HOW TO BE AN OUTSTANDING REVIEWER FOR JGIM AND OTHER JOURNALS!

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Additional Faculty

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David Cook, MD, Mayo Medical School
Marshall H. Chin, MD, MPH, University of Chicago
Leonard E. Egede, MD, MS, Medical University of South Carolina
Martha Gerrity, MD, PhD, Portland VAMC and Oregon Health & Science University
Gustavo Heudebert, MD, University of Alabama at Birmingham
Richard Hoffman, MD, MPH, New Mexico VA Health Care System
Jeffrey Jackson, MD, MPH, Uniformed Services University of the Health Sciences
Adina Kalet, MD, MPH, New York University School of Medicine
Wally R. Smith, MD, Virginia Commonwealth University
William Tierney, MD, Indiana University School of Medicine
Judith Walsh, MD, MPH, University of California, San Francisco
Jeff Whittle, MD, Milwaukee VAMC and Medical College of Wisconsin
Brent Williams, MD, MPH, University of Michigan

Summary:
JGIM Deputy Editors will highlight the benefits of participating as a reviewer and provide specific suggestions about how to become an effective reviewer. The interactive workshop will be helpful to prospective, new, and experienced reviewers. A good review discusses the importance and originality of the study, identifies the strengths and weaknesses, provides specific and constructive suggestions supplying examples from the manuscript, and comments on the interpretation of the results.

Learning Objectives:
1. List features or elements of an effective reviewer of peer-reviewed manuscripts
2. Identify benefits of becoming a reviewer
3. List strategies and practical suggestions for preparing reviews

Agenda:
1. Introduction, Goals, and Objectives (5min)
2. Overview, benefits, characteristics of a good review (10min)
   a. Samples of reviewer comments
   b. Points for discussion using the samples: a) identify salient features of good reviews, b) identify areas in need for improvement, c) write specific suggestions to rephrase them
4. Discussion and Summary (40min). Group discussion
5. Conclusions (5min)
6. Evaluation (5min)
What Do We Know About Reviews?

- Quality of peer reviews vary widely

- Improves
  - Precision of reporting, results, discussion, temper conclusions
  - Manuscript in general, abstract quality, readability, accuracy of references (technical editing)

- Better quality reviews
  - Younger
  - Lower academic rank
  - Strong academic institutions
  - Previous research training
  - Postgraduate degrees
  - Known to the editors

- No benefit:
  - Blinding the review process
  - Training/feedback to reviewers

**JGIM Manuscript Management Process** (Cond. accept = conditional acceptance)

**JGIM Steps**
- 2-3 reviewers/ manuscript
- DE rate quality of review (1= poor, 6= excellent)
- Annual recognition (best reviewers, special recognition)
- Authors receive blinded copy
- Reviewers receive a copy of the decision letter and other reviewers’ comments
Why Should I Become a Reviewer?

Personal
- Motivation to write / be creative
- Fun, intellectually satisfying
- Demystifies publishing process
- Indicator of regional/ national prominence
- Promotion / advancement
- Sharpen your skills, tutorial
  - Writing style (“What are they trying to say?”)
  - Research methods (“I never thought of that- what a great idea”)
  - Content area (“Hey I could be doing this kind of work also”)

Scientific Community
- Clarify/ highlight important areas
- Integrity of the decision to publish

TIPS: What Makes a Good Review?

- Research question
  - Importance
  - Originality
- Identifies strengths/ weaknesses of the methods
- Provides specific and constructive suggestions
- Comments on the interpretation of results

Additional Suggestions
- Cover major areas and be concise
- Prioritize and organize your concerns
- Be specific and give examples from the manuscript
- Suggest corrective actions if possible
- Be respectful of the authors
- Act as the expert
- Use guidelines or checklists as appropriate
- Follow the instructions
- Be frank when making confidential comments to the editor
- Do not convey different messages to the author and editor

TIPS: Cover Major Areas and be Concise

- Is the paper a useful original contribution?
- Is the paper appropriate for the *JGIM* audience?
- Is the literature review current and does it place the study in appropriate context?
- Are there any ethical issues that need to be addressed?
- Are the methods and analysis valid and clear?
- Are the tables and figures clear? Is there good use of space in the tables?
- Are the conclusions valid?
- Is the discussion insightful?
- Are the limitations discussed in enough detail?
- What are the relevance and implications of the findings?
- Is the writing clear and concise?


