

English Grammar and Style

Good Writing Practice

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Pleasing the reader (3)

The fundamental principle in the practice of medicine, 'first, do no harm', could be transposed to the world of medical writing to 'first, do not annoy'. The Good Writing Practice (GWP) group at EMWA has been focussing on our readership and on writing for the reader. We want the reader to want to read what we've written and then appreciate it, so what we must avoid at all costs is causing annoyance. The GWP group came up with a list of writing habits that annoy them. Some of those habits that cause us to bristle come in the category of pet hates and can sometimes be put down to personal taste, whereas others are clearly seen as writing errors.

We've discussed the first impressions a document makes on the reader, and how the document layout, titles and headers contribute to a good first impression. We've highlighted how clearly identifiable mistakes and typos make the reader lose faith in the content of the document, and we've looked at the habit of overwriting, i.e. repeating information unnecessarily or providing excess information.¹

In this issue, we look at some other sources of annoyance cited by the group.

Incomprehensible sentences

If the reader doesn't understand what is meant, the writer has failed in the task. The reason for not understanding a sentence might be (a) that it is effectively nonsense, maybe due to a forgotten verb or a misplaced pronoun, (b) that it is too long or convoluted, (c) that certain words are not understandable because they are too long, too specialized (jargon) or have not been explained (abbreviations), or (d) that the sentence is ambiguous. Ambiguity may be caused by a grammatical error, but also by inappropriate punctuation. A slash '/' might mean 'either', 'or' or both of these and if it is interpreted differently by different readers (e.g. by investigators reading instructions in a clinical study protocol) then those readers will record and produce different data. Stephen de Looze wrote a much-quoted article in TWS in 2001 on writing blighted by the slash,² and this is well worth a (re)-read. Ambiguous phrases, such as 'within + time period' should be

avoided at all costs,³ although almost every clinical study protocol I have ever read contains a phrase equivalent to 'within a week of baseline', which can mean either a week before baseline, or a week after baseline, or both. In an effort to clarify, many writers have taken to writing 'within a week prior to baseline', which I don't like (see below under 'Verbosity'), but which is understandable. On the other hand, when that is extended to 'within 4 weeks prior to the first study drug administration' my brain needs a second or two to work out what is meant. Much simpler, more easily understandable solutions are 'in the week before baseline' and 'in the 4 weeks before the first dose'. Any time the reader has to spend re-reading or puzzling over a sentence will cause annoyance at best, but might also lead to the reader giving up completely.

Patronizing the reader

Avoiding the use of long, involved sentences must not lead to a text that is so simplified that the reader feels patronized. Even a text written for children, such as the patient information in a paediatric study, must take into account the fact that the children reading it are likely to have become experts in their disease. Deciding which abbreviations to spell out in a text must also take into account the readership, but including abbreviations such as *e.g.* and *i.e.* in the list of abbreviations is to my mind always patronizing (like saying 'just in case you didn't have Latin at school'). Unnecessary repetition is patronizing, boring, and leads to confusion because the reader assumes there is something new being said and can't quite understand what. As an editor, how often have you attempted to unravel three paragraphs of text only to discover that everything essential was already contained in the first?

Verbosity

Even careful medical writers can be prone to verbosity, perhaps because they are too wrapped up in their own writing. The use of long words where a short word would do comes high on my list of annoying habits, for we are not writing novels. I always prefer 'before' to 'prior to', and 'after' to 'following'. The habit of replacing 'than' with

‘compared with’ is rapidly gaining ground, and I increasingly find myself editing it out of texts that come my way. ‘Scores were higher in Group A than in Group B’ – it’s so simple! Why dilute the result by writing ‘Scores were higher in Group A compared with Group B’?

I also do my best to edit the clumsy ‘he/she’ construction out of documents. The sight of a dozen or more of these on a single page of the clinical study protocol makes me wrinkle my nose. The best way to avoid causing such annoyance is to use the plural: *Investigators and their staff are to ensure ... they should ... Patients should be interviewed and their answers recorded ...* Sometimes putting a verb in the imperative can get around the problem: *Record the data directly on the CRF.* Medical writers seem to shy away from this form in a clinical study protocol, possibly because they feel they are writing not only to the investigators, but also to all the reviewers in their company and to health authorities and ethics committees. Anyone who feels very uncomfortable about this might consider writing the imperative as a note: *Note: Record any abnormal findings on page 14 of the CRF.*

