EMWA European Medical Writers Association

The Write Stuff

The Journal for European Medical Writers

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Medical Communications

Journal insights

The *Write Stuff* is the official publication of the European Medical Writers Association. It is issued 4 times a year and aims to provide EMWA members with relevant, informative and interesting articles and news addressing issues relating to the broad arena of medical writing. We are open to contributions from anyone whose ideas can complement these aims, but opinions expressed in individual articles are those of the authors and are not necessarily those held by EMWA as an association.

Articles or ideas should be submitted to the Journal Editor (see below) or another member of the Editorial Board.

Subscriptions

Subscriptions are included in EMWA membership fees. By writing to emwatws@associationhq.com non-members can subscribe at an annual rate of:

- €35 within Europe
- €50 outside Europe

Instructions for contributors

- The *Write Stuff* typically publishes articles of 800–2500 words although longer pieces or those with tables or graphics will be considered.
- All articles are subject to editing and revision by the Editorial Board. Any changes will be discussed with the author before publication.
- Submissions should include the full address of the author, including the telephone and fax numbers and email address. Suitable quotes for side boxes can be indicated or they can be selected by the Editorial Board.
- Material should be submitted by email as an MS Word file using Times New Roman (or equivalent), 10 point size, and single spacing.
- Published articles generally include a recent photograph of the author (portrait picture, CV or passport style, min. 360 x 510 pixels).

Timelines

Month distributed	Deadline for receipt of articles	Deadline for receipt of adverts
March	1st January	15th February
June	1st April	15th May
September	1st July	15th August
December	1st October	15th November

Advertising rates (in euro, €)

Corporate		**Private** / Freelance members only	
• Full page	**€1000**	• Full page	**€200**
• Half page	**€500**	• Half page	**€100**

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The *Write Stuff* is printed on 100% recycled paper.

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Medical Communications

Vol 18, No. 4, 2009

Cover picture
Cover photograph from Nadja Meister (nadja.meister@inode.at)

Regular features

From the Guest Editor's desk:

Medical communications writers: Dancing in the tunnel

by Ursula Schoenberg

Why are we doing a special issue on medical communications? For one thing, results of the last EMWA Member Satisfaction Survey indicated that there are a number of EMWA members and/or *TWS* readers interested in learning more about it. For another thing, it has been one of the ongoing ambitions of this journal to continually broaden its scope and explore the whole spectrum of work that medical writing professionals are involved in. So what exactly is 'medical communications', how does it compare to regulatory writing and what are the perspectives for medical writers working in this field?

The most succinct definition I found states that 'Medical communications refers to the written, audiovisual, or oral dissemination of medical information with a goal of informing audiences about health issues' [1]. The operative word in this definition is 'audiences' when delineating where a 'regulatory medical writer' stops and a 'medical communications medical writer' begins, though this line is necessarily blurred in the middle of the medical writing spectrum (Figure 1). In very general terms, the further left on the spectrum you are writing, the closer you are to research and drug development, the further right you are, the closer you are to a product's market.

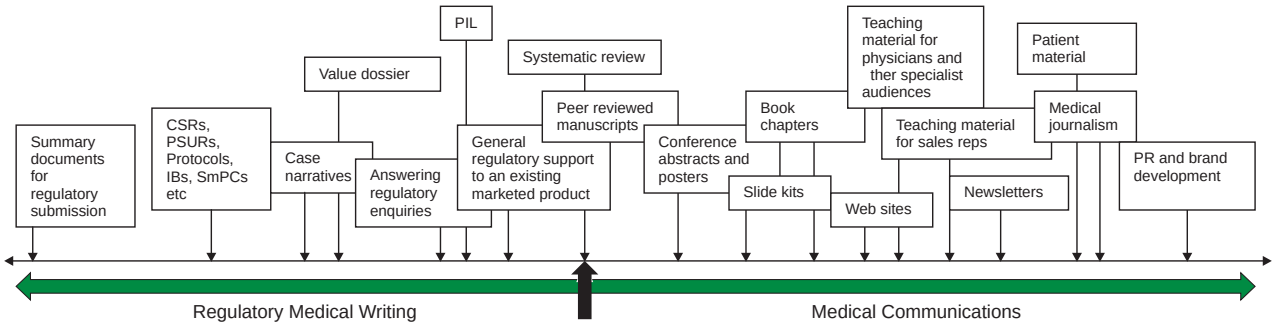
Regulatory medical writers typically create formalised documents or manuscripts read by medical professionals and/or regulatory authorities, with some writing also done for patients. A medical writer working in medical communications may write for healthcare professionals, journalists, opinion leaders, the general public and/or specific patient groups. This diversity means the writer has to put on a more varied number of 'thinking caps' in order to find a writing tonality that engages each audience effectively.

The proximity to the market also means that medical communications writers are very aware of the need to balance medical accuracy and the 'key message' demands of marketing departments. But like his or her regulatory colleague, a solid knowledge of the medical or scientific background, the ability to structure content, and a clear and concise writing style adapted to the needs of the target audience are all a 'must' for a good medical communications writer. How to get into this area of writing, how to improve your writing once you have entered the field, and some of the guidelines and codes that established writers should adhere to can be gleaned from the books discussed in this issue's 'In the Bookstores' (page 243).

In the last couple of years, four key factors have dramatically changed (and are still changing) the face of medical communications. They are globalisation, patient (and physician) empowerment, technology and cross-media opportunities. They have led to the current situation in medical communications being a bit like driving into a tunnel on a very bright day: At first you are virtually blinded by the darkness and experience a moment of panic because you feel like you are out of control. Then the outlines of shapes slowly emerge and you sigh with relief that there are some visible landmarks for you to navigate by. People working in medical communications are beginning to see some outlines, but they are far from relaxed about where they are headed.

The rising complexity engendered by these changes carries the risk of distracting medical communicators responsible for overarching communications strategies from key questions: What exactly do I want to say? Who do I want to communicate with? And: Is this channel the most effective way of reaching that audience? On the other hand, medical communications writers can get exciting new chances to expand their know-how and writing abilities.

Figure 1: The medical writing spectrum



CSR, Clinical Study Report; PSURs, Periodic Safety Update Reports; IBs, Investigator Brochures; SmPCs, Summary of Product Characteristics; PIL, Patient Information Leaflet; PR, Public Relations

This figure is a modification of the Figure 1 originally published in McIntosh A. Broad-spectrum medical writer: Nature or nurture? *TWS* 2009;18 (1):7-8

They should, so to speak, be dancing in the tunnel at the wealth of new experiences on offer in this field. (If I get to guest edit, I won't miss the chance of wildly mixing my metaphors!) For each challenge being posed, there is a chance for growth to go with it.

Globalisation offers opportunities to the medical writer (and translator, I may add) who is fluent in more than one language and has intimate knowledge of at least one national healthcare market. There is still a clear bias here in favour of the medical writer who has English as one of these languages, but even with more eclectic language combinations there are certainly niches that can be exploited. Global communications campaigns may work very nicely on paper, but still need to be honed to individual markets. Versatile medical writers with an ear for tonalities and marketing savvy can be essential for making a national advertising campaign work, for example. Not that things are always easy or straightforward when working in an international environment, as Diarmuid De Faoite highlights in his article (page 234). Globalisation also has an impact on the way writing work is timed and exchanged across the globe: I recently spoke to an agency manager who sends her urgent writing and translations assignments to Australia for a just-in-time next morning delivery. >

Medical communications in *TWS*

Although this is a special issue on medical communications, readers may not realise that *The Write Stuff* has already covered a variety of topics related to medical communications over the years. We have compiled a list for easy referencing:

Inaccuracies: press releases, referencing, statistics, and the 'Dizzy Awards'
by Sara Hughes | Vol. 18, No. 3, 2009

Broad-spectrum medical writer: Nature or nurture?
by Alison McIntosh | Vol. 18, No. 1, 2009

Some thoughts on writing slide presentations: Avoiding 'death by Power Point'
by Richard Clark | Vol. 17, No. 2, 2008

How to write web articles that charm readers and search engines
by Simon Hillier | Vol. 17, No. 1, 2008

What makes science news?
by Cathy Holding | Vol. 16, No. 3, 2007

Investigative medical writing: Marrying medical writing and journalism
by Catherine Mary | Vol. 16, No. 1, 2007

Conference highlight reports for marketing purposes: A cross between medical writing and journalism
by Anita von den Oetelaar and Hélène van Moorsel | Vol. 16, No. 1, 2007

Medical writers in drug development and marketing
by Keith Dawes and Katherin Kauper | Vol. 15, No. 1, 2006

Welcome to the blogosphere
by Ursula Schoenberg | Vol. 15, No. 1, 2006

A potpourri of links introducing the world of blogs
by Joeyn Flauaus | Vol. 15, No. 1, 2006

Meeow! Marketing medicine in Germany
by Ursula Schoenberg | Vol. 14, No. 4, 2005

Successful abstract writing: An essential skill for medical writers
by Keith Dawes and Munise Ohri | Vol. 18, No. 1, 2005

Medical journalism – a career move?
by Jo Whelan | Vol. 14, No. 2, 2005

Life in the Underworld
by Keith Dawes | Vol. 12, No. 3, 2003

From the Guest Editor's desk:

Empowerment of patients and physicians is a trend that is here to stay. In this issue, Ursula Kramer describes how medical education can be used to increase awareness for vaccinations in patients and doctors (page 215), and Juliet Roberts gives insights into how patient compliance can be improved (page 218). There is a widening gap between the need and right of patients to receive information about health issues and the exponentially growing body of detailed scientific and medical knowledge. A good medical writer or journalist is capable of transforming this complexity into something understandable, an excellent one may even make it enjoyable to read. Cathy Holding makes us take a minute to think about who actually fuels what is written and the way health issues are reported (page 230), In addition to patients, physicians themselves are also increasingly using the power of social networking to make informed decisions, as David Stevens explains (page 225).

Technology in the form of the Internet and its underlying computing and programming platforms is something that no one can ignore, especially writers of any description. Gone are the days when you just wrote your text, and that was it. A good medical communications writer called upon to write for the Internet needs to understand the underlying technological and/or design constraints and use them to their best advantage, as the article by Silke Wolter and Heike Wagner illustrates (page 227). It also makes sense to learn to use a content management system (e. g. TYPO 3 or Plone), which is not just fun, but also allows freelance medical communications writers direct access to clients' Inter- or Intranet platforms from the comfort and security of their own office.

Closely linked to the issue of technology in general is the issue of 'cross-media competency' in particular, i.e. the ability to use the various new media to their best advantage. With the decline of traditional publishing, this is one area where the pharmaceutical industry is definitely still very much 'in the tunnel' and trying to find its way between Twitter, blogs, YouTube, podcasts, video casts, social networking sites etc., as Ruth Bastuck touches on in her article (page 221). For a medical communications writer, this means actively broadening one's perspective about what 'writing' actually means. Writing is just thinking on paper, and every well-crafted piece of oral (podcast) or visual (video cast) information needs a good storybook to make it work. Someone has to write those, too. In this vastly expanding media galaxy, putting social media to conscientious use may even be a moral responsibility for medical writers, says Camilla Cooke (page 232).

Regardless of where you are on the medical writing spectrum, the opportunities to the left and right are there and exciting—so put on the music and go out and dance!

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References:
1. 'Medical Communications, Clinical Pharmacy Careers in', by Lara E. Storms, Cindy W. Hamilton; from 'The Encyclopedia of Clinical Pharmacy', by Joseph T. DiPiro, American College of Clinical Pharmacy, American Society of Health-System Pharmacists

EMWA European Medical Writers Association

We are delighted to announce that the venue for EMWA's 31st conference will be Nice, France. This is a great location by the Mediterranean for our 2-day autumn conference to be held from 11th to 13th November 2010. The photograph shown here is of the Radisson's terrace by the sea: www.radissonblu.com/hotel-nice.

Many workshops will be on offer covering a wide range of medical writing topics for those wishing to obtain credits towards their foundation or advanced EMWA professional development programme certificates, or simply to update their knowledge and skills.

In addition there will be a chance to meet old friends and make new ones at the welcome buffet on the Thursday evening and the conference dinner on the Friday evening. These social events are excellent opportunities for networking with other medical writers from Europe and beyond.

Further details will be posted on the website at www.emwa.org.

Press release

Ghostbusting in medical research: latest guidelines reinforce the importance of ethics in scientific publications

The European Medial Writers Association, EWMA, welcomes the affirmation of the role of medical writers in the updated guidelines on Good Publication Practice for Pharmaceutical companies (GPP 2) in the British Medical Journal.

The guidelines reaffirm the legitimate role that professional medical writers can play in the publication of medical research, and echo EMWA's own comprehensive guidelines on ethical publication practice. Both the EMWA and GPP2 guidelines aim to stamp out the practice of "ghostwriting" – where a pharmaceutical company pays a medical writer to write a paper without this arrangement being disclosed.

Medical writers are skilled communication professionals who can help ensure that research is presented clearly and effectively, and to rigorous scientific standards. Their role is to draft a concise scientific paper using the mass of highly detailed results generated by clinical trials. EMWA and GPP guidelines emphasise that this should always be done in close collaboration with the researchers who are named as the paper's authors.

The coordinating role of the medical writer can speed up the publication process so that research is presented more quickly. But it is the named scientific authors who have control over – and responsibility for – the final published document. EMWA guidelines stress that to ensure transparency, the role of the sponsoring company in paying for medical writing should be clearly disclosed in the paper.

Recent research by EMWA (jointly with the American Medical Writers Association) has shown that ghostwriting has become substantially less common over the last few years, suggesting that the guidelines have been effective. GPP2 is the latest in a series of initiatives designed to ensure that publication of clinical research results by the pharmaceutical industry is done to the highest ethical standards. The original GPP guidelines, published in 2003, were written by a group of professional medical writers in response to criticisms that publications of clinical research sponsored by pharmaceutical companies had a commercial bias, at the expense of good science. Such criticisms were particularly likely when "ghostwriters" were used.

EMWA and the American Medical Writers Association have been at the forefront of initiatives designed to improve ethical standards in medical publications. EMWA published guidelines in 2005 which clarified the role of professional medical writers based on clear ethical principles. EMWA hopes that the GPP 2 guidelines will help to ensure that ethical standards in medical publication continue to improve.

Notes to editors

The European Medical Writers Association (www.emwa.org) is the main professional organisation for medical writers in Europe. It has almost 1000 members, working in pharmaceutical companies, contract research organisations, specialist medical writing companies, and as freelancers. It promotes good practice in medical writing through its extensive training programme in all aspects of medical writing, as well as being the official voice of medical writers in Europe.

The EMWA guidelines can be found at http://www.emwa.org/MembersDocs/GuidelinesCMRO.pdf

Details of the research showing that ghostwriting is becoming less common can be found at http://www.emwa.org/JournalArticles/JA_V18_I2_Jacobs1.pdf

The latest version of the GPP guidelines (GPP 2) can be found at: http://www.bmj.com/cgi/doi/10.1136/bmj.b4330

The original GPP guidelines (2003 version) can be found at http://www.gpp-guidelines.org/

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Message from the President

EMWA creates new role of Conference Director—Your chance to become involved

by Helen Baldwin

I can't believe I'm already writing my third message since becoming EMWA President in May. Time really does fly when you're having fun! As usual, there has been plenty of activity behind the scenes of your association, and I'd like to give you an update here.

Firstly, at the time of writing this, the plans for the Frankfurt conference are well underway. By the time you read this, I hope we will all be saying what a great conference it was! The choice of EMWA Professional Development Programme (EPDP) workshops has been substantially expanded this year in response to suggestions from members for new workshop topics. Thus you will see a broader range of topics to choose from in both Frankfurt and Lisbon. We are grateful to all of the new and 'old' workshop leaders for taking the time to develop their workshops and agreeing to share their expertise with the rest of us.

EMWA gets even greener

EMWA recently implemented a new online system for downloading pre-workshop and post-workshop assignments via our website. This has reduced administrative work for our head office and also reduces the risk of participants receiving their documents late due to lost emails. We also took our efforts to 'go green' a step further at the Frankfurt conference. The conference bags provided were a selection of unused bags from several previous EMWA events, the conference workbook was replaced with a reusable ring-binder and, like the last two issues of *TWS*, all handouts were printed on recycled paper. As a keen ecologist, I am very happy that EMWA is trying as hard as possible to reduce its carbon footprint!

New executive committee position created: Conference Director

In the last few years, overseeing the conferences has been the job of the President and/or Vice President (VP). However, EMWA has grown considerably and the President and VP now have more work and responsibilities than before. The number of participants at our conferences has also increased and the conference programmes have expanded to include many events on top of the EPDP workshops, including plenary lectures, seminars and discussion panels. As a result, the management of two conferences per year has become unfeasible for the President and VP. Therefore the EC have agreed to create a new position of 'Conference Director'. This will be a two-year elected position on the EC starting from May 2010. The responsibilities will include visiting and selecting conference hotels in various European cities (I can definitely recommend this aspect of the job!), participating in the selection of the conference theme, putting together and managing a conference subcommittee, contacting potential speakers and enticing them to participate, overseeing all head office activities regarding conferences etc. It's an exciting job for someone who is good at project management—and would look great on your CV.

Can you see yourself as EMWA's next Vice President?

There will also be another EC position up for election at our Lisbon conference in May—that of Vice President. Some of you may be wondering why this is one year earlier than planned. The reason is that the EC have decided to reduce the terms of office of the VP and President to one year each (i.e. a total of two years). In fact both positions were always one year each until 2007 when a decision was made to extend them to two years each (i.e. a total of four years). I was elected VP in 2007 and was the 'guinea pig' for the new system (lucky me!). However, we have now realised that it is too much to expect a volunteer to devote four years to EMWA whilst juggling their 'real job' and we believe more members will be willing to take on these roles if we reduce their terms of office back down to one year each. The other reason for our decision is that, thanks to the creation of the Conference Director position, the VP and President will be able to concentrate on managing the association, instead of organising the conferences, and will therefore be able to achieve more in a shorter time period. So we are also calling for candidates for the position of VP for May 2010. The elected VP will then automatically become President the following year.

The responsibilities of the VP and President include defining and pushing forward the strategy of the association, liaising with other organisations, lobbying on behalf of the medical writing profession, facilitating the work of the other executive committee (EC) officers, managing EMWA's head office staff, and many other activities. To be eligible to stand for the position of VP you must have attended at least one EMWA conference in the last 3 years and have performed an official role for EMWA in the last 5 years (e.g. committee member, workshop leader etc.). I highly recommend the job—of course it's a lot of work, but the rewards are well worth the effort. Please don't hesitate to contact me if you would like to know more about what the job entails.

If you would like to apply for either of the EC positions, please send a 100-200 word description to EMWA's head office (info@emwa.org) telling us who you are and why you think the members should elect you.

That's enough from me for now. Thanks for listening. Now I'll leave you in peace to read this excellent issue of *TWS*!

Helen Baldwin
SciNopsis
president@emwa.org

News from EMWA's Frankfurt Conference

EMWA had a successful conference in Frankfurt from 12-14th November. Barry Drees gave an entertaining and enlightening welcome lecture on 'surprising' Frankfurt and those who were up bright and early on the first full day of the conference enjoyed an interesting plenary lecture at 8am as reported in the following.

What reviewers want: EMWA Frankfurt conference plenary lecture

The plenary lecture at EMWA's Frankfurt conference (12-14 November 2009) was given by Leighton Chipperfield who is an executive publisher in Elsevier's Global Medical Research Department. The lecture titled 'What Reviewers Want' presented the results of a survey of peer reviewers of articles submitted to 249 of Elsevier's speciality journals.

Peer review, Chipperfield, pointed out began with the very first true scholarly journal published and here there was a German connection. Its editor Henry Oldenburg was born in Germany in 1618. He later moved to London and was appointed joint Secretary to the Royal Society, which published its fist journal *Philosophical Transaction of the Royal Society* on 6th March 1665.

Why reviewers review and will enough continue to do so

Elsevier's survey elicited responses from 9,580 reviewers and was conducted between 2005 and 2008. The number of submissions of articles to biomedical journals nearly doubled in this period, primarily due to growth in submissions from developing countries. Fortunately the number of reviewers grew proportionally. Problems could naturally arise in future if the increase in reviewers fails to keep pace with the increase in submissions. Anecdotal evidence suggests there is an increasing strain on the review process because of the increase in submissions and difficulty in recruiting reviewers. However, the survey found that although the rate of reviewers declining to review had dropped there was not yet a dramatic trend in this direction: 74% had declined invitations to review in 2005 and 71% in 2008. Reviewers are taking less time (3.9 days in 2008 vs 5.2 days in 2005) to agree to review, indeed the time taken for a review is on average only 16 days of the 16-18 weeks which is the average time from submission to e-publication. Chipperfield put the quicker reviewer response down to the automated electronic processes that have been implemented for reviewers to communicate >

The photographs on this and the following page were taken by Crispin Hodges at EMWA's Frankfurt Conference

EMWA news

> with and deliver their reviews to the editorial office. He noted, however, that reviewers rated editor communication as the third most important factor in whether they agreed to review an article, after the article's relevance to the reviewer's expertise and the quality of the review system. The journal's reputation came a surprising fourth in the list of factors, but this reflects the reasons why reviewers review at all, which are their commitment to the field, personal education, being the 'first' to know about the research, career advancement, networking, and recognition. Generally reviewers do not review for reward, although in the Peer Review Survey 2009[1] undertaken by Sense About Science 41% of reviewers said they would like payment for review provided it was not the authors who had to cover the cost. However, most just want acknowledgement in the journal.

What reviewers don't want and do want from authors

Heartening for medical writers was that poor use of English is one thing that reviewers didn't want along with results that do not justify claims made in the discussion, papers that add nothing new to knowledge in the field, a weak sample and other methodological weaknesses. Another thing that reviewers did not want was a paper outside the journal's scope but at many large journals these papers never reach external reviewers because they are returned to the author after a review within the editorial office only. The lesson here is to examine the journal and its scope carefully to ensure that the paper falls within the journal's area of interest.

Reviewers want original valid and significant research, clear and concise presentation of the work, papers that conform with the requirements of the journal and fall within its scope and also conforms with guidelines such as those published by the International Committee of Medical Journal Editors (ww.icmje.org).

Questions relating to the Elsevier survey can be addressed to Leighton Chipperfield at L.Chipperfield@eslsevier.com

1 The preliminary findings of the Peer Review Survey 2009 are available at http://www.senseaboutscience.org.uk/index.php/site/project/395

EMWA's green conference

The Frankfurt conference was as environmentally friendly as possible. Everything from badges to signage was either produced from recycled materials, or was recyclable or biodegradable. At previous meetings, a large wire-bound conference guide along with a bag had been given to each delegate, but to improve efficiency and reduce costs EMWA decided to use bags already in stock and provide an empty binder made from 65% recycled materials with the tabs made of 100% recycled card for hand-outs. Also, instead of a heavy and expensive conference guide a mini-guidebook was produced and printed on recycled paper. Handouts for each workshop were sourced 100% recycled oxygen bleached paper. The badges will biodegrade within 1-5 years. All the foamboards produced were also biodegradable.

With thanks to **MCI** (info@emwa.org) for all their green efforts and for providing the text for this box.

A selection of readers' comments on the new *TWS* format

Recycled paper

Three cheers, congratulations, 'félicitations', and all other good appreciative words to EMWA for the decision to use recycled paper for *TWS*. It's really great!

I prefer it to the old format. It is much lighter and therefore easier to roll up and stick in a bag! I also like the fact that recycled paper is used. It looks and feels more in touch with the environment, and as a group which can generate a lot of paper waste, that's no bad thing in terms of a small offset. The photos aren't so sharp, but this is the trade-off for recycled paper.

I have mixed feelings about the recycled paper. It's nice to know we're doing our bit for the planet, but it does make it look a bit cheap and amateurish.

Table of contents (move from back cover to first inside page)

The back page is in principle a tad more suitable for the table of contents, but the first inside page comes a very good second. However, the white-on-green type on the back page made it require concentrated reading (for me anyway, and that's with very good glasses) while the black-on-white of page 2 leaps into the eye in a manner that I have missed for ages.

Moving the table of contents was definitely a good move. It makes so much more sense at the beginning.

Me, I happen to like the back-page tables of contents. So I'm sorry to miss them.

I think I preferred contents on the cover for speed/my laziness, but can live with the move to the inside.

Binding (changed from stapled to perfect binding)

I think the perfect binding is a great improvement. I think it makes it look much more professional.

The new journal lies flatter, but it does not open so well and the text closest to the gutter tends to vanish. My suggestion: try keeping the new binding but increasing the gutter measurement a bit. Sacrificing some of the outer margins would not seem a problem. (Editor: this suggestion has been implemented in the current issue.)

Upcoming EMWA Conferences (2010)

Lisbon: 11-15 May (see backcover)

Nice: 11-13 November (see page 207)

Did you know that all URLs in *TWS* are active in the online version?

Copying out website URLs from the print version of *TWS* can be cumbersome. Therefore, we have taken steps to ensure that a mouse click on the URL in the online journal on www.emwa.org will take you directly through to the website.

Themes of upcoming issues of *TWS*

The March issue of *TWS*, guest edited by Iain Patten (iain.patten@ubcscisols.com), will have an authorship theme. Articles are also invited on preclinical regulatory topics and on readability. Future issues featuring business and electronics for medical writers are planned.

Articles (up to 2500 words) and short reports/boxes (up to 1000 words) on these topics or any that are of interest to medical writers, medical translators, or trainers in the field are very welcome.

Elise Langdon-Neuner
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"Medical writing is a great career, Olly. Let me tell you how you get started." Oliver looks less than convinced.

Photograph kindly provided by **Geoff Hall** (Geoffreymhall@aol.com)

You do what, exactly? A medical communications glossary

by Ursula Schoenberg and Lisa Chamberlain-James

We have compiled a glossary of the kind of work medical communications writers may be asked to do, which might be helpful for readers who are more familiar with the world of regulatory writing.

Advertising: Advertising encompasses a very broad range of written material that can be targeted towards pharmaceutical salespeople, patients, and/or healthcare professionals. It includes everything from strategic product branding to ads in medical and consumer media (print, radio and TV) to print material (leaflets, flyers, direct mailings, folders etc.) and/or preparing material for conferences and fairs. In large pharmaceutical companies, much of the work is planned by a global team. This work may need to be modified to address individual national target groups in an effective manner. Medical writers may be asked to write headlines and/or long copy (jargon for 'longer text') or to adapt English slogans, headlines and/or copy into the local language. Knowledge of branding principles and a very good feel for language is a must when working in advertising.

Books and book chapters: This can include everything from the medical text book to popular medical and/or scientific books. Medical writers are usually given a detailed brief on structure and content, and may have the opportunity to liaise with key opinion leaders (KOLs) on the topic in question. This is especially the case if the chapter is being written by the writer from scratch, or if the KOL is supplying an introduction to the book or chapter. Writers may also be expected to suggest graphics, tables or charts to accompany the text, and should be aware of copyright issues surrounding the use of such illustrations. Most usually, the illustrations themselves will be produced by the production team involved with the piece but as the writer, you may be asked to liaise with them to ensure that the appropriate illustration is produced to accompany your text. The extent of your involvement in this side will vary according to the client.

Conference posters, abstracts and reports: Conferences are a good way for research to be put in the public domain, and to generate interest around drugs. For work to be accepted at a conference—either as a presentation by a speaker or as a poster presentation—an abstract must be written and submitted to the conference organisers for consideration. As a writer, you will be expected to produce the abstract, which must comply to the guidelines set out by the conference organisers. These guidelines are similar to 'Instructions to Authors' given by journals, but they also sometimes have a template (often a text box) that the abstract must fit into before submission. As with manuscript writing, you should expect to be given all the information needed and/ or access to the principal person responsible for the work. The writer may also be asked to take responsibility for the submission of the abstract and liaison with the conference organisers. For poster production, the instructions for dimensions, orientation etc. will be available from the conference organisers. You will usually work with the graphics company/department responsible for producing the poster itself, and should be very aware of jeopardising future manuscript publication from the work. Conference reports are produced after the conference has taken place and their length and detail will be dictated by the client. Writers would be expected to report on specific sessions, agreed beforehand with the client. The client should also state the form that they would like the report in, and if they have any special emphasis that they would like the writer to focus on.

Media kit: What a medical journalist receives when attending a press conference or when requesting material from a company. It typically includes: table of contents, press release, background material and/or fact sheets, relevant studies that have been published, CVs of press conference speakers, abstracts of speaker lectures, picture material in analogue or digital form, graphs and/or statistics. Writers may be asked to contribute to some or all of the material in a press kit.

Medical journalism: In medical journalism, a journalist (or team) independently researches and writes an article which is subsequently published in a newspaper (or on a newspaper website), popular magazine or special interest title. Good medical journalists strive to present topics in a language that is lively and can be easily understood by a wide audience. Medical journalists may sometimes work outside of the classical field of journalism and venture into the field of contract work (see Medical articles).

Medical articles: A medical article differs from medical journalism insomuch as it is not an independently researched and published article, but is contract work for a specific client. Articles may be contracted for publication in medical newspapers (often targeted towards GPs) and/or non-peer reviewed medical journals. The writing

is geared towards a medical audience, but is not as high level as when preparing a paper for a peer-reviewed journal. Readability often wins out over 'image enhancement' style in this kind of writing.

