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The AMWA Journal expresses the interests, concerns, and expertise of members. Its purpose is to inspire, motivate, inform, and educate them. The Journal furthers dialog among all members and communicates the purposes, goals, advantages, and benefits of the American Medical Writers Association (AMWA) as a professional organization. Specifically, it functions to

- Publish articles on issues, practices, research theories, solutions to problems, ethics, and opportunities related to effective medical communication
- Enhance theoretical knowledge as well as applied skills of medical communicators in the health sciences, government, and industry
- Address the membership’s professional development needs by publishing the research results of educators and trainers of communications skills and by disseminating information about relevant technologies and their applications
- Inform members of important medical topics, ethical issues, emerging professional trends, and career opportunities
- Report news about AMWA activities and the professional accomplishments of its departments, sections, chapters, and members

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CHRONOLOGY OF DIRECT-TO-CONSUMER ADVERTISING REGULATION IN THE UNITED STATES

By Scott A. Mogull, MS, MA
Austin, TX

ABSTRACT:
Promotion of pharmaceutical drugs to consumers, called direct-to-consumer (DTC) advertising, has increased significantly since 1997, when the US Food and Drug Administration (FDA) reevaluated its regulations of pharmaceutical manufacturers. DTC advertising has been debated in the literature, with most articles citing the 1997 shift in FDA policy. However, the current position of the US government on DTC advertising has more than a century of developments. This article outlines the legislative and regulatory milestones that have given rise to the current legal framework of DTC advertising in the United States.

Direct-to-consumer (DTC) advertising, in which pharmaceutical companies market therapeutic agents directly to consumers, is unique to the United States and New Zealand. The United States represents the largest DTC advertising market and accounts for approximately 50% of global pharmaceutical sales.1

DTC advertising has been vehemently debated in the literature.1 The primary argument in favor of DTC advertising is to provide disease and treatment information to health care consumers.2 Opponents argue that harmful consequences can result from DTC advertising. A chief concern is that health care consumers may not adequately comprehend the use, benefits, and risks associated with such highly technical products as prescription drugs.1,2 Because the primary arguments for and against DTC advertising both scrutinize the role of health information, DTC advertising is an important consideration for medical writers. In fact, much of the technical information for DTC advertising comes from the documentation produced during the drug development process.3

In the United States, the Food and Drug Administration (FDA) is the government agency with the authority to regulate DTC advertisements.4 The FDA has noted an increase in DTC advertising and the crucial role of regulation. According to the FDA:4

Accurate and complete information is vital to the safe use of drugs. While drug companies have traditionally promoted their products directly to physicians, more and more they are advertising directly to consumers. Advertising of OTC [over-the-counter] drugs is regulated by the Federal Trade Commission, but CDER [Center for Drug Evaluation and Research; a division of the FDA] oversees the advertising of prescription drugs.

Many papers published on DTC advertising provide limited historical context—focusing on the single decision in 1997 when the FDA clarified DTC advertising regulations and made advertisements feasible in the prominent broadcast media of the time (specifically television and radio). A few of the more extensive reviews provide more historical context—with a timeline extending to the 1980s, when the first modern examples of DTC advertising appeared on television.1 This article chronicles the regulatory trends of DTC advertising in the United States and describes a century of legislation and regulation.

CATEGORIES OF DTC ADVERTISING
The FDA currently categorizes DTC advertising into 3 categories:5
• **Product claim**—includes the product name and therapeutic use of a product
• **Help-seeking**—discusses a disease and encourage a doctor’s visit (these advertisements do not mention the product’s name)
• **Reminder**—includes the product’s name but does not refer to the disease
Of these 3 types of advertisements, the product claim advertisement is the only one over which the FDA has jurisdiction. The therapeutic claim must be accurate and not mislead the consumer. Print advertisements must have a “fair balance” between the space devoted to benefit and risk information and the space allotted to a summary of side effects, contraindications, and precautions directly from the product’s label. Broadcast advertisements, which typically range from 30 to 60 seconds, must clearly state important risk information and direct consumers to a source of more information (such as a Web site, toll-free telephone number, health care provider, or print source with large circulation).

### CHRONOLOGY OF US LEGISLATION AND REGULATION OF THE MARKETING AND ADVERTISING OF THERAPEUTIC AGENTS

Pharmaceutical drug development is a highly regulated process that ensures therapeutic agents are safe and effective for use. In the United States, the FDA’s regulatory authority dates back to 1906 when Congress passed the original Food and Drugs Act (Table 1). This act prohibited interstate commerce of misbranded and adulterated food and drugs. The original Food and Drugs Act provided limited regulation of the marketing claims made by drug manufacturers and salespeople, but it is important in establishing the role of the FDA.

In the first major case regarding marketing claims (United States v Johnson [1911]), the Supreme Court ruled that the 1906 Food and Drugs Act required manufacturers and salespeople to accurately divulge the ingredients or identity of a drug. Although an important step toward accurate marketing and advertising, this act had one critical limitation—it did not prohibit false therapeutic claims of agents. Therefore, as long as a therapeutic agent was properly identified, manufacturers and salespeople could legally claim that the agent could be used to treat or cure any disease.

In 1912, Congress quickly responded to the Supreme Court’s ruling by passing the Sherley Amendment, which prohibited the labeling of medicines with false therapeutic claims with the intent to defraud consumers. Although Congress intended to ensure accurate declarations of curative effects, the FDA reported that proving the intent deliberately to defraud consumers was a standard too difficult to prove in a court of law.

In 1933, the FDA recommended a complete revision of the 1906 Food and Drugs Act. As part of the recommended revisions, the FDA requested the authority to prosecute false therapeutic claims. Despite this request by the FDA, it took a US catastrophe in order for major changes to be legislated. In 1938, the S.E. Massengill Company began selling a liquid form of sulfanilamide, which had been used in tablet and powder form to treat streptococcal infections. The liquid configuration, called elixir

### Table 1. Summary of Milestones

<table>
<thead>
<tr>
<th>Date</th>
<th>Milestone</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906</td>
<td>Congress passes the Food and Drugs Act</td>
<td>Prohibits interstate commerce of misbranded food and drugs; establishes regulatory authority of FDA</td>
</tr>
<tr>
<td>1911</td>
<td>Supreme Court decision in United States v Johnson</td>
<td>Requires manufacturers and salespeople to divulge the identity of a drug’s ingredients</td>
</tr>
<tr>
<td>1912</td>
<td>Congress passes Sherley Amendment</td>
<td>Prohibits labeling of medicines with false therapeutic claims with the intent to defraud consumers</td>
</tr>
<tr>
<td>1938</td>
<td>Congress passes The Federal Food, Drug, and Cosmetic Act of 1938</td>
<td>Requires manufacturers to show that new drugs are safe before they are marketed</td>
</tr>
<tr>
<td>1938</td>
<td>FDA limits access to certain drugs</td>
<td>Declares that select drugs must be administered by qualified experts</td>
</tr>
<tr>
<td>1951</td>
<td>Congress passes the Durham-Humphrey Amendment</td>
<td>Expands the list of drugs requiring medical supervision; restricts sales, requires prescriptions written by licensed practitioners</td>
</tr>
<tr>
<td>1962</td>
<td>Congress passes the Kefauver-Harris Amendments</td>
<td>Requires manufacturers to provide evidence to the FDA that drugs are safe and effective before they are marketed</td>
</tr>
<tr>
<td>1967</td>
<td>Congress enacts the Fair Packaging and Labeling Act</td>
<td>Requires manufacturers to provide drug information to consumers</td>
</tr>
<tr>
<td>1970</td>
<td>FDA requires patient package inserts</td>
<td>Requires manufacturers to provide information related to benefits and risks to consumers</td>
</tr>
<tr>
<td>1993</td>
<td>FDA regulates DTC advertising</td>
<td>Requires manufacturers to include all side effects and contraindications in DTC advertising; FDA requests that manufacturers voluntarily submit marketing materials for review</td>
</tr>
<tr>
<td>1997, 1999</td>
<td>FDA publishes Guidance on DTCA (draft and final version)</td>
<td>Permits promotional advertisements on broadcast media (eg, television, radio) that does not devote equal time to promotion and risks</td>
</tr>
<tr>
<td>2006</td>
<td>FDA updates product label requirements</td>
<td>Requires manufacturers to provide clear and concise prescribing information</td>
</tr>
</tbody>
</table>
In 1960, the William S. Merrell Company submitted a new drug application for Kevadon (a brand name of the drug thalidomide), a sleeping pill that had been available for treatment in Europe since 1956. The FDA medical officer assigned to review the drug application, Dr Frances Kelsey, believed that the data were incomplete to support safe use, and this drug was not approved for sale in the US market. In 1961, the drug was suspended from the German market because of birth defects in which newborns exhibited abnormally short limbs with toes sprouting from the hips and “flipper-like” arms. News reports that the strict FDA regulation kept this drug from the US market fostered public support for stronger drug regulation. As a direct result of these events, Congress passed the Kefauver-Harris Amendments in 1962, which require that manufacturers prove to the FDA that their drugs are safe and effective before they can be marketed. Furthermore, the FDA gained the responsibility and authority to regulate the advertising of prescription drugs.

Although the distribution of prescription drugs has remained essentially the same since 1960, the FDA and Congress have continued to refine modes by which drug information is communicated to consumers. In 1967, Congress enacted the Fair Packaging and Labeling Act, which stated:1

In 1970, the FDA required the first prescription drug information, commonly referred to as the patient package insert. This document reports specific risks and benefits of the therapeutic agent.

Through the 1980s, the FDA did not prevent drug manufacturers (ie, modern-day pharmaceutical companies), from advertising to the general population. In general, pharmaceutical companies focused advertising to health care professionals, and the absence of DTC marketing was primarily a result of the lack of attention by the pharmaceutical companies to the health care consumer.1 In the 1980s, the pharmaceutical industry started to redirect their marketing of therapeutic drugs to the general public. The advertising of therapeutic agents at that time was for “recognized nonserious conditions” such as arthritis. For example, in the early 1980s, Rufen was advertised on television for arthritis pain. In 1982, the FDA requested a voluntary moratorium on DTC advertising while the agency evaluated the shifting trend in directing advertising more toward consumers and less toward health care practitioners. In 1985, the FDA lifted this moratorium, and DTC advertising gradually increased.1

In the early 1990s, pharmaceutical companies began advertising therapeutic agents for more serious conditions such as migraine and epilepsy.1 In 1993, the FDA requested that pharmaceutical companies voluntarily submit marketing and advertising materials targeted to patients and the general public for review and comment. As part of this change in policy, the FDA mandated that these DTC advertising materials included a list of all side effects and contraindications for use of the therapeutic agent. These regulations specified that pharmaceuti-

The conclusions of the FDA were mixed—DTC advertising has both a positive and negative impact.
tual companies had to devote equal space to advertising and risk communication. Thus, if 1 page in a magazine contained advertising information for a drug, a second page was needed to convey the risk information. Although this regulation could be easily accommodated in print, pharmaceutical companies found television and radio advertising to be impractical.1

In 1997, the FDA published preliminary guidelines for DTC advertising. In Guidance to Industry: Consumer-Directed Broadcast Advertising, the FDA clarified vague regulation of DTC advertising by permitting promotional advertisements on broadcast media (such as television and radio) that did not devote an equal amount of time to promotion and risks, as long as sources for more information were provided. After the 1999 publication of the FDA’s Final Guidance on DTCA, pharmaceutical companies began large marketing campaigns for therapeutic agents. In 2002, the authority of the FDA to regulate DTC advertising was challenged, as this authority was considered by one company to violate its First Amendment right of “freedom of speech.” The reported outcome was that DTC advertising was not banned in the United States and the FDA could continue to regulate advertising as part of the organization’s mandate to protect consumers.1

Starting in 1999, the FDA began to investigate the impact of DTC advertising through large surveys of patients and physicians. In the final report, published in 2004, the FDA concluded that DTC advertising appears to increase awareness of conditions and treatments, motivate questions for health care providers, and help patients ask better questions.9 However, in the same survey, patients expressed a modest rating of the understandability of a product’s risks. The conclusions of the FDA were mixed—DTC advertising has both a positive and negative impact. However, because the negative impact did not appear to outweigh the positive benefits of DTC advertising, the FDA will probably continue to permit DTC advertising.

In an ongoing effort to improve health communication, the FDA updated the requirements for prescription drug information: Clear and concise prescribing information must be provided with the most important drug information being prominently displayed. This new regulation, which went into effect in 2006, benchmarks a century of the FDA’s refinement of communication of drug information among manufacturers, physicians, and consumers.

CONCLUSION
This article has chronicled a century of US regulation of therapeutic drug agent manufacturers. An important conclusion from this review is that advertising to consumers, although not prominent in recent history until the FDA decision of 1997/1999, was primarily due to a lack of focus on this audience. The sale of drugs by prescription only, which began in 1938, resulted in the manufacturers shifting their focus from consumers to prescribers. DTC advertising has been prominent in the US media since the late 1990s. This trend illustrates that modern pharmaceutical companies are refocusing again on the final consumer. While this change may appear to be a recent and significant change, the historical analysis of DTC advertising regulation shows that advertising to the consumer has had a much longer history in the United States.

Acknowledgment
I acknowledge Dr Amy Koerber for insightful comments on earlier drafts of this article. Additionally, I thank the anonymous reviewers for their constructive recommendations.

References
Setting the Pace

AMWA’s 68th Annual Conference
October 23-25, 2008

By Robert J. Bonk, PhD
Annual Conference Administrator

And we’re off! Registration is heading toward the finish line for AMWA’s 68th Annual Conference in Louisville this October. As you’ve been making your travel plans to join your AMWA colleagues, have you saved enough time in your schedule to take advantage of all that our conference has to offer? Consider these activities as you finalize your conference stay.

Arrive in time for festivities at the starting gate of the annual conference on Wednesday, October 22. Will this be your first (of many!) AMWA annual conference? Then join other new members—as well as colleagues who have been around the track more than a few times—for the New Member Orientation, 4:15-5:00 PM. You can pair up with a more experienced attendee for the Conference Coach Connection, 5:00-6:00 PM. You’ll then have new friends for the Welcome Reception, 6:00-8:00 PM, sponsored by RPS.

Exhibits will also be open during the reception so that you can see who has the latest tools, techniques, and recruitment opportunities to help you in your career as a medical communicator. In fact, exhibits will be open on Thursday and Friday as well, so you’ll have plenty of time to visit. To top off your evening, drop in for the Creative Readings, 8:15-9:30 PM, to read one of your own works or to take in the creativity of your new colleagues.

Calling all AMWA Coaches!
Sign up for the Conference Coach Connection as a mentor for colleagues attending our annual conference for the first time. Show your colleagues the ropes, take them through the paces, and saddle up for refreshments later! For information on becoming a conference coach, visit the AMWA Web site at www.amwa.org.

Plan to attend the Keynote Address on Thursday, October 23, 9:00-10:30 AM, to hear about “Prevention of Coronary Heart Disease in the Millennial Woman” from our guest speaker, Nanette K. Wenger, MD, FACC, of Emory University School of Medicine in Atlanta. Dr Wenger’s presentation will provide important information on how coronary heart disease affects women differently than men, as well as emphasize preventive interventions across each woman’s lifespan to reduce her cardiovascular risk.

Be sure to attend the John P. McGovern Award Luncheon that same day, 12:15-1:30 PM. Doors open at 12:00 PM for those who purchased lunch tickets, and at 12:45 PM if you can attend for only the presentation. Our speaker is Kerri Remmel, MD, PhD, of the University of Louisville Stroke Center. Dr Remmel’s presentation, “Domo Arigato, Dr Roboto (Thank You Very Much, Dr Robot),” will focus on using robotics to provide better stroke care to those who live far from a state-of-the-art medical center.

Horse photo courtesy of www.kentuckytourism.com.
Also on Thursday, catch up with fellow chapter members at the Chapter Greet & Go. Held 5:30-6:15 PM, the Greet & Go gives your chapter a place to meet before going out to dinner. You’ll still have time to attend the Coffee & Dessert Klatches, 8:00-9:00 PM.

On **Friday, October 24**, take some time to meet our poster presenters, 7:45-8:45 AM. The posters will be on display throughout the conference. *(Review the abstracts for the posters beginning on page 118.)* Also drop in for Breakfast with the Exhibitors, 8:00-9:00 AM. Visit with the exhibitors while you energize yourself for the educational sessions and other activities throughout the day.

Don’t forget to attend the Alvarez Award Luncheon on Friday, 12:15-1:30 PM. Doors open at 12:00 PM for those who purchased lunch tickets, and at 12:45 PM if you can attend for only the presentation. Our awardee, T. L. (Tedd) Mitchell, MD, is president and chief operating officer of Cooper Clinic, Dallas, a preventive medicine clinic that operates on the philosophy that it is far easier to maintain good health than to regain it once it’s lost. The title of Dr Mitchell’s presentation is “Move Yourself: Getting Americans Back on the Path to Good Health.”

As usual, our Annual Business Meeting will occur on Friday, 5:30-6:30 PM. Hear what Cindy Hamilton, our incoming president, has set for AMWA’s direction during her term in office. Meet our new Executive Committee and contribute to setting our pace.

Throughout the 2008 AMWA Annual Conference, you’ll have the traditional wide variety of credit and noncredit workshops, breakfast roundtables, open sessions, tours, and other events to fill your days. This year, there are also 2 exciting new options: the AMWA Pavilion, which features health awareness booths, and the complimentary Cybercafé.

Afterward, join your colleagues at the Swanberg Awards Dinner, 7:00-9:00 PM. Don’t miss this prestigious event, when Sue Hudson, 2007-2008 AMWA President, and Karen Klein, Administrator of Awards, recognize AMWA members for their distinctive contributions to our profession. Celebrate their accomplishments with all of us.

