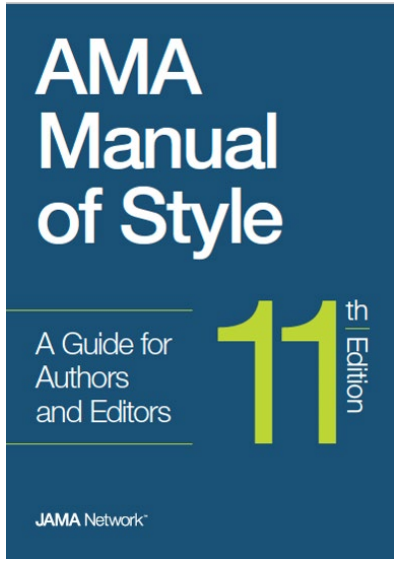
What's New in AMA Style?



Implemented Updates

11th Edition (Almost here!)

Stacy Christiansen and Annette Flanagin

AMA Manual of Style Committee Members

American Medical Writers Association annual meeting

November 7, 2019

Presenter disclosures

- We are authors/committee members of the *AMA Manual of Style* and current or former paid employees of the American Medical Association, which owns the *AMA Manual of Style.*
- Stacy is the Managing Editor of *JAMA*; member of AMWA; and serves (unpaid) on several committees for CSE.
- Annette is Executive Managing Editor and VP Editorial Operations, JAMA Network; Executive Editor, JAMAevidence; and Executive Director, International Congress on Peer Review and Scientific Publication; member of AMWA; and also an unpaid board member of STM: International Association of Scientific, Technical, and Medical Publishers.
- Other *AMA Manual of Style* committee members include co-chair Cheryl Iverson, Connie Manno, Phil Fontanarosa, Lauren Fischer, Tracy Frey, Brenda Gregoline, and Edward Livingston (all current or former editorial staff of the JAMA Network).

Updates to be reviewed in this session

- The stylebook revision process
- References: changes and updated examples
- Tables and figures: style changes and more examples
- Grammar, Punctuation, and Abbreviations
- Preferred and Correct Usage: new terms and usage examples
- Nomenclature: genetics
- Statistics and Study Design
- Resources and publishing glossary
- Ethical and legal considerations
- Corrections and pervasive errors
- Updates on authorship policies
- Updates on conflict of interest policies
- Intellectual property updates
- Ethical review of research and informed consent
- How to access stylebook updates

Stylebook revision process

The first stylebook was an in-house document prepared in 1962 encompassing 68 pages of advice for *JAMA* and specialty journals staff.
It grew through the next 9 editions to 1032 pages for the 10th edition in 2007.

10 Committee members have revised 23 chapters: they met regularly to discuss changes and updates, consulted experts in various areas, and drafted multiple revisions following external reviews. This has been a 4-year iterative process.

The 11th edition will publish in January 2020 (print and online versions).

Authors/Committee Members

- Stacy L. Christiansen, MA
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- Edward H. Livingston, MD
- Lauren Fischer, BA, BS
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- Brenda Gregoline, ELS
- Tracy Frey, BA
- Phil B. Fontanarosa, MD, MBA
- Roxanne K. Young, ELS

Manuscript preparation: death dagger

Discontinuation of the death dagger

The convention of using a dagger (†) next to a name in an article byline, connected to a footnote to indicate a deceased author, has been discontinued.

If desired, this information can be included in the Acknowledgment section at the end of the article.

➢For example:

Additional Information: Coauthor John Doe, MD, died January 30, 2018.

References: publisher location no longer required

In the 11th edition, AMA style will **no longer recommend including the publisher's location** for several reasons:

- Many publishers have more than 1 location and determining which location is appropriate to include can be challenging.
- Location can be difficult to determine if looking at an online resource (eg, an e-book).
- Publisher location is not a necessary piece of information in retrieving the reference.
- (This mirrors the update from 2011 of not requiring the location of a drug/device manufacturer.)

Publishers in book citations

Formerly:

Iverson C, Christiansen S, Flanagin A, et al. *AMA Manual of Style: A Guide for Authors and Editors*. 10th ed. New York, NY: Oxford University Press; 2007.

Future style:

Christiansen S, Iverson C, Flanagin A, et al. *AMA Manual of Style: A Guide for Authors and Editors*. 11th ed. Oxford University Press; 2020.

DOIs in reference list

When a DOI is included for journal references, no period follows

- The ability to easily and accurately copy and paste DOIs is important.
- Because of this, a period should not be included after the DOI; the risk of the period becoming a part of the DOI itself is too great and would create problems with linking.
- Online linking is one of the key reasons to have a DOI.

1. Harman S, Verghese A. Protecting the sanctity of the patient-physician relationship. *JAMA.* Published online October 29, 2019. doi:10.1001/jama.2019.17965

URLs in reference list

In reference lists, the URL will be the last item, following dates posted/updated/accessed. No period follows it.

This style will mirror current formatting for citations with a DOI.

1. Centers for Disease Control and Prevention. Million Hearts: meaningful progress 2012-2016. Published May 2017. Accessed August 9, 2019. https://millionhearts.hhs.gov/files/MH-meaningful-progress.pdf

Social media references

Facebook: JAMA Facebook page. Accessed November 2, 2019. https://www.facebook.com/JAMAJournal/

Twitter: @AMAManual. In the 11th edition: More examples of references in scientific publications, including newer sources such as trial registries, data repositories, preprints, and social media. Posted November 1, 2019. Accessed November 2, 2019. https://twitter.com/AMAManual/status/1190283198544203776

Blog: Orellana J. Resources for references. *AMA Style Insider* blog. Posted October 25, 2019. Accessed November 2, 2019. https://amastyleinsider.com/2019/10/25/resources-for-references/

Preprints and digital references

References chapter will include citation guidelines for **preprints, manuscripts in institutional repositories, apps, podcasts**

1. Bloss CS, Wineinger NE, Peters M, et al. A prospective randomized trial examining health care utilization in individuals using multiple smartphone-enabled biosensors. Preprint. Posted online October 28, 2015. bioRxiv 029983. doi:10.1101/029983
2. Tseng V. Effect of noise reduction methods in the ICU on sleep quality. UC Irvine. June 8, 2016. Accessed August 17, 2016. http://escholarship.org/uc/item/190551hq
3. *JN Listen*. Version 1.0.15. American Medical Association. Updated March 1, 2019.
4. Bauchner H. Editor's audio summary. *JAMA*. October 22, 2019. Accessed October 31, 2019. https://edhub.ama-assn.org/jn-learning/audio-player/17983772

References for data repositories and data

1. HUGO Gene Nomenclature Committee (HGNC). Human Gene Nomenclature database search engine. Accessed March 14, 2018. http://www.genenames.org

When citing data, the data package or data set should be cited in the original publication to link the publication and the data.

1. Francuzik W. Data from: Skin microbiome in atopic dermatitis: 16S gene sequence data. *figshare.* 2016. doi:10.6084/m9.figshare.4028943

When citing data from a repository associated with research published in a journal article, cite the data used in addition to the original publication.

1. Cutter AD, Gray JC. Data from: Ephemeral ecological speciation and the latitudinal biodiversity gradient. *Evolution.* 2016;70(10): 2171-2185. *Dryad Digital Repository*. Deposited August 17, 2016. doi:10.5061/dryad.734v9

Citing clinical trial databases

Common trial registries: ClinicalTrials.gov (US), anzctr.org.au (Australia and New Zealand), isrctn.org (UK), trialregister.nl (the Netherlands), umin.ac.jp/ct (Japan), and EU Clinical Trials Register/ EudraCT (Europe).

1. Evaluation of phage therapy for the treatment of *Escherichia coli* and *Pseudomonas aeruginosa* wound infections in burned patients (PHAGOBURN). ClinicalTrials.gov identifier: NCT02116010. Updated July 23, 2015. Accessed October 13, 2019. https://www.clinicaltrials.gov/ct2/show/NCT02116010

2. German Cancer Research Center. Use of acetylsalicylic acid (ASA) for enhanced early detection of colorectal neoplasms. EudraCT Identifier: 2011-005603-32/DE. Posted May 30, 2012. Accessed November 2, 2019. https://www.clinicaltrialsregister.eu/ctr-search/trial/2011-005603-32/DE

Tables and figures: formatting and style update

Current style (alignment on single digits or opening parenthesis, centered column headings)

Change in tables:
left alignment of all cells to aid readability

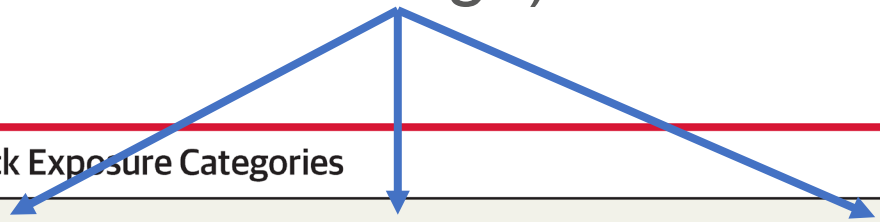
Table 3. Rates and Adjusted Hazard of Death for Negative Wealth Shock Exposure Categories

	Positive Wealth Without Shock[a]	Negative Wealth Shock[a]	Asset Poverty at Baseline[a]
Person-years, No.	52 788	12 621	5274
All deaths, No.	1617	819	387
Unadjusted rate/1000 person-years (95% CI)	30.6 (29.1-32.1)	64.9 (60.4-69.3)	73.4 (66.1-80.7)
Unadjusted rate difference (95% CI)	0 [Reference]	34.3 (29.6-39.0)	42.8 (35.3-50.2)
Adjusted hazard ratio (95% CI)[b]	1 [Reference]	1.50 (1.36-1.67)	1.67 (1.44-1.94)

Tables and figures: formatting and style update

Future style: left alignment of all cells

And – change to sentence-style capitalization in all elements of tables and figures (axis labels, column headings)



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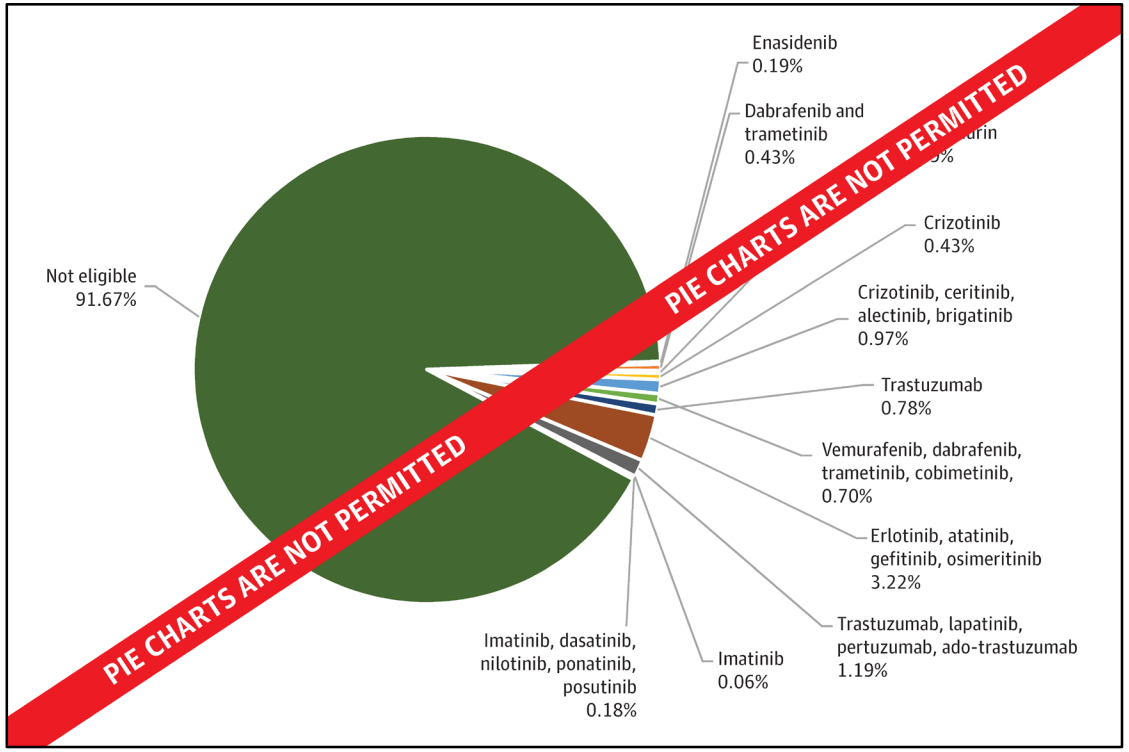
Figures: Updated (and new) examples of data display

