Manuscript: Lunny C, et al. Exploring Decision Makers' Challenges and Strategies when Selecting Multiple Systematic Reviews: Insights for AI Decision Support Tools in Healthcare

Appendices Table of contents:

Appendix A - Checklist for Reporting Results of Internet E-Surveys (CHERRIES)

Checklist Item	***Explanation***	***Page Number***
Describe survey design	Describe target population, sample frame. Is the sample a convenience sample? (In "open" surveys this is most likely.)	Page 4
IRB approval	Approval from the University of British Columbia Ethics Board was not necessary as the survey was targeted at healthcare professionals in their workplace.	Page 4
Informed consent	Describe the informed consent process. Where were the participants told the length of time of the survey, which data were stored and where and for how long, who the investigator was, and the purpose of the study?	Page 4
Data protection	If any personal information was collected or stored, describe what mechanisms were used to protect unauthorized access.	Appendix B
Development and testing	State how the survey was developed, including whether the usability and technical functionality of the electronic questionnaire had been tested before fielding the questionnaire.	Page 4
Open survey versus closed survey	An "open survey" is a survey open for each visitor of a site, while a closed survey is only open to a sample which the investigator knows (password-protected survey).	Page 6-7
Contact mode	Indicate whether or not the initial contact with the potential participants was made on the Internet. (Investigators may also send out questionnaires by mail and allow for Web-based data entry.)	Page 5-6
Advertising the survey	How/where was the survey announced or advertised? Some examples are offline media (newspapers), or online (mailing lists – If yes, which ones?) or banner ads (Where were these banner ads posted and what did they look like?). It is important to know the wording of the announcement as it will heavily influence who chooses to participate. Ideally the survey announcement should be published as an appendix.	Page 5-6
Web/E-mail	State the type of e-survey (eg, one posted on a Web site, or one sent out through e-mail). If it is an e-mail survey, were the responses entered manually into a database, or was there an automatic method for capturing responses?	Page 4
Context	Describe the Web site (for mailing list/newsgroup) in which the survey was posted. What is the Web site about, who is visiting it, what are visitors normally looking for? Discuss to what degree the content of the Web site could pre-select the sample or influence the results. For example, a survey about vaccination on a anti-immunization Web site will have different results from a Web survey conducted on a government Web site	N/A as we used Qualtrics
Mandatory/voluntary	Was it a mandatory survey to be filled in by every visitor who wanted to enter the Web site, or was it a voluntary survey?	Page 5
Incentives	Were any incentives offered (eg, monetary, prizes, or non-monetary incentives such as an offer to provide the survey results)?	Page 5
Time/Date	In what timeframe were the data collected?	Page 6

Randomization of items or questionnaires	To prevent biases items can be randomized or alternated.	Page 5
Adaptive questioning	Use adaptive questioning (certain items, or only conditionally displayed based on responses to other items) to reduce number and complexity of the questions.	N/A
Number of Items	What was the number of questionnaire items per page? The number of items is an important factor for the completion rate.	Page 4
Number of screens (pages)	Over how many pages was the questionnaire distributed? The number of items is an important factor for the completion rate.	Page 4
Completeness check	It is technically possible to do consistency or completeness checks before the questionnaire is submitted. Was this done, and if "yes", how (usually JAVAScript)? An alternative is to check for completeness after the questionnaire has been submitted (and highlight mandatory items). If this has been done, it should be reported. All items should provide a non-response option such as "not applicable" or "rather not say", and selection of one response option should be enforced.	-N/A -Appendix D responses
Review step	State whether respondents were able to review and change their answers (eg, through a Back button or a Review step which displays a summary of the responses and asks the respondents if they are correct).	Page 4
Unique site visitor	If you provide view rates or participation rates, you need to define how you determined a unique visitor. There are different techniques available, based on IP addresses or cookies or both.	Page 5
View rate (Ratio of unique survey visitors/unique site visitors)	Requires counting unique visitors to the first page of the survey, divided by the number of unique site visitors (not page views!). It is not unusual to have view rates of less than 0.1 % if the survey is voluntary.	N/A
Participation rate (Ratio of unique visitors who agreed to participate/unique first survey page visitors)	Count the unique number of people who filled in the first survey page (or agreed to participate, for example by checking a checkbox), divided by visitors who visit the first page of the survey (or the informed consents page, if present). This can also be called "recruitment" rate.	N/A
Completion rate (Ratio of users who finished the survey/users who agreed to participate)	The number of people submitting the last questionnaire page, divided by the number of people who agreed to participate (or submitted the first survey page). This is only relevant if there is a separate "informed consent" page or if the survey goes over several pages. This is a measure for attrition. Note that "completion" can involve leaving questionnaire items blank. This is not a measure for how completely questionnaires were filled in. (If you need a measure for this, use the word "completeness rate".)	Page 7
Cookies used	Indicate whether cookies were used to assign a unique user identifier to each client computer. If so, mention the page on which the cookie was set and read, and how long the cookie was valid. Were duplicate entries avoided by preventing users access to the survey twice; or were duplicate database entries having	N/A

	the same user ID eliminated before analysis? In the latter case, which entries were kept for analysis (eg, the first entry or the most recent)?	
IP check	Indicate whether the IP address of the client computer was used to identify potential duplicate entries from the same user. If so, mention the period of time for which no two entries from the same IP address were allowed (eg, 24 hours). Were duplicate entries avoided by preventing users with the same IP address access to the survey twice; or were duplicate database entries having the same IP address within a given period of time eliminated before analysis? If the latter, which entries were kept for analysis (eg, the first entry or the most recent)?	Page 5
Log file analysis	Indicate whether other techniques to analyze the log file for identification of multiple entries were used. If so, please describe.	N/A – IP addresses were used
Registration	In "closed" (non-open) surveys, users need to login first and it is easier to prevent duplicate entries from the same user. Describe how this was done. For example, was the survey never displayed a second time once the user had filled it in, or was the username stored together with the survey results and later eliminated? If the latter, which entries were kept for analysis (eg, the first entry or the most recent)?	N/A
Handling of incomplete questionnaires	Were only completed questionnaires analyzed? Were questionnaires which terminated early (where, for example, users did not go through all questionnaire pages) also analyzed?	Page 6
Questionnaires submitted with an atypical timestamp	Some investigators may measure the time people needed to fill in a questionnaire and exclude questionnaires that were submitted too soon. Specify the timeframe that was used as a cut-off point, and describe how this point was determined.	N/A
Statistical correction	Indicate whether any methods such as weighting of items or propensity scores have been used to adjust for the non-representative sample; if so, please describe the methods.	N/A

This checklist has been modified from Eysenbach G. Improving the quality of Web surveys: the Checklist for Reporting Results of Internet E-Surveys (CHERRIES). J Med Internet Res. 2004 Sep 29;6(3):e34 [erratum in J Med Internet Res. 2012; 14(1): e8.]. Article available at https://www.jmir.org/2004/3/e34/; erratum available https://www.jmir.org/2012/1/e8/.

Appendix B – Full survey questions

[PAGE 1]
Introduction
Welcome to the WISEST (WhIch Systematic Evidence Synthesis is besT) Project survey. This survey is part of a larger project to develop an automated decision support tool to assess the strengths and weaknesses of one or more systematic reviews when there are multiple on the same topic. Our target audience for the WISEST tool is clinical decision makers and learners.

The purpose of this survey is to understand how you as a decision maker (e.g. student, clinician, researcher or policymaker) use systematic reviews in your decision making or learning. Specifically, when there are multiple systematic reviews on a particular question, do you pick one or more systematic reviews to use or read? Would you use a supporting tool with Artificial intelligence (AI) capability, if one was available, to help you assess the strengths and weaknesses of the systematic reviews on your topic of interest?

This project is led by a steering group of international experts in systematic review methodology including: Carole Lunny, Sera Whitelaw; Andrea Tricco, Ebrahim Bagheri, Ba' Pham, Salmaan Kanji, Dawid Pieper, Bev Shea, Areti-Angeliki Veroniki, Clare Ardern, Karim Khan, Candyce Hamel, Emma Reid, Nicola Ferri, Yuan Chi, Janet Zhang, and the working group: Harrison Nelson, Lindy Pangka; Banveer Kalkat; Wendy Zheng; Reema Abdoulrezzak; Kevin Kang; Tasnim, Sara; Anmol Sooch; Sai Surabi Thirugnanasampanthar; Dian Wang; Parisa Safavi, and Cynthia Ramasubbu. This project has not received any targeted funding to date.

Definitions:
A systematic review attempts to collate all study-specific evidence that fits pre-specified eligibility criteria to answer a specific research question. It uses explicit, systematic methods that are selected with a view to minimising bias, thus providing more reliable findings from which conclusions can be drawn and decisions made. Traditional meta-analysis is a statistical method to combine the results from two or more primary studies (e.g. randomised controlled trials, cohort studies). comparing an intervention to a placebo/control or another intervention. Artificial intelligence (AI) is a wide-ranging branch of computer science concerned with building smart machines capable of performing tasks that typically require human intelligence. Examples are Siri, Alexa, self-driving cars, and in the evidence synthesis realm RobotReviewer (https://www.robotreviewer.net). Our study protocol can be found here.

Your answers to this survey will be used to inform the development of the automated WISEST decision support tool to choose one or more systematic reviews when there are multiple on the same question. This survey is voluntary and you may exit the survey at any time.

Survey Instructions:
The survey has 20 questions in total and five sections. It should take you 10 minutes to complete. You can skip through any question or section and submit your survey answers on the last page. You can send any comments to the primary investigator, Dr Carole Lunny at carole.lunny@ubc.ca

Request for Participation: It is up to you whether you would like to participate. If you decide not to participate, you will not be penalized in any way. You can also decide to stop at any time without penalty. If you do not wish to answer any of the questions, you may simply skip them. Once you submit an anonymous survey, we will not know which survey or test is yours.

Exclusions: You must be at least 18 years of age to participate in this study.

Privacy: All of the information we collect will be anonymous. We will not record your name, student number, or any information that could be used to identify you OR a sentence describing the identifiers you are collecting. Your

confidentiality will be maintained to the degree permitted by the technology used. Specifically, no guarantees can be made regarding the interception of data sent via the Internet by any third parties.

