Reading, writing, reviewing and editing for

Critical Care Medicine

2015

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Disclosures Relevant To This Presentation

• I am the Editor-In-Chief of Critical Care Medicine
• This is a part-time position paid for by the Society of Critical Care Medicine

Disclaimers

• The opinions expressed are strictly personal. They may or may not represent the opinions and views of any organization or publication with which I am affiliated.
• The contents of this presentation are solely the responsibility of the presenter.

Why am I suggesting that we share almost an hour of your valuable time?

In order to make the subsequent hours you spend with the journal even more valuable...

• Interdependence among
  • readers
  • authors
  • reviewers
  • editors
  • publisher
The last disclaimer

- I’ve had four of the five roles
  - Reader
  - Author
  - Reviewer
  - Editor
- This is an Editor-In-Chief perspective on four of them

Context:
Rate of growth of medical knowledge

Growth Rates of Modern Science: A Bibliometric Analysis Based on the Number of Publications and Cited References

Latz Bommer
Division for Science and Innovation Studies, Administrative Headquarters of the Max Planck Societies, Marburg, Germany. E-mail: bommer@mpipg.de

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Journal of the Association for Information Science and Technology, publication before print; also available at arxiv

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Publications Since 1980

1.88 million
In 2012
+3% annually
24 year doubling time
Health Science Citations

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Medicine and Health Sciences only

First Issue of The Lancet, 5 October 1823

Peak 8.9 million

Natural Logarithm (ln, log

~1000

That’s a lot of content

• All of you have an interest in reading
• Some of you have an interest in writing
• Some of you have been called upon to review
• Perhaps a few of you have an interest in editing
• The journal’s focus is on its readers—primarily the membership of the Society of Critical Care Medicine, primarily bedside providers

Question: Does it make sense to read any particular journal regularly?
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- Periodical: scheduled distributions, standard organization
- Yield: Is the content reliably worth the investment of time and treasure?
- Confidence: Willingness to stake your patient’s life and your professional reputation on the content?

If a positive answer is your answer, strategy for “best use”?

Reading

- Paper is good (on the airplane, in the break room, in a classroom or journal club)
- Electronic is better (Online is better than reader)
  - Search tools
  - Seven components are online ONLY...

CCM online only components....

1. Published ahead of print: latest articles are ALWAYS online first
2. Free content (more about Editor’s Choice)
3. Basic science reports—What, why and how biology works
4. Technical notes—Upcoming example: clinical cost analysis
5. Case reports—CCM publishes them only rarely, but if we do it you want to read it
6. Supplemental Digital Content—The nitty gritty
7. Letters to the editor—Perhaps most important—direct conversation between authors and readers. CCM will publish almost any letter provided it is about an article and provided that it is not an ad hominem/feminem attack. Authors do respond.

A sidebar why online is growing

- Print/distribution cost minimized
  
**COLOR**

- Evolving restrictions on length
- Personal searches/notifications
- Ecologically sound
- Foundational to new knowledge presentations (more on that later).
Scientific Writing
- ALL journals depend on written presentations
- Scientific writing is a discipline
  - Competencies include knowledge, skills, attitudes
  - Broadly applicable, not specific to journal or domain
  - Not the topic of this talk

In Memoriam...
William Zinsser, Author of ‘On Writing Well,’ Dies at 92

Writing for CCM
- Writing for CCM
  - First, you need to know our values
  - Journals have values?
  - Foreword to the February 2015 issue
    - Clear communication
    - Public debate
    - High standards for quality and for scientific ethics
    - Concern with illness and health, not just syndromes and diseases
    - Airing of ethical tensions

Airing of ethical tensions—July, 2015
The Very Elderly Admitted to ICU: A Quality Finish?
Editors: Deborah Cook, MD; MC; Kay M. Hospers, MD, MSc; Alan Garfield, MD; Howie E. Nossen, MD; Michael D. Zwygart, MD; Karen Burns, MD, MSc; John Barquet, MD; Alain F. Tardif, MD; Bob Forster; MCM; Xuan Xing, MD; Andrew G. Day, MD on behalf of the Canadian Critical Care Trials Group and the Canadian Resuscitation Society
Editorials taking opposing positions: Joel Zivot, David Crippen
Foreword: Margaret Parker
Solicited vs Author-Initiated

- Forewords—those are written by the senior editors;
- Editorials—there are solicited by the editors from experts because we think explanations or qualifications are needed around an article;
- Concise Definitive Reviews—Because we think a particular expert is uniquely qualified to synthesize a complicated field; and
- Point-of-view style presentations: essentially professional debates and we solicit debaters who really know the problem.
- Everything else is author-initiated.

Writing for CCM--Novelty

- While there might be value in a repeat performance, most of our readers aren't interested in reading isolated reports of established practice. As one reader said to me, “I already deliver the best care today. I'm trying to figure out how to do better tomorrow.” Thus CCM tends not to publish “confirmatory” reports.

Writing for CCM-Generalizability

- There are a lot of single-center “lookbacks” that cross my desk—often these are couched as a center’s experience with something or even a report out of a QI project—we did this and it improved that.
- The problem with most of these is one of generalizability. There are as many different styles of care as there are ICUs, and while benchmarking and improvement are important, our readers are interested in things they can take to their own bedside with reliable results. So they have come to expect reports of change that’s are multicenter … or prospective…and preferably both.
Writing for CCM – Fostering change in thinking and/or practice

- Our readers are clinicians
- They want to improve outcomes, or the experience of care, or cost
- If what they read can change their thinking or practice, the time they spent is lost
- This does not limit the science: CCM publishes basic, translational, clinical and implementation science
  - There have to be implications for thinking or practice of clinical critical care medicine.

