The Write Stuff

The Journal of the European Medical Writers Association

Survival Skills Issue

Featuring:

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EMWA European Medical Writers Association

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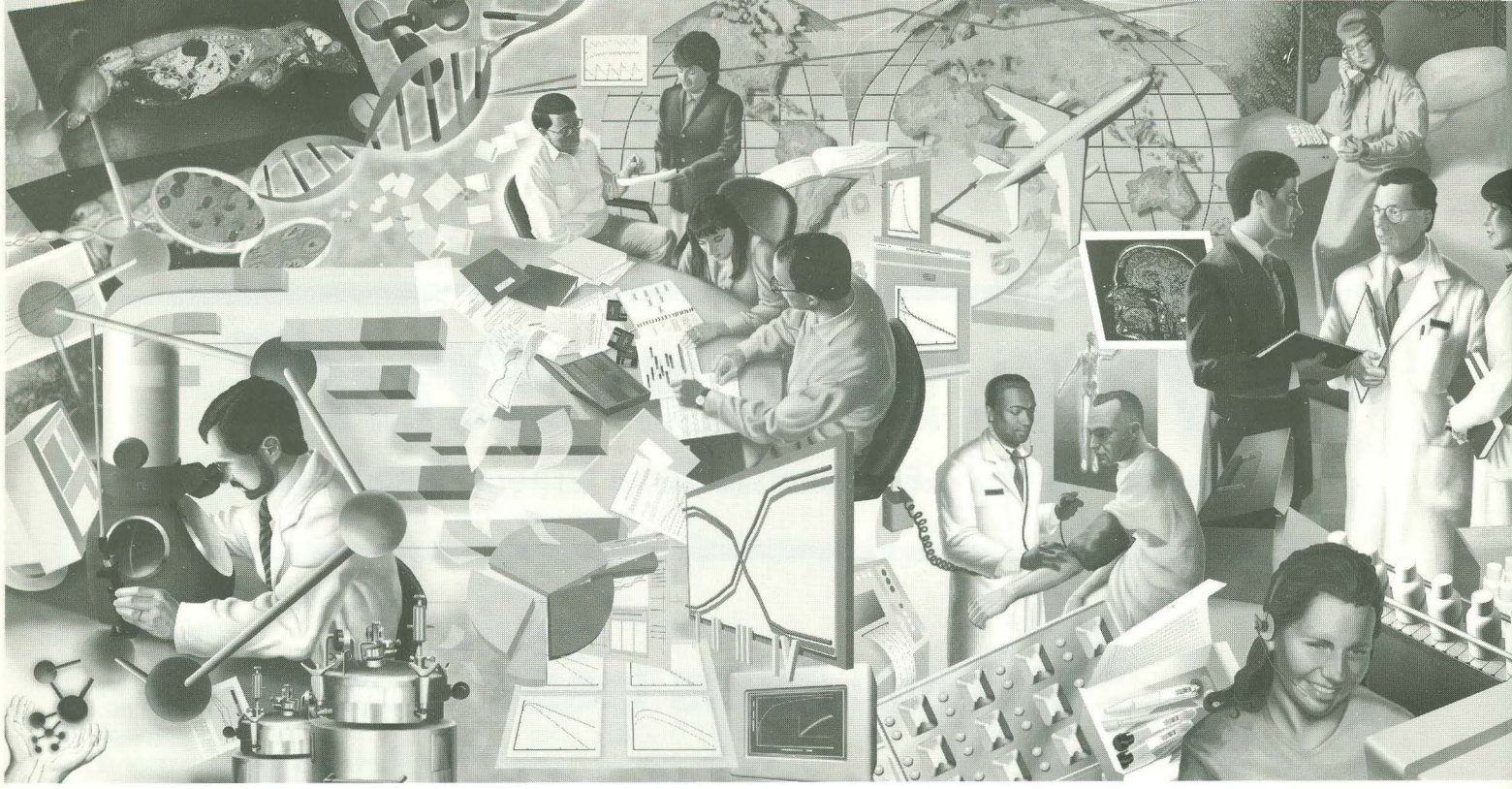

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Regular Columns

[INT] - this symbol indicates that the article also has been or will be published at the EMWA internet site: http://www.emwa.org

Journal Insights

The Write Stuff is the official publication of the European Medical Writers Association. It is issued quarterly and aims to provide EMWA members with relevant, informative and interesting articles and news addressing issues relating to the broad arena of medical writing. We are open to contributions from anyone whose ideas can complement these aims.

Articles or ideas should be submitted to the editor-in-chief:

Barry Drees
Tel: (+49) 69 305 3834
Fax: (+49) 69 305 80070
e-mail: barry.drees@hmrag.com

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Instructions for Contributors:

- **The Write Stuff** typically publishes articles of 500 - 1500 words although longer pieces or those with tables or graphics will be considered.
- All articles are subject to editing and revision by the Editorial Board. Any changes will be discussd with the author before publication.
- Submissions should include the full address of the author, including the telephone/fax numbers and e-mail address. Suitable quotes for side boxes can be indicated or they can be selected by the Editorial Board.
- Material should be submitted electronically on computer disc or by e-mail as an MS Word file using Arial font (or equivalent), 11-point, and single spacing.
- Published articles generally include a recent photograph of the author (portrait picture, CV-style).