Explanation of Risks: The risks associated with participating in this study are similar to the risks of everyday life.

Explanation of Benefits: You will benefit from participating in this study by getting firsthand experience in research.

Data Protection Statement: All data collected in this survey will be stored anonymously and securely on a password-protected university server. We do not retain any personal data except with your permission (i.e. email). Cookies (i.e. personal data stored by your Web browser) are not used in this survey.

If you have any questions or comments, please contact:
Carole Lunny, MPH, PhD
Postdoctoral Fellow, Methodology and Research Synthesis
carole.lunny@ubc.ca
@carole_lunny

Please click the following indicating your choice to be in this study:
Yes I agree to participate in the study.
No I do not want to participate in the study

[PAGE 2]
START SURVEY
EXPERIENCE WITH SYSTEMATIC REVIEWS
1. Are you familiar with systematic reviews as a type of evidence summary of all primary research on one topic?
o Yes
o No
o Unsure

2. According to Moher and colleagues, the PRISMA checklist is not a quality assessment instrument to judge the quality of a SR

o True
o False
o Unsure

3. Which of the following could be discussed as limitations that occurred at the SR level (as opposed to limitations in primary studies)?

a. Selective reporting of results of analyses
b. Risk of bias of the primary studies
c. Relevant studies missed due to a flawed search strategy or limited databases and other sources searched
d. Missing relevant studies when screening for inclusion
e. Excluding foreign language (non-English) articles
f. All except A
g. All except B

4. How often did you seek out systematic reviews as a source of evidence in decision making/learning in two years?
o Never
o Sometimes
o Often

5. How long have you, your working group or your work colleagues, been producing systematic reviews?
- o Never
- o Less than 1 per year
- o 1-2 per year
- o 3-5 per year
- o >5 per year

EXPERIENCES AND BARRIERS TO CHOOSING SYSTEMATIC REVIEW(S) WHEN MORE THAN ONE EXISTS ON THE SAME TOPIC

6. How often have you faced a situation where you find more than one systematic review on a given topic of interest to you?
- o Never
- o Sometimes
- o Often

7. If a free, automated, AI-informed, web-based tool was available to assist you in choosing the best systematic review(s) among multiple on the same question, would you use it?
- o Yes
- o No
- o Unsure
- o If no or unsure please comment_____

8. When you encounter multiple systematic reviews on the same topic how do you choose the one(s) most likely to address your clinical question/learning needs?
- o I typically choose the first one I find that is relevant to my topic
- o I find as many as I can that are relevant to my topic and then review them all
- o I typically choose the most recently published one(s) that are relevant to my topic
- o I typically choose the one from the highest impact factor journal
- o Other, please specify_____

9. When you have encountered multiple systematic reviews on the same topic, which of the following statements resonates most with you?
- o I can usually identify the systematic review(s) best suited to my needs
- o I sometimes struggle to identify the systematic review(s) that are best suited to my needs
- o I often struggle to identify the systematic review(s) best suited to my needs

10. If/when you struggle to choose the systematic review(s) best suited to your needs, the barriers to you being able to make this decision are (select all that apply):
- o Insufficient data from titles and abstracts to assess relevance to my question(s)
- o Inexperience with assessing the methodological quality of systematic reviews
- o Not enough time to read each systematic review in full to evaluate all the options
- o You don’t trust the conclusions
- o Different results and conclusions across the systematic reviews
- o Variation in the quality of, how the systematic reviews were conducted
- o Variation in literature searches across the systematic reviews
- o Variation in included primary studies across the systematic reviews
- o Variation in how across the systematic reviews results were synthesized
- o Other: please specify_____

[PAGE 3]

RANDOMISED QUESTION A

DATA ELEMENTS TO CONSIDER WHEN CHOOSING THE SYSTEMATIC REVIEW(S) BEST SUITED TO MY NEEDS FROM MULTIPLE ON THE SAME TOPIC

11. Which elements should be considered when choosing the systematic review(s) best suited to my needs among multiple on the same topic:

a. Recency of publication date
b. The review is conducted by a reputable organisation (e.g. NICE, Cochrane, or AHRQ)
c. Reputation / expertise of the systematic review author team or affiliation
d. Country of publication (country of first author)
e. Language of publication
f. Integrity of publishing journal (e.g. peer-reviewed publication, publication in one of my preferred journals, journal of high impact factor or high prestige (e.g. JAMA, Lancet, BMJ))
g. A protocol or pre-registration for the systematic review was registered or published (i.e. an a priori plan of the review)
h. Relevance of the systematic review's research question to my clinical question/learning needs
i. Methodological quality and reproducibility of the systematic review
j. The review assessed both efficacy and harms
k. Comprehensive search strategy (scope of search terms and number of databases searched)
l. Number of included primary studies
m. Risk of bias / quality of the included primary studies
n. Types of primary studies included (RCTs versus non-randomized studies)
o. Availability of a meta-analysis
p. Congruence with my own opinion
q. Reported conflict(s) of interest of the systematic review author team
r. Other (please specify): _____

[PAGE 3]

RANDOMISED QUESTION B

12a-c Which criteria would help you choose among the systematic reviews? Please do not limit your choice to just the Main features (column 1) in the table. We would like to know all the features of systematic reviews that would inform your choice(s).

Scenario - How to choose one or more systematic reviews on your question based on its strengths and weaknesses. Consider the question below and what type of systematic review(s) might be most suited to your needs based on the clinical question.

Case study

A woman enters your clinic with menstrual pain (i.e. primary dysmenorrhea) and is interested in alternative therapies. She asks you advice about acupuncture and its effectiveness and safety.

You search the literature for systematic reviews based on the question "Is acupuncture effective/efficacious and safe for women with primary dysmenorrhoea" and find 3 systematic reviews, seemingly with the same research question. After reading the abstracts, you notice they used different methods, and have slightly different conclusions. How do you decide which one(s) is/are the most informative and trustworthy?

The 3 studies you found were (full abstracts are found below the table):

1. Liu T; Yu J-A; Cao B-Y; Peng Y-Y; Chen Y-P; Zhang L. Acupuncture for Primary Dysmenorrhea: A Meta-analysis of Randomized Controlled Trials. Alternative Therapies in Health & Medicine, 2017.
2. Yu S, Lv Z, Zhang Q, Yang S, Wu X, Hu Y, Zeng F, Liang F, Yang J. Electroacupuncture is beneficial for primary dysmenorrhea: the evidence from meta-analysis of randomized controlled trials. Evid Based Complement Alternat Med 2017;2017;1791258.

3. Woo HL, Ji HR, Pak YK, Lee H, Heo SJ, Lee JM, Park KS. The efficacy and safety of acupuncture in women with primary dysmenorrhea: A systematic review and meta-analysis. Medicine (Baltimore). 2018 Jun;97(23):e11007.

The table below briefly describes the key features of the reviews with menstrual pain as the intervention

	Main features	**Liu 2017**	**Yu 2017**	**Woo 2018**
	Study design	Meta-analysis of RCTs	Meta-analysis of RCTs	Meta-analysis of RCTs
	Journal	Alternative Therapies in Health & Medicine	Evidence-Based Complementary and Alternative Medicine	Medicine (Baltimore)
	Journal impact factor	1.3	2.6	1.9
	Number of included primary studies	5	3	14
	Population	Patients with PD	Patients with PD	Women with PD
	Intervention	Manual acupuncture	Electro-acupuncture	Manual acupuncture
	Control	No treatment	Waitlist	No treatment
	Number of participants	404	143	1715
	Search end-date	Up to March 2016	Up to April 2017	Up to December 2017
	Number of databases searched	5	6	11
	Specific databases searched	PubMed, Embase, Cochrane, CNKI, CBM, Wanfang	PubMed, Embase, ISI Web of Science, CENTRAL, CNKI, Wanfang	MEDLINE, Embase, CENTRAL, The Cochrane Library, AMED, CiNii, CNKI, VIP, Wanfang, OASIS, and the Korean TK
	Outcomes	1. Pain relief (VAS or other scale) 2. Adverse effects	1. Pain (VAS) as measured 30 minutes after treatment	1. Pain intensity (VAS or other scale) 2. Adverse events
	Quality of the review using AMSTAR-2	Critically low	Critically low	Low
	Risk of bias assessment of the RCTs	Most trials at high risk	2 were low risk, one high risk	Most studies at low or unclear risk of bias
	Reported adverse effects of the intervention	One trial reported fainting, hematoma, and needling sensation	Not reported	Not reported
	Statistical heterogeneity (I^2)	Low (0%)	High (84%)	High (98%)
	Results of the primary outcome pain	Mean difference = -21.95 (-25.45 to 18.45)	Odds ratio= 27.15 (13.74 to 40.55)	Standardised mean difference = −7.83, (−10.67 to −1.90])
	Authors interpretation of the results/ Main conclusion	Acupuncture also showed superiority to the control arms on the VAS, but those findings have been influenced by methodological flaws [of the included primary studies].	Electro-acupuncture can provide considerable immediate analgesic effect for PD and its immediate effect of pain relieving seems to be superior to control interventions.	Acupuncture might reduce menstrual pain and associated symptoms more effectively compared with no treatment.

	Evidence of spin (i.e. authors reporting their results in a more favourable way than they deserve, that is, to add some spin)	No	No	Yes

QUESTIONS:

12a. Based on the abstracts and the table comparing the systematic reviews, which systematic review(s) would you choose to inform your discussion with the patient? (you may choose more than one)

a. Liu 2017

b. Yu 2017

c. Woo 2018

12b. Which features criteria would you use to choose among the systematic reviews? Please do not limit your choices to the features highlighted listed in the table. We would like to know all the features of systematic reviews that would inform your choice(s).

o Please list the features you would choose, and explain why you chose them _____

12c. Do you have any other comments on how or why you would choose one of the 3 reviews?

