Getting Ready to Write your Paper!

Presenters: Prof Liz Ward, Dr Pim Kuipers, Dr Steve McPhail, Dr Emma Finch
Timetable for CFAHR writing workshop
Date: 16 November 2011
Time: 3:00 – 4:45pm

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>Introduction</td>
<td>Sue</td>
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<tr>
<td>Choosing a journal</td>
<td>Steve</td>
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<tr>
<td>Authorship and author order</td>
<td>Pim</td>
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<tr>
<td>Writing process and content</td>
<td>Liz, Steve, Pim</td>
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<tr>
<td>Process of publishing</td>
<td>Emma</td>
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<tr>
<td>Questions</td>
<td>All</td>
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How to choose a journal: Where should I submit my manuscript?

Dr. Steven McPhail
Senior Research Fellow
Centre for Functioning and Health Research, QHealth &
Institute of Health and Biomedical Innovation and School of Public Health
Queensland University of Technology
Maybe you have an octopus called Paul?
Some things to consider?

• Why are you publishing?
• Audience
• Traditional publishing versus open access
• Impact and ranking
• Journal specific information
Purpose - why are you publishing?

- I mentioned it during my performance appraisal
- I want to pad out my resume
- I want a promotion
- It’s a requirement of… (job, funding, degree etc.)
- I want to influence local clinical practice
- I want to influence health policy
- I want to improve patient care and outcomes
- I want to impress my mom
Audience

• National vs. International
• Discipline specific
  – Discipline journals
    • The Journal of Physiotherapy
• Niche area
  – Field journals
    • Journal of the American Geriatrics Society
• Broad application
  – Wide multi-disciplinary audience
    • Medical Care
Audience

• What do your peers read?
• Who do you want to read your manuscript?
• Where are the influential articles in your field published?
• How will people find your articles?
  – Indexation in key databases
• Does your audience have access to restricted access journals?
Traditional publishing versus open access

• Traditional publishing
  – Free to publish
  – Pay to read
    • May narrow your audience

• Open Access
  – May require payment to publish open access
    • Grant or university
  – Free to read
    • May be easier to access
Impact and ranking

• Excellence in Research Australia Ranking
  – A* A B C
    • Australia only, some ratings questionable
    • Abolished in 2011 – was being misused

• Impact factor
  – Average number of citations per article
  – First two years after publication
  – Tracked by Thompson-Reuters
  – Web of knowledge journal citations reports
  – Most widely used metric for impact of journal
<table>
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<tr>
<th>Mark</th>
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<th>Abbreviated Journal Title</th>
<th>ISSN</th>
<th>JCR Data</th>
<th>Eigenfactor Metrics</th>
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### Journal Summary List

**Journals from:** REHABILITATION  
**Sorted by:** Impact Factor  

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<th>ISSN</th>
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<td></td>
<td>42</td>
<td>HONG KONG J OCCUP TH</td>
<td>1869-1051</td>
<td>Impact Factor 0.027, 5-Year Impact Factor 0.000, Articles 10</td>
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*Ranking is based on your journal and sort selections.*
Journal specific information

• Scope
• Response / publication time
  – Time until first decision
• Instructions for authors
  – Article type
  – Length
  – Tables / Figures
  – Supplementary files
• Acceptance rate
  • Likelihood of success
Steven McPhail – Senior Research Fellow

Centre for Functioning and Health Research, Queensland Health
Institute of Health and Biomedical Innovation and School Public Health, QUT

steven_mcphail@health.qld.gov.au
Authorship

Sounds like a no-brainer, but can be very difficult . . .
There are clear rules about authorship

THE AUTHOR LIST: GIVING CREDIT WHERE CREDIT IS DUE

The first author
Senior grad student on the project. Made the figures.

The third author
First year student who actually did the experiments, performed the analysis and wrote the whole paper. Thinks being third author is “fair”.

The second-to-last author
Ambitious assistant professor or post-doc who instigated the paper.


The second author
Grad student in the lab that has nothing to do with this project, but was included because he/she hung around the group meetings (usually for the food).

The middle authors
Author names nobody really reads. Reserved for undergrads and technical staff.

