

Two papers bearing on the meaning of **Article 27** for science & medicine

- 1. We the Scientists: A Human Right to Citizen Science**
by Effy Vayena and John Tasioulas
- 2. The History and Development of N-of-1 Trials**
by Reza Mirza, Salima Punja, Sunita Vohra, and Gordon Guyatt

Article 27 The Universal Declaration of Human Rights:

Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

A Human Right to Participation in Science

Self-observation and self-experiment predate professional science by thousands of years, shading incrementally into the general ability to think. If practices associated with the Quantified Self ask something new of science, it's not only because devices to measure and track experience give us more data to reason with, but also because these tools are being used in the service of very old purposes and needs.

In this pamphlet, we republish two short articles that help explain the challenge the Quantified Self brings to science. The first, "We the Scientists: a Human Right to Citizen Science," by Effy Vayena and John Tasioulas, describes some of the implications of the first part of Article 27 of the Universal Declaration of Human Rights.¹

Everyone has the right to freely participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

In their discussion, Vayena and Tasioulas outline the far-reaching implications of Article 27, explaining that the right to freely participate in scientific advancement articulated in the Declaration involves more than the right to enjoy the fruits of professional scientific discovery. Article 27 additionally advances a positive right to science, understood to be essential to human development, on par "with freedom of thought and speech, education, work, health, non-discrimination, and so on."

The positive dimension of Article 27 was neglected during the first sixty years after its publication in 1948, but has been revived in the last decade as part of the opposition to barriers to accessing scientific literature created by an aggressive expansion of intellectual property rights. Access to literature is necessary for participation in science; but, as Vayena and Tasioulas acknowledge, there are also other missing pieces, such as recognition of citizen scientists as valued contributors, frameworks for addressing ethical risks of participation, opportunities to learn scientific technique, and financial and institutional support.

The introduction of a positive right to participate in science into the Universal Declaration of Human Rights was believed by its drafters to have "tremendous repercussions." But, contrary to expectations, these repercussions have barely been felt. The expense and complexity of scientific research continue to severely restrict participation. This limit is quantitative, restricting the number of people involved, and qualitative, narrowing the range of questions considered worthy of attention. This brings us to the second article published in this pamphlet, which reviews a specific domain where the kind of participation in sci-

ence envisioned by Article 27 ought to have especially important consequences: participatory research in medicine.

In “The History and Development of N-of-1 Trials,” authors Reza Mirza, Salima Punja, Sunita Vohra, and Gordon Guyatt describe over thirty years of experience with single-subject research in clinical care, much of it done with active participation from patients.² The authors begin by acknowledging two distinct antecedents: first, commonplace “trials of therapy” performed by physicians and their patients using informal methods, and second, a sparse but striking history of formalized individual trials that have used techniques like placebo control, blinding, and crossover designs.

The modern part of this story begins in 1986, when Gordon Guyatt and colleagues at McMaster University reported the results of a blinded individualized study of a treatment regimen for asthma involving two drugs, theophylline and prednisone. As Mirza writes:

The N-of-1 trial they designed addressed the utility of the theophylline the patient was using. After the second paired block of theophylline and placebo, the patient ended the trial early: the results were clear to him, and, from the symptom diary he had been keeping, to the clinician who instituted the trial. When the blind was broken, it was clear that during the periods when the patient had been using theophylline his symptoms were much worse. Improvement was sustained when theophylline was withheld after the trial ended, with much better asthma control despite a reduced dose of steroids. The trial proved spectacularly helpful: improved symptom control, reduced drug burden and decreased costs.

The success of this case inspired the McMaster physicians to endeavor to bring N-of-1, participatory research into the mainstream. In two years they completed 57 additional N-of-1 trials. They also created a clinical N-of-1 trial service, published guides for N-of-1 practitioners, and collaborated with researchers and clinicians interested in replicating their findings. At the University of Washington, Eric Larson completed 34 N-of-1 trials, and in 1999 the University of Queensland, Australia, created a national service to aid physicians and patients in individualized testing of interventions. However, despite this flurry of activity, impact on research and practice in medicine has been minimal.

What accounts for this failure? Mirza and his co-authors point to the difficulty of conducting single-subject trials in a clinical setting where time is limited. Also, strong concerns about generalizing from individual cases have made N-of-1 approaches appear weak to investigators trained to treat average effects in group interventions as a research endpoint. However, it's important to note that while earlier initiatives produced operational failures, they also produced scientific successes, supplying proof that single-subject methods are valid and useful. A 2011 series on N-of-1 experiments in the *International Journal of Epidemiology*³; the 2014 manual *Design and Implementation of N-of-1 Trials*;

A User's Guide from the Agency for Healthcare Research and Quality⁴; a 2016 special issue on N-of-1 technique in the *Journal of Clinical Epidemiology*⁵; and, the 2017 focus theme on N-of-1 research in *Methods of Information in Medicine*⁶: All of these publications provide evidence that it is possible to use single-subject methods to make consequential discoveries about individual cases.

In thinking about what's needed to break the logjam, the papers reprinted here stand in provocative counterpoint, each offering a kind of answer to the other. The specific cases reported since the 1986 trial of theophylline and prednisone provide Vayena and Tasioulas with a beautiful example of the possibilities latent in Article 27's claim of a human right to science. Quietly, with scant notice from the main line of biomedical research, a new genre of clinical investigation has in fact emerged. Both practitioner and patient participate in a process of discovery that takes individual improvement as its goal. I believe this qualifies as the type of "tremendous repercussion" anticipated by Article 27, because it fundamentally shifts the locus of control in medical science. Patients gain agency as research collaborators. Also, an individual self-investigator's need for benefits that are sensible and personal, rather than merely detectible at a group level, radically changes what it means for a finding to count as significant. The implications of this change on current concepts of quality of evidence in medicine are profound.

But if Mirza and his colleagues supply Vayena and Tasioulas with a crucial example, Vayena and Tasioulas may supply something even more important in return; for they help point a way out of the tactical and operational dead end associated with supporting single-subject science solely through engagement of clinicians. If there is a human right to science, then convincing clinicians and clinical researchers can never be more than a small part of the answer. Note what happened in Guyatt's first reported trial:

"After the second paired block of theophylline and placebo, the patient ended the trial early: the results were clear to him..."

The first discoverer was not the doctor, but the patient. His clarity was hard won; it may never have been gained by guesswork or intuition. But with experiment and support, the answer became obvious: _first_ to the patient, who knew the results from direct experience, _and then_ to his physicians, his allies, who designed his experiment and could watch for errors. Importantly, nowhere in this report is a passive research subject induced to join by extrinsic rewards or generalized social altruism. Instead, we find an active collaborator seeking a true answer to a vital problem. What powers the collaboration is need. The existence of these needs, and a commitment to meet them, is the "will" for which N-of-1 methods provide a way.