Patient resources: Writing for patients requires a different skill set. You must produce text that patients can understand without any prior medical knowledge, and it must be honest and unbiased. Most importantly, it must not frighten the reader, merely inform. The type of pieces that you may be asked to produce include patient information leaflets, instructions specifically aimed at children, the elderly, or those for whom English is not their first language. Since these pieces will be available to the general public, writers must take great care that they do not write anything that cannot be fully supported, or anything that could be construed as advertising to the public and should be aware of the responsibilities surrounding this type of writing.

Public relations (PR): Differs from advertising in that it does not typically disseminate messages directly towards the consumer, i.e. patient, but uses more indirect channels. Among other things, specialised PR agencies support the marketing departments of pharmaceutical companies by strategic planning and implementation of media work, by identifying and engaging with KOLs and interest groups and/or by planning and implementing creative events to reach different target groups. Writers with PR experience can be asked to support media work (see Media kit) or KOLs (see Slide kit, Conference posters, Book chapters and/or Medical articles).

Slide kit: Technology has made this word something of a misnomer, since today the 'slides' are usually generated in Power Point. However, the principle remains the same: a topic is to be presented by a speaker, for example at a medical conference, press conference or in an in-house corporate setting. The material needs to be structured and written up in a concise form (often in bullet format), optimally with clear headings to help the listener keep his/her bearings and with an eye to keeping listeners engaged (for example by switching between word charts and graph charts, adding interesting pictures etc.). Sometimes companies commission slide kits on a certain topic that they offer to physicians to use at conferences or meetings. Writers may be asked to develop a slide kit from scratch or to edit and/or streamline an existing presentation. Familiarity with Power Point is a prerequisite, since you are working with a medium that combines text and design elements.

Training material: All pharmaceutical companies need to train their medical representatives so that they have the knowledge necessary to both convince prescribers to use the company's product, and also to deal with any questions that the prescribers may have. Writers may be asked to produce training manuals for the representatives. These cover the therapeutic area, the mode of action and clinical trials of the drug in question, plus marketing sections and discussions comparing and contrasting the client's drug with those already on the market. Writers will also be expected to produce a set of questions on the manual so that the company can test their representatives' understanding and knowledge at the end of the training. Increasingly, training is done on-line or at least with some electronic component. Writers should be aware that training material is subject to the ABPI Code of Practice (to be found at: http://www.pmcpa.org.uk/?q=getcopiesofcode).

Web content: The Web needs to be filled with what the jargon typically calls 'content', meaning the written word. Most of this work is ultimately geared towards the patient and can include writing a corporate website for medical/pharmaceutical clients, writing about specific indications, blogging on a topic for a client and/or preparing electronic newsletters, to name just a few. Writing for the Web differs from all other kinds of writing, because you are working with readers who have an infinitesimal attention span. You have to engage them with lively headlines and try to draw them quickly into a topic so they want to read more.

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TWS and its editorial board wish you a merry Christmas and a happy New Year

Befitting this festive season we have set out below a few holy utterances seen on religious-based signs and notices pinched from the section 'In the beginning the word was good' *East Shites & Leaves* by A. Parody[1]:

- Eight new choir robes are currently needed, due to the addition of several new members and to the deterioration of some old ones.
- Persons are prohibited from picking flowers from any but their own graves.
- A bean supper will be held in the church hall. Music will follow.
- Due to the rector's illness, Wednesday's healing services will be discontinued until further notice.
- Our thanks are due to Miss Goodman who labored the whole evening at the piano, which once again fell upon her.

1 A. Parody. *Eats, Shites & Leaves. Crap English and how to use it.* Michael O'Mara Books Limited, 2007.

Medical education—An ideal remedy to cure our health care systems?

by Ursula Kramer

Health care systems all over the world are suffering from a growing financial burden. Nobody can deny the rising economic pressure all players—physicians, patients, pharmaceutical companies and health insurance companies—are faced with. Physicians are no longer the only decision makers determining which drug to use or which treatment to start with, and they are increasingly obliged to act within the narrow framework of guidelines based on criteria of evidenced-based medicine. Reimbursement is controlled by government-associated institutes that assess what is an innovation and needs to be paid for. Ultimately, physicians are faced with the worsening dilemma of finding a reasonable balance between optimal and rational medical treatment. That puts a great strain on the trustful patient relationship and threatens physicians' role of being patients' advocates.

Patients' role is gaining in importance

In parallel with the increasing regulative control of government, official bodies intend to strengthen the role of patients. Patients expected to pay for their health out of their own pockets may demand concessions regarding decision processes and quality control. How they should exercise their new rights in a reasonable manner remains unclear. It's true—medical knowledge was never accessible as easily, cheaply and conveniently as it is today. The variety and depth of information concerning health or diseases is impressive. Physicians' lead in the field of medical knowledge seems to be melting away. Patients' expectations are growing, but also their need for guidance, since a confusing jungle of information is growing steadily.

What role can medical education play?

Facing the landscape in which medical education is embedded, it is legitimate to ask what the future contribution of medical education can really be. Isn't the battle already lost? Wouldn't it be better to drop the idea of enabling every patient to gain access to the therapeutic innovations that medical progress is offering today and will be offering tomorrow? Is it an unattainable goal to improve overall health and quality of life since ethics have already been superseded by monetary considerations? On the contrary—prospects were never better to make a real difference by means of medical education.

Leveraging the partnership between physicians and patients

Most of our health care money is spent to cover the cost of diseases caused by eating the wrong food, overeating and lack of exercise. Treatments for hypertonia, diabetes and arteriosclerosis are the main cost drivers, and a lot of money is wasted due to a huge lack of patient compliance. If this fatal development cannot be stopped, growing health care expenditures will ruin economic systems all over the world.

To start implementing change, we don't need better treatments to control symptoms and prevent or slow progression of the above-mentioned diseases. Physicians with a changed mindset are the cure! They need to stop seeing their role primarily as treaters of disease, but must instead learn to think of themselves as enablers of disease prevention. Accordingly, patients need to be guided so that they accept personal responsibility and actively contribute to staying healthy. Prevention and preventive medicine are the buzzwords here, and medical education, focusing on physicians and patients, is the communication channel that can help leverage their future partnership.

Helping physicians adapt to future challenges

The impetus of this article is to highlight opportunities that may arise from defining medical education in broader than usual terms. In addition to merely making knowledge available, this broader definition of continuing education also includes offering solutions on how to implement and convey this knowledge (organisation, division of labour, delegation, workflow). We believe that gradually establishing a physician-patient relationship based on partnership involving empowered and self-determined patients is more easily achieved by involving and training physicians by helping them, in very practical terms, to improve communication with their patients in daily practice. To get physicians to participate in this vision, they first have to become aware of and understand the benefits for themselves and their practice.

From medical expert to expert motivator

New skills are necessary to motivate patients to become partners, partners who are willing to take responsibility for staying healthy. In addition to their medical expertise, health care professionals have to develop additional skills, similar to teachers or coaches, to become efficient motivators of their patients. Therefore, special training in the fields of communication and organisation is required. Services that support optimised workflows and reveal new time resources are also needed so that physicians can find the time to create an empathic and caring atmosphere as a basis for effective interaction with their patients.

An example: Your vaccination status

Let's take a look at an example from the field of preventive medicine. It begins with a short experiment in the form of three simple questions you should try to answer honestly:

1. Do you know your vaccination status documented in your vaccination certificate?
2. Has your gynaecologist or GP ever asked you to check your vaccination certificate?
3. Do you know which preventive check-ups are offered and paid for by your health insurance?

You probably answered "no" to all three questions. Welcome to reality, the starting point of our efforts. When physicians were asked to give an explanation for this dire situation, the main answers were:

1. We agree, vaccination is important, but unfortunately we are not thinking about it—not on purpose, it just happens. There are so many other diseases and problems we have to tackle.
2. We really don't feel able to delve too deeply into the complex topic of vaccination. Every single year the experts' recommendations change, so that we are not sure whether we are acting according to recent recommendations. So we step back and wait until patients bring up the subject. And unfortunately, that doesn't happen very often.

The Vaccination Watch—Complex recommendations made easy to use

After consultation with physicians and their staff we developed two handy information tools. The first was the Vaccination Watch (Fig. 1) which condenses and transforms recent experts' recommendations (20 pages!) and makes them easy to use and remember by physicians and assistants in real-life situations. The watch was implemented in three different versions to meet the demands of three medical target groups—GPs, gynaecologists and paediatricians, that all deal with different patient profiles. Demand for the Vaccination Watch was high after its launch: to date, more than 100,000 watches are being used by physicians across Germany.

Figure 1 **Vaccination Watch for Physicians and Assistants (GPs) Facilitates the checking of vaccination certificates based on recent experts' recommendations** ***(STIKO-Empfehlung, Ständige Impfkommission am Robert Koch Institut, Berlin)***
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The Prevention Watch—Supporting access to healthy patients

The second tool was the Prevention Watch which has an interactive, self-explaining display that creates awareness for vaccinations and preventive check-ups, depending on the age, sex and health status of the patient. It is placed in the waiting area of doctors' offices or in pharmacies. Physicians who already use this watch confirm that engaging healthy people on the topic of prevention is easier now, since patients themselves take the initiative and ask the doctor's team about it more often.

Team training in vaccination management

Besides introducing these hands-on tools, we also trained the physicians' teams by confronting small working groups with real-life problems in a positive and interactive learning atmosphere. First they learned to check the vaccination documents and discussed vaccination schemes, indications and adverse effects. Then they were given the opportunity to apply their new knowledge directly and show what they had really understood.

Nearly as important as leveraging the medical facts is improving vaccination management, e. g. by discussing proven concepts and implementing examples of how to organise a more efficient workflow. And since this question concerns the whole team, our training involved the assistants as well. Over the last four years we trained more than 2,000 teams. By strengthening team spirit and supporting a common understanding of how to divide labor efficiently, training helped garner acceptance for the changed workflow and subsequently helped foster success.

Patients need to be addressed proactively

One of the most important steps to improve vaccination management is to address patients proactively. In order to do this—to ask for the vaccination certificate, to deal with patients' constraints properly, to inform comprehensibly within the restricted time frame in real-life situations—assistants and physicians need to master far more than medical facts. First they need to be made aware of the impact of communication, including the underlying rules and tools of empathic, caring and comprehensible transmission of verbal and non-verbal messages.

Communication skills make a difference

By analysing real consulting situations, moderated by experienced coaches, physicians and assistants learn that their communication skills make a real difference—whether they are convincing or not, whether they are seen to be self-confident or insecure. They realise that patients who have been addressed adequately are more willing to speak frankly about their fears, hopes, personal motives or constraints regarding vaccination. And with this information in mind, physicians and assistants can achieve better and quicker results by finding the suitable set of arguments to address patients' needs and gain patient acceptance for the procedure. >

Medical education—To cure our health care systems?

> Development, implementation and validation process

Once the ideas for a training programme (CME certified, target group specific) or informational tool have been developed, we start looking for a sponsor making the service material available nationwide to the target group through their sales force or sponsoring physicians who want to participate in the programme. Only if we succeed in convincing third parties (pharmaceutical manufacturers, sick funds, public institutions) of our activities and if we can prove, based on direct demand, that the target group does in fact show an interest in our programmes can we implement them across Germany.

As a general rule, we first assess the level of acceptance of the programme we have developed. With the Vaccination Watch, for example, we initially had only 15 000 watches produced, later 30 000 and then 60 000. The Prevention Workshops started out as a pilot project (10 events). In view of the positive feedback (high demand, evaluations by workshop participants), the number of workshops was, in subsequent years, increased to 20, 40 and 60 per year.

This process differs fundamentally from the development of patient information folders or decision aids made available by universities or state-run organisations. These institutions develop materials on behalf of a government agency, they receive government funding to provide scientific advice through the development and validation process and produce the materials with public monies. Whether or not the physicians themselves consider the materials of any use in their daily practice is not one of their main concerns, and acceptance testing is based mostly on random sampling.

For example, we directly asked physicians for their feedback about the usefulness of the Prevention Watch displayed in their waiting room. On a questionnaire, they were asked to rate (using grades from 1 to 6) how well the watch was able to catch their patients' attention, how often their patients asked them about the watch, how they rated the medical information and how much time the watch actually saved them. Overall, 98% of physicians commended the Vaccination and Prevention Watch.

Medical education is one component of system 'treatment'

So is medical education an ideal remedy to cure our health care systems? It's like with every chronic disease that shows a complex set of symptoms—you need combination therapy! Successful medical education is just one component of treatment. Ignoring preventive medicine and neglecting the impact of patient adherence to treatment outcomes and quality of life has caused a lot of gaping wounds. If the 'remedy' of medical education is administered to farsighted and keen players, and is fostered by competitive pressure and social responsibility, the prospects are good to stop the bleeding. So to avoid future pain due to unfair rationing of resources, it would be better for all of us to take the proposed remedy.

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The best quality journal is the one with a 100% rejection rate!

In their thought-provoking paper, Macdonald and Kam [1] are concerned with the definition of a 'quality journal' because publication in flagship journals is a major indicator of research performance in UK universities (I would say almost everywhere in the world and in about any discipline). The article investigates the notion of 'quality journal' and finds dizzying circularity in its definitions. Actually, what a quality journal is does not really matter. What matters is that there is agreement that quality journals do exist. As so often happens with indicators of performance, the indicator has become the target. The challenge is thus to publish in quality journals, and the challenge rewards gamesmanship. Vested interests have become particularly skilful at the game, and at exercising the winners' prerogative of changing the rules. All but forgotten in the desperation to win the game is publication as a means of communicating research findings for the public benefit. The paper examines the situation in management studies, but the problem is more widespread. It concludes that laughter is both the appropriate reaction to such a farce, and also, perhaps, the stimulus to reform.

Macdonald and Kam also refer to the well-known fact that rejection rates are often seen as telling indicators of quality journals: the higher the rejection rate, the higher the quality of the journal to the point that we are now perilously close to the **ultimate in quality journals**: **a journal with a rejection rate of 100% that publishes nothing at all**!

The authors also report that, in management research at least, a) of the papers cited, the half more cited is actually 10 times more cited than the rest; b) between 10 and 30% of citation is self-citation; c) more than half of academic papers are never cited at all, and d) the majority of academics never receive as many as three citations in a lifetime. I wonder what the situation is other fields. Anybody know?

Macdonald and Kam reckon that reminiscing about a golden age when academics published to improve the lot of mankind is as pleasant as it is deluding. They indeed posit that there never was such a golden age. Academic publishing, they assert, has always been ridden with self-interest, and academics have always schemed to promote themselves. (What about Newton? Boyle? I ask). They also assert that papers published in quality journals are money rather than wealth in the sense that they are meant to be counted rather than read.

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Patient compliance: New media tools to help patients take their medications

by Juliet Roberts

Patient support programmes are the politically correct term for initiatives, sometimes called patient compliance (or adherence) programmes, that aim to support patients in their illness, and include elements that help them to take their medications as prescribed. Although strategies to support patients in taking medication have been around for a long time, new media are now facilitating original approaches that fit with patients' lifestyles. This article aims to look at some ways in which new technologies are helping provide novel solutions to an old problem.

Rationale for patient support programmes

Briefly, before looking at the role of new media, it is worth reviewing why patient support programmes are necessary. First and foremost, the scale of non-adherence is immense—according to the World Health Organization, more than half of all patients with chronic conditions do not take medications as prescribed[1]. The consequences of poor adherence are that the effectiveness of treatment is severely compromised, and the cost to patients are poorer health outcomes and even death.[1] In the cardiovascular disease area alone, failure to take treatment results in an estimated 125,000 premature deaths each year, just in the US [2].

The price of non-compliance is also high to health systems. Diabetes is a prime example. The CODE-2 study (Cost of Diabetes in Europe—type 2) found that although costs of treating type 2 diabetes are 66% more than for the general population, for patients with complications, costs increase up to three times further[3]. This is despite the existence of well-documented evidence that compliance reduces diabetic complications.

There is also the cost to the pharmaceutical industry in terms of lost sales—estimated at 30 billion USD per year. With pipelines drying up, and health systems tightening their budgets by putting the brakes on some new drugs, the pharma industry has to look at new ways to sell products. It is no wonder that pharma interest in patient support programmes has perked up. It is simple mathematics—helping patients stick to their treatment means they take more doses—and more of the drug is sold.

Win–win–win scenario

So, improving patient compliance is likely to be better for everybody concerned: fewer patients will die prematurely, they will have better health, improved quality of life and will be admitted to hospital less often, healthcare professionals will be happy to have healthier patients, costs for health systems will be reduced and, last but not least, pharmaceutical companies will maximise sales of individual products.

Why do patients become non-compliant?

To understand initiatives used in patients support programmes, it is first necessary to understand why non-compliance occurs. However, just understanding non-compliance has become a highly specialised discipline, partly because all patients are different; the reasons a forgetful 77-year-old man fails to take his antihypertensives will most likely differ from the reasons a 15-year newly diagnosed with type 1 diabetes has not taken her insulin (see Box). So programmes to help patients adhere to their medication need to take account of multiple factors, including the characteristics of the patients, such as differences in patient knowledge, abilities, behaviour and attitudes, as well as issues specific to their disease or the treatment.

Some reasons for non-compliance

- Forgetfulness
- Side effects
- Difficulty in keeping medication to hand
- Difficulty in storing medication (sometimes a problem for homeless people)
- Complex treatment regimen (high pill burden, several times daily)
- Cost of the drug
- Patient sees no benefit from treatment (an issue with many preventative treatments)
- Patient decides to try non-prescription alternatives
- Patient does not understand the need for medication
- Patient struggles with self-administration
- Long-term treatment 'fatigue'
- Short-term benefit (eg weight loss in non-compliant type 1 diabetics)

It is known that simple, single interventions (e.g. simpler drug packaging) in themselves are usually insufficient to make a real difference to patient compliance, particular in chronic diseases [4]. On the other hand, a combination of factors, including greater patient medication knowledge of doses, frequency and indication for each of a patient's medications in conjunction with good skills, such as dexterity, literacy and ability to recognise individual tablets, appear to improve adherence [5]. A Cochrane review of interventions for enhancing adherence supports this view [4]. It looked at 70 randomised controlled trials, found 36 (of 83) interventions used in these trials improved adherence (and 25 improved outcome). Where interventions made a difference, nearly all included combinations of interventions, such as more convenient care, information, reminders, self-monitoring, reinforcement, counselling, family therapy, psychological therapy, crisis intervention, manual telephone follow-up and supportive care. Overall, it seemed that the key to good patient support programmes is the ability to change complex factors involving patients' attitudes and behaviours, which involves combinations of interventions. >

So, how do you influence patients' attitudes?

Healthcare systems have taken data, such as the Cochrane review [4], on board and now recognise that telling patients to take medication is less effective than helping them understand why medication is necessary and getting them to agree (become concordant) to take their medication. To achieve better understanding and concordance, patient education is needed.

Educational materials used to be available only in print form or through oral education (for instance where nurses talk to patients about their illness and treatment). Now new media offers additional means of helping patients understand their disease (although printed information and nurse education remain essential components of many patient support programmes).

When new media is added into the mix, as well as old favourites like printed magazines, patients also receive emailed newsletters that educate and remind them of the need to take medication. Websites are frequently used to provide patients with the information they need, such as downloadable patient information leaflets—either for health professionals to download for patients or for patients to access themselves.

As well as basic information about the disease, websites also supply a range of materials in different media, such as written tips on coping (for example at: www.cancerhelp.org.uk/) to patient stories and documentary videos from healthcare professionals and patients (for example at: www.kcuk.org). Additionally, with the proverb: 'I *see* I forget. I *hear* I remember. I *do* I *understand*' in mind, interactive elements (like patient quizzes, an example of which is: www.infoprostate.com/Patient-quiz.asp) are also useful to improve patient understanding.

Combinations of interventions

'Multi-channel patient compliance programme' is fast becoming one of the buzz phrases among proponents of new media in such programmes. Basically, this is just new media speak for implementing the findings of the Cochrane review [4]. One intervention (whether it is new or old media) is insufficient to change adherence and a rational selection of interventions is usually needed.

For example, in addition to education, patients may receive counselling and get reminders to take their medication. Reminders are a simple intervention that may be appropriate for elderly forgetful patients or rebellious teenagers. Where telephone reminders used to be used to help patients stay adherent, now SMS text messages and iphone applications (iphone apps) may be used. For an active teenager with diabetes or ADHD, a text message is a much 'cooler' method of being reminded to take medication than a parental reminder.

New media supports for patients

The Internet and interactive forum platforms makes patient peer-to-peer support easy. Patient forums include patient-initiated forums, for example: www.patientslikeme.com/, or those started by other organisations, for example www.facebook.com/ADHDMoms by Johnson & Johnson and www.cancerchat.org.uk/ set up by Cancer Research UK. Forums are particularly useful for those who find it difficult to meet other patients face-to-face in conventional support groups, such as patients in remote locations, those with rare diseases or those who have mobility difficulties. Other advantages of on-line patient support forums and the Internet are that patients are able to learn from their peers, and they can become empowered when they blog about their illness and share experiences with other patients. For those who are too shy to blog, sites like http://www.healthtalkonline.org/, which have online interviews with patients of many different ages and with a myriad of conditions, can show how others cope.

Other ways in which new media may aid patient adherence is in smoking cessation programmes, where the instantaneous medium of Twitter can help prevent someone about to give into a nicotine craving or support someone during the quitting process (as described here: http://qwitter.tobaccofreeflorida.com/). Similarly, www.tweetwhatyoueat.com/ uses Twitter to help people keep an electronic diary of food intake and provokes public shame for those breaking their diets. What is not certain about Twitter in these applications is whether the social element is more important than keeping fingers busy by Twittering and emailing on a Blackberry or iphone.

The importance of self-monitoring

Encouraging patients to self-monitor their illness is another strategy to improve compliance [6]. New media can help in this respect. For instance, iphone apps are already available to help patients keep a log of blood pressure measurements or blood glucose measurements (for more information, see: http://mashable.com/2009/07/11/iphone-save-lives/). For dieters or people with type 2 diabetes encouraged to lose weight, recording the distance walked everyday using an application such as the Nike+ipod sports kit may motivate patients to continue dieting and exercising (it records, time, distance, pace and calories burned). Whether patients walk or run there is a group to join at the Nike+ community (http://nikerunning.nike.com/) to support and spur them on. The future may see more relevant apps developed.

'Big brother' technologies

Some companies in the US are looking at methods of remotely monitoring patient compliance. Remote monitoring covers a range of technologies and devices. One old media method involved telephone calls to or from patients to log pill taking (sometimes called telephone surveillance). The new media method is by telephonic interactive voice activated technology (VAT), in which patients respond to recorded questions about their medication on automated telephone calls [7] .Pre-recorded supporting information can be provided to patients at the end of each call, tailored according to their responses to the questions

asked. Similarly, stand-alone interactive voice response surveys using VAT technology can help healthcare professionals identify patients who need further education about their illness.

Another remote monitoring approach is The Pill Phone application (www.pillphone.com/) for internet-enabled mobile phones, which not only acts as a reminder device but it also logs pill-taking, confirms the dose taken and logs the information on a website accessible by others (such as a parent or healthcare professional). Other methods involve the devices administrating medication themselves. For example, patent applications have recently been filed for nebulisers that also incorporate technologies allowing healthcare professionals to remotely monitor delivery of aerosol medications for conditions such as asthma or chronic obstructive pulmonary disease (COPD). One study showed that such technology not only accurately assessed medication used but it also improved treatment adherence [8]. Whether technology with such 'big brother is watching you' connotations would be acceptable in Europe remains to be seen.

Pill 'n' chips tackles non-compliance

Patient compliance with antihypertensive medications has previously been boosted by using battery-powered radiofrequency identification (RFID) tags embedded in the lids of pill bottles or in medication blister packs. These RFID tags record each time the bottle is opened or a pill is popped from the blister pack. Now, pharmaceutical companies are pushing the boundaries further by producing 'robo-pills' containing tiny microchips. The microchips send a text message to patients' phones if they fail to take their medication and are said to increase compliance by 30–80%.

Making patient compliance fun

One big surprise to those learning about patient compliance for the first time is that, even where life depends on taking medication (such as someone with cancer), some patients are non-compliant. How do you boost compliance for patients with cancer? The answer may lie in making compliance fun.

Imagine piloting a nanobot through the bodies of fictional cancer patients, destroying cancer cells in your path, battling bacterial infections, and managing side effects. This is the Re-Mission game, developed for adolescents and young people with cancer, that www.hopelab.org/innovative-solutions/re-mission believe will help them develop a positive attitude, learn about their cancer and has been shown to improve adherence [9].

Healthy games have also been developed to help young people with asthma (www.kickasthma.org.uk and http://www.bubbliboo.com/ are just some examples) and diabetes (examples include: www.escapefromdiab.com/ and www.nanoswarmthegame.com) stay compliant. Another approach is Bayer's www.bayerdidget.co.uk, a website designed to give children a fun way to monitor their glucose levels and where they earn points exchangeable for Nintendo DS™ games. Games are not just for children. Exergaming (physical activity combined with interactive video games) has been shown to help people with osteoarthritis adhere to exercise plans. It should have been obvious that fun is important: after all, what new crazes have got people exercising in recent times? it is games like Dancing Stage EuroMIX and Wii Fit.

Conclusions

In summary, in many therapy areas there is a great need for good patient support programmes. Traditionally, these programmes included provision of some information by a healthcare professional (which was reinforced on subsequent contact) together with, for example, additional support from counselling or by calling a telephone helpline.

With new media there is no doubt that methods for reaching patients have expanded, with social networking, mobile phone technology, specially designed computer games and voice activated telephone systems providing additional options for helping them manage their illnesses. Some of these options appeal to teenagers and young adults because they fit well with their computer-literate, SMS texting lifestyles. However, different patients require different means of communication. An 80-year-old woman with poor eyesight is unlikely to respond to text messages but maybe stimulated to adhere to therapy through old media, such as magazine articles and paper patient diaries or respond to other talking/sound media. Homeless and disadvantaged patients may not have regular Internet access and may only be reached through face-to-face interactions.

Therefore, each patient support programme needs to take into account not only the illness or medication but also the characteristics of the patients involved. New media is not the answer to non-compliance but may provide tools to support patients in their illness.

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Medical, health and science communications: Public relations trends in Germany

by Ruth Bastuck

Introduction

For a long time, the healthcare PR sector in Germany seemed to be an orderly playing field with predefined roles for companies, agencies, print media, doctors, and patients. Today, the business is undergoing sweeping changes that are affecting every one of these players. Complex market conditions, an altered media landscape and society's shifting media habits are major changes. Therefore modern communications strategies must not only convey the medical facts of a new treatment to an expert audience (**medical communications**). More than that, it is a matter of establishing a way of 'thinking outside the box', across disciplines and media. This thinking focuses on both patients and consumers (**health communications**), and takes the scientific and research effort behind a new treatment into account when addressing the research community, universities, funding agencies and political opinion-makers (**science communications**). It goes without saying that this kind of perspective demands new ideas and fosters new trends in public relations.

Medical communications—Between print crisis and online boom

Leading daily newspapers and magazines have long been worried about their dwindling advertising income. Publishing houses are discontinuing publications, reducing editorial staff, pooling departments and working more with freelance journalists. This feeling of uncertainty has spilled over onto medical publishers. The medical print media landscape in Germany has traditionally been very broad. General practitioners, for example, can choose from more than 30 journals, and many specialised niche journals figure prominently on the market. The segment catering to GPs has been hit especially hard by the crisis. A case in point is the *Ärztliche Praxis*, a journal with a long tradition that was just recently discontinued. Other publishing houses concentrating their forces under a common brand, like 'Springer Medizin'. However many publishers are seeking other sources of income, notably by expanding their online products. German doctors are increasingly looking for information on the Web. Roughly two out of three GPs and internists use the Internet for advanced professional training; 45 per cent take part in Internet discussion forums [1]. Many physicians find they need to market their practices professionally on the Internet, because today's patients expect an online introduction to the surgery's team and its medical services.

Medical communications in general addresses medical experts, i.e. doctors in clinics and surgeries as well as pharmacists and other specialists. Particularly in the field of prescription drugs, communication with experts remains a mainstay of PR. The doctor is still the ultimate authority, deciding whether or not a drug will be prescribed. Even patient communications measures (e.g. Direct-To-Consumer campaigns) will only be successful if doctors have been convinced first. So, will everything remain the same in medical PR? No, it won't, and communications managers must be prepared for a new era in specialised PR.

Classic press conferences are becoming rarer

To begin with, companies' expectations have changed. Today, more than ever, they are demanding strategic and creative PR approaches that convey messages across several media. Where the classic press conference was once the standard tool of medical communications, it is being used more sporadically today. The reasons for this development are that medical publishing houses are being consolidated and the print media market in general is shrinking. The approach of press conferences has changed, with the aim of intensifying the dialogue with journalists. This has fostered new settings and event formats, e.g. more informal talk sessions and small roundtable or 'meet-the-expert' get-togethers that facilitate in-depth discussions with specialists.

Digital formats becoming more popular

Live video streams of events at congresses and press conferences have long been the rule in some industries. The healthcare sector has been slower to embrace such practices, but digital formats are making inroads. More publishing houses are offering platforms for video podcasts, accommodating online inquiries and enabling the publication of electronic newsletters. Advanced training for doctors via the Internet is on the rise. Certified continuing medical education (CME) is usually offered in print and online, giving doctors a choice of communications channels.

Supporting medical practice marketing

Direct communication with the doctor is becoming increasingly important in the communications mix targeting expert audiences. That is why PR strategies aimed at supporting the marketing activities of medical practices are gaining in significance. Doctors need to know how to go about staging patient events in their surgeries and attracting the necessary attention in the local media. German doctors also need advice on how to broach the topic

Figure 1 Elements of Modern Communications in the Healthcare Sector

of privately reimbursed individual healthcare services (IGEL) during consultations with patients. A whole new field of activity is opening up here for PR.