The last author
The head honcho. Hasn’t even read the paper but, hey, he got the funding, and his famous name will get the paper accepted.
Authorship credit should be based on:

1. substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
2. drafting the article or revising it critically for important intellectual content;
3. final approval of the version to be published.

Authors should meet conditions 1, 2, and 3.
Some journals now request and publish information about the contributions of each person named as having participated in a submitted study, at least for original research.
DISCLOSURE STATEMENTS & COPYRIGHT ASSIGNMENT

Disclosure During Revision of Evaluation in Progress: Each coauthor must complete and sign a separate copy of this document. Email PDF to archivesmail@archives.acrm.org or the completed forms can be faxed to +1.312.377.1940 to the Editorial Office.

The manuscript code number is: ARCHIVES-PMR-D-11-00820 (mandatory).

Manuscript Title: Investigating changes in quality of life and function along the lifespan for people with spinal cord injury

Authorship Responsibility: I have read the submitted manuscript that includes my name as an author and vouch for its accuracy. I certify that I have participated sufficiently in the conception and design of this work and the analysis of the data (where applicable), as well as the writing of the manuscript, to take public responsibility for its content. I believe the manuscript represents honest and valid work. To the best of my knowledge, it contains no misrepresentations. I have reviewed the final version of the submitted manuscript and approve it for publication. If requested, I shall produce the data on which the manuscript is based for examination by Archives or its assignees.

Signature: ______________________

Prior or Duplicate Publication: I warrant that the manuscript is original and its essential substance, tables, or figures have not been previously published in part or in whole. The manuscript or one with substantially similar content under my authorship or the data within it has not been accepted for publication elsewhere and it is not presently under review by any other publisher. The manuscript will not be submitted for publication elsewhere until a decision has been made on its acceptability for publication in Archives. This restriction does not apply to brief abstracts or press reports published in connection with scientific meetings.

Signature: ______________________

Financial Disclosure: Choose one of the following statements. Insert the selected Financial Disclosure into the title page of the manuscript submission.

☑️ I certify that no party having a direct interest in the results of the research supporting this article has or will confer a benefit on me or on any organization with which I am associated AND, if

[Signature]
It says …

✓ I have read the submitted manuscript that includes my name as an author and vouch for its accuracy.
✓ I certify that I have participated sufficiently in the conception and design of this work and the analysis of the data (where applicable), as well as the writing of the manuscript, to take public responsibility for its content.
✓ I believe the manuscript represents honest and valid work. To the best of my knowledge, it contains no misrepresentations.
✓ I have reviewed the final version of the submitted manuscript and approve it for publication. If requested, I shall produce the data on which the manuscript is based for examination by Archives or its assignees.
What doesn’t constitute authorship?

• Being head of department, holding other positions of authority, or personal friendship with the authors.
• Providing a technical contribution (such as collecting data or “doing the stats”), but no other intellectual input to the project or publication.
• Providing routine assistance in some aspects of the project, the acquisition of funding or general supervision of the research team.
• Providing data that has already been published or materials obtained from third parties, but with no other intellectual input.
But how do you interpret these clear rules?

How do you define?

• Leadership role.
• Technical contribution.
• Writing & editorial role.

How do you exclude?

• Provider of funding.
• Author of successful grant application.
• Supervisor of the research team.
Responsibilities

• Follow policies
• Include everyone who IS an author
• Exclude those who do not meet the criteria
• Acknowledge other contributions fairly
  • Agree on authorship at an early stage
  • Agree on authorship at an early stage
  • Agree on authorship at an early stage
  • Agree on authorship at an early stage
Writing the paper!

Some general pointers + things to think about for each section of the paper
General Considerations
Scientific writing takes time!!

