

Clarity and brevity: writing an article for this Journal

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The editors of the Journal welcome all submissions that have a bearing on the practice of hand surgery and are likely to inform and guide our readers. This editorial is intended to guide those preparing an article for submission to *The Journal of Hand Surgery (European Volume)*. The number of submissions increases every year and is currently around 500 full-length articles and 200 short report letters. About 20% of each category will be accepted and published. The criteria for an acceptable article are shown in Table 1. Put in a slightly different order, these can be set as the following questions: '*Is it new? Is it true? Does it matter?*' Articles will be rejected if they fail to satisfy one or more of these criteria. Other common reasons for rejection are shown in Table 2. Of those articles that are accepted, almost all will require extensive revision by the authors and editors before final acceptance (Supplementary Figure S1, accessible online). Very few articles that require minimal revision and correction are submitted. Indeed, many are like early drafts.

The preparation of an article for publication is a fundamental skill that should be acquired during the training of all investigators. However, it seems that this skill is rarely taught, or indeed even considered to be of importance. Without training, no-one would expect to pick up a musical instrument and play a tune, or take a brush and paint a picture, or hold a scalpel and operate on a patient. In the same way, learning to write an article requires guidance, supervision and above all practice.

There are many guides to help the aspiring medical or scientific author, for example those of Albert (2016), Huth (1990), Manske (2006), Matthews and Matthews (2014), Shah and Smart (2016) and the excellent short book by Thorne (1970), well worth reading but unfortunately no longer in print (Drife, 2013). The purpose of this review is not to substitute for such sources, but to guide authors in the preparation of submissions specifically for this Journal. We look at common problems and errors that we regularly encounter in submissions and advise how to avoid them.

This review is complementary to this Journal's Submission Guidelines (2017), which should of course be read and carefully followed during the

writing of an article. The guidelines are available in several languages. As part of the submission process, authors are required to include a statement to say that they have read the Submission Guidelines and that the article adheres to them in every respect. It is clear that most authors regard this statement as a formula: if the statement has been made, the article will therefore follow the guidelines, even though it does not.

The structure of an article

An article should follow the well-known IMRAD formula (Introduction; Methods; Results and Discussion). However, before the IMRAD part, there are some important preliminaries.

Title

The title does not accurately state what is in the article. Titles are often changed as part of the process leading to acceptance. It is obvious that the title should clearly indicate what the article is about. It should also attract the reader's attention. 'Does performing hand surgery outside of the operating theatre increase the risk of infection? A systematic review of the literature' is a title that would attract attention, but it became 'Surgical site infection after hand surgery outside the operating theatre: a systematic review' (Jagodzinski et al., 2017), since the question in the original title could not be answered definitively by the available evidence. Changing the title also allowed elimination of 'performing' 'outside of' and 'of the literature', which are examples of unsatisfactory English words or expressions. Avoid jokey titles or the inclusion of allusions that may be lost on the readership.

Authors

Inappropriate authors. Listing as an author someone who has not been closely involved in the design and execution of a study and preparing the submission is known as *honorary (or gift) authorship*. For example, including the name of someone

Table 1. Criteria for acceptance of an article by the Journal.

Criterion
Relevant to the practice of hand surgery, i.e. about conditions affecting the hand or wrist, or the peripheral nerves in the upper limb
Contains new information
Scientifically sound

Table 2. Common reasons for rejection of a submission (after Giddins (2014)).

Reason
Failure to obtain ethical approval and consent
Use of non-validated scoring systems
Studies of new designs of implant arthroplasty with a follow-up less than 2 years, unless to report early failure
Studies of established designs of implant arthroplasty with a follow-up of less than 5 years
Follow-up studies with a high drop-out of patients
Early results from new techniques

Table 3. The International Committee of Medical Journal Editors criteria for authorship. To justify authorship, all four must be met.

Criteria
Substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data AND
Helped draft the article or revise it critically for important intellectual content AND
Final approval of the version to be published AND
Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

whose contribution is no more than early discussion of the planned project or glancing at a first draft of the article, is wrong and unethical. Suspicions are certainly aroused when a well-known name appears as a senior author on an article that is full of problems. What guidance did that supposedly experienced author provide? The Editors rely on the integrity of the listed authors because they are not able to investigate the contributions of individual authors.