Those of us who have been working in the Quantified Self movement have had a glimpse of the vast range of experiments people are now doing with their data, many of them addressing challenging health-related issues for which off-the-shelf solutions have failed. In the domain of cardiovascular health alone—a

domain as well studied as any sub-field in medicine—a single out-of-range result in a single metric, like a high cholesterol number, or a high blood pressure reading, inevitably leads directly to additional questions for which existing recipes are not adequate. Medicines, diet, activity, sleep, stress, and emotional health: all of these may effect long-term changes in cholesterol and blood pressure, and a person driven to try to pursue any approach to improving them will be beset by contradictory suggestions and claims.

Where are our allies in reasoning about these claims? The Quantified Self Public Health Symposium has been designed to bring some of them together. Not all of them, certainly, nor even a representative sample, but perhaps enough to expose the main topics that concern us all, and to set an agenda for common efforts to make progress. We have a lot to work with. On the one hand, millions of people who are reasoning about their own condition, using whatever tools we have at hand. On the other hand, millions of potential allies, including not only professional clinical researchers, but countless others working in healthcare and allied professions, including nurses, caregivers, pharmacists, psychologists, and physical therapists. Potentially connecting us, a set of methods and techniques for participatory, single-subject research that have been developed by a relatively small group of researchers with intense care over a thirty-year period, and a new set of instruments that make it vastly easier to collect and analyze our data.

Without the cultural work that brings us together, these instruments are unlikely to become anything more than upgrades to existing systems of surveillance and control. We have a lot to do. But at least we've started, and we've gotten far enough to recognize the debt we owe to the work reflected in the articles reprinted here.

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1.

“We the Scientists”: a Human Right to Citizen Science

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Abstract The flourishing of citizen science is an exciting phenomenon with the potential to contribute significantly to scientific progress. However, we lack a framework for addressing in a principled and effective manner the pressing ethical questions it raises. We argue that at the core of any such framework must be the human right to science. Moreover, we stress an almost entirely neglected dimension of this right—the entitlement it confers on all human beings to *participate* in the scientific process in all of its aspects. We then explore three of its key implications for the ethical regulation of citizen science: (a) the positive obligations imposed by the right on the state and other agents to recognize and promote citizen science, (b) the convective nature of the participation in science facilitated by the right and (c) the potential to mobilize the right in rolling back the unprecedented expansion of intellectual property regimes.

From Thales of Miletus’ geometrical theorems to Benjamin Franklin’s lightning rod, the history of science is studded with the contributions of individuals who were not professional scientists in the contemporary sense. These intrepid amateurs made observations, conducted experiments or devised methods of investigation that prompted major advances. By contrast, the professionalization and institutionalization of science did not get into full swing until well into the nineteenth century, and when it did so, it had the effect of crowding non-professionals out of the scientific enterprise.

In recent decades, however, there has been a tremendous flowering of non-professional involvement in scientific research. This phenomenon has been dubbed *citizen science* (Bowser and Shanley 2013). Although the term lacks a precise and widely accepted definition, we take it to mean any form of active non-professional participation in science that goes beyond human subject research conducted by professional researchers. In both scope and format, citizen science traverses the full extent of scientific activity. Projects

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range from bird watching, earthquake reporting and the cataloguing of galaxies to do-it-yourself biology and self-experimentation with medical compounds and genetic testing (Nielsen 2012). This broad spectrum of activity is matched by high levels of popular participation. One of the largest citizen science platforms is [zooniverse.org](https://www.zooniverse.org/), with its various websites so far drawing over a million participants (<https://www.zooniverse.org/>). Moreover, a work by citizen scientists, sometimes originating in projects devised and led by themselves, has appeared in reputable scientific journals. Indeed, the impact of citizen science is liable to be underestimated because publications drawing on it are not easily identifiable as such (Cooper et al. 2014).

The contemporary flourishing of citizen science can be traced to two large-scale societal developments. One is the high degree of internet penetration around the world and the increasing availability to ordinary people of online tools and mobile devices that can record, store, process and transmit data. In particular, online social media provides the essential infrastructure that sustains global networks of citizen scientists. Another factor is the growing acceptance of the idea that ordinary citizens should be empowered to have a say, and play an active role, in political, scientific and cultural processes that affect them. Today's citizen science movement is the product of this conjunction of unprecedented technological means at the disposal of the general public together with the heightened value accorded to individual participation in all the myriad facets of social life, including those formerly regarded as the exclusive domain of specialists.

Citizen science unquestionably has great potential as a catalyst of valuable scientific innovation. However, it also generates pressing ethical and regulatory concerns that have barely begun to be addressed. These include the potential exploitation of citizen participants in scientific projects, whether set up by fellow citizens or established institutions; the adequacy of oversight mechanisms to ensure the scientific validity and ethical acceptability of research projects in which citizens are involved; the role of informed consent, especially in communities of peers; ownership of personal data and intellectual property issues in cases where discoveries are made; physical, psychological, privacy and other risks, especially where self-experimentation takes place; and the nature of society's responsibility to recognize and foster scientifically valid and ethically sound citizen science.

We urgently need a widely accepted ethical framework—an underlying set of values and principles—to orient us in addressing such questions in an effective and defensible way (Vayena and Tasioulas 2013a). For the framework to enjoy maximal legitimacy, it must be the product of deliberation and consensus among all relevant stakeholders, prominently including the constituency of citizen scientists. In its absence, citizen science cannot realize its full potential as a socially recognized source of valuable scientific knowledge.

1 The Human Right to Science, Participation and a Path not Taken

Like ethical frameworks developed for science conducted by professional scientists, the one adapted to the challenges posed by citizen science must take into account many different ethical considerations. Nonetheless, we contend that the human right to science (HRS) has a central, and radically transformative, role to play in practical deliberation about citizen science.

The HRS is first and foremost an ethical principle, but the one that has acquired political and legal recognition in the post-war era. Article 27 of the 1948 Universal Declaration of Human Rights (UDHR) established a HRS as part of a broader human right to science and culture (RSC). The latter has two limbs:

- (1) Everyone has the right to freely participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.
- (2) Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author (UDHR 1948).

A prescient 1952 UNESCO document explained the first limb's significance as "not merely adding a final touch" to the UDHR, but stating, for the whole world, *an entirely new principle, whose application may have tremendous repercussions* (UNESCO 1952).