Comments: _____

[PAGE 4]

INTEREST AND ENGAGEMENT IN DEVELOPMENT, PILOTING, DISSEMINATION AND TRAINING

13. Please indicate your interest in being further engaged in this project (select all that applies):

o Being on an email list to receive project updates
o Being involved in piloting the automated algorithm/decision support tool
o Receiving training in using the new tool
o Reading the final study reports
o Disseminating the research
o No interest in being further involved
o Other (please specify)

14. If you are interested in being further involved, please sign up for email updates here.

[PAGE 5]

DEMOGRAPHIC QUESTIONS

Please tell us a little bit more about you. This will help us to grasp the diversity of people who respond to the survey. We will not collect any directly identifiable information

15. Indicate your current role (check all that apply):

o Practitioners (individuals/organizations that provide care, e.g., nurses, physicians, pharmacists, mental health counsellors, community-based workers)
o Decision maker (government representative, public funding agency representative, hospital administrator, Clinical Practice Guideline developer, Health Technology Assessment [HTA] developer)
o Industry representative (e.g., drug/device manufacturers)
o Researcher, academic
o Journal editor, publishers, news media
o Student, postdoctoral fellow, graduate student/post graduate trainee/ practicum
o Information scientist/medical librarian
o Patient, caregiver, family member, patient and consumer advocacy organization representative

o Other, please specify:

16. I have been practicing for:
o Less than 5 years
o 5 to 10 years
o 11 to 15 years
o More than 15 years

17. What is your primary affiliation?
o Academic Setting (e.g. university, research institute)
o Clinical Setting (Hospital, clinic, care facility, private practice)
o Public setting (government, non-profit organization [e.g., NGO, charity]
o For-profit private organization (e.g. industry)
o Other, please specify:_____

18. In which geographic region do you primarily reside?
o Australia & New Zealand
o East Asia & Pacific
o Europe
o Latin America & Caribbean
o Middle East & North Africa
o North America
o South & Central Asia
o Sub-Saharan Africa
o Other, please specify:_____

19. How do you describe yourself?
☐ Man
☐ Woman
☐ Non-binary
☐ Two spirit
☐ None of the above. I identify as: _____

20. What is your age in years?
☐ <24
☐ 25-34
☐ 35-44
☐ 45-54
☐ 55-64
☐ 65-75
☐ 75+

21. What racial or ethnic group do you belong to? Check all that apply:
☐ Arab
☐ Black
☐ Chinese
☐ Filipino
☐ Indigenous
☐ Japanese
☐ Korean

☐ Latin American
☐ South Asian (including East Indian, Pakistani, Sri Lankan, etc.)
☐ Southeast Asian (including Vietnamese, Cambodian, Laotian, Thai, etc.)
☐ West Asian (including Afghan, Iranian, etc.)
☐ White
☐ Other, please specify: _____

Appendix C – Dissemination list

CL:

- TI Blog and email about the blog (clinicians)
- 2800 emails sent out via Qualtrics (mainly researchers)
- UBC email to graduates at Faculty of medicine through the Graduate Program Coordinator
- Several email lists: 'metrics_international@lists.stanford.edu'; 'evidence-use@jiscmail.ac.uk'; 'LIS-SYS-REVIEWS@jiscmail.ac.uk'; 'LITERATUREREVIEW@jiscmail.ac.uk'; 'SR-AUTOMATE@jiscmail.ac.uk'; 'SYS-REVIEW@jiscmail.ac.uk'; 'evidence-based-health@jiscmail.ac.uk'; AERA_SIG176-ANNOUNCE@LISTSERV.AERA.NET;
- Canadian Physiotherapy Association newsletter (16,000) July 28
- Cochrane Canada group (n=39)
- Knowledge Translation program newsletter and postdoc newsletter
- VPRI Update from Unity Health Toronto (1600 emails)
- Twice a Week newsletter for Unity Health
- RTC Newsletter for Unity Health
- SRSM membership (n=160)

SW:

- all the Health Research Methodology (HRM) students & alumni
- HRM faculty/associate members
- McGill Medicine newsletter and
- post on the physician clinical investigators Facebook groups & other medical student groups

SK:

1. Ottawa pharmacists: General hospital, civic hospital, riverside hospital, heart institute, Queensway-Carleton hospital
2. Ottawa physicians: Same hospitals but only sending to people I know. Will ask for them to forward to colleagues.
3. Ontario College of Pharmacists: Seems promising. Am waiting to get approval.
4. Canadian Society of Hospital Pharmacists: They have email list-serves that I can use to disseminate. Unfortunately I am not a member but am asking a colleague to post on my behalf.
5. Will also pick through my contact list and send to national and international colleagues.

YC:

- Translated the survey into mandarin and distributed to her EBM group (how many people?)

NF:

- " Gruppo Italiano di Metodologia della Ricerca Clinico-Assistenziale" (Fb group, 1066 members),
- LinkedIn account
- A.I.FI. (Italian Association of Physiotherapy) 6,000 contacts mailing list aug 9th. We got 42 responses Aug 8 and 16 responses Aug 9 (today) so far
    - 22,976 contacts received the Survey email
    - 6525 contacts opened the link
        - So it is a 28%. I think maybe it is quite technical for physios, both for the language (English) and for the contents.
- Researchgate

EKR:

- Drug Evaluation Alliance program for NS (contributes to provincial formulary decisions)
- Hospital pharmacist colleagues

Appendix D – Responses by decision maker types

Table 1: Characteristics of respondents (n = 684)

Characteristic	All respondents (n=458)	Policy makers	Health Practitioners	Industry reps	Researchers	Patients and their carers	Journal Editors, publishers	Students, trainees	Info. specialists
Primary and current roles*									
• Policymaker (n=62)	62 (13.5%)	62 (100%)	14 (8.2%)	1 (33.3%)	37 (13.9%)	4 (26.7%)	9 (22.0%)	4 (4.5%)	1 (3.7%)
• Practitioners (n=170)	170 (37.1%)	14 (22.6%)	170 (100%)	0 (0%)	67 (25.1%)	6 (40.0%)	13 (31.7%)	27 (30.7%)	0 (0%)
• Industry representative (n=3)	3 (0.7%)	1 (1.6%)	0 (0%)	0 (0%)	2 (0.7%)	1 (6.7%)	1 (2.4%)	1 (1.1%)	0 (0%)
• Researcher (n=267)	267 (58.2%)	37 (59.7%)	67 (39.4%)	2 (66.7%)	267 (100%)	9 (60.0%)	35 (85.4%)	44 (50.0%)	13 (48.1%)
• Patient, consumer (n=15)	15 (3.2%)	4 (6.4%)	6 (3.5%)	1 (33.3%)	9 (3.4%)	15 (100%)	1 (2.4%)	5 (5.7%)	0 (0%)
• Journal editor, publishers, news media (n=41)	41 (9.0%)	9 (14.5%)	13 (7.6%)	1 (33.3%)	35 (13.1%)	1 (6.7%)	41 (100%)	11 (12.5%)	1 (3.7%)
• Student, trainee (n=88)	88 (19.2%)	4 (6.5%)	27 (15.9%)	1 (33.3%)	44 (16.5%)	5 (33.3%)	11 (26.8%)	88 (100%)	0 (0%)
• Information scientist, medical librarian (n=27)	27 (5.9%)	1 (1.6%)	0 (0%)	0 (0%)	13 (4.9%)	0 (0%)	1 (2.4%)	0 (0%)	27 (100%)
Primary affiliation	**(n=459)**	**(n=62)**	**(n=170)**	**(n=3)**	**(n=267)**	**(n=15)**	**(n=41)**	**(n=88)**	**(n=27)**
• Academic Setting (e.g. university, research institute)	255 (55.6%)	20 (32.2%)	54 (31.8%)	2 (66.7%)	204 (76.4%)	9 (60.0%)	32 (78.0%)	65 (73.9%)	12 (44.4%)
• Clinical Setting (Hospital, clinic, care facility, private practice)	128 (27.9%)	10 (16.1%)	99 (58.2%)	0 (0%)	31 (11.6%)	3 (20.0%)	4 (9.8%)	19 (21.6%)	10 (37.0%)
• Public setting (government, NGO, charity]	54 (11.8%)	25 (40.3%)	12 (7.0%)	0 (0%)	21 (7.9%)	3 (20.0%)	4 (9.8%)	3 (3.4%)	3 (11.1%)
• For-profit private organization (e.g. industry)	12 (2.6%)	2 (3.2%)	1 (0.6%)	1 (33.3%)	5 (1.9%)	0 (0%)	0 (0%)	0 (0%)	1 (3.7%)
• Other	10 (2.1%)	5 (8.0%)	4 (2.3%)	0 (0%)	6 (2.2%)	0 (0%)	1 (2.4%)	1 (1.1%)	1 (3.7%)