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Editor-in-Chief
Barry Drees

Artistic Director
Julia Forjanic Klapproth

Copy Editing
Chris Priestley, Judi Proctor

Columnists:
Adam Jacobs
Liz Wager
Karen Shashok

From the Editor's Desk

by Barry Drees

Greetings fellow members,

When I started as editor of the EMWA journal, I took over Keith Veitch's editorial page with its title, *The Editor's Red Pencil*, despite the fact that I wasn't very thrilled about that name. I don't know, something about the red pencil just seemed so negative, as if the only thing we ever contribute to a document is the finding of other people's mistakes. It seemed to just contribute to the unfortunate stereotype that we occasionally have with some people that we are nothing more than the dreaded "glorified secretaries". I have since learned from long experience that, strange and pseudoscientific as it may sound, marking corrections in some other colour (as you might suspect from *TWS*, I prefer green) adds greatly to the acceptability of editorial comments. Thus I've decided to change the name of this column to reduce the negative connotations and at the same time highlight the other side of medical writing.

An extremely important, but frequently underestimated part of the profession of medical writing is what I call the diplomatic or interpersonal aspect of what we do.

I have always felt that an extremely important part of the profession of medical writing which is frequently overlooked is what I call the diplomatic or interpersonal aspect of what we do. Clearly any situation which involves correcting or commenting on the work of others is going to require sensitive interpersonal skills (check out the AMWA/EMWA "Author-editor Relationship" workshop if you don't believe that), especially when dealing with the fragile egos of scientists, clinicians, or biostatisticians. Just think of some of the following familiar situations and how careful one has to be in dealing with them:

- unreadable, incomprehensible text from a self-styled expert who tells you that you can use it "as it is";
- far too many data tables, each an impenetrable mess;
- requests for "write" access for the entire team
- authors who agree with you that text sections are final and then later suggest changes, usually with the remark, "don't you want it to be as good as it can be?"

I could go on for ever, but I'm sure that you can all think of your own favorite examples. I presented the examples above, among others, at a presentation entitled "Internal Relationships - What Drives Me Crazy! The Medical Writer's Perspective" (now if only I could figure out a way to make a living from that lecture!) at the recent DIA meeting, "Survival Strategies for Medical Writers" (advertised in the last issue of *TWS*). What makes these situations so annoying, however, is not that we have to correct them, but that we have to do it whilst keeping on good terms with the perpetrator.

From the Editor's Desk

But there is another way in which a medical writer needs diplomatic skills, and this comes from the unique position they have within any team as the producer of the end product. Although teamwork seems to be part of just about any activity these days, medical writers truly are unique within any team because they are the only member who is directly involved with and, even more important, dependent on, all the other members. Clinical study and submission teams seem to be getting bigger all the time and are often separated, not only by function, but increasingly in this global industry, geographically as well. Although some of the team members may be content to do their work or provide their comments in relative isolation; it is the medical writer who has to bring all these pieces together and thus must seek workable compromises when different groups or individuals don't agree. Thus medical writers often find themselves in the role of peacemaker between warring nations, and this role requires strong diplomatic or interpersonal skills (i.e. the ability to get people to do things they don't want to while feeling good about it).

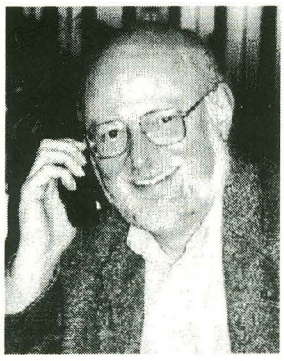
It seems, however, that this aspect of the job of medical writing is finally getting the recognition it deserves. I was extremely pleased to hear that one of the principle themes at that DIA meeting, stressed repeatedly by almost all of the speakers, was that a successful medical writer needs to develop and utilize strong interpersonal skills. Now if we can only get the message through to corporate upper management that not only are we invaluable for our matchless writing and editing skills, but that we also employ the diplomatic skills of a Talleyrand (French diplomat who served for both Napoleon and the Royalists) on a daily basis.

Now if we can only get the message through to corporate upper management that not only are we invaluable for our matchless writing and editing skills, but that we also have brilliant diplomatic skills.

Finally, in a TWS programme note, I'd like to mention the start of what I think is going to be an exciting new series. I was recently asked a question about the format of an Investigator's Brochure by someone who took my workshop in Copenhagen. It occurred to me that due to the notoriously vague European Notice to Applicants, a lot of people might be curious about these kinds of issues. At the same time, within the membership of EMWA we happen to have some of the world's experts on these topics. Therefore, I have decided to start a new series where we will take such questions and pose them to EMWA members with a lot of experience in the area in question. Who knows, maybe we'll begin to get something of a consensus which even the European regulatory authorities might want to use. We will kick off this series in the next issue when we look at the medical writer's nightmare: the Investigator's Brochure. A member wrote asking whether it is permissable to use attractive graphics and complex visuals to make it more likely that the investigator might actually read the thing.

So, here's your chance. Let me know what regulatory document issues are particularly perplexing for you and we'll try to generate some priceless advice from those EMWA experts who've been there and done that - successfully.

Barry Drees
Hoechst Marion Roussel
Tel: (+49) 69 305 3834 Fax: (+49) 69 305 80070
barry.drees@hmrag.com



Message from the President:

by Geoff Hall

Right, cup of coffee time. Surely I have done enough today. Better check the e-mail.

> Subject: Message from the president
> Content:
>
> Hi Geoff,
>
> Article time!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

It's from Barry Drees, editor, Edinburgh banquet performance artist, highly intellectual bird-watcher and bully. At the end of a busy period that has seen me: having to read through briefing documents fully 10 cm thick in preparation for writing a conference report that will run to no more than eight pages, run around trying to organise trips to China (got last seat on the flight) and the US (oh, I am so looking forward to the AMWA meeting), as well as writing copy and reports on topics as diverse as quality control in clinical trial packaging, the pharmacoeconomics of osteoporosis management and luxury cruises up the Amazon to Manaus - I don't need Barry chasing me for an article. (Diary note: must try to write shorter, less complex sentences.)