A version of the right eventually appeared in Article 15(1) of the International Covenant on Economic, Social and Cultural Rights (ICECSPR 1966). Although legally binding on parties to the convention, the HRS for the most part lays dormant until very recently, activating none of the anticipated *tremendous repercussions*. However, this situation has changed in the last few years, largely thanks to the UN Human Rights Council. In part, the HRS's emergence from its prolonged slumber is due to activist efforts to invoke it in rolling back the unprecedented expansion of intellectual property rights that have taken place in the post-war period (Shaver 2010).

Yet, even in this revival, a fundamental dimension of the HRS has been neglected. This is the entitlement it confers on everyone actively to *participate* in the scientific enterprise. Such participation goes well beyond merely passively receiving the benefits—such as knowledge, technology, therapies and so on—generated by scientific advances made by professional scientists. Differently put, it treats participation in the scientific enterprise as one of the benefits of science to which we all have a right.

Unfortunately, the UN Committee on Economic, Social and Cultural Rights' General Comment No. 21 on Art 15 (1)(a) of the Covenant offers no extended discussion of participation in science (UNHRC 1966). Equally, the UN Special Rapporteur on cultural rights' report of 2012, on Art 15(1)(b), stresses that "access must be to science as a whole, not only to specific scientific outcomes or applications" (Shaheed 2012). However, it does not elaborate on the participatory dimension of such access. Again, in the AAAS's survey of American scientists' attitudes to the HRS, the question of citizens creating science is briefly raised but left unaddressed (http://www.aaas.org/sites/default/files/content_files/UNReportAAAS.pdf). Yet, the participatory aspect of the HRS is at the heart of what is distinctive about this right. Participation is a key to the *added value* that it brings to our existing entitlements under more familiar human rights, such as the rights to freedom of thought and speech, education, work, health, non-discrimination and so on.

This hypothesis is supported by a closer look at the pioneering 1952 UNESCO study, with the report highlighting "participation by the amateur who works creatively, however humble his sphere, or carries out his own observations in the scientific field (particularly in biology, geology, geography, sociology, etc.)" (UNESCO 1952). Yet, for whatever reason, this participatory aspect was muted or disregarded in subsequent interpretations. It is imperative now to recapture it.

We contend that participation in science, for the purposes of the HRS, should include a broad spectrum of activity that ranges from embarking on a career as a professional scientist, on the one hand, to participation in a standard clinical trial carried out by an established research institution, on the other hand. However, our focus here is on the extraordinarily diverse forms of participation that come under the rubric of citizen science. It is these forms of scientific participation that disclose the radical, but hitherto untapped, potential of the HRS.

Various taxonomies of these forms of participation have been constructed (Shirk et al. 2012). However, for present purposes, an indicative list ordered according to escalating levels of participation includes the following: (a) *crowd-sourced* participation in a project established and governed by professional scientists, e.g. individuals contribute relevant data, observations, etc.; (b) participation in financing, agenda setting or governance in projects established by professional scientists, e.g. crowd funding; (c) collaborative participation in which citizen and professional scientists play a broadly comparable role in the initiation, pursuit and governance of a research project; and (d) in the most radical version of participation, citizens themselves take the lead in initiating, designing and conducting a project—a type of activity that has come to be known as participant-led research (PLR).

Understanding these forms of citizen participation is indispensable in getting a better grip on the content of the HRS. Conversely, armed with the HRS, citizen scientists are better placed to assert their justified claims to recognition and support from the wider society.

2 Why the Right to Participate in Science Matters

The participatory dimension of the HRS is a key element in a compelling ethical framework for citizen science. Some major implications of conceiving of citizen participation in science as flowing from the HRS can be grouped under three rubrics:

A Positive Right Human rights impose duties on us to comply with them. This is what makes them practical guides to action and their violation a matter of grave moral concern. Some duties associated with the HRS are *negative*, i.e. they are duties to refrain from undue interference with scientific activity. However, other duties imposed by the HRS are *positive*. They demand positive action on the part of duty bearers to enable and promote scientific activities or to facilitate participation in them by ordinary people. These may include positive duties to equip people with the basic scientific knowledge needed to participate in science or to provide citizen scientists with various forms of support and recognition, e.g. sources of research funding, access to oversight mechanisms and the opportunity to publish in scientific journals. Given the global character of much citizen science, an important question concerns the extent to which these obligations apply to those outside our own state.

As the 1952 UNESCO report grasped, the revolutionary potential of the HRS is primarily located in these positive duties, especially those concerned with fostering broad-based participation. However, the study of these duties has been neglected. One topic that urgently calls for investigation is the positive duty to provide citizen scientists operating outside of standard institutional contexts with mechanisms of oversight to

ensure compliance with relevant scientific and ethical standards. Only in this way can citizen science responsibly achieve the goal of making a socially recognized contribution to scientific knowledge. However, it is essential that these oversight mechanisms are well adapted to the distinctive character of the activities pursued by citizen scientists, so that they do not choke off a vital source of scientific innovation.

Convective Participation It is generally recognized that broadening the participatory base of science governance is a highly desirable objective. Broader participation enhances transparency, accountability and the sense of shared responsibility for advancing the social good. However, wider participation in science governance has proved difficult to achieve in a way that is more than tokenistic (Jasanoff 2003).

In response to this challenge, it is vital to notice that the participation fostered by the HRS has the fertile property of being convective. By this, we mean that citizen participation in one domain of scientific activity spurs participation in other domains. It can do so through various means, e.g. by increasing relevant capacities, motivation and opportunities for engagement with scientific matters. For example, there is evidence that citizen scientists engaged in environmental projects often progress to advocacy roles (Franzoni and Sauermann 2013). Participation in scientific research projects may also naturally lead to citizen scientists playing a role in research governance, whether one specific to the particular project in which they are engaged or one in broader governance, such as peer reviewing for scientific journals or involvement in research oversight mechanisms. Elsewhere, we have suggested that in some forms of citizen science, oversight mechanisms might be operated exclusively by citizen scientists themselves (Vayena and Tasioulas 2013b).

Informed and engaged citizens are more likely to take advantage of existing avenues for making their voices heard in science governance, and they are more likely to push for the creation of additional opportunities for involvement in governance, including at a global level. The result is a mutually reinforcing virtuous circle of participation, as participation in one domain spurs and bolsters participation in others, and vice versa. The noble idea that citizens should play a real part in the *whole of science* can, in this way, come closer to being a reality.

Intellectual Property Reform One of the major reasons for the contemporary revival of the HRS is its deployment as a weapon in combating the massive expansion of intellectual property rights that have taken place in recent decades. The idea is that the expansion of intellectual property entitlements, notably under international regimes such as the 1994 Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), has adversely impacted on the rights of individuals to share in the public good of scientific knowledge (Shaver 2010; Shaheed 2012). The participatory dimension of the HRS stands to make at least two major contributions to this ongoing intellectual property rights debate.