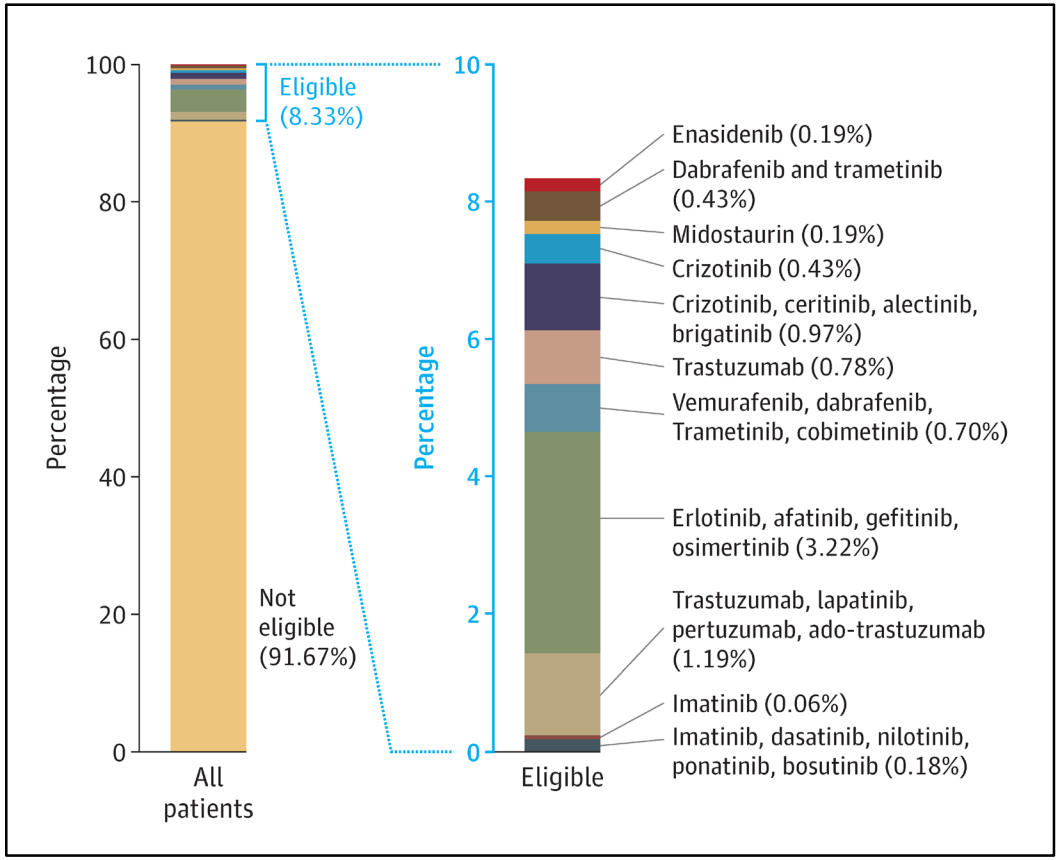
- Line graph
- Survival curve
- Scatterplot
- Histogram
- Frequency polygon
- Bar graph
- Dot plot
- Box and whisker plot
- Individual-value plot
- Spaghetti plot
- Forest plot
- Funnel plot
- Hybrid graph
- Flowcharts
- Decision tree
- Treatment algorithm
- Pedigree
- Maps
- Genetic heat map
- Network maps
- Illustrations
- Clinical images: radiographs, ultrasonographs, MRIs, photomicrographs, photographs, diagrams, gel electrophoresis
- Multipart figures
- in **FULL COLOR**