• Set realistic deadlines
  – Have deadlines and due dates to work to
    • talk to your research mentor

• Clear a writing schedule!
  – Create blocks of time
    • Minimum of 3 hours each + Don’t separate by more than 1 week or you forget your literature and arguments
Look to published literature for examples

- Everything you need to write a good paper is in the literature you have in front of you
  - Scientific writing is very structured and each section of a paper has key information which must be in it
  - Examine the style of intro, methods, results
    - Don’t know what to put in your participants section? Look through 4 papers and underline the key common things included in them all
    - Don’t know how to write up your results? Look for a study which has analysed data in the same way you have and follow that style
Consult your instructions for authors

Instructions for Authors

Manuscript Submission

All manuscripts are to be submitted in English. Manuscripts should be typed double-spaced on 8 1/2” x 11” (DIN A4) paper, with 1” to 1 1/2” margins. The order of the manuscript should be: title page, abstract and key words, text, references, tables, legends, and figures. The original of the manuscript, including figures and tables, etc., should be submitted to the online submission site. Editorial Manager at the following URL:

Abstract and key words. On a separate sheet, a concise abstract of 50-200 words should be accompanied by about 2-3 relevant keywords (Index terms).

Text Formatting

Manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or MathType for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

Word template (zip, 154 kB)

Manuscripts with mathematical content can also be submitted in LaTeX.

LaTeX macro package (zip, 182 kB)

Headings

Please use no more than three levels of displayed headings.

Abbreviations

Abbreviations should be defined at first mention and used consistently thereafter.
Make a writing plan

- Set a plan to tackle one section at a time
  - small bite sized pieces – usually methods, intro, results then discussion

- Create a skeleton outline
  - Create your document headings and sections
  - Before you worry about the actual paragraphs, create a series of dot points that demonstrate the flow of the arguments

- Introduction
  - Introduction of the issue
  - Limitations of literature to date
  - Aims and hypothesis

- Methods
  - Participants
  - Procedure
  - Methods of analysis

- Results
  - (All reported in order)

- Discussion
  - main findings & comparison to literature
  - Limitations
  - conclusions
Intro outline: “Challenges assessing swallowing function via telerehabilitation”

• **Paragraph 1:**
  - Current evidence for using telerehabilitation to assess dysphagia (swallowing disorders)

• **Paragraph 2:**
  - General barriers and challenges to delivery of telehealth services
    • Literature - Constantinescu et al.; Hill et al.; Theodoros et al.; Ward et al. etc

• **Paragraph 3:**
  - Specific Barriers and challenges identified in literature for to conducting a CSE via telerehabilitation – implications for service delivery
    • Literature - Lalor et al.; Myers; Ward et al (both 2007 & 2009)

• **Paragraph 4:**
  - The AIM: To examine issues encountered during the clinical assessment of dysphagia via telerehabilitation and to present the strategies undertaken to address these specific challenges
Writers block

• Nothings flowing?
  – Accept then that there is a change needed
    • You may need to cut and start again – you may be taking the wrong approach or have got off the main point
  – Stop and stew over it for a day or two – but no more – get back into it!!
  – Say the key issues / concepts you are trying to get across out aloud to partner/cat/mirror – is the flow of your argument clear?
  – Re-read and analyse the structure of the literature
    • do any published studies present things in a way that could work for your study?
Specific Considerations for each section of the paper
The sections

• Abstract    “What was done, how and what was found – in a nutshell”

• Introduction “What is the issue needing investigation & why?”

• Methods    “How was it investigated?”

• Results    “What was found?”

• Discussion “What does this mean?”
Abstract

“What was done, how and what was found – in a nutshell”
Rehabilitation of olfaction post-laryngectomy: a randomised control trial comparing clinician assisted versus a home practice approach

Ward, E.,* Coleman, A.,* van As-Brooks, C.,† & Kerle, S.*

*Division of Speech Pathology, The University of Queensland, Qld, Australia, and †Department of Head and Neck Oncology and Surgery, Netherlands Cancer Institute, Amsterdam, the Netherlands

Accepted for publication 9 October 2009

Objectives: To determine (i) the prevalence of impaired olfaction in a group of individuals post-laryngectomy, and (ii) whether intensive, clinician-supported training of the Nasal Airflow Inducing Manoeuvre (NAIM) was more effective at improving olfactory acuity than intensive, home practice over a 6-week period.

Designs: Cohort study followed by a randomised control trial of two treatments over a 6-week period with a 3-month review.

Participants: Olfactory acuity was evaluated in 43 laryngectomy patients. Results revealed 95% had impaired olfactory acuity (anosmic or hyposmic). From this group 40 eligible participants with reduced olfactory acuity were then randomly assigned into either the clinician-supported or home practice treatment group.