A good medical writer pool is a must

A fundamental prerequisite for professional communication that addresses an expert audience is always an accurate and credible representation of the issue, often a very complex one. PR agencies and the press departments of companies need good medical writers who understand the subject matter and are able to present the topic in a form that is tailored to the target group and satisfies specified demands. Agencies are well-advised to have a pool of medical writers with different strengths on hand. Obviously, writing a review article for a sophisticated science journal demands a more formal academic style, while engaging PR copy calls for a more journalistic approach that breaks topics down so they are comprehensible for a wider audience.

Health communications—New chances and challenges

Health communications traditionally addresses patients. Keeping doctors and pharmacists informed has always been essential, but developments in recent years have increased the importance of communicating with patients. With magazine articles, TV programmes and many websites providing health-related information, doctors and pharmacists often encounter very well-informed patients. Patients in general are more health-conscious and want to exert greater control over their health. All this has given rise to a tremendous demand for communication on the part of this target group. This opens up many opportunities for the PR sector, but also poses challenges. For example, in Europe the law on advertising in the health care system (Heilmittel-Werbegesetz, HWG) still prohibits direct communication with patients about prescription drugs. It takes smart strategies geared towards credible communications to succeed with a PR campaign on this terrain. Reasonable expectations and a sustainable approach are essential because the forces that influence opinions and change consumer behaviour act over a long period of time. Success will also hinge on print publishers' ability to adapt to the challenges of the new media age.

Focused PR in the print sector

Despite the increasing importance of the Internet, print media remain a significant channel of information for health-related topics in Germany—witness the fact that major publishing houses are marketing new formats like *Stern Gesundheit* and *Spiegel Wissen*. However, companies and PR agencies need to rethink their approach, factoring in publishing houses' increasingly strained resources. Even major publishers such as Springer and Bauer are working with much smaller editorial departments than just a few years ago. The scope of health communications measures in the print sector is also changing. Elaborate and time-consuming media events are giving way to a more personal and focused approach. It is essential for PR managers to know what topics are currently relevant and when they have the best chance of being addressed—not to mention who is the best person in an editor's office to approach. Success comes to those who help editorial departments emphasise their role as advisors.

Online communication on the upswing

While doctors constitute a target group whose media habits are changing at a rather leisurely pace, patients' habits are evolving much faster. Best-agers, the target group that is so important to health communications, account for the fastest growth rates among Internet users today. More than 60 per cent of 50- to 59-year-olds are now on the Web [2].

The trend towards Online PR is clearly picking up steam. Some companies now employ PR managers for online communication and PR agencies are key trend scouts on the online frontier. Many press departments have shifted media co-operations into the online realm because Internet forums catering for special interest groups can be used to target precisely this audience. There is a general trend towards greater visualisation and a stronger focus on dialogue in online communication, for example incorporating animated graphics into online newsletters or the increasingly popular use of video podcasts.

Social media is empowering patients

'Dialogue' has become another buzzword in Internet and especially patient communication, heralding the rise of social media enabling interactive discourse across Internet platforms. Once merely passive recipients of information, they are now engaging in dialogues with other concerned and interested parties, tracking blogs and online consultations >

Figure 2 Modern Media Structures Require Dialog Focussed Communications

> or asking pointed questions in patient forums. Journalists and the media are no longer the sole gatekeepers of information. Players in the healthcare market are certainly aware of this trend towards social media, since it offers companies the opportunity to communicate on an equal footing with relevant target groups. A study conducted by the University of Applied Sciences in Cologne [3] shows that bloggers definitely want information from companies. Many companies are still reluctant to engage in social media and Twitter, perhaps because using these channels means relinquishing some control over one's messages. It is, however, imperative to monitor discussions concerning issues of interest to the company. The opinion-making potential of Twitter and the like is palpable, and companies are well-advised to extend their media monitoring to cover this area.

Science communications—Emerging role in the PR-Mix

Yet another trend in PR is the rising significance of science communications, which is a diverse field that addresses different target groups. Simply launching a new drug is not enough to succeed on the market, but that another approach is needed to convince all key healthcare players that a new treatment has merit. Science communications does things like stress the scientific and research effort behind a drug to underpin its credibility. It also gives journalists the opportunity to imbue what appears to be a rather bland academic topic with emotion, for example by flavouring the article with a vivid personality story about the agent's 'inventor'. It also entails activities that encourage communication within the scientific community and supports research facilities' efforts to share information with a broader audience.

Science PR as image factor

Even top-notch science journalists value a talk session with a small but select group of scientists as a source of information for a focus article or editorial. The key to success is to enable open scientific discourse, freed from the all-too-constraining restrictions of marketing demands. Points can be scored by providing well founded press material that offers real added value, e.g. sophisticated visualizations or well founded research content.

When approaching a top level journalist it is important to choose the right moment. For example, a company on the verge of licensing a new drug offers the perfect opportunity to contact a top-level newspaper or magazine and offer a special interview session with the CEO or the director of international research. A move like this promises success when working with the mainstream press that shapes public opinion. Science communications provides valuable support for a company's image-enhancing PR. Personal relationships with editors and freelance authors, developed and nurtured over time, are important in establishing a feeling of trust which is essential for good communication.

Science PR to support emerging market access strategies

Today the development of specific market access strategies is an important part of communications in the healthcare market. For example in these difficult economic times, increasingly demanding healthcare policies are posing challenges for many healthcare and pharmaceutical companies. The days of simply informing prescribers about a drug's benefits are over. Today, authorities like Germany's Institute for Quality and Efficiency in Health Care (IQWiG) assess drugs' benefits, compelling pharmaceutical companies to argue their cases. Other regulations like reference pricing and the need to directly negotiate individual pricing and discounts with health care insurance funds are challenging. On top there is a broad discussion on so called "Scheininnovationen" (supposed me-too products) that also influences the climate for market access.

Companies are responding by installing specific market access strategies in which they step up efforts to communicate with the people who make fiscal and political decisions. An important part of such market access strategies is direct communications and negotiations with political key opinion leaders and payers including health insurance funds.

Many healthcare companies also want to use concerted PR to voice their arguments in the health policy debate. This is a tall order to fill. It requires striking a delicate balance, framing the issue in a health policy and socio-political context without the company representative being written off as a lobbyist with a biased agenda. And it demands the courage to take part in an open discourse, even engaging opponents without complaint or condescension, as well the support of relevant opinion-makers. This is why the quest for alliances is an important aspect of health policy-related communication. PR tools in this field also include informal background discussions and health policy roundtables as well as classic media relations like arranging interviews and distributing press releases.

Conclusion

Manifold changes in the healthcare market will have a lasting impact on PR strategies and tools. Complex challenges are inspiring new ways of thinking in many areas. This is true of medical, health and science communications, and in the ways healthcare companies deal with health and socio-political developments and increasingly difficult market access. Only those professionals who are able to work in multiple dimensions and persistently cultivate all relevant fields of communication are ready to face the future.

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Are repeated presentations or publications of presentations at scientific conferences self-plagiarism?

Self-plagiarism is when an author re-uses text that he or she has published before without citing the original publication and, possibly, the term also applies to where the original is cited but not placed in inverted commas to indicate that it is a direct quote. Quote marks are unusual in scientific text and paraphrasing is usually recommended to avoid textual plagiarism or self-plagiarism [1].

Interestingly, self-plagiarism does not seem to apply to republishing ideas—as with plagiarism from another person—that the author has published before. Views vary as to how serious a misdemeanour self-plagiarism is; some consider it a deceit which should not be imposed on readers who believe that they are reading something original and others that it is almost unavoidable when describing a method that the author has used before.

In a recent paper Tracey Bretag and Saadia Mahmud [2] attempt to distinguish between appropriate and inappropriate re-use by authors of their own text in academic publications. They take 10% re-use of text as their cut-off. Beyond 10% the text would need at least a citation to the author's original text, if not quote marks, to avoid self-plagiarism. They used Turnitin in their search for self-plagiarism but found that manual analysis and subjective judgement were imperative for assessing if plagiarism had actually occurred. The paper gives examples of where mechanical examination alone was unreliable and also where such examination confirmed that an author had created a paper entirely by piecing together identical text from the author's previous publications, without referring to those publications.

Bretag and Mahmud touch on a point that has interested me for sometime, which is whether successive presentations of the same material at different conferences are self-plagiarisms. On the basis that self-plagiarism relates to text, there would need to be a written/recorded publication for self-plagiarism to come into play. Therefore, Bretag and Mahmud argue that where there has only been an oral presentation there would be no need to cite the presentation in a subsequent written paper, although they concede that it would be polite to state that the content of the paper had been presented at a particular conference. They justify their argument with the contention that a paper originally presented at a conference which is then revised as a result of feedback from the conference and submitted to a journal is 'work in progress'. It is not clear here what type of a 'paper' they are referring to as conference organisers publish conference presentations as either a short abstract, a longer summary of a paper or a whole paper. Bretag and Mahmud do, however, suggest it is not uncommon for papers published in conference proceedings and then as journal articles to be identical, which would clearly be self-plagiarism, and indeed duplicate publication, with the only possible (and in my view insufficient) let-out that the book of proceedings is only available to conference delegates while the article is available to a wider audience.

Miguel Roig, who has published several papers on the topic of self-plagiarism [3-6], takes the view that those who make oral presentations at a conference have an ethical obligation to disclose that the material has already been presented elsewhere. Although in some case conference organisers and audiences expect that the work being presented has been presented before, they nevertheless have a right to know whether the presentation is a recycling of an earlier presentation or if new material is included (personal communication).

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Comments from authors of 'Self-plagiarism or appropriate textual re-use?'

This is a fair commentary on our work but we would like to clarify two points:

1. Our reference to 'work in progress' oral presentations at conferences (which can then be reasonably submitted to a journal as an original work) assumes that nothing longer than a short abstract of the paper has been previously published.

2. We agree that while many people would argue that it is acceptable to publish a conference paper as a journal article (which we agree constitutes duplicate publication), we have concerns about this practice. We made our position on this issue clear in our paper as follows:

"...the potential ethical issue here again relates to the author's intention to deceive. If the author neglects to mention the original conference paper and therefore implies that the journal article is original, this could arguably be described as self-plagiarism. The same argument applies to conference papers already published electronically. In both cases, in addition to acknowledging the original conference paper, the author may need to seek permission from the editor of the conference proceedings to ensure that no copyright has been infringed."

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Do you know what your physician is doing online?

by David Stevens

There's a strong likelihood your physician belongs to a social network. Social networking is big and getting bigger. How big? Nearly 10% of all time spent on the Internet is spent in social networking sites [1]. To put it in perspective, more time was spent last year interacting on social networks than reading and sending personal emails. If recent data captured by Nielsen Online are any indication, that 10% figure will quickly expand, reflecting the fact that social networking sites are growing three times faster than the rest of the Internet [2].

65% of all active internet users have now joined a social network site, up from 57% just last year [3].

And it's not just the younger generation getting involved. As social networking and blogs mature, the audience they attract has also matured. This shift in demographics has been led by Facebook, whose greatest recent growth has come from people aged 35-49 years of age (+24.1 million). From December 2007 through December 2008, Facebook added almost twice as many 50 to 64-year-old visitors (+13.6 million) than it has added visitors younger than 18 years (+7.3 million) [4].

Similar adoption rates are evident in healthcare-related social networks. The percentage of physicians going online to research or interact with colleagues is growing rapidly. Manhattan Research (a pharmaceutical and healthcare market research and services firm) estimated last year (2008) that 88% of all physicians go online to access pharmaceutical, biotech and medical device information. Additionally, the report noted that 41% of all research conducted by physicians is currently taking place online, and that most physicians anticipate that percentage of online research to double in the coming year[5].

Why do physicians use open social networks like Wikipedia and physician-only social networks such as Sermo and Medscape Physician Connect?

Wikipedia

Surprising to many was the recent discovery that a significant percentage of online research done by physicians is taking place on Wikipedia (wikipedia.org) [6].

"Wikipedia, the free encyclopedia" is a massive endeavor that exemplifies the spirit and practice of Web 2.0 social media. The website is a "multilingual, web-based, free-content encyclopedia project based mostly on anonymous contributions " [7]. At this writing, the English version of Wikipedia is the 9th most popular destination on the Internet, garnering between 50 and 70 million unique visitors every month [8].

> The vast majority of medical and scientific content on Wikipedia is generated anonymously without formal peer review. Nearly anyone with an Internet connection can contribute new articles or edit existing articles on the website. This unprecedented openness has been both Wikipedia's greatest weakness and strength. As addressed in the Wikipedia Medical Disclaimer:

Wikipedia contains articles on many medical topics; however, no warranty whatsoever is made that any of the articles are accurate. There is absolutely no assurance that any statement contained or cited in an article touching on medical matters is true, correct, precise, or up-to-date. The overwhelming majority of such articles are written, in part or in whole, by nonprofessionals [9].

Certainly such a disclaimer ought to dissuade healthcare professionals from visiting the website; but, the opposite appears to be true.

Physicians and medical researchers are using the site as a destination resource in record numbers [10]. "The number of physicians turning to Wikipedia for medical information has doubled in the past year alone [2009]", reports Manhattan Research, noting that fully 50% of physicians use Wikipedia as a medical resource [11].

The accuracy of Wikipedia's content has been the subject of many articles and blog posts. The few scientific enquiries into the website's accuracy [12] have indeed demonstrated that errors of omission exist in high numbers, and the general depth of medical and scientific content is often shallower and less complete than other traditional online sources. However, many of these same studies appear to substantiate the accuracy of the website's factual content. A study published in November of 2008 in *The Annals of Pharmacotherapy* found that Wikipedia contained fewer factual errors than the Medscape Drug Reference and that quality of content on Wikipedia generally improved over time, as current entries were superior to those 90 days prior ($p = 0.024$) [13]. A second study published in 2006 by *Nature* found the accuracy of science in Wikipedia was "surprisingly" good. Stating, "The number of errors in a typical Wikipedia science article [was] not substantially more than in Encyclopaedia Britannica" [14,15].

Beyond the accuracy (or inaccuracy) of content, there are three primary reasons why physicians and other medical researchers find a Wikipedia attractive:

1. Timeliness
   Content on Wikipedia is in a constant state of update. Articles that reflect items in popular culture or the news are routinely updated within minutes. FDA black box warnings and other more monumental changes to medical and scientific topics are typically updated within 24 hours.

2. Editorial diversity
   The editorial diversity of Wikipedia is unrivaled. Anyone with an Internet connection can edit or author an article on Wikipedia. As a result, a great number of stakeholder perspectives are represented in Wikipedia articles. Overall, most writing feels neutral and absent of political ideologies.

3. Referencing
   Using diabetes as an example, the main article on this subject has over 100 external references, many possessing the peer-reviewed authority currently lacking in Wikipedia itself. In contrast, WebMD, has 16 external references on a page crowded with ads and other distractions.

The great promise made by Wikipedia and other similar social networking platforms is accessibility. These online communities aggregate unprecedented amounts of data from a myriad of sources and effortlessly distill the information into pockets of data relevant to a single participant. Ultimately, Wikipedia may not contain better medical information, but because of its broad structure and overall mission, it may serve as an access point for better information.

Sermo and Medscape Physician Connect

Over the past three years, a new kind of closed social network has evolved among physicians: physician-only online communities where physicians can share considered opinions, ideas, and treatment information with their colleagues.

In terms of size, the big fish in this pond are Sermo and Medscape Physician Connect, each boasting an online population of over 100,000 physicians. Sermo, established first in 2006, was originally imagined as an adverse effect reporting system [16]. The site has since grown into a platform containing thousands of discussion boards, polls, continuing medical education, and industry-sponsored questionnaires.

Medscape Physician Connect was launched in April 2008, and has quickly grown through promotion by the Medscape brand into arguably the largest physician-only social network [17]. In addition to the functionalities contained within Sermo, Medscape Physician Connect can mine a decade's worth of physician oriented content.

It is not surprising that physicians have become quick adopters of this technology that enables them to interact safely and privately with colleagues from around the world. *Newsweek* has reported that 15% of all practicing physicians in the United States have signed up for Sermo [18].

To illuminate the collective wisdom and user-generated content available on these physician-only social networks, Sermo has publicized a dramatic case study:

> 28 year old male construction worker impaled left thumb with a reciprocating saw blade (8 inch blade used to cut through wooden walls). The patient was able to remove the blade from the saw and presented with the blade in his thumb. He had an intact neurological exam. The blade appeared to pass along the bone and not through it. What would you do at this point? [19]

This particular case has to date received 968 physician responses. It was presented by an ER physician who wrestled with the dilemma of either pulling the serrated blade out, causing damage, or pushing it through, thereby causing damage.

In the midst of a lively discussion around which direction, push or pull, would produce the lesser amount of damage, a single physician presented an innovative solution. The answer? To slit a common drinking straw down the middle and slide it in over the serrated edge of the blade like a scabbard, then guide the tool out while protecting the thumb from the teeth of the saw [20].

This particular solution demonstrates how social networks can harness the collective wisdom of a large group to generate meaningful solutions to real-world challenges.

In summary, social networks such as Wikipedia, Sermo, and Medscape Physician Connect stimulate a new level of communication to what has otherwise been an incommunicative global healthcare system. The great diversity of experience represented by the thousands of physicians on Wikipedia, Sermo and Medscape Physician Connect create an unprecedented opportunity for meaningful collaboration. Opinions, insights, and answers to clinical quandaries can now be quickly aggregated and assessed, leading to better-informed decisions and improved patient care.

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Medical practice websites: Getting the most out of them

by Heike Wagner and Silke Wolter

When people are looking for a medical expert to meet their individual requirements, they are increasingly turning away from traditional sources of information—friends, neighbours, yellow pages—and are accessing the Internet instead [1]. So a website has become a marketing 'must' for a medical practice if a doctor wants his or her services to be found. But what makes a website not just attractive, but effective in bringing doctors and patients together?

Relevance for the user

Information should always be structured according to the users' needs: first-time patients want to know who they will be talking to, what they need to bring along, what qualifications the doctor has and what diagnostic and treatment options are offered. What patients want and need to know also depends very much on the problem at hand: an anxious patient will want to know whether the dentist can address his fears, a mother will want to know whether the practice has a play corner and a dialysis patient will want to know how the rooms are equipped and what machine types are available.

Intuitive navigational paths

It is also important to take users' habits into account when leading them around a site. For example, first level subjects are often listed horizontally at the top of the page and opened levels cascade down to the next levels on the left from top to bottom. This is the way users have learned to navigate sites and they expect to be able to 'steer' their way around a site without thinking, like they would a car. Similar principles apply to navigation headlines: clever synonyms of commonly used headlines (e. g. Home, About Us, Services etc.) are unnecessary and subject the user to irritating guesswork. It must also always be easy for users to find their way back to the page above the level that they are on, or to the home page, by making sure that 'back to [name of page]' or 'home' buttons are clearly visible on every page of the website. Access to relevant information should be made as easy as possible: if users have to search too long, they will quickly leave the site and the chance for winning a new patient will have been lost.

Clear directions for 'real life'

How do patients find the practice in real life? Where can they park and how much will it cost? It is common courtesy to provide a small illustration of the immediate neighbourhood of the medical practice and the nearest public transport with an estimate of how far it is to walk from the bus stop or train station. However, scanning and copying maps into a site is an absolute no-no. Maps and photographs are copyrighted by their designers and special permission needs to be granted if they are to be used on the Internet. Adding a link to a map service isn't a problem, though, and can be a helpful service for patients (e.g. http://code.google.com/apis/maps/gallery/mapsAPI.html; or for UK sites http://www.streetmap.co.uk/idlinkto.htm).

Interactivity

A site should not just be informative, but also interactive. That doesn't mean using visual gimmicks and flashy animations. They may interfere with the message, annoy the user, and search engines don't like them much. Instead, communication between the doctor and the potential patient should be as simple as possible. Every level of the website should have a 'Contact' option that can be activated without having to fill out any extraneous forms. Visitors should be able to see the practice's phone number and opening hours on each page of the website. Medical practices should decide in advance how they prefer to communicate and design the site accordingly to channel patient access: for example, if phone calls during consulting hours are getting out of hand, the e-mail option should be made easiest to access on the site. Further services can include: a list of frequently asked questions and their answers, sending patients an e-mail reminder the day before an appointment, or posting estimated waiting times on the site.

Added value for the patient

Whenever possible, extra value should be added to a site by offering additional information that is relevant for users. This might include links to sites that explain Latin medical terms and the way drugs work or give access to additional health programmes (e.g. weight reduction or rehabilitation). The patient should be informed about the doctor's professional network and colleagues (e.g. who stands in for him/her during the holidays and for emergency care). Impressive websites stress the importance of prevention: for example, patients with heart disease can benefit from a weekly recipe that suggests healthy food and adds some variety to their life. Service or entertainment can also be put to use, e.g. by announcing art exhibits in the community, highlighting a doctor's expertise by inviting patients to a public lecture on '5 minutes exercise at work' or by publishing interesting scientific papers on the site.

Good legibility

Part of good corporate design is ensuring that everyone can read the contents of the site. Many users may be elderly, so the lettering chosen should be large or appropriately adjustable in size to meet different users' needs. The contrast between the lettering and the background also needs to be strong for easy legibility, especially in the navigation areas or on buttons. Fonts without serifs are easier to read, and using system fonts (like Arial) makes the visual outcome on each computer more predictable. So does using web-safe colours, i.e. the specific kinds of colours used to design web pages. Because this topic is rather complicated for a non-professional, it is best to talk to a graphic designer about it and/or read up on it here [2]. Since no one has a handle on other people's monitor calibration, a basic colour scheme is just fine.

Attractive 'look' and 'feel'

And speaking of colours: if someone has chosen their doctor based on a website with a bright and dynamic design, they will be disappointed if they end up in rooms with a white-and-grey colour scheme. Because a website makes a promise that the actual practice has to keep, similar colours should be chosen for both. While playing around with different colour ideas is fine, certain colours merit caution: swimming pool green, for example, may make pictures of staff look like they are slightly ill. An adventurous approach is fine, but should be tinged with subtlety. Designs should always be tested on different computer screens and browsers before going online, since there may be technical difficulties like certain font sizes not showing or lines looking differently than they should. The use of bold to highlight key words that people are likely to be looking, bullet points, simple language, short sentences and short paragraphs with subheadings helps people scan pages more quickly. A common mistake is putting text within a box to make it stand out more. Many eye-tracking studies have shown that people tend to ignore text within boxes if it resembles an advertisement [3]. All the pictures for the site should be taken by a professional photographer because visitors always remember the quality of the photographs.

An important partner: The search engine

Users looking for information on the Internet almost always use a search engine like Google or Yahoo. That means that a website has to be registered in a search engine's database before it can be found. Whether this is the case can be tested, for example in Google, by typing the website name into the search slot like this: 'site:www.myhomepage.com'. Google will then show the links of all the pages on the website that are stored in the Google database. Search engines have their own methods that a site needs to cater to: for example, pictures, animations, or films are hardly relevant for search engines—instead, they focus on so-called 'keywords' that they use to rank the relevance of a site in relation to the search. If the Internet is going to be used effectively to bring a medical practice and potential new patients together, a high search engine ranking is a 'must'.

The power of 'key'words

As a result, a doctor needs to know what keywords patients are using to look for his or her services. It is worth investing in a professional keyword research instead of resorting to guesswork, since a patient's choice of words is often miles away from a doctor's. A doctor may say 'flatulence' or 'abdominal pain' where a patient is looking for 'wind' or 'stomach ache'. When the right keywords have been identified, it is time for a professional writer to use them to their best advantage. Writing for the Internet has its own rules, due to the fact that users are not so much 'readers' as impatient 'scanners' of Internet content.

The writer's role is to strike a fine balance between crafting readable text that clearly defines a benefit for the user, and using enough keywords so the site will be found by search engines. Keywords should be used liberally in headlines, subheads and the first paragraph of texts. Bullet point lists and hyperlinks to further content are user-friendly and add value to a practice website because they help users to scan, navigate and find the information they are looking for quickly.

Finding the website

The intelligent use of keywords determines whether a search engine will judge a site as being relevant to a particular search. Many users type the keywords 'dermatologist in Littletown' when searching for a new practice to register at, so judicious use of the keywords 'dermatologist' and 'Littletown' in the headings, subheadings and first paragraphs of pages will increase the likelihood that the search engine will direct users to the website.

The more relevant a website is, the higher it ranks in the list of search results. That sounds simple, but it entails a lot of diligent work. This process of search engine optimisation (SEO) can be contracted out to professionals, but should be closely monitored to ensure quality. For example, being offered certain rankings for a fixed price will not necessarily guarantee long-term success, since SEO is an ongoing process whose results need to be measured constantly. The technical configuration of a site also determines whether it will be found by search engines, e. g. what programming language or content management system is being used.

A link from another topic-relevant homepage to your site can be compared to a verbal recommendation in 'real life' and helps search engines and people to rate your site as competent. That means that a link from a scientific paper about breast cancer onto the homepage of a gynaecologist helps, but not the one from a florist friend. And beware of service providers that offer links for pay—they tend to do more harm than good. Other ways of increasing search ranking is by making sure the site contains plenty of content (i.e. text) and by adding new content frequently (e.g. announcements, new staff, events, news).

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Medical practice websites

> Analysing and promoting a site

After investing a lot of time, effort and money in a new website, doctors should always analyse its success. They should ask new patients how they found the practice, monitor traffic to the site, note which key words are leading people there and which topics are generating a high level of interest. Website analysis software (e.g. Google Analytics—see box) can give information on all of this and much more. There are a wide range of tools on offer on the Internet, and many of these programmes are free. By asking the right questions and making adjustments accordingly, a website will become increasingly successful, and the initial investment will have paid off. This success can be improved still further by promoting a site at every opportunity. Staff can ask patients for their e-mail addresses and keep them up to date about news. They can also send out mailings or newsletters by post or e-mail to (potential) patients. Even distributing stickers or give-aways with the URL at the next community event might be helpful. The bottom line is: if doctors make their website a part of their daily practice, then patients will too.

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Cardiologist sues former employer under Whistleblower's Act

Dr David Gossman is suing Lahey Clinic in Burlington, USA under the Massachusetts Healthcare Whistleblower Act. Gossman was fired after he asked questions at a lecture on medical ethics at the hospital. He claims that doctors at the hospital were pressurised to use Medtronic products, that a director of the department earns a substantial yearly income as a speaker for Medtronic and that the director's wife holds stocks with and is employed by, Medtronic. Furthermore a new doctor was told to increase her use of Medtronic stents because she was jeopardising the hospital's access to cutting-edge medical technologies. The clinic denies the allegations.

Source: Hughes S. Interventional cardiologist sues hospital under Whistleblower's Act. 3 November 2009 available at http://www.theheart.org/article/1018685.do

Google Analytics

http://www.google.com/analytics/

This free website analysis tool is one of many that allow you to monitor how visitors are using your site. It can be added to your website by simply signing up for an account and then following the instructions for adding some code (not visible to users) to all pages of your website.

What does it tell you?

You can see how many people visited your website over a particular period of time (you can specify exactly which dates) and many other details such as:

- Which pages were viewed the most
- Which links were clicked on and how many times
- What keywords people used to find your site (i.e. what they typed in search engines immediately before visiting your site)
- How many pages each user looked at per visit
- How long visitors spent on the site and on each page
- What countries users visited from
- How users reached the site
- Search engines (which ones)
  - Direct visit (typed URL in their browser, or clicked on bookmark)
  - Referring sites (clicked on a link from another website)
  - Which sites people were referred from

What does it not tell you?

The identity of visitors and their exact location is not available, and it is not possible to track the website usage patterns of specific individuals. A pilot study, where you watch how volunteers use the website to find specified information, would be more useful to check how user-friendly your website is at an individual level.

How do you use it?

You access data and reports by logging into your Google Analytics account. The login details can be the same as your personal Google account but if there will be multiple users you should set up a new Google account. Additional users can be added as administrators or with restricted access (reports only).

Information is displayed in graphs, charts and tables, and can be downloaded in reports in a choice of file types (e.g. PDF for user-friendly display, and CSV for Excel). The terminology used in the reports is explained briefly in pop-up boxes on your Google Analytics account page. These definitions are not always adequate but fuller definitions and explanations can be found easily via search engines or Wikipedia.

Interpretation of the reports is up to you and your imagination. Otherwise, call in some experts!

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Who profits from balanced health reporting?

by Cathy Holding

The balanced reporting of science and health issues is a hot topic, and rightly so. A highly-charged place to view one side of the debate is in Ben Goldacre's column *Bad Science* in *The Guardian* newspaper and his related blog [1]. "If you're a journalist who misrepresents science for the sake of a headline … then beware: your days are numbered," runs the column's strapline.

I'm not advocating misrepresenting science but you do need a good headline! When making a pitch, you have about thirty seconds to catch the news editor's eye if you are going to make the sell (for more on the difficulties of being a freelance science reporter, see my article in *TWS*, 'What makes science news?'[2]). The headline has to be something that will be important to Joe Public reading the news, and something the editor will feel is relevant to his readers. Then you need an angle—a hook on which to reel in the editor, let alone the readers. Whether it's writing up the results of a clinical trial, or a research paper coming from an academic laboratory, for the news, the principle is entirely the same. This is the heart of the matter—it's all about the sell.