Characteristic	All respondents (n=458)	Policy makers	Health Practitioners	Industry reps	Researchers	Patients and their carers	Journal Editors, publishers	Students, trainees	Info. specialists
Number of years practicing working in your profession	**(n=455)**	**(n=62)**	**(n=169)**	**(n=3)**	**(n=264)**	**(n=15)**	**(n=41)**	**(n=88)**	**(n=27)**
• less than 5 years	86 (18.9%)	4 (6.4%)	31 (18.2%)	0 (0%)	35 (13.2%)	4 (26.7%)	1 (2.4%)	37 (42.0%)	1 (3.7%)
• 5 to 10 years	124 (27.2%)	18 (29.0%)	41 (24.1%)	2 (66.7%)	80 (30.3%)	4 (26.7%)	10 (24.3%)	37 (42.0%)	6 (22.2%)
• 11 to 15 years	79 (17.3%)	14 (22.6%)	32 (18.8%)	0 (0%)	51 (19.3%)	2 (13.3%)	14 (34.1%)	11 (12.5%)	8 (29.6%)
• more than 15 years	166 (36.4%)	26 (41.9%)	65 (38.2%)	1 (33.3%)	98 (37.1%)	5 (33.3%)	16 (39.0%)	3 (3.4%)	12 (44.4%)
Geographic location	**(n=458)**	**(n=62)**	**(n=170)**	**(n=3)**	**(n=267)**	**(n=15)**	**(n=41)**	**(n=88)**	**(n=27)**
• Australia & New Zealand	17 (3.7%)	2 (3.2%)	9 (5.2%)	1 (33.3%)	13 (4.9%)	1 (6.7%)	6 (14.6%)	6 (6.8%)	1 (3.7%)
• East Asia & Pacific	4 (0.9%)	0 (0%)	1 (0.6%)	0 (0%)	3 (1.1%)	1 (6.7%)	1 (2.4%)	3 (3.4%)	0 (0%)
• Europe	157 (34.2%)	26 (41.9%)	51 (30.0%)	2 (66.7%)	94 (35.2%)	2 (13.3%)	13 (31.7%)	22 (25.0%)	11 (40.7%)
• Latin America & Caribbean	12 (2.6%)	5 (8.0%)	1 (0.6%)	0 (0%)	8 (3%)	1 (6.7%)	2 (4.9%)	5 (5.7%)	1 (3.8%)
• Middle East & North Africa	6 (1.3%)	1 (1.6%)	5 (2.9%)	0 (0%)	4 (1.5%)	0 (0%)	1 (2.4%)	2 (2.2%)	0 (0%)
• North America	242 (52.8%)	25 (40.3%)	94 (55.2%)	0 (0%)	129 (48.3%)	8 (53.3%)	15 (36.6%)	44 (50.0%)	13 (48.1%)
• South & Central Asia	10 (2.1%)	1 (1.6%)	4 (2.3%)	0 (0%)	10 (3.8%)	0 (0%)	3 (7.3%)	2 (2.2%)	0 (0%)
• Sub-Saharan Africa	3 (0.7%)	1 (1.6%)	3 (1.8%)	0 (0%)	1 (0.3%)	1 (6.7%)	0 (0%)	2 (2.2%)	0 (0%)
• Other	4 (0.9%)	1 (1.6%)	1 (0.6%)	0 (0%)	3 (1.1%)	0 (0%)	0 (0%)	1 (1.1%)	0 (0%)
How do you describe yourself?	**(n=457)**	**(n=62)**	**(n=170)**	**(n=3)**	**(n=266)**	**(n=15)**	**(n=41)**	**(n=88)**	**(n=27)**
• Man	196 (42.9%)	27 (43.6%)	95 (55.9%)	1 (33.3%)	118 (44.3%)	2 (13.3%)	28 (68.2%)	39 (44.3%)	4 (16.7%)
• Woman	248 (54.2%)	32 (51.6%)	70 (41.1%)	2 (66.7%)	138 (51.9%)	12 (80.0%)	11 (26.8%)	46 (52.2%)	22 (81.2%)

Characteristic	All respondents (n=458)	Policy makers	Health Practitioners	Industry reps	Researchers	Patients and their carers	Journal Editors, publishers	Students, trainees	Info. specialists
• Non-binary	2 (0.4%)	1 (1.6%)	0 (0%)	0 (0%)	1 (0.3%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
• Two spirit	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
• None of the above	1 (0.2%)	0 (0%)	1 (0.6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
• Prefer not to answer	10 (1.4%)	2 (3.2%)	4 (2.3%)	0 (0%)	9 (3.3%)	1 (6.7%)	2 (4.9%)	3 (3.4%)	0 (0%)
Age range	**(n=457)**	**(n=62)**	**(n=170)**	**(n=3)**	**(n=265)**	**(n=15)**	**(n=41)**	**(n=87)**	**(n=27)**
• 24 or younger	7 (1.5%)	0 (0%)	1 (0.6%)	0 (0%)	2 (0.8%)	0 (0%)	0 (0%)	6 (6.9%)	0 (0%)
• 25-34	136 (29.8%)	15 (24.1%)	52 (30.6%)	1 (33.3%)	64 (24.1%)	5 (33.3%)	5 (12.2%)	56 (64.3%)	4 (14.8%)
• 35-44	125 (27.3%)	17 (27.4%)	52 (30.6%)	1 (33.3%)	83 (31.3%)	4 (26.7%)	19 (46.3%)	17 (19.5%)	8 (29.6%)
• 45-54	89 (19.4%)	17 (27.4%)	28 (16.4%)	0 (0%)	58 (21.9%)	3 (20.0%)	4 (9.8%)	4 (4.6%)	10 (37.0%)
• 55-64	62 (13.6%)	10 (16.1%)	22 (12.9%)	1 (33.3%)	34 (12.8%)	2 (13.3%)	7 (17.0%)	3 (3.4%)	3 (11.1%)
• 65-75	26 (5.7%)	1 (1.6%)	12 (7.0%)	0 (0%)	15 (5.7%)	0 (0%)	4 (9.8%)	0 (0%)	2 (7.4%)
• 75 or older	3 (0.7%)	0 (0%)	0 (0%)	0 (0%)	1 (0.3%)	0 (0%)	1 (2.4%)	0 (0%)	0 (0%)
• Prefer not to answer	9 (1.3%)	2 (3.2%)	3 (1.8%)	0 (0%)	8 (3%)	1 (6.7%)	1 (2.4%)	1 (1.1%)	0 (0%)
Racial or ethnic group	**(n=449)**	**(n=62)**	**(n=170)**	**(n=3)**	**(n=265)**	**(n=15)**	**(n=41)**	**(n=87)**	**(n=27)**
• Arab	10 (2.2%)	1 (1.6%)	9 (5.2%)	0 (0%)	5 (1.9%)	0 (0%)	1 (2.4%)	4 (4.6%)	0 (0%)
• Black	14 (3.1%)	3 (4.8%)	5 (2.9%)	0 (0%)	7 (2.6%)	1 (6.7%)	2 (4.9%)	6 (6.9%)	1 (3.7%)
• Chinese	21 (4.7%)	1 (1.6%)	9 (5.2%)	0 (0%)	13 (4.9%)	2 (13.3%)	3 (7.3%)	5 (5.7%)	1 (3.7%)
• Filipino	2 (0.4%)	0 (0%)	1 (0.6%)	0 (0%)	0 (0%)	0 (0%)	1 (2.4%)	1 (1.1%)	0 (0%)

Characteristic	All respondents (n=458)	Policy makers	Health Practitioners	Industry reps	Researchers	Patients and their carers	Journal Editors, publishers	Students, trainees	Info. specialists
• Indigenous	1 (0.2%)	0 (0%)	1 (0.6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
• Japanese	3 (0.6%)	1 (1.6%)	2 (1.1%)	0 (0%)	1 (0.3%)	0 (0%)	0 (0%)	0 (0%)	1 (3.7%)
• Korean	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
• Latin American	25 (5.6%)	7 (11.2%)	6 (3.5%)	0 (0%)	15 (5.7%)	2 (13.3%)	3 (7.3%)	12 (13.8%)	1 (3.7%)
• South Asian (including East Indian, Pakistani, Sri Lankan, etc.)	25 (5.6%)	4 (6.4%)	12 (7.0%)	1 (33.3%)	17 (6.4%)	1 (6.7%)	2 (4.9%)	4 (4.6%)	1 (3.7%)
• Southeast Asian (including Vietnamese, Cambodian, Laotian, Thai, etc.)	8 (1.8%)	2 (3.2%)	5 (2.9%)	0 (0%)	6 (2.2%)	0 (0%)	1 (2.4%)	1 (1.1%)	0 (0%)
• West Asian (including Afghan, Iranian, etc.)	7 (1.5%)	2 (3.2%)	2 (1.1%)	0 (0%)	6 (2.2%)	0 (0%)	1 (2.4%)	2 (2.2%)	0 (0%)
• White	326 (72.6%)	41 (66.1%)	114 (67.0%)	2 (66.7%)	185 (69.8%)	9 (60.0%)	28 (68.2%)	55 (63.2%)	22 (81.4%)
• Other race, please specify:	9 (2.0%)	1 (1.6%)	5 (2.9%)	0 (0%)	3 (1.1%)	0 (0%)	1 (2.4%)	0 (0%)	3 (11.1%)
• Prefer not to answer	27 (4.0%)	5 (8.0%)	8 (4.7%)	0 (0%)	19 (7.1%)	1 (6.7%)	3 (7.3%)	3 (3.4%)	0 (0%)
Q5. 5. How long have you, your working group or your work colleagues, been producing systematic reviews? (n=10)									
	n = 10	n = 1	n = 7	n = 0	n = 4	n = 1	n = 0	n = 0	n = 0
Never	1 (10.0%)	0 (0%)	1	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Less than 1 per year	3 (30.0%)	0 (0%)	3	0 (0%)	1	0 (0%)	0 (0%)	0 (0%)	0 (0%)
1-2 per year	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
3-5 per year	4 (40.0%)	0 (0%)	2	0 (0%)	1	0 (0%)	0 (0%)	0 (0%)	0 (0%)
>5 per year	2 (20.0%)	1	1	0 (0%)	2	1 (100%)	0 (0%)	0 (0%)	0 (0%)
Q15. I have been practicing/working for (n = 455):									
	n = 455	n = 62	n = 168	n = 3	n = 264	n = 1	n = 41	n = 88	n = 15
less than 5 years	86 (18.9%)	4 (6.5%)	31 (18.3%)	0 (%)	35 (13.3%)	0 (%)	1 (2.4%)	37 (42%)	4 (26.7%)

Characteristic	All respondents (n=458)	Policy makers	Health Practitioners	Industry reps	Researchers	Patients and their carers	Journal Editors, publishers	Students, trainees	Info. specialists
5 to 10 years	124 (27.3%)	18 (29%)	40 (23.7%)	2 (66.7%)	80 (30.3%)	0 (%)	5 (12.2%)	37 (42%)	4 (26.7%)
11 to 15 years	79 (17.4%)	14 (22.6%)	32 (18.9%)	0 (%)	51 (19.3%)	0 (%)	14 (34.1%)	11 (12.5%)	2 (13.3%)
more than 15 years	166 (36.54%)	26 (41.9%)	67 (38.5%)	1 (33.3%)	98 (37.1%)	1 (100%)	16 (39%)	3 (3.4%)	5 (33.3%)

*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)