Figures: NO pie charts



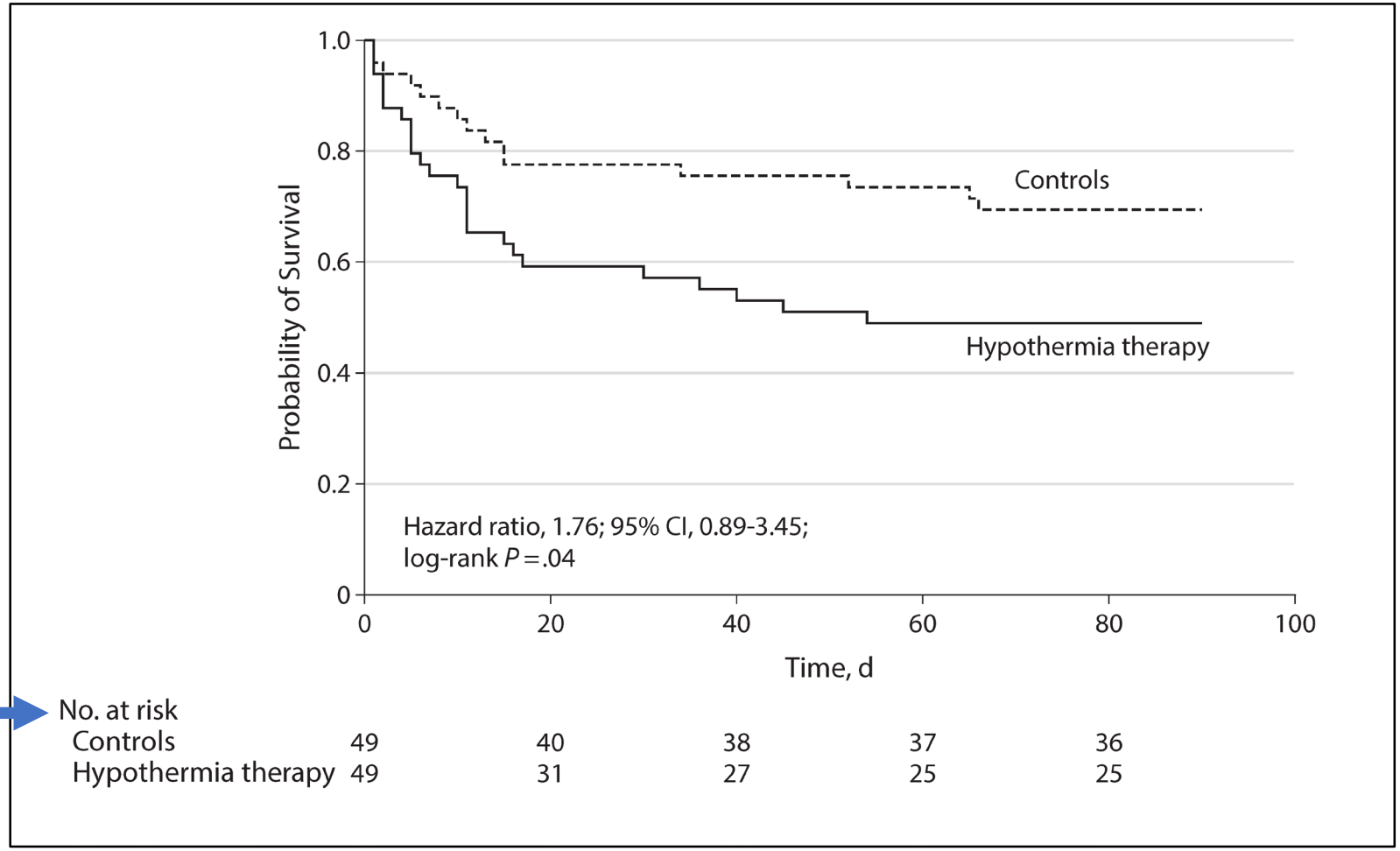
Author's original

Published version



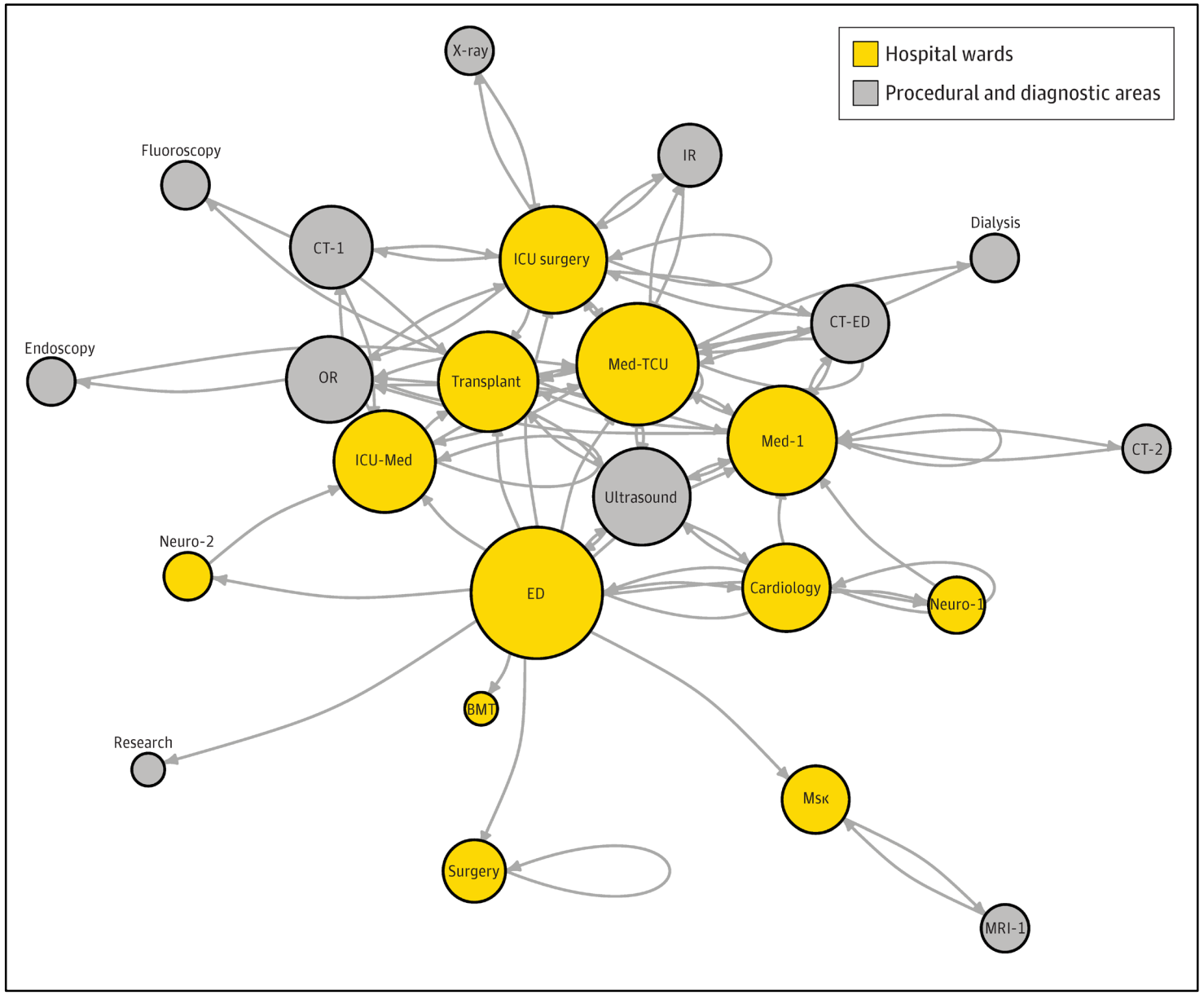
Figures: Kaplan-Meier survival curves

A table of the number of patients at risk is required for each graph



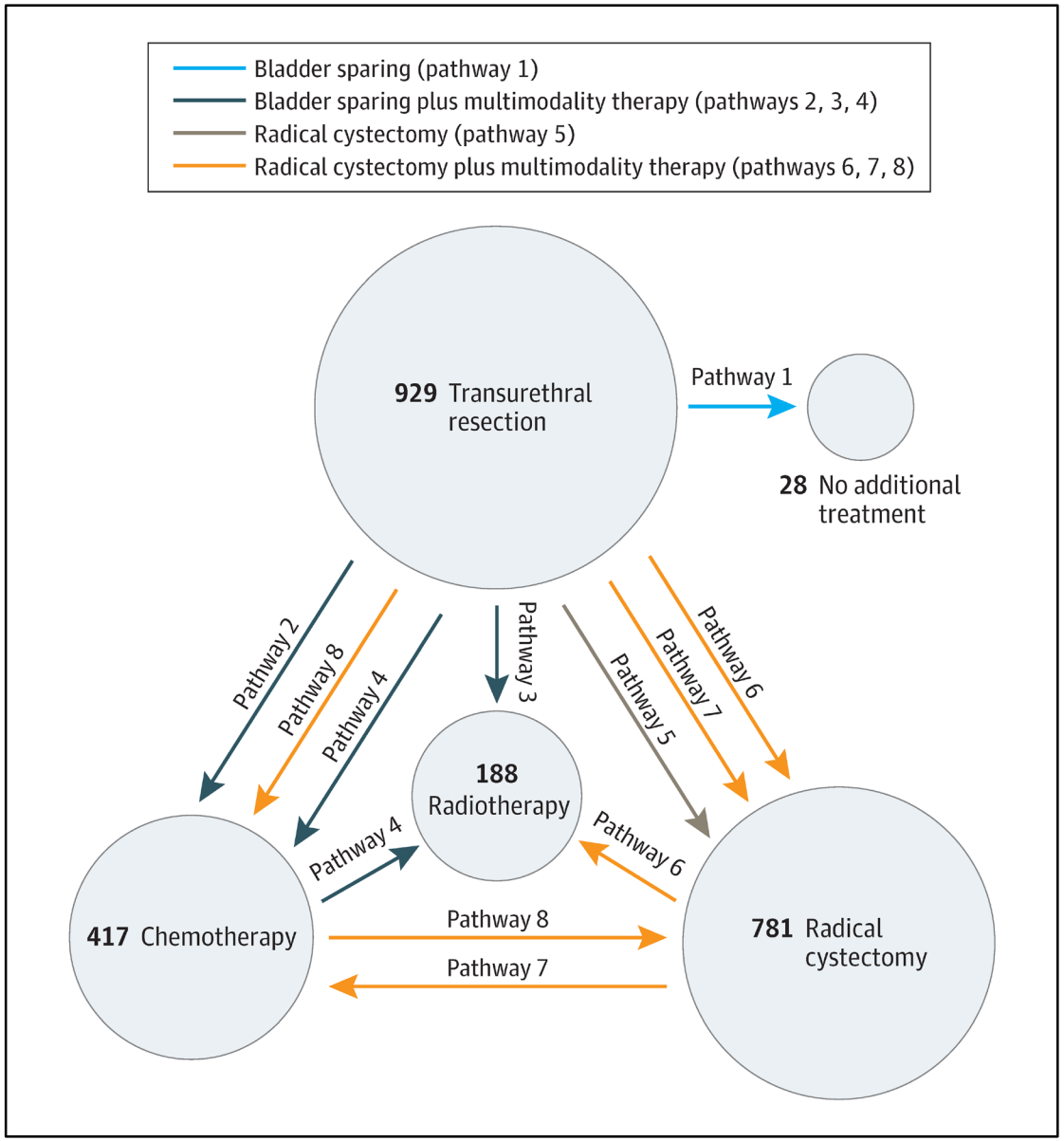
Figures: Network maps

Flow of patients with *C difficile* infection from the ED throughout the hospital



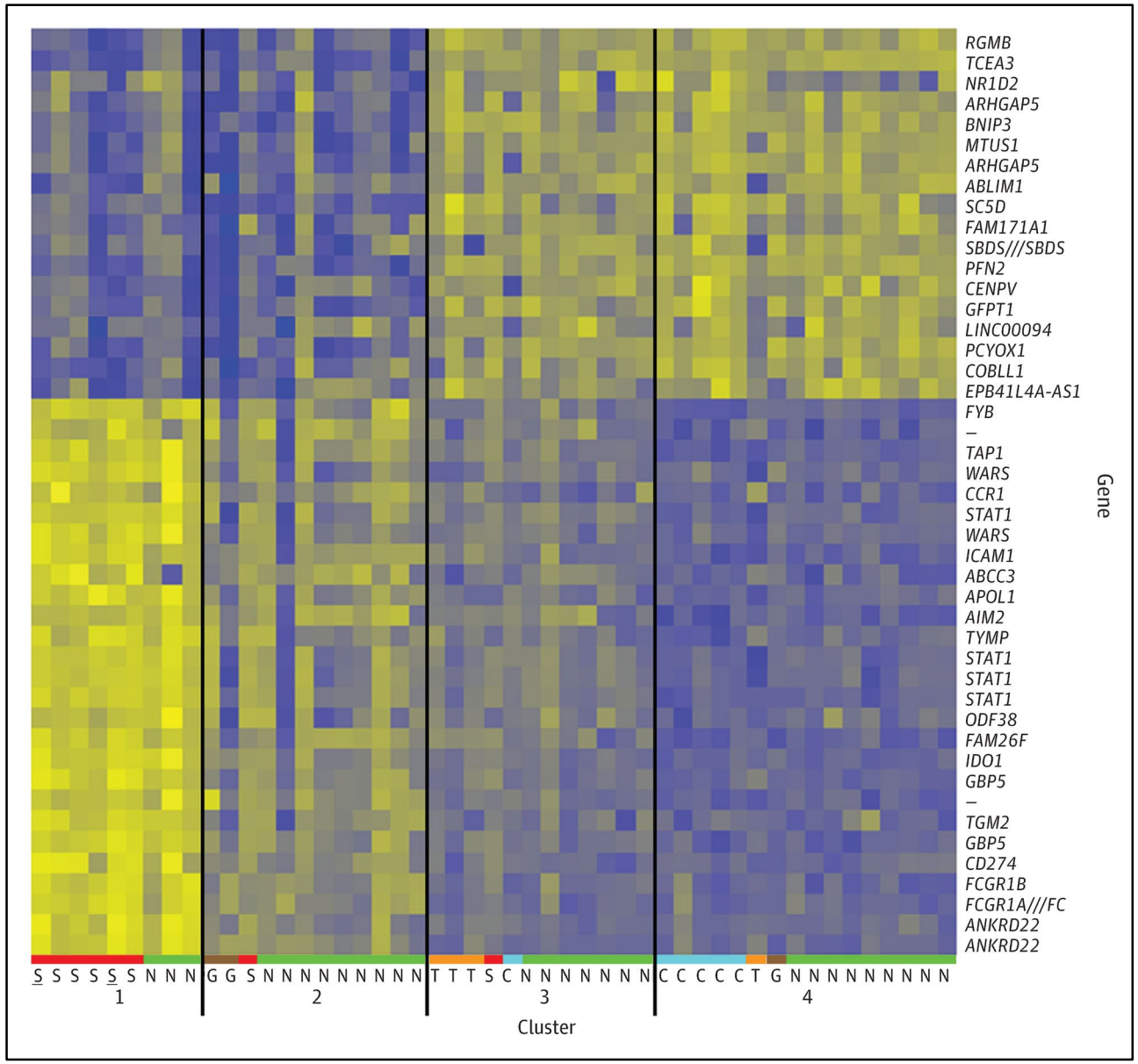
Figures: Network maps

Network structure of multimodality treatment outcomes



Figures:
Heat maps

Relative expression levels in 4 genetic clusters based on core probe sets



Grammar update: singular “they”

AMA Manual of Style will join other resources, such as *The Chicago Manual of Style* and *AP Stylebook*, in permitting use of ***they* as a singular pronoun** when rewriting the sentence as plural would be awkward or unclear. [Note: rewording usually is possible and preferable.]

> “The author is responsible for the accuracy and completeness of their references.”
>
> “Every patient should take their medication.” Could be reworded “Patients should take their medication.”

This construction can be useful in medical articles in which patient identifiability is a concern (eg, removal of gender-specific pronouns).

> “The patient was adamant that they were not taking illicit substances.”

Grammar: choosing the indefinite article

Deciding whether to use *a* or *an* depends on how the subsequent noun (or modifier) is pronounced aloud, regardless of spelling. “An” is always used before a vowel sound (but not necessarily always before an actual vowel).

- a eukaryote
- a histogram
- a laryngoscope
- a mammogram
- a neurologist
- a one-way street

- an eye
- an hour
- an LV anomaly
- an MMSE score
- an NSAID
- an otoscope

But: a LASIK procedure

But: a MRSA outbreak

But: a NICU incubator

Grammar for social media

Scientific articles often have a life beyond their formal full-text publication, including social media such as Twitter and Facebook.

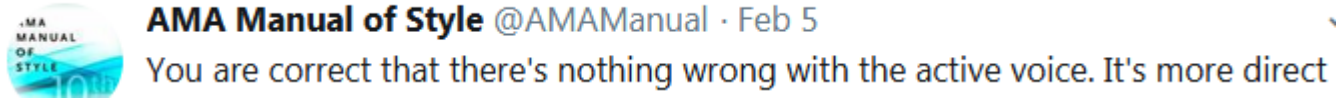
Because these posts have strict space limits (Twitter allows just 280 characters) or expectations of brevity from followers, it is usually not possible, or even desirable, to strictly adhere to grammar, punctuation, and usage norms.

However, some standards are necessary to ensure clarity.

In blogs and social media posts about scientific content

- Use proper capitalization; capital letters don’t take up more characters than lowercase.
- Use basic punctuation to help ensure clarity.

- Avoid texting jargon, such as “U” for “you” or “L8” for “late”; these abbreviations are too colloquial and may not be widely understood.
- Contractions are fine, as are easily recognized symbols such as &, <, and =.



e words and web words

In line with contemporary usage, we have removed the hyphen in *email* and now lowercase *internet* and *website*.

- In text: “Send me an email.” In titles: “How Writers Use Email”
- The hyphen is retained in other *e-* compounds (eg, *e-cigarette*, *e-book*).
- In titles, capping of words that follow *e-* will be on the first letter of the word that follows: “State Restrictions on e-Cigarette Use”
- website, webcam, webcast, webpage, the web

Punctuation: when not to use hyphens

Expanded list of nonhyphenated terms

- Do not hyphenate modifiers in which a letter or number is the second element.

type 1 diabetes	phase 2 study

- Some combinations of words are commonly read as a unit.

amino acid levels	bone marrow biopsy
deep venous thrombosis	health care system
lower extremity amputation	open access journal

Abbreviations: new entries

New abbreviations added

ACEI	angiotensin-converting enzyme inhibitor
ACL	anterior cruciate ligament
GWAS	genome-wide association study
LGBTQAI	lesbian, gay, bisexual, transgender, queer (or questioning), asexual (or allied), intersex
MERS	Middle East respiratory syndrome
OUD	opioid use disorder
SNV	single-nucleotide variant

Usage: terms updated

Addition of socioeconomic status

- **11.12.5 Socioeconomic Status.—**Avoid labeling people with their socioeconomic status, such as *the poor* or *the unemployed*. Instead, terms such as *low income* and *no income* are preferred.
- Use of the terms *first world/third world* and *developed/developing* are not recommended as descriptors when comparing countries or regions.
- **low-income, limited-income, resource-limited, resource-poor, transitional** terms added

Usage: more terms

Addition of terminology on **addiction**

- Avoid use of “alcoholic,” “addict,” “user,” and “abuser” —replace with “she was addicted,” “people with opiate addiction,” “he abused alcohol,” “alcohol misuse disorder”

New additions to correct and preferred usage list, for example:

- **nauseous, nauseated**
- **foreign-born**—replace with specifics, eg, “non-US born”
- **elicit, illicit, solicit**
- **alternative, alternate**

Abbreviations: fellowships removed from bylines

Omission of all fellowship designations – authors often have more than the length of their names

In current style (10th ed), only fellowships in the UK and Canada are permitted in bylines, but not US (American) fellowships. What qualifies for inclusion? – formal testing vs application/admission? Challenging to manage - straightforward rules needed for fairness and consistency

11th ed: FRCP, FRCPC, etc, are removed from the list of credentials published with author names.