Don’t miss the exciting events scheduled for **Saturday, October 25**: not only breakfast roundtables, open sessions, and workshops, but also the special information on health awareness and other topics available from the participants at the AMWA Pavilion. End the day with the fun-filled President’s Reception and kick-off for next year’s conference in Dallas; the reception will be held 5:30-6:45 PM. You might even win a great prize!

Make plans to stay over Saturday night to end your stay in fabulous Louisville with the Lexington Horse Park tour on **Sunday, October 26**.

**See you at the finish line!**
RPS has created the industry’s first Pharmaceutical Resource Organization (PRO) to provide business process outsourcing solutions for clinical drug development. Pharmaceutical, Biotechnology and Medical Device companies that partner with RPS have experienced:

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WITH RESPECT TO PATIENTS AND READERS: DEADLY TERMS TO EXCISE*

By Mary E. Knatterud, PhD
University of Minnesota Medical School, Minneapolis, MN

ABSTRACT: In the rhetorical space of my one-on-one teaching and editing relationship with surgeon-scientists, I strive to excise terms that dehumanize patients or derail readers (ie, terms that are insensitive or obfuscating or both). To distill my empathy-oriented advice into manageable, memorable bite-sized chunks—à la 7 deadly sins, or 7 wonders of the publish-or-perish world—I herein present 7 dismay-causing terms to avoid if you want to show respect for patients on paper or screen and another 7 deour-causing terms to avoid if you want to show respect for your readers. These 14 terms are the polar opposite of "user-friendly," and they are fairly easy to banish from your prose, with a little good-faith effort.

My list of patient-unfriendly terms to cut includes (1) "patient management," (2) "clinical material," (3) "case" used for a patient, (4) "present" used of a patient, (5) "failure" attributed to patients, (6) "elderly," and (7) "rule of thumb." Likewise, I recommend jettisoning, in most contexts, these reader-unfriendly terms: (1) "respectively," (2) "former" and "latter," (3) "this" bereft of a noun, (4) "there" clauses, (5) "it" clauses, (6) vague uses of "between," and (7) undecipherable references to "the authors." Leaving out such easy-to-remember, hard-to-stomach contaminants would leave more breathing room and heart in medical publications.

A longtime author’s editor in a bustling surgery department, as a change agent in the powerful and power-laden genre of medical writing, I know that overtaxed faculty and residents cannot readily squeeze intensive writing practice, or grammar or usage training, into their 24/7 workweeks. But as surgeon-scientists schooled in the art of removing offending body parts and wiping out dangerous disease processes, they do know how to take things out, to excise whatever blocks the way to restored health: they dissect out necrotic gallbladders or pancreases, amputate gangrenous toes, scrape away arterial plaque, burn off plantar warts, suction out peritoneal fluid, drain pus, retrieve aspirated toys, ablate tumors, debride wounds, cut out polyps, enucleate eyeballs.

Why not marshal all that can-do bravado and use it to surgically remove terms that are demeaning to patients and obfuscating to readers in the medical journals and textbooks drafted by these researchers? Sometimes zeroing in on the negative is the most authoritative way to ensure truly affirmative action à la the Ten Commandments: “Thou shalt nots” and official position statements and guidelines encouraging nonsexist or nonracist language.

Other examples of negative commands include the Joint Commission on Accreditation of Healthcare Organizations’ list of dangerous “Do Not Use” abbreviations, acronyms, and symbols (such as “IU” for international unit, potentially mistaken by pharmacists and other caregivers as “IV” for intravenous or “10”); Michigan’s Lake Superior State University annual “List of Banished Words” (which in 2007 included such disrespectful, breezy-sounding euphemisms as “Gitmo” and “gone/went missing”); and a commentary in the journal Minnesota Medicine by Gary Schwitzer, University of Minnesota Health Journalism scholar. Schwitzer skewered 7 words that “reporters should never use in medical news”: namely, miracle, cure, breakthrough, promising, hope, victims, and dramatic. As Schwitzer elaborated, “In research I conducted in 2002, I found almost a thousand stories about experiments to develop a drug for the common cold. A third of them referred to the drug as a miracle, a wonder drug, or a super drug, or used some other sensational term. Many predicted imminent Food and Drug Administration (FDA) approval. An FDA advisory committee unanimously rejected the drug”—a fact that few, if any, original reports ever bothered to prominently follow up.

In the rhetorical space of my one-on-one teaching relationship with both aspiring and seasoned surgeons (a space that incorporates ongoing field, observational, and text-based study all at once), I strive to close the gate, firmly and forever, on terms that heartlessly dehumanize patients or hopelessly derail readers; ie, terms that are insensitive or obfuscating or both. Whether scrawled in the margin of one of my colleagues’ manuscripts or stressed in a quick meeting in my office or theirs (or, more likely, in the hallway or elevator), my litany of outright banned unhealthy terms aims to set in motion, in their writerly hands, the same visceral “take it out” zeal that their physiologic operations inspire. I’m on their side, helping them revise; and we are both ineluctably on the reader’s side or, as the case may be, the patient’s side. The ethos of skilled caring aspired to by well-meaning physician-authors is harmed, simply and profoundly, by terms that are problematic. Of course, such terms

*Several passages and quotations from the first half of this article (on patient-unfriendly terms) are from Knatterud’s doctoral dissertation-turned-book. First Do No Harm: Empathy and the Writing of Medical Journal Articles (New York and London: Routledge; 2002). In addition, Knatterud presented portions of this material at the Twin Cities Shriners Hospital (May 23, 2006, Minneapolis, MN) and as part of a panel titled Does Science Matter? at the annual convention of the Conference on College Composition and Communication, a division of the National Council of Teachers of English (March 19, 2005, San Francisco, CA).
will most likely continue to appear in the work of writers who are unaware of the disrespect they perpetuate, but that is all the more reason for their sensitized colleagues to start setting a better example.

From my vantage point as an English PhD amid a sea of MDs and basic science PhDs in an academic surgery department, I wrote an entire dissertation-turned-book on the topic of empathy toward patients on paper (a work that grew from a paper, published as an article in this journal, that I had presented at my first-ever AMWA conference in Los Angeles in 1990). To distill some of that empathy — and another 7 detour-causing terms to excise if you want to show respect for patients on paper or screen — into more manageable, memorable, bite-sized chunks in the spirit of Schwitter’s 7 words to zap out of newspaper stories — I herein present 7 dismay-causing terms to excise if you want to show respect for patients on paper or screen and another 7 detour-causing terms to excise if you want to show respect for your readers. The 14 terms listed and briefly annotated below are the opposite of “user-friendly”; in fact, they are rude (in my opinion). But they are also fairly easy to banish from your prose, with a little good-faith effort.

**EXCISE THESE 7 PATIENT-UNFRIENDLY TERMS**

1. **any form of the word “management” inflicted directly on patients, as in “patient management” or “other options for managing this patient”**

   Why not “patient care,” which is shorter and much sweeter, or “other options for caring for this patient”?

   “Management” is the realm of bottom-line-obsessed businesspeople and supervisors. In compelling contrast, physicians and nurses and pharmacists and orthotists and other health workers are in a profession that professes a deep humanistic commitment, ideally collaborating with patients and involving them as active participants in their own recovery, not bossing them around as underlings or commodifying them into products. It is fine to “manage” patients’ blood pressure, or their diabetes, or their care, or their postoperative pain, or their hospital discharge, but not to manage the patients themselves.

2. **the oxymoron “clinical material,” as in “Our study’s clinical material consisted of 50 children with cerebral palsy and 50 with scoliosis.”**

   Why not instead write, “Our study participants...” or “Our study group...”? I personally don’t like the top-down whiff of the overwhelmingly common “study subjects” either, as if physicians are ensconced on a throne looking down on their pliant serfs, but it’s slightly better than reducing patients to “material.”

3. **“case” substituted for a patient, as in “The first case with this complication developed type 1 diabetes at the age of 6,” or “We operated on several cases that came in by ambulance the night before.”**

   This is an oldie but not goodie that has still not been eradicated. Morris Fishbein, MD, the storied former editor of the Journal of the American Medical Association, railed against equating patients with “cases” 6 decades ago: “A case is an instance of disease, the totality of the symptoms and of the pathologic and other conditions; a patient is the human being afflicted. One continually finds in medical manuscripts such sentences as ‘The case had a fever,’ ‘Thirty cases were admitted to the hospital’ and ‘The case was operated on.’ In the publications of the American Medical Association such usages are banned.”

   “Case” as a stand-in for the patient is not recognized by the Oxford English Dictionary except as an afterthought in definition 8b: “Also (colloq.), a patient.” Ironically, its 1864 illustration of the word seemingly condemns this colloquialism: “Nothing else could teach him that patients are not cases but persons.”

4. **a form of the verb “to present” used of a patient, as in “a 37-year-old man who presented with localized melanoma”**

   Why not delete “who presented” and simply write, “a 37-year-old man with localized melanoma”? If more details are needed, add them; eg, “When we first examined this 37-year-old man, he had localized melanoma.” To me, applying “present” directly to patients underscores the imbalance of power, as if patients are offering themselves up to some formidable military inspector or self-aggrandizing monarch or priest — rather than seeking care from a fellow human being who happens to have medical expertise. This usage conjures up the primatologist’s langur, which “exhibits no visible sign when she is in estrus other than to present to a male and to shudder her head” — not an apt image
of what a mutually respectful physician-patient relationship should be!

5. any form of the word “failure” attributed to patients, as in blame-the-victim putdowns like “patients who failed cardiac resynchronization therapy” or “treatment failures were asked to return for further workup”

It is the therapy or the treatment that failed, not the human being valiantly undergoing it. Phrasing such as the examples must be recast, as in “for patients whose cardiac resynchronization therapy failed” or “patients whose treatment results were suboptimal.”

6. the term “elderly,” especially the amorphous lumping and dumping of people into that group with the definite article, as in “the elderly”

For a field like medical writing that putatively honors exactness and careful observation, wouldn’t the descriptor “patients 80 years or older” be more precise as well as less patronizing? The sheer inaccuracy of “elderly” is illustrated by the term “elderly primigravida,” endorsed by the International Federation of Obstetricians and Gynecologists as recently as 1959 and referring to any woman age 35 or older! Empathetically enough, a 1995 New England Journal of Medicine editorial wishes that this term would “become outmoded.”12 The October-November 1999 issue of the Copy Editor newsletter, describing “a recent survey of 803 American men and women ages 50 to 75,” notes that topping their list of “most objectionable labels” was the phrase “the elderly.”13

7. the etymologically challenged cliché “rule of thumb,” as in “The rule of thumb for transplant recipients who experience an episode of rejection is to increase their immunosuppressive drug doses”

This term carries some violently disgraceful baggage and should never be allowed to intertwine with statements about patients or anyone else. Like the casual use of “wife-beater” for a sleeveless T-shirt (a use banned by The Boston Globe), “rule of thumb” has at least a few tortuous roots in court-sanctioned domestic abuse. Its unsavory legal past, though widely dismissed on the Internet as an urban legend, is a fact. As Linda Hirshman, a professor of women’s legal studies, notes, “there are at least three 19th-century American cases that refer explicitly to the right of a husband to beat his wife with a ‘stick as large as his finger but not larger than his thumb.’”14 With the expert help of a reference librarian at the University of Minnesota Law School, I tracked down copies of those 3 cases15 cited by Hirshman (and there may be many more). In Calvin Bradley v The State (a case that came before the Supreme Court of Minnesota in December 1824), the Honorable Powhatten Ellis referred to “those, who might think [it] proper to use a whip or rattan, no bigger than my thumb, in order to enforce the salutary restraints of domestic discipline.” In State v A.B. Rhodes (a case that came before the Supreme Court of North Carolina in January 1868), the prior history section noted that “His Honor was of [the] opinion that the defendant had a right to whip his wife with a switch no larger than his thumb.” In State v Richard Oliver (a case that came before the Supreme Court of North Carolina in January 1874), the headnotes stated, “The doctrine of years ago, that a husband had the right to whip his wife, provided, he used a switch no larger than his thumb, no longer governs the decisions of our Courts....”

Granted, the above legal references represent just one tiny (albeit volatile) branch of the phrase’s history. The Oxford English Dictionary includes citations as early as 1692 for “rule of thumb,” defined as “[a] method or procedure derived entirely from practice or experience, without any basis in scientific knowledge; a roughly practical method,” with no mention of its legal use in wife abuse cases.16 And what may or may not be written about English common law and “the rule of thumb” is the topic for another research project. Nonetheless, the

ugly reality of the sexist and savage wording of those US court documents in the 1800s is enough to sully “rule of thumb” for me.

Excising all 7 of the above patient-unfriendly terms would enhance respect not only for innocent patients but also for readers forced to absorb such uncaring, objectifying wording.

And now, here are 7 terms that are particularly jarring for readers (whether or not any patients are in sight). Most readers are busy and already information-overloaded: subjecting them to time-wasting lack of clarity is an insult to their attention and good will. Granted, most writers are also busy and information-overloaded, so they must make an increased effort to selectively and effectively lay out their thoughts in a considerate, effortless-to-follow manner. It is the writer’s job to make the reader’s job as easy as possible.

The 7 terms discussed here are usually plopped in and misused when writers are too harried (or sometimes, too lazy or self-absorbed) to properly align the subparts of their message, leaving it to the poor reader to backtrack in an attempt to figure out what goes with what. To illustrate what’s at stake, after naming each term, I will give 1 or more examples of a clumsy, and in some cases, maddeningly confusing, passage using that term, followed by a suggested revision.

(Caveat lector: I certainly do not deny that some instances of the following 7 terms might be relatively harmless, if carefully deployed in a concise and well-crafted sentence or in a crystal-clear context, and if not overused within a given document. Nonetheless, I believe that the medical literature would be far better if these 7 terms were less ubiquitous or even nonexistent.)

**EXCISE THESE 7 READER-UNFRIENDLY TERMS**

1. the word “respectively”

Clumsy passage

A few years later, in 1906, Mathieu Jaboulay, professor of surgery in Lyon, France, connected the renal vessels of
a sheep and a pig kidney, respectively, to the brachial vessels of two patients who were dying of renal failure. [Morris PJ. Transplantation—a medical miracle of the 20th century. New Engl J Med. 2004;351(26):2678.]

**Suggested revision**
A few years later, in 1906, Mathieu Jaboulay, professor of surgery in Lyon, France, attempted the first human transplants in 2 patients who were dying of renal failure: he connected the renal vessels of a sheep kidney to the brachial vessels of one of the patients and a pig kidney to the brachial vessels in the other patient.

**Clumsy passage**
Lymphocytes require synthesis of purine and pyrimidine nucleotides for replication, regulated by inosine monophosphate dehydrogenase (IMPDH) and dihydroorotate dehydrogenase (DHODH), respectively. [Halloran PF. Immunosuppressive drugs for kidney transplantation. New Engl J Med. 2004;351(26): 2715.]

**Suggested revision**
To replicate, lymphocytes require synthesis of purine nucleotides, regulated by inosine monophosphate dehydrogenase (IMPDH) and pyrimidine nucleotides, regulated by dihydroorotate dehydrogenase (DHODH).

**2. the pair “former” and “latter”**

**Clumsy passage**
Even more important was the development of synthetic purine nucleoside analogues inhibitory to the herpes family of viruses, first acyclovir, and then ganciclovir and valganciclovir. Compared with acyclovir, both ganciclovir and valganciclovir proved to be more effective as treatment and prophylaxis against cytomegalovirus infection.

**Suggested revision**
None of the donors reported problems with depression postdonation. However, it should be remembered that this is based purely on voluntary responses to a voluntary survey. It is difficult to know the degree of psychological detriment in those who did not return the surveys. This represents an important question that needs to be further addressed.

**3. the word “this” alone, bereft of an immediately following noun**

**Clumsy passage**
None of the donors reported problems with depression postdonation. However, it should be remembered that our study was based purely on voluntary responses to a voluntary survey. It is difficult to know the degree of psychological detriment in those who did not return the surveys: This important question needs to be further addressed.

**4. the word “there,” too often the opening of a filler-heavy opening clause (as with “it,” discussed next)**

**Clumsy passage**
There is plenty of evidence to suggest that these health care investments have paid handsome dividends. [Frist WH. Shattuck Lecture: Health care in the 21st century. New Engl J Med. 2005;352(3):268.]

**Suggested revision**
Plenty of evidence suggests that these health care investments have paid handsome dividends.

**Clumsy passage**
The results of glucose-tolerance testing in donors are biphasic: (1) an initial phase of suppression of pancreatic endocrine function resulting in low insulin levels and (2) a subsequent phase of spontaneous normalization of insulin levels and an elevation in C-peptide levels. [Wood KE, et al. Care of the potential organ donor. N Engl J Med. 2004;351(26):2737.]

**Suggested revision**
The results of glucose-tolerance testing in donors are biphasic: (1) an initial phase of suppression of pancreatic endocrine function resulting in low insulin levels and (2) a subsequent phase of spontaneous normalization of insulin levels and an elevation in C-peptide levels.
5. the word “it,” too often the opening of a filler-heavy opening clause (as with “there,” as previously described)

Clumsy passage
It may be that there has always been a significant percentage of recipients with renal dysfunction whose biopsy specimen did not reveal cellular infiltrate would always have had C4d positivity.

Suggested revision
Perhaps a significant percentage of recipients with renal dysfunction whose biopsy specimen did not reveal cellular infiltrate would always have had C4d positivity.

6. the word “between,” frequently so vague as to be meaningless when followed by a pair of years or ages

Clumsy passage
Between 1997-2004, 49 living donor liver transplants were performed.

Suggested revision
From July 1, 1997, through June 30, 2004, we performed 49 living donor liver transplants.

