Guidance for conference abstracts and presentations of company-sponsored research is not uniform. Each conference has its recommendations, and there is a need for consistency. A group of editors and communicators has posted a preprint describing the GP-CAP (Good Practice for Conference Abstracts and Presentations). The authors are gathering comments on the draft guidelines, with a plan to revise and publish the document. There are recommendations for researchers and for conference organizers.

1. Authorship: authors (see International Committee of Medical Journal Editors [ICMJE] and GPP3), contributors/study groups, and presenters/society sponsors are described. Listing fewer than 10 authors and study group names is recommended. “In certain circumstances, and if all authors agree, it is permissible for somebody whose contribution does not (or will not) meet the ICMJE authorship criteria for a journal article to present findings at a conference.”

2. Conference abstracts: These should include a study identifier such as a registration number (for clinical trials), study name, protocol number, or grant number. “Most conferences will not consider reports of findings that have already been published in full (i.e., in a peer-reviewed journal). This requirement must be respected and, even if permitted, presenting findings after full publication should be avoided.”

3. Encore abstracts: “It is permissible to present the same research findings at more than one conference if both the first and subsequent conferences allow this. This practice may be referred to as an encore (or, more specifically an encore abstract or encore presentation). However, presentations of the same findings to the same audience should be avoided.”

4. Conference presentations (slides and posters): “Author listing and sequence on posters and oral presentations should be the same as that on the abstract. Authors should not be added to a presentation after the abstract is accepted.… If research findings change substantially between abstract submission and conference presentation and this change affects the conclusions of the research, we recommend that authors alert the conference to this discrepancy… Posters are not peer-reviewed by conferences and may not describe all aspects of the research. Posters should therefore not be viewed as a substitute for a full article in a peer-reviewed journal.”

Reference

Catalogue of bias
The Center of Evidence-Based Medicine (CEBM), University of Oxford, has launched a Catalogue of Bias, an online resource at https://catalogofbias.org/biases that features definitions of the types of bias that can affect health research. The worthwhile effort is supported by the McCall MacBain Foundation. Currently, there are 30 entries with a short definition. The team wants to expand the list and they welcome any suggestions or comments.
Roles for the corresponding authors:

When reanalyses are possible, these mostly "To discourage ghost authorship, corres -
All journals in the physical, life, and social
Problems in contacting corresponding authors,
Journals should use the 14 CRediT taxonomy
Data availability was not optimal in two
Universities/research institutions, funding
researchers gathered data from 37 published
Naudet and colleagues undertook a large project
to determine the effectiveness of data sharing
policies in The BMJ and PLOS Medicine. The
researchers gathered data from 37 published
randomised controlled trials (RCTs) and
reanalysed primary outcomes. In reassuring
findings, the reanalyses mostly yielded similar
results. Methods are detailed in the paper and all
data are available. It showed that the sharing data
policy, as recommended by ICMJE, can be
implemented, even if not optimal.

The study notes the following:

- Data availability was not optimal in two
  journals with a strong policy for data sharing,
  but the 46% data sharing rate observed was
  higher than elsewhere in the biomedical literature.
- When reanalyses are possible, these mostly
  yield results similar to the original analysis;
  however, these reanalyses used data at a mature
  analytical stage.
- Problems in contacting corresponding authors,
medical research (Inserm) has issued a nice
brochure on authorship good practices.3 They
have internal data showing that 40% of the
individual files (n = 100) processed over 10
years by the scientific integrity office related to
conflicts concerning the list of authors. The list
of co-authors is a sensitive subject, as
researchers are assessed on publications. The
topics are: What are the ethical rules to be
applied? How can authorship be determined?
The document also provide advice for how to
address these issues throughout the duration of
a project and editorial submission.

References
1. McNutt MK, Bradford M, Drazen JM,
Hanson B, Howard B, Jamieson KH, et al. Transparency in authors’ contributions
and responsibilities to promote integrity in scientific publication. Proc Natl Acad Sci
2. Brand A, Allen L, Altmann M, Hlava M,
Scott J. Beyond authorship: attribution, contribution, collaboration, and credit.
3. Inserm. The authorship of scientific
goods. Paper practices.
https://www.inserm.fr/sites/default/
files/media/entity_documents/Inserm_
Brochure_SignaturePublications
ScientifiquesBonnesPratiques_
EN.pdfBonnesPratiques_EN.pdf.

RCTs published in The BMJ and PLOS Medicine can be reanalysed when authors share data
Researchers from McMaster University, Hamilton, Canada, searched databases to survey the existing evidence of inconsistencies between protocols or registrations and full reports published in biomedical journals. They searched studies in English up to September 30, 2016. They followed guidance to perform a systematic review, retrieved 9123 records, and included 37 studies (33 surveys and 4 systematic reviews) for analysis. They observed high levels of inconsistency between the described research plan in protocols/registrations and what was reported in the journal literature for the categories of outcome reporting (ranging from 14% to 100%), subgroup reporting (from 12% to 100%), statistical analysis (from 9% to 47%), and other measure comparisons. Some factors, such as outcomes with significant results, sponsorship, type of outcome, and disease specialty were reported to be significantly related to inconsistency reporting.

This 20-page article contains many troublesome examples from RCTs (complete references are in the paper):

- 49% (75/152) showed some discrepancies in outcomes, most related to introducing or omitting a primary outcome; 28% (21/75) of these discrepancies favored statistically significant results;
- 29% (32/108) of registered trials had a discrepancy of primary outcomes between registrations and full reports; 92% of the discrepancies in primary outcomes (in 22 out of 24 full reports) favored a statistically significant finding;
- 100% (69/69) of full reports had discrepancies in primary outcome specifications (POS); 30% (21/69) of full reports had unambiguous POS discrepancies, with significantly higher percentages of non-industry-sponsored than industry-sponsored full reports having unambiguous POS discrepancies;
- 19% (17/88) of full reports were registered;
- 45% (32/71) of full reports had inconsistency of primary outcomes; 71% (15/21) had discrepancies in primary outcomes that favored significant findings.

Reference