Emphasis is on academic degrees. Honorary degrees and other awards (eg, knighthood) are not included.

Licensing and certifications still published (eg, RN, ELS)

Abbreviations not needing expansion

Abbreviations that are really well known (some more by their abbreviation than expanded term) are indicated in the Abbreviations chapter of the 11th edition.

Newly added to this list are

- CME
- HIV
- OMIM
- PMID

And some have been removed, such as CD (compact disc) and PDA (personal digital assistant)!

Nomenclature: genetics

Genetics: Discourage use of aliases/nicknames for genes and proteins

Gene symbol	Gene description	Acceptable expression
TP53	tumor protein p53 (Li-Fraumeni syndrome) gene	The *TP53* gene (p53 is the alias; the official term is preferred to the alias)

May be necessary to "dual report" for aliases well-entrenched in use: "*ERBB2* (previously HER2/*neu*)"

Nomenclature: genetics

The Human Genome Variation Society recommends avoiding the terms *mutation* and *polymorphism*, preferring instead the terms *sequence variant, sequence variation, alteration,* or *allelic variant*.

In view of this recommendation, single-nucleotide variation (SNV) is now more frequently used instead of SNP (single-nucleotide polymorphism) and may become standard.

To aid readers' understanding during this transition, at first mention SNV may be used, with SNP in parentheses:

"…SNV (formerly SNP)…"

Numbers: CI not expanded

Joining other measures of variance such as SD, SE, and SEM, we no longer expand CI (confidence interval).

- "Low-quality evidence has shown that risedronate reduces the risk of fragility fractures (hazard ratio, 0.27; 95% CI, 0.09-0.83; *P* = .02)."
- "The primary analysis followed a modified intention-to-treat principle and used a 1-sided 95% CI for noninferiority."

Units of Measure: Spacing in Temperature

Per SI convention, we no longer close up degree symbols in temperature but use a space after the number:

- temperature of 37.5 °C (not 37.5° C or 37.5°C)

Was: The patient had a temperature of 99°F.
Now: The patient had a temperature of 99 °F.
Also: The temperature range was 99-101 °F (no longer need to repeat °F).

Note: Degree symbols for angles (eg, 45° angle) and for longitude and latitude (45°35′N) remain closed up.

Statistics: terms updated

The terms ***multivariable* and *multivariate* are not synonymous**, as the entries in the current Glossary suggest (Section 20.9, page 881).

Multivariable refers to multiple independent variables for a single outcome (dependent variable).

Multivariate refers to 1 or more independent variables for multiple outcomes. See the Update on the stylebook site.

- Most clinical studies use a *multivariable* approach (a single outcome)
- "Using sex-stratified multivariable-adjusted Cox proportional hazards models, black women and men were more likely to develop diabetes than white men and women (black women: HR, 2.86 [95% CI, 2.19-3.72]; black men: HR, 1.67 [95% CI, 1.28-2.17])." Diabetes is the single outcome; sex and race are independent variables.

Study designs and reporting guidelines identified

- Randomized clinical trial
- Cohort, Case-control, Cross-sectional study
- Meta-analysis
- Economic evaluation
- Comparative effectiveness research
- Genetic association study
- Diagnostic/prognostic study
- Quality improvement study
- Survey study
- Qualitative study

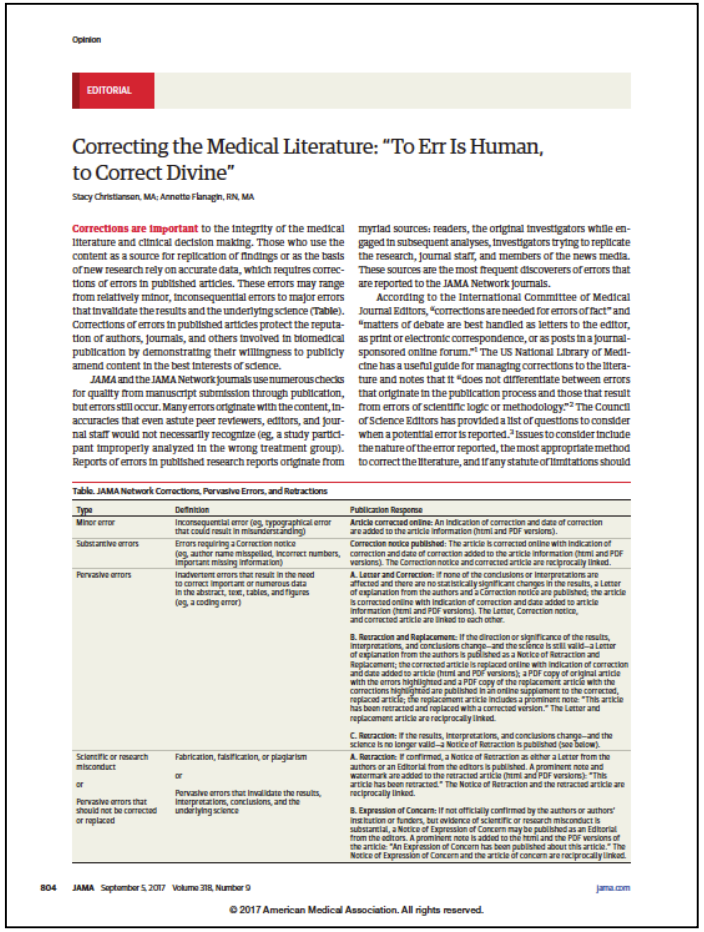
- CONSORT
- STROBE
- PRISMA, MOOSE
- CHEERS
- ISPOR
- STREGA
- STARD, TRIPOD
- SQUIRE
- AAPOR
- SRQR, COREQ

Statistics glossary updated – new terms added

- Bias – 21 types, including detection bias, lead-time and length-time biases, recall bias, publication bias, etc
- Other types of trial design – cluster randomization, mendelian randomization, equivalence, noninferiority
- Mediation analysis
- Difference-in-differences analysis
- Forest plot
- I^2 statistic
- Detailed guidance on proper use of *P* values and preference for presentation of effect size (OR, HR, etc) and estimates of error (95% CIs)

Editorial responsibilities: corrections

- Corrections are important to the integrity of the published literature.
- Errors range from relatively minor and inconsequential errors to major errors that invalidate the results and the underlying science.
- Christiansen S, Flanagin A. Correcting the medical literature: “to err is human, to correct divine.” *JAMA.* 2017;318(9):804-805. doi:10.1001/jama.2017.11833



Opinion

EDITORIAL

Correcting the Medical Literature: “To Err Is Human, to Correct Divine”

Stacy Christiansen, MA; Annette Flanagin, RN, MA

Corrections are important to the integrity of the medical literature and clinical decision making. Those who use the content as a source for replication of findings or as the basis of new research rely on accurate data, which requires corrections of errors in published articles. These errors may range from relatively minor, inconsequential errors to major errors that invalidate the results and the underlying science (Table). Corrections of errors in published articles protect the reputation of authors, journals, and others involved in biomedical publication by demonstrating their willingness to publicly amend content in the best interests of science.

JAMA and the JAMA Network journals use numerous checks for quality from manuscript submission through publication, but errors still occur. Many errors originate with the content, inaccuracies that even astute peer reviewers, editors, and journal staff would not necessarily recognize (eg, a study participant improperly analyzed in the wrong treatment group). Reports of errors in published research reports originate from myriad sources: readers, the original investigators while engaged in subsequent analyses, investigators trying to replicate the research, journal staff, and members of the news media. These sources are the most frequent discoverers of errors that are reported to the JAMA Network journals.

According to the International Committee of Medical Journal Editors, “corrections are needed for errors of fact” and “matters of debate are best handled as letters to the editor, as print or electronic correspondence, or as posts in a journal-sponsored online forum.”[1] The US National Library of Medicine has a useful guide for managing corrections to the literature and notes that it “does not differentiate between errors that originate in the publication process and those that result from errors of scientific logic or methodology.”[2] The Council of Science Editors has provided a list of questions to consider when a potential error is reported.[3] Issues to consider include the nature of the error reported, the most appropriate method to correct the literature, and if any statute of limitations should

Table. JAMA Network Corrections, Pervasive Errors, and Retractions

Type	Definition	Publication Response
Minor error	Inconsequential error (eg, typographical error that could result in misunderstanding)	**Article corrected online:** An indication of correction and date of correction are added to the article information (html and PDF versions).
Substantive errors	Errors requiring a Correction notice (eg, author name misspelled, incorrect numbers, important missing information)	**Correction notice published.** The article is corrected online with indication of correction and date of correction added to the article information (html and PDF versions). The Correction notice and corrected article are reciprocally linked.
Pervasive errors	Inadvertent errors that result in the need to correct important or numerous data in the abstract, text, tables, and figures (eg, a coding error)	**A. Letter and Correction:** If none of the conclusions or interpretations are affected and there are no statistically significant changes in the results, a Letter of explanation from the authors and a Correction notice are published; the article is corrected online with indication of correction and date added to article information (html and PDF versions). The Letter, Correction notice, and corrected article are linked to each other. **B. Retraction and Replacement:** If the direction or significance of the results, interpretations, and conclusions change—and the science is still valid—a Letter of explanation from the authors is published as a Notice of Retraction and Replacement; the corrected article is replaced online with indication of correction and date added to article (html and PDF versions); a PDF copy of original article with the errors highlighted and a PDF copy of the replacement article with the corrections highlighted are published in an online supplement to the corrected, replaced article; the replacement article includes a prominent note: “This article has been retracted and replaced with a corrected version.” The Letter and replacement article are reciprocally linked. **C. Retraction:** If the results, interpretations, and conclusions change—and the science is no longer valid—a Notice of Retraction is published (see below).
Scientific or research misconduct or Pervasive errors that should not be corrected or replaced	Fabrication, falsification, or plagiarism or Pervasive errors that invalidate the results, interpretations, conclusions, and the underlying science	**A. Retraction:** If confirmed, a Notice of Retraction as either a Letter from the authors or an Editorial from the editors is published. A prominent note and watermark are added to the retracted article (html and PDF versions): “This article has been retracted.” The Notice of Retraction and the retracted article are reciprocally linked. **B. Expression of Concern:** If not officially confirmed by the authors or authors’ institution or funders, but evidence of scientific or research misconduct is substantial, a Notice of Expression of Concern may be published as an Editorial from the editors. A prominent note is added to the html and the PDF versions of the article: “An Expression of Concern has been published about this article.” The Notice of Expression of Concern and the article of concern are reciprocally linked.