News is all about the sell

Selling stories runs at many different levels, from the top down. The editor needs a headline and an angle in his stories to sell his newspaper. Researchers need to publicise their work, and so they emphasise their best results to the press, ultimately with their eyes on more funding for future research. The institution in which the work was carried out needs headlines for its press releases and news pages, so hoping also to grab the attention of the press and ultimately to attract funding and high-calibre researchers. If it's a clinical trial, the pharmaceutical industry wants to present its latest drug in the best possible light so that it can sell it in a fiercely competitive market. Then add to this the fact that the reader needs to understand the article: the research must be 'translated' into plain English, with a simple, plain, punchy point.

The issue of balanced science reporting is currently (at the time of writing) being discussed on the Association of British Science Writers (ABSW) website [3], with particular reference to the 'MMR-causes-autism' disaster. Ben Goldacre and Steve Connor, Science Editor with *The Independent* newspaper, opened the debate. Goldacre says that every journalist, including Connor, is responsible for that fiasco, because all journalists misreported the facts at that time, presumably in a successful conspiracy to mislead the public in the name of turning a profit; yet in that 'debate' Steve Connor shows us exactly how measured and balanced his reporting actually was.

So what can we conclude from that? Well, *I* conclude that people read what they want to believe and disregard the rest. Presumably the vaccination-haters chose not to read *The Independent* (and other equally well-balanced reports) because they didn't want to; and presumably the editors fuelling the falsehoods produced what they knew their readers wanted to read (and turned a profit from that).

In the ABSW 'debate', Goldacre refers to a "baffling resistance [by the media] to engaging with its flaws". In a Perspective article in the *New England Journal of Medicine* [4], Susan Dentzer plainly attempts to engage with those very flaws. She suggests that "when interviewed by journalists about a news development such as a new study, [the authors] should offer to discuss the broader context, point reporters to any similar or contradictory studies, refer journalists to credible colleagues with differing perspectives, and mention any study limitations or caveats about the results, as well as any potential or real conflicts of interest among the study authors." Is it me, or is that so naïve as to be almost laughable? Let's say a scientist is amazingly stupid enough to suggest during his interview that his work might not actually be credible because it contradicts other publications on the subject, and that some of his peers disagree with him: what will a news journalist do with that information? At the very best, I can see the headline: "Study shows [item X] affects [condition Y]—but then again, maybe not…" (I don't want to think about the very worst headline.) Also, we reporters have a word limit, and in a (for example) six-hundred word long piece, there simply isn't the space to deal with a debate on the validity of the results. And another thing: in my experience of writing up latest research results, there is often rivalry between groups researching the same subject—sometimes it's as bad as a soap opera! Some scientists I have interviewed have deliberately steered me away from people who disagree with their results, or they have run those scientists down to me (and not always off the record).

Goldacre says that every journalist is responsible for the MMR fiasco because all journalists misreported the facts at that time, yet Steve Connor shows us exactly how measured and balanced his reporting actually was

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Who profits from balanced health reporting?

> Furthermore, Susan Dentzer, who as Editor-in-Chief of the policy journal *Health Affairs* knows a thing or two about science journalism, suggests that "our profession …should … require that health stories, rather than being rendered in black and white, use all the grays on the palette to paint a comprehensive picture of inevitably complex realties." Are we on the same planet? Are we talking about news? Sounds more like a peer-reviewed journal to me (and they sell like hot cakes on the news-stands, don't they?)

Readers don't want shades of grey. I asked the opinions of some esteemed colleagues of mine (my drinking buddies down the pub), what they thought of the reporting of health issues in the press. They actually said that they *wanted* facts to be reported in black and white. One asked me, "Ok Cathy, bottom line: the flu jab—yes or no?" I rest my case.

If the news has to *sell*, then logically we have to conclude that there is a *market* for that news. And having concluded above that people read what they want to read and ignore what they don't want to read, and are fed what they want to read by their editors, we must conclude that supply must satisfy demand. So, I have to further conclude that it is the reader himself who determines what is written—in other words, badly written science is consumer-driven.

Badly written science is consumer-driven

However, my aforementioned esteemed colleagues do not subscribe to my view of consumer-driven news. Their view is that it is unscrupulous news editors who are entirely to blame. It goes back to the need for a black-and-white answer by certain sections of the population. Thus the field is wide open for unscrupulous editors who recognise that requirement in their readers. These editors play upon ignorance. But it's not just a question of inventing a whole load of 'facts' and arriving at a wrong and potentially dangerous conclusion (here's Goldacre again [5]). The newspapers (editors) that push out this kind of trash exploit the currently prevalent mistrust of scientists by the ordinary man on the street. They appear to the reader to be letting him in on secrets that he couldn't possibly otherwise know, warning him of the terrible truths behind the white-coated twits who are trying to poison or kill us all in the name of turning a profit. The last thing that that ordinary man would do would be to pick up a copy of *The Independent* or other broadsheet if it cannot tell him straight what his best mate, his newspaper, has just now made crystal clear—and confirmed what he always knew all along.

So I see what Susan Dentzer means by advocating a shades-of-grey style of reporting: it might well indeed put a halt to sensationalist, and hence unbalanced, reporting. But that's not going to sell newspapers—and it certainly won't be adopted by those unscrupulous editors with their eyes on the bank balance. I believe that badly reported news is consumer-driven (though I may be in a minority of one). Ask any Hollywood celebrity about truthful reporting! You may believe that they court and therefore deserve the aggro, but that's not the point—the situations have certain parallels. Am I the only one to deplore the paparazzi's relentless pursuit of celebrity? Yet the glossy gossip mags disappear off the shelves in the millions—because there is a market for it. Whether you like it or not, the news *has to sell*—and *that's* the problem.

Going back to Goldacre's bafflement at the media's supposed lack of interest in improving its reporting, it is I who am baffled by his belief that all journalists should be all tarred with the same brush (which they should not be), and by his extraordinary assumption that all newspaper editors want to report the truth (back to my celebrity point).

I am baffled by Goldacre's belief that all news editors want to report the truth

While certain editors can peddle lies and rumours (in the name of turning a profit) without fear of retribution, while certain sections of the population are willing to believe that scientists are evil geniuses hell-bent on destroying us all (in the name of turning a profit), while people want simple black-and-white answers to complex questions… then the misrepresentation of science and health issues will continue. And while intelligent and brave journalists and whistleblowers shoot each other in the foot, or cannot perceive or comprehend the concept of news as being in the market place and therefore all about turning a profit, then nothing co-ordinated or sensible will ever be done about it.

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Disclosure

Cathy Holding is a freelance consultant science editor and writer for *The Independent* newspaper (but has never met or engaged in conversation with Steve Connor); and she follows the *Bad Science* blog. Cathy Holding is currently working as a full-time employed medical writer with PreScript Communications Ltd., Baldock, Herts. (www.prescript.co.uk).

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Using the power of a digital campaign to disseminate information about health to more people

by Camilla Cooke

The Australasian Medical Writers Association's 26th annual conference was held at the University of Sydney on Friday 16 and Saturday 17 October, 2009 [1]. The title of the conference was 'Medical writing in focus'. Camilla Cooke gave a plenary lecture titled 'Using the power of a digital campaign to disseminate information about health to more people'. Camilla Cooke worked on the digital campaign for Kevin Rudd's successful bid to become Australia's Prime Minister in December 2007. Her group was the first to run a political campaign mobi site, kevin07.mobi, a technique which was subsequently used by the Obama campaign [2].

EMWA and The Write Stuff thank the Australasian Medical Writers Association (AMWA) and Camilla Cooke for allowing us to publish the following report of the lecture written by Camilla which she has posted on her website [3]. Slides from the presentation are available on the AMWA website at www.medicalwriters.org.

The AMWA gave me the title '*Using the power of a digital campaign to disseminate information about health to more people'* for my plenary lecture**.** Not being sure how relevant this was to an audience of writers, I added 'And why you should care', in order to focus on the writer's role in the digital distribution of their work.

It's obvious to most of us that social media has gone bonkers. I'd spoken to a related organisation, the National Prescribing Service, a year before, and they had all gasped when I told them that Facebook had reached 3.7 million, and of course it's now > 8 million, Twitter > 1.5 million blaa blaa. In fact, I'm sick of hearing about 'social media'—it's up there with 'Australian working families' and 'we are facing the worse financial crisis since the great depression' No! Really? More interesting for this group are the health stats; health topics represent over 42% of Australian searches[1] and rising, 61%[2] of Americans consult the web on health and 41%[2] of them consult each other (non-medical professionals) whilst (to quote the European Journal of Integrative Medicine in May 09) "the evidence for most of the recommendations [on health websites] is weak to nonexistent". So whilst 'digital health' is exploding, with the rise of health and 'wellness' websites, content, services and communities everywhere online, this is a haven not only for the 'cyberchondriac' but also the 'cyberquack'.

Looking at the 'dissemination' of health content and messaging online, traditional digital media communications are being practiced extensively by commercial and government organisations across the health spectrum; specialist health digital agencies are proliferating (for example Big Pink recently opened in Sydney) and we've seen great banner advertising from Panadol and drive to web from Pfizer (with the 'getthefacts' campaign). A cursory glance in Google under 'menopause' brings up quite a range of paid ads—the pharmas are in there with 'Promensil', Blackmores is there, and Wellspring are offering a herbal remedy for $39.95 that gets rid of the menopause in 24 hours (fantastic! I'll take 2!). The government(s) are making great use of SEM (you can't MOVE at the moment without a government ad for the swine flu vaccine) and are, reassuringly perhaps, coming up tops in natural search on a lot of specific health issues.

It's not exactly 'health', but the recent Clearasil campaign (around digital 'friends' etiquette, running applications on both Bebo and Facebook) is fairly typical, and follows on from the Kotex U site that successfully engaged girls in conversations regarding teenaged female health. This sort of diversionary branding of content is becoming very typical and it's a great form of sponsorship, if you like, providing relevant value added content and obviously with applications and widgets yielding lots of viral opportunities, but this now also falls into the area of traditional marketing.

Where it's really at is, of course, the mainstream conversation in social media environments. 'authentic' is the new black. We've seen cheesy attempts at chatter (the recent Windows 7 party video from Microsoft made us all cringe but at least we knew it was fake). The Witchery 'man in the jacket' case was interesting, as it attempted to appear genuine (although I'm surprised if people thought it was—I thought it was about as convincing as the Godwin Gretch e-mail, just a little to convenient and so self-consciously casual, but perhaps the fact that I'm an ex-actress in advertising gives me excellent fraud credentials). Some of us were alarmed by the recent blatant agency advertisement for a paid job in astroturfing (or 'social infiltration'). More sinister still are the 'Champix/Chantix' video testimonials (a drug by x that is meant to help you give up smoking, and was subject to claims that it caused depression resulting in suicide in some cases). Melissa Sweet pointed out >

1 Hitwise July 08 (Australia)
2 Pew Internet & American Life Project June 09

in The Australian Prescriber last year that these appeared 'spontaneously' from across the globe on You Tube. Now, we don't know if these are genuine or semi-genuine, but my point is that people will believe anything—you've only got to look at the continued success of horoscopes to see that. And they don't interrogate the 'evidence' of any 'evidence-based' medical facts very deeply.

People are definitely searching for information on health, but they read (and believe) what's in front of them, what comes up first in Google, what their mates say on Facebook. They buy miracle cures for $39.95. A University of Texas study in 2008 found that 5% of pages on breast cancer contained inaccurate information and that complementary medicines pages were 15 times more likely to be inaccurate.

So DO SOMETHING about medical misinformation. Medical writers should explain the importance of evidence-based sources in everything they write. Publishers of evidence-based medical information should use good digital marketing to reach people. Organisations should work with government to extend the use and awareness of a consolidated accreditation system and this should be extended to writers themselves. Make a virtue of the bewildering volume of medical content, and the public's curiosity by giving them a symbol they can trust.

But why should medical writers do this? What relevance has it to them? And my answer to this is; because they care. They wouldn't have joined the AMWA, membership of which excludes any "person whose sole work is directed to the promotion of a product or a commercial organisation". In other words, they are not in it just for the money, or they could have made a lot more. So if they care, they should also care about being *read*, not just *published*. They should care about bringing evidence-based content to the fore to compete with all the other material that is successfully reaching a public increasingly thirsty for health information.

In this day and age, it is no longer a question of handing over material to a publisher who is then responsible for 'disseminating' it—job done. We are all publishers, we are all broadcasters. I'm probably one of the worst practitioners, but what I think or write doesn't matter, what *they* write *does* matter. So my directive was: write a blog, tweet your articles, RSS your blog, tweet your blog, stream your tweets into Facebook, follow everyone relevant, join every relevant group, comment and link, edit Wikipedia and Medipedia, write Wikipedia and Medipedia, bookmark all your work, and create a Google virtuous circle. Social media is not a just a pastime for medical writers, it's a moral responsibility.

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Definitions box

Adrenergic

The suffix *–ergic* means to work by means of (from the Greek *ergos*, meaning to work). Thus, *adrenergic* means working by means of adrenaline. In the US, ergic is used to classify receptors, so that *adrenergic* receptors are receptors that respond to epinephrine (the US name for adrenaline). This usage of ergic does not meet the recommendations of the The International Union of Pharmacology (IUPHAR), which say that ergic should be reserved for the classification of neurones in terms of the neurotransmitter they store and release in response to action potentials. *Adrenergic* should therefore be used only to describe nerves that release adrenaline (epinephrine for US readers) from their terminals [1].

When neurotransmitters were first being discovered and identified in the 1930s, adrenaline was thought to be the principal neurotransmitter in peripheral sympathetic nerves (nerves involved in controlling such things as blood pressure over which we have no voluntary control). However, it was eventually shown (1945) that the neurotransmitter in these peripheral nerves is *nor*adrenaline (norepinephrine in the US), rather than adrenaline, whereas adrenaline is the hormone released from the adrenal medulla in response to shock, fear or excitement. Nerves that have noradrenaline as their neurotransmitter should therefore be referred to as *noradrenergic*, although they seldom are—old habits die hard.

IUPHAR recommends that receptors on end-organs that respond to noradrenaline should be referred to as *adrenoceptors*, not *adrenergic* receptors [1]. Similarly, IUPHAR recommends that receptors that respond to the neurotransmitter acetylcholine should be called *acetylcholine* receptors rather than *cholinergic* receptors.

The recommendations of the Nomenclature Committee of IUPHAR are published in the journal *Pharmacological Reviews*. For a regular update of internationally agreed names of receptors and channels see The British Pharmacological Society's Guide to Receptors and Channels [2].

Finally, there is no such chemical as adrenalin.

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Communication tips for English-speaking medical writers in a German-language environment

by Diarmuid De Faoite

"English is the language of the most widely read and quoted medical journals."
CHEST (2006) [1]

In common with many readers of *The Write Stuff*, I work in an English-language setting in a German-speaking environment. Most of my colleagues are German mother tongue speakers, yet most of our written work is produced in English. Our not-for-profit organisation conducts medical research and offers surgeons training in four major specialities—trauma, spinal, craniomaxillofacial, and veterinary sciences. Because we are active in over 100 different countries, there is a demand for our material to be released in English.

The role of the medical writer for non-English speakers is an important one. Studies have shown that while poor scientific content is the main reason why papers are rejected by publishers, a well-presented paper free of grammatical errors is subject to less revision [2, 3].

Living and working abroad inevitably presents barriers and obstacles of many kinds. I won't spend time on the usual cultural and language misunderstandings that take place. Online forums like ones on www.toytowngermany.com or www.englishforum.ch have countless discussion threads on these topics. Instead, this article will outline my cross-cultural experiences over a decade of working in Switzerland and Germany. The tips I give are not exclusively about medical communication, but also touch on language and differences in communication styles between native English speakers (and writers) and their German-speaking counterparts.

Tip 1: Learn German, a valuable aid in guessing what the German speaker has said or written in English which might otherwise be unclear to you

Not all of us are necessarily gifted linguists, but learning to speak and write good German can be an invaluable help in learning to cope with working as a writer in a German-speaking environment. This applies both to dealing with English-language texts written by a German-speaking author and to general communication in the workplace.

Knowledge of correct terminology can be a problem in any field, but English-speaking medical writers are lucky because the English language has similar roots to German and many medical words are either the same or quite similar. Here is a short list of German words whose meaning should be fairly obvious to English speakers:

Anästhesie, Orthopädie, Allergie, Dermatologie, Internist, Neurologie, Onkologie, Psychiater, Radiologie, Urologie.

The predilection for 'scientific-sounding' Latin or Greek expressions rather than the common Teutonic terms may also come to the aid of the writer.

The usual caveat to beware of false friends applies to this tip of course. One graphic example will suffice to illustrate this. *After* is the proper German medical term for anus…

The sagacious Homer Simpson once commented [4], "Boy, those Germans have a word for everything!" In fact, they usually have two or more words for everything which may perplex you depending upon whether the word used has a common ancestor to the word in English. For example, *Autopsie* is easy to understand, *Leichenobduktion* less so. Similarly, which one can you guess more easily: *Patella* or *Kniescheibe*, *Abszess* or *Eiterbeule*, *Diaphragma* or *Zwerchfell?* If you are momentarily stumped by a new word, it may well save time if you ask your work colleagues if there is another term for it.

Difficulties can also arise in the workplace when two German speakers use English as a *lingua franca* for the benefit of non-German speakers. A typical conversation by your colleagues might run like this:

"How can I get the patient's fracture type? I need it until 4 o'clock."
"I explain you, it stands at the start of the case form."

This conversation would cause most native English speakers to scratch their head in puzzlement. However, if you understood German, you would still be able to follow the conversation by guessing where the mistranslations/common mistakes have occurred:

"How can I get the patient's fracture type? I need it until 4 o'clock (typical mistake, translating *bis* as 'until' instead of 'by' in this case)."
"I (will) explain (to) you, it stands (German: *Es steht*—it is) at the start of the case form."

Tip 2: Be aware of the different types of English you'll come across

German speakers are quite focused (at times too much so!) on the differences between American English and British English. This is possibly a result of learning English formally and having had teachers from different backgrounds. This fixation is despite the fact that with the exception of >

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> spelling, there is no essential difference between American English and British English in scientific writing.

Pre-empt any protracted discussions about which English to use by reading the submission guidelines for journals, conferences etc. Reinforce your choice by letting your client know what the preferred type of English for the target media is. In the absence of guidelines or when there is a free choice (like in the journal *Arthritis Research & Therapy*), it is important to choose one variant and use it consistently throughout.

A basic knowledge of the influence of English on German is helpful. There are now many words in the German language which 'sound English' but do not mean anything or mean something else to English speakers. (This is probably not so surprising when one considers that in the year 2000, almost 30% of all slogans used in German advertising were in English [5].) For example, Germans give presentations with the help of a *Beamer* (a projector, not a BMW!) and they use a *Handy*, not a mobile/cell phone. This trend of inventing English-sounding terms can be seen in orthopaedics where the word 'reduction' (meaning the realignment of fractured bone) is often written by German speakers as *Reduktion*, even though the proper term is *Reposition*.

Note from the editor: The challenges facing editors of text written by non-native English speakers

Many of *TWS*'s readers are native English-speakers who work in countries where English is not the native tongue. Their work often involves editing or rewriting text written in English by scientists who are not native speakers of English. Almost 30% of EMWA members work in countries where German is the local language. Some of these members are native German-speakers who are translators and have excellent knowledge of English. But for the rest of us there is the problem of understanding the in some points different linguistic mindset behind the English written by a non-native speaker of the language and of knowing how to handle the author and his or her text.

I have worked with Austrian scientists for well over 10 years now. I admire these authors greatly for their high standard of English, which is far beyond my skills in German—but my work can be frustrating. I constantly encounter the same mistakes (often repeatedly from the same authors), which mainly relate to sentence structure, an aversion for parallel construction and compulsion at all costs to avoid using the same word twice. The last is a legacy from teaching in Austrian schools which discourages repetition of words. Diarmuid De Faoite mentions 'back-to-front' sentence structures in Tip 3. Alistair Reeves will deal with this topic in an article on sentence structure which will be published in the next issue of *TWS*.

Another challenge that I face is that my authors do not always accept my version of English. Why? Because they read articles in journals and text in the Internet—also written by authors whose native tongue is not English—that have the same syntax as their own writing. The disadvantage English has in achieving its status of the *lingua franca* of science is that it has ceased to 'belong' to the English native speaker. To what extent then should English be written to meet the expectations of readers for whom English is not their native language? Should we accept an English language of science as a separate English language? One problem that I see with this is that it could leave a phrase written in English open to more different interpretations than if we stick to native English, i.e. precision and accuracy diminish. In a litigious age this could cause unexpected problems for authors.

An excellent analysis of English scientific text written by Japanese authors is set out in the article 'Logic and Accuracy of Expression in English Writing' written by Mark Petersen and published in the *Journal of English Medical Education* [August 2002, vol 3 (1)]. Interestingly, many of the examples given are similar to the type of text that might have been written by a native speaker of German, e.g. "A 6-month female infant was admitted to our out patient because of diagnosed arachnoid cyst of the posterior fossa by magnetic resonance imaging". Mark Petersen's article exemplifies the importance of consulting with authors, which you can also read about in the Translation section of this issue where Iain Patten and Greg Morley have written about the challenges of bilingual publication.

Another fascinating exercise in editing English text, written this time by a native-speaker of Dutch, is set out on page 252 of this issue in the Vital signs exchange between Neville Goodman and David Alexander together with his co-investigator Joy Burrough-Boenisch.

Diarmuid De Faoite's personal account and tips is a good starting-point for opening up discussion about the problems facing editors of English text written by non-native speakers of English. I join with Diarmuid in inviting feedback on his article and any further tips for editors working with non-native English speakers.

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An awareness of the potential influence of German should be borne in mind when reviewing a paper written in English by a German-speaking author. Literal translation of German expressions (scientific or general) into English is a not uncommon phenomenon, something particularly encountered with less-experienced authors.

The pervasiveness of English can also lead to people overestimating their ability in the language. In fact, if you wait long enough, you can have your mother tongue corrected by a German speaker!

Tip 3: Don't be afraid to completely rewrite a sentence

As anyone who speaks a second language can tell you, to really express yourself like natives you need to think like them. This different way of thinking naturally leads to differences in the ways people express themselves. Direct translations sound clunky to native speakers for this reason.

It is generally quite easy to recognise a text in English that has been written by a German speaker. A study by Busch-Lauer [6] found that the abstracts in German medical journals translated into English by the German-speaking authors "contained structural and linguistic inadequacies which may hamper the general readability for the scientific community." In particular, sentence structure differs fundamentally between the two languages. Noun position in a German sentence is much less rigid than in English, making comprehension a little more difficult for English speakers used to the subject-verb-object structure. German sentences make much greater use of inversion, with the main subject and verb often coming at the end of a long sentence. Frequent use of the passive voice as compared to the active voice is also an area in which German differs from English. (I heartily recommend Mark Twain's *The Awful German Language* [7] for a fuller and funnier discourse on this.)

With a bit of practice, you can learn techniques to polish up the systematic mistakes made in English by speakers of a foreign language. For example, a sentence written by a German speaker can often be improved by simply moving the first part of the sentence to the end. I have spent a lot of time tinkering with sentences only to finally scratch them out and rewrite them completely. Oftentimes the sentences are not wrong as such or are good enough to convey the meaning, but no native speaker would express themselves in that way. I therefore strongly recommend that if a sentence can be improved by rewriting it, don't be afraid to do so.

Tip 4: Eliminate long sentences

Long and complex sentences are more common in German than they are in English [8]. (As you might expect, even among English mother tongue speakers there appears to be some difference in sentence length [2].) While long sentences in English may be elegantly written and contain cogent arguments, they are generally not ideal in the world of medical communications, not least because many practitioners in the field are from non-English speaking backgrounds. In the study by Coates et al, German and French authors wrote sentences twice the length of the other nationalities (including American and British) in the study. This is perhaps not surprising given that long sentences are par for the course in German.

The same paper also notes that, "Shorter sentences in English denote a simple style and clearer science" [2]. Assuming that the piece is good science to begin with, simply breaking up long sentences can have a very positive effect on a paper's impact and readability.

Tip 5: Build up a list of online help sites

There are many websites which may help you to a greater or lesser extent. The following is a non-exhaustive list of the websites I have found to be of most use in my work:

English ⇔ German dictionary

http://www.leo.org/:
includes forums where you can ask for help.

http://www.dict.cc/:
contains a 'medicine' category currently containing almost 20,000 English ⇔ German entries.

http://quickdic.org/index_e.html
http://dictionary.reverso.net/:
Collins dictionary (also has a specialised French ⇔ English medical dictionary).

http://www.linguee.de/:
as featured in the last issue of *The Write Stuff* (Translation section).

English ⇔ German medical dictionary

http://www.englischwoerterbuch-medizin.de/
http://www.gesundheit.de/roche/

Medical terms—German only

http://users.ugent.be/~rvdstich/eugloss/DE/lijst.html/:
also gives the everyday name of medical conditions/terms in German.

In addition, there are a number of books available which will suit the same purpose. Some of them are even available online for free such as the one below:

Medical terms—English only

http://www.merck.com/mmpe/index.html

Tip 6: Find creative ways to get a missing word in a translation

It can often be frustrating for medical writers to find a translation of an obscure or new medical term. Such words cannot be found in most standard dictionaries. At times even medical ones draw a blank. However, in my work in writing orthopaedic texts, I have often found the term I am looking for by going online and comparing the English and German catalogues of major orthopaedic device manufacturers.

Another trick is to enter the English word you need the translation for into the PubMed database (www.pubmed.gov). Use the 'Limits' function to select the options for 'Abstracts' and 'German'. It is a condition of inclusion that only abstracts in English are listed on PubMed, regardless of the paper's actual language. >

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> You can now trace backwards to find the word you need. Plug the name(s) of the author(s) into the Internet, go to the publication's website, look up the institutions mentioned or follow any leads using the information published in PubMed. You may well be able to locate the title, abstract or even the full paper in German and thereby the word or term you are looking for. While not foolproof, this is an avenue that can be explored when all others have been exhausted. (It will also work for a variety of other languages—see the languages available in the 'Limits' section of PubMed.)

I hope you have found this article useful and I would be very pleased to receive feedback and any further tips by e-mail in order to develop this topic further.

Vielen Dank!

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Concern over REACH legislation

The EU's REACH (Registration, Evaluation, Authorisation and restriction of Chemicals) legislation requires chemicals sold in Europe in quantities of more than one tonne per year to be registered by 2018. Each chemical needs to have a chemical-safety report. REACH is the world's most extensive attempt to improve the safe use of chemicals. A report produced by the Trans-Atlantic Think Tank for Toxicology indicates that the costs and numbers of animals required to complete the tests will exceed Europe's laboratory capacity and cause delays in testing. One problem is the requirement to test a chemical's effects on two generation of animals. The report calls for increased funding of new toxicology testing methods to find alternatives to animal experimentation.

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Update on EMEA-FDA cooperation

A Transatlantic Administrative Simplification Action Plan was agreed between the FDA and EMEA in June 2008. The 2009 Implementation Report (dated 26 October 2009) can be found at

http://www.fda.gov/InternationalPrograms/FDABeyondOurBordersForeignOffices/EuropeanUnion/EuropeanUnion/EuropeanCommission/ucm114338.htm

Projects include:
- Collaborations on inspection in the US and in the EU
- 3rd country inspections, 18-month pilot programme began November 2008
- Combating counterfeit medicines
- Collaboration on biosimilars
- Collaboration on development of medicinal products for children and convergence in paediatric submissions
- Advanced therapy medicinal products
- Safety reporting from clinical trials
- Regulatory collaboration on the outputs of the Critical Path and Innovative Medicines Initiatives
- (e) CTD

Linda Tollefson, who is the director of the FDA's new office in Brussels, gave a plenary lecture at EMWA's conference in Ljubljana in May this year [see report in *TWS;*18(2):77]. On 26th October 2009 the FDA and EMEA issued a joint press release on the progress that has been made with the action plan. This included work towards a guideline for transatlantic convergence of paediatric submissions and a guideline on the development of safety update report (E2F), which is soon to be signed off.

Industry representatives from Europe and the US have been invited to compare formats on risk management (E2F, Volume 9A RMP guidance, and REMS) to identify opportunities for convergence.

Progress has also been made on the EMEA-FDA Parallel Scientific Advice Procedure in that the agencies released their 'General Principles' on 22 July 2009. With this procedure the agencies' goal is that EMEA and FDA assessors and sponsors discuss views during the development phase of new products to prevent duplication of work. The initiative focuses on oncology, vaccines, orphan drugs, drugs for children, nanotechnologies, advanced therapies, pharmacogenomics and blood products. Nevertheless paragraph 8 states that "the advice of each agency may still differ after the joint discussion". Revised General Principles were published in October 2009 on EMEA's and FDA's websites (see http://www.fda.gov/InternationalPrograms/FDABeyondOurBordersForeignOffices/EuropeanUnion/EuropeanUnion/EuropeanCommission/ucm114345.htm)

Proposed EU changes in animal experimentation regulations

by Angela K. Turner

Current regulations for the protection of animals used in scientific experiments across the European Union are now over 20 years old. Since the 1986 directive (86/609/EEC) the number of member countries of the EU has more than doubled, with several others potentially joining in the near future, creating a wide range of animal welfare standards across Europe, some of which are higher than those provided by the EU directive itself. In addition, the 1997 Treaty of Amsterdam included a protocol requiring the EU to consider animal welfare in its policies. To raise standards overall, the European Commission has therefore proposed a revision of the directive [1]. This will also take into account changes since 1986 in scientific procedures, such as the development of genetically modified animals, and recent research on animal welfare, such as the possibility that some invertebrates feel pain. Most importantly, the revision will adopt the Three Rs framework (refinement of experiments to reduce suffering, reduction of numbers of animals used in experiments and replacement of animals with other material such as tissue cultures or virtual organisms). These principles have already been widely adopted in the UK and elsewhere but are not mentioned in the existing directive.

