PREVENTION OR TREATMENT; QUALITY IMPROVEMENT
- Random allocation of participants to interventions
- Outcome measures of known or probable clinical importance for ≥ 80% of the participants who entered the investigation.

DIAGNOSIS
- Inclusion of a spectrum of participants, some (but not all) of whom have the disorder or derangement of interest
- Each participant must receive the new test and the diagnostic standard test
- Either an objective diagnostic standard or a contemporary clinical diagnostic standard with demonstrably reproducible criteria for any subjectively interpreted component.
- Interpretation of the test without knowledge of the diagnostic standard result
- Interpretation of the diagnostic standard without knowledge of the test result.

PROGNOSIS
- An inception cohort of persons, all initially free of the outcome of interest
- Follow-up of ≥ 80% of patients until the occurrence of either a major study end point or the end of the study.

CAUSATION
- Observations concerning the relation between exposures and putative clinical outcomes
- Prospective data collection with clearly identified comparison group(s) for those at risk for the outcome of interest (in descending order of preference from randomised controlled trials, quasi-randomised controlled trials, nonrandomised controlled trials, cohort studies with case by case matching or statistical adjustment to create comparable groups, to nested case control studies)
- Masking of observers of outcomes to exposures (this criterion is assumed to be met if the outcome is objective).

ECONOMICS OF HEALTH CARE PROGRAMMES OR INTERVENTIONS
- The economic question must compare alternative courses of action in real or hypothetical patients
- The alternative diagnostic or therapeutic services or quality improvement strategies must be compared on the basis of both the outcomes they produce (effectiveness) and the resources they consume (costs)
- Evidence of effectiveness must come from a study (or studies) that meets criteria for diagnosis, treatment, quality assurance, or review articles
- Results should be presented in terms of the incremental or additional costs and outcomes incurred and a sensitivity analysis should be done.

CLINICAL PREDICTION GUIDES
- The guide must be generated in 1 set of patients (training set) and validated in an independent set of real not hypothetical patients (test set), and must pertain to treatment, diagnosis, prognosis, or causation.

DIFFERENTIAL DIAGNOSIS
- A cohort of patients who present with a similar, initially undiagnosed but reproducibly defined clinical problem
- Clinical setting is explicitly described
- Ascertainment of diagnosis for ≥ 80% of patients using a reproducible diagnostic workup strategy and follow up until patients are diagnosed or follow up of ≥ 1 month for acute disorders or ≥ 1 year for chronic or relapsing disorders.

SYSTEMATIC REVIEWS
- The clinical topic being reviewed must be clearly stated; there must be a description of how the evidence on this topic was tracked down, from what sources, and with what inclusion and exclusion criteria
- ≥ 1 article included in the review must meet the above-noted criteria for treatment, diagnosis, prognosis, causation, quality improvement, or the economics of health care programmes.

Evidence-Based Medicine has a related journal, ACP Journal Club. It is generated using procedures identical to those used for Evidence-Based Medicine and is published by the American College of Physicians-American Society of Internal Medicine. Approximately one third of the abstracts in ACP Journal Club are published in Evidence-Based Medicine, and the abstracts not published are listed, by their declarative titles, in the section titled Additional Articles Abstracted in ACP Journal Club.