804 JAMA September 5, 2017 Volume 318, Number 9 jama.com

Editorial responsibilities : corrections

Minor error	Substantive errors
Inconsequential error (eg, a typographical error that could result in misunderstanding)	Errors requiring a Correction notice (eg, author name misspelled, incorrect numbers, important missing information)
Article corrected online An indication of correction and date of correction are added to the article information (HTML and PDF versions) No Correction notice	Correction notice published Article is corrected online with indication of correction and date of correction added to the article information (HTML and PDF) Correction notice and corrected article are reciprocally linked

Pervasive errors

- Inadvertent errors that result in the need to correct important or numerous data and information in the abstract, text, tables, figures, and supplement (eg, a coding error)

No major changes	Change and valid	Change and invalid
If none of the conclusions or interpretations are affected and there are no statistically significant changes in the results	If the direction or significance of the results, interpretations, and conclusions change—and the science is still valid	If the results, interpretations, and conclusions change—and the science is no longer valid
Letter of explanation and Correction	**Retraction and Replacement**	**Retraction**

New option: retraction and replacement

Why? 21% of retractions are due to error, not misconduct

This mechanism allows authors to do the right thing without the stigma or penalties associated with retractions

When? Used judiciously – for cases of inadvertent pervasive errors that when corrected change the findings, interpretations, and/or conclusions

And after review – the science is still considered valid

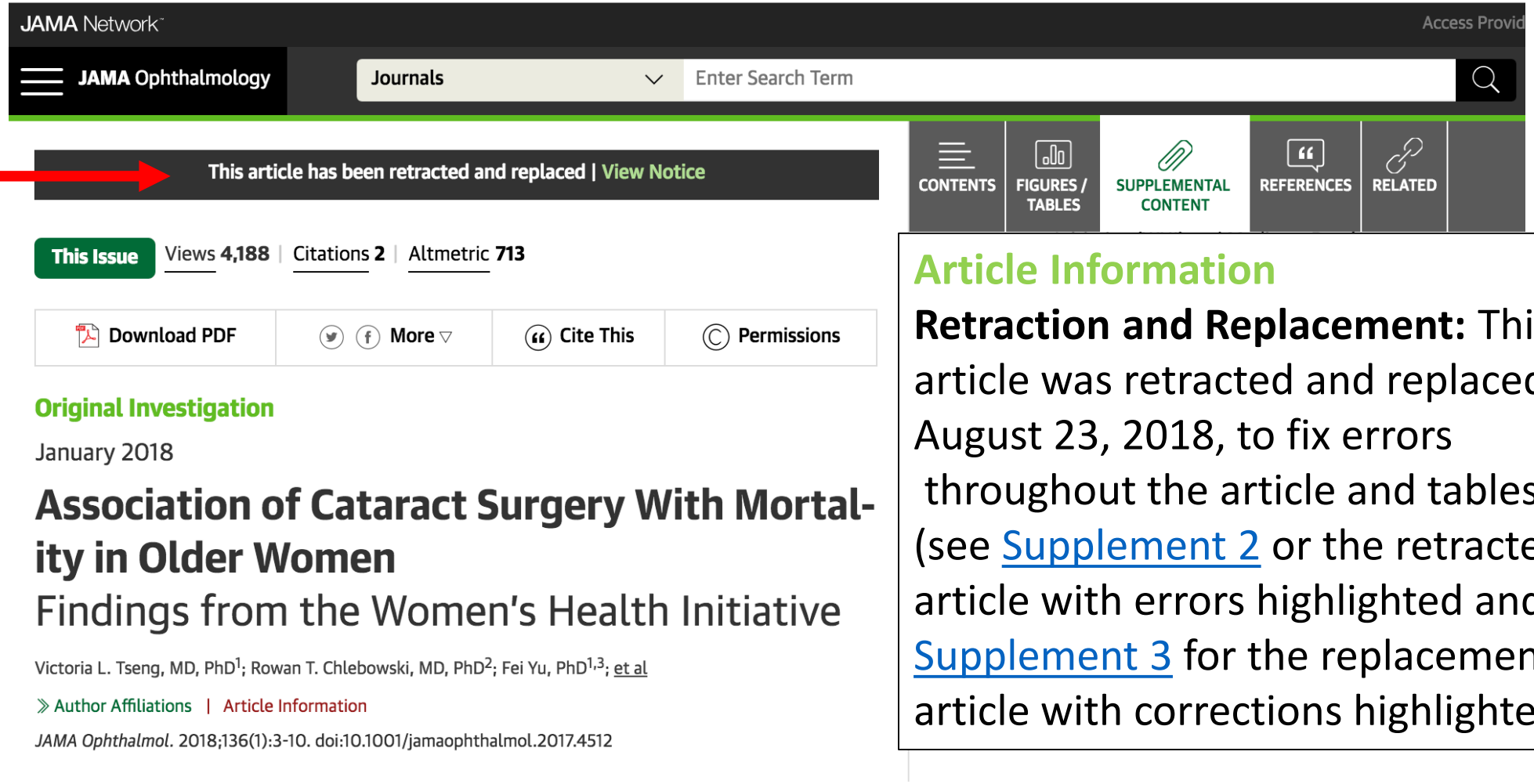
How? Requires a Letter of explanation from all authors

An itemization of all errors and corrections

Replacement article retains the original article DOI and any usage and citation metrics

No “retraction” or do not use watermark

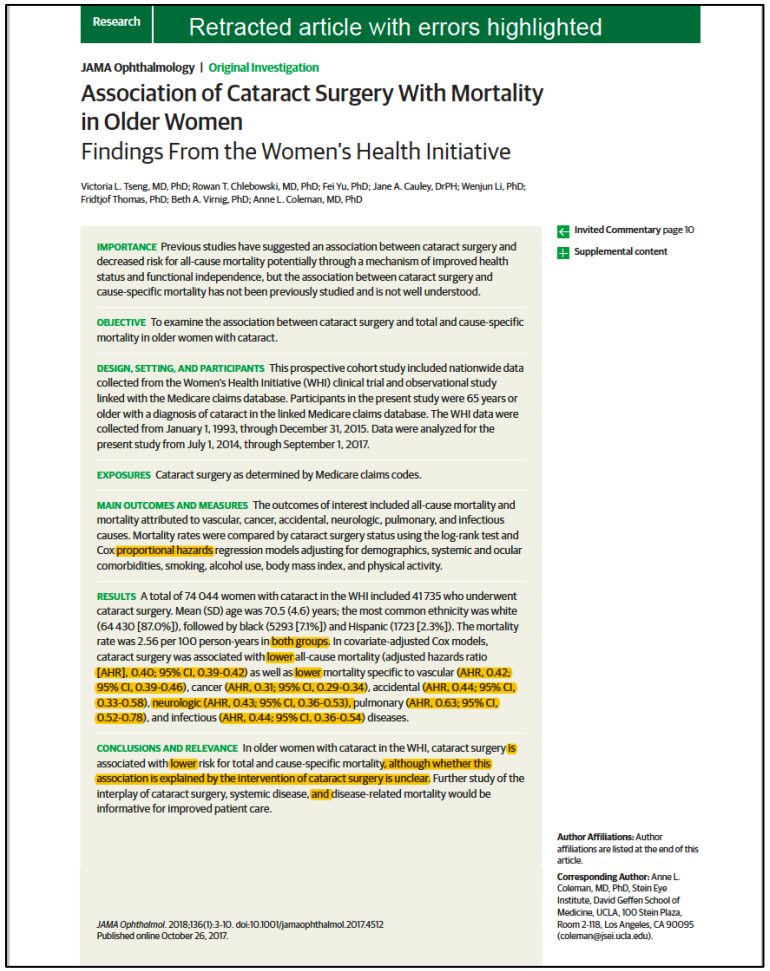
Retraction and replacement



Article Information

Retraction and Replacement: This article was retracted and replaced on August 23, 2018, to fix errors throughout the article and tables (see Supplement 2 or the retracted article with errors highlighted and Supplement 3 for the replacement article with corrections highlighted).

Retraction and replacement



Research | Retracted article with errors highlighted

JAMA Ophthalmology | Original Investigation

Association of Cataract Surgery With Mortality in Older Women

Findings From the Women's Health Initiative

Victoria L. Tseng, MD, PhD; Rowan T. Chlebowski, MD, PhD; Fei Yu, PhD; Jane A. Cauley, DrPH; Wenjun Li, PhD; Fridtjof Thomas, PhD; Beth A. Virnig, PhD; Anne L. Coleman, MD, PhD

IMPORTANCE Previous studies have suggested an association between cataract surgery and decreased risk for all-cause mortality potentially through a mechanism of improved health status and functional independence, but the association between cataract surgery and cause-specific mortality has not been previously studied and is not well understood.

OBJECTIVE To examine the association between cataract surgery and total and cause-specific mortality in older women with cataract.

DESIGN, SETTING, AND PARTICIPANTS This prospective cohort study included nationwide data collected from the Women's Health Initiative (WHI) clinical trial and observational study linked with the Medicare claims database. Participants in the present study were 65 years or older with a diagnosis of cataract in the linked Medicare claims database. The WHI data were collected from January 1, 1993, through December 31, 2015. Data were analyzed for the present study from July 1, 2014, through September 1, 2017.

EXPOSURES Cataract surgery as determined by Medicare claims codes.

MAIN OUTCOMES AND MEASURES The outcomes of interest included all-cause mortality and mortality attributed to vascular, cancer, accidental, neurologic, pulmonary, and infectious causes. Mortality rates were compared by cataract surgery status using the log-rank test and Cox proportional hazards regression models adjusting for demographics, systemic and ocular comorbidities, smoking, alcohol use, body mass index, and physical activity.

RESULTS A total of 74 044 women with cataract in the WHI included 41 735 who underwent cataract surgery. Mean (SD) age was 70.5 (4.6) years; the most common ethnicity was white (64 430 [87.0%]), followed by black (5293 [7.1%]) and Hispanic (1723 [2.3%]). The mortality rate was 2.56 per 100 person-years in both groups. In covariate-adjusted Cox models, cataract surgery was associated with lower all-cause mortality (adjusted hazards ratio [AHR], 0.40; 95% CI, 0.39-0.42) as well as lower mortality specific to vascular (AHR, 0.42; 95% CI, 0.39-0.46), cancer (AHR, 0.31; 95% CI, 0.29-0.34), accidental (AHR, 0.44; 95% CI, 0.33-0.58), neurologic (AHR, 0.43; 95% CI, 0.36-0.53), pulmonary (AHR, 0.63; 95% CI, 0.52-0.78), and infectious (AHR, 0.44; 95% CI, 0.36-0.54) diseases.

CONCLUSIONS AND RELEVANCE In older women with cataract in the WHI, cataract surgery is associated with lower risk for total and cause-specific mortality, although whether this association is explained by the intervention of cataract surgery is unclear. Further study of the interplay of cataract surgery, systemic disease, and disease-related mortality would be informative for improved patient care.

Invited Commentary page 10

Supplemental content

Author Affiliations: Author affiliations are listed at the end of this article.

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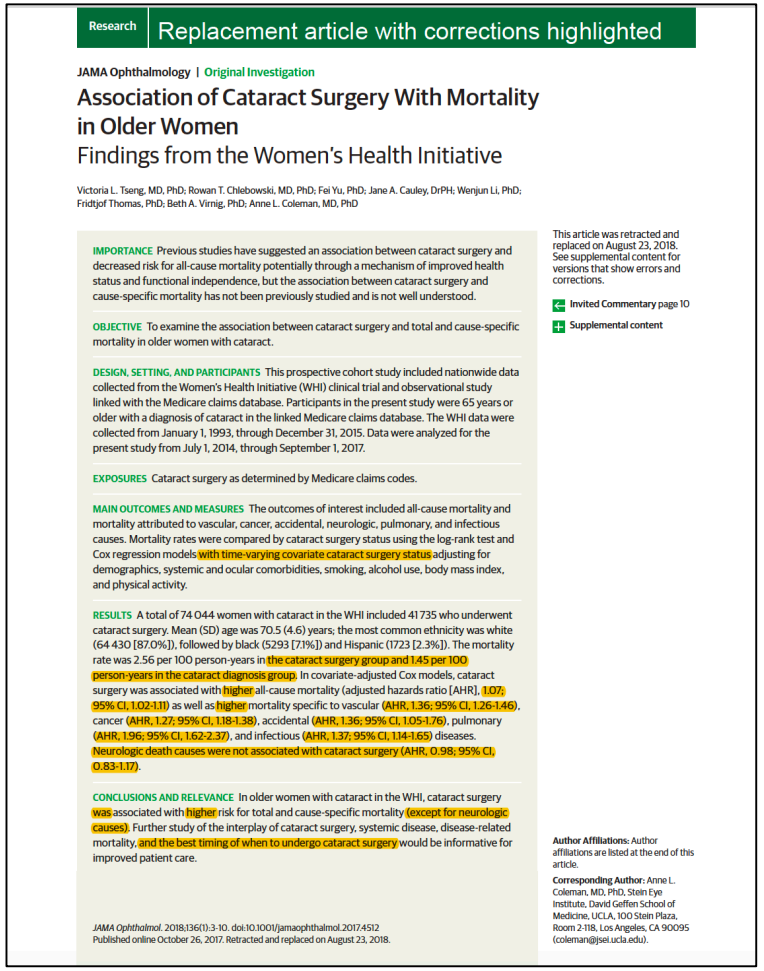
JAMA Ophthalmol. 2018;136(1):3-10. doi:10.1001/jamaophthalmol.2017.4512
Published online October 26, 2017.