Over 12 million animals are used in scientific experiments in the EU each year

The revised directive would improve on the previous one in several respects. As well as promoting the Three Rs, it requires member countries to have a regulatory framework for licensing individuals, institutions and experiments involving animals, and for making sure institutions comply with the directive; institutions also need to have their own ethical review body. Secondly, the 'animals' covered by the directive, currently 'vertebrates', would include some invertebrates and possibly also foetuses, immature and larval stages, as well as animals bred for tissues and organs. Thirdly, the directive would restrict the use of animals, in particular non-human primates, taken from the wild. Fourthly, experimental procedures would have to be classified according to the degree of harm to the animal. Finally, the directive would lay down certain minimum standards of housing and care.

Some of these changes are mostly uncontroversial and indeed are already implemented by some EU countries. The UK for example has long had both a national framework and local committees to authorise and review scientific research involving animals, although the revised directive may increase bureaucracy in this regard. The adoption of the Three Rs framework is also an important step in reducing the numbers of animals (currently more than 12 million a year) involved in scientific experiments in the EU. Other parts of the new directive, notably those concerning non-human primates and invertebrates, however, have led to major objections [2]. There are concerns that valuable fundamental research will be restricted, leading to the possibility of such research being driven away to countries outside the EU, that the development of new medicines and treatments may be hampered, and that there will be more red tape for researchers to deal with without a corresponding increase in animal welfare. To address such concerns, over 50 organisations in 19 EU member states formed the European Coalition for Biomedical Research in 2006 [3]. In the UK, in March 2009, nine bioscience organisations also produced a 'declaration of concern' [4].

A particularly controversial plan is to protect certain invertebrates. The UK already includes the common octopus in its welfare regulations but the revised EU directive would extend this to lampreys, cephalopods (squid as well as octopus) and decapod crustaceans such as crabs and prawns, and larval and embryonic forms of these and vertebrate animals. Recent research on prawns and hermit crabs suggests that they can feel pain and that crabs remember details of the painful experience [5, 6]. But it is not known whether other crustaceans experience pain in a similar way. In some respects, the larger crustaceans such as crabs have similar nervous systems to those of vertebrates, but critics point to the differences, in size and complexity, rather than the similarities [7]: despite the evidence, they say crustaceans may just automatically react to a painful stimulus but not feel it and be aware of it. Including these animals in the directive would hamper their use as models of humans, for example in studies of the vestibular system.

Some research on primates may be banned

Protecting larval and embryonic forms, which are not proven to feel pain, would also create administrative problems, as it can be impractical to record, for example, the huge numbers of eggs produced by fish and frogs which are widely used in toxicological studies [8, 9, 10]. In addition this proposal may affect the development of vaccines which involves the use of chickens' eggs [10].

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Proposed EU changes in animal experimentation regulations

The revised directive indicates specific circumstances when non-human primates can be used in experiments, restricting their use in certain areas. There is thus a concern that the directive will curtail basic research on, for example, brain function and reproduction, which could eventually lead to treatments for human conditions such as autism, depression, memory and visual disorders, and early miscarriage [2, 3, 4, 8, 10]. Currently in the UK the use of non-human primates is already tightly controlled but is allowed when this can be justified on scientific grounds and there is no alternative animal model. With a few exceptions such as conservation of the species or for study of life-threatening human clinical conditions, laboratory research on great apes would be banned, as it has been in the UK since 1998. The directive provides most protection to primates but its failure to extend this to other similarly sentient species, such as pigs, is also a concern.

Plans to phase out the practice of taking animals from the wild for scientific experiments, except in certain scientifically justified circumstances, are also problematic. The aim is to use only captive bred animals and in particular primates bred from parents who were also born in captivity (i.e. the second or later generations) on the assumption that they will suffer less from being in captivity, although whether this is true is not known. However, there are currently insufficient second generation primates being bred, especially within the EU [2, 3, 4, 8, 10]. Many captive bred primates are sourced from outside the EU and the suppliers are unlikely to be able to provide second generation animals or may raise their prices if they have to change their breeding regimes to do so. At best, the costs of research in EU member states would increase; at worst, the scarcity of these primates may mean that some research is not done at all or is moved to other countries, which may have lower welfare standards. There is also no clear provision for studies of animals that cannot yet be bred in the laboratory such as marine fish and crustaceans. Banning the use of stray or feral animals also prevents research on, for example, the spread of diseases in such populations.

Protection may be extended to crustaceans which are now thought to feel pain

The revised directive requires scientific procedures to be classified according to their severity, taking into account factors such as the duration and intensity of pain or suffering and the restriction of behaviour. The four categories proposed are 'up to mild', 'moderate', 'severe' and 'non-recovery' (i.e. the animal is killed after surgery done under anaesthetic). This classification is broadly similar to that already in place in the UK although the categories are not clearly defined. However, some severe procedures where the animal suffers over a prolonged period may be prohibited and this may affect the use of non-human primates as models of, for example, Parkinson's disease and other neurological conditions in humans [8].

Some provisions of the directive might actually increase the number of animals used and increase suffering overall. Re-using animals would be limited to mild or 'non-recovery' procedures; in the UK this would be costly and result in more dogs and non-human primates being used in surgical procedures [8]. It is also sometimes impractical as one procedure may involve surgery, for example to implant a device to monitor heart rate, before the animal undergoes other procedures.

The strict standards proposed for housing and care of animals used in scientific research may also increase both costs and numbers of animals used without improving welfare and scientists would like more latitude to adapt housing to particular situations [8, 10]. Indeed, the proposed directive is inflexible in some respects in not allowing for changes resulting from advances in our understanding of what comprises good welfare for animals.

There are also important omissions in the revised directive such as the lack of guidance for marking animals. Mutilations such as cutting off toe digits, for example, would still be allowed, even though such procedures are thought to be painful. Some scientists think they should be banned outright.

Revising the directive is inevitably taking a long time and is far from complete. Work on the revision started in 2002 and included a public consultation in 2006. The European Parliament adopted the First Reading of the proposal in May this year and at the time of writing the document was with the European Council. Within the UK, a consultation process finished in July; the Lords EU Committee have held their own inquiry into the revision of the directive and were expected to produce their report in November this year [8, 9]. A number of amendments to the revision have already been proposed and there will undoubtedly be further changes by the time the final version of the directive is confirmed after a second reading in the European Parliament and by the European Council. These changes should go some way to meeting the main concerns I've discussed here. Whatever the final form of the directive, though, there will inevitably be repercussions for scientific research, as well as animal welfare, throughout the EU.

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4-letter words and others (7)

by Alistair Reeves

5 real 4-letter words this time. *Last*, *past* and *next* form a sort of group, and have important nuances in time phrases in English. *Plus* and *over* have interesting uses—and limitations in formal writing. And I have sneaked in *QCed* as an honorary 4-letter word. These are followed by 3-letter words, of which there are 2. The second signals that this is the last contribution to this column because it is *end*; you will see what the other one is.

Last, past, next

A few simple things should be observed when using *last*, *past* and *next* as modifiers in time phrases.

It is very unusual, if not impossible, to say *During the last years, we have been investigating this issue ...* , and it is a typical error that I often correct in texts. Without further modification with, for example, a prepositional phrase (see below), *the last years* needs to be made more precise in some way in English: either by adding an actual number, *the last 10 years*, if you can, or most frequently by adding the word *few*. *Over the last few years, we have received several reports of ...* sounds correct. Of course, it is always better to be precise if you can, so if you can use an actual number, so much the better. Whether you use a number or *few*, this means that you are referring to a continuous period up to the time of writing. Ah yes, you say: but how many is *a few*? The pragmatic amongst us stopped asking this question years ago, and are happy in assuming that here the word *few* will generally be understood to mean 3–5 years. Those who cannot live with this condemn themselves to being more precise, where it is probably not that important.

If *the last years* is modified by a subsequent prepositional phrase, *During the last years of her presidency, she often tackled controversial issues*, then the word *few* is understood and is not needed. It can be there for emphasis, and if you could specify an actual number, you might. But I suspect that it would not be important whether the controversial issues were tackled in the last 2, 3 or 4 years of the presidency; the important thing is that this president had the courage to do it often. *Last* used in this way coupled with the simple past always indicates that the person is **no longer** president.

So far, so good. Things are both a little simpler and a little more complex with *past*, however. Let us substitute *past* for *last* in the first example above, *During the past years, we have been investigating this issue ...* . Unlike the use of *last*, this is quite acceptable without being modified by *few* or a number. *Few* or a number can be added, as with *last*. But whereas *during the last years* sounds incorrect, *during the past years* sounds correct and is the formulation chosen by speakers and writers to express this idea. *Past* used this way refers to a continuous period up to the time of writing.

If *the past years* is modified by a subsequent prepositional phrase, *During the past years of her presidency, she has often tackled controversial issues*, then the word *few* is understood and is not needed. It can be there for emphasis, and if you could specify an actual number, you might. *Past* used this way coupled with the present perfect always indicates that the person is **still** president.

It is not possible to say *In last years, we have held the meeting in June*, but it is possible to say *In past years, we have held the meeting in June*. However, this does not mean the same as *In the past years*. The latter means that since you started holding meetings they have been in June each year up to the time of writing. Without *the*, it means that you have been holding meetings for the past 15 years, for example, and that in some of those years, the meetings were held in June. This is a good illustration of the weight the definite article can carry in English—and often does!

Next is used in the same way as *last* in time phrases like those above. *We will contact you for further details in the next days* therefore does not sound correct. Add *few* or a number and it does sound correct.

Plus

Plus is one of those multitasking words that can be a preposition, an adjective, a noun or a conjunction. Most ways it is used are informal.

Preposition. The most obvious accepted use here is 5 *plus* 5 equals 10. Except you don't normally write *plus* but +, and just say *plus* when speaking something out. Using the plus symbol in this way is acceptable when writing formally in our context. *+ 2°C* is the same—quite acceptable. Not acceptable in formal writing but definitely otherwise is its use as a preposition in the following way, meaning *with* or having some sort of addition: infusion bottles *plus* a free holder. This is frequently used in advertising or marketing, often when the suggestion is that you are getting something for nothing.

>

4-letter words and others (7)

> ***Adjective.*** An informal adjectival use is to say: *The patient was 40 plus*, or *We saw 50 plus cases of interstitial lung disease in our 6,364 patients.* One of those rare—and interesting because inexplicable—occasions when we put the adjective after the noun in English. *Plus* is also generally used adjectivally in mathematics to mean the opposite of negative, so this is also acceptable when written. The *plus pole* (positive electrical charge) is also acceptable.

Noun. When used as a noun, the word *plus* definitely has a spoken ring or an informal feel, for example, in an email or on a presentation slide, where it may well be appropriate for brevity: *A definite plus is …* .This also applies to its use in the plural: *The plusses are that we will save on paper and ink. Plusses* has not established itself in formal writing. *Plus points*, using plus as an adjective is, however, better established and can fairly safely be written.

Conjunction. Plus is very often used as a conjunction when speaking or in emails: *If we buy the new device, we will have to rearrange the laboratory furniture, plus we will have to have window blinds fitted.* The *plus* here sounds as if it were chosen instead of *and* because it was perhaps an afterthought, or maybe even to underline the fact that buying the new device would have more far-reaching consequences than just rearranging the furniture. So it may be used by a speaker to stress what follows the *plus*, or may just be used as an alternative to *and*. I more than sometimes see a comma after *plus* when used this way, which suggests to me that it is used when the user wants to add some stress and thinks that the comma underlines this. As usual, when writing formally you should try to be as precise as possible, so if you wanted to indicate that having the window blinds fitted would be an additional, possibly unexpected expense, then when writing formally you would have to say something like: *If we buy the new device, we will not only have to rearrange the laboratory furniture, but also have to have window blinds fitted* or *If we buy the new device, we will have to rearrange the laboratory furniture, and on top of this we will have to have window blinds fitted.*

Over

Whilst you improve *on* something, something new that is better is an improvement *over* or *on* the older something. It is not necessarily an improvement *of* the older something. If you improve a device, for example, but it is basically the same device and just does its job more quickly, you might say *Device X is an improvement of Device Y*. For an indefinable reason, possibly just frequency of usage, I still prefer to say *Device X is an improvement on Device Y*. It has been suggested to me that saying *Device X is an improvement over Device Y* implies that Device Y completely replaced Device X because of different technology, for example. Rather in the way that the iPod replaced the Walkman. A change of preposition can often change meaning entirely, but this looks very much to me like trying to find a difference where there is actually none.

A slight digression: you can make improvements *to* something, but unless you are further qualifying the improvements in some way (*We made the first improvements to the device in February and further improvements in June*), it is best just to stick to simple improve. *We first improved the device in February and then in June* is probably still better, however.

Over is also used in the following way: *amoxicillin was given over 5 days*. Some claim that this formulation should be avoided because of the possibility of confusing *over* with *more* or *longer than*. This is looking for a problem where this is none: without *for* before *over*, there is no possibility of confusion. If you wish to express the idea that ampicillin was given for *longer* than 5 days, that is exactly what you should say. When speaking, you might say *for over* 5 days, but, for me at least, this formulation should remain in the realms of the informal.

QCed

QCed and *QCing* have come to stay in emails and when we are speaking. And it really is the best way to describe this activity. It sounds a bit strange to say: *Have these documents been quality-controlled?* And on top of that, you are not sure whether to write it with a hyphen or not! *To do QC on something* is a possibility, as are *to put something through QC* and *to go through QC* (*Have these documents been through quality control*), but in the face of simple *to QC*, they are all something of a mouthful and sound as if you are trying to avoid saying *QCed*. The big question is: can we use it in formal writing? I have to admit I have started to, and no-one has complained yet! I draw the line at writing *QC'd* though. And qced still looks like a typing error.

Die

Do you die *of* or *from* something? I have come to the conclusion that it is useless to try to make a distinction. I have seen claims that you use one for diseases and the other for accidents, or one for causes of death which you can do nothing about (from outside agents) and the other for things that might have been preventable, or one for abstract terms (injuries, causes) and the other for non-abstract terms (sepsis, haemorrhage). Tracking this sort of thing used to be a laborious process, sifting through all sorts of documents for years. Now all you need to do is spend 30 minutes searching around Google (which I agree is not validated, nor does it hold any absolute truths, but it does turn up a vast number of scientific articles) and you will also come to the conclusion that it doesn't matter whether you die of or from something. Let's face it, when it actually happens, the very last thing of any importance are a couple of prepositions that are not worth arguing about. One thing is certain though: if you die *by* the sword, this will usually have happened in a swash-buckling movie, a romantic novel, or a poem, and not in our type of text.

End

I am usually for brevity. I have discussed the merits of the word *stop* and its interchangeability with the word *end* as a

4-letter words and others (7)

noun and a verb in an earlier issue in this column. So what I am about to say should be seen in the context of those comments. Which is preferable: *at study end*, or *at the end of the study*? This is a matter of personal preference; I still go for *at the end of the study* even though it goes against my basic principle of always choosing the shorter version. *Study end* looks like a deliberately abbreviated table or CRF column header where there was too little space to say *End of the study*. But bear in mind that I have no problem with *at study entry* and much prefer this to *at entry to the study*, which just goes to show that as much as I may plead for consistency, I can be inconsistent myself.

End is problematic because of the many possibilities of putting a hyphen between it and other words that it is linked with. I found myself correcting endphase to endphase the other day—and then thought, why shouldn't it be endphase? Nobody will misunderstand it. I have got to the point where I can write endstage without even thinking of the possible hyphen everyone used to insist on. Now I write enddiastolic and endsystolic without hesitation, and the hyphen in endpoint was jettisoned years ago. Somehow, however, I don't think I will ever feel tempted to hyphenate end product, and certainly never to write it together.

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Ig Nobel Prizes 2009: Cows, bras, knuckles and beer bottles

It leaves a warm feeling when a piece of research finds out what you already knew in your heart, especially when it is something close to your heart and the discovery was made at the university where you graduated. So, it is a great pleasure to report that Catherine Douglas and Peter Rowlinson of Newcastle University, Newcastle-Upon-Tyne, UK, were awarded this year's Ig Nobel Veterinary Prize for showing that cows who have names give more milk than anonymous cows. I have always adored cows and my youth, much of which was spent naming cows, was clearly not misspent.

The Ig Nobel Prize theme this year was risk, chosen in honour of the world's financial crisis and as a symbol of risk the prize winners each received a pair of dice. Alas, one prize went missing and there is a call on the website hosted by Improbable Research, which awards the prizes, for the thief to return the trophy. No questions will be asked. The ceremony took place on 1 October at Harvard University and for all those who were unable to attend a webcast can be viewed at http://improbable.com/ig/2009/

The risk element of whether a cow has a name or not might not was a little lost on me but the explanation according to the website is that the risk relates to the goings on at the ceremony and not necessarily to any of the prize-winning achievements. Nevertheless, it is certainly risky to be hit over the head with a beer-bottle and, as a Swiss team from Bern University found, more so if the bottle is empty than if it is full. For this research they received the Ig Nobel Peace Prize.

Donald Unger, an immunologist from California, also took a risk by cracking his knuckles on his left, but not on his right, hand twice a day for 60 years. His reward was the Ig Nobel Prize for Medicine and to disprove his mother's prediction that knuckle cracking causes arthritis. It seems a lot of effort to expend on proving one's mother wrong. The literature prize went to Ireland's police service (An Garda Siochana) for writing out more than fifty traffic-offence tickets for the most frequent driving offender in the country; his name was Prawo Jazdy, which is Polish for 'Driving License'.

photo: Marlies Neuner

"Josephine, I must say you look quite Ignoble with that piece of grass hanging out of your mouth".
"And there are no prizes for guessing which of us gave the most milk today, number 6000".

But perhaps the riskiest of all was the Public Health Prize awarded to Elena Bodnar and colleagues for inventing a brassiere that doubles as a protective face mask—well, two actually. Elena Bodnar demonstrated the invention by pulling her bra out from her dress, separating the two sides and attaching them to the Nobel laureates who were in attendance. It sounds like a good Christmas present for a wife or girl-friend to me—provided relations are sufficiently amicable at the time the emergency pops up for you to be able to rely on the second cup.

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In the bookstores ...

Practical advice on how to stay compliant with the ABPI and EFPIA Codes

Judith Grice. Compliance, Codes and Communications. A practical guide to pharmaceutical marketing in the UK, with important European insights. Stanford Publishing Limited, 2009. ISBN: 978 0 85369 7176. 29.95 GBP. 127 pages. Available to buy direct from the author: http://www.pharmacodes.com/PharmaCodes%20Publications.html

It is well known that regulatory writers have to follow guidelines in order to write compliant documents, however what might be news to some is that medical writers working in the medical communications arena also have guidelines and codes of conduct that they must adhere to. Applicable across Europe, these guidelines are based on the European Federation of Pharmaceutical Industry Associations (EFPIA) Code (1) which "provides the minimum standard that national associations must adopt." Each country has interpreted these guidelines separately. In the UK those involved in reviewing and writing promotional and communications material for prescriptions medicine must adhere to the Association of British Pharmaceutical Industry (ABPI) 2008 Code (2).

In this book the author provides practical information and guidance on interpreting and implementing the ABPI Code. A useful summary of the key differences and similarities between European countries is also provided for those working across European countries. As well as suggestions on how to interpret the code, each chapter also contains case studies with learning points highlighted for each one.

The first chapter reviews the principles and procedures of the code. As the author points out these are applicable whether "it is an electronic or printed advertisement or a detail aid used by sales representatives or a booth panel." Therefore if you work in this area of medical writing it is essential that you understand and interpret these basic principals correctly. This chapter is essential reading for those new to the industry or unfamiliar with the code of practice.

Additional chapters deal with individual topics in greater detail. For example, chapter 3 discusses how the code relates to printed material and highlights the need for it to be applied to both promotional and non-promotional material such as educational information. The types of written material that must adhere to the code include journal advertisements, detail aids, leave pieces, booth panels, product monographs and formulary packs. Helpful and relevant suggestions for interpreting the code are provided throughout, which if followed, will allow writers to maintain compliance.

The internet and electronic media are vital methods of communication for many companies and the need for promotional compliance covers webcasting, podcasting, blogs and e-mails as well as the content of company websites. The issues relating to this form of medical communication are addressed in chapter 7. The provision of patient information is also tightly regulated and prescription-only medicines must not be advertised to the public. The difficulties encountered in this area are discussed in detail by a guest author, Paul Woods, in a separate chapter.

The code also has implications for clinical research, investigator meetings, and advisory boards and issues surrounding compliance in these areas are discussed. In principal, research carried out by a company should not be disguised promotion and key related issues are covered in several chapters. There are also chapters dedicated to public relations, gifts and company representatives each providing useful and practical advice on successfully interpreting the code in these areas.

Although there are similarities relating to how prescription medicines can be promoted across Europe the difference in interpretation and implementation of guidelines leads to variation in different European countries and the author has provided summary tables highlighting many of these important differences. For example, do you know the standards of proof required to substantiate a promotional claim in a particular country, e.g. whether 'data on file' is acceptable and if so, in which Country? Some countries require a head-to-head study to make a competitive claim, do you know which ones? If you don't know the answer to these questions and you feel you should then you need to read the book to find out!

If you are working in this area of medical writing and this is the kind of information you are required to know, I thoroughly recommend you add this book to your reading list.

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In the bookstores ...

The book's author is giving the plenary lecture at the EMWA Conference 2010

Judith Grice will be giving a plenary lecture titled 'Stand out from the crowd—by having an understanding of European pharmaceutical industry codes and compliance' at the EMWA Conference in Lisbon on 15 May 2010. The lecture will focus on providing a basic understanding of Compliance, Codes and Communications across Europe and how an awareness of these can help in making you 'stand out from the crowd'. The areas covered will be

- How promotion is controlled in Europe
- Why codes exist & what is covered by them
- Why complying with them is important
- What is the scope of the codes
- Focus on written materials
  - Basic Principles
- Differences between the codes/regulations across Europe
- Some practical examples of where an understanding of the codes may help when producing communications.

Judith is a director of PharmaCodes Medical Communications Limited. She has extensive experience in approving promotional materials. This included regulatory accountability for the compliance of international marketing campaigns for a major global company. She also delivers compliance training courses and details of these can be found at www.pharmacodes.com.

Thanks we all deserve

Carol Norris teaches medical students in Finland and came across the following acknowledgement from a Swedish native-speaker Finn enamoured of thesauruses, "I thank my thesis director for his relentless aid in making my writing translucent."

With thanks to Carol Norris (carol.norris@helsinki.fi) for sending this example to *TWS*

Advice and information on a medical writing career in medical communications

Annick Moon: From academic to medical writer: A guide to getting started in medical communications. 28 pages. Published by NetworkPharma and available free from http://www.medcommsnetworking.co.uk/startingout

Written by a freelance medical writer working in the UK as a medical communications consultant, this booklet provides useful advice and information for those considering a career as a medical writer in a medical communications environment. As the author explains, the main aims of the guide are to give industry information on the role of a medical writer and to provide the "insider knowledge needed to excel at interview".

The booklet introduces the different phases of clinical development as well as describing the types of job opportunities that can be encountered in a medical communications environment. Job titles include account manager, medical editor, editorial project manager, conference manager and medical writer and as explained all have different roles within the medical communications field. By reading the descriptions a potential candidate will learn what each role involves and which attracts them most.

When desperately trying to find your first job as a medical writer, the need to demonstrate relevant industry experience coupled with the relevant skills seems an insurmountable task. Many people who want to begin a medical writing career are postdoctoral scientists, and at first glance they do not appear to have the necessary experience or skills. In this booklet, useful ideas to translate existing scientific skills into essential medical writing skills are presented. Examples include "*Teamwork:* liaising with colleagues and collaborating with other research groups" and "*Project Management*: designing experiments and scheduling resources."

Candidates applying for a medical writing post should not be surprised when asked to complete a writing test. The test is often set as a means of selecting candidates who will be considered further and interviewed. There is no industry standard for the writing test and many companies design their own. Faced with the writing test for the first time when candidates are not familiar with the therapeutic >

In the bookstores ...

area, or style of writing, can be quite daunting. Examples of the types of writing test that can be set are presented in the booklet. Some suggestions for completing a good writing test are paying attention to detail, and structuring the text well to ensure information flows in a logical sequence. The booklet also contains an exercise (with the answers) to check and improve editorial skills.

Testimonials from those already working as medical writers for communications agencies are presented, and provide interesting background information on the many routes that can be travelled before becoming a medical writer. Overall, the booklet provides a good introduction to what is expected from a medical writer working in the medical communications environment. By studying the information, those who are considering the leap into medical writing can make an informed career choice, as well as prepare themselves for the writing test and interview. For those choosing medical writing as a new career option it will help make that elusive first medical writing job an attainable goal.

This careers guide is an annual publication and will be updated in March 2010. The update will ensure that the directory of agencies is current. The core copy will not change unless any changes are needed but more profiles might be added.

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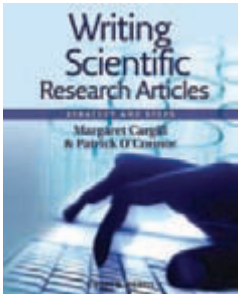
Practical help for beginning scientific writers



Margaret Cargill and Patrick O'Connor. Writing Scientific Research Articles: Strategies and Steps. Wiley-Blackwell, 2009. ISBN 978-1-4051-9335-1. Approximately 18 GBP, 20.00 euro, 173 pages.

I can honestly say that I found nothing wrong with this book. I thought that my New Yorker's critical and judgmental eye would uncover something to criticize, but I was mistaken. The authors, a linguist and a researcher from the University of Adelaide, aim to teach beginning researchers how to prepare a scientific research article for submission to an international journal, and they succeed. The keyword here is 'prepare'–the authors focus not only on writing articles but also on the entire submission process from choosing a journal to responding to reviewers. The book includes many examples and exercises to support a learning-by-doing approach. Both writers and teachers will find this book valuable, as will experienced writers looking for a little metaphorical pencil sharpening while working on their own articles. Now to the specifics.

The book is organised into five sections: four sections of instruction and one section with two sample articles for completing exercises. The first section prepares the writer and includes information about article structures, selecting titles, and reviewers' criteria for evaluating articles. A list of typical questions that reviewers use to evaluate articles is very helpful. By doing the exercises before writing my article, I learned what information reviewers look for and where in my article they expect to find it.

The second section addresses writing articles section by section, starting with the results and ending with the abstract. All chapters are brief but thorough. However, to get the most out the book, I strongly recommend that writers complete the exercises. Matters of English grammar are treated judiciously. Rather than laying down the law to avoid using the passive voice, the authors explain when and why to use which voice for clear and effective writing. The chapter on tables and figures covers the basics, and writers can quickly improve their articles by following the suggestions.

The third section explains how to get your manuscript published. The chapter on selecting a journal seemed a little out of place to me because I prefer to choose before I start writing. Nonetheless, I was very grateful for an exercise on how to analyse journal scope, time to publication, and impact factor across several potential journals. Responding to editors and reviewers is always tricky, but the authors' systematic recommendations make me believe that it is at least manageable. A table including comment type and possible responses goes a step further and tells me what I need to do to improve my article and which section in the book to review.

The fourth section on developing publication skills is targeted primarily at writers of English as an additional language. Common grammar and usage mistakes are reviewed to the benefit of most writers of English, native or not. The two example articles provided in the fifth section are good for working through the exercises, but, although I started out using both, I settled into using the one most similar to my research area. It seemed to work well enough.

A final and potentially helpful benefit of this book is the authors' website www.writeresearch.com.au. However, the website is pretty sparse at this time and is not much use. I plan to check back in the future and expect to find more exercises and checklists to support the book. All in all, this book is very helpful, and I will use it again when I write my next article. And, at about 20€/18£ for the softcover version, it makes my bargain-hunter's heart sing.

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The Webscout

Principles of communication

by Joeyn Flauaus

"We can't not communicate"
(Paul Watzlawick, 1972).

One of the basic needs of humans is communication. Communication is a very dynamic process as it is a two-way activity between two or more people. We constantly communicate with our environment, not only by using words, but also through the tone of voice, gestures, and body language (e.g. facial expression). Even if we try not to communicate we communicate something.

The exchange of information, ideas, opinions and feelings between people through a common system of symbols enables humans to interact with their environment which is the prerequisite for social integration and development. A lively discussion can be a source of inspiration which in consequence can lead to advancement and further development of civilization. A requirement for successful communication is of course that both parties speak the same language, use the same symbols (i.e. words, gestures, letters), and have the same level of understanding. Language is the tool that transforms thoughts into meaningful symbols.

> ***"There are few human activities we value more, understand less, and perform worse, than person-to-person communication."***
>
> Robert M. Soucie 1979

Generally, communication can be classified into three categories: verbal communication, non-verbal communication and written communication. Each type of communication has its advantages and disadvantages, e.g. written communication is only significant to those who can read.

Most of us are born with the ability to hear and speak. However, communication is an acquired skill. You learn to speak and communicate well by observing the people around you. And as you all know, the skill to produce well-structured documents that explain complex scientific topics clearly and concisely can also be learned. Clarity is key to good communication. The most important thing in communication is not to speak or write, but to be clearly understood. To make things even more complicated, you always need to keep the context in mind when communicating. You simply can't exclude the psychological, environmental and cultural context that affects communication. You see, accurate communication is difficult!