The International Committee of Medical Journal Editors (2016) has provided criteria for authorship and it states that authors should meet all four criteria (Table 3). Adhering strictly to this policy is difficult because a ‘substantial contribution’ cannot be defined precisely and it is possible to contribute to a study by

Table 4. Examples of research misconduct and bad science.

Example
Adding honorary authors or failing to give credit to an author
Hypothesizing after the results are known (‘HARKing’)
Fabrication of data
Using data selectively or applying statistical tests in a way that supports conclusions that may be unwarranted (data dredging and <i>p</i> -hacking)
Exaggerating the importance of the findings
Plagiarism
Multiple publications in different journals using the same data set
Salami slicing (chopping up the data set to publish results as a series of articles, rather than one)

fulfilling one or two criteria but not all (Shaw, 2011). Some journals have a more permissive approach, such that the four criteria are linked by OR rather than AND, but all authors must acknowledge their involvement in all versions of the manuscript (Baskin and Gross, 2011). Others who have contributed to the study but do not fulfil one or more of the criteria should be listed in an acknowledgement. It should not be forgotten that gift authorship can lead to serious professional damage: when fraudulent work or other unscrupulous practices (Table 4) (Benson, 2016) are exposed, all authors will be held to account. When they occur in submissions to this Journal, the authors will be asked for an explanation. Further actions may include notifying the authors’ employers and bodies that award grants and supervise professional standards.

Ghost authorship. This occurs when a submission is written by a professional writer who has not otherwise contributed to the study and who may not be named as an author (Baskin and Gross, 2011). The concern here is that evidence may be skilfully manipulated to appear better than it is, particularly if the ghost author is an employee of a company that has sponsored the research. This form of malpractice is compounded if, to boost credibility, honorary authorship is then offered to an established figure who has not contributed.

Too many authors. There should be no more than six authors for a full-length article in this Journal. We frequently receive requests to accept more than six authors, with assurances that they have all contributed equally and substantially. Only in the most exceptional cases will more than six authors be considered, after receiving detailed explanations of their individual contributions.

Table 5. Common types of study.

Study type	Relevant guidelines
Case report	Journal guidelines for a short report letter
Cohort (group) study: prospective or retrospective	STROBE guidelines (2007)
Case/control study	
Cross-sectional study	
Clinical trial (including randomized control trial)	CONSORT guidelines (2010)
Systematic review/Meta-analysis	PRISMA guidelines (2015)
Assessment of new diagnostic procedure	STARD guidelines (2015)
Basic science study	

STROBE: Strengthening The Reporting of Observational studies in Epidemiology; CONSORT: CONSolidated Standards Of Reporting Trials; PRISMA: Preferred Reporting Items for Systematic reviews and Meta-Analyses; STARD: STAndards for the Reporting of Diagnostic accuracy.

Abstract

The structure of the Abstract. Most readers will look at the Title and Abstract first and will not read further unless the topic is of direct relevance to them. As a service to readers it is essential that the Abstract states clearly what was done and what was found. Unlike some journals, we do not have a structured form for the Abstract, but it is useful to have a structure in mind when writing it. The following points should be considered for mention in the Abstract (although not all may be relevant and some can therefore be excluded): type of study (Table 5); aims and objectives; setting; methods; results; and conclusion. This must be done within the 150-word limit. Do not use any abbreviations in the Abstract. They can be defined in other sections of the article when first used.

Level of evidence

Overstating the level of evidence. The Journal uses the levels of evidence established by the Oxford Centre for Evidence Based Medicine (OCEBM) 2011, not those of any other organization or journal. They are applicable to clinical articles, but not to basic scientific articles, which are not given a level of evidence. Authors frequently claim that their submission has a higher level of evidence than is warranted. To maintain scientific credibility, the Editors make the final decision.

Introduction

Usually far too long. The appropriate length of an Introduction section for this Journal is about 300 to 500 words and it should clearly state what is known, what is not known and why you did your study. The contents can be arranged in one, two or three paragraphs. It is rare that an Introduction requires more than three paragraphs and certainly should normally not exceed 500 words.

An article is different from a thesis. Writing a thesis is part of training in research methods and requires an extensive critical analysis of previous work to introduce the study. There is no need for such a review of previous publications in an article. If an article is based on work done for a thesis, the temptation to 'cut and paste' large sections should be resisted. An article for this Journal is usually read by surgeons who know that Dupuytren's disease is a proliferation of fibrous tissue in the palm, that carpal tunnel syndrome is the most common compression neuropathy and so on. Such statements are redundant.