Table 2: Experience with using or developing systematic reviews

Item	Responses	ALL	Policymaker	Practitioner	Researcher
		(n=684)	**(n=62)**	**(n=170)**	**(n=267)**
Q1. Familiarity with SRs as a type of evidence summary of all primary research on one topic	Yes No Unsure	621 (90.8%) 35 (5.1%) 28 (4.1%)	60 (96.8%) 0 (0%) 2 (3.2%)	164 (96.4%) 3 (1.8%) 3 (1.8%)	267 (100%) 0 (0%) 0 (0%)
		(n=542)	**(n=62)**	**(n=170)**	**(n=267)**
Q2. According to Moher and colleagues, the PRISMA checklist is not a quality assessment instrument to judge the quality of a SR	**True** False Unsure	335 (61.8%) 126 (23.2%) 80 (14.8%)	42 (67.7%) 14 (22.6%) 5 (8.1%)	70 (41.1%) 54 (31.8%) 35 (20.6%)	192 (71.9%) 43 (16.1%) 24 (9.0%)
		(n=547)	**(n=62)**	**(n=170)**	**(n=267)**
Q3. Which of the following could be discussed as limitations that occurred at the SR level (as opposed to limitations in primary studies)?	A. Selective reporting of results or analyses	7 (1.3%)	0 (0%)	1 (0.6%)	3 (1.1%)
	B. Risk of bias of the primary studies	8 (1.5%)	2 (3.2%)	2 (1.2%)	3 (1.1%)
	C. Relevant studies missed due to a flawed search strategy or limited databases and other sources searched	9 (1.6%)	1 (1.6%)	5 (2.9%)	3 (1.1%)
	D. Missing relevant studies when screening for inclusion	5 (0.9%)	0 (0%)	1 (0.6%)	3 (1.1%)

	E. Excluding foreign language (non-English) articles	8 (1.5%)	0 (0%)	2 (1.2%)	4 (1.5%)
	F. All except A	199 (36.4%)	19 (30.7%)	58 (34.1%)	85 (31.8%)
	G. All except B	308 (56.3%)	38 (61.2%)	90 (52.9%)	159 (59.6%)
		(n=558)	**(n=62)**	**(n=170)**	**(n=267)**
Q4. How often did you seek out SRs as a source of evidence in decision making/learning in the past two years?	Never	16 (2.9%)	0 (0%)	8 (4.7%)	3 (1.1%)
	Sometimes	182 (32.6%)	8 (12.9%)	68 (40.0%)	53 (19.9%)
	Often	360 (64.5%)	54 (87.1%)	91 (53.5%)	209 (78.2%)

*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)

**Highlighted text indicates the correct answer.

Table 3: Experience with using or developing SRs

Item	Responses	ALL n/N (%)	Policymaker 62/684 (9.0%)	Practitioner 170/684 (24.9%)	Researcher, academic 267/684 (39.0%)	Industry Representative 3/684 (0.4%)	Journal editor 41/684 (6.0%)	Student, trainee 88/684 (12.9%)	Informational specialist 27/684 (3.9%)	Patient 15/684 (2.1%)
Q1. Familiarity with SRs as a type of evidence summary of all primary research on one topic	Yes	621/684 (90.8%)	60/62 (96.8%)	164/170 (96.4%)	267/267 (100%)	3/3 (100%)	41/41 (100%)	86/88 (97.7%)	25/27 (92.6%)	12/15 (80.0%)
	No	35/684 (5.1%)	0/62 (0%)	3/170 (1.8%)	0/267 (0%)	0/3 (0%)	0/41 (0%)	2/88 (2.2%)	0/27 (0%)	1/15 (6.7%)
	Unsure	28/684 (4.1%)	2/62 (3.2%)	3/170 (1.8%)	0/267 (0%)	0/3 (0%)	0/41 (0%)	0/88 (0%)	2/27 (7.4%)	2/15 (13.3%)
Q2. According to Moher and colleagues, the PRISMA checklist is not a quality assessment instrument to judge the quality of a SR	**True**	335/542 (61.8%)	42/62 (67.7%)	70/170 (41.1%)	192/267 (71.9%)	2/3 (66.7%)	29/41 (70.7%)	49/83 (59.0%)	24/27 (88.9%)	7/13 (53.8%)
	False	126/542 (23.2%)	14/62 (22.6%)	54/170 (31.8%)	43/267 (16.1%)	1/3 (33.3%)	11/41 (26.8%)	24/83 (28.9%)	1/27 (3.7%)	5/13 (38.4%)
	Unsure	80/542 (14.8%)	5/62 (8.1%)	35/170 (20.6%)	24/267 (9.0%)	0/3 (0%)	1/41 (2.4%)	10/83 (12.0%)	2/27 (7.4%)	1/13 (7.7%)
Q3. Which of the following could be discussed as limitations that occurred at the SR level (as opposed to	A. Selective reporting of results or analyses	7/547 (1.3%)	0/62 (0%)	1/170 (0.6%)	3/267 (1.1%)	0/3 (0%)	0/41 (0%)	0/84 (0%)	0/27 (0%)	0/13 (0%)
	B. Risk of bias of the primary studies	8/547 (1.5%)	2/62 (3.2%)	2/170 (1.2%)	3/267 (1.1%)	0/3 (0%)	0/41 (0%)	1/84 (1.1%)	0/27 (0%)	0/13 (0%)

limitations in primary studies)?	C. Relevant studies missed due to a flawed search strategy or limited databases and other sources searched	9/547 (1.6%)	1/62 (1.6%)	5/170 (2.9%)	3/267 (1.1%)	1/3 (33.3%)	2/41 (4.9%)	4/84 (4.8%)	0/27 (0%)	1/13 (7.7%)
	D. Missing relevant studies when screening for inclusion	5/547 (0.9%)	0/62 (0%)	1/170 (0.6%)	3/267 (1.1%)	0/3 (0%)	0/41 (0%)	0/84 (0%)	0/27 (0%)	0/13 (0%)
	E. Excluding foreign language (non-English) articles	8/547 (1.5%)	0/62 (0%)	2/170 (1.2%)	4/267 (1.5%)	0/3 (0%)	0/41 (0%)	0/84 (0%)	1/27 (3.7%)	0/13 (0%)
	F. All except A	199/547 (36.4%)	19/62 (30.7%)	58/170 (34.1%)	85/267 (31.8%)	1/3 (33.3%)	10/41 (24.3%)	28/84 (33.3%)	13/27 (48.1%)	5/13 (38.4%)
	G. All except B	308/547 (56.3%)	38/62 (61.2%)	90/170 (52.9%)	159/267 (59.6%)	1/3 (33.3%)	29/41 (70.7%)	51/84 (60.7%)	13/27 (48.1%)	7/13 (53.8%)
Q4. How often did you seek out SRs as a source of evidence in decision making/learning in the past two years?	Never	16/558 (2.9%)	0/62 (0%)	8/170 (4.7%)	3/267 (1.1%)	0/3 (0%)	1/41 (2.4%)	0/85 (0%)	0/27 (0%)	1/14 (7.1%)
	Sometimes	182/558 (32.6%)	8/62 (12.9%)	68/170 (40.0%)	53/267 (19.9%)	2/3 (66.7%)	7/41 (17.0%)	25/85 (29.4%)	8/27 (29.6%)	8/14 (57.1%)
	Often	360/558 (64.5%)	54/62 (87.1%)	91/170 (53.5%)	209/267 (78.6%)	1/3 (33.3%)	33/41 (80.4%)	60/85 (70.6%)	19/27 (70.3%)	5/14 (35.7%)

*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)
**Highlighted text indicates the correct answer.

Q15b. Overall, 65% of respondents (n=444) were interested in being involved further in some capacity (**Appendix E**), and 135 respondents (30.4%) provided their emails for this purpose. Most were interested in receiving training in using the new tool (52%) or being involved in piloting a new automated decision support tool (46%).

Table 4: Comparing or choosing SR(s) when there are multiple on the same topic

Item	Responses	ALL n/N (%)	Policymaker	Practitioner	Researcher, academic	Industry rep	Journal editor	Student, trainee	Info. specialist	Patient
Q6. How often have you faced a situation where you find more than one SR on a given topic of interest to you?	Never	12/538 (2.2%)	0/62 (0%)	4/167 (2.3%)	5/266 (1.9%)	1/3 (33.3%)	2/41 (4.9%)	2/85 (2.3%)	0/27 (0%)	2/14 (14.2%)
	Sometimes	295/538 (54.8%)	30/62 (48.3%)	106/167 (63.4%)	123/266 (46.2%)	1/3 (33.3%)	20/41 (48.8%)	47/85 (55.2%)	13/27 (48.1%)	7/14 (50.0%)
	Often	232/538 (43.1%)	31/62 (50.0%)	57/167 (34.1%)	138/266 (51.9%)	1/3 (33.3%)	19/41 (46.3%)	36/85 (42.3%)	14/27 (51.9%)	5/14 (35.7%)
Q7. If a free, automated, AI-informed, evidenced-based online tool was available to assist you in choosing the best SR(s) among multiple on the same question, would you use it? The tool would be founded on empirical research and monitored by evidence-synthesis experts for accuracy	Yes	335/385 (87.0%)	31/39 (79.5%)	124/137 (90.5%)	146/168 (86.9%)	2/3 (66.7%)	17/24 (70.8%)	64/71 (90.1%)	11/15 (73.3%)	9/11 (81.8%)
	No	21/385 (5.5%)	6/39 (15.4%)	6/137 (4.4%)	8/168 (4.8%)	1/3 (33.3%)	5/24 (20.8%)	2/71 (2.8%)	1/15 (6.7%)	1/11 (9.1%)
	Unsure	29/385 (7.5%)	1/39 (2.6%)	7/137 (5.1%)	14/168 (8.3%)	0/3 (0%)	2/24 (8.3%)	5/71 (7.0%)	3/15 (20.0%)	1/11 (9.1%)
	Comments	170/385 (44.2%)	25/39 (64.1%)	35/137 (25.5%)	100/168 (59.5%)	0/3 (0%)	17/24 (70.8%)	16/71 (22.5%)	12/15 (80.0%)	4/11 (36.4%)
Q8. When you encounter multiple SRs on the same topic how do you choose the one(s) most likely to address your clinical/public health/policy question or your learning needs?	I typically choose the first one I find that is relevant to my topic	13/552 (2.4%)	1/62 (1.6%)	2/170 (1.1%)	4/266 (1.5%)	0/3 (0%)	1/41 (2.4%)	3/87 (3.4%)	1/27 (3.7%)	0/15 (0%)
	I find as many as I can that are relevant to my topic and then review them all	207/552 (37.5%)	34/62 (54.8%)	45/170 (26.4%)	111/266 (41.7%)	1/3 (33.3%)	20/41 (48.8%)	31/87 (35.6%)	20/27 (74.0%)	6/15 (40.0%)
	I typically choose the most recently published one(s) that are relevant to my topic	171/552 (31.0%)	7/62 (11.2%)	75/170 (44.1%)	60/266 (22.6%)	0/3 (0%)	5/41 (12.1%)	28/87 (32.1%)	3/27 (11.1%)	5/15 (33.3%)
	I typically choose the one from the highest impact factor journal	34/552 (6.2%)	1/62 (1.6%)	18/170 (10.6%)	10/266 (3.8%)	1/3 (33.3%)	3/41 (7.3%)	10/87 (11.4%)	0/27 (0%)	2/15 (13.3%)
	Other	128/552 (23.2%)	18/62 (29.0%)	29/170 (17.0%)	80/266 (30.0%)	1/3 (33.3%)	12/41 (29.2%)	15/87 (17.2%)	3/27 (11.1%)	2/15 (13.3%)