I have put together a selection of websites on the topic of communication. These provide some insight about the complexity of human communication as well as useful tips on how to improve communication.

Wiio's laws: http://www.cs.tut.fi/~jkorpela/wiio.html
This website provides a tongue in cheek commentary on Prof. Osmo Wiio's laws (Finnish researcher of human communication on the Institute for Communications Research, University of Helsinki). These laws are observations on why communication usually fails—except by chance. For example: 1. If communication can fail, it will. 2. If a message can be understood in different ways, it will be understood in just that way which does the most harm. 3. There is always somebody who knows better than you what you meant by your message. 4. The more communication there is, the more difficult it is for communication to succeed.

How you can communicate better: http://www.utmb.edu/otoref/Grnds/Med-comm-2002-09/Med-comm-2002-09-slides.pdf
Even though the slide show is targeting physicians, it provides very useful tips on how to develop good communication skills, to prepare medical talks, to prepare a written article and to give presentations. However, one negative aspect is that the author does not explain all abbreviations. The mentioned KISS principle (**http://www.englishcafe.com/blog/The-KISS-Principle-and-Presentations-7158**) for presentations is not an invitation to kiss the audience but rather a recommendation to Keep It Simple Stupid, i.e. to avoid complexity.

Communication Disorders: http://www.nlm.nih.gov/medlineplus/speechandcommunicationdisorders.html
Unfortunately, many disorders can affect the ability to communicate. Communication disorders range from having slight impairments in speech, language, and hearing to being unable to speak, hear or understand at all. The National Institute on Deafness and Other Communication Disorders (NIDCD, **http://www.nidcd.nih.gov/**) conducts and supports research related to impairments in hearing, balance, smell, taste, voice, speech and language.

The Communication, Medicine and Ethics (COMET) Society: http://www.cometsociety.com/

The COMET Society's aim is to build a multidisciplinary network of researchers, educators, healthcare professionals and research students. The network is encouraging the exchange of ideas within the broad fields of healthcare. Conferences are offered as well.

If you find a website that should be mentioned in the next issue, or if you have any other comments or suggestions, please email me at: Joeyn.Flauaus@sanofi-aventis.com.

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Journal watch

Transparency and bias in reporting clinical trial results, meta-analyses, conflicts of interest and medical publications, and more on ghostwriting

by Melanie Lee

Transparency and bias in reporting clinical trial results

The International Committee of Medical Journal Editors (ICMJE) requires, as a precondition of consideration for publication, that investigators register clinical trials in a public registry before patient enrolment. Mathieu and colleagues [1] have compared the primary outcomes specified in trial registries with the results reported in published articles in high impact factor journals. They found that just 45.5% of the 323 included trials were adequately registered; 315 of these showed some discrepancies between the registered and published outcomes. The authors concluded that selective outcome reporting is prevalent.

Kanaan and colleagues [2] have examined the tendency of peer-reviewed surgical journals to publish positive reports or negative and inconclusive outcomes as a function of the impact factor of the journal. They reviewed 2,457 articles from 15 journals and found an inverse correlation between impact factor and publications of negative or inconclusive reports. They concluded that journals with a lower impact factor may therefore play an important role in maintaining balanced reporting of studies; this is important, as the available published evidence is generally the basis for essential decision making in medical care. Erick Turner [3] has evaluated multiple publication of positive versus negative trial results in review articles, extending previous work on selective publication focusing on duloxetine. He found that positive trials were fully published, whereas negative trial results were bundled with positive trials in review articles. This significantly skewed the apparent weight of evidence favouring drug efficacy.

Meta-analyses

Systematic reviews of clinical trial results, preferably with meta-analyses, are regarded as the most reliable resource when making decisions about disease prevention and treatment. However, data extraction can be complicated, and different observers may get different results. Tendel and colleagues [4] report the results of an observer agreement study that aimed to study inter-observer variation related to the extraction of continuous and numerical rating scale data from trial reports for use in meta-analyses. Five experienced methodologists and five PhD students independently extracted data from trial reports used for a random sample of ten Cochrane reviews that presented a result as a standardised mean difference (SMD). They found that disagreements were common and often larger than the effect of commonly used treatments, and concluded that meta-analyses using SMDs are prone to observer variation. They suggest that more detailed review protocols, more than one observer, and statistical expertises are required to improve the reliability of meta-analyses.

Dissemination biases, more commonly known as publication biases, arise from suppression of whole studies, selective reporting of outcomes or subgroups, data 'massaging' (e.g. selective exclusion of patients from the analysis), and biases regarding timelines. Publication bias can be a problem when doing meta-analyses. To address this problem, statistical methods have been developed both to detect publication bias and to correct for suspected publication bias. Moreno and colleagues [5] have assessed the performance of novel contour enhanced funnel plots (a scatter plot of effect size versus associated standard error) and a regression based adjustment method to detect and adjust for publication biases. They have done a secondary analysis of a published systematic literature review using this novel method, and included analysis using established statistical methods for comparison. They concluded that the novel method worked convincingly, and suggest that it may become an important tool in combating publication biases.

Conflicts of interest and medical publications

Conflicts of interest (COIs) are currently being widely discussed in relation to publication of clinical trials in medical journals. COIs, authorship, and disclosure in industry-related scientific publications are discussed in a commentary by Laurence Hirsch [6], and are also the subject of an accompanying editorial by William Lanier [7]. Laurence Hirsch argues that disclosure policies vary between journals, and that their implementation is asymptomatic and biased. William Lanier makes the point that high-quality industry-sponsored research benefits journals, patients, and clinicians, and that industry benefits by being able to publish in credible journals. Therefore, authors and industry should seek out medical journals that have high publication standards that are applied equally to all parties.

Moher and colleagues [8] have developed a financial conflicts of interest (fCOI) checklist. The checklist contains four sections (administrative, study, personal financial, and author information) that are divided into six modules. It is intended to be completed by an investigator for an individual study, with different modules being completed

at different transition points over the course of the study. The checklist takes less than 20 minutes to complete. The authors invite comments and suggestions to improve the checklist.

More on ghostwriting

In an editorial in *PLoS Medicine* [9], the *PLoS Medicine* editors discuss ghostwriting in medical publications, and question the effectiveness of current policies for eliminating ghostwriting. The World Association of Medical Writers policy on ghostwriting is available at http://www.wame.org/resources/policies#ghost, and the European Medical Writers Association guidelines are available at http://www.emwa.org. ICMJE criteria for authorship in biomedical publications are available at http://www.icmje.org/#author.

The results of the *Pharma Marketing News* online 'Pharma-Sponsored Medical Article Ghost Writing Survey' have been published [10]. From 21–31 August 2009 there were 83 responses to the survey, which asked participants to what degree they agreed or disagreed with nine statements regarding issues surrounding ghostwriting and medical publications sponsored by drug companies. Selective comments from respondents are also discussed. The survey has now been re-opened for further comments (see http://bit.ly/2BYB2b).

Finally, Woolley and colleagues [11] have quantified how involved declared medical writers and the pharmaceutical industry have been in publications retracted for misconduct. A PubMed search was used to identify publications retracted for either misconduct or mistake. 463 retractions were reviewed, and 213 (46%) of these were misconduct retractions. Statistical analysis showed that the involvement of declared medical writers or the pharmaceutical industry in misconduct retractions was very low or non-existent. In comparison with mistake retractions, misconduct retractions were significantly involved with absence of a declared medical writer or pharmaceutical industry involvement (odds ratio {OR}, [95% confidence interval {CI}]; 3.74 [1.66, 8.40]), single authorship (OR [95% CI]; 2.04 [1.01, 4.12]), first author having at least one other retraction (OR [95% CI]; 2.05 [1.35, 3.11]), or an affiliation with a low/middle-income country (OR [95% CI]; 2.34 [1.18, 4.63]).

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MedComms Networking

MedComms Networking is an informal initiative, led by Peter Llewellyn of NetworkPharma. It encourages networking and dialogue amongst individuals working in and around specialist medical education, medical communications and medical publishing businesses primarily based in the UK. For more information please visit http://www.MedCommsNetworking.co.uk and please help spread the word.

A medical writer's blog

I have recently joined the Web 2.0 age and started writing a blog. Much of it will, I hope, be of interest to medical writers. I have so far blogged on a range of topics, including medical writing ethics, the way some medical stories are reported in the popular media (i.e. very badly), my experiences as a member of a research ethics committee, and some of the trials and tribulations of running a medical writing company. The blog is open for anyone to leave comments (there's no need to register), and it would be splendid to hear what other medical writers think of my musings. So please do come and read what I have to say, and tell me what you think, at http://dianthus.co.uk/dianthus-medical-blog.

Out on our own

Following the excellent response at the Ljubljana conference, we established a Freelance User Group to support the Executive Committee in better understanding how members can be served by EMWA—and how freelance members can serve EMWA, of course. Current members are Ingrid Edsman, Debbie Jordan, Elaine O'Prey, Claudia Frumento and Diana Raffelsbauer—supported by Sam and Alistair. Ingrid Edsman of Sweden and Neil Fisher of the UK have already invested quite some time in putting together materials for a Freelance Support Centre on the website. Head Office and members are often asked by new freelancers, or those thinking about becoming a freelancer, where they can find helpful information. The aim of the Freelance Support Centre is to bring together this type of information, so that we and Head Office can point people to this resource. Neil Fisher can no longer assist with this activity due to other commitments, so we are looking for a volunteer to replace him in the User Group and to support Ingrid. We can't yet say when the Freelance Support Centre will be 'going live', but hope that it will be in the first quarter of next year.

Other issues the User Group have discussed and are working on are the setting up of a more interactive discussion forum on the website, not only for freelance members, and the 2010 web-based Freelance Business Survey, which we will be running between the end of January and mid-March next year. The results will be published in the June issue of *TWS*.

In this issue, Gillian Pritchard, Scotland-based EMWA treasurer and freelance regulatory advisor and writer tells us about a typical working week, and also shows us that we are not always 'out on our own', even if sometimes we don't see a colleague from one day to the next! At present, she is working on a project with two EMWA colleagues, showing how important the networking aspect of EMWA is for freelancers.

As ever, we are always on the lookout for contributions to this section of *TWS*. It is your journal and your opportunity to let off steam about something or give insights into our work that we may not have thought of before—so please come forward with ideas. Articles or shorter contributions relevant to freelancers on any aspect of our work are always welcome.

Let's hope the economic climate picks up next year. Things don't seem to have been as disastrous as many of us thought at the beginning of 2009, but quite a few colleagues have reported a clear drop in business. Here's to 2010.

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Freelance Business Forum at the 29th EMWA Conference

Despite full schedules and a tight slot between the end of workshops and the social events on the Friday evening at the Frankfurt Conference, 47 participants found time to attend the Freelance Business Forum chaired by Sam Hamilton and Alistair Reeves. Only few of the participants were salaried employees or owners of small businesses, which means that about 25% of delegates in Frankfurt were freelancers, reflecting the overall membership of EMWA. Topics ranged from improvements to freelance services and the setting up of a Freelance Support Centre on the EMWA website to copyright issues for freelancers when dealing with literature services for clients. Barbara Grossman will be preparing a report for the next issue of *TWS*.

A Week in the Life of ...

Gillian Pritchard

by Gillian Pritchard

I have been a freelance medical writer and pharmaceutical physician for three years. I work from home a few miles from Dundee on the east coast of Scotland. Like so many writers I also juggle work and family, and six months ago I added the role of EMWA Treasurer to the juggling act.

I am currently writing a clinical summary and overview with another freelance colleague, Iain Colquhoun. We had travelled to France the previous week to review the draft documents with our client. All we had to do now was finalise the summary and write the overview - oh, and this all had to be done in the next three weeks. Once I had caught up with some e-mail correspondence and administrative tasks on Monday morning I was able to review a section of the clinical summary that my colleague had been busy finalising over the weekend. Yes, we freelancers work funny hours! Iain had done a good job; there were few comments and the review didn't take very long. This was fortunate because I needed to finish work early in order to collect my son from school to take him to a hospital appointment. I usually go to an aerobics class on a Monday after work, but not this week.

Monday morning's administrative tasks included some EMWA-related work: reviewing the monthly management accounts from EMWA head office and forwarding them to the finance sub-committee for their review, and approving the previous week's payments so that they could be set up on the bank ledger. I also logged on to the EMWA bank account and authorised some payments, including the deposit for the 2010 Spring conference in Lisbon. My role as Treasurer is made so much easier by the finance team at head office who deal wonderfully with the day-to-day financial activities.

On Monday evening, once the children had gone to bed, I started work on the clinical safety section of the clinical summary. After about two hours I stopped, or rather my citation software stopped and told me that 'the server had thrown an exception and needed to close'. Well, I didn't know what this meant, the Help menu wasn't very helpful, and it was too late in the evening to start investigating, so I turned off the computer and hoped that it would recover by the morning!

Tuesday was a productive day; I had a meeting in the morning, there were very few e-mails or administrative tasks and I made good progress finalising the clinical safety summary section. The citation software was still 'throwing exceptions' though. Wednesday was another productive day; I finished the clinical safety summary section and tried to send it to Iain for review. Alas, the computer had other ideas and refused to send or receive any e-mail (perhaps this explained the low volume of e-mails during the day). Fortunately my husband soon resolved the problem and the document disappeared from the outbox. Iain is an expert with the citation software and formatted the references and bibliography for me. I think there is a potential EMWA workshop here! As there were only a few comments to address, the section was soon ready to send to the client—two days ahead of schedule. However, because Wednesday is the end of my working week it was important to finalise the section early.

Another deadline was looming: materials for new workshops to be presented at the Spring Conference were required by the end of the week, so this was a task for Wednesday evening. The drug safety workshop had become unwieldy and so was being split into two workshops. Wendy Kingdom, who has led this popular workshop for some time, had asked me to co-present the new workshops with her. She had done a fantastic job revamping the workshop materials and so it didn't take long to review the updated slides and workshop assignments. Another deadline met.

On Thursday morning I took my daughter to her Gymtime class and in the afternoon we filled two boxes with gifts for the annual Blythswood Shoebox Appeal which our church supports. My artistic ability and patience were challenged trying to gift-wrap the shoeboxes, though! On Thursday evening I did some book-keeping and caught up with e-mails received during the day: some needs analysis questionnaires for the GCP workshop which I am leading at the Autumn Conference in Frankfurt, and proposals received from companies tendering for EMWA's website management services which are being outsourced.

After taking my son to the school bus on Friday morning, my daughter and I went for a walk to the local stables and back via the park where we collected some conkers before heading off to the pool for her weekly swimming lesson, followed by a quick visit to the bank, then to the mobile library before it left for its next destination, and finally back home just in time for the decorator who came to quote for some work. I also had to remember that school finished early on a Friday and that I must be at the bus stop half an hour earlier than usual. Non-working days can be hectic and just as busy as working ones! Whilst my daughter played, making the most of the peace and quiet before her brother came home, I took the opportunity to check my e-mails: a few from EMWA about the forthcoming Frankfurt conference and the 2010 Spring and Autumn Conferences and one from our French client with a bibliography format query which, thankfully, Iain resolved.

Friday evening was spent at an outdoor party and firework display at my son's school—a nice way to end the week ... and it didn't rain.

So that was my week; a fairly typical mixture of client and EMWA work and family life.

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Preventing errors becoming facts

Surveys analysed by the American Newspaper Publishers' Association have found that half of all newspaper stories have errors, of which only 10% are typographical or spelling errors—the rest are factual errors. An article in *Intelligent Life* provides some examples [1].

How are these errors corrected? The survey found that less than 2% of the facts are ever corrected. Fact-checking departments at publishers hardly exist anymore. Publishers simply rely on authors to get things right!

Errors in books might be corrected if authors ask readers to send them an email with the correction, which the authors post on a website. The corrections are then incorporated in the next edition of the book, if a further edition of the book is indeed published. Some newspapers and magazines also post corrections on their websites. But the error might remain in the original online version and certainly remains in the original printed version.

A printed 'fact' is a trusted source. Readers, other than the few who consult the website, will accept the error as truth. The article in *Intelligent Life* shows how errors have been perpetuated into 'known' facts—Sherlock Holmes never said "Elementary, my dear Watson" (or anything like it)—and argues that mistakes in books and newspapers should be corrected, and readers advised of the correction, when discovered by the publisher. Electronic reading gadgets could make such a procedure commonplace for online versions in future. Correcting errors in this way is however not without its own difficulties. There is a danger that all record of the original would be removed if the paper only existed online. One respondent to the article in *Intelligent Life* strongly protested, likening such a practice to "trying to rewrite history" by matching facts to truths as unsavoury governments would like to see them—echoes of Stalin's manipulation of historical facts.

Mistakes in biomedical research articles can be corrected by a letter to the editor, or a corrigendum for an author's error and erratum for a publisher's error, although both are usually denoted as an erratum. The guidelines produced by the International Committee of Medical Journal Editors (ICMJE) state that corrections "should appear on a numbered page, be listed in the Table of Contents, include the complete original citation, and link to the original article and vice versa if online" [2].

The problem of ensuring that the reader is aware of the correction is particularly important in science, where research builds on established findings. Once a journal publishes a labelled, citable erratum to a previously published article, The National Library of Medicine (NLM) amends its citation to the original article with a bibliographic reference to the erratum notice. In the Medline format, the erratum information appears in the EIN (Erratum in) field. Nevertheless, not only articles containing errors but even articles that have been labelled on Medline with a notice of retraction as a result of deliberate fraud continue to be cited [3]. The problem of perpetuating errors could be alleviated by removing the article at least from the electronic record but the objection to this course is as above: that it destroys the scholarly record.

Although *Circulation*'s action in replacing an original article with a corrected version on its website (after complaints about the accuracy of the report) appears not to have been taken up as a destruction of the scholarly record, other similar actions have met with protests [4]. *JAMA*'s recent removal without trace of a controversial editorial from its website caused uproar [5], but was tolerated by Medline because the original version had been published online only and not included in the issue's table of contents. Several years ago an extreme example of deletion of the scholarly record was the attempt by *Human Immunology* to destroy all traces of an article it had published which concluded that Israelis and Palestinians are genetically similar. Although scientific error was not evident, phrases in the article were seen as political. The article was deleted from the online edition and subscribers were asked to tear out and destroy the print version of the article [6,7]. (Possibly linguistic errors led to a misunderstanding in this case. For an analysis see [8].) The journal's action was heavily criticised and some university librarians in the USA were uncomfortable with the editor's letter asking subscribers to tear the article out of the print issue, so even if they did tear out the pages, some of them stored the loose pages 'under the counter' so they could still provided access to the article if users requested it. There is no certainty therefore that the solution proposed by *Intelligent Life* of removing the original so as to prevent errors evolving into facts through citation Chinese whispers would find favour with the scientific community.

However, clearly more needs to be done to avoid errors and bring errors that do occur to readers' attention. Writers should be extra vigilant when checking galley proofs. Errors that come to light after publication should immediately be reported to the journal's editor. The journal should publish an erratum as specified by the ICMJE. Authors should take care to avoid citing erroneous or fraudulent publications. In addition to checking Medline, it might be worth searching the list of fraudulent publications provided by The Scientific Red Cards website at www.scientificredcards.org.

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The simpler the better: What non-native readers prefer?

Dear TWS,

I have noticed a tendency for contributors to *The Write Stuff* to use examples of such dreadfulness that starting again is really the only option. David Alexander (*TWS* 2009; 18(2): 96-7) gives excellent advice on making the sentence subject the same as the sentence topic, but his rewrite, while illustrating his point, still needs shredding.

> *Congenital heart defects have a multifactorial aetiology, in which subtlegenetic factors and periconceptual exposures interact. This aetiology may involve derangements in the homocysteine and detoxification pathways. An important role in both pathways is played by the recently identified nicotinamide M-methyl transferase (NNMT) gene and its substrate, nicotinamide.* (revision1)

Ignoring Tim Albert's suggestion that this is what medical journals want (*TWS* 2009; 18(2): 83-4) look at the markers here of bad style: "aetiology", "involve", "role... played by". Aetiology (which properly is the science of the causes of disease) is not synonymous with cause, and "multifactorial aetiology" (many causes) should be banished, along with "therapeutic armamentarium" (range of drugs). Now I've seen it, "periconceptual exposures" should probably join them. "Involve" is almost always an imprecise replacement for the correct verb. Role play is best left to social workers. I am not familiar with the science under discussion and so will ignore the confusion (to me) that nicotinamide is the substrate of the enzyme (NNMT) and not of its gene. So how about:

> *Congenital heart defects are caused by a complex interaction of subtle genetic factors and exposures around the time of conception in which derangements in the homocysteine and detoxification pathways, particularly perhaps the recently identified nicotinamide M-methyl transferase gene and its substrate, nicotinamide, may be important.* (revision 2)

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Author's reply

We applaud Dr Goodman for bringing a subject expert's eye to these passages and for showing how much more accessible scientific writing might become. The question now is whether he might have gone further. As we felt that his single-sentence solution might not be readable enough—especially for non-native speakers of English (NNSs)—we tested both revisions on 32 PhD students attending the 15-week course in English for biomedical communication we teach at Erasmus University Medical Centre, Rotterdam. All are NNSs: 27 Dutch, 2 German, and 1 each of Spanish, Turkish and Chinese. With the exception of two (one a data manager, the other a health-science researcher), all had backgrounds in medicine (in disciplines including paediatrics, oncology, psychiatry, and rheumatology).

At the end of class they filled in a short questionnaire that presented the original text and the 2 revisions: revision 1 (DA's) and revision 2 (NG's). They were asked to 1.) assign each revision a readability score (from 1 to 10, with 1 = poor); 2.) say whether they had had to read each text more than once, and, if so, how many times; 3.) give the >

Comment on 'Preventing errors becoming facts'

One possibility for online articles containing errors would be to replace them with a corrected 'second edition'. The corrected version could be placed where the original one was found, and thereby reduce the likelihood that people ignore the errata as occurs in the current situation. The only caveat is that it would also require editors to archive the original, uncorrected version in an accessible form. This would be effectively a reversal of the current situation, as the imperfect original would not link to an erratum explaining the change (and making the reader do the work) but rather a corrected version would be found in its place and link back to the imperfect original for the purpose of verification and interest (a trail only those with a special interest would follow). The record would be verifiably corrected but not erased. Obviously, this would require a complete shift from the way things are currently done. However, the current procedures are clearly based on a logic designed to suit hard-copy, paper-based journal publishing. Moreover this procedure has already been adopted for new editions of books in Wiley Online books, where the new version is posted 'in front' but the previous one is left there in some form for librarians who like the complete archive.

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Vital signs

reasons for needing to reread; and 4.) to briefly state the characteristics of each revision.

They had seen the original text and revision 1 in class a few weeks previously. Now, when given the questionnaire, they were told merely that revision 2 had since been suggested, and that we were interested to know their reaction to it.

The responses confirmed our hunch that, despite the admirable demystification of its terminology, revision 2 is difficult to read. The mean readability scores were 4.3 for revision 2, against 7.4 for revision 1. Revision 2 scored 10 only once, but revision 1 was assigned this score 3 times. Over 90% of the respondents needed to read revision 2 more than once (on average, they read it 1.9 times); this compares with 50% who needed to reread revision 1 (on average, rereading 1.5 times).

As for *why* the revisions were reread, the most important reason for rereading revision 2 had to do with the sentence length. Twenty of the 29 respondents used the word 'long' in their reason; 3 referred to the sentence's complexity. Sentence length was not mentioned as a reason to reread revision 1; here, the main reason (8 out of 16) was to check the meaning/compare the revision with the original. Only 4 of the 29 respondents who had reread revision 2 mentioned this reason.

When describing the characteristics of the revisions, the respondents used more negative terms for revision 2 than for revision 1. As well as its length ('long' was mentioned 19 times), it was "not easy to read", "very unclear", "woolly", "complex", "complicated" and "difficult to understand". Four respondents, however, made positive comments: it had "clearer flow of thought", was "easy to understand", "very nice to follow", "very successful when used for [sic] people with a little bit of background". As for revision 1: half (16) of the respondents used the word 'clear' to describe it, and 4 mentioned ease of reading. One respondent pointed out the scientific incorrectness of the use of aetiology in revision 1, noting that revision 2 had corrected it.

Our quick and by no means flawless survey shows the importance of readability to NNS readers, especially those who are novice readers (and writers) of scientific English. It also demonstrates the complementarity of language professionals and subject experts in improving NNS texts (cf. [1]). Language professionals can improve style, but subject experts can more easily identify the core message of a text and cut out unnecessary jargon.

This is partly why we decided to leave the last word to the writer of the original passage—the only person, we felt, who could now advise us on its best formulation. Before this had been agreed, however, she made two interesting points.

The first concerned the definition of aetiology, which she had looked up (under its US spelling) in Merriam Webster's Dictionary: "**1 :** CAUSE, ORIGIN; *specifically***:** the cause of a disease or abnormal condition". Presumably, this dictionary was compiled by English native speakers. If this is the definition *they* give, who else should an NNS writer trust?

Her second point concerned verb constructions such as "involved in", "associated with" and "play a role in". Yes, they're grossly overused—but as it's not *always* possible to describe everything in concrete terms, there are times when they're all you *can* use. We were nonetheless very pleased to add some very useful concreteness to her new formulation:

> *Congenital heart defects are caused by a complex interaction between subtle genetic factors and exposures around the time of conception. This process is influenced by derangements in the homocysteine and detoxification pathways, which may themselves be influenced by mutations in the recently identified nicotamide M-methyl transferase (NNMT) gene, and by different concentrations of its substrate, nicotinamide.*

Acknowledgement

With many thanks to Lydi van Driel.

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Reference:
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Comment from Neville Goodman: "Fascinating! Yes, the last rewriting is the best".

Team work in translation

Dear TWS

It was at the Barcelona conference that I first learned about the team-based translation approach Iain and Greg describe in this issue of *TWS*. I admit that listening to their experience with the translation project left me a bit envious. Being a medical translator myself, I know that translating can be a very lonesome journey, particularly for those of us who are freelancers. I was fascinated to hear about translators who work in an autonomous, integrated and creative team. The approach offers each translator involved the possibility to both contribute his or her know-how to the team and benefit from the group's 'accumulated' expertise. In other words, you are given the chance to grow, both professionally and personally. This is certainly a very special working environment not commonly found, at least in Germany. While I appreciate the challenges faced by the team's coordinator(s) and every team member in terms of establishing a stable, reliable and trusted group of translators, implementing processes to manage the shared know-how and resources, and providing the necessary tutoring of new members to the group, I am still sure that the effort is worth-while. The approach is truly encouraging in a translation business that often does not leave much room for creativity.

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Bony vs bone

Dear TWS

Alistair Reeves poses an interesting question and, I think, goes a long way to answering it.

He points out that we have an adjective from bone, but no appropriate adjective from brain or liver. Since we have this adjective available, why not use it.

The reason why I prefer the adjective bony to the noun bone is that it points to the important clinical point that if a patient has cancer cells in the bones as a result of progression of, say, prostate cancer these are prostate cancer cells, not bone cancer, though they may be like bone. Treatment is for prostate cancer not bone cancer and so the distinction, though rather nice, may have some small value. I suppose that the term bone metastases could be used to describe secondary tumours arising from a primary bone tumour (except this is rare).

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Different from: An explanation

Dear TWS

In his article (Four letter words and others (6) *TWS* Vol. 18, No. 3, 174-5) Alistair Reeves says that he has no good explanation why it should be different from rather than different to. Can I suggest the origin of the word in Latin—*differens,* present participle of *differre* to differ—provides sufficient clue. I can't imagine anyone saying that their view differs to some else's, still less that they hold an opinion that differs than the norm.

Alistair is not alone in feeling uncomfortable with different than. My favourite dictionary (and I'm a native British English speaker) is a battered elderly copy of the American Heritage Dictionary of the English Language. It comments on the use of the word different: "*Different from* and *different than* are both widely used but the Usage Panel has a strong preference for *different from*. This is especially marked when *different from* can be used without inducing wordiness (when it is followed by a single noun or pronoun or by a short phrase or clause). *This illustration is different from that. This was different from what we expected.* In the first example only 11 per cent of the Panel consider the alternative *different than* acceptable; in the second only 17 per cent would accept *different than."*

The entry goes on to give reasons why, and circumstances when, *different than* is acceptable or even prefered. On this point I beg to differ than them.

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Communication in quotes

"There are few human activities we value more, understand less, and perform worse, than person-to-person communication".

Robert M. Soucie 1979

The rules of writing by Thomas Jefferson "Don't use two words when one will do".

"The most important thing in communication is to hear what isn't being said".

Peter Drucker American (Austrian-born) management guru (1909-2005)

With thanks to **Joeyn Flauaus** (Joeyn-Flauaus@sanofi-aventis.com) for providing the quotes.

Linguistics corner

Current medical discourse research

The Linguistic corner aims to publish abstracts of papers related to oral or written medical discourse of interest to the *TWS* readership. Abstracts are numbered consecutively to build into a series that can be saved as a collection. Contributions should be in English but can relate to papers published in other languages. Francoise Salager-Meyer invites you to send abstracts to her at: francoise.sm@gmail.com.