It makes you wonder what I ever did to find myself in this position. A question often asked by medical writers, as we discovered at a plenary panel discussion at the Copenhagen conference. I always knew that there are many types of medical writers. Some of us write study reports, papers for publication, are involved in the design and writing of study protocols, work in communications agencies. The brief life histories revealed in "Sounds like a good job" demonstrated the variety of ways in which people became medical writers and the diversity of job descriptions.

Mike Matthews, who chaired the session, is a physician who had worked for big pharmaceutical companies in the UK and France and for medical communications agencies. He then endured a four-year spell as a freelance medical writer before becoming Director of Medical Affairs with ICON Clinical Research in the UK. Jane Stock's route took her by way of academia to clinical research to freelance medical writing. Dave Peters qualified as a pharmacologist but found white-coated life at the bench unfulfilling. He then worked for communications agencies in New Zealand and the UK before joining Zeneca.

From the President's Desk

And the writing of medical writers is not confined to the medical. Joan Affleck was there - a medical journal editor who has written poetry reviews, articles for the feminist press, and even authored a survival guide for expatriates in Paris. My co-workshop leader in Copenhagen, Chris Roose, advertising copywriting guru and 'creative' in specialist pharma ad agencies, scored a first for an EMWA member during the summer by devising and writing a show that ran in London's West End. OK, so it was one of the West End's smaller theatres, but you have got to be impressed (Hey Chris, how about an article for *TWS*?). Julia Forjanic Klapproth has actually published her poetry in a literary journal (a movie deal is being negotiated).

So we are a diverse bunch, and as more and more different facets of medical communication become represented among our membership, the greater the opportunities to share and learn from each other. Our membership is now over 300 as EMWA keeps growing in numbers and variety. This has been achieved almost entirely by word of mouth, so keep spreading the word. Here's to 400 members by next spring.

Best wishes

Geoff Hall
58 Church Road
Worcester Park
Surrey, KT4 7RW, UK
Tel: (+44) 181 715 1368
Fax: (+44) 181 715 1369
medwritehall@worldscope.co.uk

The 301 members by country:

147	UK
40	Germany
23	Belgium
18	France
11	USA
10	Netherlands
10	Sweden
8	Switzerland
8	Ireland
5	Spain
5	Denmark
5	Italy
3	South Africa
2	Austria
1	Iceland
1	Israel
1	New Zealand
1	Norway
1	Singapore
1	Australia

151 are also AMWA members.

Pricing Strategies for Freelance Medical Writers

by Laurie Lewis

Adapted from an article printed in the AMWA Journal, Vol 14, No. 2, 1999.

All freelancers have qualms about pricing. For those who recently took the plunge into self-employment, pricing anxiety accompanies practically every new assignment. Even seasoned freelancers experience uncertainties about their fees from time to time.

At its simplest, the pricing decision consists of two specific questions: What method of pricing should you use? What dollar rate should you assess? Beyond these two basic questions, which must be answered for every job, lurk other concerns. Are you asking enough for this particular assignment? Will you lose the job if you ask for more? Can you charge client A top dollar, because you know the corporate pockets are deep? If you charge client B, a small nonprofit operation, less than your usual rate, will you set a bad precedent? How often can you raise your rates? By how much?

Selecting the Best Pricing Method

Freelance writers have many options in pricing. The most common methods are to assess a flat fee or project rate, to charge by the hour, to work for a per diem rate, to arrange a retainer, or to be paid by the word or page. Most writers use several of these methods, each method having advantages and disadvantages, depending on the particular assignment, the freelancer's working style, and the idiosyncrasies of the client.

Project rate — A project rate can be the best choice or the worst choice for the freelancer. With project rates, you have to commit in advance to a fee, often before you know much about the job. If you set the rate high enough to cover all unforeseen disasters, the result can be more than satisfactory. On the other hand, if you agree to do a job for a flat fee and the project becomes bigger or more complicated than you were led to believe, the result can be horrendous.

Hourly rate — When you don't know enough about a job to set a reasonable project rate, an hourly fee may be the best pricing strategy. That way, if the assignment ends up taking 30 hours instead of the 20 that the client anticipated, you will get paid for all your labor. Also, hourly fees may be the best approach for freelancers who operate at a slow pace.

Per diem — Some freelancers like to charge a fixed rate per day, but I generally shun this method of pricing. The problem with a per diem arrangement is that the freelancer and the consultant have to agree on the definition of "day." Is it an 8-hour work day? Or 24 hours? Or until the job is done? The one time I think a per diem method of pay makes sense is for meetings, especially out-of-town affairs. Traveling takes time, and these are hours that might otherwise be billable. A per diem rate allows for compensation when attending meetings, for example, or when sharing a cab with a client.

Pricing Strategies for Freelance MWs

Retainer — A retainer works best if the freelancer does the same work in each payment cycle, whether that is defined by a period of time (such as a monthly retainer) or by a project (like an issue of a newsletter). Retainers can be poor arrangements if the work is unpredictable or if the client expects the freelancer to be available on demand, regardless of other commitments.

Page and word rates — Unlike many other methods of payment, the freelancer rarely sets the page or word rate; it is dictated by the client. The main caveat regarding the page-rate method, surprisingly, is the definition of "page." Most writers assume that it is a double-spaced typed page, which usually translates in the US into 250 words. The client, though, may have another definition in mind: a single-spaced typed page (which means twice as many words), a double-spaced page typed in a small font with narrow margins (which may squeeze 350 to 600 words into a page), or a typeset page (even more words). If you agree to work at a page rate—or any other rate—that the client sets, be sure you are speaking the same language.

