Conclusions The MEWS independently predicts the likelihood of MICU readmission. Since the MEWS score can be automatically generated by the EHR it is prudent for clinicians to use it for frequent monitoring of patients during the first 72 hours of their discharge from the intensive care unit.

2 RETHINKING BIAS AND TRUTH IN EBM

[1,2]Sietse Wieringa, [3]Eivind Engebretsen, [2]Kristin Heggen, [1]Trish Greenhalgh. *[1]University of Oxford, Oxford, UK; [2]University of Oslo, Oslo, Norway; [3]University of Oslo, Norway, Norway*

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Objectives Abstract In modern philosophy, the concept of truth has been problematized from different angles, yet in evidence-based health care (EBHC), it continues to operate hidden and almost undisputed through the linked concept of 'bias.' To prevent unwarranted relativism and make better inferences in clinical practice, clinicians may benefit from a closer analysis of existing assumptions about truth, validity, and reality. Here we give a brief overview of several important theories of truth, notably the ideal limit theorem (which assumes an ultimate and absolute truth towards which scientific inquiry progresses), the dominant way truth is conceptualized in the discourse and practice of EBHC.
Method We draw on Belgian philosopher Isabelle Stengers' work to demonstrate that bias means one thing if one assumes a world of hard facts 'out there,' waiting to be col- lected. It means something different if one takes a critical view of the knowledge- power complex in research trials. Bias appears to have both an unproductive aspect and a productive aspect as argued by Stengers and others: Facts are not absolute but result from an interest, or interesse: a bias towards a certain line of questioning that cannot be eliminated.
Results The duality that Stengers' view invokes draws attention to and challenges the assumptions underlying the ideal limit theory of truth in several ways. Most impor- tantly, it casts doubt on the ideal limit theory as it applies to the single case scenario of the clinical encounter, the cornerstone of EBHC. To the extent that the goal of EBHC is to support inferencing in the clinical encounter, then the ideal limit as the sole concept of truth appears to be conceptually insufficient.
Conclusions We contend that EBHC could usefully incorporate a more pluralist understanding of truth and bias and provide an example how this would work out in a clinical scenario.

3 DON'T LABEL AGEING AS DISEASE: THE KIDNEY AGE COMMUNICATION TOOL

[1]Richard Stevens, [1]Clare Bankhead, [1]Jennifer Hirst, [2]Jeremy Horwood, [1]Gavin Hubbard, [1]Chelu Mfalila, [1]Chris O'Callaghan, [1]Sara Ryan. *[1]University of Oxford, Oxford, UK; [2]University of Bristol, Bristol, UK*

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Objectives Previous research shows that the terminology 'chronic kidney disease' (CKD) is problematic for both patients and general practitioners, arguably because it represents an ageing process rather than a disease. We have previously proposed an alternative terminology 'kidney age' to supersede the terminology of CKD stages 2, 3a, 3b and 4. We aim to develop a communication tool that can be used to discuss declining kidney function with patients without using the terminology of 'disease'.
Method We used electronic health record data from UK primary care to design a prototype communication aid: a table and explanatory text showing how eGFR values map to bands of 'kidney age', and the increasing CVD risk at each band of kidney age. The design and content were refined iteratively in consultation with patient-public involvement representatives. UK general practitioners were then interviewed about the proposed design and content.
Results Interviews are ongoing but results to date suggest that GPs would welcome 'kidney age' terminology and our communication tool, possibly modified, as a potential intervention.
Conclusions A web-based version of the communication aid is currently under development, that can be tested as an intervention in a future parallel-group trial.

4 THE SECTION ON MATERIALS AND METHODS IN PUBLISHED REPORTS OF RANDOMIZED CONTROLLED TRIALS (RCTS) DOES NOT PROVIDE SUFFICIENT INFORMATION TO ALLOW CLINICAL REPLICABILITY OF COMPLEX INTERVENTIONS: A COCHRANE REHABILITATION METHODOLOGICAL PAPER

[1]Stefano Negrini, [2]Chiara Arienti, [2]Joel Pollet, [3]Julia Patrick Engkasan, [4]Gerard E Francisco, [5]Walter Frontera, [2]Silvia Galeri, [6]Kamila Gworys, [6]Jolanta Kujawa, [7]Mazlina Mazlan, [8]Farooq A Rathore, [9]Fabienne Schillebeeckx, [9]Carlotte Kiekens. *[1]University of Brescia, Brescia, Italy; [2]IRCCS Fondazione Don Carlo Gnocchi, Milan, Italy; [3]University of Malaya, Malaya, Malaysia; [4]The Neuro-Recovery Research Center, TIRR Memorial Hermann, Huston, USA; [5]University of Puerto Rico School of Medicine, San Juan, Puerto Rico; [6]Medical University of Lodz, Lodz, Poland; [7]University of Malaya, Malaya, Malaysia; [8]PNS Shifa Hospital Pakistan, Karachi, Pakistan; [9]University Hospital Leuven, Leuven, Belgium*

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Objectives To study if Randomized Controlled Trials (RCTs) on complex interventions published in top journals include all the practical details needed to replicate the intervention in everyday clinical practice (clinical replicability). We chose rehabilitation as a case-study because the World Health Organization calls for its development within health services, and due to its intrinsic complexities.
Method Online survey of a pre-defined sample of clinical expert teams from different world regions with diverse rehabilitation competences. Forty-seven clinicians from 7 Physical and Rehabilitation Medicine (PRM) teams (Belgium, Italy, Malaysia, Pakistan, Poland, Puerto Rico, USA), including 20 physicians, 12 physiotherapists, 6 occupational therapists, 6 psychologists and 3 others. The team leaders were active researchers. All RCTs published between January and July 2017 in the top PRM journals (76 RCTs) were reviewed by each team leader. 14 questions developed using CONSORT and TIDIeR checklists through consensus and piloting.
Results The response rate was 99%. Inter-rater agreement was moderate/good. All participants considered unanimously 12 (16%) RCTs clinically replicable and none not replicable. Of the other, 56 (74%) RCTs have been considered replicable and 45 (59%) not replicable by at least one complete team. At least one 'absent' information was found by all participants in 60 RCTs (79%), and by a minimum of 85% in the remaining 16 (21%). Information considered to be less well described (8-19% 'perfect' information) included two providers (skills, experience) and two delivery (cautions, relationships) items. The best described (50-79% 'perfect') were the classic methodological items included in CONSORT (descending