An emerging medical genre: The research letter

The research letter may go some way towards resolving the dilemma facing authors who are keen that their research reaches audience quickly but also need to clock up peer-reviewed publications in high impact factor journals for their curriculum vitae (for more on this dilemma see 'Why do researchers publish their findings' on page 257)

Abstract 4

Maci, Stefania Maria. Forthcoming. An emerging medical genre: the research letter. In Di Martino, Gabriella / Polese, Vanda / Solly, Martin (eds) Identity in English Domain-Specific Discorse. Naples: Edizioni Scientifiche Italiane.

Progress in medical research is accelerating at a rate that is becoming faster and faster. The proliferation of research articles (RAs) and new specialised medical journals reflects this trend. However, authors who would like to publish their research papers in international specialized journals with high impact factors have sometimes to cope with editorial limitations. The time-span between submission of the paper and its publication may be 6 or more months: this, in scientific terms, is an enormous amount of time. Editors of the most important international scientific journals such as *The Lancet* (I.F. 21,713), and *The Journal of American Medical Association* (I.F. 24,831) have recognised this problem and have decided to solve it by introducing an new genre: the research letter (RL).

RLs are indeed *letters* in the sense that they formally address the editor. Yet they do not follow the canonical structure of the letter genre, since they are scientific primary documents. RLs do not seem to differ from research articles in that they are precisely organised according to the Introduction-Method-Results-Discussion (IMRD) sections. Nevertheless, the rhetorical strategies used by the authors of research letter are slightly different: because the text is shorter, the author is obliged to be more direct. In particular, as the conclusion of the RL usually occupies the last 4-6 sentences of the paper, its author needs to adopt slightly different rhetorical strategies to convince her/his readership of the correctness of the theory that is being postulated. To do so, a different behaviour in linguistic terms has been identified, according to whether RLs are published in the US or in the UK. In the British version, the RL author seems to use hedging devices from the *Results* section onwards; in the American version, the RL author firmly adheres to the standard RA sections and uses hedges in the *Discussion* section only. However, in both UK and US RLs, over 65% of the hedges are expressed by one single verb, i.e. *suggest*, which indicates that here the most exploited hedging devices are lexical markers. Positive findings are never openly declared as the authors' responsibility: results, findings and data *suggest* the conclusions to which the authors have arrived, as if the author is simply a narrator giving voice to the result of the experiment. The statements introduced by *suggest* are rendered as more cautious, more in tune with scientific writing. This is clearly an attempt to avoid both negative face threats (to gain consensus from the scientific community) and future research attacks proving the present research wrong. In any case, hedging in RLs published in the UK and the US reflects both the rhetorical and conventional procedure of scientific discourse and the realisation of the perlocutionary function (i.e. the effect or consequence of a communicative event on the addressee which may exert a certain degree of influence on her/him) of a speech act [1] in which the author, while maintaining objectivity, reports what data *have revealed*.

Reference:

1. Salager-Meyer, F I Think that perhaps you Should: A Study of Hedges in Written Scientific Discourse, 2006. Available at www.exchanges.state.gov/education/engteaching/pubs/BR/functionalsec3_8.htm [02/05/2006].

Call for volunteers to participant in design of journal pages experiment

Professor James Hartley at Keele University, UK, is planning some experiments on the design of journal pages and is looking for volunteers to take part. Participants will be asked to compare two different typographical layouts and rate them on various measures. If you are willing and able to help, please send him a message to this effect at: j.hartley@psy.keele.ac.uk.

British libel laws threaten open debate in science—but things might change

The threat—and implementation—of libel actions in the UK against doctors and journalists who criticise manufacturers of medical products is endangering public debate by scientists and is contrary to public interest according to Richard Dawkins [1]. He told the Liberal Democratic conference in Bournemouth that scientists should settle their difference in the laboratory, not in court. He also criticised British libel laws saying that London had become the libel capital of the world. These comments were no doubt sparked by the cases brought by the British Chiropractic Association against the *Guardian*'s science reporter Simon Singh and by NMT Medical's case against Peter Wilmshurst. (NMT Medical is an American company suing in the UK for comments made in an American journal.)

A recent debate at the City University London also called for reforms. Here the point was made that journalists' fear of being sued results in publication of articles that have been gutted of content or prevention of publication of many articles—"even the *BMJ* uses a lawyer on a weekly basis". Singh, who took part in the debate, pointed out that even when the truth is reported lawyers may advise against the risk of defending the action, especially because a successful defence is likely to leave the defendant severely out of pocket with legal costs [2].

The Liberal Democrats have put forward three main proposals for reforming libel laws. The first is that the burden of showing that there has been a libel should be shifted to the plaintiff as is the situation in the USA where the party who challenges a statement has to prove that it is false or malicious. Currently in the UK it is the defendant who has to prove that the statement is not libellous. The second proposal is that the jurisdiction of the British courts should be narrowed and finally that the costs of libel cases, which have been escalating and cause many defendants to cave in rather than to fight a case, should be cut. But there are already signs of moves that will favour publishers. A new costs regime took effect on 1 October (http://www.justice.gov.uk/news/newsrelease240909a.htm) and a consultation paper on the multiple publication rule, which as it stands means that effectively there is no limitation period for online libel, has been posted at:
http://www.justice.gov.uk/consultations/defamation-internet-consultation-paper.htm

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Pharma company sues principal investigator for libel

A joint principal investigator in a trial sponsored by NMT Medical, Peter Wilmshurst who is a heart specialist at the Royal Shrewsbury hospital in the UK, refused to sign a copyright transfer agreement and was therefore not listed as an author on a paper submitted to *Circulation* [1]. He criticised the conduct of the study and as a result of considerable correspondence with *Circulation*, a corrected version of the paper, on which Wilmshurst is still not listed as an author, has been posted on their website. NMT Medical is suing Peter Wilmshurst for libel relating to comments he made in a lecture criticising the trial which were published on http://theHeart.org.

References:
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Duplicate/overlapping publication guidelines

BioMed Central has recently announced duplicate publication guidelines for journals published by its publishing group. The guidelines, which can be found at http://www.biomedcentral.com/info/about/duplicatepublication, set out a useful table of permissible and non-permissible forms of duplicate/overlapping publication. Any publication planners looking to produce as many articles as possible from clinical trial results should note that, like many other journals, BioMed Central journals require that any potentially overlapping publications should be declared on submission because they reserve the right to judge potentially overlapping or redundant publications themselves on a case-by-case basis.

Of interest in relation to the box on page 224 on publication of presentations at scientific conferences is that under the heading 'Incomplete manuscript Abstracts/posters' the guidelines specify that "Manuscripts resulting from abstracts and posters presented at, or published as part of, academic meetings represent a formal advance to the citable scientific record and therefore should be considered for peer review. Published abstracts should be cited."

Biomedical publishing shorts

Why do researchers publish their findings?

The answer is surely that they are motivated by a desire to communicate knowledge and increase understanding of the world we live in. But this is not a complete answer—not least because publication is used to assess a researcher's performance and governments and funders are increasingly keen to demonstrate social and economic returns on their investment.

A recently published report[1] found that researchers use publication to register their claim to the work they have done and gain peer esteem together with the benefits that flow from it. Specific requirements from funders, institutional guidelines and pressure from collaborators are less influential. In other words, career advancement is the most important influence and therefore the manner of performance assessment is the driving force in publication behaviour. But how do researchers feel about this and is the current method of assessment good for research and society?

The report titled 'Communicating Knowledge: How and why UK researchers publish and disseminate their findings' was commissioned by the Research Information Network and the Joint Information Systems Committee. The prime aim of the work was to find out how and if researches' decisions on publication and citation are influenced by considerations arising from research assessment. The investigation covered the humanities and sciences and used a literature review, bibliometric analysis of a sample of published research, and interviews and a survey of researchers.

Researchers can disseminate their findings through books, journal articles, conference presentations and by the less formal means of web-based tools for social networking.

The report found that because journal articles can be more easily measured, ranked and assessed they are increasing in number and importance over other forms of dissemination. However, many researchers are unhappy with the dominance of journals and feel that too much pressure is exerted on researchers to publish too much, too soon. Dependence on journal article publication for assessment was also felt to restrict movement into new areas of research by individual researchers because of the time it takes to build up a portfolio of publications within the field of expertise.

Relatively few researchers disseminate their results through web-based tools, i.e. open access repositories, blogs, and wikis. The main influence for those using repositories is the moral obligation they feel to reach their audiences quickly, e.g. researchers in cancer, nursing and midwifery are keen to make their material accessible to staff on the ground as quickly as possible. Fewer books are being written and proceedings from conferences were likewise unpopular because of the low status attached to them.

As for citation behaviour, some researchers concentrate on the quality of the work, others cite authors they respect. Very few authors receive training on how to cite. Access to material online has facilitated finding material but the report pointed out the risk that researchers will only cite what they can find easily online or will cite material that they have not read properly. A third of the researchers in the life sciences said that easy accessibility has a major influence on what they cite and this proportion was even higher among young researchers. As young researchers were also found to primarily cite based on their knowledge of the author and standing of the journal, citation behaviour is likely to change in the future.

The report concluded that more publications, especially in high impact journals, but a greater tendency for researchers to make their work open access will flow from a proposed assessment system based on analysis of citations to incorporate the socio-economic impact as well as research quality. Citation practice will also change if publications are directed beyond the research community to audiences that place less value on citation because researchers will be more reluctant to site competitors' work.

TYOS (Type Your Own Script) for non-native speakers

A significant proportion of the research articles published in the world today is written by non-native speakers (NNS) from non-Anglo-Saxon countries. While NNS scientists may have sojourned as PhD students in an Anglo-Saxon country, they are likely not to possess oral communication skills fully equivalent to those of a native speaker. On the other hand, their written scientific English, although recognisably not of native-speaker origin, may well reach a sufficient level of accuracy to be accepted for publication

1 http://www.rin.ac.uk/communicating-knowledge

in the international journals of their specialty. Moreover, owing to interlanguage, the phenomenon whereby the members of one language group such as the French are likely to commit similar errors when they write or speak a foreign language such as English owing to interpenetration between the two languages, it paradoxically becomes profitable in learning terms to take NNS productions and to transform them didactically into learning material for particular NNS target groups such as NNS scientists. It is this hitherto largely disregarded approach that TYOS adopts by highlighting the errors committed by Francophone scientists and transforming them into learning input.

The objective of TYOS is to process a small corpus of texts covering several disciplines (medicine, biology, biochemistry, wine science, dentistry, psychology, pharmacology) encompassing the various genres written by NNS researchers (articles, abstracts, case reports, letters, replies to reviewers, responses as reviewer). The corpus comprises the corrected first drafts of Francophone researchers, not their finally published texts. The rationale and construction of TYOS have been previously described[1]. The designers of TYOS believe that this small corpus of 'acceptable English'—acceptable in that the drafts were subsequently accepted for publication after further in-house editing from the sub-editors of the journals to which the drafts were submitted–can be used to illustrate how scientific writing functions. The typical language errors of the first drafts can be exploited pedagogically and compared with the text editors' corrections and reformulations. The learner's attention can then be drawn to typical features such as discourse moves, frequently used expressions, verb forms, link words and grammar and vocabulary points that the designers consider noteworthy. In this way, it becomes possible for users to guide themselves as they write. Special attention is paid to the structure of the sub-genres that classically pose problems for NNS scientists, i.e. introductions and discussions.

With thanks to **Ray Cooke** (ray.cooke@u-bordeaux2.fr) for providing this information.

More information is available at www.tyos.org

1 R. Cooke & S. Birch-Becaas, Help on the spot: online assistance for writing scientific English, in *LSP and Professional Communication*, Vol 2, Winter 2008.

New PhRMA principles include stipulations on ghostwriting and registration of clinical trials

The Pharmaceutical Research and Manufacturers of America (PhRMA) released new 'Principles on Conduct of Clinical Trials and Communication of Clinical Trial Results on 1st October 2009. The key issues covered by the principles are protecting research participants, conduct of clinical trials, ensuring objectivity in research and providing information about clinical trials. The principles address authorship contributions and ghostwriting, disclosure of conflicts of interest, registration of clinical trials and publicly assessable 'summaries' of all clinical trial results. Compensation for investigators and restrictions on gifts to people not involved in studies are also tackled. The principles aim to increase transparency, enhance standards for medical research authorship and improve the process and management of conflict-of-interest disclosure.

The authorship recommendations will be of particular interest to medical writers. The principles endorse the ICMJE authorship criteria (www.icmje.org) and state that individuals who do not meet these criteria do not warrant authorship. They stipulate that authors should identify individuals who provide writing and other assistance and disclose the funding source of the assistance. Authors must also describe the role of the study sponsor, if any, in study design, the collection, analysis and interpretation of data, as well as in the writing of the report and the decision to submit the report for publication. People who help analyse and interpret data, produce manuscripts and presentations must act in conjunction with the investigator author and be named as an author or acknowledged, depending on their level of contribution.

All authors should be given the relevant statistical tables, figures and reports needed to support the planned publication.

A report on The heart.org states that Harlan Krumholz, who is well known for his articles on ethics and the industry, was disappointed that the principles fail to deal with 'seeding trials' but he thought in general industry is on the right track to regain some of their lost reputation. The test, he said, is going to be if they can adhere to them. There are no penalties for failing to comply with the recommendations.

Sources: Principles on Conduct of Clinical Trials Communication of Clinical Trial Results. Available at: www.phrma.org/files/042009_Clinical%20Trial%20Principles_FINAL.pdf

New "principles" on authorship and COI from PhRMA get mixed response. October 2009. Available at: http://www.theheart.org/article/1010093.do

Biomedical publishing shorts

Double-blinded peer review to combat bias but are papers written by woman less likely to be accepted than papers written by men?

Single-blinded peer review is where reviewers are aware of the identity of the authors but authors are not aware of the identity of the reviewers. Double-blinded peer review is where the reviewers are also not aware of the identity of the authors. A recent survey found that 58% of reviewers would be less likely to review if their signed report were published. 76% favour the single blind system where just the editor knows who the reviewers are [1]. Double-blinded review therefore has not found great favour with reviewers or journals. However, the single-blinded review system appears to be open to bias.

A study in 2006 on the effect of double-blinded peer review found that as a result of concealing the identity of authors and their institutions from reviewers of abstracts submitted to the American Heart Association's Scientific Sessions the number of abstracts accepted from non-prestigious institutions, from non-English-speaking countries and from countries outside the USA significantly increased. Whether the author was male or female was found to have no effect on the likelihood of abstract acceptance. The researchers believed that their findings could be extrapolated to acceptance of manuscripts by biomedical journals [2].

However, research by Amber Budden and colleagues published in 2007 found bias against female authors in the field of ecology [3]. The journal *Behavioral Ecology* introduced a double-blinded peer review system in 2001 and Budden and colleagues did a comparative case study of the consequent effect on author demographies. The journal *Behavioral Ecology and Sociobiology*, in which reviewers are aware of authors' identities but authors are unaware of the reviewers' identities, served as the prime comparator. The journals have a similar subject matter and impact factor. The researchers found that while the proportion of papers published in *Behavioral Ecology* with women as first authors statistically significantly increased (by 7.9%) in the 4 years following the introduction of double-blind peer review no similar increase occurred in *Behavioral Ecology and Sociobiology* or four other journals in the field that used the single-blinded review procedure. The increase was 3 times more than the increase in women graduates in the field over the same period and resulted in a better representation of the proportion of women and men in the field.

The two studies are particularly interesting because inter-disciplinary differences in the proportion of papers published by women would predict that women would suffer more bias in cardiology, where the relative proportion of men is higher than in ecology. However, even within a discipline journal level variation may arise from variation in the editorial board, reviewer selection etc. and this is something that Budden and colleagues are interested in looking at (Editor: personal communication).

References:

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2. Ross JS, Gross CP, Desai et al. Effect of Blinded Peer Review on Abstract Acceptance. *JAMA.* 2006;295(14):1675-1680
3. Budden AE, Tregenza T, Aarssen LW, Koricheva J, Leimu R, Lortie CJ. Fouble blind review favours increased representation of female authors. *TRENDS in Ecology and Evolution* 2007; 23(1):4-6.

The PRISMA Statement for systematic reviews

The QUOROM Statement has been replaced by a new guideline called the PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) Statement for reporting systematic reviews and meta-analyses http://www.prisma-statement.org/. Journals and other organisations are being encouraged to update their instructions and resources to refer to these new guidelines. Medical writers should also be aware of this change. The PRISMA Statement consists of a 27-item checklist and a four-phase flow diagram. Papers on the PRISMA guidelines have been published simultaneously in several journals (in short and long versions) including *BMJ, Journal of Clinical Epidemiology, Open Medicine, Annals of Internal Medicine.*

Beate Wieseler has coauthored an excellent paper on reporting a systematic review which includes advice on how to follow the PRISMA statement. The paper will be published by *CHEST* in its Medical Writing Tip of the Month section, which is available online without subscription (www.chestjournal.org/cgi/collection/mwt). Contact Beate Wieseler (beate.wieseler@iqwig.de) for information on the expected date of publication.

Negative effects of guest/ honorary authorship

A survey of corresponding authors of research papers published in *the Journal of the American Medical Association, Canadian Medical Association Journal, British Medical Journal* and *Lancet* found that 52% had had honorary co-authors at some point in their career. Most of the corresponding authors thought that there were potential negative effects of honorary authorship on the honorary authors and on their co-authors such as personal liability for honorary authors and dilution of co-authors perceived contributions to papers. 62% felt that honorary authorship could have a negative effect on patient care. The authors of the survey concluded that more research on the influence of honorary authorship on patient care might help to curb its practice.

Source: O'Brien J, Baerlocher MO, Newton M, Gautam T, Noble J. Honorary Co-authorship: Does It Matter? *Can Assoc Radiol J*. 2009 Oct 8. [Epub ahead of print]

Effect on scientific integrity of pressure to obtain research funding

A survey mailed to biomedical and social science faculties at US universities revealed that the pressure to obtain outside funding from the public or private sector was associated with statistically significantly higher reports of 1 or more of 10 misbehaviours and neglectful or careless behaviours. Researchers with private industry funding were more likely than were those without to report 1 or more of 10 serious misbehaviours (28.5% vs 21.5%) and to have engaged in misconduct (12.2% vs 7.1%). The authors of the survey concluded that the intense competition for research funding may be undermining scientific integrity.

Source: Martinson BC, Crain AL, Anderson MS, De Vries R. Institutions' expectations for researchers' self-funding, federal grant holding, and private industry involvement: manifold drivers of self-interest and researcher behavior. *Acad Med*. 2009;84(11):1491-9.

COPE newsletter now Open Access

The Committee on Publication Ethics (COPE) launched a news letter at the beginning of this year. The Committee have recently made access to the newsletter freely available on their website at http://publicationethics.org/newsletters. The theme of their fourth and latest issue is 'Research'.

New ICMJE standard conflict of interests form

The Vancouver group is a group of editors of general medical journals which originally formed to produce guidelines for the format of manuscripts submitted to biomedical journals. Manuscripts that complied with these guidelines would not be returned to authors without peer review on grounds relating to format. Since the guidelines were first published in 1979 the group, now known as the International Committee of Medical Journal Editors (ICMJE), have expanded their remit to include issuing guidance to editors on ethical principles related to biomedical journals.

Many journals require authors to disclose financial associations which they have with the subject matter of their articles that *might* cause them to have a conflict of interest which would bias their interpretation of the results or affect their opinions expressed in the article. Until now there has been no standard form for reporting financial interests and the information requested of authors varied between journals. The lack of uniformity burdened authors with additional form filling and could lead to confusion when the same person was required to report different information to different journals. The ICMJE have now produced a standard form which can be downloaded from their website (www.icmje.org/coi_disclosure.pdf). Authors are required to disclose four types of information:

- their associations with commercial entities that provided support for their work reported in the submitted manuscript
- their associations with commercial entities that could be viewed as having an interest in the general area of the submitted manuscript
- any similar financial association involving their spouse or children under 18 years of age
- non-financial associations that may be relevant to the submitted manuscript

The advantage for authors is that once they have completed the form they can use it for any journal that adheres to the ICMJE guidelines. Comments about any problems that might be experienced by users of the form, which should be submitted to the ICMJE website, are invited up to April 2010.

Source: Drazen JM, Van Der Weyden MB, Sahni P, Rosenberg J, Marusic A, Laine C, Kotzin S, Horton R, Hébert PC, Haug C, Godlee F, Frizelle FA, de Leeuw PW, DeAngelis CD. Disclosure of competing interests. *BMJ* 2009;339:874-875 (this editorial was also published in other journals).

Words, Grammar & Co

Watch their words

More than what is immediately apparent might lurk behind an author's choice of words. The preliminary results of two research projects on 'spin' in the reporting of research results were presented recently at the Sixth International Congress of Peer Review and Biomedical Publication. One team found that 40% of the 72 reports of randomised controlled trials they examined used linguistic 'spin', e.g. "[The treatment] is expected to be a very important modality in the treatment strategy" and, "[The treatment effect] approached but did not achieve conventional statistical significance. [1]" The second presentation was of a quantitative study of the language used in reports of 35 randomised controlled drug studies [2]. 49% of the statements in the reports claiming an effect did not mention statistical significance. The word 'significant' was only rarely used in statements that claim the drug's safety.

The concept of a hidden agenda working on the reader's subconscious through word choice is exemplified in the BBC News report titled 'Lesson one: no Orwellian language' [3]. The report was about how education has been taken over by a language directed at controlling the way we think and act. It arose from Professor Richard Pring's speech at an education conference in the UK at the beginning of last year. Pring was protesting about the language of management, which has permeated discussions about education. He pleaded for people to talk again about 'teaching' rather than 'delivery', 'schools' instead of 'new providers'. Expressions such as 'efficiency gains' 'funding systems that respond to customer demand' clearly indicate that education is no longer seen as personal enrichment but merely as preparing fodder for the workforce.

Sensibilities are another influence behind word choice. Hence the word 'gender' rose to prominence on the back of prudish dislike for the word 'sex'. Even level-headed scientists have adopted the (wrong) word [4]. I have a suspicion that authors reporting animal studies jump through the hoops of avoiding the word 'kill' by using such inappropriate words as 'sacrifice' or 'euthanise' to give the impression that the animals were not really killed in these experiments.

How about this change that was required to be made to a presentation about communications agencies? One of the services that communication agencies provide was written as 'Key opinion leader development' but changed to 'Thought leader education' so as not to infer a desire to influence a medical professional to endorse a product.

And what is the difference between a 'code' and a 'set of recommendations'? The American delegation at an annual forum of the World Health Organisation objected to a resolution calling for the development of a code that would promote responsible marketing to children of foods and beverages that are high in undesirable fats and sugars [4]. Codes and recommendations are both voluntary but the Americans thought 'code' could possibly be construed as binding.

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Academic writing: Do you ever read your prose aloud?

Gail Hornstein likes gardens and vegetables—and writing. She agrees in her article 'Prune That Prose'[1] that you can get away with prose that is lifeless, "cumbersome to read, filled with unnecessary complication, often disdainful and strictly obscure in style and tone"—yes, she's talking about academic writing—if your audience is other academics who will read your work even if it is impenetrable. But she questions whether the abstruseness makes academics seem irrelevant at a time when they are increasingly being called upon to justify their work.

Hornstein maintains that the contempt academics have towards writing in a way that would be accessible for the broader public is in reality contempt for the ordinary reading public. She does not accept that the public are unable to understand science unless it's 'dumbed down', arguing instead that popular audiences are tougher than fellow academics because unless you say something important they lose interest and do something else, like play video games or watch TV.

The article describes her struggle to unlearn the academic writing skills she had been forced to acquire. One of the

1 http://chronicle.com/article/Prune-That-Prose/48273/

hardest lessons, which she likens to thinning a bed of carrots, was to make choices "something that academic writing allows you to avoid at all costs. Much of what makes that kind of prose so complicated is that nothing gets left out" whereas for a popular audience you have to "figure out what the hell you're trying to say and come right out with it."

With thanks to **Ursula Schoenberg** (u.schoenberg@t-online.de) for alerting *TWS* to this article.

There's more to metaphors than meets the eye

Drake Bennett of the *Boston Globe* has been hot on the trail of research that tests the links between metaphors and their physical roots [1]. Metaphors reveal the extent to which we think with our bodies. The argument is that we think with our brains, and our brains are part of our bodies. For instance, we associate power with elevation ('friends in high places'), and so we unconsciously look up when we think about power.

Psychologists have been studying the relation between abstract thought and physical experience. For example, in one study in which participants were asked to estimate the value of several foreign currencies, the participants were given questionnaires on clipboards of two different weights. The participants who completed the questionnaires on the heavier clipboards not only judged the foreign currencies to be more valuable; they also gave more careful, considered answers to the questions they were asked.

The research has naturally turned to how physical manipulation might be used to influence our thoughts. Nils Jostmann, the lead author of the clipboard-weight study, suggests that pollsters might consider using heavier clipboards and heavier pens for issues where they want considered answers, and lighter ones for questions to which they want gut reactions.

It's early days for this research, but next time someone hands you a hot drink before asking for your opinion on an important matter, it might be wise to put the drink down before you give your answer.

Wendy Kingdom
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Reference

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Would it be good/bad if English were the only language spoken in the world?

An article in *BBC Today* asks what is lost when a language dies. Currently 7,000 languages are spoken but 6% of the world's languages are spoken by 94% of the world's population. One prediction is that with the increasing extinction of languages 90% of the languages spoken today will disappear by 2100.

Claude Hagege, a French linguist, says that "If we are not cautious about the way English is progressing it may eventually kill most other languages." The main loss when a language becomes extinct is that the culture which goes with it is also lost: a way of expressing relationships with the world around us and our kith and kin. There is also a close link between language and identity, so that when people perceive their language as useless they also see their own identity as having little value leading to social disruption in these communities. The article gives examples of languages that have been successfully revived; Welsh, Maori and Hebrew. Hebrew was a dead language at the beginning of the 19th Century, existing only as a scholarly written language without words for such mundane phrases as "I love you". Now Hebrew is in everyday use, but one reader commented that this was at the expense of Yiddish and Ladino (Judaeo-Spanish), which used to be vibrant Jewish languages.

Many respondents to the article felt that languages that are dying out should just be catalogued for the interests of linguists. Some pointed out that a single language (English) had many economic advantages for the world and that, as one person wrote, "Most of the problems in the world stem from a lack of communications. If we all spoke English then these problems might disappear." On the other hand as another correspondent who grew up in the US speaking German wrote "My father always asked us if we were richer having two dollars or one dollar. He said the same was true of language."

Source: http://news.bbc.co.uk/today/hi/today/newsid_8311000/8311069.stm

It's English and its apostrophes again

An extract from an email sent out by the Recruitment and Events Officer at Bristol University on 15 September 2009 could leave you wondering about the standard of English education you might expect to receive at the university:

"As we hope you are aware, the University will be holding it's second university-wide Open Day on Friday 18 September 2009 from 10 am - 4.30 pm."

With thanks to **Neville Goodman** (nevwgoodman@mac.com) for alerting *TWS* to this grammatical howler.

Words, Grammar & Co

A good style site with some entertaining articles

The Economist has a style guide online to help you improve your writing. The site has some good advice, even for medical writers. The URL for the site is www.economist.com/research/styleguide/

There is also an expanded hardback version of the guide that can be purchased through the site. Explanations in the online guide are short and arranged under headings including, Unnecessary words, Metaphors, Capitals, Plurals, Punctuation, Spelling and so forth. I particularly like the Dos and don'ts section and its treatment of 'case' and when '-ee' should not be added to the end of words, e.g. attendee. I am heartened by the recommendation to avoid 'relationship' and use the word 'relation' instead. 'Relation' is shorter than 'relationship', which as I understand it is something that happens between human beings, not things.

Writers are advised to use words with care: "A heart condition is usually a bad heart. A near miss is probably a near hit. "Positive thoughts" (held by long-suffering creditors, according to *The Economist*) presumably means optimism, just as a negative report is probably a critical report. Industrial action is usually industrial inaction, industrial disruption or a strike."

The capitals section is extensive, even covering e-expressions, most of which are lower case. The forward to the section states that the rules laid down leave some decisions to individual judgment. If in doubt, lower-case initial letters should be used unless it looks absurd. This point is emphasised by reference to a delightful quote from Emerson: "A foolish consistency is the hobgoblin of little minds".

A link takes you to a column called 'Johnson' written by Stephen Hugh-Jones, which *The Economist* ran between 1992 and 1999. His tongue-in-cheek style is a joy to read and he covers a miscellany of topics from terms for females to quaint rules. Thus, we learn from him that it's rough these days being a preposition. He points to *on* and *over* as having become prepositions-of-all-work, driving poor old *about* almost into retirement. He also refers to the elegant distinction between *Compare to* which emphasises similarity and *compare with* which emphasises dissimilarity (probably here 'neutrality', irrespective of dis-/similarity, would be more accurate). This must be one of the most common mistakes I see in medical writing. Another word where the preposition makes all the difference is *contrast*; *In contrast* is simply unlike; *by contrast* implies unlike by comparison.

An article on words with opposite meanings starts with the classic *quite*. *Sanction* is another of these words and *table*, unbeknown to me, has a different meaning on the other side of the Atlantic: Congress tables an item that it does not want to discuss; Parliament tables one that it does. Watch out for trapeziums, which look very different to Americans. I rather like the *dead chuffed* example. Hugh-Jones explains that Partridge's magisterial dictionary of slang states that it can also mean *displeased*; indeed Partridge cites *dead chuffed* as used specifically in the *displeased* sense.

