Writing for Impact

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Disclosures

• None relevant to this topic.
Why work on your writing?

- IMPACT
- DISSEMINATION
- Change practice or policy
- A good paper is a good paper, no matter where it is published
- Good writing isn’t just good writing. Good writing is clear thinking
Why right brainers will rule the future
Recipe for a high impact publication:

Challenge: Finding surgical topics that appeal to a broad audience

- An important question
- Rigorous methods
- A well written manuscript
National Cluster-Randomized Trial of Duty-Hour Flexibility in Surgical Training


ABSTRACT

BACKGROUND
Concerns persist regarding the effect of current surgical resident duty-hour policies on patient outcomes, resident education, and resident well-being.

METHODS
We conducted a national, cluster-randomized, pragmatic, noninferiority trial involving 117 general surgery residency programs in the United States (2014–2015 academic year). Programs were randomly assigned to current Accreditation Council for Graduate Medical Education (ACGME) duty-hour policies (standard-policy group) or more flexible policies that waived rules on maximum shift lengths and time off between shifts (flexible-policy group). Outcomes included the 30-day rate of postoperative death or serious complications (primary outcome), other postoperative complications, and resident perceptions and satisfaction regarding their well-being, education, and patient care.

RESULTS
In an analysis of data from 138,691 patients, flexible, less-restrictive duty-hour policies were not associated with an increased rate of death or serious complications (9.1% in the flexible-policy group and 9.9% in the standard-policy group, P = 0.92; unadjusted odds ratio for the flexible-policy group, 0.96; 92% confidence interval, 0.87 to 1.06; P = 0.44; noninferiority criteria satisfied) or of any secondary postoperative outcomes studied. Among 4330 residents, those in programs assigned to flexible policies did not report significantly greater dissatisfaction with overall education quality (11.0% in the flexible-policy group and 10.7% in the standard-policy group, P = 0.86) or well-being (14.9% and 12.0%, respectively, P = 0.40). Residents under flexible policies were less likely than those under standard policies to perceive negative effects of duty-hour policies on multiple aspects of patient safety, continuity of care, professionalism, and resident education but were more likely to perceive negative effects on personal activities. There were no significant differences between study groups in resident-reported perception of the effect of fatigue on personal or patient safety. Residents in the flexible-policy group were less likely than those in the standard-policy group to report leaving during an operation (7.0% vs. 13.2%, P < 0.001) or handing off active patient issues (32.0% vs. 46.3%, P < 0.001).

CONCLUSIONS
As compared with standard duty-hour policies, flexible, less-restrictive duty-hour policies for surgical residents were associated with noninferior patient outcomes and no significant differences in residents’ satisfaction with overall well-being and education quality.

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Karl Bilimoria, MD, MS

Impacting work hour policy for surgical residents
Kidney Paired Donation and Optimizing the Use of Live Donor Organs

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Daniel S. Warren, PhD
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Renal transplantation has emerged as the treatment of choice for medically suitable patients with end-stage renal disease. More than 60,000 patients await kidney transplantation and are listed on the United Network for Organ Sharing (UNOS) recipient registry.1 Live donor renal transplantation represents the most promising solution for closing the gap between organ supply and demand.

Unfortunately, many patients with willing live donors will be excluded from live donor renal transplantation because of blood type incompatibility or positive donor-specific crossmatch. Based on blood type frequencies in the United States, there is a 39% chance that any 2 individuals will be ABO incompatible. Furthermore, 30% of the patients awaiting donation from the UNOS recipient registry are sensitized to allo-HLA due to previous transplants, pregnancies, or blood transfusions. While successful desensitization techniques have been developed to overcome incompatibilities, these have been limited to specialized programs and are very resource intensive.1,10

Kidney paired donation (KPD) offers an incompatible donor/recipient pair the opportunity to match with another donor and recipient in a similar situation.11 In the United States, these transplantations are currently performed at few institutions, with matches identified through local or regional patient databases.12,13 However, even with the increasing popularity of KPD, only 51 patients have received transplants via paired donation, with nearly half of them performed at Johns Hopkins University.13 UNOS has recently proposed a national live donor KPD program through the Organ Procurement and Transplantation Network, but regulatory obstacles to a national program still exist (including the question of “valuable consideration”); therefore, no data exist regarding the impact of national vs regional programs.12,13 Because it is critical to find the most effective method of matching patients and donors at the outset, before any national strategy is implemented, we investigated virtual paired donation programs on simulated patient populations.

Context
Blood type and crossmatch incompatibility will exclude at least one third of patients in need from receiving a live donor kidney transplant. kidney paired donation (KPD) offers incompatible donor/recipient pairs the opportunity to match for compatible transplants. Despite the increasing popularity, very few transplants have resulted from KPD.

Objective To determine the potential impact of improved matching schemes on the number and quality of transplants achievable with KPD.