First, the HRS demands that any acceptable intellectual property regime should be configured so as not to unduly burden citizens' capacities to engage in scientific research. It is impossible, for example, to engage in citizen science if relevant scientific knowledge is either inaccessible or prohibitively costly to access. This conclusion may have radical implications for standard intellectual property regimes, such as copyright law, insofar as they erect formidable barriers to citizen scientists accessing scientific knowledge. More

positively, it may reinforce emerging developments that seek to liberalize access to scientific knowledge, such as open access publishing, the activities of the open science movement and the licensing options available under the Creative Commons schemes.

Second, citizen science opens up the possibility of literally thousands of people being *co-authors* of the research outputs and acquiring a corresponding sense of ownership. Pursuing this idea requires that existing intellectual property regimes be imaginatively redesigned. For example, control over scientific knowledge gleaned through some types of citizen science might be better regulated by means of the idea of commons (Madison 2014). The HRS may be a powerful tool in stimulating and shaping new approaches to ownership tailored to the mass participation made possible by citizen science and the legitimate expectations that it generates on the part of citizen scientists.

3 Conclusions

We currently stand at the crossroads of two developments: growing citizen participation in science and a renewed interest in the unexplored potential of the HRS. This is an ideally opportune moment to negotiate how best to facilitate the phenomenon of citizen science within an ethical framework that takes seriously the right of all to participate in, and benefit from, scientific progress. All stakeholders in the scientific enterprise, including citizen scientists themselves, need to be given the opportunity to engage in the dialogue about the duties that arise under the RSC and how best to give effect to them. There is no better starting point for this dialogue than the prophetic words of the 1952 UNESCO report, “The first question of all to be considered in relation to the present state of scientific knowledge is in what ways can the non-specialist take an active part in scientific advancement (experiments, observation of nature, sociological observations, etc.)? How may active participation of this sort benefit the individual and science? How can it be encouraged and promoted?”

The upshot of such a dialogue should be an actionable agenda that includes practical means of addressing the funding, oversight and regulation of citizen science, and the allocation and specification of property rights.

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2.

The history and development of N-of-1 trials

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Introduction

‘Trials of therapy’, in which physicians ‘try out’ treatments and assess patients’ responses, are long-established, common elements of routine medical practice. Because ‘trials of therapy’ are usually informal, they may only be reported if treatments are associated with dramatic changes in a patient’s condition – whether by improvement or deterioration.

Our understanding of bias suggests that informal ‘trials of therapy’ – comparisons of patients’ condition before and after treatment – do not provide a trustworthy basis for inferring treatment effects. More sophisticated comparisons are usually needed: for example, comparing a patient’s responses when treatments are given or withheld (‘crossed over’) and conducting formal assessment of outcomes.

In 1676, Richard Wiseman (a surgeon to King Charles II) reported an unplanned experiment. He had prescribed a pair of laced stockings for a patient suffering from leg oedema. The stockings had reduced the oedema to the extent that the patient ‘was able to walk to his closet, and take the air in his coach, and was well pleased with them’.¹ However, someone suggested to the patient that the stockings might do him harm and persuaded him to remove them. His legs swelled up, he became confined to bed again and developed leg ulcers. Dr Wiseman waited six weeks for the ulcers to heal, restored the laced stockings, with the result that the patient recovered.

A century after Wiseman’s crude crossover trial of laced stockings, Caleb Parry,^{2,3} a doctor in Bath, England, published a more formal, planned use of between two and six crossover periods of variable duration in 13 patients, to compare the purgative effects of three varieties of rhubarb. Parry was unable to find any advantage of the more costly Turkish rhubarb compared with English rhubarb.

Parry’s ‘trials of therapy’ were important in having used at least two crossovers, but he took no steps to ensure that his and his patients’ assessments of the treatment effects were not influenced by his or the patients’ knowledge of the type of rhubarb being given. Fourteen years later, also in Bath, John Haygarth⁴ compared the

effects on rheumatism of a metal ‘tractor’ with a matched wooden (placebo) tractor. This demonstrated that the assumed treatment effects of the metal tractor resulted from patients’ imagination.⁵

Haygarth’s study made clear that informal ‘trials of therapy’ can be plagued by false positives (due to placebo effects, physicians’ and patients’ desires to please, the pre-existing expectations of both parties and natural history). And they can also result in false negatives (patients destined to deteriorate and the intervention resulting in them remaining stable). Although more than a century passed after Haygarth before Paul Martini set out principles for designing unbiased crossover trials in his 69-page book,^{6,7} it appears that it was not until 1953 that serious scientific consideration was given to how controlled trials in individual patients could complement traditional parallel group trials. Hogben and Sim⁸ recognised that:

The now current recipe for a clinical trial based on group comparison sets out a balance sheet in which individual variability with respect both to nature and to previous nurture does not appear as an explicit item in the final statement of the account; but such variability of response to treatment may be of paramount interest in practice.

Trialists conducting parallel group trials using alternate or random allocation had been trying for half a century to deal with the challenge of deducing how to treat individual patients by using estimates of effects in subgroups of participants, but this was only a partial way of addressing the fundamental underlying issue – ascertaining individual responses.⁹

The experiment reported by Hogben and Sim is a methodological landmark (see Appendix 1 for a list of N-of-1 trials completed to date), celebrated more than half a century later by republication and commentaries in the *International Journal of Epidemiology*.^{10–12} One of the commentaries¹² summarises the features of the study:

Because they used patient's self-reported symptoms, they put a particular emphasis on careful blinding: the use of a placebo and keeping both clinical and patient unaware of the sequence of treatments. They were also concerned about the non-specific response to prostigmine so they used two comparators: dexamphetamine (a stimulant) and lactose (as an inert placebo). Their weighted analysis, based on concerns about wash-out and wash-in effects, also appears to be novel. Finally, with a minimum of eight periods for each treatment, they seemed to have set a new record for the number of crossovers in any crossover trial in an individual patient.

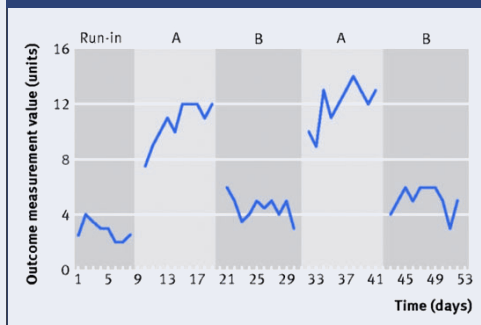
Hogben's and Sim's paper does not appear to have had an impact – possibly because it was published in a non-clinical journal. Glasziou¹² identified only 12 citations, and only one of those reported a replication of their methods (in 30 patients in a neurosis unit).¹³ Thereafter, these two studies and developments in the application of single subject design methodology in the social sciences¹⁴ appear to have gone unnoticed in the medical community until 1986.