Q9. When you have encountered multiple SRs on the same topic, which of the following statements resonates most with you?	I can usually identify the SR(s) best suited to my needs	268/548 (48.9%)	35/62 (56.4%)	56/170 (32.9%)	152/264 (57.6%)	0/3 (0%)	25/40 (62.5%)	33/87 (37.9%)	12/27 (44.4%)	6/15 (40.0%)
	I sometimes struggle to identify the SR(s) that are best suited to my needs	238/548 (43.4%)	24/62 (38.7%)	94/170 (55.2%)	101/264 (38.2%)	3/3 (100%)	15/40 (37.5%)	49/87 (56.3%)	13/27 (48.1%)	6/15 (40.0%)
	I often struggle to identify the SR(s) best suited to my needs	41/548 (7.4%)	3/62 (4.8%)	19/170 (11.1%)	10/264 (3.8%)	0/3 (0%)	0/40 (0%)	5/87 (5.7%)	2/27 (7.4%)	3/15 (20.0%)
Q10. If/when you struggle to choose the SR(s) best suited to your needs, the barriers to you being able to make this decision are	Insufficient data from titles and abstracts to assess relevance to my question(s):	180/505 (35.6%)	21/60 (35.0%)	55/165 (33.3%)	77/251 (30.7%)	3/3 (100%)	14/36 (38.9%)	34/84 (40.4%)	6/24 (25.0%)	6/15 (40.0%)
	Inexperience with assessing the methodological quality of (or biases in) SRs	140/505 (27.7%)	9/60 (15%)	72/165 (43.6%)	30/251 (12.0%)	1/3 (33.3%)	4/36 (11.1%)	33/84 (39.2%)	7/24 (29.1%)	7/15 (46.7%)
	Not enough time to read each SR in full to evaluate all the options	279/505 (55.2%)	23/60 (38.3%)	110/165 (66.7%)	119/251 (47.4%)	0/0 (0%)	17/36 (47.2%)	46/84 (54.8%)	9/24 (37.5%)	9/15 (60.0%)
	You don't trust the conclusions	56/505 (11.0%)	11/60 (18.3%)	21/165 (12.7%)	34/251 (13.5%)	3/3 (100%)	2/36 (5.6%)	9/84 (10.7%)	5/24 (20.8%)	5/15 (33.3%)
	Different results and conclusions across the SRs	251/505 (49.7%)	28/60 (46.7%)	94/165 (57.0%)	130/251 (51.8%)	3/3 (100%)	24/36 (66.7%)	45/84 (53.6%)	9/24 (37.5%)	9/15 (60.0%)
	Variation in the quality of how the SRs were conducted	274/505 (54.2%)	34/60 (56.7%)	79/165 (47.9%)	146/251 (58.1%)	3/3 (100%)	25/36 (69.4%)	49/84 (58.3%)	8/24 (33.3%)	8/15 (53.3%)

	Variation in searches across the SRs	172/505 (34.0%)	23/60 (38.3%)	46/165 (27.9%)	95/251 (37.8%)	0/0 (0%)	19/36 (52.8%)	21/84 (25.0%)	3/24 (12.5%)	3/15 (20.0%)
	Variation in included primary studies across the SRs	225/505 (44.6%)	30/60 (50.0%)	63/165 (38.1%)	120/251 (47.8%)	2/3 (66.6%)	18/36 (50.0%)	34/84 (40.4%)	4/24 (16.7%)	4/15 (26.7%)
	Variation in how across the SRs results were synthesized	194/505 (38.4%)	28/60 (46.7%)	51/165 (30.9%)	106/251 (42.2%)	2/3 (66.6%)	19/36 (52.8%)	31/84 (36.9%)	3/24 (12.5%)	3/15 (20.0%)
	Slightly different clinical focus between SRs	218/505 (43.1%)	27/60 (45.0%)	74/165 (44.8%)	107/251 (42.6%)	2/3 (66.6%)	13/36 (36.1%)	30/84 (35.7%)	5/24 (20.8%)	5/15 (33.3%)
	Other, please specify	35/505 (6.9%)	5/60 (8.3%)	5/165 (3.0%)	24/251 (9.6%)	0/0 (0%)	3/36 (8.3%)	4/84 (4.8%)	1/24 (4.1%)	1/15 (6.7%)
Q11. *Random question:* Which elements should be considered when choosing the SR(s) best suited to my needs among multiple on the same topic	Recency of SR search date	205/274 (74.8%)	24/30 (80.0%)	67/68 (98.5%)	110/125 (88.0%)	1/2 (50.0%)	22/27 (81.4%)	45/54 (83.3%)	15/19 (79.0%)	5/8 (62.5%)
	The review is conducted by a reputable organisation (e.g. NICE, Cochrane, or AHRQ)	162/274 (59.1%)	17/30 (56.7%)	67/68 (98.5%)	76/125 (60.8%)	2/2 (100%)	16/27 (59.2%)	35/54 (64.8%)	12/19 (63.1%)	6/8 (75.0%)
	Reputation / expertise of the SR author team or affiliation	106/274 (38.7%)	14/30 (46.7%)	40/68 (58.8%)	58/125 (46.4%)	2/2 (100%)	19/27 (70.3%)	23/54 (42.6%)	9/19 (47.3%)	4/8 (50.0%)
	Country of publication (country of first author)	9/274 (3.3%)	3/30 (10.0%)	1/68 (1.4%)	6/125 (4.8%)	1/2 (50.0%)	3/27 (11.1%)	4/54 (7.4%)	0/19 (0%)	1/8 (12.5%)
	Language of publication	69/274 (25.2%)	10/30 (33.3%)	18/68 (26.4%)	32/125 (25.6%)	0/2 (0%)	6/27 (22.2%)	15/54 (27.8%)	7/19 (36.8%)	1/8 (12.5%)

	Integrity of publishing journal (e.g. peer-reviewed publication, publication in one of my preferred journals, journal of high impact factor or high prestige (e.g. JAMA, Lancet, BMJ))	137/274 (50.0%)	14/30 (46.7%)	56/68 (82.3%)	64/125 (51.2%)	1/2 (50.0%)	17/27 (63.0%)	36/54 (66.7%)	8/19 (42.1%)	3/8 (37.5%)
	A protocol or pre-registration for the SR was registered or published (i.e. an a priori plan of the review)	162/274 (59.1%)	21/30 (70.0%)	50/68 (73.5%)	97/125 (77.6%)	1/2 (50.0%)	20/27 (74.0%)	33/54 (61.1%)	11/19 (57.9%)	2/8 (25.0%)
	Relevance of the SRs research question to my clinical question/learning needs	229/274 (83.6%)	30/30 (100%)	68/68 (100%)	125/125 (100%)	1/2 (50.0%)	25/27 (93.0%)	43/54 (79.6%)	18/19 (94.7%)	5/8 (62.5%)
	Methodological quality and reproducibility of the SR	217/274 (79.2%)	30/30 (100%)	61/68 (89.7%)	125/125 (100%)	1/2 (50.0%)	24/27 (88.9%)	45/54 (83.3%)	16/19 (84.2%)	4/8 (50.0%)
	The review assessed both efficacy and harms	118/274 (43.1%)	13/30 (43.3%)	46/68 (67.6%)	63/125 (50.4%)	1/2 (50.0%)	10/27 (37.0%)	20/54 (37.0%)	6/19 (31.6%)	4/8 (50.0%)
	Comprehensive search strategy (scope of search terms and number of databases searched	189/274 (69.0%)	25/30 (83.3%)	52/68 (76.4%)	106/125 (84.8%)	2/2 (100%)	21/27 (77.8%)	41/54 (75.9%)	16/19 (84.2%)	5/8 (62.5%)
	Number of included primary studies	64/274 (23.4%)	9/30 (30.0%)	26/68 (38.2%)	31/125 (24.8%)	1/2 (50.0%)	5/27 (18.5%)	13/54 (24.0%)	8/19 (42.1%)	0/8 (0%)
	Risk of bias / quality of the	167/274 (60.9%)	22/30 (73.3%)	52/68 (76.4%)	92/125 (73.6%)	2/2 (100%)	17/27 (63.0%)	33/54 (61.1%)	13/19 (68.4%)	4/8 (50.0%)