Narrowing Down the Going Rate

There are two ways to learn what the market will bear: ask the client, and ask the competition.

Whether you decide to bill by the project, hour, day, or some other method, you still need to determine exactly what rate to charge. In all probability, you will want to charge within the range of rates earned by your colleagues. If you ask much more, the client will probably look for another freelancer. If you ask much less than the going rate, the client will likely think you are not a professional and, again, will seek help elsewhere.

There are two ways to learn what the market will bear: ask the client, and ask the competition. Clients can be surprisingly reticent to reveal what they expect to pay for a job. They often insist that the freelancer suggest a price, hoping to save a buck or two if the figure is less than the budget. You may find it easier to learn the going rate from your colleagues. Get to know other EMWA members so you'll feel comfortable calling them for pricing advice. Also, encourage group surveys to use as starting points.

The last nationwide AMWA survey of freelance rates was part of the 1994 AMWA Salary Survey (see the *AMWA Journal*, vol. 10, no. 2, 1995). This survey assessed rates earned in 1993, so it is now quite dated. The results of the survey were presented in terms of hourly rates. The mean hourly rate reported by the 95 writers was $64.50; the median was $54.50. Rates were considerably lower for the 86 AMWA members who placed themselves in the "writing and editing" category: a mean of $45.90 and a median of $43.60.

In the spring of 1996, the New York AMWA chapter conducted an informal freelance rates survey, to which 40 members responded. Most often, hourly rates for writing ran between $60 and $70 (full range: $25-$125), while fees for editing centered around $45 to $50. The survey also collected information on project fees earned for the types of work we typically do. As shown in the following table, the rates reported by New York freelancers varied widely, even for pharmaceutical-sponsored work. (Anyone who has been in this business more than a month knows that drug companies and their agencies pay a lot more than book and journal publishers.)

Project Rates Reported by AMWA-NY Members in 1996 for Pharmaceutical-Sponsored Writing

Project	All Responses*	Most Common Rates*
Journal article	$1,200-10,000 (22)	$2,000-4,000 (12)
Monograph (40 ms pages)	$1,500-25,000 (19)	$4,000-6,000 (10)
Slide kit (20 slides)	$1,000-10,000 (17)	$2,000-2,500 (12)
Review article	$1,500-15,000 (16)	$2,500-4,500 (8)
Newsletter (8 printed pages)	$1,000-8,000 (13)	$2,000-3,500 (7)
Video script (20 minutes)	$2,500-7,500 (10)	$3,000-5,000 (6)

*In the All Responses column, the number in parentheses is the number of writers reporting fees for this type of project. In the Most Common Rates column, the number in parentheses is number of writers reporting fees within this range.

This spread should convince freelancers that the notion of a "right fee" is a myth. The right fee is whatever you can get.

The Only Rules for Pricing

If fee-setting seems to have no bounds, rest assured that a few rules do exist. I limit the rules to two, both of which involve the same principle: Think before you talk to the client. I can't take credit for the first rule. It is advice that I heard the first time I ever attended a meeting of freelancers and wisdom I've heard repeatedly since. This principle has saved me (a notorious low-baller) on numerous occasions. *Rule no. 1: Never quote a price on the spot. Get as much information as you can about a job. Then take time to assess the project thoroughly and calculate the best rate.*

The second rule of pricing almost could be considered an extension of the first rule. I distinguish them only to emphasize the time period that should separate the conversations between client and freelancer. Rule no. 1 warns the freelancer not to answer impetuously when the client first inquires about the fee; rule no. 2 cautions against a rash reaction when the client responds to the bid. Rule no. 2: Before quoting a fee, determine the lowest acceptable rate—and the concessions you want if you have to go that low. Never agree to work for less than you know a job is worth and your services merit. Do not regret losing a job that pays less than it is worth.

You have much to do between your initial conversations with the client and presentation of a bid. What you do during this period will affect your pricing success. You won't receive financial compensation for this work, but you will be rewarded in the long run by obtaining the best possible fee for the job at hand.

The right fee is whatever you can get.

Begin by reviewing everything the client told you about the job. Based on your experience, you will probably come up with a list of points that the client failed to mention. Consider the merits of different pricing strategies (e.g., hourly rate, project fee) for the particular job. Talk to other freelancers about the going rate for this type of job from this type of client. Then, based on all the information that you have garnered, calculate the fee. Use several methods, if possible, to arrive at the best price. Once you've figured out what you want, consider how low you are willing to go if the client won't meet your price. Decide what concessions you would like if you can't get top dollar: more time, for

example, or asking the client to assume responsibility for part of the job (such as incorporating final-round changes). Only when you have thoroughly calculated the best and the lowest acceptable fee, as well as your negotiating strategy, are you ready to talk price with the client.

Getting the Most Mileage From Your Records

The secret to pricing success lies in the records you keep for each job you undertake. The most useful type of project log lists every task performed during an assignment and the amount of time each task required. For medical writers, common tasks include client meetings, background reading, interviews, preparing an outline, writing the first draft, editing the draft, developing tables and figures, and incorporating reviewers' changes. As you begin each task, list it on your project log. Note how long you spend on the task, adding to the tally whenever you return to that aspect of the job. Also include on the project log other information that will help you calculate your average speed in completing various tasks, such as the number of pages written. Keep this kind of record for every job, whether you are being paid by the hour, the day, the word, or the project.