Research | Replacement article with corrections highlighted

JAMA Ophthalmology | Original Investigation

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DESIGN, SETTING, AND PARTICIPANTS This prospective cohort study included nationwide data collected from the Women's Health Initiative (WHI) clinical trial and observational study linked with the Medicare claims database. Participants in the present study were 65 years or older with a diagnosis of cataract in the linked Medicare claims database. The WHI data were collected from January 1, 1993, through December 31, 2015. Data were analyzed for the present study from July 1, 2014, through September 1, 2017.

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MAIN OUTCOMES AND MEASURES The outcomes of interest included all-cause mortality and mortality attributed to vascular, cancer, accidental, neurologic, pulmonary, and infectious causes. Mortality rates were compared by cataract surgery status using the log-rank test and Cox regression models with time-varying covariate cataract surgery status adjusting for demographics, systemic and ocular comorbidities, smoking, alcohol use, body mass index, and physical activity.

RESULTS A total of 74 044 women with cataract in the WHI included 41 735 who underwent cataract surgery. Mean (SD) age was 70.5 (4.6) years; the most common ethnicity was white (64 430 [87.0%]), followed by black (5293 [7.1%]) and Hispanic (1723 [2.3%]). The mortality rate was 2.56 per 100 person-years in the cataract surgery group and 1.45 per 100 person-years in the cataract diagnosis group. In covariate-adjusted Cox models, cataract surgery was associated with higher all-cause mortality (adjusted hazards ratio [AHR], 1.07; 95% CI, 1.02-1.11) as well as higher mortality specific to vascular (AHR, 1.36; 95% CI, 1.26-1.46), cancer (AHR, 1.27; 95% CI, 1.18-1.38), accidental (AHR, 1.36; 95% CI, 1.05-1.76), pulmonary (AHR, 1.96; 95% CI, 1.62-2.37), and infectious (AHR, 1.37; 95% CI, 1.14-1.65) diseases. Neurologic death causes were not associated with cataract surgery (AHR, 0.98; 95% CI, 0.83-1.17).

CONCLUSIONS AND RELEVANCE In older women with cataract in the WHI, cataract surgery was associated with higher risk for total and cause-specific mortality (except for neurologic causes). Further study of the interplay of cataract surgery, systemic disease, disease-related mortality, and the best timing of when to undergo cataract surgery would be informative for improved patient care.

This article was retracted and replaced on August 23, 2018. See supplemental content for versions that show errors and corrections.

Invited Commentary page 10

Supplemental content

Author Affiliations: Author affiliations are listed at the end of this article.

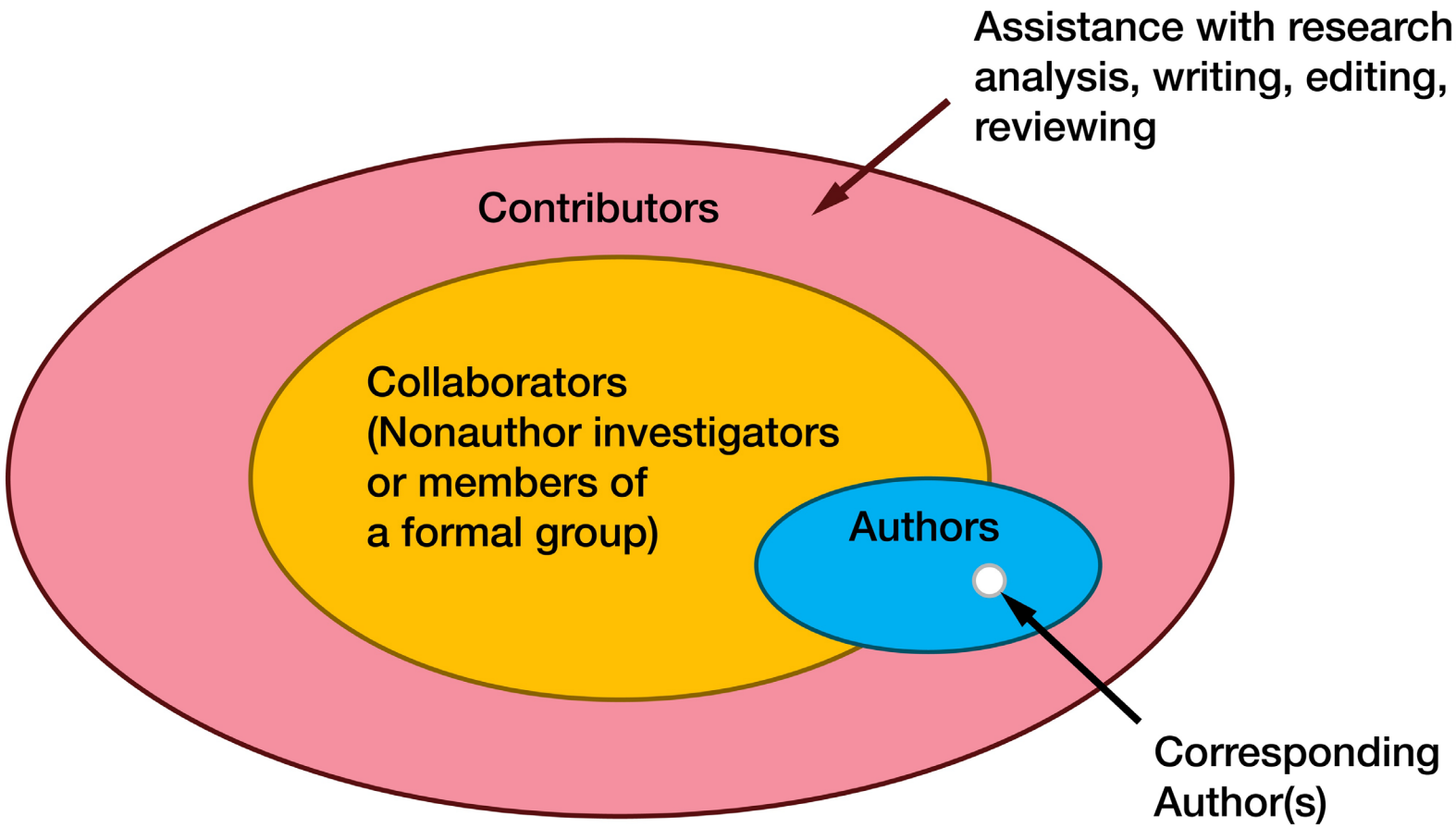
Corresponding Author: Anne L. Coleman, MD, PhD, Stein Eye Institute, David Geffen School of Medicine, UCLA, 100 Stein Plaza, Room 2-118, Los Angeles, CA 90095 (coleman@jsei.ucla.edu).

JAMA Ophthalmol. 2018;136(1):3-10. doi:10.1001/jamaophthalmol.2017.4512
Published online October 26, 2017. Retracted and replaced on August 23, 2018.

Authorship updates: roles and definitions

- **Contributor:** anyone – an author, a collaborator, writer, assistant, etc
- **Author:** meets all 4 ICJME criteria and completes an authorship form
  - **Byline author**: author name in byline
  - **Nonbyline author**: author name not in byline – listed at the end of article
- **Group author**: a group of individuals, usually involving multicenter study investigators, working groups, and expert boards, panels, or committees, who wish to display a group name to indicate authorship
- **Collaborator**: nonauthor member of a formal group who contributes significantly

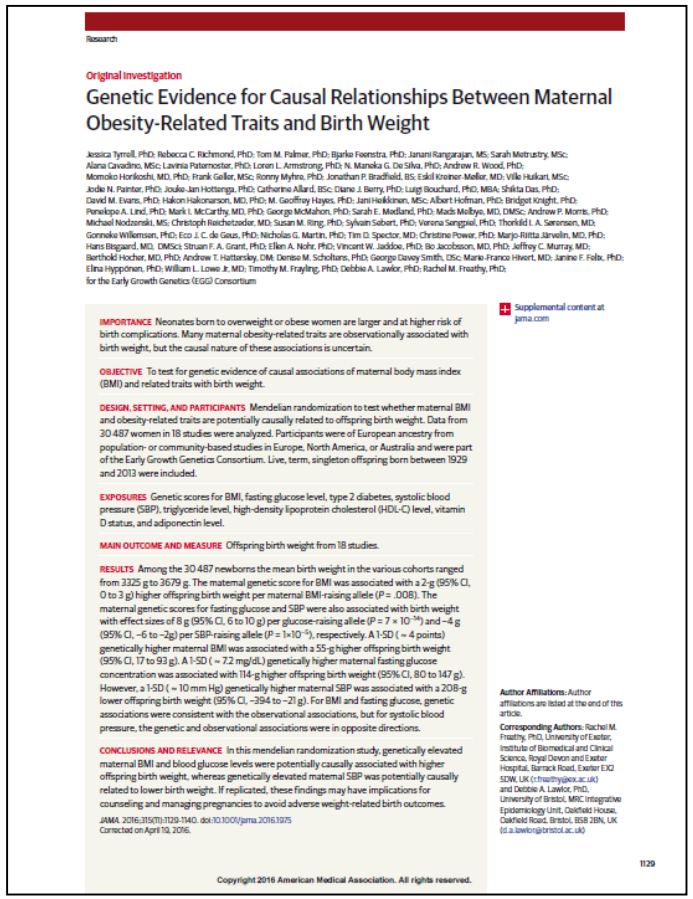
Authorship – who is who?



Team science and group authorship

Guidance on the numbers of authors and group author bylines

64 authors + group



Research

Original Investigation

Genetic Evidence for Causal Relationships Between Maternal Obesity-Related Traits and Birth Weight

Jessica Tyrrell, PhD; Rebecca C. Richmond, PhD; Tom M. Palmer, PhD; Bjarke Feenstra, PhD; Janani Rangarajan, MS; Sarah Metrustry, MSc; Alana Cavadino, MSc; Lavinia Paternoster, PhD; Loren L. Armstrong, PhD; N. Maneka G. De Silva, PhD; Andrew R. Wood, PhD; Momoko Horikoshi, MD, PhD; Frank Geller, MSc; Ronny Myhre, PhD; Jonathan P. Bradfield, BS; Eskil Kreiner-Møller, MD; Ville Huikari, MSc; Jodie N. Painter, PhD; Jouke-Jan Hottenga, PhD; Catherine Allard, BSc; Diane J. Berry, PhD; Luigi Bouchard, PhD, MBA; Shikta Das, PhD; David M. Evans, PhD; Hakon Hakonarson, MD, PhD; M. Geoffrey Hayes, PhD; Jani Heikkinen, MSc; Albert Hofman, PhD; Bridget Knight, PhD; Penelope A. Lind, PhD; Mark I. McCarthy, MD, PhD; George McMahon, PhD; Sarah E. Medland, PhD; Mads Melbye, MD, DMSc; Andrew P. Morris, PhD; Michael Nodzenski, MS; Christoph Reichetzeder, MD; Susan M. Ring, PhD; Sylvain Sebert, PhD; Verena Sengpiel, PhD; Thorkild I. A. Sørensen, MD; Gonneke Willemsen, PhD; Eco J. C. de Geus, PhD; Nicholas G. Martin, PhD; Tim D. Spector, MD; Christine Power, PhD; Marjo-Riitta Järvelin, MD, PhD; Hans Bisgaard, MD, DMSci; Struan F. A. Grant, PhD; Elliot A. Nohr, PhD; Vincent W. Jaddoe, PhD; Bo Jacobsson, MD, PhD; Jeffrey C. Murray, MD; Berthold Hocher, MD, PhD; Andrew T. Hattersley, DM; Denise M. Scholtens, PhD; George Davey Smith, DSc; Marie-France Hivert, MD; Janine F. Felix, PhD; Elina Hyppönen, PhD; William L. Lowe Jr, MD; Timothy M. Frayling, PhD; Debbie A. Lawlor, PhD; Rachel M. Freathy, PhD; for the Early Growth Genetics (EGG) Consortium

IMPORTANCE Neonates born to overweight or obese women are larger and at higher risk of birth complications. Many maternal obesity-related traits are observationally associated with birth weight, but the causal nature of these associations is uncertain.

OBJECTIVE To test for genetic evidence of causal associations of maternal body mass index (BMI) and related traits with birth weight.