Design, Setting, and Population
We developed a model that simulates pools of incompatible donor/recipient pairs. We designed a mathematically verifiable optimized matching algorithm and compared it with the scheme currently used in some centers and regions. Simulated patients from the general community with characteristics drawn from distributions describing end-stage renal disease patients eligible for renal transplantation and their willing and eligible live donors.

Main Outcome Measures
Number of kidneys matched, HLA mismatch of matched kidneys, and number of grafts surviving 5 years after transplantation.

Results
A national optimized matching algorithm would result in more transplants (47.7% vs 42.0%; P<.001), better HLA concordance (3.0 vs 4.5 mismatched antigens; P<.001), more grafts surviving at 5 years (34.9% vs 28.7%; P<.001), and a reduction in the number of pairs required to travel (2.9% vs 18.4%; P<.001) when compared with an extension of the currently used first-accept scheme to a national level. Furthermore, highly sensitized patients would benefit 6-fold from a national optimized scheme (2.3% vs 14.1% successfully matched; P<.001). Even if only 7% of patients awaiting kidney transplantation participated in an optimized national KPD program, the health care system could save as much as $750 million.

Conclusions
The combination of a national KPD program and a mathematically optimized matching algorithm yields more matches with lower HLA disparity. Optimized matching affords patients the flexibility of customizing their matching priorities and the security of knowing that the greatest number of high-quality matches will be found and distributed equitably.

ORIGINAL CONTRIBUTION

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(Reprinted) JAMA, April 20, 2005—Vol 293, No. 15

• Dorry Segev & Sommer Gentry

• Created math and methods for large-scale paired kidney donation
High impact academic writing

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Diversify your research portfolio:

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Variation in Hospital Mortality Associated with Inpatient Surgery

Amir A. Ghaferi, M.D., John D. Birkmeyer, M.D., and Justin B. Dimick, M.D., M.P.H.

ABSTRACT

BACKGROUND
Hospital mortality that is associated with inpatient surgery varies widely. Reducing rates of postoperative complications, the current focus of payers and regulators, may be one approach to reducing mortality. However, effective management of complications once they have occurred may be equally important.

METHODS
We studied 84,730 patients who had undergone inpatient general and vascular surgery from 2005 through 2007, using data from the American College of Surgeons National Surgical Quality Improvement Program. We first ranked hospitals according to their risk-adjusted overall rate of death and divided them into five groups. For hospitals in each overall mortality quintile, we then assessed the incidence of overall and major complications and the rate of death among patients with major complications.

RESULTS
Rates of death varied widely across hospital quintiles, from 3.5% in very-low-mortality hospitals to 6.9% in very-high-mortality hospitals. Hospitals with either very high mortality or very low mortality had similar rates of overall complications (24.6% and 26.9%, respectively) and of major complications (18.2% and 16.2%, respectively). Rates of individual complications did not vary significantly across hospital mortality quintiles. In contrast, mortality in patients with major complications was almost twice as high in hospitals with very high overall mortality as in those with very low overall mortality (21.4% vs. 12.9%, P=0.001). Differences in rates of death among patients with major complications were also the primary determinant of variation in overall mortality with individual operations.

CONCLUSIONS
In addition to efforts aimed at avoiding complications in the first place, reducing mortality associated with inpatient surgery will require greater attention to the timely recognition and management of complications once they occur.

Amir Ghaferi, MD
• Understanding & improving failure to rescue in surgery
• AHRQ K-award
• AHRQ P30 grant
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DATE: FEB 1
TIME: 10 AM (SHARP)
PLACE: FRONT GARDENS

WONKA
“Opportunity is missed by most people because it is dressed in overalls and looks like hard work.”  ~Thomas Edison
Seek out the right coach: Someone who writes better than you

Surgical Mortality as an Indicator of Hospital Quality

The Problem With Small Sample Size

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Shelton Walsh, MD, MPH
John H. Reisman, MD


However, these programs are based on the premise that surgical mortality is a reliable gauge of hospital quality. In fact, surgical mortality rates are being used to measure hospital quality. It is not a surprise, however, that many hospitals have shown significant variation in their mortality rates, especially between hospitals with and without heart surgery programs.

Objectives: To determine whether the variation in hospital mortality rates is large enough to be significant and whether it could be used as a measure of hospital quality.

Methods: We analyzed data from 108 hospitals participating in the New York State Medical Group (NYSMG), a group of hospitals that provide hospital care to the elderly and fraud prevention programs. The hospitals were divided into two groups: those with and those without heart surgery programs.

Results: There was no significant difference in hospital mortality rates between the two groups. However, the mortality rates were significantly lower in hospitals with heart surgery programs.