When you have to price a job, list the tasks that will be involved in the new assignment, then scour your records of old projects that involved similar tasks. How long did it take you to do all of these tasks in the past? If you once spent 10 hours doing a comparable job, your fee should cover at least 10 hours of labor, preferably more. This is especially important when quoting a project rate or some other type of flat fee, such as a per diem. Some freelancers work with average time allowances, but I prefer to use ranges (best-case, typical, and worst-case scenarios) to get the best pricing option. Once you have calculated how long you can expect all aspects of a job to take, multiply the total number of hours by the hourly rate you would like to make. Augment the fee to cover expenses that won't be reimbursed. If working only with an average scenario, add a cushion to protect yourself in case the job turns out to be anything but normal. You now have a fee based on your own experience.

One reason I like task-oriented project logs is that they remind me that a writing assignment entails much more than writing. Sitting at the computer and producing words may account for only one third of the time spent on an assignment. A client who says, "You should be able to write this in a few hours," is not telling the whole story. It may take a few hours just to prepare for writing and several more to revise the work with the client's input.

Analyzing Your Fee-Setting Success

Re-examine your pricing strategy before filing a completed job. Begin by calculating how much you earned per hour, even if you didn't bill on an hourly basis. To calculate the "effective hourly rate," simply subtract nonreimbursed expenses from your total earnings and divide the difference by the number of hours logged. Compare the effective hourly rate with your standard hourly rate (if you have one), with the rate you hoped to earn, and with the amount you would have earned if you had charged on a different basis.

Ask yourself relevant questions, such as:

- Would an hourly rate have been better than the agreed-upon project fee?
- Would per diem compensation have made more sense for this job?
- Is the word rate the client paid fair for the amount of work involved?

Compare your actual project log with the time-estimate worksheets you used to set the fee. How accurate were your estimates? Did you neglect to account for major portions of the work? Did the project grow beyond what your client led you to anticipate? Did you guess that certain tasks would be more time-consuming than they actually were, thereby earning yourself a heftier effective hourly rate than expected? Did you buckle under pressure and accept less than your estimates told you the job could be worth?

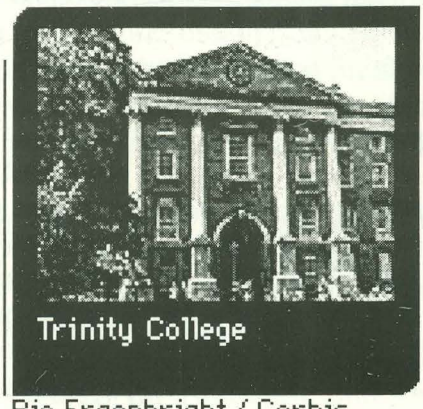
The results of each project analysis can be applied to make future work more profitable. Don't repeat past price-setting mistakes. Do stick with strategies that reward you well for your time and effort.

Another excellent time for analysis is the end of the year, when you are totaling your income in preparation for your final tax estimate. Take a few moments to analyze your income by client, by pricing method, and by type of work if you are a multitalented editor/writer/desktop publisher/whatever.

I am always amazed that many freelancers do not analyze their fee-setting practices. There's no better way to hone your pricing skills than to discover your mistakes and to replicate your successes.

Laurie Lewis
64 E 94th Street, Apartment 5F
New York, NY 10128 USA
Fax: (+001) 212 369 4434

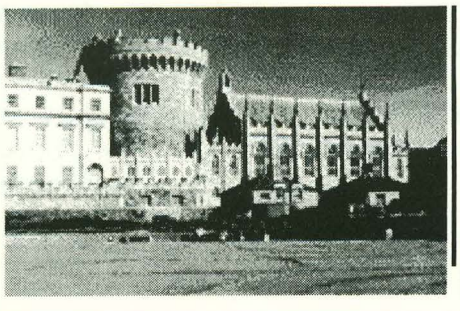
Laurie Lewis has written a book, *What to Charge: Pricing Strategies for Freelancers and Consultants*. It is available from Aletheia Publications, 46 Bell Hollow Road, Putnam Valley, NY 10579. Tel: (+001) 914 526-2873. Fax: (+001) 914 526 2905. E-mail: AlethPub@aol.com. Web site: http://members.aol.com/AlethPub



Ric Ergenbright / Corbis

The land of Celtic mystique,
literary Giants and
the dark brew beckons thee...

The EMWA millenium Conference Dublin, Ireland May 9 -12, 2000



Millennium Conference: Dublin 2000

Dublin is the venue for the 9th International EMWA Conference. The conference will be held at the Stakis Dublin Hotel, located in the centre of the city overlooking the Grand Canal. The hotel is located close to the shopping and business area of the city and close to Stephen's Green, the largest garden square in Europe. The city's many attractions are within walking distance of the hotel.

Workshops:

The conference will extend to 4 days with an increase in the number of workshops. There will be 20 workshops, with 8 for AMWA/EMWA certification credit.

The conference will begin on Tuesday afternoon with 4 workshops, followed by 4 workshops in the morning and 4 in the afternoon of both subsequent days.

Official Social Programme

Wednesday night: The conference banquet will be a "Shindig" at the Old Jameson Distillery situated in the heart of old Dublin. The "Shindig" consists of a walking tour of the recreated distillery culminating in whiskey tasting in the Jameson bar. A five course dinner is served followed by musicians playing a wide variety of traditional and contemporary Irish songs and ballads with a selection of Irish dances.

