much or as little time as you like looking at the information that we will show you; the whole trial will take roughly 15 minutes.
All the information you give us, and your answers to any questions are completely confidential. The questions we ask are not testing you; they are helping us discover the best ways of showing the information about treatments.

1) If you agree to participate, we will ask you for some basic background information about yourself.

2) Then we will give you a scenario, and we will ask you to imagine you need to make a decision about using a treatment.

3) We will then show you information about the treatment, based on the best available research, presented in different ways, some of which are interactive.

4) We will ask you to make a decision based on your scenario, and ask some questions about the information you have been given. You may not be able to answer all these questions with the information you have been given.

5) Lastly we will show you all the different ways of presenting the information and ask which you prefer.

When you click **CONSENT** below you are consenting to participate in this trial.

Participants’ responses to the questions on the trial website will be entered directly into a database and stored anonymously. Confidentiality of the data will be ensured by not collecting information that would make it possible to identify participants.

We have discussed the need for ethics approval with the Research and Governance Committee of the University of Aberdeen and they have decided that ethics approval is not necessary for this trial.
Reporting, Dissemination and Notification of results

The results of this trial will be disseminated to members of the DECIDE consortium, to the GRADE working group (and their respective webpages) as well as to the participants in the trial. The trial will be written up for publication in a peer-reviewed journal.
Discussion

In this randomized trial we make three main comparisons: the effects of iSoF tables compared to evidence-based patient information on participants’ understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision; the effects of iSoF tables compared with static SoF tables (with and without absolute effects) on participants’ understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision; and the effects of the initial iSoF table presentation on understanding of, and satisfaction with, information about the benefits and harms of treatments when making a decision. We also evaluate participants’ preferences for the type of information they are given, and for the initial presentation in an iSoF table.

The results of the first comparison, iSoF tables versus standard evidence-based patient information will inform decisions made by people responsible for preparing evidence-based patient information, such as NHS Choices, BMJ, and UpToDate. Specifically, it will document the potential value of incorporating iSoF tables in patient information.

The second comparison of iSoF tables versus static SoF tables that include absolute effects will inform decisions about the value of using an interactive SoF table in place of a static one.

The third comparison of iSoF tables versus static SoF tables that do not include absolute effects will inform decisions about the inclusion of iSoFs with plain language summaries of systematic reviews, such as those prepared by the Cochrane Collaboration.

The comparison of different initial presentations in iSoF tables will inform decisions made by producers of iSoFs about which initial presentation might be best for target audiences that are not health researchers and not familiar with SoF tables.
References


http://nokc.academia.edu/SarahRosenbaum/Papers/369198/Improving_the_user_experience_of_evidence._A_design_approach_to_evidence-informed_heath_care