Main outcome measures: Olfactory acuity and functional impact measures relating to olfactory acuity (participation restriction, wellbeing/distress).

Results: Although olfactory acuity significantly improved in both treatment groups following 6 weeks of therapy, results indicated significantly greater improvement in the clinician-assisted group immediately post-treatment. By 3 months, post-treatment effects were maintained. Both modes of treatment improved levels of patient wellbeing, however, only the clinician-assisted mode made a significant positive effect on levels of perceived participation restriction.

Conclusion: Reduced olfactory acuity is prevalent post-laryngectomy. Olfactory acuity can be significantly improved using either 6 weeks of clinician-assisted or home practice using the NAIM manoeuvre, although the current data suggest that intensive clinician-assisted treatment can assist patients to improve more rapidly and have a positive impact on functional state.
Ludwig's angina is a rare clinical condition characterized by bilateral swelling of the sublingual and submandibular spaces. Although dysphagia is reported to occur in 44% to 83% of patients with this condition, there are no reports in the literature describing the nature of the dysphagia or its management. Therefore, the aim of this study was to provide descriptive information regarding the presentation and characteristics of dysphagia in this clinical population. A retrospective chart audit of 26 patients with Ludwig's angina revealed that speech pathology was involved with only 42% of patients, specifically those patients with more severe infection. Dysphagia severity at initial assessment revealed mild to severe impairments, with 36% of patients placed nil per os at their first assessment. Patients present with oropharyngeal dysphagia caused by extensive edema, impacting on bolus control, mastication, bolus transit, and airway protection. The presence of a tracheostomy tube had further negative impact on swallowing for some individuals. Management involved repeated clinical swallow assessments and compensatory management techniques to maximize swallow safety and comfort. Recovery is rapid, although the majority of patients are discharged on modified food textures because of residual swelling. The current data provide the first descriptive information on dysphagia and its management in patients with this rare clinical condition.
The Introduction

“What is the issue needing investigation & why?”
Writing the Introduction

• My tip…….Begin by writing the Aims and the hypothesis (if relevant) for your study

• Now…build on the aim. Think about what you need to tell the reader BEFORE THE AIMS to explain why this is aim is justified as new and interesting research
Writing the introduction

• Be sure to be clear in introduction **what your work adds**.....
  – If no prior research, identify this gap and how this study will fill this gap
  – If lots of prior work – highlight the limitations/weaknesses/issues with the prior and draw clear links to how the current study will overcome these
Writing the introduction

• Don’t clutter and confuse the issue!!
  – A paper introduction is NOT a detailed and comprehensive literature review!
    • Use literature to BUILD the argument
    • Brief & succinct presentation key literature to date
  – Go through your literature – what are the key studies to cite? Are there any systematic reviews which you could reference which cover the topic well?
  – Think “SHORT SWEET & TO THE POINT”
Writing the introduction

• Think about the audience, the journal, and instructions to authors
  – Do you need to explain terminology? Provide more background??
    • eg., a paper on dysphagia in telehealth going to a telehealth journal versus a SP journal

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<tr>
<th>Issue</th>
<th>TELE Journal</th>
<th>SP Journal</th>
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<td>Yes-detail</td>
<td>no- shared knowledge</td>
</tr>
<tr>
<td>Explain telehealth and why it's important?</td>
<td>minimal</td>
<td>more detailed</td>
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<tr>
<td>Length of intro (to total length of paper)</td>
<td>v.short (500-600)</td>
<td>longer (1500ish)</td>
</tr>
<tr>
<td>Language</td>
<td>general</td>
<td>discipline specific</td>
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Methods

“How was it investigated?”
Methods

• Methods should be
  – CLEAR
    • Simple writing. Fact stating. Logical order
  – REPLICABLE
    • All details provided so another research can repeat your experiment/study
  – JUSTIFIED
    • validity of tools used, reliability of raters, controls for bias
Methods

• Standard structure – look at published papers!
  – Participants
    • Explains where sample came from, inclusion and exclusion factors, the important/relevant demographics of the participants
  – Methods
    • Materials
    • Procedure
    • Statistical analysis
    • Ethics statement
Population