Thursday evening: there is a choice between:

- the Dublin literary pub crawl, described by *In Dublin* Magazine as, "A highly enjoyable evening that gives you the pleasant notion of simultaneously replacing brain cells as you drown them....."
- a visit to a restored Georgian House
- a visit to Dublin's Writers Museum or the Viking Centre

Unofficial Social Programme

Nowhere in the world has a better selection of pubs, bars and other social watering holes than Dublin. Thus, we will have almost infinite possibilities for networking, socializing and making new friends.

The conference registration pack will be sent out in January. This will include details of final registration costs, workshops on offer and accommodation at the Stakis Dublin Hotel. The pack will also contain information on alternative accommodation, entertainment in Dublin, maps and details of flights to Dublin.

Kay Duggan-Walls
Conference Manager
Quintiles (Ireland) Limited
e-mail kduggan@qdub.quintiles.com

The pleasure of being a "non-native":

How rootless wanderers find their ideal corner among thick dictionaries

by Ernesta Palombo-Kinne

Hilde Joosen has called for a dialogue on the issues related to being a non-native English speaking medical writer [TWS, 8:16-7, 1999]. As an Italian who has been living in Germany for the last 11 years (after having spent a few years in the United States), the "non-native" business is a three-headed monster that often takes paradoxical twists. You can hear the noise when the brain tries to sort the right drawer in the right situation (English-German at work; English-German-Italian at home).

Not only are we non-native English speakers, but we typically work in a non English-speaking environment. Even if most of our clinical or research colleagues are fluent in English, their documents are, editorially speaking, based on a non-English style. The British/American English dilemma, for example, remains a mental obstacle for those who have learnt their English in Europe but must write their documents in American English. We also are constantly faced with academic titles or denominations that do not have a counterpart in the British or American educational system, or that are stated in a country-specific style. Those of us who work in Germany know the long lists of Prof. Prof. Dr. Dr. titles in front of a single name; although clearly defining the academic weight of the person, these must be mercilessly reduced to a one-piece "Prof." or "Dr."; or the formulation "Dr. X. Such, MD", which must also be mercilessly cut at one end.

My Italian origin spoils me to the use of Latin-root terms (supposedly more elegant, what a kick for a "non-native")

I always have at hand the Webster's Style Manual of the New Encyclopedic Dictionary, for example to convince myself (and the pluri-professors I intend to declass) that such disrespectful rules truly exist (whereby I can also save my neck). Rather than consulting concise dictionaries, I also rely massively on the unabridged Webster's (comfortably open on my left side). This is for three reasons: My Italian origin spoils me to the use of Latin-root terms (supposedly more elegant, what a kick for a "non-native"); sometimes I resort to thinking in Italian when I am dissatisfied with a certain English formulation. By doing so, however, I often end up anglicising terms that do not exist at all. Verification from the big Webster's not only saves me from big embarrassments, but also represents a constant source of learning. The second reason is that the automatic correction of the word-processing underlines many terms that are actually correct, if only unusual or medical/technical (cause of severe irritation for somebody who writes medical texts *and* survives anglicising Italian terms!). The third, and in fact more frequent reason, is that large dictionaries provide more examples of which preposition must be used after a certain verb (and I tell you, this is not a joke if three languages strive for supremacy).

A typical "non-native" problem is also the use of terms loaded with a country-specific valence. In Germany, for example, the term "subject", commonly used in UK and USA to define healthy volunteers [TWS 8:18-20, 1999], is not appreciated very much (I suspect because "*Subjekt*" implies a subordinate/impersonal position of the person receiving a certain treatment).

More generally, we are confronted with the necessity that our terminology also be accurate in its legal implications. Although we do not bear any primary medical/legal responsibility for our documents, it is part of our profession to provide our (mostly "non-native") clinical colleagues with a high quality text. While this may prolong the completion time compared to "natives", I console myself thinking that after all, the legal/administrative slang is Greek to everybody, "native" or "non-native".

The medical-scientific terminology (for example laboratory parameters or disease definitions) is mostly regulated by our companies. However, no matter how standardised, the medical terminology is immense and the abbreviations endless. The "Medical Dictionary in Six Languages" (Raven Press) can already deliver a certain relief, especially with its smart 6-column cross-comparison. However, I could not survive without the (comfortably open on my right side) Stedman's Medical Dictionary. Although, or perhaps because, I trained as a medical doctor and worked in research for some years, the scrupulous checking of every doubtful definition gives me added confidence. In this aspect, Hilde is absolutely correct: accuracy can transform our language weakness into communicative strength, because as long as we are looking for a term, why not look for the most accurate one? Indeed, our starting handicap trains us to the general philosophy: if good, why not better?

Accuracy can transform our language weakness into communicative strength, because as long as we are looking for a term, why not look for the most accurate one?

Medical writing, as we've all experienced, is a painful/delightful mixture of editorial and scientific skills. To learn how to couple sound content with impeccable form involves several years of professional education and experience. For "non-natives", a scientific training in English-speaking countries remains the easiest way to grow up to the professional expectations, especially if laboratory heads, acquainted with publishing in first-class journals, are capable of transmitting their enthusiasm for scientific writing (on this occasion, may I mention Dr. Louis Sokoloff, NIMH, Bethesda, MD, for his demanding but selfless dedication to his "non-native" alumni).

The experience in a multicultural laboratory also teaches a basic lesson: in the end, country-specific systematic mistakes can be easily identified and listed in a ready-to-use "don't" lexicon (I can cite the Italians' tendency to slip a "partecipate" because it is nearly identical to the Italian "partecipare", and the Germans' "with so-many years of age"). Silvia Rogers, in her Copenhagen seminar on "Medical/Technical English for Non-native Speakers", has already provided us with a robust list of possible pitfalls and improvements, based on her multi-national professional experience. We can proceed

with and customise her list for our purposes. Once we have identified our weak spots, gaining control of the English language becomes a progressive, balancing exercise between what we have learnt (no matter how simply we write at the beginning) and what represents our next learning challenge. Additional updates on emerging terminology can then be achieved via med-line searches.