Baskerville *et al.*¹⁵ were the first to apply principles of adaptive design to the N-of-1 model. Instead of fixed treatment periods, length was determined by adverse events, clinical deterioration, and patient preference. Their model was further expanded to account for typical crossover features, including carry-over effects.¹⁶

N-of-1 trials come of age

In 1986, in the *New England Journal of Medicine*, a group of clinical investigators at McMaster University, Canada, published a paper entitled 'Determining optimal therapy – randomized trials in individual patients', in which they labelled such studies 'N of 1 randomized control trials'.¹⁷ Their interest had been prompted by a poorly controlled asthmatic patient treated with inhaled beta agonists, theophylline and prednisone. The N-of-1 trial they designed addressed the utility of the theophylline the patient was using. After the second paired block of theophylline and placebo, the patient ended the trial early: the results were clear to him, and, from the symptom diary he had been keeping, to the clinician who instituted the trial. When the blind was broken, it was clear that during the periods when the patient had been using theophylline his symptoms were much worse. Improvement was sustained when theophylline was withheld after the trial ended, with much better asthma control despite a reduced dose of steroids. The trial proved spectacularly helpful: improved symptom control, reduced drug burden and decreased costs.

Figure 1. Depiction of N-of-trial. Modified from Shamseer *et al.*²¹



Among the class of single patient/person study designs,^{18–20} N-of-1 trials are unique as rigorously controlled intervention studies that can provide a basis for inferring cause and effect. Though many variations exist, the work that originated at McMaster University focused on single patient trials with two or more pairs of treatment periods, one for the intervention and one for the comparator, ideally with blinding of both patients and healthcare providers (Figure 1). The outcome measures in such trials are the experiences of the patients, recorded using individualised, patient-reported outcomes.

Clinicians have now formally reported on hundreds, if not thousands, of N-of-1 trials, exploring their utility in avoiding unnecessary treatment and improving patient outcomes, and also in facilitating drug development (See Appendix 1). Despite these reports, and the enormous potential that the originators saw for use of N-of-1 trials, their uptake has remained limited in the decades since 1986, although there have been recent signs of renewed interest.^{22–25}

The N-of-1 niche

The N-of-1 trial identifies whether an intervention is likely to benefit or cause unwanted effects in an individual patient. The design is most suited to assessing interventions that act and cease to act quickly. It is particularly useful in clinical contexts in which variability in patient responses is large, when the evidence is limited, and/or when the patient differs in important ways from the people who have participated in conventional randomised controlled trials. Examples include conditions with quickly acting symptomatic treatment, in which variability in response is large (e.g. chronic pain, obstructive lung disease); conditions with a prevalence too low for large, parallel group randomised controlled trials;

medically complex patients who differ substantially from patients who have participated in existing trials; and patients who have been treated over a long time when there is uncertainty about ongoing need for treatment (e.g. proton pump inhibitors in longstanding dyspepsia). Indeed, the applicability of the results of parallel group randomised clinical trials to individual patients (i.e. external validity) may sometimes be limited by narrow inclusion criteria and the exclusion of patients with co-morbidities and/or concurrent treatment. Reviews of randomised controlled trials have found average exclusion rates of 73% and recruitment of less than 10% of patients with the primary diagnosis.²⁶ These concerns, however, should be tempered by knowledge that true subgroup effects are very unusual.²⁷ The real issue of importance to N-of-1 trials is the likelihood, in many instances, of large variability in responses among patients.²⁸

N-of-1 trial services

The result of their first N-of-1 trial inspired the team at McMaster to develop a full N-of-1 referral service to address patient dilemmas that met criteria for our N-of-1 designs: therapeutic impact was uncertain, the treatment target was to reduce daily or otherwise frequent symptoms, the intervention (typically a drug) worked quickly, and it quickly ceased acting. Within two years, the group had completed 57 N-of-1 trials. Results had provided a definite therapeutic answer in 88% of the patients studied and these results prompted 39% of physicians to change their prior-to-trial treatment plan. This experience led the McMaster team to offer guides for clinicians wishing to apply the N-of-1 concept in their own practice.²⁹ Ultimately, however, the clinical communities interest in conducting N-of-1 trials diminished and the service was terminated.

Eric Larson was in the audience at a presentation of the McMaster work at the American Federation for Clinical Research.³⁰ Appreciating the utility of the design, Larson developed an N-of-1 clinical service at the University of Washington. Over two years, Larson's group completed 34 trials, again demonstrating that N-of-1 trials could provide physicians with useful treatment guidance in uncertain cases and improve patient satisfaction.³¹ Unfortunately, funding for the service ran dry and it was discontinued.

In 1999, the University of Queensland in Australia created the first national N-of-1 research service, referred to as a 'single patient trial service'.³² The service was designed to acquaint general practitioners with research methodology and to introduce research-derived data into clinical decision-making for conditions where treatment effectiveness was uncertain. Physicians could refer their patients to the service,

which was centrally located, and so used mail and telephone communication only. The service managed all major components of trial management: randomisation, preparing tablets, sending all materials to patients, following up, and relaying results to clinicians. Of the N-of-1 trials carried out by this service and which had available data, post-trial management decisions were consistent with trial results at 12 months in approximately 70% of attention deficit hyperactivity disorder trials³³ 45% of osteoarthritis trials,³⁴ and 32% of neuropathic pain trials.³⁵ This is a successful example of how N-of-1 trials can be implemented at a national level, though, again, only as a temporary research initiative.

Another example of the versatility of N-of-1 trials began when the Complementary and Alternative Research and Education (CARE) programme at the University of Alberta established the first academic paediatric integrative medicine programme in Canada. In 2006, as part of this programme, a paediatric N-of-1 service responded to the increased use of complementary therapies in children with chronic conditions. The goal of this service is to offer an objective, evidence-based approach to assessing whether a given complementary therapy is effective for a specific patient. The service is designed to assist patients, their parents and referring physicians throughout all stages of the N-of-1 trial, including the design and implementation of the N-of-1 evaluation. For example, this service has assessed natural health products (e.g. melatonin, probiotics, micronutrients) and acupuncture for conditions including attention deficit hyperactivity disorder, eczema, sleep disturbances, chemo-induced nausea and vomiting, irritable bowel syndrome and autism.