Due to the low incidence of the condition, the study used a retrospective audit of all patients admitted to a large metropolitan adult tertiary care hospital with a diagnosis of Ludwig’s angina over a 6-year period between January 1, 2002, and December 31, 2007. The total population was identified through a medical records search of the 6-year study time period using the International Classification of Diseases (ICD)-9-CM code K12.2 relating to “Cellulitis and abscess of mouth.” This search revealed 153 charts; of these, only two charts were unable to be accessed. The 151 available records were subsequently reviewed for specific cases with a diagnosis of Ludwig’s angina. Of the charts reviewed, a total of 26 patients had a diagnosis of Ludwig’s angina. Exclusionary criteria involved a history of dysphagia or a coexisting neurologic injury that could impact on swallowing. No patients met the exclusionary criteria; therefore, all 26 patients were included in the study. The group consisted of significantly more males than females (20 males; 6 females; $\chi^2 = 7.54; P = 0.006$). The mean age of the patients was 44 years (standard deviation [SD], 18.5; range 21–87 years). For 73% (19 of 26) of the group, the origin of infection was related to dental causes such as tooth extractions, infection, decayed teeth, and dental swelling. For the remaining participants, the origin of infection was reported to be a nondental abscess in four cases, fractured mandible in one case, and unknown causes in two cases. Ethical clearance and permission to conduct this research were obtained from both the executive director of Medical Services and the Medical Research Ethics Committee in the hospital setting.
Results

“What was found”
Results

- Factual reporting of results only
  - no interpretation beyond stating the direction of the differences observed
    - eg., group A had a significantly higher number of falls than group B

- Consider what is written & what goes in tables/figures
  - Large amounts of data go into tables/figures. Do not replicate/restate data that’s in tables figures – write only sentences that direct the reader to the table and the main pattern of findings they need to see
    - eg., The results of the between group comparisons across the 10 acoustic parameters are detailed in Table 1. Results reveal Group A had significantly lower voice quality ratings across 7 of the 10 parameters.
Results

• See how inferential statistics are reported by your journal and follow this

• Always report any inferential analysis FIRST, then any descriptive patterns discussion

• Be clear what has been determined by inferential statistics findings and what just descriptive speculations
  – Only use the term “significant” (i.e. there was a significantly greater effect of the treatment…) when you have run statistics and proved a significant difference

Admission statistics of the SP and NSP groups revealed that the SP group required a significantly longer stay in the hospital, averaging approximately 10 days compared with nearly 5 days in the NSP group (Table 1). While admitted, 91% (10 of 11) of the SP group required management in the ICU compared with 53% (eight of 15) of the NSP group. The average length of stay in the ICU for the SP group was significantly higher than the NSP group (Table 1). All 11 (100%) patients in the SP group required ventilation compared with 53% (eight of 15) in the NSP group. The duration of ventilation was also significantly longer in the SP group (Table 1). Of the 16 patients who required initial intubation via ETT, eight (50%) of these patients were in the SP group. Comparison of the duration of ETT intubation revealed that patients in the SP group were intubated for a significantly longer period of time (t = 2.60; P = 0.021)
Results

• Present results in the logical order in which they were collected
  – Eg., Baseline assessment, 3 months assessment, 6 months assessment

  – This logical order should be followed in the methods, the results and the discussion
Discussion

“What does it mean?”
Discussion

- As per introduction – begin by creating an outline of the flow of the discussion & what literature you will discuss where

- My style…..Begin discussion with a summary paragraph

The purpose of the current investigation was to describe the preparation and training, extent of clinical support, and confidence of SLPs involved in the care of clients with a tracheostomy tube in Australia. Consistent with the initial project hypothesis, the present data demonstrated that the majority of SLPs are pursuing ways to enhance their preparation for managing the tracheostomized population, are working in supported clinical environments, and feel confident to provide the clinical management of clients with a tracheostomy tube. Nevertheless, the results also indicated that only a minority of SLPs work consistently as part of an optimal team approach while managing this clinical population, and the majority feel they would benefit from additional clinical training and education opportunities. In relation to clients with a tracheostomy who require ventilator support, current data revealed that fewer SLPs feel confident to care for such clients than the nonventilated population and that their preparation and support for this area of management need to be enhanced.