So, being a "non-native" medical writer can definitely be a pleasure. Belonging nowhere and everywhere (language-wise but, who knows, perhaps also mentality-wise) prepares us to understand hidden lines that must be rendered in a good written form. Being anchored with a few familiar dictionaries helps us to tame the daily load of scientific matter.

Ernesta Palombo-Kinne
Jenapharm
Otto-Schott-Str. 15
D – 07743 Jena, Germany
Tel: (+49) 3641 64 6110
Fax: (+49) 3641 64 6376
ernesta.palombokinne@schering.de

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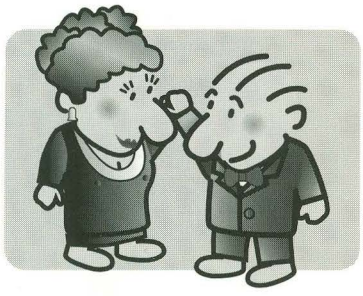
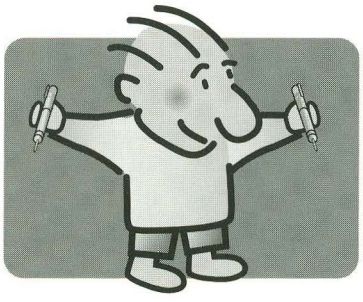
Real Life Stories



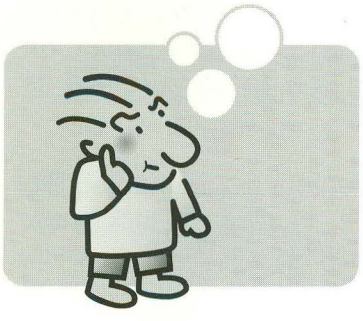
Learn from other people´s experiences living with diabetes.
Real Life Stories is a collection of over 100 stories that touch everyday situations and emotional issues of life with diabetes.

Diabetes Encyclopedia



Search the Diabetes Encyclopedia to find detailed information about diabetes-related issues.

Diabetes Quiz



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Can Europe Become One?

by Katharine Gladstone

Over one and a half millennia ago, the Roman Empire ruled Europe. As we enter the next millennium, Europe is attempting to unite once more. Do Europeans believe that they will succeed where the Romans ultimately failed?

Thirty years ago, Europe was at the forefront of science, discovering 65% of the world's new medicines. In 1997, out of 47 new substances in the world, only 19 (40%) were discovered and developed in Europe. The European pharmaceutical industry has weakened and in order to remain competitive with the global market, European countries are combining their political and economic strength to form a single market. As the European Union (EU) began to integrate the European pharmaceutical industry, they uncovered a wealth of problems.

Do Europeans believe that they will succeed where the Romans ultimately failed?

The EU improved the drug approval process as a first step towards a single market. Previously, each EU country approved medicines according to their own set of regulations and specifications. Medicines were often reconfigured to meet requirements in another country. This was an extremely costly process as well as a barrier to the free circulation of medicines. The EU, therefore, created the European Medicines Evaluation Agency to evaluate drugs centrally. In addition, the mutual recognition approval process was introduced, which recognised that one country's regulations could offer equivalent levels of protection to that of the others.

Despite integral flaws in current approval processes, the EU have created a more unified market together with the means to bring products to the market more effectively. By 1997, trade in the European pharmaceutical industry was looking more promising. The EU produced ECU 87,000 million worth of products, that is 40% of global production. The trade balance (the balance of exports and imports) for the EU was ECU 15,000 million in Europe's favour. Two-thirds of this income was spent on research and development. However, Europe still has a long way to go to regain its competitive share of the global market.

Improving the drug approval process alone is not enough to create a single market. Big differences exist between the national markets, for example, in disease incidence, standard of living, demand for and consumption of pharmaceuticals, distribution costs, and health care systems. Drug demand is further complicated by the interactions of the patient, the prescribing doctor and social security bodies.

All these factors summate to large variations in drug pricing across European countries. Each country controls drug prices either directly or indirectly by policies that affect prescription and demand. These price differences have created a parallel market. Traders can buy medicines in a 'low-cost' country to sell for profit in a 'high-cost' country. Ultimately, the patient and the health care systems suffer from the loss of profits.

At the end of 1998, the EU met to discuss their next move. "We realise that we have to consider whether the Single Market means having the same price, and if we were to have the same price what the price would be" Martin Bangemann, the EU Industry Commissioner, reported ("Speech by Martin Bangemann, Member of the European Commission at the Second Frankfurt Round Table on the Pharmaceutical Single Market" at www.europe.eu.int). He added that "having prices converge to the level at which they are in the lowest-price countries would mean that research would in future be undertaken outside Europe or not at all. Selling medicines throughout Europe at the higher level would mean potentially denying citizens of medicines".

Nneither option, that is, to leave drug prices as they are or to force price convergence, was viable. The EU agreed that the aim of the single market is to give patients access to the medicines they need at affordable prices and to create incentives for innovation and industrial development. To achieve these aims, they are taking a 'middle way' approach. Drug companies and the public authorities of individual countries are being encouraged to negotiate reasonable prices and profit margins that also allow companies to sustain competitive research and development.