Clumsy passage
Between 2001 and 2002, Peter rode the subway almost every day, snapping photographs with a little camera hidden in a bag. [Review of The Subway Pictures (by Peter Peter), The New Yorker, October 11, 2004, p. 99]

Suggested revision
Throughout 2001 and 2002, Peter rode the subway almost every day, snapping photographs with a little camera hidden in a bag. or In 2001 and 2002, Peter rode the subway almost every day, snapping photographs with a little camera hidden in a bag.

Clumsy passage
The preoperative evaluation for all donors was similar: We chose only donors who were between 18 and 55 years old, whose blood group was compatible with the recipient, and who were medically in good health.

Suggested revision
The preoperative evaluation for all donors was similar: We chose only donors who were 18 through 55 years old, whose blood group was compatible with the recipient, and who were medically in good health.

7. the term “the authors,” which can render it impossible to decipher which ones are being invoked: the authors of the current piece? authors cited in a previous paragraph? authors whose article is about to be cited in the current sentence?

Clumsy passage
The authors contend that....

Suggested revision
In this follow-up study, we contend that... of Smith et al, contend that.... or The 2006 commission’s authors contend that.... or In the worldwide registry report, the lead biostatisticians contend that....

Just as the abolition of certain products (eg, tobacco, personal handguns, high-fructose corn syrup) would help prevent bodily harm, the abolition of the 7 patient-unfriendly and 7 reader-unfriendly terms delineated in this article would also help prevent much of the morbidity and mortality now infesting medical prose. So, out with such patient-unfriendly terms as (1) “patient management,” (2) “clinical material,” (3) “case” used for a patient, (4) “present” used of a patient, (5) “failure” attributed to patients, (6) “elderly,” and (7) “rule of thumb.” And out with such reader-unfriendly terms as (1) “respectively,” (2) “former” and “latter,” (3) “this” bereft of a noun, (4) “there” clauses, (5) “it” clauses, (6) vague uses of “between,” and (7) undecipherable references to “the authors.” Excising such easy-to-remember, hard-to-stomach contaminants would pare physicians’ prose of some of its most deadly malignancies, leaving more breathing room and heart in medical publications.

References
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12. Cunningham FG, Leveno KJ. Child-
Achieving Integration: A Project Management-Based Process to Unify Writing Teams in Large-Scale Grant Projects

Joseph Tam, PhD, Helen Chan, PhD, and Jodi Braunton, MA, ELS, Toronto, Ontario, Canada

Opportunities for the international research community to create multidisciplinary networks or consortia have increased significantly over the last few years. Creating the multi-investigator grant application, however, is not a straightforward process. By encouraging researchers to design fully integrated projects, the level of complexity associated with the single investigator or small group grant development process escalates. In addition, writers working on large-scale grant projects often face challenges in maintaining team integration and cohesion on projects of extended duration.

We have previously formulated and reported a streamlined approach to multi-investigator application development with an emphasis on project management tools. More recently, our research communications team completed the development of successful, fully-funded large-scale $230 million grant application involving more than 80 scientists and clinician-investigators at 4 sites over 9 months. Building on our past experiences, we have adapted our approach (eg, layered work breakdown structures) and applied it to achieving integration of writing teams in large-scale grant application projects.

In this poster, we describe specific strategies to address the challenges of creating cohesion among groups of writers who work with investigators with varying research backgrounds and grantmanship approaches. It describes obstacles to achieving integration and outlines a project management-based process to overcome these challenges. Specific tactics are:

1. Involve Writers Early along the Critical Path
2. Define Interim Deliverables
3. Establish a Communications Plan
4. Develop a Style Quality Plan
5. Maintain a Project Health Checklist for Writers
6. Share the Lessons, Share the Credit

By optimizing work practices at various stages throughout the grant development cycle (ie, planning, preparation, implementation, evaluation), we identify a flexible strategy to achieve integration and produce high-quality grant applications for large-scale research teams.

References/Notes
2. University Health Network Research Communications is a 6-member team providing communications and proposal development services to researchers across the University Health Network.
creating key messages in patient education materials

Mary M. L. Curtis, Amy J. Hahn, and Jacqueline Stevermer-Bakken, Rochester, MN

Patients often feel overwhelmed by the amount of information they receive from their health care provider. As a result, they can have difficulty understanding and following instructions. Medical writers can help minimize confusion and help patients understand important health education by emphasizing and bringing attention to the most important elements of the material through the use of “key messages.” Key messages are those 4 or 5 critical pieces of information that a patient absolutely needs to know. They are the answer to this question: “If your patient only has 5 minutes to read your material, what do you absolutely need that patient to understand?”

Learning objectives of this poster presentation include:

Provide a definition of key messages.

What are they?

How do you use them?

Why use them?

Explain how to develop key messages.

How do you decide what to include?

When do they lose their effectiveness?

Understand the difference between summary and action key messages.

What topics benefit most from summary-style key messages?

What topics benefit most from action-style key messages?

Mayo Clinic patient education writers will present the poster session.

Editorial best practices in a quick-turnaround, client-driven environment

Marceline Bunzey Murawski, Research Triangle Park, NC

Our organization works on newsletter-type publications for external clients who often demand frequent and complex editorial changes after a publication has been typeset in a graphic design program. This includes, on average, about 4 client-driven page-proof revisions per publication.

This environment creates increased challenges when changes are requested because the changes have to go through a minimum of 3 staff hands, which introduces more entry points for error. In addition, changes are usually required by the client within several hours of receipt.

Previously, changes were made, proofed, and sent on to the client as part of a page proof editorial process. However, because of the tight time frame and the complex nature of the changes (end note changes and additions, table and figure modifications, complete sentence rewrites), errors were pretty common.

We reviewed and revisited our established editorial best practices to identify where and when errors were occurring. As a result, we added additional and different quality control steps, including complete rereads of the publications at critical points and quality control checklists, to help eliminate errors brought about through multiple client requests for changes and having changes made after the page proof stage.

This poster will outline for readers some additional editorial best practices and steps that can be taken to mitigate copyediting and editorial errors in a high-pressure, quick-turnaround publications environment.

Results

The Editorial Services team is capturing data on these 6 variables for each deliverable produced by the organization. At month 6 of data collection, we will examine the data to identify successes and areas for improvement.

Conclusion

Quantitative review of the editorial process will lead to an improved process and, ultimately, higher quality deliverables.

A New Era for the Newsletter: Switching from an HTML-based Newsletter to a Web Application and Back Again

Katherine Karakasis, MSc, and Jodi Braunton, MA, ELS, Toronto, Ontario, Canada

Effective communication not only involves knowing one’s audience preferences but most importantly, understanding how one’s audience receives and processes information. This key piece of information is essential when designing and producing newsletter communications in the electronic realm.

Most communicators will agree that many pieces of information received over the day are in electronic format. How one processes these packets of information is equally important to how we react to what we are viewing—do we open the e-mail? do we download the pictures in the document? Currently, many communicators use an HTML-based program to design and produce electronic information for their audiences; however, there is a growing movement toward Web-based applications or e-mail marketing campaigns that promise novel ways to revolutionize content delivery.

Web-based applications or e-mail campaigns prove to be one of the most effective marketing tools today, providing audiences with information catered to their interests. Other functionalities include detailed reporting on issue metrics—such as highest delivery, total number of hits—data-rich lists, specific e-mail lists and automated sending from a reliable source. However, when compared with HTML-based applications, issues of usability and design appear at the forefront of discussion.

This poster will attempt to provide a detailed comparison of HTML-based versus Web-based applications as they apply to electronic newsletters. It will compare detailed design and delivery processes on both platforms. The poster will distill a list of best practices in this growing field.
The number of patients going online to learn about therapy options is increasing as a result of improved accessibility of online health information. In the case of patients with multiple sclerosis, several therapy options are presented to patients with relapse-remitting MS (RRMS). Patients with RRMS are increasingly encouraged by their neurologists to participate in the process of choosing a therapy appropriate for their diagnosis and lifestyle. This study analyzed the usability levels of 3 pharmaceutical Web sites that provide information about RRMS therapies.

**Methods**

With use of guidelines set forth by Web site usability experts Whitney Quesenbery and Jakob Nielsen, and pharmaceutical Web site design suggestions by Lewis Glinert, 3 Web sites were analyzed in 20 subcategories under 5 principal guidelines: effectiveness (consistency in style, identification with examples, elapsed time of tasks, education versus drug promotion); efficiency (ease of topic navigation, employment of search options and indexes, organization of topics, and mapping); ease of learning (ease of answering questions, learning new information, addressing user confusion, and defining technical terms); error tolerance (use of next topic links, clear labels, home page identification, and ease of returning if user gets lost); and engagement (user’s need/want to explore more; site encouragement of further exploration, unique information, and easy recollection of information learned). Points were assigned on each level to create a score out of a possible 100 points. A score of 70% or higher deemed that the Web site was “usable” via the discourse analysis.

**Results**

Two of the Web sites were found to be more usable than the third. Factors that determined a Web site to be “more usable” included building identification with the user, speed of tasks, ability to address needs without frustration, completeness of coverage, and addressing information presentation at a variety of levels to accommodate user need (ie, single sourcing). Factors that determined a Web site to be “less usable” by patient users included user alienation, lack of depth in information, too much brevity with important topics, and lack of overall topics covered.

**Discussion**

Since the 1990s, there has been a rhetorical shift of pharmaceutical Web sites from a physician audience to a patient audience. The increase in online information and patient access is changing the idea of “who holds power” within the patient-physician dyad. As more patients go online to supplement information from their physician or to prepare themselves for ever-shorter doctor appointments, online health information must be analyzed closely to ensure that audience needs are being addressed appropriately. When online health resources are used appropriately, patients have the ability to make better choices about their care. A national preventive health approach could lead to earlier disease detection and a more proactive rather than reactive health care system. Health communicators, especially those in charge of designing Web-based health and pharmaceutical information, could have a great impact on the health care system by providing the right information to empower patients to take this proactive, educated role in their own care, ultimately helping patients and physicians form a partnership.
Almost everyone knows what a package insert (PI) is. But can everyone distinguish a PI from a patient package insert (PPI)? How many of us understand the difficulties related to drug inserts? Are government regulators, drug manufacturers, physicians, pharmacists, and lay people really satisfied with the present status of inserts? I know I'm not. There are multiple advantages to inserts but with them come multiple problems.

Let us first look at the types of drug inserts and their history and review some of the related content issues, primarily language and design format. I will discuss what I believe to be the most important existing—and potential—problems with drug inserts and my ideas for how to improve these important documents.

Types of Inserts and Their History
PIs are created to provide specific information about a medication to physicians, whereas PPIs are created to provide specific information about a medication to patients. Many inserts are not labeled adequately as to whether they are a PI or a PPI; a reader must decide from the complexity or technicality of the language. Except for this complexity, PIs and PPIs are indistinguishable from each other, which probably confuses many patients and certainly does not help them.

The first PI was issued by the US Food and Drug Administration (FDA) in 1968 when the agency required that isoproterenol include a package warning that excessive use could create respiratory problems. The insert seemed to be meant for the consumer; that is, it was more like a PPI rather than a PI. In 1970, the FDA ordered a second insert, this one to describe the specific risks and benefits of combined oral contraceptive pills. The apparent purpose of both inserts was to let the buyer and user of a drug know that certain dangers could occur. Therefore, it was logical for the insert to be in understandable language.

True PPIs (written specifically for patients) were first developed in 1970. Many PPIs include the exact content of the PI or include only those parts that consumers might understand; for example, the sections related to clinical pharmacology are omitted. PPIs are available (or dispensed) for a small number of drugs; PIs are included with most drugs. In the long run, PPIs could have a more substantial effect than the PIs. Currently, federal regulations require that every prescription be dispensed with an insert (either PI or PPI), usually provided by the manufacturer as part of a closed package. All PIs require FDA approval, and PPIs and advertisements are subject to FDA review (but this is seldom a high-priority matter).

It is my observation that inserts are rarely read by either physicians or patients. One reason is that neither is distributed adequately to reach its intended audience.

Because PIs are included with prescriptions dispensed to patients, physicians rarely see PIs, unless they have researched a drug in the Physicians’ Desk Reference (PDR), a compilation of all PIs. When I was in practice, I guess I was like most other physicians. I frequently used the PDR to check on specific questions I had about products, dosages, and side effects, but never in my 30 years of practice did I sit down and read a PI in its entirety. I suspect that is true for most physicians. The only time I have seen a PI is with prescriptions for me or my family. The PDR remains a good source reference for anyone wishing to read a PI for information about a specific medication.

Because both PIs and PPIs are found only in factory-packaged drugs, most consumers never see either type of insert, as many drugs are prescribed in amounts different from those in pre-packages. For example, a physician may prescribe enough medication for one dose daily for a month, but the factory package contains 60 doses. Or a physician may order 120 doses and the medication is packaged with 100 doses.

When filling a prescription for a number of pills other than that in the unit package, the dispensing pharmacy usually attaches its own form of a PPI. Some retail drug chains and individual pharmacies (often using an independent provider of inserts) dispense a drug insert with every prescription delivered; however, even though some of these inserts are specific to the drug dispensed, many include simple generalizations, with no standardization of the facts presented. To their credit, most of these inserts are at least written in understandable language, but some are erudite, probably because content was taken from the manufacturer’s original PPI. In examining a moderate sample of these inserts, almost none comes near to including the content of an official PPI. One insert from a chain drugstore in Texas included an advertisement for a commercial brand of cereal, claiming that the cereal “can help” reduce blood pressure and cholesterol—the same problems for which the prescription was dispensed. Conflict?

Design of Inserts
The design elements—font size and shape and graphic layout—of PPIs and PIs offer nothing but confusion and contribute considerably to the lack of effective commu-
nication and reader understanding. As a result, patients often ignore inserts and physicians rarely read them.

Inserts are approved by FDA administrators, obviously with input from pharmaceutical manufacturers and company and government lawyers. Combining the writing from these disciplines to achieve clear reading is a formidable task. As a result, the development of most inserts—especially PIs—is restricted by legalese, required government language, and federal regulations. Little input is sought from consumers or consumer-interest groups, which could help to ensure that PPIs are understandable to the average consumer. With the gradual addition of FDA-mandated wording over the years, plus the use of legal language, inserts have become “scientific documents,” most of which are not understood by the targeted audience—practicing physicians (PIs) or consumers (PPIs). Thus, inserts are not created with a primary purpose of being understood. I was impressed by a former high executive with a drug manufacturing company (and a medical writer) who acknowledged, “[PPIs] are never written with the intention of being truly helpful to patients. [PPIs] are written to meet an FDA requirement and not for the purpose of informing patients.”

Language is the primary reason that drug inserts do not communicate effectively. PIs are mostly in-depth scientific treatises, written in obtuse and esoteric language that may be understood by pharmacologists (and maybe lawyers) but by very few clinical physicians. In addition, they are not effective for the audience they do reach—consumers. The following is an example of erudite and confusing language in a typical PI.

Drug X is extensively metabolized in humans. Three metabolites have been shown to be active: hydroxybupropion, which is formed via hydroxylation of the tert-butyl group of bupropion, and the amino-alcohol isomers threo-hydrobupropion and erythro-hydrobupropion, which are formed by the reduction of the carbonyl group.

This insert continued, with similar language, through 4 full-size pages with 6-point typeface. (Yes, I had to use a magnifying glass to read it.) Is this PI doing its job?

Most inserts are printed in small type (6 to 8 points)—certainly not large enough to be read by a growing segment of drug consumers, the geriatric population. In addition, some inserts are so large that their multiple folds create an insert that seems like a jigsaw puzzle. I found one insert (not labeled as to whether it was a PI or a PPI) that measured 11” x 18” when fully open; it had 55 folds in it, ultimately decreasing its size to 2” x 3”. How inviting for a lay person—or anyone—to read! I believe that anyone not seeking a specific piece of information would be immediately discouraged by the necessity to unfold an insert 55 times. Among the other inserts I have come across are one that measured 36” x 2 ½”, with 40 folds, and text in 4-point type, and one that measured 34” x 2”, had 37 horizontal folds, and was glued to the underside of the pharmacy label. How bizarre can it get?

Not long ago, I found a PPI for a drug distributed in the United Kingdom. I must praise the drug manufacturer (and UK officials) for an insert written in plain and simple English, with no legalese or bureaucratic language. This PPI communicates effectively by using informal language; clear writing; no jargon or medical terms; and no charts, statistics, or graphs. The insert is directed to the lay reader/consumer by frequent use of the second person (you) and the use of lay terms to present clearly accurate scientific and medical details. Even the headings are designed for easy reading—14-point bold type in color—and their wording is immediately understandable: How to take Drug X; What if you miss a dose?; Does Drug X cause side effects?; How to store Drug X; and so on. Even though the type is a little small (perhaps 10 points), the entire insert is printed on 2 sides of an 11” long sheet, easily folded. And every word is understandable and clear.

Just as clear was an insert I found for another drug from a foreign source, this time from Canada. Why must US drug inserts be confusing, when those from other countries are clear? These other inserts communicate beautifully—and fulfill their purpose. Why is such communication withheld from our citizens but circulated to foreign audiences?

**Drug Advertisements**

Inserts are also frequently used as the basis for drug advertisements in print and other media. As a result, these advertisements do not communicate effectively to the intended reader. Take, for example, the serendipitous juxtaposition (for this exposition, I should have written “lucky coincidence”) of 2 drug advertisements in Parade, the popular newspaper insert. In one issue of Parade were 2 double-page advertisements, just a couple pages apart, one for Drug A and one for Drug B. Here is a portion of the advertisement for Drug A, selected from one side of the full-page spread. The heading for this section, formatted in very small typeface was confusing: “Brief Prescribing Information.” The section as it’s formatted here is similar to the format in the original:

Based upon the results of _in vitro_ human microsome studies, there is low-likelihood of drug-drug interactions. In _in vitro_ studies using human liver microsomes indicate that cytochrome P450 isoenzymes are not involved in the metabolism of [Drug A].