Punctuation

The over or under use of punctuation will irritate some readers no end, while the wrong use of punctuation will cause misunderstanding. The rules of punctuation must always be observed, but much in English punctuation comes down to personal taste. I recently reviewed a CSR written by a contractor, and although I requested a few changes of style, I had no criticism of the punctuation. A colleague (American, but I’m not sure whether that is relevant) who reviewed the same report sent in a review file speckled with red commas. Equally, the overuse of any type of punctuation mark (brackets, dashes, semicolons, exclamation marks), even if used correctly, can lead to annoyance. As medical writers, our job is to look for alternatives to excess punctuation. We are not aiming for literary heights where a sentence covering a third of a page might be exulted as refined composition, we are usually writing to inform. Some of us are rattled by the use of the comma after abbreviations such as *e.g.* and *i.e.* (e.g., like this). What does a comma add here? According to Strunk and White,⁴ it is necessary because *e.g.* and *i.e.* are parenthetical. Thankfully, other style guides quite rightly disagree, as they so often do with Strunk and White’s odd claims about the use of English.⁵ The English Style Guide issued by the European Commission Directorate-General for Translation⁶ instructs its employees to use a comma, colon, or dash before *e.g.* and *i.e.*, but

no comma after them. The Oxford Guide to Style⁷ agrees, but tells us that ‘commas are often used in US practice’. Unfortunately, the AMA Manual of Style,⁸ which is often taken as the work of reference in medical writing, is one of these US practitioners! Surely a comma after *e.g.* and *i.e.* should come after the entire phrase, for that is the parenthesis: ‘Any OTC pain medication, e.g. paracetamol, should be recorded’ is the same as ‘Any OTC pain medication (e.g. paracetamol) should be recorded’.

Excessive cross-referencing

In regulatory documents I have the impression that we often over-cross-reference because we err on the side of caution. We fall over ourselves to ensure that the regulatory reviewers find what they want because we don’t want to be accused of not following the templates, or worse, of hiding (unfavourable) results. This attitude is commendable, but can lead to a document littered with cross-references that don’t actually give the reader any further information. No reader wants to be sent off on such a wild goose chase! The rule of thumb should be that if a referenced source does not add any further information, it should be omitted. Hence, in the section presenting the main efficacy results in a Summary of Clinical Efficacy it may be appropriate to cross-reference to the section on subgroup analyses for a particular variable, but it would probably not be useful to do the opposite, because the main efficacy results will not add extra value to the sub-group analyses. Clinical study protocols are often strewn with cross-references, a great many of them to the schedule of assessments. All readers of study protocols should know that the schedule of assessments is always provided and they do not need to be sent to it at every mention of an assessment. One clear reference to it at the beginning of the procedures and variables section should suffice. Lastly, a reference to a reference that then leads to an appendix is guaranteed to annoy. We owe our readers more than that.

Misspelling

There is really no excuse for misspelling in these days of spell-checkers. We should all be aware of the pitfalls involved in using them (they don’t pick up misspellings if the misspelling is also a legitimate word) but they are a huge aid to those not blessed with good spelling ability. No reader should need to be annoyed by misspellings in a document that has been written on a word-processing system (and any reader who is lucky enough to receive hand-written correspondence these days should



Photograph taken by Neville W. Goodman in the car park of the broadminded Royal United Hospital in Bath, UK.

probably think themselves lucky and excuse a small spelling mistake!).

Awareness of a problem is the first step to resolving it. If we know what annoys us, we are less likely to annoy others. So, the next time you are accused of

being picky, pedantic or particular, take it as a compliment. Medical Writers are by nature all of those and worse, but these traits should be the only sources of annoyance that we cause. The texts we write will be appreciated for their clarity and readability.

References

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Points of View

You can be too careful: When language filtering goes wrong

Subscribers to a UK company's TV service were recently given something to snigger at when unwarranted censorship of programme information left then reading about Charles D***ens and Alfred Hitchc**k.¹ The temporary glitch, blamed on new software aimed at filtering out offensive language, also saw the censoring of pop star-turned-radio DJ Jarvis Cocker, London football club Arsenal and even a programme on canals¹. The title of Will Smith movie Hancock suffered the same fate, although viewers were left disappointed when the film itself was broadcast in full.

This latest incident follows others in which overzealous obscenity filters variously prevented residents of Scunthorpe in the UK from creating accounts with AOL because of the taboo word lurking in their town's name;² caused US sprinter Tyson Gay to be referred to as 'Tyson Homosexual' and 'the 25-year-old Homosexual';³ and resulted in CIA assassination plans being described as 'plots to buttbuttinate foreign leaders'^{2,3}.

Long may the problems continue!

Notes

1. Presumably because 'canal' minus the c = anal.
2. Whoever created the filtering software must have deemed the word 'ass' to be more offensive than 'butt', even when part of a longer, non-backside-related word.

References

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