The last article in 1999 was in *The Economist*'s millennium issue and is about the world language. This is the final paragraph: "The web of course works both ways. An American has far better access today than ever before to texts in German or Polish or Gaelic. But the average American has no great incentive to profit from it. That is not true the other way round. The web may even save some mini-languages. But the big winner will be English." I wonder. There is some food for thought there.

Finally, there's a link where you can do a quiz based on *The Economist*'s style guide. It's called 'The write stuff' and asks if you've got it.

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Pronoun virus cause of restaurant cleaners' distress

Oysters, which can be contaminated with human sewage, were found to be the cause of the vomiting and diarrhoea suffered by 529 patrons and staff of Heston Blumenthal's world-famous Fat Duck restaurant in the UK. It was one of the largest outbreaks of norovirus reported in medical literature. *The Guardian*'s report of the incident on 11th September 2009, in which they referred to the 17 members of staff who had reported symptoms, included the following sentence:

"One even vomited in the restaurant toilet, though happily it was closed at the time."

Whether the restaurant cleaners were happy that the toilet lid was down at the time is perhaps questionable.

With thanks to **Tim Albert** (tim@timalbert.co.uk) for alerting *TWS* to this interesting sentence.

Gained in translation

Science at the multilingual crossroads

In this issue's translation section, we learn how a Spanish biomedical journal—and its Spanish-to-English translators—deal with the challenge of making Spanish-language content available to an international audience. The editors of *Actas Dermo-Sifiliográficas* have committed themselves to continuing the journal's centenary tradition of publishing in the country's common vernacular language, Castilian. Since 2007, however, articles indexed in Medline have also been translated into English.

The case study by Iain Patten and Greg Morley is a best-practice example of a team of translators working together to produce high-quality output. What makes their approach stand out is the experienced project coordinators themselves not merely managing but being part of the translation team and all team members being able and willing to freely interact with each other.

Also, this case study impressively illustrates the powerful concept of a *lingua franca*: through English translation, a journal originally targeted to an exclusively Spanish-speaking readership becomes accessible not only to the Anglophone world but to specialists around the globe—from France to Japan, from Norway to India, from South Africa to Greenland.

The Encyclopædia Britannica defines translation as "a continuous concomitant of contact between two mutually incomprehensible tongues and one that does not lead either to suppression or extension of either" [1]. Indeed, one argument in favour of publishing research in authors' native languages rather than in English is to allow vernaculars to continue to develop as languages of modern science. Conversely, it is only fair to expect that the English translation be of high linguistic quality to make sure that English, today spoken and written by more non-native than native speakers, does not itself fall prey to globalisation. The team-based approach described below appears to guarantee both.

"Language", the afore quoted encyclopaedia tells us, is a system of conventional "symbols by means of which human beings, as members of a social group and participants in its culture, express themselves. […] Even between the languages of communities whose cultures are fairly closely allied, there is by no means a one-to-one relation of exact lexical equivalence between the items of their vocabularies" [2]. Should you now be searching for an example, look no further: Diana Epstein gives a taste of some of the linguistic idiosyncrasies of 'Glaswegian', which have even lead to Glaswegian-to-English interpreters being in high demand.

We are also in this issue given the honour of the last of three visits by Señor y Señora Malaprop, whose lexical concoctions are again expertly transposed into proper Spanish by Fernando Navarro in the last of his three-part series on medical malapropisms.

Finally, there's an immensely reassuring bit on machine translation, proving once more that human translators will remain indispensable for some time to come. Overall, therefore, the Italian saying *Traduttore traditore,* "The translator is a traitor", is only half true at best.

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Patientspeak: A Spanish-English glossary of lay medical malapropisms—Part 3

by Fernando A. Navarro

Malapropisms are common among patients with scant formal education when attempting to pronounce technical terms they have never seen in writing. Such malapropisms do not, however, normally pose any particular difficulty in conversations between native speakers of the same language. The experienced English-speaking physician will readily recognize in nonsense expressions such as *Low Overall*, *moral reflex*, *sick-as-hell anaemia*, *TV test* or *watery tension* a medically unsofisticated person's version of *Lo/Ovral*, *Moro reflex*, *sickle cell anaemia*, *TB test* or *water retention*, respectively.

The situation is much more complex when two languages are involved. English-speaking physicians or interpreters may find it extremely difficult to understand what Spanish-speaking patients mean by phrases such as *desarrollo ciclomotor*, *riesgo sanguíneo*, *tic cerebral*, *traca de tórax* or *vagina urinaria*.

Translators, interpreters, and healthcare professionals working in settings involving Spanish as one of their working languages can now draw from an extensive Spanish-English glossary which lists nearly four thousand medical malapropisms frequently used by Spanish-speaking patients. This glossary is designed to be easy to use so that readers can go straight to the word they want. Its structure, marks and style labels were explained in a previous article published in the June 2009 issue of *TWS* [18(2):149-150].

The third and final part of the glossary, covering the letters from N to Z, has now been made available on the EMWA website at www.emwa.org/Journal-public.html.

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Challenges of bilingual publication—Translating a Spanish biomedical journal

by Iain Patten and Greg Morley

In many areas of medical science, the link between career progression and research output measured in terms of publication success inevitably places pressure on authors to publish in high-impact journals. While many countries have increased their investment in research, the results are often likely to be first communicated outside of that country and in a language that most of the population, investigators included, do not speak proficiently. While international communication of research generally benefits the larger scientific community, efforts are needed to ensure that this does not create a publications drain away from its original source. One solution is to raise the international profile of local journals, usually by gaining an impact factor or increasing it. Success in this endeavour requires local journals not only to reach a wider audience but also to succeed in attracting extensively cited articles from within their own community. Although some authors may choose to publish their best work in a local society journal out of loyalty, it seems self-evident that a larger number would follow their lead if those journals were to have a high impact and strong international reputation. Breaking the circle of limited international prestige that makes it difficult to attract the highest quality work is clearly a formidable task.

When seeking to strengthen their international profile, journals from non-English-speaking countries are faced with a choice—publish in English, the current lingua franca for scientific publication, or take a bilingual approach to gain access to a wider audience while continuing to support the local scientific and clinical language. Strong arguments have been made for the importance of retaining a local language for a country's scientific output [1], and this is perhaps most apparent in the case of the clinical sciences. Advances in treatment must filter back as quickly as possible to the clinic, where the working language is unlikely to be English. Furthermore, policy makers might reasonably expect that a country is not held back in reaping the benefit of its own research effort. Preventing non-English-speaking countries, particularly those in the developing world, from being handicapped by the need to access research published primarily in English is a question for global policy makers [2], but local scientific societies have the power to ensure that their own output reaches both local and international audiences quickly and effectively.

A case study in bilingual publication

In the case of Spain, although the country spends a lower proportion of its wealth on research and development than many other European countries (1.27% of GDP in 2007 compared with 2.54% for Germany and 2.08% for France [3]), it still has a relatively large research community. This community is extended still further if we take into account Spanish-speaking countries in Latin America, which have both cultural and linguistic ties with Spain. Nevertheless, although Spain's scientific output has increased almost exponentially in the last 30 years, authors have largely favoured international English-language journals for publishing important research [4]. In an effort to compete, many Spanish journals have sought access to a wider scientific community by publishing their abstracts bilingually in English and Spanish, and many of these are listed on MEDLINE. More recently, however, some Spanish journals have introduced full-text translation of the articles destined to appear on MEDLINE. One such journal is *Actas Dermo-Sifiliográficas*, the official journal of the Spanish Academy of Dermatology and Venereology.

Actas Dermo-Sifiliográficas is currently celebrating its centenary year. It has been printed continuously since 1909, except for a brief pause during the Spanish Civil War, and is currently the primary dermatology publication in Spanish, attracting authors not only from Spain but also from Latin America. To increase the international profile of the journal, one of the stated aims of the editors is to obtain an impact factor [5], and at the beginning of 2007 they explored the possibility of English-language publication. Publishing solely in English was not considered an option, because aside from the cultural arguments outlined earlier for publishing in the native language, the editors were certainly not inclined to break with the journal's long and proud tradition of publication in Spanish. Bilingual Spanish–English publication was therefore necessary, the question now was how best to go about it.

Models for cover-to-cover translation

Evidently, bilingual publication requires cover-to-cover translation, or at least translation of those articles that are indexed in MEDLINE. This is not an easy task, and a number of different translation models, with varying degrees of complexity, have been used. Perhaps the simplest involves sending the articles to be translated by a single translator. While this approach may have certain benefits, for example uniformity of style and ease of contact between the journal and the translator, it is simply not feasible for larger journals. Even if an individual translator could handle the volume,

most freelance professionals would be wary of committing to such a large project with the consequence that almost all of their income would become reliant on a single client.

The volume of work would certainly not be a problem if the journal were sent to a translation agency, and this solution may be attractive to publishers because it allows translation to be seen as a 'black box' that requires no further action or interaction on their part. This black box may also be the source of problems, however. While the best agencies can reasonably be expected to review individual translations, poor translations—particularly of something as complex as a research article—may not be easy to salvage. Consequently, the final quality of the product is inevitably linked to the skills of the individual translators, and these may well vary according to availability. In Spain, many skilled and experienced medical translators have enough work from direct clients to mean that their availability for collaboration with agencies, which generally pay lower rates, can be sporadic at best. Even if an agency has access to a pool of top-quality translators, it may be difficult to maintain a strong, stable team over a long period.

But finding skilled and experienced translators is not the only challenge. Research articles are often highly complex texts that may be ambiguous or contain problems, such as inconsistencies or omissions, that have yet to be picked up in the publication process. Consequently, the only way to clarify the author's intended meaning, or resolve errors that have slipped through the net prior to translation, may be through a query, either to the author directly or via the publisher. In many cases, agencies discourage contact between the translator and the end client, and the conditions are not conducive to the kind of dialogue required to address problems in unclear and sometimes imperfect texts.

A team-based model

An alternative approach, pioneered in different Spanish journals by Mary Ellen Kerans and Karen Shashok, has a central coordinator responsible for developing a translation team and, depending on the model used, for implementing quality control procedures [6]. Given the reputation for quality gained by journals that had previously used a team-based translation model, and also the success of those journals in achieving and improving their impact factors, the editors of *Actas Dermo-Sifiliográficas* placed their faith in such a model, with a dedicated team of freelance translators and initially two coordinators who would share responsibility for interacting directly with the journal and publisher and for overseeing quality control through revision. Bilingual publication has now been continuous since 2007, with the English translations appearing free online via MEDLINE soon after publication of the Spanish articles, which are available in print and online.

Two features distinguish translation models such as the one applied for bilingual publication of *Actas Dermo-Sifiliográficas*—teamwork and dialogue. A key role of the coordinator is to establish a reliable translation team. This is an ongoing process that extends well beyond recruitment and orientation, and may involve additional aspects such as establishing and maintaining systems for sharing translation memories and other resources such as corpora [7], all of which aim to raise the overall quality of the product. In addition to assigning texts to the most appropriate translator (according to preferences, experience, etc.), the coordinator usually also translates for the team and is therefore familiar with the challenges the other translators in the team may be faced with. Unlike the situation normally found when working with agencies, in this model translators gain a strong sense of belonging to a group with a common goal. Teamwork not only extends the available pool of knowledge but also makes the translators feel more empowered and, in our experience, more likely to take pride in their work. The team becomes the first port of call for addressing doubts, and in most cases, group queries are sufficient to resolve them. When further clarification is required, either the translator or the coordinator will query the author (using a tested format and protocol to maximise the chance of getting a useful answer while not offending the sensibilities of the authors). In this model, lines of communication are deliberately opened—between individual translators and others on the team, between the team and the author of the article, between the coordinator and the journal, etc.—at all times to provide opportunities to resolve doubts and improve the quality of the published article [6].

Revision—The lynchpin of the model

By far the most important area of dialogue in this model, however, is during translation revision, which is a defining feature of the approach. All translations are revised before the final version is returned to the publisher. This includes texts translated by the coordinator—in the case of *Actas Dermo-Sifiliográficas*, having more than one coordinator/reviser means that all texts can be treated similarly. Rather than representing a unidirectional quality control step, revision in this case is an ongoing dialogue and may involve multiple stages before a final version of the text is agreed. The first round of revision may throw up doubts that were not addressed at an earlier stage. If these are not resolved easily by reviser and translator, they can be discussed by the group or they may necessitate an author query. This process takes time, and it is preferable for the coordinator/reviser to receive the translation some time before the deadline to return it to the publisher. The production process must therefore be established in such a way that sufficiently long timelines are allowed for translation. After the first revision, the text is returned to the translator for comment. We believe this is an important step—the coordinator/reviser is not infallible and may wrongly edit what appears an unusual turn of phrase or word that, on the basis of the translator's research, is actually the most correct rendering. Including translators in this revision loop also helps to make them feel more involved in the process, >

> providing further general motivation to do top-quality work (see Box). These revision loops will continue until both coordinator and translator are happy with the final version of the text. They also represent an opportunity for the coordinator to act as a mentor to individual translators, especially those with less experience—an investment that will pay ample dividends over time.

Revision is of course not unique to this model and indeed is the cornerstone of the recently introduced EN15038 quality standard for translation [8]. However, in most situations, including EN15038, this extensive dialogue between translator and reviser is far less likely to occur.

Practical implications and challenges

While we believe that this system can deliver the highest-quality translations, it comes at a cost. The coordination and revision work can be demanding and needs to be paid for, thereby increasing the total cost of the project (though we also note that, contrary to an agency, no percentage of the overall cost goes to the 'middle-man' figure). Without sufficient remuneration, it may prove difficult to retain coordinators, detracting from the stability that is necessary for such a set-up to be viable. Coordinator 'burn-out' can be a problem, although sharing the burden, as we have done for *Actas Dermo-Sifiliográficas*, can help. Translators should also be well paid to reflect the high demands placed on them, as their task often extends beyond the normal remit of the translator.

It is not only the translation team that faces substantial demands, however. Bilingual publication is more than simple publication of translations. Just as acceptance of an article for publication in a monolingual journal is far from the only element required to produce a final, corrected and formatted version in print or online, there are many elements beyond translation per se that must be effected in the English component of a Spanish–English bilingual journal. An example is in the preparation of article proofs. The style applied in English will usually differ from that in the other language—in *Actas Dermo-Sifiliográficas*, for instance, the English version uses American Medical Association style. Consequently, if the same typesetters and production editors are used in both versions of the journal, it may be difficult to strictly differentiate between the style conventions used in the local- and English-language editions. To help avoid errors, it was agreed that translators should proofread their own translations (a privilege not often afforded to translators in other settings, but one that usually benefits the final product).

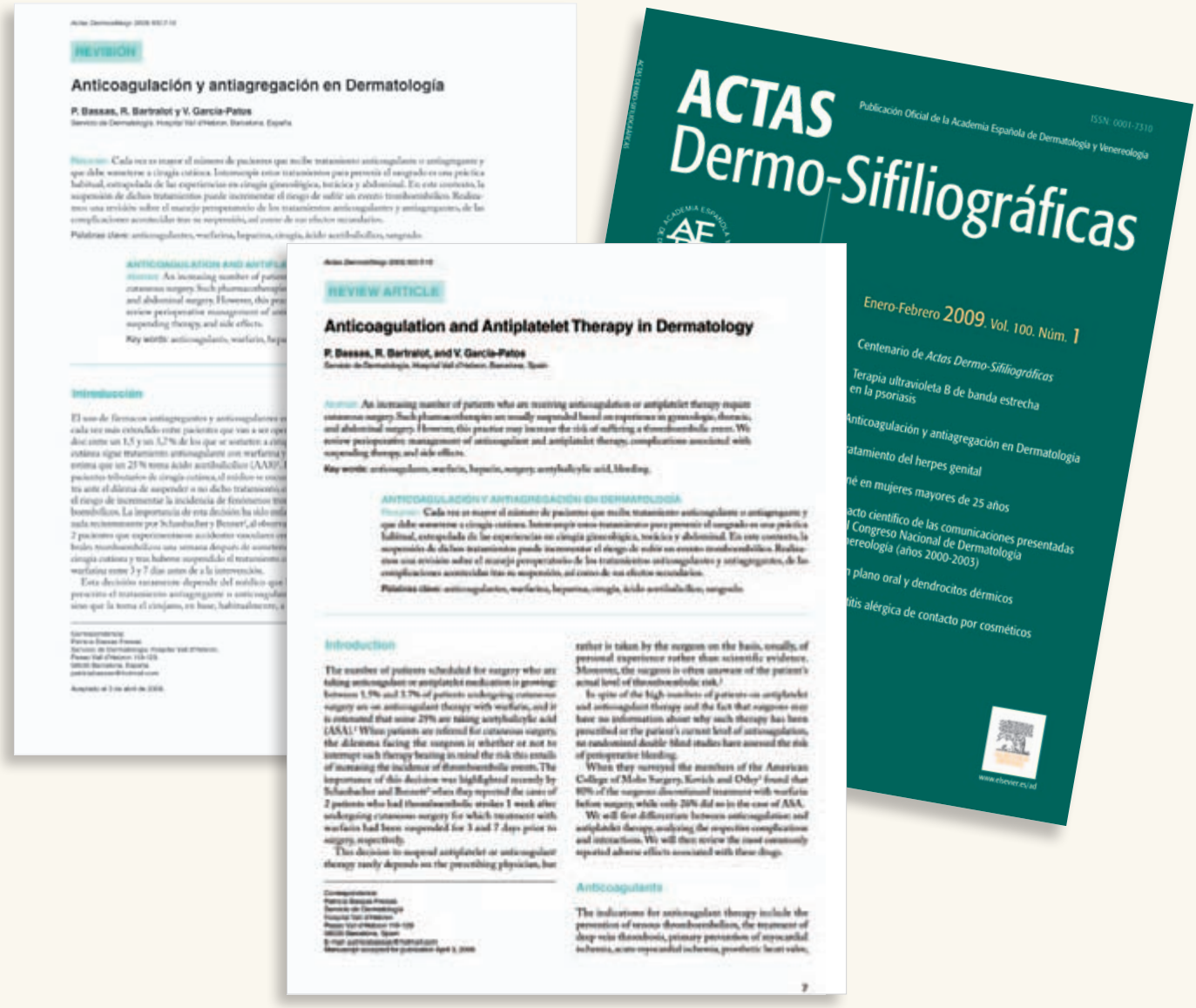
Publication processes are inevitably complex, and there are many points at which errors can be introduced. This is particularly the case, of course, when there are subtle stylistic differences between two versions of a bilingual publication. Consequently, the translation team, through the coordinator, tries to ensure that the publisher does not make any changes in the English version without prior consultation. But this requires a great deal of trust and flexibility on the part of both publisher and editors. Publishers will naturally be reluctant to allow anyone to interfere with processes that they have taken time to establish and they will be concerned not to introduce additional costs as a result of errors or time spent negotiating changes. Editors will also wish to ensure that the translators have an adequate grasp of the material to guarantee that apparently beautiful translations are not plagued with scientific inaccuracies. Although this may appear self-evident, some editors have bad experiences of poor translations and are understandably keen to oversee the process. Likewise, many translators also have experience of errors being introduced in good translations as a result of linguistic subtleties that may not have been fully understood by the person attempting to *correct* them. All these and other factors mean that developing trust between all parties is a key element in ensuring the success of a bilingual publication project. In the case of *Actas Dermo-Sifiliográficas*, we have been lucky to have had dedicated contacts with both the publisher and the editorial board. Discussing any potential issues as and when they arise is just one way to increase the likelihood of avoiding or resolving problems in a project of this type.

Bilingual publication—Beyond translation

As it enters its fourth year of bilingual publication, *Actas Dermo-Sifiliográficas* faces a new and interesting challenge. Following a publishing trend to make accepted articles available online as soon as possible, the translation team will no longer receive full issues of the journal in a single batch. Instead, articles will be received as and when they are available and translation timetables will not be so closely linked to a publication date. Although it remains to be seen how this will affect the translation process, it may provide an exciting opportunity for greater integration of the English and Spanish versions.

Bilingual publication is usually a two-tier process in which translation is seen as an additional step following the production of the original version in the local language. This is perhaps an understandable response to the problem created by adding a lengthy translation step into tight publication schedules. Rather than hold up publication in the original language, translations can follow as soon as possible after publication of the definitive original versions. However, this approach relies on the assumption that while the translation is dependent upon the original, the original is unaffected by the translation. Yet, the rigour required to achieve high-quality translations involves many of the same skills used in the traditional copyediting process (which has now all but disappeared from many publishing houses as a result of downward pressure on production costs). The translation team, who often read a text more closely than practically anyone else, may be ideally positioned to highlight errors in the original texts without any additional effort beyond that already required to produce a high-quality translation. For bilingual publication to be considered a truly valid model, however, errors should either be corrected in both languages or not at all. This requires that we either wait for both versions to be ready

Translating a Spanish biomedical journal



before finally going to print or risk the cost (financial and otherwise) of publishing errata.

Clearly the need for rapid publication must be balanced against the added value obtained from allowing the results of the translation process to feed back into the original articles. This requires careful negotiation of production schedules and processes. Some streamlining can be achieved by initiating translation while the finalised version of the source-language article is being laid out. However, there may be ways of improving the process further by shifting the conceptual focus towards a truly bilingual model, with translation as a central element. Technology is now becoming available, for instance, that will allow translators to work with the publication software used to lay out the articles for publication. This allows a formatted text provided by the publisher to be returned as a similarly formatted version in another language, thereby removing the need to typeset the translated articles from scratch. It remains to be seen whether such approaches could be applicable within the new production system to be used by *Actas Dermo-Sifiliográficas* or whether greater integration of the Spanish and English versions will be possible. In principle, publication of the articles as *early online* versions could allow greater scope for ensuring parity between articles in both languages before the final version in Spanish goes to print in the event that any changes are necessary. However, we will have to see what the future holds.

Conclusions

Bilingual publication presents a number of challenges. Producing high-quality translations is necessarily time-consuming and costly and so may be considered a luxury by some. When publishers and editors decide which model they wish to use for translation, they must clearly consider how important it is to them that the translation be of the highest quality, and whether they can afford the time, money and effort involved. The availability of new technologies, whereby translators can hand in formatted and typeset documents, may help streamline the publication process and save on production costs. Ultimately, the ideal approach is to see bilingual publication as a single process >

> in which both versions carry equal weight and publication processes ensure that both of their needs are taken into consideration.

Acknowledgements

We are indebted to Mary Ellen Kerans and Karen Shashok, pioneers of bilingual publication in Spain who have been valued mentors to both of us over the years. We are also grateful to all of the members of the *Actas Dermo-Sifiliográficas* translation team for their dedication and commitment and the publishers and editors of the journal for their willing cooperation.

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Revision makes for quality texts and translation experiences

As a freelance translator and new member of the *Actas Dermo-Sifiliográficas* translation team, I was asked to deliver a 20-minute presentation on my experiences of revision processes with agencies and direct clients at the Mediterranean Editors and Translators Meeting (METM) in Split, Croatia, in September 2008.

I trained in-house as a translator and editor for the Inter-Press Service (IPS) in Montevideo, Uruguay, and have worked for various Latin American NGOs including UNICEF-TACRO over the last 15 years. Since my return to the UK in 2000 I have also worked with a selection of European translation agencies.

The following questions formed the basis of my presentation:

1. Do you know for sure that your work for agencies gets revised?
2. Do you as a translator get any feedback about this revision process?
3. Do you have the opportunity to dispute a correction you think is wrong?
4. Are comments constructive? (Would they help you to make a better translation next time, or is there a lack of explanation?)

I looked at each of my clients—in two groups as agencies and direct clients—and simply answered 'yes' or 'no' to each question on the basis of my experience and the documentation provided by each client. I then tabulated the outcomes and totted up the number of positive responses.

Only six out of a potential 32 responses were positive for the eight agencies, whereas all 20 potential responses were positive for the five direct clients. The most striking difference was with questions 3 and 4, where the agencies provided no feedback except in the case of one direct error and one case where the agency allowed me to establish a direct working relationship with the client on my own initiative.

After a few years of working freelance for agencies I felt that I was largely left adrift, and the irregular workflow, low pay, tight deadlines, poor feedback and general insecurity discouraged me from pursuing further work with them. Meanwhile, direct clients tended to agree to more realistic deadlines, pay better and be willing to provide and accept professional feedback—all elements that form the basis of satisfying long-term working relationships.

My personal best case scenario has occurred with the *Actas Dermo-Sifiliográficas* project. All texts for translation are delivered with deadlines that allow time for thorough research of unknown concepts and terminology. We use the American Medical Association's style guide, our shared translation memory and a group internet dermatology searchroll (created by Iain Patten) to advise our choices, and any remaining doubts can generally be resolved by other members of the team—a group that includes medics, life-scientists and experienced professional translators.

Each text goes from the translator to the senior editor and back at least twice, allowing for respectful professional discussion of points of style and terminology. As a new medical translator I feel secure, supported and confident in my work. Many members of the team encounter opportunities for professional development on the project and in the group, and the end client receives a superior product as an outcome of our efforts.

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Original presentation available at
http://www.griffin-mason.com/pages/pub_art/revisions.pdf

Machine translations: It's a dog's life

Garry Jenkins has written a knol with the English title "Canine lifespans: Which dog breeds live longest—and why." He used the Google translation kit to translate the knol into German. The title in translation is "Canine Lebensdauer: Welche Hunderassen live Längste—und warum." This title in which the kit preferred the English 'live' to the German 'leben' is only the start of the idiosyncrasies.

The article begins with the interesting sentence in English, "The oldest dog on record was an Australian cattle dog called Bluey. He was put to sleep at the age of 29 years and 5 months." This sentence becomes even more interesting in German translation as

Der älteste Hund auf Rekord wurde ein Australian Cattle Dog namens Bluey. Er wurde zu im Alter von 29 Jahre und 5 Monate schlafen.

Apart from 'Rekord' in German primarily relating to sporting achievements and being a 'false friend' to the English 'record', literally back translated the sentence means, "The oldest dog on record became an Australian dog called Bluey. He became in the age of 29 years and 5 months to sleep."

In general it seems the longest living breed is the miniature poodle with an average lifespan of 14.8 years, but let's not digress. To continue with the translation: "Most canines, however, live considerably shorter lives than this. Scientists are constantly learning more about the factors that dictate the average lifespan of different breeds" in translation became

Die meisten Eckzähne, aber leben erheblich kürzer leben als diese. Wissenschaftler sind ständig mehr über die Faktoren die die durchschnittliche Lebensdauer von verschiedenen Rassen zu diktieren.

Literally back translated the sentence means, "The most canine teeth, but live considerably shorter living than these. Scientists are constantly more over the factors that the average lifespan of different breeds to dictate."

For more enlightenment see: http://knol.google.com/k/garry-jenkins/canine-lifespans-which-dog-breeds-live/19tjln1ywaolr/14# for the English original and http://knol.google.com/k/garry-jenkins/canine-lebensdauer-welche-hunderassen/19tjln1ywaolr/133# for the German translation.

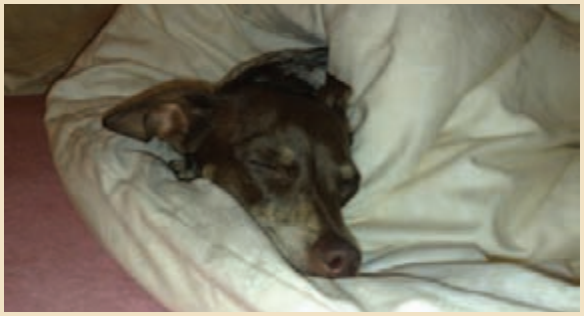

photo: Gabi Berghammer

Translating is a dog's life

Translation job

"Glaswegian" Interpreters: Translation company seeks speakers of Glaswegian English with knowledge of vocabulary, accent, nuances, to meet interpreting needs of clients who find it an unexpected challenge. Email CV to info@todaytranslations.com"

The Herald 13 October 2009 (http://news.bbc.co.uk/2/hi/uk_news/scotland/glasgow_and_west/8306582.stm)

This advertisement for translators of Glaswegian, which drew more than 30 applicants, needs to be understood in context. Glaswegian is a language of its own and as such can be thought of as a 'second language'. A spokesman for the translation company explained that they needed translators to assist foreign visitors to the city whose 'business English' was not good enough to understand the local dialect. Having relocated back *hame* to Glasgow I understand the difficulties that might face an unsuspecting foreign/English business executive. A man approaching six feet tall has a 'big' before his name in Glaswegian as in Big Hughie and Big Wullie. A female of five feet is *wee* as in Wee Samantha and Wee Polly. These descriptions are, I hasten to add, bestowed with certain affection. If a businessman/woman is met with disapproval, for instance an unkempt individual, they are called *bachle*. *Bachles* usually wear clothes for meetings which are a size or two too large for them. The 'ch' in *bachle* is pronounced as in the Scottish word 'loch'. Scots shudder when they hear an English person speaking of 'Lock Lomond'. The word *bachle* should not be confused with *bauchle* which is a worn-out shoe. A *bachle* wearing *bauchles* may result in his having a stumbling gait when he would be described as a *shachly bachle*.

Now that we have established some basics of Glaswegian perhaps the businessman/woman wants to go shopping. In Glasgow this can be quite an entertaining adventure, you may be advised by the shop assistant "Don't buy it. It'll make ye stink like hell an' wee min hate it." Or in a hat shop you may hear "Ah aye think if ye're kinda full in the face ye shouldny wear a wee pillbox hat. It looks like a thimble on top o' a dumpling."

So, Bringacerryoot ta ye'r pals and hiv a good Hogmany!

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Source: Stanley Baxter's Bedside Book of Glasgow Humour. ISBN:1841582468 Birlinn books

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