The typeface used appeared to be a 8-point, sans-serif font (which is less easy to read than a serif font). In the brief excerpt are several scientific/medical terms among more
recognizable everyday words. I am sure not a single lay person ever reads this insert, and I’ll bet that few physicians attempt to read it either. (Maybe a pharmacologist or two will read it.) Admittedly, the front, or advertisement part of the page, was written in consumer-directed language. So why publish “scientific” gobbledygook to confuse the consumer: to satisfy some outmoded legal language requirement, manufacturer’s preference, or bureaucratic regulation?

Now look at a brief sample from the advertisement for Drug B, also formatted here as closely as possible to the original format.

Tell your doctor:

• About all medications you take, including prescriptions, over-the-counter medications, vitamins, and herbal supplements.

• If you have muscle aches or weakness.

Note that this excerpt is set in about 10-point, serif (easier-to-read) type. And the language is perfect for lay people—not a single scientific/medical term. Overall, the ad is easy for the consumer to read; a large, attractive typeface was used, headings were large and in color, and the headings were clear (eg, “Important Facts”).

My Perspectives
To me, these examples illustrate the fact that PIs and PPIs are not developed in a uniform manner and are not identified by drug manufacturers as PIs or PPIs, even though they probably all pass inspection by their legal departments. Most important, because they do not communicate effectively, drug inserts do not accomplish the goal of informing physicians and patients. More effective PIs and PPIs not only benefit by better informing physicians and patients but they may also help to avoid many of the medication-related deaths each year.

From my personal vantage point as a physician, a consumer, and a medical writer, here are my perspectives.

As a physician, I think that PIs should communicate to physicians with greater clarity and less scientific minutiae. PIs should not be distributed to consumers, because the information can be confusing or frightening to patients, can conflict with the physician’s instructions to the patient, or, worse, can have an effect contrary to the physician’s expectations. PIs should be distributed to physicians by a new method, if the FDA does not consider their presence in the PDR sufficient for physicians.

As a consumer, I want my physician to have all the necessary clinical information he or she needs about drugs he or she prescribes, without having to take the time to study complex statistics and related research literature. I want to be able to recognize important information about prescriptions ordered for me without having to wade through scientific information that is over my head. Rather, the PPI should give me facts that I should know for my own safety or that might cause me to consult my physician or pharmacist prior to taking the medication.

As a medical writer, I believe that PIs should undergo scrupulous rewriting to enhance understanding by physicians. PPIs should undergo similar scrutiny to enhance understanding by consumers. FDA and industry are at often odds by their very nature and goals; it would be almost impossible to expect wordsmiths from both sides to find agreement on language. Thus, I think that both types of inserts should be carefully evaluated through consultation with writers outside of FDA and drug manufacturers. These writers should be experienced in “translating” complex scientific concepts at the physician’s level and the consumer’s level.

My Ideas for Improvement
Because I am only an observer and not an expert, I can only suggest what seems logical. Here are my suggestions for improving the current system of drug inserts.

1. Stop putting PIs in prescriptions—they are overwhelmingly wasted.

2. Insist that every prescription carry an approved (and improved) PPI, so that every consumer gets one, regardless of the quantity of medication being dispensed.

3. Distribute to every physician the PI of each new drug when it is released—and at any time the PI has changed. This approach would cost a great deal, but some of the money could be taken from the advertising budgets used to promote prescription drugs to the public; after all, this approach certainly would be great advertising for the product.

4. Modify any present FDA regulation that requires drug advertisements directed to consumers to include information from the PI and mandate that the advertisement include information from the PPI instead.

5. Create PPIs for every medication and distribute them to pharmacies so that every patient gets easy-to-read information about the medication he or she is about to take, regardless of the size of the prescription—even 1 pill. This approach may also help to create awareness of problems or questions the patient may want to discuss with the physician before he or she takes the medication.

6. Before release or approval of every PPI, have it reviewed by a group of experts in the communication of medical information, especially writers accustomed to translating scientific information into language that the average consumer can understand.

7. Adopt a guideline that if a PPI is so complex that it is understood only by physicians, or only by scientists, or only by pharmacologists—or only by lawyers—it is not fit to disseminate to the public at large.

8. Develop an easily-accessible Web site, made free of charge, that contains PPIs in simple, accurate language. Such a Web site would be of value to pharmacists, who...
could download an insert immediately and inexpen-
sively for every prescription dispensed; physicians, who
could quickly download an insert to give to patients in
advance; and patients, who otherwise not have access
to the important information provided in a PPI. With
technical know-how that exists in the pharmaceutical
and information technology industries, such a resource
should be relatively easy to develop. In fact, in South
Africa, all PIs are available electronically through the
Internet and a similar plan is in the works in Canada.

A noticeable trend is comforting: clearer PPIs have
appeared more frequently in recent months. However,
improvements can still be made; for example, most inserts
are still produced in a small typeface.

I must emphasize that no single party is to blame for
the current status of drug inserts. Maybe all of us are. After
all, PIs and PPIs can be a valuable asset for all of us, and
each of us bears a responsibility to aid in the process to
make them more effective. All entities are trying to do the
best job possible—that is, to protect the public. None of
what I have written should be taken as a negative reflection
of FDA regulation, drug manufacturers’ objectives, or legal
imperatives. Instead, my focus is on the medical writing
and content design.

As medical writers, we should help to ensure that the
writing in both types of inserts—and ideally, in any drug-
related document targeted to the general public—is clear,
concise, easy to read, and, most of all, understandable. In
turn, our understandable writing will help drug manu-
facturers and the FDA. We will then have true medical
communication, and we can be more certain of helping
patients, which is everyone’s primary goal.

Postscript
A perfect illustration of the package insert situation was
the juxtaposition of 2 advertisements in successive issues
of Parade magazine (Parade seems to be the place to watch
for package inserts) that appeared while this article was
undergoing review. One ad was for bipolar medication and
consisted of 3 full pages of ad (fairly well-written), followed
by 2 jam-packed pages of text in 6-point type, written in
medical language. The second ad was for diabetes medica-
tion; it consisted of 1 page of advertising (also well done)
and two-thirds of a page that was labeled “Important
Facts.” The latter was graphically separated into 8 well-la-
beled sections of easily readable English, with understand-
able (and large) headings and no confounding medical
terminology. Which was doing the job of informing the
public? This coupling of advertisements demonstrates
clearly that someone is missing the boat—the manufactur-
ers, the marketing staffs, the advertising agencies, or the
regulatory bodies (including FDA).
Storyboarding is a highly effective multimedia technique that communicates information by “telling a story.” The approach was originally developed by Walt Disney in the early days of animated film and continues to be an important organizational and production tool in the film industry. Perhaps the earliest storyboards appeared on cave walls where our ancestors used drawings to tell legends, record events, and teach social values. Today, the storyboard has evolved technologically and has taken on a variety of formats, including animations and videos, to accommodate different clients and target audiences. Storyboarding is frequently used by the drug and device industries, because it can be applied to a wide audience using a variety of media types. It is used to train and educate the sales and marketing forces, as well as to provide information to the public sector. Its format easily allows modification of learning materials specific to each audience, as well as dissemination through media, such as CD-ROM, DVD, and the Web.

Surprisingly, a recent review of the literature failed to identify resources for writing professionals that provide simple and direct instructions for producing a storyboard in this setting. We describe here how we write a storyboard and provide an example to illustrate our principles.

Project Initiation and Instructional Design Model
The key to producing an effective storyboard is having an in-depth knowledge and understanding of the information to be presented. A common-sense approach is to use that knowledge to take the viewer step-by-step through the information, as this increases comprehension and retention of the material over time. Retention is further enhanced through the use of auditory and visual cues. Original and innovative images and drawings make the information “come to life.” Both narration and animation of the images serve to reinforce the information presented and assign it to memory. Generation of a storyboard also engenders brainstorming and simplifies revisions before animation is developed.

Before beginning to write, it is important to determine the level of scientific sophistication required and the best way to compose and convey the information to the learner. For example, a storyboard for scientists working on drug development may require molecular information, whereas sales and marketing groups may require a more generalized scientific explanation to convey similar concepts. To determine the level of information, we consider the 5 key elements of the ADDIE model.

- **Analyze** and understand the characteristics of your target audience and the topics to be learned.
- **Design** and outline an organizational and instructional approach to achieve the general and specific learning objectives of the topics.
- **Develop** and create appropriate instructional and training materials.
- **Implement** the above through interactive integration of text and graphics.
- **Evaluate** early drafts with the client to ensure effective communication of learning objectives and accuracy of information.

It is essential to maintain an open dialogue with the client to ensure that the approach to the project is appropriate to the audience and that the material is presented clearly and accurately. Writers of a storyboard usually work with professional animators and narrators to produce the final product.

Storyboard Format
Each slide (see example below) should include 4 major components: title, narrative, graphical description, and screen text and images.

- **Title** includes the following in consecutive order: project title, topic title, slide title, and slide number.
- **Full-Text Audio Narration** is the narrator’s script that will accompany the final animation.
- **Graphical Description (for Animation of Images)** gives detailed instruction to the animator for integration of the audio portion with the simultaneous and sequential appearance of the images (drawings, graphs, tables, or text).
- **Screen Text and Images** are the actual materials, including drawings and images that will be animated.

A font style and point size should be chosen that is legible and enhances readability. Drawings may be original or may be images copied from a variety of sources. The animator, producer of the video, or publisher should be
Migraines are classified as primary headaches whose symptoms are almost always unilateral. They are less frequent but longer in duration than cluster type headaches and more severe than tension-type headaches. Persons who suffer from migraine headaches often have an inherited risk that predisposes them to attacks. These headaches may occur with or without auras, which are perceptual disturbances experienced prior to or during the actual headache pain, and that result from changes in brain function. Auras are often visual disturbances, but may also manifest as numbness in the face or hand, unsteadiness, or weakness. Migraines are episodic and unilateral and may last from 4 to 72 hours. They may occur 3 to 4 times per month and are often incapacitating. Migraines are accompanied by allodynia, which is pain from stimuli that would not normally cause pain (such as light).

Characteristics of a Migraine Headache

- Migraines are classified as primary headaches with unilateral symptoms, which are less frequent and longer in duration than cluster-type headaches. Tension-type headaches are milder, bilateral, and of shorter duration than either migraine or cluster-type headaches.

- May have a strong family history.

- May be associated with or without aura.

- Moderate to severe in intensity and last 4-72 hours.
- Often incapacitating and episodic in nature.
- Accompanied by allodynia, described as pain from stimuli that does not normally cause pain, such as light.

Slide Example

The example presented is targeted to sales and marketing forces and illustrates the interaction of text with audiovisual components. The use of succinct and plain language with bolded and underlined words emphasizes the key characteristics of migraine headaches. The narrator’s script (audio portion) coupled with the visual images (animation) enhances the understanding and retention of the information. Additionally, by defining medical terms (ie, allodynia), the “non-physician” will be able to effectively communicate with all levels of health care professionals.
advised of images that were acquired from published resources, especially copyrighted materials, so that permission can be obtained as appropriate. All material should be referenced, and a bibliography maintained. The storyboard should be carefully edited and proofread to ensure a professional product.

References

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US Food and Drug Administration (FDA) dumps Helsinki Declaration – Starting in October, the FDA will drop its requirement for clinical trials reported in new drug applications (NDAs) to adhere to the World Medical Association Declaration of Helsinki, a statement of ethical principles for clinical trial design. The new rule requires only that trials conducted abroad follow good clinical practices (GCP) and include a review and approval by an independent ethics committee. A major difference between the Helsinki Declaration and GCP is the former’s insistence on using best-available treatment instead of placebo when possible. Already an estimated 35% of all trials reported in NDAs take place abroad, and the rule change is expected to increase that number.

Pfizer dumps MECCs – The company announced on July 2 that, effective immediately, it had ceased to provide direct financial support for continuing medical education (CME) courses offered by for-profit medical education and communication companies (MECCs). A spokeswoman told The Wall Street Journal that the decision “has to do with mitigating the perception of a conflict of interest.” Pfizer will continue to support CME programs arranged by academic institutions, teaching hospitals, and medical societies, and it acknowledges that it will be supporting commercial CME indirectly if such organizations contract with MECCs. In addition, the company will honor its existing commitments to MECCs. At press time in early July, no other pharmaceutical or biotechnology company was known to have adopted a similar policy regarding MECCs. (Tip of the nib to Brian Bass.)


Drug Information Portal – The National Library of Medicine has created a portal Web site, http://druginfo.nlm.nih.gov/drugportal, for people seeking information on drugs. Type in a drug name and a list of consumer and professional sites appears. More than 12,000 records are available for searching.

New feature in PubMed – A new feature has been added to AbstractPlus (one of the options a PubMed user can choose for displaying search results—see “Display” near the top of the search screen). Just as Related Articles now appear at the right of the AbstractPlus results screen, Related Reviews will appear during randomly selected PubMed sessions. Initially, not all users will see them, but the National Library of Medicine will make this feature routine if it proves to be popular.

Caplan on “ghostwriting” – Following the blistering editorial about authorship in the April 16 issue of The Journal of the American Medical Association, pharma blogger Ed Silverman asked noted bioethicist Art Caplan to weigh in. Caplan said in part, “All papers must originate with a scientist or scientific author who’s done the study . . . you must take the first stab at writing and only then do you call someone to do editing.” Caplan, who directs the Bioethics Center at the University of Pennsylvania, added that “those doing the editing should not be supplying substantive content. Their task is to achieve better clarity of expression, provide conciseness and improve readability, not supply data, analysis or interpretation. [If] that’s done [then] they’re the author.” Read the entire (short) interview at http://tinyurl.com/4hubxz.

Items in Briefly Noted appear earlier on AMWA’s Editing-Writing, Freelance, and Pharma listserves. To subscribe to one or more of these listserves, go to www.amwa.org and click on Members Only>Networking>Listserves.
In many cases the client makes the decision on the type of rate. Some clients prefer to pay an hourly rate and others favor a project price. It is also somewhat dependent on the type of writing you do. For example, if you work for a client on a regular basis, doing editing, proofreading, or frequent, relatively short writing assignments (eg, a monthly newsletter, press releases, Web site updates), then an hourly rate would probably be the best choice and acceptable to the client. For larger, more complex projects (eg, sales training programs, white papers, monographs, journal articles) many clients prefer negotiating a project price for budgeting purposes.

Obviously, there are advantages and disadvantages to each. Charging an hourly rate would seem to be preferable, because it’s the best way to be sure you get paid for all the time you spend on a project. However, in most cases, I actually prefer having a project price, and, in fact, most of the clients I’ve had over the years have insisted on per-project pricing. For me, the big issue with charging an hourly rate is that the client may have an unrealistic estimation of the number of hours a project should take (and it’s rarely on the high side). When I’m working at an hourly rate, even after all my years of experience, I always have a nagging worry that it may be taking me longer to complete the project than the client expects. Of course, there is always a danger that you will underestimate how long a project takes and set the price too low; and there is a chance you will overestimate and set the price too high. I’ve found that, over time, things tend to even out.

Granted, it can be tricky to come up with an accurate project price, but there are ways to protect your interests. As we’ve discussed in a previous Freelance Forum [AMWA J., 2005;20(3):120-121], whether the client is offering you a set price or asking you to submit an estimated cost, it is important to find out as much as possible about what the client expects of you before settling on a price. Once you get as much information as you can about the project and determine a price, it’s crucial that you specify exactly what your price does and does not include. One final caveat: Even when you are not being paid by the hour, it is important to keep track of the time you spend on every project. This helps you determine how much to charge the next time you’re asked to provide a project price on a similar project.

– Donna Miceli

In my opinion, the age-old debate of hourly-based versus project-based fees is no debate. There is certainly a time and place for hourly fees; for example, when you’re just getting started (for a short while), or when you’re working on premises (and the number of hours you are putting in is incredibly obvious to the person buying your services). Otherwise, as I’ve mentioned in numerous presentations, I believe that charging an hourly rate punishes the proficient and rewards the inefficient.

The reasons are simple: (1) there is a maximum hourly rate that companies are willing to pay; (2) most people get better and faster the more they work in a chosen field; and (3) the bottom-line cost is what matters most to the company hiring the freelance writer.

Viewed a different way, consider this example:

**Hourly Rate**

A writer starting out may charge $85 an hour and take 50 hours to complete a project, for a total of $4,250, which is quite acceptable to the client. As the writer gets better, he or she increases the hourly rate to $100, completes the same project in just 30 hours, and earns only $3,000—a $1,250 (29%) cut for being a better writer. In time, the writer becomes even more proficient, and increases his or her hourly rate to $125. The same project is now completed in just 20 hours, and the writer earns only $2,500—41% less than when the writer started out and was charging 32% less per hour.

In this scenario, the better you get at what you do, the more you are financially punished, and the harder you have to work to earn the same pay as when you were a less-proficient writer.

**Project Rate**

A writer starting out charges $4,250 for a project, a rate that is quite acceptable to the client. He or she takes 50 hours to complete the project, earning the equivalent of $85 per hour. As the writer becomes more proficient, he or she charges $4,250 for the same project, but now completes the project in 30 hours. He or she has just earned $141.67 per hour, a 67% rate increase. In time, the writer becomes even more proficient. Charging $4,250 again for the same project, he or she now completes it in just 20 hours, earning the equivalent of $212.50 per hour!

In this scenario, you are rewarded for getting better at what you do, earning a rate I dare say few clients would be...
willing to pay. You can then choose to either work less for the same income or continue working hard and earn lots more money!