	included primary studies									
	Types of primary studies included (RCTs versus non-randomized studies)	151/274 (55.1%)	19/30 (63.3%)	55/68 (80.9%)	80/125 (64.0%)	2/2 (100%)	16/27 (59.2%)	26/54 (48.1%)	13/19 (68.4%)	3/8 (37.5%)
	Availability of a meta-analysis	120/274 (43.8%)	20/30 (66.7%)	42/68 (61.8%)	63/125 (50.4%)	1/2 (50.0%)	18/27 (66.7%)	26/54 (48.1%)	6/19 (31.6%)	1/8 (12.5%)
	Congruence with my own opinion	9/274 (3.2%)	2/30 (6.7%)	3/68 (4.4%)	4/125 (3.2%)	0/2 (0%)	1/27 (3.7%)	6/54 (11.1%)	0/19 (0%)	1/8 (12.5%)
	Reported conflict(s) of interest of the SR author team	124/274 (45.2%)	20/30 (66.7%)	40/68 (58.8%)	65/125 (52.0%)	1/2 (50.0%)	17/27 (63.0%)	23/54 (42.6%)	10/19 (52.6%)	5/8 (62.5%)
	Clinically relevant outcomes	180/274 (65.7%)	25/30 (83.3%)	62/68 (91.1%)	93/125 (74.4%)	1/2 (50.0%)	17/27 (63.0%)	38/54 (70.3%)	11/19 (57.9%)	4/8 (50.0%)
	Other	16/274 (5.8%)	5/30 (16.7%)	3/68 (4.4%)	11/125 (8.8%)	0/2 (0%)	1/27 (3.7%)	2/54 (3.7%)	1/19 (5.2%)	1/8 (12.5%)
Q12a. Which SR(s) would you choose to inform your discussion with the patient?	Liu 2017	57/186 (30.6%)	8/21 (38.1%)	20/61 (32.8%)	29/94 (30.9%)	0/0 (0%)	5/14 (35.7%)	7/34 (20.6%)	3/8 (37.5%)	5/7 (71.4%)
	Yu 2017	36/186 (19.4%)	6/21 (28.6%)	11/61 (18.0%)	20/94 (21.3%)	0/0 (0%)	4/14 (28.6%)	3/34 (8.8%)	1/8 (12.5%)	4/7 (57.1%)
	Woo 2018	161/186 (86.6%)	14/21 (66.7%)	52/61 (85.2%)	80/94 (85.1%)	0/0 (0%)	6/14 (42.9%)	24/34 (70.6%)	4/8 (50.0%)	4/7 (57.1%)
	More than one	30/186 (16.1%)	5/21 (23.8%)	12/61 (19.7%)	27/94 (28.7%)	0/0 (0%)	3/14 (21.4%)	2/34 (5.9%)	1/8 (12.5%)	1/7 (14.3%)
	All three	27/235 (14.5%)	13/29 (44.8%)	14/75 (18.7%)	43/126 (34.1%)	0/0 (0%)	6/14 (42.9%)	5/34 (14.7%)	3/8 (37.5%)	2/7 (28.6%)
	Comments	64/186 (34.4%)	12/21 (57.1%)	13/61 (21.3%)	42/94 (44.7%)	0/0 (0%)	5/14 (34.7%)	5/34 (14.7%)	3/8 (37.5%)	2/7 (28.6%)
Q12b. Random question: Which criteria would help you choose among the SRs? (free text answers were coded)	Assessment of overlap in primary studies	1/186 (0.5%)	0/25 (0%)	0/60 (0%)	1/110 (0.9%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	1/6 (16.7%)	0/6 (0%)
	Comprehensive search	24/186 (12.9%)	4/25 (16.0%)	4/60 (6.7%)	16/110 (14.5%)	0/1 (0%)	0/5 (0%)	1/30 (3.3%)	1/6 (16.7%)	0/6 (0%)
	Conflicts of interest	2/186 (1.1%)	0/25 (0%)	2/60 (3.3%)	0/110 (0%)	0/1 (0%)	1/5 (20%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Databases	18/186	1/25	14/60	3/110	0/1	0/5	2/30	1/6	0/6

		(9.7%)	(4.0%)	(23.3%)	(2.7%)	(0%)	(0%)	(6.7%)	(16.7%)	(0%)
	Evidence of spin	15/186 (8.1%)	1/25 (4.0%)	2/60 (3.3%)	12/110 (10.9%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	1/6 (16.7%)	0/6 (0%)
	GRADE approach used	10/186 (5.4%)	0/25 (0%)	1/60 (1.7%)	9/110 (8.2%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Used a hierarchy of features (i.e., not just once feature)	136/186 (73.1%)	9/25 (36.0%)	49/60 (81.7%)	78/110 (70.9%)	0/1 (0%)	1/5 (20%)	6/30 (20%)	3/6 (50%)	0/6 (0%)
	Methodological quality of the review	49/186 (26.3%)	4/25 (16.0%)	15/60 (25%)	30/100 (27.3%)	0/1 (0%)	1/5 (20%)	3/30 (10%)	2/6 (33.3%)	0/6 (0%)
	Integrity of publishing journal	13/186 (7.0%)	1/25 (4.0%)	5/60 (8.3%)	7/110 (6.7%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Languages	1/186 (0.5%)	0/25 (0%)	0/60 (0%)	1/110 (0.9%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Meta-analysis conducted	23/186 (12.4%)	1/25 (4.0%)	4/60 (6.7%)	18/110 (16.4%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Recency of SR search date	55/186 (29.6%)	2/25 (8.0%)	17/60 (28.3%)	36/110 (32.7%)	0/1 (0%)	0/5 (0%)	2/30 (6.7%)	2/6 (33.3%)	0/6 (0%)
	Number of included studies or patients	84/186 (45.2%)	3/25 (12.0%)	39/60 (65%)	42/110 (38.2)	0/1 (0%)	1/5 (20%)	4/30 (13.3%)	2/6 (33.3%)	0/6 (0%)
	Outcomes of interest including adverse effects	20/186 (10.8%)	5/25 (20.0%)	8/60 (13.3%)	7/110 (6.4%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	1/6 (16.7%)
	Primary study quality assessed	53/186 (28.5%)	4/25 (16.0%)	21/60 (35%)	28/110 (25.5%)	0/1 (0%)	0/5 (0%)	1/30 (3.3%)	2/6 (33.3%)	0/6 (0%)
	Protocol written or registered	4/186 (2.2%)	0/25 (0%)	0/60 (0%)	4/110 (3.6%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Publication bias	4/186 (2.2%)	0/25 (0%)	0/60 (0%)	4/110 (3.6%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Relevant to my PICO question	46/186 (24.7%)	5/25 (20.0%)	11/60 (18.3%)	30/110 (27.3%)	0/1 (0%)	1/5 (20%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Reporting comprehensiveness	2/186 (1.1%)	1/25 (4.0%)	0/60 (0%)	1/110 (0.9%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Reputation of author group or organisation	3/186 (1.6%)	2/25 (8.0%)	1/60 (1.7%)	0/110 (0%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Review all SRs (not just one or a few)	1/186 (0.5%)	0/25 (0%)	1/60 (1.7%)	0/110 (0%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)
	Process to select, extract, assess studies	9/186 (4.8%)	1/25 (4.0%)	2/60 (3.3%)	6/110 (5.5%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	0/6 (0%)	0/6 (0%)

	Study design	8/186 (4.3%)	0/25 (0%)	2/60 (3.3%)	6/110 (5.5%)	0/1 (0%)	0/5 (0%)	2/30 (6.7%)	0/6 (0%)	0/6 (0%)
	Heterogeneity explored	29/186 (15.6%)	2/25 (8.0%)	6/60 (10%)	21/110 (19.1%)	0/1 (0%)	0/5 (0%)	0/30 (0%)	1/6 (16.7%)	0/6 (0%)

**Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)*

Features	Policymaker (%)	Practitioner (%)	Researcher (%)
Relevance of the SRs research question to my clinical question/learning needs	30/30 (100%)	68/68 (100%)	125/125 (100%)
Methodological quality and reproducibility of the SR	30/30 (100%)	61/68 (89.7%)	125/125 (100%)
Comprehensive search strategy (scope of search terms and number of databases searched	25/30 (83.3%)	62/68 (91.1%)	93/125 (74.4%)
Clinically relevant outcomes	25/30 (83.3%)	52/68 (76.4%)	106/125 (84.8%)
Recency of SR search date	24/30 (80.0%)	67/68 (98.5%)	110/125 (88.0%)
Risk of bias/ quality of the included primary studies	22/30 (73.3%)	52/68 (76.4%)	92/125 (73.6%)
A protocol or pre-registration for the SR was registered or published (i.e. an a priori plan of the review)	21/30 (70.0%)	50/68 (73.5%)	97/125 (77.6%)
Availability of a meta-analysis	20/30 (66.7%)	42/68 (61.8%)	63/125 (50.4%)
Reported conflict(s) of interest of the SR author team	20/30 (66.7%)	40/68 (58.8%)	65/125 (52.0%)
Types of primary studies included (RCTs versus non-randomized studies)	19/30 (63.3%)	55/68 (80.9%)	80/125 (64.0%)
The review is conducted by a reputable organisation (e.g. NICE, Cochrane, or AHRQ)	17/30 (56.7%)	67/68 (98.5%)	76/125 (60.8%)
Reputation / expertise of the SR author team or affiliation	14/30 (46.7%)	56/68 (82.3%)	64/125 (51.2%)
Integrity of publishing journal (e.g. peer-reviewed publication, publication in one of my preferred journals, journal of high impact factor or high prestige (e.g. JAMA, Lancet, BMJ))	14/30 (46.7%)	40/68 (58.8%)	58/125 (46.4%)
The review assessed both efficacy and harms	13/30 (43.3%)	46/68 (67.6%)	63/125 (50.4%)
Language of publication	10/30 (33.3%)	18/68 (26.4%)	32/125 (25.6%)
Number of included primary studies	9/30 (30.0%)	26/68 (38.2%)	31/125 (24.8%)
Country of publication (country of first author)	3/30 (10.0%)	1/68 (1.4%)	6/125 (4.8%)
Congruence with my own opinion	2/30 (6.7%)	3/68 (4.4%)	4/125 (3.2%)

