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Tips on Writing for Medical Journals

Robert Freedman, M.D.
Editor, *The American Journal of Psychiatry*

I am frequently asked by young authors for tips on how to “get papers into highly ranked journals.” No journal receives more good papers than it can accept, and therefore we are always looking out for good papers from young authors who may not have published with us previously. Nonetheless, most papers are rejected. Good writing alone will not assure success. Your paper has to make an important and definitive point that readers can appreciate. Much of the success therefore depends upon the scope of the study that you have undertaken and the quality of the discoveries you have made. However, once you have made an important discovery, you can improve your chances of acceptance of your paper for publication by a journal editor. Here are my tips for you:

1. Follow Instructions to Authors, and proofread, proofread, prove reed

Reviewers look for abstracts, figure legends, and other features to be in the journal's usual format, as specified in the Instructions. Submission of papers that are over the word limit leads to automatic rejection. Most important, reviewers cannot see your data, but they can see the quality of your manuscript. Careful attention to proofreading, for grammar and spelling, is critical. Minimize the use of abbreviations, and make sure that the paper is intelligible to the average readers. Chances are that some or all of your reviewers will be less familiar with the area in which you are working than you are. Read the Instructions to Authors on the journal's website, and then read your paper one more time before you submit.

2. Don't submit salami

Editors are wary of papers that seem to be small parts of a single study. While we understand that you want many papers from your work and that a particular paper may be your best chance to be first author, we nonetheless try to fill our pages with papers that tell as complete a story as possible. Therefore, do not submit two weaker papers to different journals when you can have a strong one in a better journal. If your part of a study is a small one, you have an understandable dilemma, but understand what its risks and rewards are before you start the project.

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3. Don't write your next paper; make the most of the data that you have for this one

A paper should be based on a single important, definitive finding. Base your title, introduction, and discussion on that finding, not on the next step that you might want to work on in the future. Many authors end papers with the conclusion that more research is necessary, or, worse, they tell us about the paper that they are currently doing, which really answers the questions that they posed. Concentrate on helping editors, reviewers, and readers understand what is important about the paper that you have submitted.

4. Listen to the reviewers; they are trying to teach you

Reviewers are generally more senior than you are. You will face them again, at other journals and at grant reviews. Try to address their concerns and win them over. The best compliment a reviewer can pay

you is: "The manuscript is now easy to read and shows very interesting results that I was not able to appreciate in its former version. Good work." Wouldn't you like to have that reviewer see your next paper? The only way to win over a reviewer is to revise your paper to meet his or her concerns.

E-mail the Editor when you have questions, even if the decision was a rejection. We know that you will be back to us with a great paper at some point. We want to establish a working relationship with you, regardless of whether the current paper reaches criterion for publication. It may seem that you can answer all the objections that the reviewers have raised, but it may also be that the reviewer was more negative about the paper's importance in the Comments to the Editor section. The Editor may allow you to respond, but may also advise you to seek publication elsewhere. Be prepared to accept either decision. Only about 5% of initially rejected papers end up published in the journal that initially rejected them.

5. Write the first draft yourself, even if there is

pressure from sponsors

Ghost writing has become a common charge, particularly for studies sponsored by pharmaceutical companies. A pharmaceutical company employee or contractor, who is not an author, may provide "notes" or even a first draft, often through a pharmaceutical company co-author. Make sure you write the first draft and acknowledge any editorial help.

6. Acknowledge the source of your words

In your new language of science, new phrases that you learn will have likely come directly from others. "Deficit schizophrenia" is attributable to Will Carpenter. If you use the phrase, acknowledge his work. If English is your second language, you may be unknowingly incorporating whole sentences from others' papers. It's a natural part of learning a new language and a new discipline, but it can also be construed as plagiarism.

Dr. Freedman is Chairman of the Department of Psychiatry, University of Colorado School of Medicine, and Editor-in-Chief of The American Journal of Psychiatry.