— Brian Bass

The ongoing discussion of charging a project fee or an hourly rate for our services is an age-old one that resurfaces year after year. While there are advantages and disadvantages to both methods, I prefer the project-fee system. It is true that sometimes you get “burned” by misjudging the amount of time a project will take to completion. However, for the most part, project-fee billing enables the freelance to invoice a greater amount of the total fee in the earlier stages of the project and to set up progressive billings. For example, I often bill 50% of the project fee at start-up, that is, as soon as the project is assigned or with the signed contract. Progressive stages are 25% on delivery of the first draft and the remaining 25% on completion of revisions. I’ve also used progressive billings of one-third upfront and one-third at each of the above stages. Lately, I have been more inclined to “top load” the project fee so that most of the fee has been billed by submission of first draft with a lesser fee remaining for revisions. Especially with journal articles, it seems that the review time between first draft and revisions is being extended, and many projects come back for revisions long after you’ve moved on through 2 or 3 other unrelated projects. Remember that since most clients wait a full 30 days (or more) before paying invoices, it is not unusual to have completed a draft or two of a manuscript before even start-up payment arrives.

Another scenario I’ve used recently with a very good repeat client for a project with a very short (2-week) turn-around time is a combination of project fee and hourly rate billing. For these projects, I have billed 100% of the project fee on submission of first draft with revision fees to be billed hourly as incurred.

Whichever billing system you use, be sure that the billing stages are completely spelled out in the contract or agreement and are stated on each invoice that is sent.

— Elizabeth L. Smith

Most clients, at least first-timers, request a dollar amount per project. Because I’m not willing to use a stopwatch, I’ve developed a formula for a page/hour cost that then translates into a project fee. Factors in the formula include page spacing (single/double), lines/page, margins, graphics, and complexity of the job. However, the client sees only a cost for number of pages. I don’t always require a contract, but the following 2 agreements (one for editing and one for writing) illustrate my strategy.

1. I, __________, agree to edit/revise the proposed __________, authored by Dr __________ and consisting of 40 single-spaced text pages of 12-point type. My fee is $____, and I trust that payment will be made in a timely manner. Dr __________ is to be the only person whose approval is required to complete this project. Completion is to be within ____ months/weeks/days of the project’s start. Additional work will be charged at __$/hour and with a completion schedule to be agreed upon separately.

2. The proposed fee range is $_____ for original writing of a 100 to 130-page manual to $______ for a 200-page version. The 1-month time interval scheduled for this work includes the preliminaries noted above and up to 130 pages of text plus graphics; delays in supplying source materials or in reviewing/editing text will alter the delivery date. Changes initiated by __________ (client/company) requiring alteration of the task described here will be charged at the rate of $____ per hour. These fees apply to this project only.

Because freelances are not free, start time, deadlines, and factors in the client’s approval process must be specific, as should be changes after the project begins. I recently forgot my own formula when making a simple agreement by phone, so I estimated a range of cost for double-spaced text. However, single-spaced pages arrived via e-mail download. When I then raised (but did not double) the price, the first-time client accused me of narrowing the margins! C’est la vie!

P.S. The client’s billing office later called to say that the invoice submitted was for the higher fee.

— Phyllis Minick
Voices of Experience

By Heather Haley, MS
Haley Writing Solutions LLC, Cincinnati, OH

➲ Interviewee: Julie Beyrer, MTSC
Scientific Communications Associate, Eli Lilly and Company

What is your current position?
Basically, I serve as the lead regulatory writer on a new neuroscience compound, which means that (in addition to writing) I attend meetings to discuss clinical development and regulatory strategy between Lilly and our partner companies and do tasks like review partner agreements, determine deliverables to be created, scope, work plan, etc. I also write documents (mostly regulatory documents) for other compounds, distribute drafts for review, revise and edit drafts, and provide project/document management for my projects. I oversee vendor projects, coach/mentor other writers, and peer review/quality check other writers’ documents. I also serve as a company subject matter expert on clinical study reports and medical writing outsourcing, which means I consult with other Lilly employees on related questions, participate in related company initiatives, revise Lilly templates, help with revisions to standard operating procedures, and so on. I also currently manage capacity/workload for a small team of medical writers while my supervisor is on a medical leave. A new role added recently is assessing vendor companies for their medical writing services and capabilities. So, in short, I do a lot of different things—not only writing.

What is your education and work background? How long have you worked in medical writing?
I have a bachelor’s degree in German with minors in chemistry and history from Hanover College. I have a master’s degree in technical and scientific communication from Miami University. I began working in medical writing at Eli Lilly and Company after completing my master’s degree and have worked there about 5 years.

What was your first medical writing position and how did you find it?
I have a bachelor’s degree in German with minors in chemistry and history from Hanover College. I have a master’s degree in technical and scientific communication from Miami University. I began working in medical writing at Eli Lilly and Company after completing my master’s degree and have worked there about 5 years.

Coming into medical writing from a nonscience background, what were the challenges and how did you overcome them?
I hear this question a lot from people, but really it has never been a challenge. I work with both people who do and who do not have extensive scientific background or degrees. A science background can help if it’s in the area in which you are writing; eg, a psychology degree if you’re writing about psychiatric drugs and patient population. But often, people find themselves working in therapeutic areas they never studied in school, and that’s okay. The ability to seek out therapeutic area knowledge, quickly learn and apply that knowledge, and critically think through the content—that’s what’s crucial. Also, medical writers usually work with content experts; ie, an expert physician in the drug and disease state under study. These content experts are generating data, reviewing, and approving your work, so it’s not as if you’re working in

her family one summer. During my senior year of college, I was struggling with what I wanted to do after college—I had several ideas but felt I would not be very happy in those roles. As a spiritual person, I spent a day fasting and praying about my question, and all day long I continued to have this thought that I should call the lady who employed me as her nanny 2 years prior. I had not talked to this lady in years and so it felt strange to call her, but finally I called and just asked her about her career and that’s when I first heard about medical writing. I was surprised, “Wow, you can combine love of science and writing and make a career of it!” So, I pursued it further and found it fit me very well. So, I definitely see that phone conversation as a major turning point in my education, career, life—a very fortuitous one. It’s what led to me to the master’s degree program at Miami University and eventually to my career at Lilly.

What was your first medical writing position and how did you find it?
How does anyone ever find out about medical writing careers? The short answer is that I knew someone who managed a medical writing department at Lilly, so I had a connection.

The longer answer is that I knew this Lilly medical writing manager during college, having been a nanny for
Is there anything you wish you had known starting out that you know now?

Some people tried to tell me a few things in one way or another, but I did not always “get it” until after I had gained a little experience.

- Strive for excellence and not “perfection.” Medical writers tend to be perfectionists, and I am no exception. But you often have so many things going on at one time that you can’t afford perfection; you just have to be able to produce; also, there really is not any such thing as perfection. Focus on what’s crucial. If the extra 5% you want to give will take 50% of your time, then maybe it is not worth it. Figure out what excellence means versus “perfection” and strive for excellence.
- Maintain a work/life balance. I had to learn why a work/life balance is important. There will always be more work to be done. Just know when to call it a day and go home.
- It’s not humanly possible to be completely productive every minute of every day. I cannot go into work every day “bright-eyed and bushy-tailed” even though I’d like to (my husband’s words). You do your best, but some days you just have to work through what feels like drudge even if you love your job.
- Mastery requires struggle. When a set of responsibilities and opportunities is new, motivation can plummet for a while and that is normal. You might start with enthusiasm but that quickly progresses to feeling somewhat disillusioned for a time as you struggle to master what you’re doing before you come up the learning curve and feel capable and confident. Just work through it. I actually learned about this cycle to mastery in a workshop at work, but I have experienced it and noted it—it helps just to notice the motivation cycles and know that your feelings are completely normal.
- Career mentors can be an immeasurable blessing and you should pick them wisely and use them!

What is a typical workday like for you?

6 AM Wake up. Drive to the Lilly gym. Or not.
7 AM Work out at the gym or go to my yoga class. Or sleep in.
9 AM Walk into the office, turn on my computer, eat a small breakfast at my computer, see what’s on the calendar, prepare for meetings, respond to e-mail and voice mail.
10 AM Project meeting/departmental meetings/other meetings OR draft regulatory documents/contact reviewers to resolve issues in my documents/review and develop work plans, spreadsheets, job aids, and so on (whatever I’m working on) OR coach a co-worker in his or her project and assist other writers by doing quality check of their documents. I eat lunch somewhere in the middle of this.
6-6:30 PM Leave the office.

What do you find most rewarding and challenging?

Rewards include
- The job itself—generally, I like most of what I do, most of the time.
- Meeting the challenge— accomplishing something I feel proud to have my name on.
- Working with smart and interesting people and role models.
- Accomplishing goals as a team and feeling that we are a “team” when we operate that way.
- Being able to try new roles/responsibilities, working on new compounds/drugs, new anything (variety is the spice of life...).
- Receiving positive and critical feedback—I use both to assess myself and grow.
- Knowing that somehow what I’m writing/doing/thinking will ultimately help patients.

Challenges are
- Determining the real scope of projects. People often say that the scope will be “small,” but that is often not the case.
- Crunch periods. Submission mode refers to some of the crunch period with which all regulatory writers are familiar. You definitely have to pace yourself and help pace the team efforts to some extent; eg, use meeting time with contributors as effectively as possible. Sometimes, but hopefully not often, you do work late nights and/or weekends to meet deadlines—regardless of how well you pace yourself.
- Making most people happy most of the time. Recently, a biostatistician colleague commented that she would not want my job because it required “making everybody happy” whereas she felt her work (statistical analyses) was much more straightforward. It is true that a large part of my role is communicating (in writing) multiple contributors’ content, expertise, perspectives, and opinions. We do not always agree. But you cannot please everybody all of the time. Knowing where to give, where not to give, or where and how to compromise, all while maintaining positive professional relationships, is essential but sometimes challenging.
- Tedium in the job. As an example, I dislike when reviewers review outside our company’s document management system. It creates extra work for me, comparing versions of documents, copying and pasting reviewer comments/tracked changes into the current version, following up with other reviewers about what Reviewer X had to say in his/her version, and so on. Sometimes people have to review outside the system (because of no access to the system while traveling)
and I can be flexible. But I prefer to use the available technology where possible to automate a tedious task and help the company spend its money on my salary more judiciously.

As a mid-career person, how do you keep the work interesting?

I seek out opportunities to do stimulating work. For example, I may do a particular type of document (a protocol) more than one time, but I generally try to avoid doing the exact same type of work over and over again. I also seek opportunities to do activities beyond writing, such as operational roles within my department or cross-departmental regulatory initiatives. This kind of variety is possible in my department at Lilly because of the diversity of the medical writing staff and because Lilly can flexibly outsource some deliverables to vendor writing companies. So, I tend to ask for work, writing or otherwise, that I know is coming down the “pipeline” that I think will stimulate me.

What surprised you most when you first started in the field?

The complexity of drug development and how much there was to know—how much knowledge, expertise, and experience is needed. I find it impressive that we really ever do get through all the hurdles and get drugs to patients.

Is there anything that surprises you now?

Now I am surprised at the amount I have learned and yet still have so much more to learn. And this industry, the science, and society, is continually changing.

What are the best ways for a newcomer to establish himself or herself as a medical writer?

Get a job doing medical writing anywhere you can and be a sponge—learn from other medical writers you work with. Or freelance if you can find relevant projects, build your experience, and create a portfolio that demonstrates your experience. I did free client projects such as writing grant proposals, editing book chapters, and designing Web sites during graduate school and those projects became my portfolio. Also, meet others in this field—network. AMWA conferences are a great way to do this, and connections are important. You may be a very qualified medical writer but your career plans might not materialize without the right connections. It might sound harsh or unfair, but put yourself in the place of a hiring company. Would you hire the qualified writer you do not know or the qualified writer you know to be reliable and trustworthy?

What resources do you recommend for a writer in his or her first position?

Definitely find a coach and mentor. It helps to have someone coach you through your first projects. As a general rule, all writers in my department are assigned a coach when they first start in the department. A mentor can help you to assess where you are in your career, give you honest and direct positive and critical feedback, be your moral support and (in my department) a confidential listening ear, and help you determine your career plans and develop them. Take advantage of educational workshops on relevant topics through AMWA, your company, books, live training recommended by your company, and other similar opportunities.

Any last advice for people just starting out or looking into transition into medical writing?

Talk to people in medical writing careers. Maybe attend an AMWA conference. Ideally, shadow a medical writer for a day or participate in an internship opportunity and see if it might be a good fit for you. When you think the fit is there, go full speed ahead down that road and see how it develops. And believe in yourself!
The EQUATOR (Enhancing the Quality And Transparency of Health Research) Network is a new quality improvement initiative that seeks to enhance reliability of medical research literature by promoting transparent and accurate reporting of health research.

The initiative was set up in 2006 by a Steering Group (see right) and is quickly developing into an umbrella organization covering all areas of health research and all nations, actively involving all its key stakeholders—developers of reporting guidelines, researchers/authors, medical journal editors, peer reviewers, and research funding bodies.

EQUATOR’s top priority is to become a recognized global center, providing resources and training relating to the reporting of health research and assisting in the development, dissemination, and implementation of reporting guidelines. Reporting guidelines specify information necessary for clear accounting of research methodology and findings. Evidence is emerging that use of reporting guidelines can lead to the improved accuracy and transparency of publications. Reports that comply with reporting guidelines are easier to appraise for research quality and relevance. During the last 10 years, several guidelines have been developed for reporting health research (eg, CONSORT Statement for randomized controlled trials,1 STARD for diagnostic accuracy studies,2 and others3-5). Each guideline represents a consensus view of experts and methodologist in a particular research field.

The EQUATOR Web site (www.equator-network.org) pulls together all available reporting guidances. This initial simple site is being gradually developed to provide a comprehensive digital library for health research reporting, guidance for the development of robust reporting guidelines, tools to facilitate their use, educational materials, and EQUATOR training courses.

The EQUATOR Network is directed by an international Executive Group that brings together leading experts in health research methodology, statistics, reporting, and editorial work. The EQUATOR Network community is steadily growing. More than 200 people have already registered through the Web site to become part of this initiative. We want to encourage mutual collaboration and harvest the expertise of this group through an online discussion forum, which is currently being developed, and through the organization of voluntary committees advising on the development of different activities (eg, Web site, training, research projects).

The EQUATOR Network Launch Meeting: “Achieving Transparency in Reporting Health Research,” was held on June 26, 2008, at the Royal Society of Medicine, London. The meeting drew nearly 170 attendees from the United States and around the world, who heard presentations by members of the Steering Group and other experts, who discussed the problems associated with health research reporting and the use of reporting guidelines, as well as potential solutions that may lead to the improvement of the health research literature. The daylong meeting ended with the First EQUATOR lecture, “Meeting the Research Information Needs of Patients and Clinicians More Effectively,” delivered by Sir Iain Chalmers, of the James Lind Library, Oxford, UK. Dr Chalmers has worked extensively to raise awareness about the need for high standards in the conduct, reporting, and interpretation of health research. The slides of the meeting presentations and Dr Chalmers’ lecture are now available in PDF format on the EQUATOR Web site. In addition, a brief report on Dr Chalmers’ lecture can be found on page 135.

Medical writers are an important community that can significantly influence the quality of health research reports. Medical writers can directly benefit from learning more about the importance of high-quality research reporting and use of reporting guidelines by visiting the EQUATOR Web site or participating in the Network’s activities.

The EQUATOR Network is currently working on establishing a formal members’ organization, which will be open to individuals and organizations with mutual interest in improving the quality of health research publications, and of research itself.
MORE Awards Recognize Excellence in Reporting about Orthopaedics

Freelance journalists who have written on musculoskeletal health issues are invited to enter the Media Orthopaedic Reporting Excellence (MORE) Award competition. The MORE awards are presented by the American Academy of Orthopaedic Surgeons to recognize writers’ efforts to further the public’s understanding of these issues and to encourage healthy behaviors in the care of bones, joints, muscles, and tendons.

MORE awards are given in 5 categories: national and local consumer print journalism (newspapers, magazines, Internet), national and local broadcast journalism (television, radio), and advocacy journalism (newspaper, magazines, Internet, television, radio). The competition is open to journalists or freelance writers/editors/producers, and entries must have been published or broadcast between October 1, 2007, and October 1, 2008. The deadline for entries is October 31, 2008.

Complete details about the MORE awards can be found on the American Academy of Orthopaedic Surgeons Web site (www.aaos.org).

Institute for Healthcare Advancement: Health Literacy in Primary Care: Best Practices and Skill Building
www.iha4health.org/index.cfm/MenuItemID/190.htm
This online resource features coverage of the 2-day annual meeting, held May 1-2, 2008. Detailed reports provide highlights of the keynote address by Richard H. Carmona, MD, MPH, 2002-2006 Surgeon General, and of several general sessions on topics such as strategies to enhance health care communication, need for improvement in drug labeling, assessment of the quality of translated materials, plain language communications, and more.

EQUATOR Network: Achieving Transparency in Reporting Health Research
www.equator-network.org
The slide presentations from this first meeting of the Enhancing the Quality and Transparency of Health Research (EQUATOR) Network address such topics as principles of good research reporting, reporting guidelines, publications ethics guidelines, the impact of clinical health research reporting on practice, and the first EQUATOR lecture: “Meeting the Research Information Needs of Patients and Clinicians More Effectively,” given by Sir Iain Chalmers, Oxford, United Kingdom. (See page 134 for a profile of the EQUATOR Network.)

AMWA members are encouraged to participate in a brief survey designed to provide answers that are essential for the continued well-being of medical writing and editing. This survey, a follow-up to a survey conducted in 2005, will help to determine the following:

- Proportion of substantial contributions by medical communicators that are undisclosed in submitted manuscripts
- Proportion of medical communicators who request acknowledgment
- Effect of familiarity with publication guidelines on disclosure

Your participation in this survey will be anonymous and will take less than 5 minutes to complete.