N-of-1 in drug development

The McMaster group speculated that drug development might also benefit from use of the N-of-1 methodology. The reasoning was that pre-approval drug development costs are high (average \$479–936 million USD^{36,37} and rising³⁸). Conducting N-of-1 trials before a costly large-scale randomised controlled trial could (a) help to assess early efficacy, (b) be less expensive than traditional approaches, and (c) identify predictors of response.³⁹

The idea of applying the N-of-1 approach to early drug development arose from experience with multiple N-of-1 trials in specific conditions. For instance, when what is now termed myofascial pain syndrome was labelled fibrositis and there had been one apparently positive randomised controlled trial of amitriptyline, the condition provided a framework for N-of-1 trials in early drug development. The McMaster team conducted 14 N-of-1 trials which demonstrated

substantial benefit from amitriptyline at doses far lower than had been used for the primary indication for the drug, depression.³⁹ The McMaster team also demonstrated the utility of multiple N-of-1 trials in Alzheimer's disease⁴⁰ and in the use of home oxygen in patients with chronic obstructive pulmonary disease.⁴¹ In each of these situations the process appeared to be efficient, requiring limited cost and time investment. Nevertheless, subsequent attempts to apply the reasoning in drug development have been sporadic and unsuccessful.

Failure to revolutionise clinical practice: were N-of-1 trials ahead of their time?

Early experience was disappointing, shattering the initial optimism that N-of-1 trials would quickly revolutionise clinical practice. There had been some tantalising results,⁴² but randomised controlled trials in which patients were randomised to conventional care or to N-of-1 trials generally failed to show dramatically convincing benefits of participation in the N-of-1 trials.^{43,44}

At McMaster University, despite educating local clinicians, playing cheerleader, succeeding in conducting 73 N-of-1 trials over three years,⁴⁵ and inspiring other 'N of 1 services', interest still faded. An attempt to use venture capital to create an efficient, marketable service went nowhere. Thirty years after our initial publication, few clinicians have even heard of N-of-1 trials.

Sporadic reports of success with N-of-1 continue. For instance, Joy *et al.*⁴⁶ reported findings consistent with 'the nocebo phenomenon' – patients sometimes report side effects to placebo:⁴⁷ in seven patients with suspected but uncertain statin-associated myalgia, N-of-1 trials failed to detect any statin-related symptoms in any of the patients, allowing patients to continue the drugs. Despite such isolated reports of successes, clinicians seldom use N-of-1 trials and most remain unaware of the design.

Renewed interest in N-of-1 trials

At the University of Alberta, recent efforts have focused on methodological issues related to N-of-1 trial design and reporting. For example, N-of-1 trials have been criticised for their lack of generalisability. The Alberta group recently partnered with the *Journal of Clinical Epidemiology* to publish a series dedicated to N-of-1 trials and included papers to address this concern. A comprehensive systematic review of the design, analysis and meta-analysis of N-of-1 trials found that the majority (60%) of published N-of-1 trials are published as a series (i.e. one

report publishing N-of-1 trial data about more than one participant for the same condition-intervention pair), suggesting their value beyond assessing individual treatment effects and their potential to provide more generalisable treatment effects. Indeed, the Oxford Centre for Evidence-Based Medicine⁴⁸ has classified N-of-1 trials as Level 1 evidence, comparable to systematic reviews of randomised controlled trials.

By virtue of their methods (i.e. use of randomisation, blinding, formal outcome assessment), the meta-analysis of N-of-1 trials may provide a valuable source of population data for conditions that have little to no randomised controlled evidence, and to help refine evidence when parallel group randomised controlled trials may exist.

Given the large number of published N-of-1 trials in attention deficit hyperactivity disorder, the condition may serve as a clinical model to explore the applicability of N-of-1 trials beyond the individual patient.⁴⁹ Investigators at the University of Alberta conducted a systematic review and meta-analysis of N-of-1 trials and demonstrated the use of traditional randomised controlled trial meta-analysis methods in N-of-1 trials.⁴⁹ In another study, Punja *et al.*⁵⁰ demonstrated the value of N-of-1 trials in meta-analyses by conducting a combined meta-analysis of N-of-1 trial data with randomised controlled trial data. The inclusion of N-of-1 data in randomised controlled trial meta-analyses improved the precision of population treatment effects, suggesting their potential to provide a rich source of data allowing for more powerful and reliable assessments of treatment effects.⁵⁰ This example also highlights the relevance of N-of-1 trials in conditions for which there is also traditional randomised controlled evidence.

Range of conditions assessed in N-of-1 literature	n
Diseases of the nervous system	27
Diseases of the musculoskeletal system and connective tissue	20
Mental and behavioural disorders	17
Diseases of the digestive system	11
Diseases of the respiratory system	09
Diseases of the circulatory system	04
Endocrine, nutritional, metabolic diseases	02
Infections and parasitic diseases	02
Other (non-specific)	08

N=100; number of published N-of-1 studies that have assessed treatments for the respective condition category (adapted from Punja *et al.*⁵¹).

Challenges and future directions

Methodological considerations for N-of-1 trials differ from those for standard, parallel group randomised controlled trials. When considering N-of-1 trials as a research endeavour, investigators have proposed solutions to three major limitations among reported N-of-1 trials: incomplete reporting, marked variability in quality, and unacceptably high rates of prospective protocol registration.

First, as is the case with parallel group randomised controlled trials, lack of complete and transparent reporting is a problem in the N-of-1 trial literature. The Alberta group⁵¹ found that authors of N-of-1 trials failed to report on a number of critical design and conduct elements: trial registration (97%), whether individuals with co-morbid conditions (77%) or on concurrent therapies (69%) were included, and whether adverse events were assessed (64%). Another review confirmed that the quality of reporting of published N-of-1 trials was highly variable.⁵² The Alberta group led the development of the CONSORT Extension for N of 1 Trials (CENT) in response to the limitations and heterogeneity in reporting,^{53,54} serving as a minimum checklist for reporting N-of-1 trials.

Second, careful development and reporting of N-of-1 protocols is necessary for researchers, ethics review boards and funders. The Alberta group is currently developing a SPIRIT Extension for N of 1 Trials (SPENT). This will recommend essential elements in N-of-1 trial protocols, in the expectation that this will help to improve the quality of published reports of N-of-1 trials and promote the inclusion of N-of-1 trial protocols in trial registries.

Third, only 3% of published N-of-1 trials are reported as having registered protocols prospectively. It is certain that not all N-of-1 trials are published and readily available (nor, for those conducted as part of optimal routine clinical practice, should they be) – unpublished trials begun as part of the research endeavour may create a risk of bias for future systematic reviews and meta-analyses. One way of capturing these trials would be to establish an electronic repository (as is done for conventional randomised controlled trials with clinicaltrials.gov) and encourage authors to register their N-of-1 trial protocols. This would help reviewers to identify selective outcome reporting and publication biases.