The results of the current investigation support that the aerodynamic modifications inherent in the new Provox Vega facilitate enhanced voice and speech quality and reduced effort during speech production for the majority of patients in the trial. When compared directly to the main competitive commercial device (Blom-Singer Classic Indwelling) the majority of individuals selected the Provox Vega as their preferred prosthesis, reporting significantly lower levels of effort and significantly improved voice and speech capabilities with the Provox Vega. These findings were supported by perceptual judgments, which revealed that listeners rated the Vega samples (on average) to be less strained, easier to understand, produced with less effort, and the better speech sample overall.
Discussion

• A discussion in NOT about
  – re-stating your results
  – discussing every single result
    • Just the main ones that answer your questions – or raise important issues

• When discussing your findings your paragraphs should cover
  – What you found
  – How that compares to previous literature
  – And what that finding means – the implications
Production of speech at high levels of aerodynamic power is associated with the perception of increased speaking effort.\textsuperscript{1} Therefore, the perceived reduction in speaking effort reported by both the participants and the listeners would seem to be the net effect of the enhanced airflow capabilities and reduced resistance properties of the new Provox Vega prosthesis, as documented in the in vitro tests.\textsuperscript{10,11} In addition to reduced vocal effort, the majority of the participants and the perceptual judges rated the voice and speech quality of the Provox Vega as superior to the Blom-Singer Classic. Numerous factors influence the overall quality of TES\textsuperscript{12}; however, as the device was the only independent variable manipulated in this investigation, it would seem that the improved airflow capabilities were also contributing to the additional improvements in voice quality reported.

It is documented that dysphagia management is a key role of the SLP working with the tracheostomized population (Dikeman & Kazandjian, 2003; Hales, 2004; Hauck, 1999; Higgins & Maclean, 1997; Kasper, Stubbs, Barton, & Pierson, 1996). In the present study, a large proportion of the cohort felt they had a defined role within their multidisciplinary team for the management of dysphagia in clients with a tracheostomy. For a number of the SLPs, however, this role was not recognized on some of the wards and/or units in which clients with a tracheostomy were managed within their respective workplaces. This finding would suggest these SLPs need to conduct hospitalwide education in order to raise other health professionals’ awareness of the role of the SLP in managing dysphagia among the tracheostomized population (Dikeman & Kazandjian, 2003).

At 6 months post-treatment, prolonged acute reactions to radiotherapy have usually settled and general improvement is expected \textsuperscript{[1]}, as was observed with functional swallowing outcomes and tolerance of diet textures. At this time point the impact of chronic side effects on function is unclear; however, the current study observed both unchanging deficits and further deterioration in swallowing physiology, nutrition, and patient-rated functional impact. Ongoing deficits may reflect a decline in early effects, where further deterioration in components may be a reflection of the onset of late effects, found to be significantly greater (for pharynx and salivary gland) in concomitant boost regimens when compared to standard fractionation \textsuperscript{[1]}. 
Discussion

• A discussion should always include some acknowledgement or discussion of any study limitations which could have influenced results
  – its better to admit to your limitations and discuss your results in light of them….. than have a reviewer reject your paper because they see them and think you didn’t!!

• Always have a conclusions paragraph at the end (often a section with subheading)
  – should be short sharp and to the point
Now you are at the end......
Final things…

- Proof read well
  - reviewers hate sloppy manuscripts, suggests sloppy research

- Give to others to read for flow etc

- Triple check it is formatted for your journals requirements
Final things...

- Then .......Send it off...and celebrate!!!
Reporting quantitative studies: a few more technical details

Dr. Steven McPhail
Senior Research Fellow
Centre for Functioning and Health Research, QHealth &
Institute of Health and Biomedical Innovation and School of Public Health
Queensland University of Technology
Remember...