The survey will be conducted November 13-25, 2008.

Watch for more information in the AMWA Update.
Got Reverted Rights?
By Christopher Kenneally*
Copyright Clearance Center, Danvers, MA

For authors, signing a book contract is an especially memorable experience—typically, it’s the culmination of years of research and wordsmithing, with the additional thrill from receiving a check for an advance against future royalties. The excitement of such a moment can be distracting, but don’t lose your head. Before you celebrate, read the contract!

Indeed, one particular standard clause in book contracts bears a measure of scrutiny in this column on copyright. On second thought, all the clauses bear scrutiny, but we only have space for one examination at the moment.

Immediately upon an author’s creation of a book in a fixed form, the literary expression of the author’s ideas is protected by copyright. When a book is to appear in print, certain specific and limited rights contained within the copyright to that work are contractually transferred from the author to a publisher. For example, the right to so-called “hard cover” publication rights only may be conveyed; for the paperback, there could be another, different contract (should you and your agent be so fortunate).

The Spaghetti Principle
The rule to recall is that copyright is not a single right, but must be thought of as a bundle of rights—imagine these rights to a work as a fistful of spaghetti held tightly together. Each spaghetti strand represents a separate right, each of which can be independently sold, licensed, or otherwise transferred.

On a high level, the bundle consists of the 5 main exclusive rights of the copyright holder listed in the copyright law: (1) copying, (2) reproduction, (3) creation of derivative works, (4) public performance, and (5) public display. Yet, each of those rights is divisible into smaller and smaller pieces that are themselves independently transferable.

As author of a book on a new medical procedure, you may assign exclusive reproduction and distribution rights to one publisher for the United States, to another publisher for all of Europe, and to yet another publisher for the rest of the world. A novelist may assign the right to create a film version of his or her book but retain the right to create new novels based on the novel.

In principle, there is no limit on the divisibility of the copyright owner’s rights.

And not that any new author really wants to think about it, but the transfer of rights usually won’t last forever. More than 200,000 new book titles are published annually, although only a very, very small number remain perennial sellers. Book contracts are like Las Vegas marriages—some may last a lifetime, but you can bet the farm that a high number will have run their course before you can even buy an anniversary card.

Nevertheless, for many authors, going out-of-print isn’t definitively the end of the publishing line for a book. Generally, a publishing contract will include a ‘reversion of rights’ clause. A reversion of rights conveys control of publishing rights from the publisher and returns that control back to the author, or creator, of the material.

Sometimes, a publisher will automatically revert rights to an author once a book has gone out-of-print (that term may be defined as sales falling below a certain number of units). Other times, an author may be required to send a written request to the publisher before rights will be reverted, even if all other conditions for a reversion of rights have been met.

If you think you may be entitled to a reversion of rights, review your publishing contract and send a written request to your publisher’s rights and permissions department asking for clarification on reclaiming these rights.

Out-of-print, Not Out-of-luck
Authors may want to explore with their agents, or on their own, several possibilities to extend the life of any work. You may want to republish your book with another publisher, for example. Or you may want to take advantage of new technologies and investigate print-on-demand publishing solutions, and online marketing, sales, and content delivery options.

If you think there is call to photocopy or electronically distribute your work in a corporate or academic setting, you may want to contact Copyright Clearance Center (authors.copyright.com). We will be happy to work with you to provide permissions for the reuse of your previously
published works so they may earn you royalties where appropriate.

*At Copyright Clearance Center, Christopher Kenneally is responsible for organizing and hosting programs that address the business needs of authors of all backgrounds. Cheryl Razin, his colleague on CCC’s Author Relations team, assisted in the preparation of this column. Kenneally is host and moderator for an ongoing series of writing conferences called “Beyond the Book” (www.beyondthebook.com) that are frequently broadcast nationally on C-SPAN’s Book-TV and in Canada on Book-Television. An award-winning journalist and author of “Massachusetts 101,” he has reported on education, business, travel, culture, and technology for The New York Times, The Boston Globe, The Los Angeles Times, The Independent (London), and many other leading publications, as well as for WBUR-FM (Boston), National Public Radio, and WGBH-TV (Boston).

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At times, punctuation can be a pain—and sometimes it even bites sophisticated writers. This column is about one of those errors that crops up frequently—too frequently—not only in our own writing, but in magazines, newspapers, and advertisements.

And it is only about a tiny swiggle of type that appears at the top of letters—an elevated comma, if you will.

Are you one of the many who come to a dead stop when you have to write the letters *i t s*? Do you always pause and wonder about the correct spelling? Do you occasionally have to go back and change what you wrote—or correct it when editing?

Well, join the crowd. These 2 forms have been puzzling (and upsetting) people for many years. Once you unlock the secret, it’s really easy, but until you do, it means more sweating.

The rule is simple. If you mean “it is,” write *it’s*. If you do not mean “it is,” write *its*. The possessive of “it” is *always its*, never with an apostrophe. And never, never, use an apostrophe after *its* (*its’*); that isn’t needed to make it possessive.

Explaining the rules about apostrophes may be a little more involved.

Possessive forms are usually created by adding an apostrophe and the letter “s” to the word. Thus, “hat” and “hat’s.” The exception is that “it” does not take an apostrophe to form the possessive: always use *its*. So when George gets a new car, it becomes *George’s new car*. That rule applies regularly. However, when Mr. and Mrs. Smith get a new car, it then is *The Smiths’ new car*.

Some time Bill Thomas may get a new car and you may have a problem. You can write *Bill Thomas’ new car* or *Bill Thomas’s new car*. Both are acceptable. If the result of your writing something like this becomes muddled, or if you just don’t like the way it looks or sounds, even though it may be correct, simply recast the sentence (as you should for any other clumsy expression) and say, perhaps, *The new car Bill Thomas bought*.

Another change occurs if you are referring to Bill and his wife and their new car. The correct phrase would then be *The Thomases’ new car* or *The Thomases’s new car*; there seems to be freedom of choice between these 2 forms. You would have to use the plural of Thomas, that is, Thomases, followed by an apostrophe, either with or without a final “s.”

So, using our basic rule, we would write

*I*t’s *my* *car*. (It is my car.)

*Its* *tires* *were* *bald*. (Because the meaning is not “it is”)  

*It’s* true. “It” does not take an apostrophe for *its* possessive form. Read that again.

As I wrote several years ago, in a facetious mode: Let IT stand for the possessive case. Then, if it’s IT, it’s *it’s*. If it’s not, then it’s *it’s*. 

---

By Arnold Melnick, DO
In medical writing, there is no danger in being too precise—only in being imprecise.

This is the Latin connection: "Lectern" comes from lectus, the past participle of legere, to read; a lector (reader) is one who presides at a lectern, a reading desk with a lamp. "Podium" (plural, podiums or podia), spelled exactly the same in English and Latin, is a raised platform on which you place your feet. The root, pes (plural, pedes; combining form, pod-), from both Latin and Greek, is the word for foot. Thus we have bipedal, podiatry, pedestrian, pedestal, pedicure and pedigree. By the way, if you’re wondering how “pedigree” got into this group, here’s the answer: It’s from the Middle English pedegrü, from the Middle French pie de grue, “crane’s foot; from the shape made by the lines of a genealogical chart” (Webster’s Third New International Dictionary).

These elements are not to be confused, however, in folk (fake) etymology with other words having different meanings but with similar element: pedagogue, pediatrics (ped, child; iatrics, physician or medicine, from Greek iatrikos), which have to do with the teaching of children and the study of childhood diseases.

Latin may be a dead language because no one now speaks it (except the pope and other Vatican inhabitants), but where would English be without it?

DEAR CHERYL: It’s possible that both you and your client were right, but only if the speaker had stepped away from the lectern and down off the podium or dais (also a platform). Just stepping away from the lectern doesn’t carry the same meaning. Leaving the podium (not just the lectern) would indeed bring the speaker closer to the participants.

For people who know Latin, there is no possibility of confusion. And preserving the difference does matter, especially to the technicians and electricians who set up the podium and the lectern. Besides, one could conceivably knock over a lectern, but I doubt that an average person (if such there be) could do that to a podium. Likewise, no one but an acrobat would jump off a lectern.

The lectern doesn’t have to be on the podium at all. It could be below the podium. (I never use either lectern or podium in my workshops, mostly because I like to walk among my students and so be closer to them, but also because I fear becoming entangled in the electric cables.)

DEAR EDIE: Your column about the pronunciation of “the” struck a chord with me. I particularly notice the mispronunciation among young people. It sounds defiant to me. I was taught that the correct way to pronounce it is as “thee” when there’s a vowel sound beginning the next word, a noun. For some reason, pronunciation things tend to get me even more worked up than grammatical mistakes!

Now, about another peeve. Isn’t this a weird use of the preposition “to”? This is from The New York Times: “The Ritz-Carlton has arrived to Paradise Valley, Arizona.”

BARBARA C. GOOD, Ph.D
Director, Scientific Publications
National Surgical Adjuvant Breast and Bowel Project
Pittsburgh, Pa.
DEAR BARBARA THE GOOD: No doubt, you will have read my previous correspondence with David Wood [AMWA J. 2008;23(2):88] about the unlovely pronunciation of “the” before a word beginning with a vowel sound.

I’m with you. To me, “to” in this advertisement, if that’s what it is, is an affectation, although it may be grammatically correct. Are “we” trying to be so, so Continental? But you have to remember that such ads are, after all, rococo pitches for (to?) upper class, moneyed people. The language isn’t weird, it’s just SOP for ad agencies, and it’s so, so ordinary to say that this Eden has arrived in Paradise Valley, Arizona. The copywriter could have said that this Eden has come to Paradise. Perhaps the Ritz-Carlton corporation should employ another advertising agency, whose writers are not coerced into being pandering or supercilious. Are there such? (Sigh)

This usage reminds me of lines in death notices, in which he was “brother to” so and so. One can be a good brother to a so and so, but what’s wrong with being just a brother of? I must confess that I am pettily annoyed at (by?) that usage especially translators[ ] for conveying niceties of relationships. It is also the part of speech that places probably the greatest demands upon speakers and writers [E.S. note: especially translators] for conveying niceties of relationships” (Harper’s English Grammar, by John B. Opdycke).

DEAR KELLY: There’s no question that mistakes in lists of references should not be perpetuated. I’d spell her name correctly. Do not use “[sic].” There are classic cases of such egregious mistakes; one of them involves a mistranslation, an unsophisticated rendering of a name in a German article. The “von” in the byline was thought by the translator to be part of the author’s name, but in that context that German word simply meant “by.” Unfortunately, the error appeared for many years in English-language medical literature, until corrected by a more experienced translator. There were many red faces.

Not so incidentally, there is no need to recite the names of all 12 authors. The AMA Manual of Style (known affectionately by me as AMAMS) says this on page 44 of the 10th edition:

In listed references, the names of all authors should be given unless there are more than 6, in which case the names of the first 3 authors are used, followed by “et al.” Note: The NLM [National Library of Medicine] guidelines do not limit the number of authors listed but, for space considerations, we have elected to depart from the NLM guidelines on this point.
Decades ago I read from an impeccable source that 75% of reference lists contain errors of one kind or another. After that, I insisted on getting actual reprints of the articles, which presumably are error-free since they emanate from the authors themselves. It paid off. Never mind what Medline or any other source does. You have the horse’s mouth. Medline has its own rules and style, most likely for history and full disclosure reasons. Go with it. I bet that if you examined the reprints of the other references in the list you’d find other errors. I speak from the experience of having edited more than a thousand articles.

You are not being picky, just careful, as you should be. Look at my quotation under the byline in the AMWA Journal: “In medical writing, there is no danger in being too precise—only in being imprecise.”

DEAR EDIE: First, on the subject of thin spaces [AMWA J. 2008;1:33], there’s no need to bother with the octothorp. We use Control-Shift-spacebar in Word for a space that is thin and nonbreaking, exactly what we need for mathematical signs and units.

Now, my questions. Is there a general name for the usage in which people attach an adjective to the wrong noun, for example, “This is a claustrophobic room”? And what do you say about “suspicious node,” a common phrase in text about cancer surgery? I’ve been changing it to “suspect node.” Am I overriding a standard usage?

RHANA PIKE
NHMRC Clinical Trials Centre
University of Sydney, Australia

DEAR RHANA: I wish I could say that I know such a word, but I don’t. Maybe an expert in rhetoric has the answer. I use AMAMS extensively for many reasons, although I don’t agree with many aspects of their style (“I don’t believe in slavish adherence to anything, much less style manuals”). My main reason for using it is that every knowledgeable medical editor or writer also has the current edition. Here’s what the AMA Manual of Style (10th ed., p. 402) has to say:

**sug**estic, **sus**icuous: To be suggestive of is to give a suggestion or to evoke. To be suspicious is to tend to arouse suspicion. Thus, the 2 phrases are not synonymous, and care should be taken to avoid confusing them. A finding may be abnormal (ie, suspicious) but may not indicate a specific diagnosis (ie, suggestive). . . . Incorrect: The chest film was suspicious for tuberculosis. Correct: The chest film was suggestive of tuberculosis. Also correct: The chest film showed abnormalities suggestive of tuberculosis. Also correct: The chest film showed a suspicious lesion, but its nature was unclear.

It’s OK to write a “suspicious node.” That meaning and style are ingrained in the medical literature.

Your query reminds me of a column I wrote years ago. A writer had questioned the use of “child psychiatrist,” believing it to be an oxymoron, an occasion for snide laughter. My reply was to emphasize that English is extremely idiomatic, and I quoted from A Dictionary of Contemporary American Usage (1957, p. 15), by Bergen Evans and Cornelia Evans (brother and sister):

Nouns that have been formed from adjectives, such as criminal and juvenile, and adjectives that are being used as nouns . . . may also be used in this way without losing their noun meanings, as in criminal law, a juvenile court, a sick room, an insane asylum, condemned cells. This is a standard English construction. Occasionally someone notices that the first element in one of these compounds can be read as an adjective. This is all very well as a source of innocent merriment. But anyone who concludes that the compound is a grammatical mistake and solemnly goes about condemning it and those who use it, is being ridiculous. These words are part of the fabric of the language and anyone who hopes to get rid of them will have to remake the language.

I loved the Evanses’ sly interpolation of a phrase from Gilbert and Sullivan. The term “claustrophobic room” has a macabre ring to it, reminiscent of the tales of Edgar Allan Poe and Rod Serling. Maybe it would make a good book title for a mystery writer?

Edie Schwager, a freelance writer, medical editor, and workshop teacher, lives in Philadelphia. She is the author of Medical English Usage and Abusage and of Better Vocabulary in 30 Minutes a Day. Queries and comments, which will be edited, should be sent directly to her in publishable form and preferably by e-mail. Edie answers queries as soon as possible.

To avoid back-and-forth, time-consuming messages, **please include permission to publish (or instruction not to publish) with the questions or comments.** For verification, correspondents must provide all addresses, especially the city and state, of the correspondent or the affiliate. The name of the affiliate and other data **may be published** unless Edie is otherwise directed (“Not for publication”). This column is essentially an open forum, a goldfish bowl in a glass house. Edie’s e-mail address, not surprisingly, is **dearedie@verizon.net.**
FOOD FOR THOUGHT FROM SYDNEY J. HARRIS,
Syndicated Columnist (1983)

As [Mortimer] Adler suggests, most people do not really
listen at all. They simply stop their motor from running
while you are talking, and then turn on the switch when it
is their turn. Such conversations never join the issue; each
person proceeds along his own track, and the tracks nev-
er meet, so there is no possibility of adjusting viewpoints—
or even in agreeing on what you are disagreeing about.

❖ ❖ ❖

The deepest continuing nourishment for the psyche comes
from the good opinion of one’s peers, and nothing can
truly substitute for this. The general public may be easily
duped or dazzled by meretricious performance; but it is
impossible to disguise or conceal such deficiencies from
the practitioners of one’s own craft.

FOOD FOR THOUGHT FROM ALFRED KAHN,

All life is a concatenation of ephemeralities.

❖ ❖ ❖

Dear Readers:

Concatenation: From the Latin concatenatus,
linked together, from com, together, + catenare,
to chain, from catena, chain. A suspension bridge
is a catenary bridge, with cables suspended from
two points. “The present work comprises five es-
says nicely concatenated.”

—Richard Hocking

Ephemeralities: From the Greek ephemeros, last-
ing a day, from epi-, to, on, upon + hemera, day.

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Dear Edie continued from previous page
Do Vaccines Cause That?! A Guide for Evaluating Vaccine Safety Concerns
Martin G. Myers and Diego Pineda

In writing Do Vaccines Cause That?! Dr. Martin Myers and AMWA member Diego Pineda have created a readable volume for parents and other interested parties who have questions about the safety of vaccines. Almost 70% of parents who refuse to vaccinate their children do so because they believe vaccines cause harm. However, the authors seek to provide science-based information to help parents understand that although science does not provide all the answers, it is still the best tool to get reliable answers. The authors consider 3 goals of their book: to help people balance the risks and benefits of immunizations; to recognize red flags in the media; and to help individuals determine whether or not a vaccine is the cause of an adverse event or disease.

This 272-page book is divided into 2 sections. The first section, “Weighing the Evidence,” shows readers how best to weigh and evaluate what they hear and read about vaccines. Chapters focus on such topics as how vaccines are really victims of their own success, how vaccine side effects cause risk perceptions, and how many confuse cause and coincident. A valuable section addresses the problems of the medical community in communicating in plain and simple English to people. A helpful page includes a chart of expressions and words that are used to communicate. Words that have a specific meaning in science do not mean the same for the lay public. For example, in medical verbage, the word “significant” is a very specific statistical term that means a test result may not show a chance difference; for the lay public, the word means “important.”