TIPS: Reviewers’ Responsibilities

- Evaluate manuscripts critically but constructively/ respectfully
- Prepare detailed comments
- Complete the review promptly
- Make recommendations regarding suitability for publication in that journal (grade: quality, accuracy, readability and interest to readers, etc.)
- Declare any potential conflicts of interest
- Treat the manuscript as a confidential document
- Must not make any use of the work described in the manuscript
- Should not communicate directly with authors

WAME, World Association of Medical Editors
http://www.wame.org/resources/editor-s-syllabus#reviewers

Conclusion

- *JGIM* needs you!!
- Sign-up to be a reviewer (http://jgim.iusm.iu.edu/)
- Improves quality?
- Well done review, beneficial to all!!
Checklists and Guidelines

- Educational interventions

- Meta-analysis of randomized studies

- Meta-analysis of observational studies
  - http://jama.ama-assn.org/cgi/search?fulltext=moose

- Economic evaluations

- Diagnostic tests studies

- Randomized controlled trials

- Non-randomized interventions

- Quality improvement interventions
  - http://qhc.bmjournals.com/cgi/content/full/14/5/319
References

General Information and Suggestions

Training Peer Reviewers

Validated instrument to measure the quality of a review

Others
GROUP A. (Manuscript #734. Reviewer #1)
GOOD REVIEW

<table>
<thead>
<tr>
<th>Reviewer #1</th>
<th>Annotated Comments</th>
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<tr>
<td><strong>CONFIDENTIAL COMMENTS TO THE EDITORS:</strong></td>
<td><strong>Bold = Good Comment</strong>&lt;br&gt;<strong>Regular= Area to improve</strong>&lt;br&gt;<strong>Identifies areas of most importance and concern</strong>&lt;br&gt;<strong>Gives Editor additional perspective to guide decision</strong></td>
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<td>Most of information from this paper is available at a website: <a href="http://www.fvpf.org/statereport">www.fvpf.org/statereport</a>. You may wish to review this site prior to your decision. Nevertheless, since most physicians are unaware of this site, this paper, with revision, could be a valuable contribution to the medical literature. I am particularly concerned with their statements about Mississippi and Massachusetts laws. If you ask them to revise the paper, please have them send you documentation that supports their views of these laws if they do not revise them.</td>
<td><strong>Addresses the relevance</strong>&lt;br&gt;<strong>Provides specific suggestions</strong>&lt;br&gt;<strong>Positive and professional tone</strong></td>
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<td><strong>COMMENTS TO THE AUTHORS:</strong></td>
<td><strong>Prioritizes comments</strong>&lt;br&gt;<strong>Provides specific suggestions</strong>&lt;br&gt;<strong>Concise</strong></td>
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<td>You have done a nice job of summarizing violence laws in the various states. Most physicians do not know this information and do not know how to find it. I recently came upon a useful website that covers this topic: <a href="http://www.fvpf.org/statereport">www.fvpf.org/statereport</a>. I urge you to mention this site in your paper since it is more recent than your data collection and is likely to be updated in the future. Reporting laws differ in the degree to which they impose responsibility on physicians and threaten patient autonomy and privacy.</td>
<td><strong>Organized comments</strong>&lt;br&gt;<strong>Identifies exact location in the manuscript</strong>&lt;br&gt;<strong>Descriptive words at the beginning of each comment helps authors organize their response</strong></td>
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<td><strong>Major Comments</strong></td>
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<td>1. <strong>Reporting laws.</strong> I believe that you would strengthen your paper by categorizing reporting laws as follows: 1) Reporting of any suspicion of DV - even non-injuries (KY) 2) Reporting of any DV injury (CO,CA) 3) Reporting of any degree of injury from a crime (AZ, GA, ID, IL, ND, OK, TN, UT, WI) 4) Reporting only for &quot;serious&quot; injuries (HI,Iowa, NC,OH) 5) Reporting only if specific wounds or weapons are noted (many) 6) Recording of domestic violence, but no required intervention by authorities (RI, OH,TX). I have tried to arrange these in order from one end of the spectrum (high physician responsibility, high risk to patient's rights) to the other.</td>
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<tr>
<td><strong>Specific comments (page &amp; paragraph)</strong></td>
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<tr>
<td>1. <strong>Reporting states.</strong></td>
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<td>a. Page 2, results - Please provide more detail about the 24 states that have reporting of injuries from crimes. Do not mention these seven states in the same sentence, since they have fundamentally different laws as noted above. More on Mississippi below.</td>
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<td>b. Page 6, para2 Again, please provide more information about these 24 states. Do you have information about whether DV is a felony in some of these states? I suspect that physicians are more liable to report DV if it is a felony offense. Your paper needs more detail about these states, since they really are “mandatory reporting&quot; states for DV.</td>
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<td>2. <strong>Additional website.</strong> Page 5, methods Nice methodology. You may wish to</td>
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include the above website in the methods as well: "These results were rechecked using the Family Violence Prevention Fund's website."