Beyond these challenges, emerging methodologies may facilitate optimal use of N-of-1 principles. Bayesian and adaptive designs have potential applicability to N-of-1 trials. Trials can be designed with preset points based on adverse effects or patient preferences to crossover, change dose or discontinuation. These methods can be used both to analyse and to

meta-analyse N-of-1 trials.^{55,56} The strength of Bayesian approaches lies in their ability to maximise the use of reliable available information from each participant, as well as the use of reliable prior information for incorporation in the statistical model so that each N-of-1 trial can inform the next. Zucker *et al.*⁵⁶ have demonstrated the use of Bayesian methods to aggregate N-of-1 trials to yield estimates of population treatment effects. Combining Bayesian approaches with adaptive designs may prove to be a useful combination for future N-of-1 trials.

Discussion

What explains the failure adopt and sustain N-of-1 trials? The obstacles to conducting N-of-1 trials as an element of routine clinical practice have been too great. For many pharmacists, preparing identical drug and placebo combinations proved too labour-intensive. For clinicians, N-of-1 trials take too much time, even with easy-to-use guidance;²⁹ preparing questionnaires, instructing patients and examining the results all require clinician commitment. By comparison, the simple question, 'did the treatment help' is too easy, and has too much face validity, compared to the more onerous substitution of a formal N-of-1 trial. The late Professor Charles Bridge-Webb proposed a workaround to the expensive, time-consuming process of arranging placebo.⁵⁷ He suggested a simplified N-of-1, The Single Patient Open Trials (SPOTs), substituting the blinded trial for an open one. This trial trades pragmatism for rigour, particularly useful for independent practitioners without access to N-of-1 services.

The advent of technological advances may help to overcome the operational complexity and costs that have hindered the uptake of the N-of-1 methodology. The emergence of mobile electronic health devices makes it easier than ever for patients to engage in their own healthcare. The creation of an IT-based N-of-1 trial platform would help clinicians and patients to collaborate in designing their own N-of-1 trials, track health outcomes and produce a report of results for patients and clinicians to discuss. Researchers from the University of California, Davis, have developed a mobile application called the 'Trialist' specifically to facilitate the conduct of N-of-1 trials in clinical settings. They are testing the feasibility and efficacy of this application in a randomised controlled trial comparing the effects on patient outcomes of participating in a mobile N-of-1 trial versus usual care.⁵⁸

This potential for N-of-1 trials as a way of providing clinical care differs from its use as a research endeavour. The distinction comes down to the intent behind conducting an N-of-1 trial. If the objective is to

inform treatment decisions for an individual patient, the trial is optimal clinical care and should therefore not require formal ethics approval⁵⁹ nor regulatory oversight from agencies monitoring clinical research. When choices from among two or more alternative treatments are being considered, patients should be informed about genuine uncertainties about their relative merits and how treatment should be selected in these circumstances.⁶⁰ Random allocation within formal treatment comparisons is one of the options that should be offered to patients.

If the primary purpose of N-of-1 trials is to produce generalisable knowledge to inform treatment decisions for future patients, these N-of-1 trials are more properly regarded as research. In these circumstances, compliance with methodological and ethics standards will be expected. In 2014, the Agency for Healthcare Research and Quality commissioned a user's guide to N-of-1 trials, which clarifies this distinction.²⁴

N-of-1 trials may have a future, both as a research endeavour complementing standard trials and as a strategy for improving clinical care outside of the research setting. Unlike conventional parallel group randomised controlled trials, which assess what is best on average for a given population, N-of-1 trials assess what is best for an individual patient.⁶¹ They are thus particularly well suited to emerging interests in patient-centred research and 'precision' or 'personalised' medicine. N-of-1 trials support the evolution of patient-centred research by offering an evidence-based approach for personalising care. They help to answer, for example, which treatment options are most effective through a process that strengthens the clinician-patient relationship and ultimately empowers the patient to be more engaged with their healthcare. Furthermore, with the advent of 'big data', and its hoped-for potential to inform care, N-of-1 trials can provide opportunities to learn how to improve care. The potential exists. The extent to which it will be realised remains uncertain.

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Appendix 1

N-of-1 timeline

Author, year	Citation	Description/significance
Hogben and Sim, 1953	Hogben L, Sim M (1953). The self-controlled and self-recorded clinical trial for low-grade morbidity. <i>Br J Prev Soc Med</i> 7:163–179.	
Hare, 1955	Hare EH (1955). Comparative efficacy of hypnotics: a self-controlled, self-recorded clinical trial in neurotic patients. <i>British Journal of Preventive and Social Medicine</i> 9:140–146.	

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Author, year	Citation	Description/significance
Guyatt, 1986	Guyatt G, Sackett D, Taylor DW, Ghong J, Roberts R, Pugsley S (1986). Determining Optimal Therapy – – Randomized Trials in Individual Patients. <i>N Engl J Med</i> 314:889-892.	N-of-I trials are first brought to the attention of a wide medical readership
Guyatt, 1988	Guyatt G, Sackett D, Adachi J, Roberts R, Chong J (1988). A clinician's guide for conducting randomized trials in individual patients. <i>CMAJ</i> 139: 497-503.	The practical approach presented encourages clinicians to conduct N-of-I trials
Guyatt, 1990	Guyatt GH, Keller JL, Jaeschke R, Rosenbloom D, Adachi JD, Newhouse MT (1990b). The n-of-I randomized controlled trial: clinical usefulness. Our three-year experience. <i>Ann Intern Med</i> 112:293-299.	Results of the first N-of-I trial clinical service
Guyatt, 1990	Guyatt GGH, Heyting A, Jaeschke R, Keller J, Adachi JD, Roberts RS (1990a). N of I randomized trials for investigating new drugs. <i>Control Clin Trials</i> 11:88-100.	A proposal that individual N-of-I randomised controlled trials could be used to elucidate drug effects at an early stage of development
Molloy, 1991	Molloy DW, Guyatt GH, Wilson DB, Duke R, Rees L, Singer J (1991). Effect of tetrahydroaminoacridine on cognition, function and behaviour in Alzheimer's disease. <i>CMAJ</i> 144:29-34.	Early use of multiple N-of-I trials in a particular condition to address drug effectiveness
Zucker, 1997	Zucker DR, Schmid CH, McIntosh MW, D'Agostino RB, Selker HP, Lau J (1997). Combining single patient (N-of-I) trials to estimate population treatment effects and to evaluate individual patient responses to treatment. <i>J Clin Epidemiol</i> 50:401-410.	Using Bayesian technique to combine N-of-I trials
Guyatt et al., 2000	Guyatt G, Haynes RB, Jaeschke RZ, Cook DJ, Naylor CD, Wilson MC, Richardson WS (2000). Users' guide to the medical literature: XXV. Evidence-based medicine: principles for applying the users' guides to patient care. Evidence-Based Medicine Working Group. <i>JAMA</i> 284:1290-96.	N-of-I trial described as top of methodological hierarchy for informing treatment decisions
Guyatt, 2002	Guyatt G, Zhang Y, Jaeschke R, McGinn T (2002). Therapy and Validity: N of I Randomized Controlled Trials. Users' Guides to the Medical Literature: A manual for Evidence-Based Clinical Practice. Chicago, IL: American Medical Association 275-290.	Users' guide to N-of-I trials