The Introduction should state, in as few words as possible, the reason or reasons for carrying out the study. The aim of the study should then be clearly stated, preferably in one sentence. This might take the form of a hypothesis to be tested. HARKing (Hypothesizing After the Results are Known, to make an exploratory analysis look as if it is a prospectively declared investigation) is bad science and must be avoided.

There is a difference between the aim of a study and its objectives. The *aim* is the overall purpose of the study and the *objectives* are subsidiary to the aim: they are essentially the steps that you will take to achieve the aim. Thus, the aim of your study might be to identify whether treatments X or Y provided better function and pain control in a particular condition; the objectives might be to carry out some form of patient-reported outcome measure and visual analogue scale pain scores before and after treatment, and then analyse them by the appropriate statistical tests.

Methods

It is not necessary to use any other terms in the heading for this section, such as 'Materials and methods' or 'Patients and methods'. Instead use subheadings, such as 'Patients', 'Surgical technique', 'Follow-up'

or 'Statistical methods' for individual sections, as appropriate.

Patients/participants/volunteers. Avoid the term 'subjects': not only does it have overtones of human experimentation, it does not acknowledge the fact that the people who are investigated in a study are making a contribution to that study (Boynton, 1998). Give details of the inclusion and exclusion criteria and confirm that all patients have provided consent.

Prospective and retrospective studies. Many surgical studies take the form of longitudinal follow-up studies after a particular type of operation. You should clearly state the structure of such a study. A *prospective study* is one in which a decision is made to follow-up all patients from the present time point and the information to be recorded at different follow-up points is documented. A *retrospective study* is one in which the decision is made to look back at all patients and record perhaps the same outcome measures. It is more likely that fewer patients will be lost to follow-up and that data recording will be more complete in a prospective study. In both types of study you must state clearly whether any patients were lost to follow-up and how many. Sometimes patients are identified retrospectively and then brought back for an individual follow-up examination, which will obviously be at a variable time after the treatment. This does not make the study a prospective one. Make sure the reader knows exactly what the study design was.

Details of operative and other techniques. It is not necessary to write exhaustive descriptions of surgical exposures, how a tourniquet was applied and details of splintage after operation, if these follow standard procedures. However, you should describe in greater detail any techniques that are unique or not previously reported, to improve the understanding of the readers and allow other surgeons or investigators to repeat the study.

Levels of expertise of the investigators. Reporting the levels of expertise of the investigators or operating surgeons provides the reader with information about their levels of proficiency. This may be particularly useful in a speciality such as hand surgery. Tang and Giddins (2016) have brought this point to the attention of authors; in some circumstances, such as reporting the results of randomized prospective studies and other comparative studies, this information must be provided.

Independent observers. Indicate who made the observations, such as measurements or examinations (by

putting their initials in brackets if they are authors) and make it clear to the reader whether or not they were independent. For example, there is a clear potential for bias if the surgeon who did the operations makes all the follow-up observations on the patients. This would not necessarily prevent acceptance of an article: the point is that the reader should know.

Equipment. State the type of equipment used (e.g. for making measurements). If proprietary equipment is used give the name of the manufacturer and their location (city, state, country).

There are some important concepts in relation to measurements: the *accuracy* of a measurement is how close it is to the true value; the *precision* of a measurement is related to its *reproducibility* and *repeatability*, i.e. whether the measurement will be the same when repeated under the same conditions. For example, a measurement of movement with a hand-held finger goniometer is probably accurate to 5° of the true movement and would produce similar variation (precision) if repeated. The *measurement resolution* is the smallest change that would produce a change in the value of the measurement and in the example cited is probably also around 5°. Failure to understand these concepts is commonly reflected in poor presentation of results. You should provide readers with an idea of the accuracy and precision of a measuring device if it is not in common use.

Statistical methods. We will not go into a detailed discussion of statistical methods here. It is obvious that advice from a statistician should be sought at the planning stage of any study, before it is carried out, but it is equally obvious that this is seldom done. As part of the review process authors may be asked to submit their original data for analysis by one of our statistical advisors. Common problems that are identified by reviewers, editors and advisors include the following.

- Failure to state clearly the statistical tests used.
- Stating several tests that were used, but failing to make clear which test was used for each analysis.
- Failure to test and state whether or not the data are normally distributed (leading to the use of inappropriate tests, such as parametric tests on non-parametric data).
- Failure to distinguish between independent and dependent observations.
- Failure to report data that are normally distributed in the form: mean (SD) (not mean \pm SD or mean (SEM)).