3. **Mississippi / Kentucky.** Page 6, para3 I think you are wrong about Mississippi. I searched the Mississippi Code using www.megalaw.com/index.php3?content=research/states/ms/ms.html including the laws that you mention (45-9-31, 93-21-1). I was unable to find a reference to mandatory DV reporting for health professionals. In fact, I think the statute only includes specific types of crimes, such as with firearms. Please mention that Kentucky requires reporting even if no injury is noted at the time of examination.

4. **Domestic violence.** Page 8, pare 2 To say that there is an "increased number" of states with DV reporting (7 vs. 3) is to oversimplify the issue of violence reporting legislation. I suggest that you omit this sentence.

5. **Table.** Table 1 Please revise the table to include a column for "serious injuries from crimes" and "any injuries from crimes." Recategorize the original 24 states (minus Massachusetts and Mississippi) accordingly. I believe that your information about Massachusetts is wrong. I used www.state.ma.us/legis/laws/mgl/ to search for Mass. Gen Laws 112-12. This law requires reporting of wounds from penetrating mechanisms only. Note above comments about Mississippi.
### REVIEWERS IN NEED OF IMPROVEMENT

<table>
<thead>
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<th>Reviewer #2</th>
<th>Annotated Comments</th>
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<tr>
<td><strong>CONFIDENTIAL COMMENTS TO THE EDITORS:</strong></td>
<td><strong>Bold = Good Comment</strong></td>
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<td>I thought this was well-written and contained important information for all practicing emergency physicians. They addressed the controversies regarding mandatory reporting, and the data collection was done well. The only addition I would suggest is that they add data on law application. For example, what is the method required by the state to make the report? How exactly does the individual seeing the patient make this report? Do they call law enforcement, do they fill out a form issued by the state etc. The practicing physician who reads this report and alters their practice based on this information will have to address this question. The article is excellent as is, but this additional information would be helpful.</td>
<td>Regular= Area to improve</td>
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<tr>
<th><strong>COMMENTS TO THE AUTHORS:</strong></th>
<th>Inconsistent comments, comments to the Editor not mentioned to the author</th>
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<tr>
<td>Well written. Documents important information necessary for the daily practice of emergency medicine. Specific Comments: Refer to: Page Paragraph 3 2 Is there more recent data since 1994 from the CDC Hospital Ambulatory Medical Care Survey?</td>
<td>Lacks specific suggestions</td>
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<th>Reviewer #3</th>
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<td><strong>CONFIDENTIAL COMMENTS TO THE EDITORS:</strong></td>
<td><strong>Identifies areas of most concern</strong></td>
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<td>Reporting requirements and their liability for Emergency Medicine Physicians remains an important issue. However, this survey does not add anything to our understanding of the complex relationship between the physician, our patients, and law enforcement officials. Furthermore, the study inaccurately reports its findings, failing to distinguish between reporting domestic violence to law enforcement and recording domestic violence in the medical record. I feel that this manuscript is unacceptable for publication</td>
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| **COMMENTS TO THE AUTHORS:** | |
|-------------------------------| **Identifies areas of most importance and concern** |
| General Comments: Reporting requirements for Emergency Physicians continue to be a major issue for our specialty and for our patients. The ethical tension that exists between the physician and law enforcement officials for reporting the criminal behaviors/injuries of our patients continues to grow. Studies to clarify reporting requirements, assess and reduce this tension and ultimately reduce injuries are needed. However, this survey (not a study, there was no hypothesis offered) does not shed new knowledge on our understanding of this tension nor does it significantly add to our existing knowledge of the reporting requirements of emergency physicians. | |
The results of the survey do not provide new knowledge and are reported in a misleading fashion that adds misunderstanding rather than clarity. Of the seven states that have specific reporting requirements for domestic violence, the authors fail to make the important distinction of emergency physicians reporting to law enforcement officials (4 states) versus the physician’s requirement to record the event in the medical record (3 states). There is no mention in the manuscript of the important regulations promulgated by JACHO and it’s impact on treating patients with domestic violence in the Emergency Departments and how these reporting requirements differ from state statutes.