DESIGN, SETTING, AND PARTICIPANTS Mendelian randomization to test whether maternal BMI and obesity-related traits are potentially causally related to offspring birth weight. Data from 30 487 women in 18 studies were analyzed. Participants were of European ancestry from population- or community-based studies in Europe, North America, or Australia and were part of the Early Growth Genetics Consortium. Live, term, singleton offspring born between 1929 and 2013 were included.

EXPOSURES Genetic scores for BMI, fasting glucose level, type 2 diabetes, systolic blood pressure (SBP), triglyceride level, high-density lipoprotein cholesterol (HDL-C) level, vitamin D status, and adiponectin level.

MAIN OUTCOME AND MEASURE Offspring birth weight from 18 studies.

RESULTS Among the 30 487 newborns the mean birth weight in the various cohorts ranged from 3325 g to 3679 g. The maternal genetic score for BMI was associated with a 2-g (95% CI, 0 to 3 g) higher offspring birth weight per maternal BMI-raising allele ($P = .008$). The maternal genetic scores for fasting glucose and SBP were also associated with birth weight with effect sizes of 8 g (95% CI, 6 to 10 g) per glucose-raising allele ($P = 7 \times 10^{-14}$) and −4 g (95% CI, −6 to −2g) per SBP-raising allele ($P = 1 \times 10^{-5}$), respectively. A 1-SD (≈ 4 points) genetically higher maternal BMI was associated with a 55-g higher offspring birth weight (95% CI, 17 to 93 g). A 1-SD (≈ 7.2 mg/dL) genetically higher maternal fasting glucose concentration was associated with 114-g higher offspring birth weight (95% CI, 80 to 147 g). However, a 1-SD (≈ 10 mm Hg) genetically higher maternal SBP was associated with a 208-g lower offspring birth weight (95% CI, −394 to −21 g). For BMI and fasting glucose, genetic associations were consistent with the observational associations, but for systolic blood pressure, the genetic and observational associations were in opposite directions.

CONCLUSIONS AND RELEVANCE In this mendelian randomization study, genetically elevated maternal BMI and blood glucose levels were potentially causally associated with higher offspring birth weight, whereas genetically elevated maternal SBP was potentially causally related to lower birth weight. If replicated, these findings may have implications for counseling and managing pregnancies to avoid adverse weight-related birth outcomes.

JAMA. 2016;315(11):1129-1140. doi:10.1001/jama.2016.1975
Corrected on April 19, 2016.

Supplemental content at jama.com

Author Affiliations: Author affiliations are listed at the end of this article.

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1129

Research

JAMA Oncology | Original Investigation

Global, Regional, and National Cancer Incidence, Mortality, Years of Life Lost, Years Lived With Disability, and Disability-Adjusted Life-Years for 29 Cancer Groups, 1990 to 2017
A Systematic Analysis for the Global Burden of Disease Study

Global Burden of Disease Cancer Collaboration

IMPORTANCE Cancer and other noncommunicable diseases (NCDs) are now widely recognized as a threat to global development. The latest United Nations high-level meeting on NCDs reaffirmed this observation and also highlighted the slow progress in meeting the 2011 Political Declaration on the Prevention and Control of Noncommunicable Diseases and the third Sustainable Development Goal. Lack of situational analyses, priority setting, and budgeting have been identified as major obstacles in achieving these goals. All of these have in common that they require information on the local cancer epidemiology. The Global Burden of Disease (GBD) study is uniquely poised to provide these crucial data.

OBJECTIVE To describe cancer burden for 29 cancer groups in 195 countries from 1990 through 2017 to provide data needed for cancer control planning.

EVIDENCE REVIEW We used the GBD study estimation methods to describe cancer incidence, mortality, years lived with disability, years of life lost, and disability-adjusted life-years (DALYs). Results are presented at the national level as well as by Socio-demographic Index (SDI), a composite indicator of income, educational attainment, and total fertility rate. We also analyzed the influence of the epidemiological vs the demographic transition on cancer incidence.

FINDINGS In 2017, there were 24.5 million incident cancer cases worldwide (16.8 million without nonmelanoma skin cancer [NMSC]) and 9.6 million cancer deaths. The majority of cancer DALYs came from years of life lost (97%), and only 3% came from years lived with disability. The odds of developing cancer were the lowest in the low SDI quintile (1 in 7) and the highest in the high SDI quintile (1 in 2) for both sexes. In 2017, the most common incident cancers in men were NMSC (4.3 million incident cases); tracheal, bronchus, and lung (TBL) cancer (1.5 million incident cases); and prostate cancer (1.3 million incident cases). The most common causes of cancer deaths and DALYs for men were TBL cancer (1.3 million deaths and 28.4 million DALYs), liver cancer (572 000 deaths and 15.2 million DALYs), and stomach cancer (542 000 deaths and 12.2 million DALYs). For women in 2017, the most common incident cancers were NMSC (3.3 million incident cases), breast cancer (1.9 million incident cases), and colorectal cancer (819 000 incident cases). The leading causes of cancer deaths and DALYs for women were breast cancer (601 000 deaths and 17.4 million DALYs), TBL cancer (596 000 deaths and 12.6 million DALYs), and colorectal cancer (414 000 deaths and 8.3 million DALYs).

CONCLUSIONS AND RELEVANCE The national epidemiological profiles of cancer burden in the GBD study show large heterogeneities, which are a reflection of different exposures to risk factors, economic settings, lifestyles, and access to care and screening. The GBD study can be used by policy makers and other stakeholders to develop and improve national and local cancer control in order to achieve the global targets and improve equity in cancer care.

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Published online September 27, 2019.

Supplemental content

Group Information: The members of the Global Burden of Disease Cancer Collaboration appear at the end of the article.

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E1

Global Burden of Disease Cancer Collaboration
631 authors

What is the record number of authors?

PRL 114, 191803 (2015) Selected for a Viewpoint in *Physics*
PHYSICAL REVIEW LETTERS
week ending 15 MAY 2015

Combined Measurement of the Higgs Boson Mass in pp Collisions at $\sqrt{s} = 7$ and 8 TeV with the ATLAS and CMS Experiments

G. Aad *et al.*[*]

(ATLAS Collaboration)[†]
(CMS Collaboration)[‡]

(Received 25 March 2015; published 14 May 2015)

A measurement of the Higgs boson mass is presented based on the combined data samples of the ATLAS and CMS experiments at the CERN LHC in the $H \to \gamma\gamma$ and $H \to ZZ \to 4\ell$ decay channels. The results are obtained from a simultaneous fit to the reconstructed invariant mass peaks in the two channels and for the two experiments. The measured masses from the individual channels and the two experiments are found to be consistent among themselves. The combined measured mass of the Higgs boson is $m_H = 125.09 \pm 0.21\,(\text{stat}) \pm 0.11\,(\text{syst})$ GeV.

DOI: 10.1103/PhysRevLett.114.191803 PACS numbers: 14.80.Bn, 13.85.Qk

The study of the mechanism of electroweak symmetry breaking is one of the principal goals of the CERN LHC program. In the standard model (SM), this symmetry breaking is achieved through the introduction of a complex doublet scalar field, leading to the prediction of the Higgs boson H [1–6], whose mass m_H is, however, not

This Letter describes a combination of the Run 1 data from the two experiments, leading to improved precision for m_H. Besides its intrinsic importance as a fundamental parameter, improved knowledge of m_H yields more precise predictions for the other Higgs boson properties. Furthermore, the combined mass measurement provides

https://journals.aps.org/prl/abstract/10.1103/PhysRevLett.114.191803#fulltext

Shared authorship positions

- It has become increasingly common for authors to request “co-first authorship,” “co-senior authorship,” or some other indication of equal contribution.
- Journals accept indication of co-first authorship – but someone’s name will need to go first in the byline or author list.
- Requests for “co-first authorship” beyond 3 or 4 named authors may not be justifiable.
- This information can be displayed in the Acknowledgment just before the list of author contributions, such as
  - “Drs Brown and Jones served as co-first authors and contributed equally to the work.”

Cash payments to Chinese authors

Table 5 Comparison of Average Amount of Cash Awards* for a Paper Published in Selected Journals (2008-2016)

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Nature, Science	$26,212	$26,006	$25,781	$25,365	$33,990	$36,658	$38,908	$43,783	$43,783
PNAS	$3,156	$3,025	$3,353	$3,443	$3,664	$3,619	$3,751	$3,513	$3,513
PLOS One	$1,096	$1,086	$1,035	$994	$991	$915	$941	$984	$984
MIS Quarterly	$2,613	$2,570	$2,553	$2,654	$2,876	$2,861	$2,992	$2,938	$2,938
JASIST	$1,737	$1,758	$1,741	$1,887	$2,066	$2,303	$2,435	$2,488	$2,488
Journal of Documentation	$1,082	$1,087	$1,042	$1,111	$1,167	$1,265	$1,329	$1,408	$1,408
Library Hi Tech	$781	$775	$726	$741	$740	$768	$795	$783	$783
LIBRI	$650	$644	$577	$560	$538	$509	$517	$484	$484

* All the amounts are full amount (in USD) awarded to the first author

Quan W, Chen B, She F. Publish or Impoverish: An Investigation of the Monetary Reward System of Science In China (1999-2016). https://arxiv.org/pdf/1707.01162.pdf

Co-corresponding authors

- New: Requests for having up to 2 individuals listed as corresponding authors on a published article will be considered if justified.
- In such cases, 1 author must be designated as the primary point of contact who will
  - Serve as primary corresponding author for all communications with the journal
  - Review an edited manuscript/proof
  - Make decisions regarding release of information to the news media
  - Handle any postpublication inquires, errors/corrections, etc
- Two can be listed in the Corresponding Author section of the published article, but the primary corresponding author will be listed first.

Formatting 2 corresponding authors

From same institution

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Guidance on changes in authorship

- Changes made in authorship (ie, order, addition, and deletion of authors) should be discussed and approved by all authors
- Any requests for changes in authorship after initial manuscript submission and before publication should be explained in writing to the editor in a letter signed by all authors, or if sent by email, all authors should be copied (ie, included as recipients of the email)
- The Committee on Publication Ethics (COPE) also has useful guidance and a flowchart for addressing changes in authorship. https://publicationethics.org/

Guidance on Acknowledgments – chapter 5.2

Acknowledging support, assistance, and contributions of those who are not authors

- General advice, guidance, or supervision
- Critical review of the manuscript
- Critical review of study proposal, design, or methods
- Data collection
- Data analysis
- Statistical, technical, research assistance or advice
- Writing assistance
- Editorial assistance
- Bibliographic assistance
- Clerical assistance
- Manuscript preparation
- Financial or material support
- Grant support

Many examples

Additional Contribution: We thank Joan Smart, PhD, for research and editing assistance, and John Smith, PhD, for assistance with statistical analysis; both are employed by Medical Bibliometrics Inc and received payment from the study's sponsor.

Example of an Acknowledgment or Article Information Section, including order of all possible elements

- Accepted date
- Publication date
- Open access information
- Correction information
- [a]Author affiliations
- [a]Group information
- [a]Corresponding author
- Author contributions
- Conflict of interest disclosures
- Funding/support
- Role of funder/sponsors
- Group information
- Disclaimer
- Meeting presentation
- Data sharing statement
- Additional contributions
- Preferred citation

[a]Indicates items that may normally appear on page 1 of a print or PDF article but would otherwise appear here in this order

Conflicts of interest policies for authors

- Authors should provide detailed information about **all relevant financial interests, activities, relationships, and affiliations**, including but not limited to employment, affiliation, funding and grants received or pending, consultancies, honoraria or payment, speakers' bureaus, stock ownership or options, expert testimony, royalties, donation of medical equipment, or patents planned, pending, or issued.
- Authors *without* conflicts of interest should indicate no COI.
- If authors are uncertain about what constitutes a *relevant* COI, they should contact the editorial office.
- A journal's conflict of interest policies should **apply to all manuscript submissions and types of articles**, including reports of research, reviews, opinion pieces, educational articles, reviews of books and other media, letters to the editor, and online-only comments.

Examples of published COI statements provided

- **Conflict of Interest Disclosures:** Dr Jones reported serving as a paid consultant to Wyler Laboratories. Dr Jacques owns stock in Wyler Laboratories. Drs Smith and Brown reported no financial interests.