- Failure to report data that are not normally distributed in the form: median, range and interquartile ranges.
- Failure to establish the sample sizes that are required to ensure that the study has sufficient power to reject the null hypothesis when the alternative is true.
- Failure to clarify whether one- or two-tailed tests have been used, or to justify the use of a one-tailed test.
- Over-emphasis on *p*-values. In clinical studies, giving the results that show the sizes of differences in their units of measurement, along with confidence intervals, is preferable to presenting *p*-values that may be statistically significant, but clinically irrelevant.
- Claiming that results 'approached' significance because the *p*-value was, say, 0.1 when the acceptable significance value was set at <0.05 .

Study the SAMPL (Statistical Analyses and Methods in the Published Literature) guidelines (Lang and Altman, 2015) to improve the presentation of statistical material in your article. The articles by Sauerland et al. (2003), Song et al. (2009) and Szabo (1997) clarify the particular problems that may occur when applying statistical tests in hand surgery.

Results

Poor presentation. Present results in the text, OR in tables, OR in figures (charts, for numerical data), whichever is most appropriate. Do not present the same results in more than one format. Repetition of results in text, tables and charts does not increase the importance or validity of your results and does not make it easier for the reader to understand them; in fact, rather the opposite.

The numbers do not add up. This is all too common. Check and recheck to ensure that they do.

Accuracy and precision. Authors very often present mean values with one or two decimal places. Returning to the example of making measurements with a goniometer, it would be inappropriate to state that the mean value of active flexion of the proximal phalangeal joint in a series of patients was, say, 30.1°. The goniometer cannot measure with that precision and the value should be rounded to the nearest degree. Similarly, if the time of follow-up is recorded in years for individual patients, the mean follow-up period should not be given as, for example, 4.56 years. Your presentation of numerical values should always reflect the precision of the measurement.

Misuse of percentages. Percentages can be misleading, particularly when used with small numbers (Cowell, 1998). Four out of five is 80% and three out of five is 60%, quite a difference and yet produced by a change of one unit. When there are fewer than 50 items, give the absolute numbers: e.g. 11 of 15 patients, not 73.33% of patients. When presenting a value as a percentage, round it to the nearest whole number.

It is very confusing when percentages are used for subsets of data and the denominator is not clearly defined. For example: '50.4% of the patients were female and 25.2% of them were under the age of 25 years'. Does the latter percentage refer to the whole group or just to the women in the group? Stating this information as: '50% of the patients were women, of whom 25% were under the age of 25 years and, of these, 10% were office workers' provides some clarification but also adds confusion because of the use of percentages to report three groups with different numbers (denominators) in them (men and women; women; and women under 25). As a general rule, avoid reporting subsets by percentages and stick to absolute numbers.

A percentage is not a *rate*. 'The study demonstrated a satisfaction rate of 86%' is incorrect and should be stated as: 'The study demonstrated that 86% of the patients were satisfied', or better still: 'Eighty-six percent of the patients were satisfied'. (Numbers, including percentages are spelled out at the beginning of sentences.) A rate includes the element of time: an interest rate of 0.5% per annum, for example.

Tables. There is a required style for tables in this Journal, to provide consistency between articles and thus aid the understanding of results. Most authors submit their tables in the style obtained when the 'Insert table' function is used in Word, as a series of simple boxes with multiple borders. When preparing a table, follow the Submission Guidelines and check the appearance of tables in recent issues of the Journal. Tables must stand alone, so that they are comprehensible if they are read without the rest of the article being available. This means that you must define any abbreviations in a footnote to the table, even if they are defined elsewhere in the article or in a footnote to another table.

Do not submit tables giving comprehensive information on the individual patients in a group. When this information might be of use to other investigators, submit it as supplementary material for online publication. The reader is interested in the conclusions that you drew from these data.

Figures and charts. As with tables, figures must stand alone, so you must define abbreviations and symbols

that appear in individual figures as a footnote to each one. When presenting numerical results in a chart, clarity is best achieved when the simplest style is used. Common errors include the following.