There is no discussion on whether these laws have had an impact on the incidence of domestic violence in states with strong reporting requirements versus those states with no reporting requirements at all. I feel that this represents an opportunity for the authors to consider. There is an unfortunate omission of the important discussion about what happens to the “reports” that go to law enforcement/health agencies for those states that require reporting. There is no discussion about a potential standardized report that emergency physicians should consider, especially since a percentage of emergency physicians practice in multiple states. There is no comparison between elder and child abuse case reporting, only a brief mention. There is no discussion of the rather complex and important emerging issue of the reporting of patients with alcohol related problems and driving by emergency department personnel.

The survey raises more questions than it answers. The complex relationship of the physician, the patients, and our duty to inform law enforcement on selected problems is an important one. Domestic violence reporting remains a major issue for emergency medicine. I would challenge the authors to more fully address it.

Specific Comments:

Harsh comments
Critical, and perhaps important comments could be re-worded to strengthen the manuscript
GROUP C. (Manuscript #749. Reviewer #1)
GOOD REVIEW AND SOME NEED OF IMPROVEMENT

<table>
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<th>Reviewer #1</th>
<th>Annotated Comments</th>
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<td><strong>CONFIDENTIAL COMMENTS TO THE EDITORS:</strong> The authors provide a retrospective chart review to achieve their reported goal to “determine the number of patients with either a chief complaint of pain or any complaint of pain.” They also classify region of pain using a modified scale adapted from a chronic pain syndrome taxonomy. While I think the concern about patients’ pain is extremely important, and timely, I do not think this study is helpful. The authors grouped numerous variations of signs and symptoms, or procedures, or medication administration as equivalent to a complaint of pain. Aside from the problems and biases inherent in chart reviews, and specifically with this study, the authors fail to pass the “so what” test. Numerous studies have indicated we under treat pain, and underestimate patients’ pain (especially for minorities). The authors note previous prospective studies that not only ask the patients themselves if they are having pain but also quantified that pain. Given that others have performed prospective studies, and used more appropriate patient centered outcomes, it seems inappropriate to step backwards to a retrospective chart review. If the previous prospective studies have design flaws, then a better-designed prospective study is more appropriate. Although this review covers 24-7 patients, from a busy ED, it still falls short of the results from a prospective study. Whenever possible the patients’ ratings of their pain, and their description of their illness should be valued over a MD or RN assessment/categorization retrospectively of the patients’ experience that is reflected in a MD chart. The authors comments in the discussion about Hawthorne effect and acquiescence bias are theoretical limitations, however it is unlikely there would be a systematic one-way bias in pain report because subjects no they are being studied or that patients would acquiesce. Acquiescence bias, that people tend to agree rather than disagree, can be avoided by a well-designed survey using alternate question and response sets, and acquiescence is more a problem if surveys are very long and patients get tired of answering questions. There are many more biases introduced by retrospective chart reviews, in which the abstractors are deciding which patient complaints should really be called pain. I think the authors comments (about the limits of the previous surveys) to justify their study, although not intentional, appear to imply that MDs and RNs abstracting a chart are more accurate than asking the patient themselves. The authors do appropriately recognize their study is descriptive, and do not overuse statistical tests. Beyond providing support for their research question/design, there are issues in the scoring and coding that need to be addressed, (especially handling of pediatric cases), the results need to be presented more clearly, the discussion needs to put the results in a context in which they are useful and needs to clarify the limitations with specific acknowledgment of how the bias/limitation affects the result. Below is a retrospective review checklist.</td>
<td>Not concise</td>
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<td>Professional tone</td>
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<td></td>
<td>Addresses relevance and importance</td>
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<td>Most of these comments are made directly to the Author (avoid repetition)</td>
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<td>Addresses relevance and importance</td>
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<td>Comments on the interpretation of results</td>
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<td>Weaknesses of the methods identified</td>
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<td></td>
<td>All comments could be more concise / succinct</td>
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<td></td>
<td>Generic comments, not specific enough to guide the Editor</td>
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**COMMENTS TO THE AUTHORS:**