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Clinical Evidence and the *Residents' Journal*

Joseph M. Cerimele, M.D.
Editor-in-Chief

Two recent papers in *The New England Journal of Medicine* (1, 2) reported regional differences in Medicare spending and diagnostic practices across the United States. The editorialist (3) commenting on these studies described an observation he made during his transition from medical school to residency training. Common clinical presentations and complaints were managed with institution-specific protocols and passed-on wisdom at his different training hospitals, and neither

hospital protocol seemed based on research evidence. This puzzled him as a house officer, and he explained that the ongoing research examining this matter continues to show practice variation.

Resident physicians in all fields have shared this observation. As a clerkship student in Cincinnati, I learned one way to convert a haloperidol dose to a risperidone dose, a conversion I stopped using when I started residency training at a

different medical school in New York. Now, psychiatry house officers at many programs will likely remove the institution-specific antipsychotic equivalency table taped to the on-call room wall and proudly hang the table on page 687 of the June 2010 issue of *The American Journal of Psychiatry* (4). While this table is helpful, it still does not explain the regional or hospital ward differences in management

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of acute agitation in patients with schizophrenia. It seems that research looking at practice variation will continue.

Regional- or school-specific practices can confuse the young physician just entering specialty training. The *Residents' Journal* is here to help. Several article types report evidence-based clinical practice. Treatment in Psychiatry articles examine the practice and evidence of clinical scenarios commonly encountered by the psychiatry house officer. These articles also include management recommendations. Review articles generally answer a question by explaining current research (5), helping the resident to understand a general sub-

ject. It is useful to read and discuss these articles with classmates; it is also useful to develop clinical questions and write about them with classmates. I encourage interns and junior and senior residents to submit these types of manuscripts to the *Residents' Journal* to clarify the evidence supporting clinical practice.

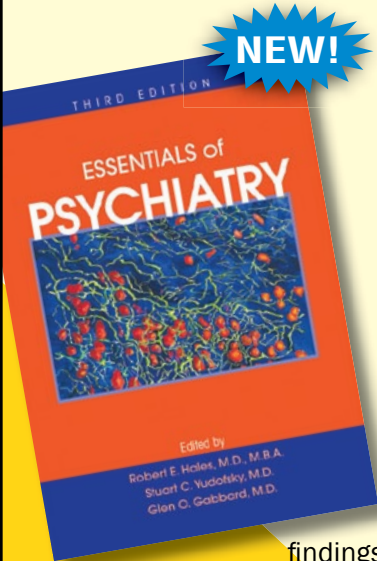
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How to Translate Clinical Research Into Evidence-Based Practice: Important Resources for Psychiatry Residents

Adam Lau, M.D.

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Evidence-based practice and psychiatry involves the application of available evidence (by assessing the strength of evidence based on research methods) to medical decision making (1, 2).

With more than 5,000 journals in the MEDLINE database, there is an ever expanding number of articles and publications every year. This includes more than 100 psychiatry journals (3). Incorporating evidence-based practice is a challenge, but it is important that residents can efficiently search large databases. They can use several helpful resources:

PubMed: (www.ncbi.nlm.nih.gov/pubmed) The MEDLINE database contains more than 18 million records from approximately 5,000 biomedical journals from 1950 to the present. You can set up personal accounts and search for articles of interest. These searches can be saved, and e-mail updates alert you when articles are published that are relevant to the search of interest. This is an efficient way to stay abreast of many of your interests.

Journals: Set up e-mail updates alerting you when tables of contents are released so you don't have to remember to look. Scan the article. If an abstract is of interest, read the complete article. Pay attention to the study design and methods, results, and limitations and whether these are reflected in the discussion and conclusions. It may be helpful to discuss papers with faculty members.

Cochrane Collaboration: (www.cochrane.org/cochrane-reviews) This database includes systematic reviews and evaluations of randomized controlled clinical trials. Available evidence is reviewed and treatment is categorized as "likely to be beneficial," "likely to be harmful," or "evidence did not support either benefit or harm."

Practice Guidelines: (www.psych.org/psych_pract/treatg/pg/prac_guide.cfm) APA provides a comprehensive review of the literature and evidence base for all major psychiatric disorders. Guidelines are written by field experts and include background, etiology, and management and give levels of evidence/recommendations for managing each disorder.

Textbooks: There are numerous textbooks that cover psychiatric assessment and evaluation, diagnosis, neurology, psychopharmacology, and psychotherapies. These are often available online. APA offers a complete listing on their website (www.psych.org).