The second section is titled “Blaming Vaccines.” In separate powerful chapters, the authors discuss the questions of vaccines causing asthma, autism, and damage to the immune system (in conditions such as diabetes, Guillain-Barre, multiple sclerosis, low blood platelet count, inflammatory bowel disease, and arthritis). A chapter also addresses other vaccine safety concerns, including febrile seizures, encephalopathy, sudden infant death syndrome, cancer, AIDS, mad cow disease, and birth defects.

This readable guide is not only a “must read” but a “must have” book for medical writers. It is a handy reference, not only for those who have questions about vaccines and specific diseases, but also for medical writers who need to explain scientific procedures to a lay audience. The chapter on where to get reliable information provides guidance not only for vaccines but for researchers assessing the vast amount of information available.

The Complete Guide to Medical Writing
Mark C. Stuart, editor

Pharmaceutical Press and Mark Stuart have collected a fine reference volume in The Complete Guide to Medical Writing. The theme throughout is writing in plain English so that one will always be understood and never misunderstood. The terms “accurate” and “readable” are used throughout the book and emphasized in each section.

The book is divided into 6 sections. Practical information is given in each section. Section 1 is an overview of writing in plain English and reviews (for most of us) some of the specifics of grammar, punctuation, and sentence structure. Section 2 shows writers how to write a research report, reviews, medical case reports, and conference posters. Tips are given in bullets and sidebars. Section 3 includes writing an editorial, letter to the editor, writing for the lay press, press releases, and advertisements. Checklists are included to help put everything together. Section 4 considers writing examinations, presentation materials, and a thesis. Section 5 is of special interest to those who write for an audience of medical and health care professionals. Section 6 on medical publishing includes medical media and the law, writing and editing books, writing for the Internet, and getting published.

Although The Complete Guide to Medical Writing is by British authors and alludes to some European specifics, it is an excellent comprehensive book on medical writing. It could be used as an introductory text to medical writing. However, it is an invaluable reference for medical writing professionals, who are called on to write different kinds of documents. This book is a solid addition to the library of any medical writer.
“Legacy Archive” of Freelance Listserve Postings Now Available

AMWA volunteers have preserved selected posts to the Freelance Listserve that were sent between September 2004 and November 2006, when the listserve began to be archived electronically. This “legacy archive” is organized into 10 topics: advertising, marketing, and networking; contracts; education and certification; equipment and software; ethics, law, and client relations; fees and rates; getting started in freelancing; other associations for medical writers; resources and reference retrieval; and running a business.

The initiative to develop this archive arose in early 2006 from e-mail and telephone exchanges between Michael Altus, Lori Keys Pender, and Faith Reidenbach. They enlisted the support of Tom Gegeny, then Administrator of AMWA’s Department of Web Site and Internet Technology (WIT), and Ronnie Streff, AMWA’s Communications & Technology Specialist. Later, AMWA’s Executive Committee (EC) approved the idea, and Michael and Faith recruited other AMWA members to serve on an Archive Committee. The committee collaborated for 18 months solely via a Yahoo Web site and e-mail.

Early on, the members of the Archive Committee agreed that the archive would focus on certain issues related to the business of freelancing. They would like to thank Bruce Dan, Joyce Griffith, Kurt Ullman, and Lili Fox Velez for helping them select topics. During February 2007, the archiving work started in earnest, when Michael developed criteria for deleting posts and started to sort through more than 2,800 posts to select the “keeps.” Each of the other committee members read through all 2,100 “keeps” and decided how/whether to archive them.

Some AMWA members have wondered, “Why archive old material when the same questions have been posed and answered subsequently?” Members of the Archive Committee point out that some of the people who were listserve members during 2004 to 2006 have left AMWA, have left the listserve, or no longer respond to the mail regularly or at all. The way to get their input is to look in this archive. Plus, plenty of topics in this archive have never been addressed since. The committee hopes you’ll enjoy finding those nuggets.

Thanks to Michael Altus, Lana Christian, Webb Key, Flora Krasnoshtein, Naomi Ruff, Mike Stillman, and Faith Reidenbach (chair) for performing this valuable service.

To access files: Visit http://listserv.amwa.org/archives/index.html

Subscription to MD Consult as an AMWA Member Benefit: 1-year Pilot Program

Past surveys have indicated that members would be in favor of AMWA’s providing a subscription to an online resource such as Ovid or MD Consult as a member benefit. At its April meeting, the AMWA EC agreed that the WIT committee should investigate the feasibility of purchasing such a resource and offering it for free to AMWA members in a 1-year pilot program.

Once this decision was made, Tom Gegeny talked with representatives from Ovid and MD Consult to see what they could offer us and, armed with this information, we conducted a brief survey over AMWA’s listserves to see which service members would prefer. On the basis of the survey results, which showed a clear preference for MD Consult, AMWA headquarters signed a contract for a
AMWA’s access to MD Consult is limited to 2 members at a time because of cost. Additional members trying to access the service will have to wait to gain access until after one of the users signs off. The service includes a customizable time-out feature, which automatically logs people out after a certain period of inactivity. Also, AMWA will be allowed an initial period of unlimited service to handle a large volume of users immediately after the benefit is first introduced.

MD Consult provides access to a collection of more than 50 leading medical reference books and the complete contents of over 80 journals and Clinics of North America. It also offers a comprehensive and regularly updated drug database of FDA prescribing information for thousands of drugs; summaries of articles from the top general interest journals, which are updated each time a new issue is released; and many other features, which are described on its Web site (www.mdconsult.com/das/journallist/body/96980402-2).

We hope that this 1-year pilot program will provide information about whether such a resource would be useful to members. We plan to evaluate the success of the program before the budget is discussed in January. If the service has been heavily used, we can investigate the feasibility of purchasing additional licenses or a way for members who use the service to help pay for additional licenses.
Each year, AMWA bestows honorary awards to recognize outstanding achievements and contributions to both the association and the field of medical writing and editing. In addition, AMWA hosts competitive awards for articles and monographs as well as for full-length books and, with generous support from sponsors, presents student scholarships to provide students with the means to attend the AMWA annual conference. The recipients of 2008 AMWA awards will be recognized this year at the Swanberg Awards Dinner on Friday evening during the annual conference (see sidebar). Brief biographies of the recipients of the Swanberg Award, AMWA Fellowships, and the President’s Award follow. The December issue of the AMWA Journal will include news items on the remaining award recipients.

Grossblatt Chosen for 2008 Swanberg Award

By Howard Smith, PhD
Chair, Swanberg Award Committee

Norman Grossblatt is this year’s recipient of the Harold Swanberg Distinguished Service Award. The award recognizes distinguished contributions of an active member to medical communication or a member’s distinguished services to the profession. When he learned of the award, Norman said, “I couldn’t believe it.”

Norman has been an AMWA member since 1975, and was president of the Mid-Atlantic Chapter in 1981-1982. For over 15 years, he served as editor of the member freelance directory, usually while filling another AMWA role as well. He has chaired the Fellowship Committee, been a judge for the Eric Martin award, and chaired the Swanberg Award Committee for 2 years; it seems fitting that he is now a recipient of this award.

Norman has been extensively involved with the AMWA Journal. He has been a mainstay among the manuscript reviewing and copyediting volunteers for many years, and he served on the Publications Committee as well, chairing that body for 2 years.

This brief description illustrates Norman’s substantive contributions to AMWA at both the chapter and national levels. Yet he is also well-known for being the “founding father” of the Board of Editors in the Life Sciences (BELS). BELS began in 1991 as a credentialing organization to evaluate the proficiency of editors in the life sciences. It has been a striking success, and hundreds of our colleagues worldwide now hold BELS certification. Norman was president of BELS from 1991-1999, and he is the current Councilor for Diplomate Examination Development. He is also the BELS liaison to AMWA and has led annual conference breakfast roundtables for many years in order to inform AMWA members about BELS and professional development opportunities in general.

While the activities above would fill the days for many people, it is worth a reminder that Norman did all of these things as a volunteer. For more than 3 decades, he has been employed full-time at the National Academies of Science. He is now senior editor in the Division of Earth and Life Studies—where he has also influenced the profession through his role in the highly respected and widely disseminated works produced by the National Academies.

Norman has been a tireless advocate for the continuing professionalism of editors in the biomedical and life sciences. He has facilitated the careers of countless people by encouraging them to become involved in AMWA or other professional editing organizations and to “give back” to the profession in many ways. By his own example, he has been a role model to countless others.

AMWA’s highest honor, the Swanberg Award is named for Dr Harold Swanberg, who founded our organization in 1940. This year’s Swanberg Award Committee consisted of MaryAnn Foote, PhD, Art Gertel, and Barbara Good, PhD.

Three AMWA Fellowships Awarded

By Susan Siefert, CBC, ELS
Chair, Fellowship Committee

AMWA awards fellowships to members who have made important contributions both to our organization and to the profession of medical communication. With our congratulations, here are the newest AMWA Fellows.

Lois Baker, a member of AMWA since 1997, has served the organization on the Executive Committee and as a delegate to the Board of Directors from the Empire State-New York Metropolitan Chapter. Her positions on the Executive Committee have included Administrator of Membership, Administrator of Awards, Administrator of Public Relations, and Annual Confer-
ence Workshop Coordinator. She has led workshops and roundtable discussions at the annual conference, served as an open session speaker, and participated as a member of the Publications Committee, Education Committee, and the Task Forces for both the Science Curriculum and Workshop Leader Benefits (she was chair of the latter). This year, Lois is the chair of the Eric Martin Award Committee. She is also the Membership Chair for her chapter, and had worked to create satellite activities for AMWA members “upstate” in the northern part of New York. Outside of AMWA, Lois is the Senior Health Sciences Editor, Office of News Services, Division of External Affairs, University at Buffalo.

**Elliott Churchill, MS, MA,** became a member of AMWA in 1978 and taught her first workshop in 1980. The rest is history. In 2004, she received the Golden Apple Award for the excellence she has brought to the workshops she has taught at the AMWA annual conference, chapter conferences, and on-site training. She has also served on the Education Committee, led roundtable discussions, and served as an open session speaker. In 2007, when Elliott accepted AMWA’s prestigious Harold Swanberg Award, her accounts of her work around the world on behalf of the Centers for Disease Control and Prevention reflected her devotion to medical communication and its most noble goals (see the December 2007 issue of the AMWA Journal to read Elliott’s speech). She recently won a prestigious Fulbright Fellowship to continue her life’s work of education and health communications in a visiting post at the University of Zimbabwe. Elliott is now president of A World of Words, based in Tucker, GA.

**Melanie Fridl Ross, MSJ, ELS,** joined AMWA in 1996, and was elected president of the Florida Chapter in 2001. After serving as the Annual Conference Open Sessions Coordinator in 2003, she was appointed to the Executive Committee, where she has served as Administrators of Chapters and Administrator of Chapters and Membership. She is now in her second year as the Administrator of Publications. In 2006, she was the Administrator of AMWA’s record-breaking annual conference in Albuquerque, AMWA’s first annual conference to draw more than 1,000 registrants. She has also served on the Education Committee, chapter conferences, and Task Forces for the Science Curriculum and for Nonmember Publications. In addition to her service to AMWA, she is the Associate Director, Senior Medical Writer and Editor at the University of Florida Health Science Center News and Communications, and an Adjunct Instructor in the University of Florida College of Journalism and Communications. This year’s Fellowship Committee included MaryAnn Foote, PhD, Barbara Good, PhD, Marianne Mallia, and Jim Yuen.

President’s Award Goes to Lanie Adamson, MS

**By Sue Hudson**

*2007-2008 AMWA President*

The President’s Award, selected each year by the AMWA president, is presented to an AMWA member who has made distinctive contributions to the association, either at the chapter or the national level, outside of the Executive Committee. The 2008 recipient is Lanie Adamson, MS, a freelance writer in Mission Viejo, CA. A member since 1986, Lanie has served as President of the Pacific Southwest Chapter, Asilomar conference director, Nominating Committee member, and Eric Martin Award judge. She has also developed and led numerous AMWA workshops, annual conference open sessions, and roundtables. In addition to these accomplishments, Lanie is a favorite chapter meeting speaker and a generous mentor to her AMWA colleagues, including me. She recently served as lead author of a letter to the editor of *Nature Biotechnology,* explaining the important role of medical writers in scientific publications.

Other 2008 AMWA Honorary and Competitive Awards

**Golden Apple Award**

Sharon Nancekivell

(Brief biography scheduled for the December issue.)

**Annual Conference Student Scholarships**

(Announcement and brief biographies of the recipients scheduled for the December issue.)

**Eric W. Martin Awards**

(Announcement and brief biographies of the recipients scheduled for the December issue.)

**Medical Book Awards**

(Announcement and reviews of the top winning books scheduled for the December issue.)
HOW AMWA PLANS
AMWA has more than 5,500 members and runs on an annual budget of more than $1.6 million. Its operations are the combined effort of the headquarters staff and legions of volunteers. How is the work of all these people coordinated to produce the many programs AMWA offers its members? Good news: We have plans.

Strategic Planning
AMWA’s officers, Executive Committee (EC), and executive director create and maintain a strategic plan to organize their efforts. This plan, which is reviewed and updated every year, lays out AMWA’s vision for the future: “AMWA will be recognized as the foremost resource for medical communicators. To meet the evolving needs of our profession, AMWA will provide relevant education, foster professional development, and promote ethical practices.” This vision says not only that AMWA will be the foremost resource, but that it will be recognized as such. Following the vision statement, the strategic plan itemizes major goals, each of which is supported by objectives, strategies, and tactics, with responsibility assignments and target completion dates.

The goals begin with AMWA’s primary focus: education. AMWA’s first goal is the continuing development of the association as the primary resource for education. This goal includes strategies for enhancing AMWA’s certificate programs, identifying new curriculum needs, keeping existing workshops vital, and developing new ways for members to access AMWA’s educational offerings. The next goal is related: to develop AMWA as the primary resource for professional and career development in the field of medical communication. The vitality of any organization depends on its ability to attract and retain good members, and this is the focus of AMWA’s third goal. After surveying members about their needs and then identifying ways to enhance the value of membership, we can educate current and potential members about the benefits of being an AMWA member. This goal also includes projects to strengthen chapters’ ability to serve their members.

An organization of communicators can’t hide its light for long. AMWA’s next goal acknowledges the importance of increasing awareness of AMWA as a valuable resource for the profession, with strategies for ensuring that AMWA’s publications are of high quality and for increasing external awareness of AMWA’s offerings. Coupled with that awareness is recognition of the value of the medical communications profession, another AMWA goal. This goal encompasses efforts to inform the professional and lay public about the value that medical writers and editors bring to health and science communication; it also includes promotion of medical communication as an attractive career option.

Development and promotion of ethical standards for medical communicators is another important AMWA goal. AMWA’s Code of Ethics establishes the principles of ethical conduct for medical writers and editors; this goal seeks to increase awareness and understanding of that code of ethics and the related position statement on the role of medical writers in scientific publications.

The final goal is focused on the future, aimed at understanding the evolving environment in which we work so that AMWA can continue to serve its members and the profession. This goal includes research and long-range planning projects.

Long-range Planning
Immediate Past President Jim Cozzarin is leading a long-range planning committee in work to define where AMWA should be 10 years from now and to propose steps for getting us there. At a weekend meeting in Cleveland in June, committee members clarified the analyses they have been developing over the past year. Their work will yield exciting new developments in the days ahead.

Thank You for a Wonderful Year
This is my last column as AMWA president, so I’d like to wrap it up by offering my thanks to the many wonderful people who have made the past year a great one. First, I appreciate the continuing dedication and hard work of the AMWA headquarters staff, who keep things running smoothly, rain or shine (and sometimes more rain). I’d also like to thank the EC, the Board of Directors, and the many officers and volunteers who keep AMWA’s chapters vibrant. And thanks also to the many generous people who served on committees and task forces to develop and produce the annual conference program; choose award winners; support AMWA’s publications, Web site, and promotional efforts; write, edit, and produce the Journal; refine the constitution and bylaws; review the budget; advance AMWA’s education program; develop new revenue sources and programs; nominate new officers; and grapple with the issues that will define our future. The heart of AMWA is beating strong. Thank you all for making it so.
On October 30, 2007, the Robert Wood Johnson Foundation (RWJF) hosted a special panel presentation for the AMWA Delaware Valley Chapter (DVC) titled “A Conversation with Leaders in Public Health and Health Care” in Princeton, NJ. RWJF is the largest domestic private foundation devoted exclusively to health and health care.

The presentation focused on the role of RWJF in the areas of health care, insurance coverage, and other public health issues, such as childhood obesity. Advice for medical communicators and resources available at RWJF were also discussed. The panel members included John R. Lumpkin, MD, MPH, Senior VP, Director Health Care Group; James S. Marks, MD, MPH, Senior VP, Director Health Group; and David J. Morse, MA, VP, Communications. The panel moderator was Adam M. Coyne, Director of Public Affairs.

Dr. Lumpkin began the meeting by describing how RWJF is addressing some current health care problems. “The US spends approximately $2 trillion per year (ie, about 16% of the gross domestic product) on health care, and yet approximately 47 million people (including 9 million children) in the United States do not have health insurance,” he said.1 In addition to working with state-level initiatives, RWJF is providing funding and research to increase access to health care. RWJF also focuses on ways to ensure that high-quality health care is accessible to all, regardless of race, income, education level, and other demographics. The foundation sponsors a variety of programs to improve the quality of care and the public reporting of health care issues. Additionally, RWJF has scholars and fellows programs that provide financial support to students and faculty in the health care industry. For example, this program is addressing the shortage of nurses and nursing faculty by exploring strategies to increase nursing faculty salaries and expedite the processes by which nurses obtain advanced degrees and faculty positions.