You provide a retrospective chart review to achieve the reported goal of determining “the number of patients with either a chief complaint of pain or any complaint of pain.” Your study is descriptive and thus the absence of statistical testing is appropriate. You need to clarify your objectives, your methods, the presentation of the results, and the discussion. Specific comments are listed below.

### Professional tone

<table>
<thead>
<tr>
<th>1. Introduction</th>
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<tr>
<td>Please provide some support for your research question. Why should the reader want to read this paper? What does it add to the literature? How can the results be used? Why did you choose a retrospective chart review, instead of prospectively collecting data as has been done in other settings? If your contention is that the previous samples are biased because they excluded patients who presented at night, why not just prospectively collect data including night visits? Why did you adopt a chronic pain taxonomy to classify the acute pain? Explain why you feel this data is important to categorize.</td>
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### Organized, numbered (assists Editors/authors respond)

<table>
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<tr>
<th>2. Methods:</th>
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<tr>
<td>You are missing a description of many key elements of retrospective chart reviews, please clarify.</td>
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<th>3.</th>
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<td>Were the patient names redacted, or were charts blinded in any way?</td>
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<td>Were the 5 abstractors blinded to the study goals?</td>
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<td>Did you have a standardized abstraction form for the “pain” coding?</td>
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<td>When the chart was copied, did one abstractor evaluate the entire chart — nursing note, resident note/attending note/consult note? Or were the charts divided so that the MD notes were coded separately from RN notes? Did one abstractor code both the presence of pain and the taxonomy?</td>
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<td>p.5 Mentions all 5 clinicians abstracted 30 pilot study charts. Was this abstraction of all the data elements? (Again as above was there 1 form for all the data?) How about the actual study data? Were the 7-day study charts double coded? Was any inter-rater reliability assessed on the main study collection? If so, how were discrepancies in coding resolved?</td>
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### Requests clarification

<table>
<thead>
<tr>
<th>2. Results</th>
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<tr>
<td>Paragraph 2 of the results is hard to read. Please present it as a table. Drop figure 1, it is not helpful. Table 2 — the number of subjects in the duration of pain add up to 1018, not 1019. You may want to consider whether presenting the data from table 2 graphically is more helpful. (e.g. try a stacked bar chart for the region of pain. A different shade for patients with 1 region of pain, vs. 2, vs. 3 or more.</td>
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### Provides specific suggestions

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<th>3. Discussion</th>
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<tr>
<td>You indicate unconscious patients or infants may have their pain underestimated. However, it is possible parents could report children tugging at ears, crying or other discomfort that you inappropriately coded as pain. A patient who had a seizure and is unconscious or altered, or an alcoholic who falls, may both show up with lacerations that are then coded as pain because a procedure is performed.</td>
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<td>While the comment is important, lacks specific suggestion for improvement – what does the reviewer want the author to do?</td>
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Page 12/12