Example

- [placeholder for embargoed review paper—will fill in detail prior to June 6 presentation]

New manuscript guidelines (effective 1 September 2015)

- 3000 word limit
- Total of tables plus figures cannot exceed 5
- Everything else in supplemental digital content

Notes for prospective CCM authors -- 1

- If you are unsure whether a topic is appropriate for CCM, write down what project was about and why the results are important to CCM readers in 3-4 sentences. Send it to me, I will answer.
- If you choose to write for CCM, follow the guidelines and always keep our readership—bedside clinicians—in mind. Novelty, generalizability and changing thought matter.
- If you are unfamiliar, look up Ernest Hemingway’s famous comment about first drafts.
Notes for prospective CCM Authors – 2

- Rewrite. Rewrite again.
- When the manuscript is “perfect”, send it to a colleague who was not involved in doing the work or writing the manuscript; ask the colleague to (a) proofread and (b) explain to you what they think the manuscript said. Revise as needed.
- Recheck that the manuscript conforms to the guidelines prior to submission.

What it’s like to look at 55 new manuscripts each week

- Author comments (2-4 sentences on what the work says and why it’s important to CCM readers)
- Author list
- Abstract
- Figures and Tables
- Intro
- Discussion
- Results
- Methods

Distilled into a 3-5 sentence note to myself on the merits of the work: represents the “first cut”
For further detail
Foreword to the May 2015 issue

The Review Process

There does not exist a category of science on which one can place the name applied science. There are sciences and the application of science found together as the fruits of the tree that bears it.

— Louis Pasteur

What happens after an author submits a manuscript to Critical Care Medicine? The questions the editor asks whether it is appropriate to add a public response.

The journal office receives approximately 1000 complete manuscript submissions each year. The first step involves determining that each new submission conforms to journal guidelines. The manuscripts that are already available at the journal website, together toward this end. Sometimes this will require additional over-sights. Sometimes this will require interpretation of data. Sometimes both will be required.

We hold our reviewers and ourselves to the highest standards of peer review. In the vast majority of cases, a positive review will result in publication of the article. Aspects of this review can be informal, such as identifying new editors, or formal, such as changing the way the journal is published. The science must not be direct, a new analysis, a novel perspective, or new finding may require a more detailed review. In some cases, this new evidence may require a decision to add new evidence. Whatever the case, we will make sure that any changes are communicated to the reader.

Editorials

• Two principal reasons to request an editorial
  – The science is sufficiently complex that interpretation and explanation will enable reader comprehension
  – The science is sufficiently controversial that one or more alternate perspectives are required for balance

• Nearly all editorials are requested by the Associate Editor handling the manuscript
• Nearly all editorials are written by a reviewer

More about the reviewers

We invite authors to suggest reviewers. We may use 0-2 of the suggested reviewers.

We have a database of ~2000 reviewers. Some are used frequently, especially the members of the editorial board.

We request 14 day turnarounds (decreasing soon to 10)

Successful authors are often asked to serve

Reviewers are given guidance on how to review

Reviews are graded. Reviewers with consistent low grades are dropped.

We try to limit reviewers to not more than one MS at a time and not more than one MS each month

The Editor-In-Chief

• Bears ultimate responsibility for content
  – Concurs with Reviewer/Associate Editor recommendations 98% of the time
  – Tasks Scientific Editors
  – Adjudicates conflicts
  – Responds to concerns of misconduct

The buck stops here.
The Editor-In-Chief

• Bears ultimate responsibility for development consistent with journal values and SCCM interests
  – Forewords -- Initiated
  – Editor Choice Articles -- Initiated

Editor’s Choice – April 2015

Wide interest, including news organizations and general public

ALL Editor’s Choice material remains free to the world (no subscription required) for two months.

Coming Attractions

– Pro/Con style debates –Topics and Authors in development
– Integration and Support of Congress Presentations
  – Forthcoming for 2016 Congress
– New Content Delivery Methods—in development (integration with EMRs)
– Studies of publication effects on practice—Under consideration

Personal Reflections
The Triple Aim

**The Triple Aim: Care, Health, And Cost**
The remaining features to integrated care are not technical, they are political.

by Donald M. Berwick, Thomas N. Newnham, and John Whittemore

*Annals* of internal medicine, 2008, 149(14), 273-278

- Conceived with a population as the focus of concern
- Distance from perspective of patients and families

In the future days, which we seek to make secure, we look forward to a world founded upon four essential human freedoms.

- The first is freedom of speech and expression—everywhere in the world.
- The second is freedom of every person to worship God in his own way—everywhere in the world.
- The third is freedom from want—which, translated into world terms, means economic understandings which will secure to every nation a healthy peacetime life for its inhabitants everywhere in the world.
- The fourth is freedom from fear—which, translated into world terms, means a world-wide reduction of armaments to such a point and in such a thorough fashion that no nation will be in a position to commit an act of physical aggression against any neighbor—anywhere in the world.

That is no vision of a distant millennium. It is a definite basis for a kind of world attainable in our own time and generation.

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**1. Freedom from harms**

no patient or family should fear an error that will culminate in a preventable harm

**2. Freedom from suffering**

no patient or family should experience unnecessary pain or misery
3. Freedom from disability

no patient or family should experience unnecessary disability and the burdens of dependence on self and loved ones

4. Freedom from healthcare impoverishment

no patient or family should fear impoverishment related to the cost of care and treatment