Conclusions: The variation in hospital mortality rates is small and not significant enough to be used as a measure of hospital quality.
Preparing Manuscripts for Submission to Medical Journals: The Paper Trail

CONTEXT. Preparing a manuscript for publication in a medical journal is hard work.

OBJECTIVE. To make it easier to prepare a readable manuscript.

APPROACH.
Start early—A substantial portion of the manuscript can be written before the project is completed. Even though you will revise it later, starting early will help document the methods and guide the analysis.

Focus on high-visibility components—Pay attention to what readers are most likely to look at: the title, abstract, tables, and figures. Strive to develop a set of tables and figures that convey not only the major results but also the basic methods.

Develop a systematic approach to the body of the paper—A standard framework can make it easier to write the introduction, methods, results, and discussion. An obvious organization with frequent subheadings and consistent labels makes the paper easier to read.

Finish strong—Improve the paper by sharing it with others and by learning how to elicit and receive their feedback. Take the time to incorporate useful feedback by revising frequently.
Our interpretation:

Chapter 9

Writing for Impact: How to Prepare a Journal Article

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I would not give a fig for the simplicity this side of complexity, but I would give my life for the simplicity on the other side of complexity.

Oliver Wendell Holmes, Jr., United State Supreme Court Justice, 1902–1932.
When Writing
Improving your Research Question

Once Submitted
Convincing Editors It’s Worthy of Peer-Review

After Publication
Getting the Rest of the Article Read

Write the abstract first to troubleshoot the research question before moving on.

Half of manuscripts at high-impact journals are rejected based on the abstract.

Readers will start here to decide if the rest of the article is worth reading.

The Three Paragraphs of an Effective Introduction

**Give Context**
Get the reader to care about the topic.

**Create a Knowledge Gap**
Get the reader curious about what is missing.

**Preview Your Plan**
Connect the knowledge gaps to your study plan.

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*Bring the reader up to speed on the why the topic is important.*

*Make clear what is known and what is unknown to date.*

*State how your study will fill the knowledge gap.*

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Critical access hospital designation was created to help ensure access to the more than 50 million people living in rural populations. Established in 1997 under the Medicare Rural Hospital Flexibility Program when policymakers were worried these hospitals would close due to financial hardship, the critical access hospital provision entitled hospitals to increased reimbursements if they had fewer than 25 inpatient beds and were located more than 35 miles away from another hospital. More than 1300 hospitals enrolled in this program, but concern about the resultant Medicare budget growing to more than $9 billion annually led government agencies and advisory groups to call for modification and even elimination of the critical access designation. Advocates for critical access hospitals argue that changes would be disruptive to communities that heavily rely on them for their health care.

Debates about the value of critical access hospitals continue with limited evidence about the clinical outcomes and costs to Medicare in these settings. Increased mortality rates and worse process of care measures have been reported for common medical admissions at critical access hospitals; however, far less is known about patients undergoing surgical procedures. To date the largest study of surgical outcomes captures only approximately one-third of critical access hospitals and lacks postdischarge follow-up and payment information. Nevertheless, this single study found no difference in postoperative mortality rates suggesting that critical access hospitals may provide comparable surgical care with their acute care counterparts. Whether these findings are representative of surgical care across all critical access hospitals and what the costs are to Medicare remain unknown.

The purpose of this study was to evaluate outcomes and costs among Medicare beneficiaries undergoing surgical procedures at critical access and non-critical access hospitals.
Components of a Compelling Discussion

- **Summarize the Findings**: Summarize plainly the study and key findings.
- **Put Your Findings Into Context**: Review other major studies on same topic.
- **Recognize Limitations**: Explain limitations & how you tried to mitigate them.
- **Implications Moving Forward**: Outline implications & recommendations moving forward.

You strike out more often than you hit a home run

“Every strikeout brings me closer to my next home run.”

“I swing with everything I’ve got. I hit big or miss big. I like to live as big as I can.”

Strike out like Babe Ruth
Developing a “growth” mindset:

New England Journal of Medicine 16-11870

From: New England Journal of Medicine <onbehalfof-editorial-nejm.org@manuscriptcentral.com>
Date: September 26, 2016 at 10:28:43 AM EDT
To: <andrew@umich.edu>, <andrew.m.ibrahim@gmail.com>
Subject: New England Journal of Medicine 16-11870
Reply-To: <editorial@nejm.org>

Dear Dr. Ibrahim:

I am sorry to inform you that your submission, "Realizing the Benefits of Hospital Consolidations by Decentralizing Specialty Care," has not been accepted for publication in the Journal. It was evaluated by members of our editorial staff and by two outside experts. After considering its focus, content, and interest, as well as the concerns expressed by the reviewers (see below), we made the editorial decision not to consider your submission further. We are informing you of this decision promptly so that you can submit it elsewhere.

Thank you for the opportunity to consider your submission.

Sincerely,

Debra Malina, Ph.D.
Perspective Editor

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