- [*Or:* **Conflict of Interest Disclosures:** None reported.]

- **Funding/Support:** This study was funded in part by Wyler Laboratories.

COI policies for peer reviewers

- Reviewers should **disclose** conflicts of interest in reviewing specific manuscripts and **disqualify** themselves from a specific review if necessary.
- Reviewers should **never use information** obtained from an unpublished manuscript to further their own interests.
- Following the same rationale applied to authors, reviewers should state explicitly if they have no relevant conflicts of interest to disclose.
- **Example** of letter sent requesting an individual to review a manuscript:

  "While most conflicts of interest are not disqualifying, if you perceive that you have a disqualifying interest, either financial or otherwise, please contact the reviewing editor immediately (if possible, with the names of alternative reviewers). This will not affect your reviewer status."

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- **Disclosure policy**: Editors should have policies that require disclosure of all relevant conflicts of interest (financial and nonfinancial)
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  - From an author who is from the same department as the editor
  - From an author in a field in which the editor has research funding
  - Their own research and review articles
- In the event that an editor works alone and has a conflict of interest with a particular manuscript, they should assign that manuscript to a guest editor or a member of the editorial board and should not take part in the review and editorial decision of such manuscripts

COI policies for editors

- Disclaimers should be published with any research or review articles that include an author who is also a decision-making editor for the journal to inform readers that the author-editor was not involved in the review or editorial decision.

  Disclaimer: Dr Brown, the journal's deputy editor, was not involved in the editorial review of or decision to publish this article.

- Guidance is also provided for how to manage undisclosed COIs on the part of authors, reviewers, and editors.

Intellectual property updates

- Public access and open access in scientific publication
- Open access and publication licenses
- Copyright – what's protected and what's not protected
- Updates on copyright terms and when works enter the public domain
- Copyright and social media
- Updates on trademark and protections for website domain names
- Data sharing

Table 5.6-1. Copyright Term and the Public Domain in the United States[a]

Never published, never registered works[b]		
Type of Work	**Copyright Term**	**What Was in Public Domain as of January 1, 2019[c]**
Unpublished works	Life of the author plus 70 years	Works from authors who died before 1949
Unpublished anonymous and pseudonymous works and works made for hire	120 Years from date of creation	Works created before 1899
Unpublished works when the death date of the author is not known[d]	120 Years from date of creation[e]	Works created before 1899[e]
Works registered or first published in the United States		
Date of Publication[f]	**Conditions[g]**	**Copyright Term[c]**
Before 1924	None	None. In the public domain due to copyright expiration
1924 through 1977	Published without a copyright notice	None. In the public domain due to failure to comply with required formalities
1978 to March 1, 1989	Published without notice and without subsequent registration within 5 years	None. In the public domain due to failure to comply with required formalities

Protecting rights of research participants

- Contemporary rules for protecting the rights of research participants and patients in scientific publication have their foundations in ethical principles and national and international guidelines and regulations
- The primary policy governing biomedical research in the US is the *Regulations for the Protection of Human Subjects* (45 CFR §46), also known as the "**Common Rule**"
- Why "Common?" – Signed by 20 federal agencies and departments (DHHS, VA, NSF….CIA…)
- Since its release in 1991, the Common Rule has been amended briefly over the years – it was revised substantially in 2017, with these revisions taking effect in January 2019

Ethical review, approval, or exemption of research

- All reports of research involving human participants should include indication of **ethical review and approval or exemption or exclusion based on institutional policies or regulations**
- For US research, according to the revised Common Rule, categories of research that involve human participants that **may be exempt or excluded from IRB review are based on the level of risk posed to the study participants**
- A list of these categories and additional specific protections for studies including pregnant women, human fetuses, neonates, children, and prisoners are available in the Final Revisions to the Common Rule
- https://www.hhs.gov/ohrp/regulations-and-policy/regulations/finalized-revisions-common-rule/index.html

Ethical review, approval, or exemption of research

- An **example of low-risk research** that may be **exempt** from formal IRB/ethical review and informed consent requirements includes **secondary research of nonidentifiable information or biospecimens from existing or publicly available data sets**
- *However, **investigators should not make independent determinations of exemption or exclusion of IRB review** because of the potential for conflicts of interest and should follow the formal policies of their respective institutions or national regulations*

Requirements for informed consent

- Authors should indicate **in the Methods section that informed consent was obtained** in a manner consistent with the Common Rule requirements or regulations of other countries or the Declaration of Helsinki
- From all adult participants and from parents or legal guardians for minors or incapacitated adults
- Should include indication of **how consent was obtained** (ie, written or oral); if oral, authors should explain why
- Should also indicate whether research participants received **compensation** or were offered any **incentive** for participating in the study
- *If informed consent was waived or not needed, authors should cite relevant institutional policy or national regulation*

Examples

Epidemiology of Brain Death in Pediatric Intensive Care Units in the United States. *JAMA Pediatr.* Published online March 18, 2019.

Submitted: “This study was deemed to be exempt by the Children’s Hospital of Philadelphia Institutional Review Board.”

Edited and Published: “This study was deemed to be exempt by the Children’s Hospital of Philadelphia institutional review board **because it was conducted using deidentified data from deceased children.”**

Association of Methadone Treatment With Substance-Related Hospital Admissions Among a Population in Canada With a History of Criminal Convictions. *JAMA Netw Open.* 2019;2(3):e190595.

Submitted: “The study was approved by the Simon Fraser University Research Ethics Board.”

Edited and Published: “**The study used exclusively retrospective deidentified administrative records and consent was not possible.** The study was reviewed and approved **without need for waiver of informed consent** by the Simon Fraser University Research Ethics Board.”

Patients' rights to privacy in publication

- Authors and editors should ensure protection of patients' and research participants' rights to privacy, anonymity, and confidentiality in publication
- Patients have occasionally recognized descriptions of themselves in medical articles even without accompanying photographs
- Several cases have occurred in which patients who had not consented to publication in medical journals were recognized by themselves or others in specific articles or subsequent news coverage
- In several recent cases, parts or entire articles have been retracted:
  - Palus S. Patients did not okay publishing brain surgery details. *Retraction Watch*. June 30, 2016.
  - Stern V. Authors couldn't find a patient to give consent for case report: then the patient found the report. *Retraction Watch*. February 27, 2017.
  - Stern V. Authors say patient threatened legal action after being subject of scholarly paper. *Retraction Watch*. July 13, 2107.

Patients' rights to privacy in publication

- **Identifying information should not be published unless the information is essential for scientific purposes** and the patient (or parent or guardian) gives written informed consent for publication
  - Written descriptions in text
  - Individual data in tables
  - Photographs, audio, video
  - Genetic pedigrees

If permission cannot be obtained

- Must deidentify
- Crop or remove identifiable images
- Identifying details in text should be omitted if they are not essential
- **But patient data should never be altered or falsified** in an attempt to attain anonymity
- Fictionalized composite scenarios should not be presented as real cases in medical publication, including opinion and narrative medicine articles
- Complete anonymity is difficult to achieve, and informed consent should be obtained if there is any doubt

AMA Manual of Style – other updates

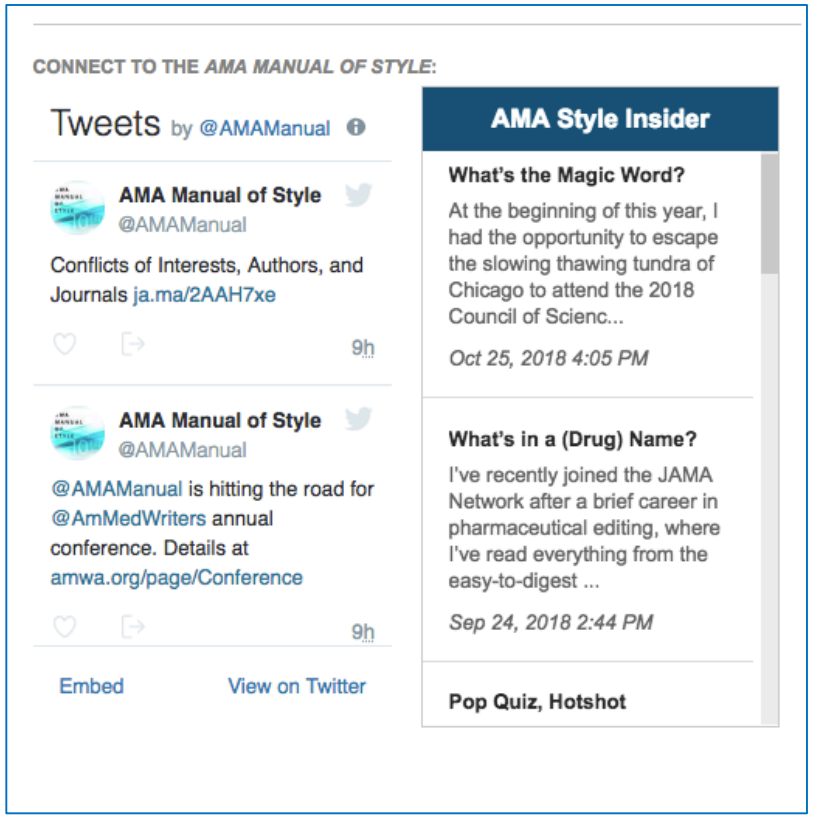
- Almost all other chapters have been extensively revised and updated to reflect best practices and developments in scientific research, writing, and publishing, with numerous new examples.
- 23 Chapters with numerous numbered cross-referenced and linked subsections to the x.x.x.x.x level
- The section on indexing has been removed, and the design, typography, and editing chapters have been combined
- The quizzes are being revised
- An introductory video will be released
- Plans for monthly podcasts
- Discounted price available for AMWA members

Stylebook updates: amamanualofstyle.com

Updates: Any new policy decisions are published on the Updates page, which is freely available to anyone: http://www.amamanualofstyle.com/page/updates

Twitter:
Regular communication via @AMAManual

AMA Style Insider Blog:
Twice-monthly entries
http://amastyleinsider.com/

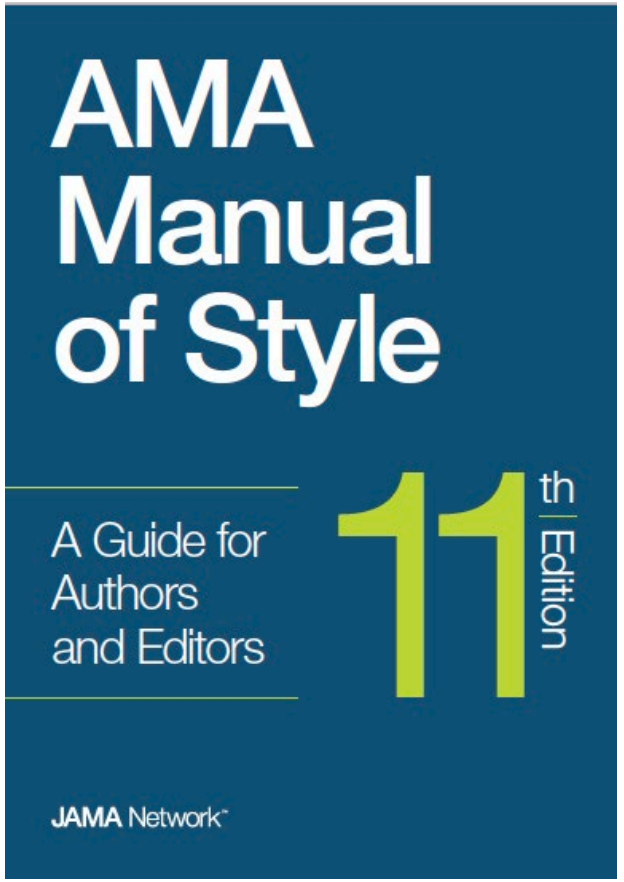


AMA Manual of Style 11th edition

Stay tuned! Every chapter has been revised, peer reviewed, and submitted to the publisher, and plans are in motion for print book and website publication in January.

Stacy Christiansen and Cheryl Iverson

Committee co-chairs:
stylemanual@jamanetwork.org



The Queen of Style and the passing of the crown

Cheryl Iverson

Stacy Christiansen

Questions?

Thank you!