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Author, year	Citation	Description/significance
Nikles, 2006	Nikles C, Mitchell G, Mar C Del, Clavarino A, McNairn N (2006). An N of 1 trial service in clinical practice: Testing the effectiveness of stimulants for attention-deficit/ hyperactivity disorder. <i>Pediatrics</i> 2006;117:2040–2046.	One of the largest series of N-of-1 trials carried out in children with ADHD - carried out by a National Service to support the conduct of N-of-1 trials (the first ever) in Australia
Zucker, 2006	Zucker DR, Ruthazer R, Schmid CH, Feuer JM, Fischer PA, Kieval RI, Mogavero N, Rapoport RJ, Selker HP, Stotsky SA, Winston E, Goldenberg DL (2006). Lessons learned combining N-of-1 trials to assess fibromyalgia therapies. <i>J Rheumatol</i> 33:2069–2077.	Using Bayesian technique to combine N-of-1 trials
Tate, 2008	Tate RL, McDonald S, Perdices M, Togher L, Schultz R, Savage S (2008). Rating the methodological quality of single-subject designs and N of 1 trials: Introducing the single-case experimental design (SCED) scale. <i>Neuropsychol Rehabil</i> 18:385–401.	Single-Case Experimental Design (SCED) Scale
Zucker, 2010	Zucker DR, Ruthazer R, Schmid CH (2010). Individual (N of 1) trials can be combined to give population comparative treatment effect estimates: methodological considerations. <i>Journal of Clinical Epidemiology</i> 63:1312–1323.	Using Bayesian technique to combine N-of-1 trials
Gabler, 2011	Gabler NB, Duan N, Vohra S, Kravitz RL (2011). N-of-1 Trials in the Medical Literature: a systematic review. <i>Med Care</i> 49:761–768.	Systematic overview of the N-of-1 literature
OCEBM, 2011	OCEBM Levels of Evidence Working Group*. "The Oxford Levels of Evidence 2". Oxford Centre for Evidence-Based Medicine. http://www.cebm.net/index.aspx?o=5653	N-of-1 trials are considered level I evidence by the Oxford Centre for Evidence-Based Medicine
Tate, 2013	Tate RL, Perdices M, Rosenkoetter U, Wakim D, Godbee K, Togher L, McDonald S (2013). Revision of a method quality rating scale for single-case experimental designs and N of 1 trials: The 15-item Risk of Bias in N of 1 Trials (RoBiNT) Scale. <i>Neuropsychological Rehabilitation</i> 23:619–38.	15-item Risk of Bias in N-of-1 Trials (RoBiNT) Scale
DEClDE Methods Center N of 1 Guidance Panel, 2014	Kravitz RL, Duan N, eds, and the DEClDE Methods Center N of 1 Guidance Panel (Duan N, Eslick I, Gabler NB, Kaplan HC, Kravitz RL, Larson EB, Pace WD, Schmid CH, Sim I, Vohra S) (2014). Design and Implementation of N of 1 Trials: A User's Guide. AHRQ	N-of-1 AHRQ Publication

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Author, year	Citation	Description/significance
	Publication No. 13(14)-EHC122-EF. Rockville, MD: Agency for Healthcare Research and Quality; February 2014. www.effectivehealthcare.ahrq.gov/N-of-1-Trials.cfm .	
Tate, 2014	Tate RL, Perdises M, McDonald S, Togher L, Rosenkoetter U (2014). The design, conduct and report of single-case research: Resources to improve the quality of the neurorehabilitation literature. <i>Neuropsychological Rehabilitation</i> 2014;24:315–31.	Reporting guidelines: Risk of Bias in N of 1 Trials (RoBiNT) Scale; Single-Case Reporting guideline In BEhavioural interventions (SCRIBE)
Shamseer, 2015	Shamseer L, Sampson M, Bukutu C, et al. CONSORT extension for reporting N of 1 trials (CENT) 2015: Explanation and elaboration. <i>BMJ</i> 2015;350:18–46	CENT explanation and elaboration
Vohra, 2015	Vohra S, Shamseer L, Sampson M, Bukutu C, Schmid CH, Tate R, Nikles J, Zucker DR, Kravitz R, Guyatt G, Altman DG, Moher D, CENT group (2015). CONSORT extension for reporting N-of-1 trials (CENT) 2015 Statement. <i>BMJ</i> 350:h1738	CENT checklist
Punja, 2016	Punja S, Bukutu C, Shamseer L, Sampson M, Hartling L, Urichuk L, Vohra S (2016c). N-of-1 trials are a tapestry of heterogeneity. <i>J Clin Epidemiol</i> 76:47–56	A systematic review of the methods of design, analysis, and meta-analysis used in published N-of-1 trials
Punja, 2016	Punja S, Schmid CH, Hartling L, Urichuk L, Nikles CJ, Vohra S (2016). To meta-analyze or not to meta-analyze? A combined meta-analysis of N of 1 trial data with RCT data on amphetamines and methylphenidate for pediatric ADHD. <i>J Clin Epidemiol</i> 76:76–81.	Combined meta-analysis of N-of-1 trials with randomised controlled trial data
Punja, 2016	Punja S, Xu D, Schmid CH, Hartling L, Urichuk L, Nikles CJ, Vohra S (2016a). N of 1 trials can be aggregated to generate group mean treatment effects: A systematic review and meta-analysis. <i>J Clin Epidemiol</i> 76:65–75.	Meta-analysis of N-of-1 trials
Tate, 2016	Tate RL, Perdises M, Rosenkoetter U, Shadish W, Vohra S, Barlow DH, Horner R, Kazdin A, Kratochwill T, McDonald S, Sampson M, Shamseer L, Togher L, Albin R, Backman C, Douglas J, Evans JJ, Gast D, Manolov R, Mitchell G, Nickels L, Nikles J, Ownsworth T, Rose M, Schmid CH and Wilson B (2016). The Single-Case Reporting Guideline In BEhavioural Interventions (SCRIBE) 2016 Statement. <i>J Clin Epidemiol</i> 73:142–152.	Provides authors, readers and reviewers of single case design studies with a tool to maximise clarity, transparency and completeness in reports of such trials