Dr. Marks, the next speaker, described the childhood obesity epidemic as an example of a significant and current public health issue. Obesity has quickly begun to rival tobacco use as the major preventable cause of disease and death in our country. The prevalence of childhood obesity has increased more than 3-fold over the past 30 years, accompanied by significant increases in the incidence of type 2 diabetes in children and adolescents.2 “We may now be at the first generation where children will be sicker and die younger than their parents,” he said. Dr Marks pointed out that this epidemic has grown so quickly that it is most likely due to changes in our culture and not to genetics. For example, the “super-size” serving is one change in the American diet that may be affecting the overall health of our country’s youth. Daily inactivity may be another factor. Fewer than 10% of US schools have daily mandatory physical education programs.3 RWJF is a partner in a program called “Alliance for a Healthier Generation,” which provides schools with standards for nutrition, wellness programs, and exercise. The program suggests changing the content of food available to students to help them make healthier food choices, and changes implemented through this program led to a 41% reduction in the total beverage calories shipped to schools in 2006-2007 compared with 2004.4

Panel member David Morse spoke about the role of medical communication and public health. Morse began his discussion by highlighting the 2 key roles of medical communicators. First, medical writers have a responsibility to present and explain data in a clear and concise manner in order to educate and inform the public and policymakers. Second, to persuade and promote change, medical writers need to know and understand their audience and tailor messages accordingly.

Morse also provided some tips for medical communicators: (1) avoid the excessive use of adverbs and adjectives; (2) eliminate jargon and other “insider terms” that may be misunderstood or vague, or that may have dual meanings; and (3) avoid elliptical or indirect writing, which limits accountability and responsibility. For more information, Morse recommended books by Tony Proscio, including In Other Words: A Plea for Plain Speaking in Foundations; Bad Words for Good: How Foundations Garble Their Message and Lose Their Audience; and When Words Fail: How the Public Interest Becomes Neither Public Nor Interesting.

Morse concluded his presentation by describing the publications available from RWJF. An anthology is published annually, summarizing the results of foundation-sponsored programs. On the RWJF Web site, (www.rwjf.org) there are press releases, journal articles, policy information, and reports describing results from grant-
funded research. Of interest to freelance writers, the anthologies and grant results are often prepared by outside consultants who have undergone training by RWJF. Interested AMWA members can find information about writing opportunities on the RWJF Web site.

In summary, the panel provided an overview of RWJF and its agenda for public health. Current health care problems, such as escalating costs and the uninsured—hot political and social issues—were discussed. In addition, the role of medical communicators was discussed as having become increasingly important, as many individuals in today’s society underestimate the risks of unhealthy behavior and would rather take a pill than make lifestyle adjustments. The panel agreed that it is essential for medical communicators to provide information in ways that will influence both the public and the policymakers to implement changes towards healthier lifestyles.

References

Elizabeth A. Manning is a clinical research specialist at Akros Pharma Inc. in Princeton, NJ.
Saturday, March 18, 2006. 11:30 AM. Two hours from home, in a nearly empty parking lot at Princeton University, I took a deep breath. A BELS Exam Study Guide and my prized supersized pink eraser were stashed in my purse. As I reached for the 3 sharp number 2 pencils that slipped under the passenger seat somewhere on the Jersey turnpike, I wondered why I was voluntarily giving up a crisp, spring weekend day with my husband and son to enter the world of standardized testing that I had last visited during my senior year in college with mixed results.

As I walked across the campus, I took one last sip of the cooling remnants of my extra large coffee. Overcaffeinated, my head swirled with commonly misspelled words, periodic table abbreviations, and scientific units of measure. As I took my seat in the exam room, I thought about some of my peers who hadn’t passed this test, even on multiple attempts. Was 12 years of battling over word choice with physicians in the editorial trenches enough to prepare me for the questions in that little blue book?

It turns out that it was (phew!), but I never imagined that the skill that would be tested most thoroughly that Saturday was one that I hadn’t used much since college—sitting in one place and concentrating on the rules of language for 3 uninterrupted hours.

If you’re like me, your average 3-hour stretch of office time consists of the work you’ve already been assigned, crammed in between a multitude of unforeseen interruptions: the e-mail from the boss asking for a “quick” project update that takes 4 detail-laden paragraphs to explain; the 2 o’clock phone call from a client who needs something edited by end of day; the coffee run with a co-worker who needs to vent about a boyfriend over a triple hot latte. But once the exam clock starts ticking, interruptions are not allowed. All that’s left is you, an exam booklet, 3 number 2 pencils, and 180 minutes of silence.

For me, concentrating for that long, in silence, was a challenge that I was unprepared for. The modern office is never quiet, and workers never get the luxury to devote long blocks of time to only 1 project. Everyone is a multitasker these days, not necessarily because we want to be, but because today’s workplace demands it of us. We are continually moving and interacting with others, leapfrogging from one project to another across cubicle walls. And even if new work isn’t interfering with old work, many of us have the Internet to lure us away from our work with continuous news updates, hilarious videos, and streaming radio stations.

Sitting in silence in a plastic chair for 3 hours that afternoon in Princeton made me realize that distractions produce energizing forces that break the monotony and intense focus of the office workday. Sometimes, they make you switch gears rapidly and require you to think on your feet; at other times, they provide you with an opportunity to laugh or learn something new. Up until that Saturday, I thought that the typical workplace distractions were hindrances to my productivity. But, as it turns out, I somehow focus better when distraction is an option.

Maria Pownall is a senior medical editor at Independence Blue Cross in Philadelphia, PA, where she edits policies on health care services. Maria’s favorite workplace distractions are her husband Rich and their 3-year-old son Jake.
MEMBER PROFILE

Robert F. Orsetti

By Bettijane Eisenpreis

To many current AMWA members, the name Bob Orsetti may not ring a bell, but without him, AMWA as we know it would probably not exist. Edie Schwager, otherwise known as “Dear Edie,” recalls a pivotal moment in AMWA history.

"On May 25, 1978, at the old Marriott Hotel on City Line Avenue in Philadelphia, the Delaware Valley Chapter was fortunate to have Bob Orsetti as the guest speaker," she says. "I have the well-peopled photo to prove it. He spoke earnestly and passionately of his 4 goals as AMWA president: (1) to return AMWA to a firm financial position; (2) to establish a core curriculum of courses at annual meetings so that members could become well-rounded in all aspects of medical communication; (3) to encourage greater activity in the 5 AMWA sections; and (4) to mount a new, intensive membership drive.

"All of Bob’s goals, with a heap of help from other devoted members, have been implemented in time, and we see the happy results. Although he is the embodiment of modesty, those of us who go way back remember him as a dynamic leader, imbued, for all his sometimes reticent ways, with bonhomie nevertheless. I’m a member of the club of people who are lucky to know him as a dear friend and cherished colleague."

The history of Robert F. Orsetti as a medical writer goes hand in hand with his rise through the ranks of AMWA. In 1965, the year he graduated from college and got his first job as a medical writer, he joined the New York/New Jersey Chapter of AMWA, now the Empire State Chapter. Encouraged by his employer, a now-defunct pharmaceutical company called Carter-Wallace, he held a number of leadership positions in the chapter, culminating with the presidency. At the same time, he became increasingly involved on the national level, serving on the Board and several planning committees, including the national Fellowship Committee in 1970-1971. In 1973, he was named an AMWA Fellow.

Orsetti continued to progress in his career. He joined the staff of Schering-Plough as a writer in the international division, working on the equivalent of new drug applications in foreign countries. At the same time, he obtained his master’s degree in science at Fairleigh-Dickinson University, Madison, NJ.

In the early 1970s, he joined the staff of CIBA, later CIBA-Geigy and now Novartis. "When I joined CIBA it was still in a writing capacity," he explains. "The person who was running the publications department left shortly after my arrival and I became manager of that department. One day one of the product people asked if we could arrange a continuing medical education (CME) meeting, and I said ‘sure.’

"I had no idea what he was talking about, but I had some pretty good people on the staff and we put together a meeting. I think it was in Bermuda, and when I look back, it was probably not the greatest event ever, but it got us started. I’ve been in CME ever since, planning the content, developing the faculty, and helping to chart national policies and practices for this profession. I haven’t abandoned publications either. While I was at CIBA-Geigy (for almost 22 years), we spent half of our lives doing publications while the other half was consigned to CME."

Orsetti served as AMWA President in 1977-1978. "If I were to select a few organizational sources of pride during my tenure as national President," he reflects, "I would point to helping to organize and support the fledgling core curriculum program, expanding the scope of the annual meeting and thus membership by making focused workshops a more integral part of the conference, and locating the annual meeting in only those states that had ratified the Equal Rights Amendment for women."

He developed and taught workshops on a variety of subjects, including career development and CME. In 1985, he received the Harold Swanberg Distinguished Service Award for his contributions to the association and the profession. He has also served on the Editorial Review Board of the AMWA Journal. In 2006, while at the University of Medicine and Dentistry of New Jersey, Orsetti launched the peer-reviewed journal CE Measure—The Journal of Outcomes Measurement in Continuing Healthcare Education, for which he continues to serve as editor.

"AMWA formed the foundation of my career, first in medical writing and communications and in more recent years, in continuing medical education," says Orsetti. "I was fortunate to have had many caring mentors, several of whom remained lifelong friends. Perhaps unknowingly they supplied the self-confidence and directional

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IN MEMORIAM

Carol L. Kornblith, 1945-2008

By LeAnn Stee

Carol L. Kornblith, PhD, a member of the AMWA North Central Chapter, died of cancer at her home on July 4, 2008. Carol was an editor in Scientific Publications at Mayo Clinic, Rochester, from 1984 to 2004. She joined AMWA in 1989. She was a regular attendee at the AMWA annual conferences and made many friends at the networking functions. She looked forward to seeing her AMWA friends each fall and, after researching the best restaurants in the conference city, organized many dinners for renewing acquaintances. She had the full AMWA conference experience by being a workshop leader and breakfast roundtable leader, for which her teaching skills were a great asset.

In her position as editor at Mayo Clinic, Carol edited innumerable articles for medical and scientific journals and provided direction and advice to their authors. She had an interest in and commitment to the ethics of medical publishing and educated the Mayo staff in these principles. Several biomedical textbooks by Mayo Clinic physicians were published as a result of Carol’s careful guidance and editing. Always the educator, Carol supported and encouraged the academic careers of Mayo Clinic staff through teaching many courses on the art of medical writing, effective oral presentations, and succinct, clear poster presentations.

Carol loved pottery and diligently pursued longed-for pieces. Her appreciation of nature was reflected in her support of animal rescue groups, the peregrine falcon program at Mayo, and her care of the wildlife in her own backyard. Her passion for world travel took her to many places, and others experienced her trips through her insightful photography. She was an ardent supporter of University of North Carolina (UNC) basketball.

Carol was born on September 6, 1945, in Chicago. She received bachelor’s and master’s degrees in psychology from the University of Michigan and a PhD in biology from the California Institute of Technology. She was a post-doctoral fellow in psychology at Princeton University and taught and did research at UNC, Illinois State University, and Oberlin College (Ohio). She is survived by a sister, Catherine Cornbleth, of Buffalo, NY. Memorials may be sent to Mayo Clinic, Development Department, Siebens 9, 200 1st St. SW, Rochester, MN 55905.

Martin Auerbach

By Tara Hun-Dorris, MMC, ELS

Martin Auerbach, owner of Citation Retrieval Services, Los Angeles, died suddenly in January. Although not an AMWA member, as a “reference guy,” he was invaluable to numerous medical writers. Marty would obtain references for us days, nights, and weekends. It wasn’t unusual to receive e-mails from him at 3 or 4 AM EST (which was still midnight or later PST). He was always there to come to the rescue during rush projects, providing excellent service at a reasonable price. Beyond his professional dedication, Marty was a great person. Although I never met him in person, we had a delightful e-mail relationship, regularly discussing work-family balance, college football, and the many weather differences between Southern California and North Carolina throughout the year. I always looked forward to working with Marty, and I’ve spoken to several other AMWA members who felt the same combination of professional respect and friendship. He is missed.
Arnold Melnick, DO, MSc, DHL (Hon.), a past president of AMWA, was recently recognized with 2 honors. He has received the Distinguished Service Award of the American College of Osteopathic Pediatricians (ACOP), his second such award from the ACOP and his 15th in total, including the AMWA Harold A. Swanberg Award for Distinguished Service. Dr Melnick was also inducted by the American Osteopathic Association as a Great Pioneer of Osteopathic Medicine. He was so honored in a group of the first 40 individuals with this new designation. Dr Melnick was the Founding Dean of Southeastern College of Osteopathic Medicine, now the Nova Southeastern University College of Osteopathic Medicine. Since retiring as Executive Vice Chancellor and Provost of the Health Professions Division at Nova, he continues with his avocation of medical writing, with 6 published books and more than 160 published professional articles.

Jane Wiggs, MLA, ELS, an editor in the Section of Scientific Publications at Mayo Clinic in Jacksonville, FL, finished seventh in this year’s American Association of Retired Persons (AARP) National Spelling Bee, held on June 14, 2008, in Cheyenne, WY. The 47 participants first took a written spelling test of 100 words. The top 16 finishers on the written test then progressed to the oral rounds. Each speller remained in the oral rounds until she or he incorrectly spelled a total of 3 words. In the oral rounds, Jane correctly spelled “orgulous,” “vendeuse,” “clerisy,” “portiere,” and “vernissage” but misspelled “montmorillonite,” “eicosanoids” (she kicked herself for missing that one), and “guidwillie.” The winning word was “debouch,” and the losing word (second-place finisher) was “umbones.” All the words used in this bee appear in Merriam-Webster’s Collegiate Dictionary, 11th edition. Jane reports the oddest word of the day has no vowel: “crwth.” To see all the spelling challenges, click on “Word Lists” at the bee’s Web site, www.seniorspellingbee.com.

The following 8 AMWA members recently passed the Board of Editors in the Life Sciences (BELS) certificate examination.

Margaret Brenner, PhD, ELS
Little Rock, AR

Ashley Collinsworth, ELS
Dallas, TX

Briget da Graca, MS, ELS
Dallas, TX

Patricia A. Ennis, PPD, ELS
Wilmington, NC

Diane Feldman, ELS
Chapel Hill, NC

Virginia Julian, MD, ELS
Irvine, CA

Diane Lattanzio, MPH, RN, ELS
Mountain View, CA

Carl Richmond, ELS
Pacific Grove, CA

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guidance needed to lead a large organization. Those specialized tools and skills were and continue to be directly applicable to the lectures, workshops, committees, boards, publications, and management style that are mainstays of my career. AWMA truly helped to launch my career and to this day, I continue to apply lessons learned.”

Cathryn Evans, AMWA President in 1982-1983, says, “Bob was the first person I was drawn to when I joined AMWA. Always professional, dignified, warm, and personable, he was both exemplar and mentor for me. We worked together on the AMWA EC [Executive Committee] and Board for many years, planning meetings, workshops, the core curriculum. Everything he did, he did well. I learned a lot from him and still consider him a close friend.”
The Big Six-Oh

By Eleanor Vincent

“When you’ve been 59 for a year, you have two choices: turn 60 or die. I’m still here at 60. I like that.”

— Pat Sajak

Those turns of the odometer get your attention. You know what I’m talking about—the “decade” birthdays. Two decades ago when I told people I was 39, I felt like a character in a Jack Benny monologue. I always got a “wink-wink” or an “oh right, sure you are…” comment. At 59, it was different. I’ve never been one for hiding my age—I’m more inclined to brag about it. But when collecting Social Security morphs from far-fetched fantasy to a line item in your monthly budget, you know you’re getting up there.

I can report that I “crossed over” without incident. One Baby Boomer will turn 60 every second for the next 19 years. In all, 78 million of us. Many of the People magazine crowd have hit their 60s already, including George Bush, Bill and Hillary Clinton, Dolly Parton, and legions of rock ‘n roll singers from the 1960s.

My birthday falls on the same day and year (May 14, 1948) as the state of Israel. India had declared itself an independent nation the prior year, and the struggles of the Civil Rights movement in the United States hadn’t yet begun. Women’s liberation was a glimmer in Simone de Beauvoir’s synapses, and polio was still a scourge. The Mickey Mouse club hadn’t been invented yet. It’s amazing to live long enough to watch countries, social movements, pop fads, and diseases wax and wane.

I graduated from college in 1970, when finding a suitable husband was as much a motivation for being there as getting a good education for many of my female classmates. When I entered the fulltime work force that year, single working women pretty much expected they’d work for a few years, get married, and retire prematurely when their first child was born. On the cusp of a radical shift in the dreams and expectations of women, I leaped straight to the bleeding edge and never looked back. I’ve always worked, even when I had babies. Work is central to my identity. And yet work-life balance has never been more important to me than now.

More than 37% of a national sample of 60-year-olds interviewed by the American Association of Retired Persons (AARP) says they plan to work “until I drop.” Sounds mighty unappetizing to me, but I guess it depends on what they mean by “work.” If they mean continue the old grind in a cubicle for another 30 years, count me out. But maybe they mean write their novels, paint their pictures, start new ventures, or volunteer for their favorite causes. If that’s the vision, I am so there.

Bonnie Raitt’s song, “Scared to Run out of Time,” pretty much sums it up. I’ve never been more passionate about making the most of every moment. People ask how I feel about turning 60. Incredibly lucky. Mighty proud. And very shocked. Back when I was growing up in the turbulent 1960s, actually being 60 was considered old. I couldn’t even imagine living that long.

Some say 60 is the new 45. Possibly. What is certain is this: more than ever before, I feel renewed urgency to spend time with loved ones and friends, take that trip to Paris, get to Yoga class, and buckle down to finish my next book. Age clarifies and sharpens your priorities. And that’s a good thing. I’ll be celebrating this milestone for some time to come. I’ve earned it, and so has every other 3-score-year-old.

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