UpToDate: (www.uptodate.com) This is an evidence-based, peer-reviewed medical information resource used by many clinicians. It is comprehensive and updated every 4 months.

Micromedex: (www.micromedex.com) This includes evidence-based documents indicating a drugs use with Food and Drug Administration indications. It details all published and unpublished trials that provide the evidence for a given drug. Areas discussed include dosage, pharmacokinetics, cautions, interactions, clinical applications, adverse effects, and comparative efficacy.

Dr. Lau is a fourth-year Chief resident in the Department of Psychiatry, Zucker Hillside Hospital, Glen Oaks, N.Y.

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3. http://www.psychwatch.com/psychiatry_journals.htm

Implications of Continuity of Care and Residency Training on Patient and Trainee Safety

Javeed Sukhera, M.D.
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I learned one afternoon that an outpatient had threatened a fellow resident physician. The patient was in his late twenties and carried a substance use disorder diagnosis as well as a history of posttraumatic stress disorder. He reported to his case manager that he had ongoing thoughts of hurting his psychiatrist (a resident physician in the clinic) because of a disagreement about the prescription of a controlled substance. The patient's threat and additional symptoms prompted the clinic staff to bring him to the emergency room, where I examined him while on-call. As I sat across from him in the interview room and listened to his description of events, my skepticism of his denial slowly grew. Given his threat, dysphoria, and history of violence, I admitted him on an involuntary legal status. He was discharged 5 days later, with a prescription for clonazepam, the medication that sparked the disagreement with and threat toward the clinic resident.

Upon his discharge, several questions were raised about where and why this patient's care had become discontinuous. The outpatient psychiatrist decided not to prescribe a controlled substance to this patient because he had a history of repeatedly abusing benzodiazepines. The inpatient team did not make contact with the outpatient providers and therefore missed this important piece of the patient's medical history. This case highlights some of the difficulties in maintaining continuity of care. While the patient coursed through outpatient, emergency, and inpatient settings, there was a breakdown in communication, resulting in a potential discharge that made staff feel unsafe. My fellow residents and I were also concerned that the patient might threaten or harm our colleague again.

Psychiatric residents often find them-

selves in unsafe situations. Research suggests that more than a third of psychiatrists have been assaulted at least once by a patient (1, 2). Most residency programs address the importance of provider safety with a simple primer on how to place one's self between the patient and the exit. While this primer teaches some skills, it does not address complex and nuanced matters of patient safety and continuity of care.

Evidence suggests that improvements in the continuity of psychiatric patient care can foster improved outcomes relating to both suicide and violence (3, 4). For example, more continuous care independently reduced suicide risk by approximately 15% among subjects in a case control study (odds ratio=0.63, 95% confidence interval=0.40–1.00, $p=0.05$) (5). Specific interventions, such as structured collaboration through conference calls between outpatient and inpatient treatment teams, can improve communication and enhance continuity among systems.

Psychiatric residents may be the only psychiatry department staff working in a variety of clinic settings. Our journeys through the emergency room, clinics, and hospital wards allow us to observe specific areas where communication breakdown may occur, thus providing an opportunity for residency training to inform improvements in continuity.

In the present case, the residents alerted the program director of concerns regarding safety after discharge and the prescription of clonazepam. Our program director facilitated communication among clinic staff and arranged for the patient to be cared for in a different outpatient clinic not staffed by residents. Through a redesign of ambulatory services and consultation with program leadership and the residency class, residents began attending outpatient team

meetings to ensure that their perspective was included. Complicated cases were discussed and communication was greatly enhanced through regular contact between providers. Through active participation with treatment teams, residents were given the opportunity to address continuity of care issues and how to avoid adverse outcomes in the future.

Dr. Sukhera is a fourth-year Child and Adolescent Psychiatry Fellow in the Department of Psychiatry, University of Rochester Medical Center, Rochester, N.Y. Dr. Sukhera is a recipient of the American Psychiatric Association Diversity Leadership Fellowship, which is funded in part by AstraZeneca pharmaceuticals; he is also a participant in the American Psychiatric Institute for Research and Education/Janssen Scholars Program.