- Use of over-elaborate styles, such as three-dimensional bar charts (which may also be misleading [Franzblau and Chung, 2012]).
- Unnecessary frames.
- Failure to label the axes and the intervals on the axes.
- The use of multiple fonts and underlining. Use a sans-serif font.
- The use of multiple colours or fills when they are unnecessary.
- Failure to use colours or fills that allow distinctions to be made between data sets.
- Failure to define in a footnote what is represented by, for example, asterisks and whiskers on the chart.

Discussion

Usually far too long and disorganized. The usual length for a Discussion in this Journal is about 700 to 1000 words, and it should rarely exceed 1200 words. Organize the Discussion section by having a structure for it in mind. There is no need for subheadings or a conclusion section in a properly organized Discussion.

Begin by stating whether the hypothesis (if stated) was confirmed and a brief summary of any new information that has been found, but do not repeat the results that have just been given in the Results section.

Avoid a lengthy review of previous studies and limit discussion to those that are directly relevant to your own. Briefly compare and contrast your findings with those from similar investigations. Include results from previous investigators if you wish to compare them with your own, but they should not outweigh discussion of your own results and their implications. Do not venture into vague speculation.

Identify any weaknesses in your study and any possible strengths in comparison with others. Mention ideas for further studies if you wish.

Reference list

Too many references. You should cite only recent pertinent references. A lengthy list containing many references of largely historical interest does not add credibility to your submission.

Frequently fails to follow the Journal style. It is rare indeed to see a list of references that is both accurate and follows the styles shown in the Submission Guidelines. Download references from a reliable

database, such as Medline or PubMed, to ensure their accuracy. Then modify each one of them using the examples in the Submission Guidelines, so that it is listed in the correct Journal style, for example for an article, a chapter or a book.

Other aspects

English language

The reviewers and editors respect the efforts of authors in preparing their submissions for the Journal and particularly those of authors whose first language is not English. The quality of the English in the submission is not a reason for rejection, unless it is incomprehensible. The editors will help the authors to improve the English in potentially acceptable submissions. However, the editorial process will be quicker if, before submission, the article is read for clarity by native English speakers, or vetted by a commercial firm specializing in the preparation of manuscripts in English. The latter is not the same as ghost authorship.

The Journal uses United Kingdom English, so make sure that your spell-checker is set to this. It is very tedious to correct all the words that are submitted with United States spelling, or articles that have been written in English using a word processing programme that is set to a different language.

Many languages do not have the definite ('the') or indefinite ('a' 'an') articles that occur in English. Vetting the manuscript to ensure that they are inserted can improve it considerably.

Ensure that the manuscript is read, re-read and discussed by all the authors several times during the process of preparation, to avoid the problem of the 'early draft submission' mentioned earlier. Being a native English speaker, or a fluent speaker of English as a second language, does not automatically enable one to write well in English. All too often a phrase such as 'It has not escaped our notice that in order to achieve the most superior results in respect of long-term outcomes, it is incumbent on the operating surgeon to ...' is encountered. Do you agree that 'To get the best long-term results, the surgeon should ...' is better? The lesson is: make it clear and make it short.

First-rate writers of English, such as George Orwell and, in the medical field, Richard Asher, could express complex ideas with brevity and clarity using simple words, although they were not born with this ability and had to work hard to develop it [Asher, 1972; Orwell, 2002]. You should aspire to achieve brevity and clarity in your submission. Avoid jargon, neologisms, hackneyed phrases and clichés. Some of the undesirable terms that are most frequently seen in submissions to this Journal, and their preferred

Table 6. Undesirable words or expressions and their alternatives.

Words or expression to avoid	Preferred
A total of (e.g.) ten	Ten
Anastomosis (in relation to nerve or tendon repair)	Repair; suture
As well as (in the meaning of and)	And
Average	State whether mean, median or mode
Calibre (used as term for the diameter of something other than a tube)	Diameter
Challenging	Difficult
Commence	Start
Diabetic (used as a noun)	Person (or patient) with diabetes
Dorsiflexion	Extension
Emergent (in the sense of acutely or as an emergency)	Acutely or as an emergency
Employ	Use
Enhance	Improve
Evaluate	Examine; assess; measure
Extensor digitorum communis	Extensor digitorum
Extensor indicis proprius	Extensor indicis
Female (as noun)	Woman
Following (used as a preposition)	After
Impact (used as a verb)	Affect
Inferior (describing result)	Worse
Literature	(Previous) publications
Male (as noun)	Man
Modalities of therapy	Treatments
Neuropraxia	Neurapraxia
Novel	New
On the other hand	However; but; alternatively; in contrast
Palmar flexion	Flexion
Performed	Did; carried out
Preaxial	Radial
Postaxial	Ulnar
Prior to	Before
Pronosupination	Rotation of the forearm
Right (left) hand dominant	Right (left) handed
Standard of care (in the sense of the usual treatment)	Usual (or standard) treatment
Subjects	Participants; patients; volunteers
Superior (describing result)	Better
The (vast) majority	Most
Utilize	Use
Volar (in relation to anything other than the palm)	Palmar; anterior; flexor
X-ray (used as the image rather than the beam)	Radiograph