- People know nothing about your study...
- Editors / reviewers read a lot of articles
  - Write what they want
  - Where they want it
- Structure
- Structure
- Structure
- Structure
Randomised Control Trials

- CONSORT Guidelines
  http://www.consort-statement.org/
- 25 Item checklist
- Flow diagram
<table>
<thead>
<tr>
<th>Section/Topic</th>
<th>Item No</th>
<th>Checklist item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title and abstract</td>
<td>1a</td>
<td>Identification as a randomised trial in the title</td>
</tr>
<tr>
<td></td>
<td>1b</td>
<td>Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts)</td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td>2a</td>
<td>Scientific background and explanation of rationale</td>
</tr>
<tr>
<td></td>
<td>2b</td>
<td>Specific objectives or hypotheses</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td>3a</td>
<td>Description of trial design (such as parallel, factorial) including allocation ratio</td>
</tr>
<tr>
<td></td>
<td>3b</td>
<td>Important changes to methods after trial commencement (such as eligibility criteria), with reasons</td>
</tr>
<tr>
<td>Participants</td>
<td>4a</td>
<td>Eligibility criteria for participants</td>
</tr>
<tr>
<td></td>
<td>4b</td>
<td>Settings and locations where the data were collected</td>
</tr>
<tr>
<td>Interventions</td>
<td>5</td>
<td>The interventions for each group with sufficient details to allow replication, including how and when they were actually administered</td>
</tr>
<tr>
<td>Outcomes</td>
<td>6a</td>
<td>Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed</td>
</tr>
<tr>
<td></td>
<td>6b</td>
<td>Any changes to trial outcomes after the trial commenced, with reasons</td>
</tr>
<tr>
<td>Sample size</td>
<td>7a</td>
<td>How sample size was determined</td>
</tr>
<tr>
<td></td>
<td>7b</td>
<td>When applicable, explanation of any interim analyses and stopping guidelines</td>
</tr>
<tr>
<td><strong>Randomisation:</strong></td>
<td>8a</td>
<td>Method used to generate the random allocation sequence</td>
</tr>
<tr>
<td>Sequence generation</td>
<td>8b</td>
<td>Type of randomisation; details of any restriction (such as blocking and block size)</td>
</tr>
<tr>
<td>Allocation</td>
<td>9</td>
<td>Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned</td>
</tr>
<tr>
<td>concealment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mechanism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td>10</td>
<td>Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions</td>
</tr>
<tr>
<td>Blinding</td>
<td>11a</td>
<td>If done, who was blinded after assignment to interventions (for example, participants, care providers, those...</td>
</tr>
</tbody>
</table>

*CONSORT 2010 checklist of information to include when reporting a randomised trial*
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11b</td>
<td>If relevant, description of the similarity of interventions</td>
</tr>
<tr>
<td>12a</td>
<td>Statistical methods used to compare groups for primary and secondary outcomes</td>
</tr>
<tr>
<td>12b</td>
<td>Methods for additional analyses, such as subgroup analyses and adjusted analyses</td>
</tr>
<tr>
<td>13a</td>
<td>For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome</td>
</tr>
<tr>
<td>13b</td>
<td>For each group, losses and exclusions after randomisation, together with reasons</td>
</tr>
<tr>
<td>14a</td>
<td>Dates defining the periods of recruitment and follow-up</td>
</tr>
<tr>
<td>14b</td>
<td>Why the trial ended or was stopped</td>
</tr>
<tr>
<td>15</td>
<td>A table showing baseline demographic and clinical characteristics for each group</td>
</tr>
<tr>
<td>16</td>
<td>For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups</td>
</tr>
<tr>
<td>17a</td>
<td>For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)</td>
</tr>
<tr>
<td>17b</td>
<td>For binary outcomes, presentation of both absolute and relative effect sizes is recommended</td>
</tr>
<tr>
<td>18</td>
<td>Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory</td>
</tr>
<tr>
<td>19</td>
<td>All important harms or unintended effects in each group (for specific guidance see CONSORT for harms)</td>
</tr>
<tr>
<td>20</td>
<td>Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses</td>
</tr>
<tr>
<td>21</td>
<td>Generalisability (external validity, applicability) of the trial findings</td>
</tr>
<tr>
<td>22</td>
<td>Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence</td>
</tr>
<tr>
<td>23</td>
<td>Registration number and name of trial registry</td>
</tr>
<tr>
<td>24</td>
<td>Where the full trial protocol can be accessed, if available</td>
</tr>
<tr>
<td>25</td>
<td>Sources of funding and other support (such as supply of drugs), role of funders</td>
</tr>
</tbody>
</table>