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Quetiapine, Methadone, and a Severely Prolonged QTc Interval

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Introduction

Most antipsychotic medications prolong the QT interval in a dose-dependent manner, likely by delaying repolarization (1). A corrected QT interval (QTc) >450 msec imparts an increased risk of *torsades de pointes* (1). Quetiapine has been shown to prolong the QT interval when taken in overdose and when taken with other medications (2, 3). QT prolongation is particularly relevant in patients with opioid dependence managed with methadone. In one study, 9.2% of methadone maintenance patients had a QTc interval >440 msec (4). We present the case of a patient who developed a severely prolonged QT interval in the setting of methadone maintenance and concomitant quetiapine use.

Case

“Mr. Z” was a 33-year-old man with alcohol, benzodiazepine, and opiate dependence who was receiving agonist therapy. He was hospitalized after a suicide attempt with an unspecified amount of benzodiazepines and opiates. The patient was initiated on a chlorthalidone taper for benzodiazepine and alcohol withdrawal and continued to receive his outpatient psychiatric medications, which included methadone (160 mg daily) and quetiapine (400 mg at bedtime). On hospital day 6, the patient was difficult to arouse. A 12-lead ECG, obtained as part of the examination for altered mental status, revealed a significantly prolonged QTc interval of 601 msec, with a QRS complex width of 104 msec. He displayed respiratory depression and miosis, and it

was determined that the sedation was due to the combined effects of methadone and benzodiazepine dosing. Naloxone was administered intramuscularly, and he awoke. Although the severely prolonged QTc interval was an incidental finding, it required management because of the risk of arrhythmia. Mild hypokalemia was corrected, and all medications that could prolong the QTc interval were discontinued, including methadone and quetiapine. Within 2 days of methadone discontinuation, the patient’s QTc interval returned to baseline (421 msec). He did not experience arrhythmias or other cardiac events. His suicidal ideation resolved, and his mood improved. Buprenorphine dosing was initiated, and the patient was discharged to a substance use rehabilitation facility.

Discussion

Recently, an expert panel was convened to address the cardiac effects of methadone (5). The panel recommended monitoring patients prescribed methadone with a pretreatment ECG, a 30-day follow-up ECG, and subsequent annual ECGs (5). Although this panel recommended that clinicians be aware of interactions between methadone and other medications that prolong the QTc interval, no additional screening recommendations were made. Many patients with opioid dependence have co-occurring psychiatric disorders requiring treatment with antipsychotic agents. For these patients, it is important to evaluate the risk of QTc prolongation and arrhythmia. Further study of the additive risk of medication-induced (specifically, methadone and

antipsychotic agents) cardiac conduction delays would assist physicians in assessing patients’ risk of developing prolonged electrocardiogram intervals.

Dr. LaLonde is a third-year resident in the Department of Psychiatry at Mt. Sinai School of Medicine, New York. Dr. Cerimele is a third-year psychiatry resident at Mt. Sinai School of Medicine and Editor-in-Chief of the Residents’ Journal.

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TEST YOUR KNOWLEDGE

In preparation for the Board Examinations, test your knowledge with these questions (answers will appear in the next issue of the *Residents' Journal*).

1. Which of the following antipsychotics has been found to cause the greatest prolongation of the QTc interval?

- A. Haloperidol
- B. Ziprasidone
- C. Thioridazine
- D. Risperidone
- E. Quetiapine

2. A 75-year-old African American woman with no previously known cardiac history is hospitalized in the intensive care unit secondary to acute renal failure and subsequent altered mental status. During her hospitalization, despite correction of electrolyte abnormalities, she becomes acutely agitated. The primary team consults psychiatry requesting recommendations of appropriate dosing of intravenous haloperidol to control the patient's agitation while her renal function normalizes. Also, she is noted to have mild hypomagnesemia. Your recommendations to the medical team, in addition to correction of the hypomagnesemia, are:

- A. Haloperidol, 0.25 mg–0.5 mg intravenously every 4 hours as needed for agitation, with 12-lead ECG prior to first dose
- B. Haloperidol, 0.25 mg–0.5 mg intravenously every 4 hours as needed for agitation, with continuous ECG monitoring
- C. Haloperidol, 2 mg intravenously every 4 hours as needed for agitation, with 12-lead ECG prior to first dose
- D. Haloperidol, 2 mg intravenously every 4 hours as needed for agitation, with continuous ECG monitoring
- E. Haloperidol, 5 mg intravenously every 4 hours as needed for agitation, with 12-lead ECG prior to first dose

ANSWERS

Answers to July Questions. To view the July Test Your Knowledge questions, go to <http://ajp.psychiatryonline.org/cgi/data/167/7/A14/DC2/1>

Question #1

Answer: D. Clozapine

The most thoroughly studied atypical antipsychotic for use in dual-diagnosis patients is clozapine. Numerous studies of clozapine have shown it to be associated with reduction of psychotic symptoms as well as a reduction in substance abuse. In a naturalistic study of patients with schizophrenia and schizoaffective disorder, Drake et al. (1) compared 36 patients receiving clozapine and 115 patients receiving typical antipsychotics, all of whom had a comorbid alcohol use disorder. Among patients receiving clozapine, 79% had remission of alcohol use, whereas the remission rate among patients receiving typical antipsychotics was only 33.7%.

Green et al. (2) proposed that the strong dopamine (D2) blockade of typical antipsychotic agents does not improve the function of the mesocorticolimbic reward system. Clozapine has a reduced D2 blockade and thereby decreases the dysfunction of this reward system in patients with schizophrenia, leading to reduction in substance abuse.

References

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Question #2:

Answer: B. 12–24 hours

Approximately 7% of patients with alcohol withdrawal syndrome will develop alcoholic hallucinosis. These symptoms occur 12–24 hours after the cessation of alcohol consumption. The symptoms include auditory, visual and tactile hallucinations. Between 5%–10% of patients will develop tonic-clonic withdrawal seizures. This develops approximately 24–48 hours after alcohol cessation. Approximately 5% of patients with alcohol withdrawal syndrome progress to delirium tremens, which typically develops within 2–4 days of cessation of alcohol use. Symptoms of delirium tremens include agitation, disorientation, diaphoresis, hallucinations, hypertension, tachycardia, low-grade fever, and increased respiratory rate. The development of delirium tremens has a mortality rate of 1%–5% and is a medical emergency (1).

Reference

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Author Information for Residents' Journal Submissions

1. Commentary: Generally includes descriptions of recent events, opinion pieces, or narratives. Limited to 500 words and five references.

2. Treatment in Psychiatry: This article type begins with a brief, common clinical vignette and involves a description of the evaluation and management of a clinical scenario that house officers frequently encounter. This article type should also include 2-4 multiple choice questions based on the article's content. Limited to 1,000 words and 10 references.

3. Clinical Case Conference: A presentation and discussion of an unusual clinical event. Limited to 750 words and five references.

4. Original Research: Reports of novel observations and research. Limited to 1,000 words, 10 references, and two figures.

5. Review Article: A clinically relevant review focused on educating the resident physician. Limited to 1,000 words, 10 references, and one figure.

6. Letters to the Editor: Limited to 250 words (including references) and three authors. Comments on articles published in the Residents' Journal will be considered for publication if received within 1 month of publication of the original article.

7. Book Review: Limited to 500 words.

Abstracts: Articles should not include an abstract.

References: Use reference format of *The American Journal of Psychiatry* (http://ajp.psychiatryonline.org/misc/Authors_Reviewers.dtl).

Upcoming Issue Themes

We invite residents who are interested in participating as Issue Editors to e-mail Dr. Cerimele at joseph.cerimele@mssm.edu (March 2011 and June 2011 are not yet assigned). If you are interested in contributing a manuscript on any of the themes outlined, please contact the Issue Editor for the specified month.

Please note that we will consider articles outside of the theme.

October 2010

Issue Theme: Research, Part II

*Contact Joseph Cerimele, M.D., Editor-in-Chief;
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November 2010

Issue Theme: Art in the Realm of Psychiatry

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December 2010

Issue Theme: Specialists in Psychiatry

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January 2011

Issue Theme: Internal Medicine Skills and Psychiatry

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February 2011

Issue Theme: Eating Disorders

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