alternatives, are shown in Table 6. We have not explained why each term is undesirable, but the interested reader may want to try and find out.

Masculine/feminine

'A good writer will make sure that he is understood by his readers'. In such a sentence in English, 'he' and 'his' refer to all persons, whether male or female. Nevertheless, this is nowadays unacceptable to some, and leads to the use of clumsy formulations, such as 'he or she', 'he/she', 's/he' or 'his or her'. One way of getting around this problem is to use a plural

form, which is gender-neutral: 'Good writers will make sure that they are understood by their readers'. There are several other ways to work around this perceived problem and avoid giving offence.

Claiming priority

Do not claim priority: 'We are the first to ...'. If you are the first person or group to publish the relevant finding, you will receive credit for this from the scientific community. If you are not the first, but have claimed to be, you will look foolish. It is permissible to use a more modest form of words such as: 'To our knowledge this

Table 7. Aspects that must be checked and re-checked during the preparation of a submission.

Section	Points to check
Title	Does it accurately reflect what is in the article?
Authors	Are they all genuine authors? Are there too many authors?
Abstract	Does it state what kind of research study this was? (See Table 5.) Does it state what you did and what you found within the 150 word limit?
Introduction	Does it state, briefly and clearly, why you carried out your study? Does it contain a statement of the intentions of the study? If the above statement is given in the form of a hypothesis, was the hypothesis formulated before the study was carried out?
Methods	If the study involved patients, have the criteria for inclusion and exclusion been stated clearly? Are the methods that you used clearly stated? Have you analysed your data with the appropriate statistical tests and have these tests been clearly stated?
Results	Have your numerical results been presented with the appropriate level of precision for the method of measurement? Have your numerical results been stated once in a clear fashion, using the most appropriate form of presentation (i.e. text, tables or charts)? Are the tables in the correct format? Are the charts simple and clear?
Discussion	Does this discuss your findings in relation to previous studies, and with respect to agreement or disagreement with such studies? Have you discussed the reasons for any discrepancies? Have you discussed the limitations and strengths of your study? Have you avoided speculation that is not supported by your study?
Reference list	Has every reference been double checked to ensure that it is in the format that is clearly given in the 'Submission guidelines'?

(finding, clinical sign, etc.) has not been previously described'. You will still look foolish if it has, but at least you will not have made a false claim.

Eponyms

Eponyms have a place in hand surgery. It would be awkward to use alternative phrases to refer to Dupuytren's disease, Kienböck's disease or Tinel's test, for example. It is well recognized that eponymous persons may not have been the first to describe whatever their names are associated with, or did not describe it at all, or else described something entirely different. For these reasons, and because the person does not have ownership of the disease (or test, or sign, or operation), some object to the use of the possessive form of the eponym. Instead the form 'Dupuytren disease' is recommended (Meals, 2011), although this sounds odd. The Journal does not have a firm policy on this point, but requires consistency in the style of usage throughout an article. Never name something after yourself in your submission: for example 'This is called the Smith test'.

Abbreviations

Avoid the creation of new abbreviations or the use of too many abbreviations, both of which make it hard for the reader to follow what you are trying to say.

Lists

Avoid numbered or lettered lists. Setting out a list as a sentence with the components in the list separated by semicolons is usually perfectly clear. An alternative is to use bullet points.

The length of an article

The usual length of a full-length article in this Journal is no more than nine printed pages. Although no strict limitation is applied, an article rarely has more than nine or ten figures and tables. If you have more figures and tables you should think carefully about reducing the number before submission.

Final message

We encourage you to submit your work to this Journal. We hope the advice that we have given will help you in the preparation of your manuscript. Please refer to the Submission Guidelines often when you are writing the manuscript and check the points in Table 7. Keep your submission short and clear.

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