*We strongly recommend reading this statement in conjunction with the CONSORT 2010 Explanation and Elaboration for important clarifications on all the items. If relevant, we also recommend reading CONSORT extensions for cluster randomised trials, non-inferiority and equivalence trials, non-pharmacological treatments, herbal interventions, and pragmatic trials. Additional extensions are forthcoming: for those and for up to date references relevant to this checklist, see [www.consort-statement.org](http://www.consort-statement.org).*
Systematic review and meta-analysis of RCTs

- PRISMA Guidelines
  - Superceded QUOROM
- 27 Item checklist
- 4-Phase Flow diagram
Meta-analysis of observational studies

- MOOSE Guidelines
- 35 Item checklist
Diagnostic accuracy

- STARD Guidelines
- 25 Item checklist
- Flow diagram
Observational studies

- STROBE Guidelines
- 22 Item checklist
- Flow diagram
Clinical guidelines

• GRADE
  • http://www.gradeworkinggroup.org/
  or
  • http://www.bmj.com/content/328/7454/1490

• Process description
  – Clinical guideline
    • Development
    • Reporting
    • 8 Factors
Take home message

• Will it pass the 1am test?

• If it’s not easy to read at 1am...

  you need to make it easier to read!
Steven McPhail – Senior Research Fellow

Centre for Functioning and Health Research, Queensland Health
Institute of Health and Biomedical Innovation and School Public Health, QUT

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...and for qualitative studies...
Writing for qualitative research

• Becoming more accepted within both health and social sciences.
• Essential for exploratory and complex topics
• Suited to theory development
• Pure qualitative research
• Mixed methods
Writing for qualitative research

- Qualitative design uses words and text to explore phenomena
- Strong participant focus
- Detail on process
- Emphasis on qualitative dimensions of rigour (but not causation)
Writing for qualitative research

• Assumes in-depth analysis
• Focus of the research (and the writing) is on the how and why
• Insider view-individual perspectives
• Researcher is important
  – Naturalistic
  – Flexibility in sampling
  – Context-specific
  – Bias is recognised and accepted as part of the research process
Writing for qualitative research

Results section is usually longer

• Themes identified (names & description)
• Categories within each theme (names & description)
• Verbatim quotes that exemplify category or theme
Writing for qualitative research

Results section is usually longer

- Audit trail of conclusions
- How rigour was established
- How findings are credible, confirmable, transferable, trustworthy, etc
The Submission process
Some handy hints before you start the submission process

- Check the ‘Instructions for authors’ section of the journal website
- Make sure your files are in the correct format
- Figures and tables should be separate from the main text
- Your cover page with author details may need to be separate to allow for anonymous review
- Have a copy of your manuscript open on the computer so you can cut and paste sections
- Have keywords ready
- Potential reviewers
First time you ever submit a paper to the journal

Subsequent times you submit a paper or make changes to a submission
Welcome

Welcome to the *International Journal of Speech-Language Pathology* site. The centre links below indicate which "roles" you can currently perform for the journal. Click on a link to begin working in the role (e.g., Author, Reviewer, etc.) in Manuscript Central. You can return to this screen to change centres at any time by clicking on the "Main Menu" link above.

- **Author Centre**
- **Reviewer Centre**

Click here if you are submitting a paper
First time you start a new paper submission to the journal

Subsequent times you log on to make changes to a paper before you submit it
Select your manuscript type. Enter your title, running head, and abstract into the appropriate boxes below. If you need to insert a special character, click the "Special Characters" button. When you are finished, click "Save and Continue."
The wait begins..........
YAY!!
That was easy!

Why??

The work continues…

3 main outcomes

Accept

Reject

Revise
Revisions

• Respond to ALL comments
• Separate document for answering the questions
• Track changes
• Meet deadlines
• Submit changes online
The wait begins again........
Once your paper has been accepted…

- pdf proof
- Copyright transfer form
- Advanced electronic copy

Carefully follow deadlines again
Now wait until your article comes out and everyone can read it!
A few final notes

- The process of submitting a paper can be very long
- Always follow the journal, editor’s and reviewers’ instructions – don’t do your own thing
- Never miss deadlines
- Keep the end goal in sight