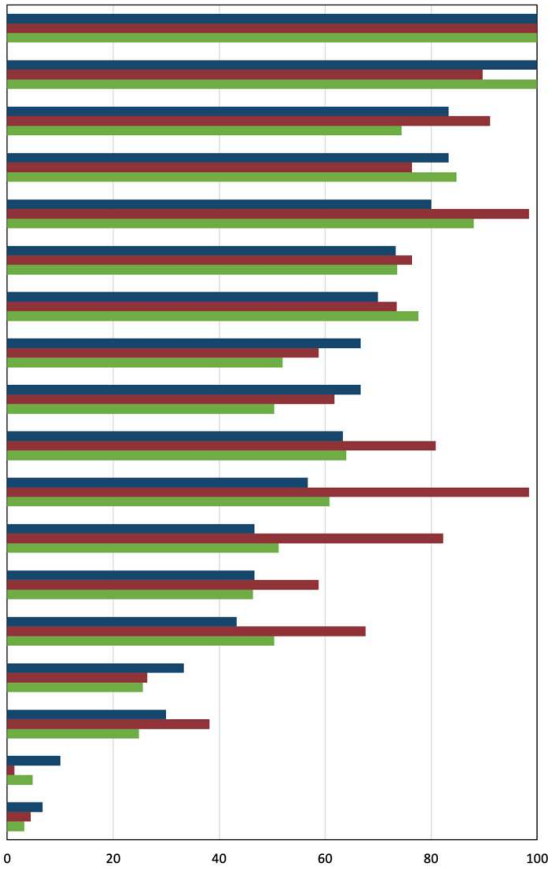

Fig. 1: Features chosen from a list by respondents as most important when comparing of choosing between SRs on the same topic by policymaker, practitioner, and researcher (Random question 11)

*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)

Features	Policymaker (%)	Practitioner (%)	Researcher (%)
Used a hierarchy of features (i.e. not just one feature)	9/25 (36.0%)	49/60 (81.7%)	78/110 (70.9%)
Number of included studies or patients	3/25 (12.0%)	39/60 (65.0%)	42/110 (38.2%)
Recency of SR search date	2/25 (8.0%)	17/60 (28.3%)	36/110 (32.7%)
Methodological quality of the review	4/25 (16.0%)	15/60 (25%)	30/110 (27.3%)
Relevant to my PICO question	5/25 (20.0%)	11/60 (18.3%)	30/110 (27.3%)
Primary study quality assessed	4/25 (16.0%)	21/60 (35.0%)	28/110 (25.5%)
Heterogeneity explored	2/25 (8.0%)	6/60 (10.0%)	21/110 (19.1%)
Meta-analysis conducted	1/25 (4.0%)	4/60 (6.7%)	18/110 (16.4%)
Comprehensive search	4/25 (16.0%)	4/60 (6.7%)	16/110 (14.5%)
Evidence of spin	1/25 (4.0%)	2/60 (3.3%)	12/110 (10.9%)
GRADE approach used	0/25 (0%)	1/60 (1.7%)	9/110 (8.2%)
Outcomes of interest including adverse effects	5/25 (20.0%)	8/60 (13.3%)	7/110 (6.4%)
Integrity of publishing journal	1/25 (4.0%)	5/60 (8.3%)	7/110 (6.4%)
Process to select, extract, assess studies	1/25 (4.0%)	2/60 (3.3%)	6/110 (5.5%)
Study design	0/25 (0%)	2/60 (3.3%)	6/110 (5.5%)
Publication bias	0/25 (0%)	0/60 (0%)	4/110 (3.6%)
Protocol written or registered	0/25 (0%)	0/60 (0%)	4/110 (3.6%)
Databases	1/25 (4.0%)	14/60 (23.3%)	3/110 (2.7%)
Assessment of overlap in primary studies	0/25 (0%)	0/60 (0%)	1/110 (0.9%)
Reporting comprehensiveness	1/25 (4.0%)	0/60 (0%)	1/110 (0.9%)
Languages	0/25 (0%)	0/60 (0%)	1/110 (0.9%)
Conflicts of interest	0/25 (0%)	2/60 (3.3%)	0/110 (0%)
Reputation of author group or organisation	2/25 (8.0%)	1/60 (1.7%)	0/110 (0%)
Review all SRs (not just one or a few)	0/25 (0%)	1/60 (1.7%)	0/110 (0%)

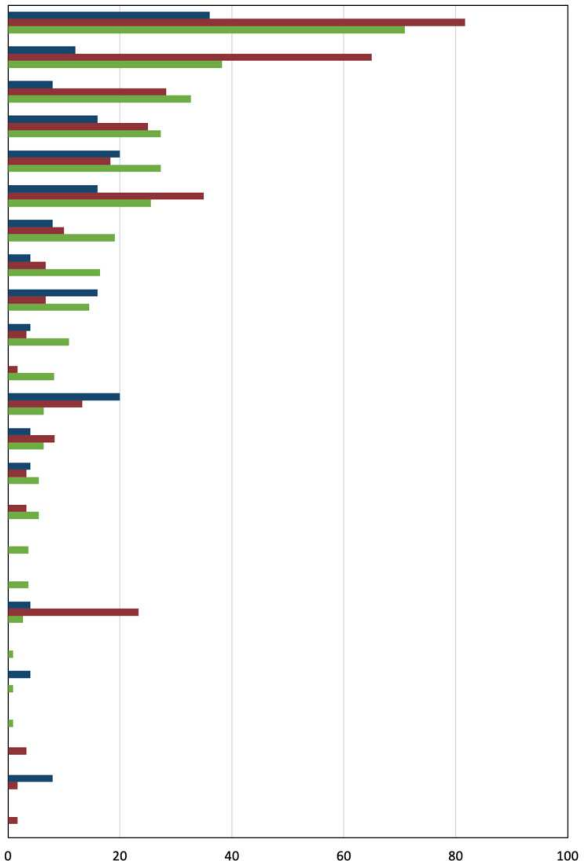

Fig. 2: Free text features identified by respondents as most important when comparing of choosing between SRs on the same topic (Random question 12b)
*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)

Features	Pre-defined features (%)	Free text responses (%)
Relevant to my PICO question	229/274 (83.6)	46/186 (24.7)
Methodological quality	217/274 (79.2)	49/186 (26.3)
Recency of SR search date	205/274 (74.8)	55/186 (29.6)
Comprehensive search	189/274 (69.0)	24/186 (22.6)
Relevant outcomes reported, including adverse events	180/274 (65.7)	20/186 (10.8)
Risk of bias of the primary studies	167/274 (60.9)	53/186 (28.5)
Protocol or pre-registration for the SR	162/274 (59.1)	4/186 (2.2)
Reputation of author group	162/274 (59.1)	3/186 (1.6)
Types of primary studies included	151/274 (55.1)	8/186 (4.3)
Integrity of publishing journal	137/274 (50.0)	13/186 (7.0)
Conflicts of interest of the SR author team	124/274 (45.3)	2/186 (1.1)
Meta-analysis conducted	120/274 (43.8)	23/186 (12.4)
Language of publication	69/274 (25.1)	1/186 (0.5)
Number of included primary studies	64/274 (23.4)	84/186 (45.2)

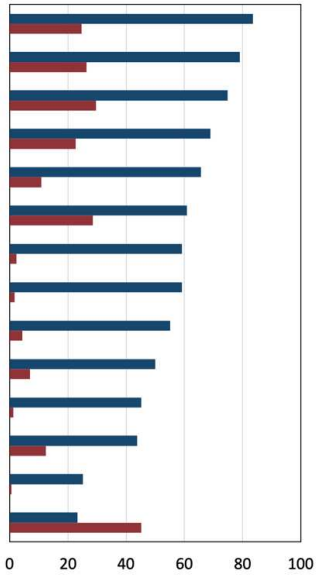

Fig. 3: Comparison of features thought to be important when comparing systematic reviews based on (i) a list of pre-defined features and (ii) free responses about features without a pre-defined list. Blue denotes that the survey respondents chose from a list of pre-defined features that were supplied by the survey methodologists. Red denotes free text responses to the question about what features are important to you when comparing SRs on the same policy, practice, or public health question.

*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient)

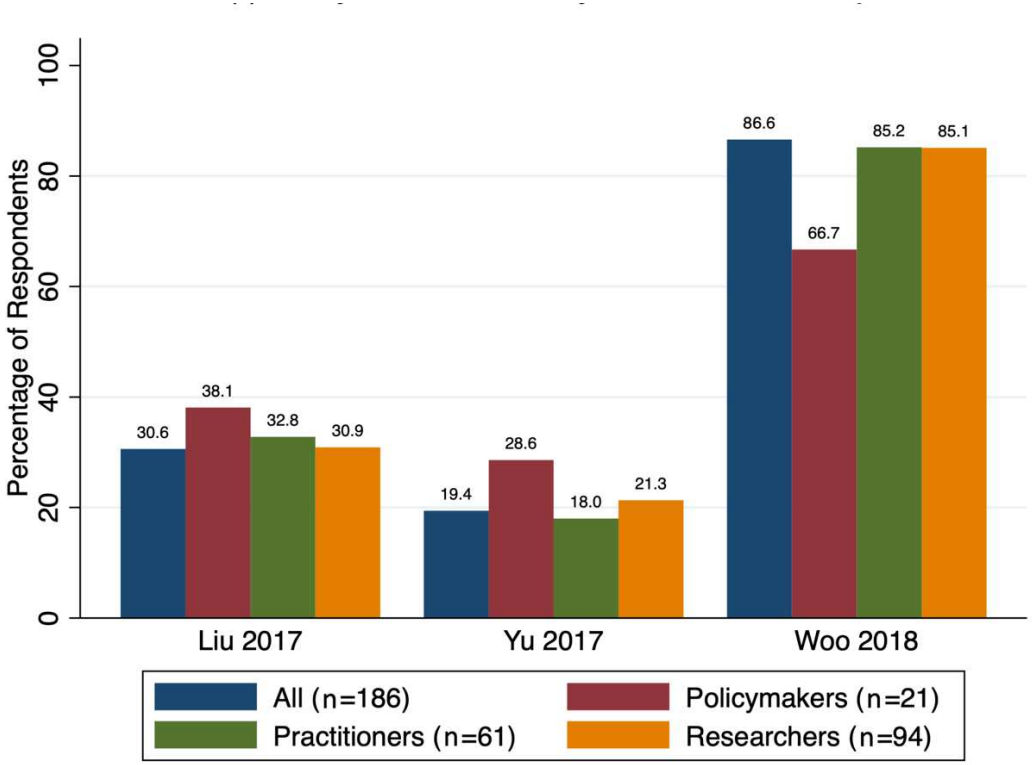

Fig 4.: Which systematic review(s) would you choose to inform your discussion with the patient? (Q12a)

*Numbers do not add up to 100% because respondents may have chosen more than one response option, and the majority of respondents identified as more than one type of decision maker (e.g. researcher and patient).