The EU have also grouped the market into three sectors: non-prescription, out-of-patent and in-patent drugs. They identified ways in which to stimulate competition in each of these areas. In 2000, the EU will review the licensing system for generic (out-of-patent) medicines, to encourage the use of generic products. They also plan to remove price controls on generic and non-prescription drugs. The extent to which price controls for in-patent products are relaxed will depend on the alternative treatments available. For example, a company thato produces a new drug for which there are no existing alternatives is in a strong position. In this situation, liberalisation could result in higher prices for patients and health care systems.

The success of the EU's actions remains to be seen, especially amidst growing pressures on countries to cut expenditure on public health, a lack of effective mechanisms for setting the price of new pharmaceuticals, delays before new products reach some parts of the European market, and the enlargement of the EU to countries with relatively low per capita incomes. In addition, the EU has failed to tackle the effect of the increasingly prevalent use of electronic commerce via the internet.

Will the disharmony of European cultures block the path to a unified Europe? Even if the EU achieves its goals for the pharmaceutical industry, can one Europe be sustained? Over a millennium ago, the Roman Empire collapsed, leaving Europe fragmented into petty states. But culture, technology, economics and politics have progressed. On the eve of the next millennium, the stage is set for Europe to become one.

UK DRUG PRICE REDUCTIONS

Prices of brand prescription medicines were cut by 4.5% in a new UK scheme effective from the 1st October 1999 to reduce pressures on the National Health Service (NHS).

The price cuts apply to all UK or other EU market-authorised brand medicines supplied to the NHS. The UK pharmaceutical industry reluctantly agreed to the cuts but recognised the benefits of the scheme. Competitiveness of the industry in the world market will be improved, so that £7 million a day can continue to be invested in the research and development of new medicines.

UK FACTS

The NHS:
- drugs bill is £5-£6 billion per year (about 25p per person per day).

The UK pharmaceutical industry:
- invests 20% of its turnover in UK research and development (£2 billion),
- exports £5 billion; imports £3 billion; leading to a trade surplus of £2 billion,
- creates 300,000 jobs,
- saves the NHS £10 billion a year due to decreased hospital admissions,
- pays £400 million Corporation Tax to the government,
- funds half the cost of all General Practitioner further education and training,
- provides £100 million support to academia,
- developed 7 out of the current top 25 medicines world-wide.

The UK spends half that of France or Germany on medicines per person.
The UK is the largest user of generic medicines in Europe but the lowest user of new medicines.

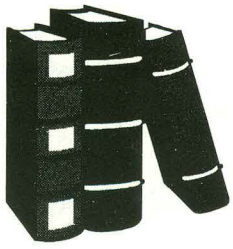
Katharine Gladstone
1 Spring Grove
Hampton, TW12 2DP, UK
Tel and Fax: (+44) 181 286 8695
katharine@sgladstone.freeserve.co.uk

The Lighter Side: What they Really Mean

Sent to TWS by an EMWA member after a long e-mail chain.

People seem to think that what separates scientific writing from other kinds of writing is that scientific writing simply describes the facts and data in an objective manner. As anyone in the field knows and the following examples clearly illustrate, however, this is far from what really happens. How many of us have not seen one of these?

When they write:	*What they really mean is:*
• It has long been known	• I haven't bothered to look up the reference
• It is believed	• *I* think
• It is generally believed	• A couple of other guys think so too
• It is not unreasonable to assume	• If you believe this, you'll believe anything
• Of great theoretical importance	• I find it kind of interesting
• Of great practical importance	• I can get some mileage out of it
• Typical results are shown	• The best results are shown
• Three samples were chosen for further study	• The others didn't make sense, so we ignored them
• The four hr sample was not studied	• I dropped it on the floor
• The four hr determination may not be significant	• I dropped it on the floor, but scooped most of it up
• The significance of these results is unclear	• Look at the pretty artefact
• It has not been possible to provide definitive answers	• The experiment was negative, but at least I can publish the data
• Correct within an order of magnitude	• Wrong
• It might be argued that	• I have such a good answer for this objection that I shall now raise it
• Much additional work will be required	• This paper is not very good, but neither are all the others in this miserable field
• I thank X for assistance with the experiments and Y for useful discussions on the interpretation of the data	• X did the experiment and Y explained it to me



In the Bookstores . . . Peering at Peer Review

by Karen Shashok

Fiona Godlee and Tom Jefferson, eds. Peer Review in Health Sciences. London: BMJ Books, 1999. ISBN 0 7279 1181 3

Members of EMWA who work closely with authors in preparing manuscripts for primary publication have probably been surprised, frustrated, disgusted, or at least bemused by apparently unjustified criticism• or even rejection• of a paper. Other colleagues may have wondered how peer review actually works, and what standards guide authors, reviewers and editors in making manuscripts acceptable for public dissemination. How are reviewers selected? How much weight do their opinions have in determining the editor's decision? Would readers agree with these decisions if they had access to manuscripts that were not accepted?

The most important message this book aims to transmit is that peer review, at least as it is practiced in biomedicine, is an untested and possibly unreliable way to decide what gets published or funded, and what doesn't. As the editors state in their introduction (p. xi), peer review is "a process with so many flaws that it is only the lack of an obvious alternative that keeps the process going". Colleagues who are shocked by this statement may also be surprised to learn that there are no universally accepted standards for running a peer review system. In fact, much research is now being devoted to discovering what peer review can and cannot do, and how the process can be improved to make it more transparent, professional, and accountable.

The most important message of this book is that peer review, at least as it is practiced in biomedicine, is an untested and possibly unreliable way to decide what gets published or funded

The contributors to this book are among the most respected "editologists" and "journal-ologists" in the world. A total of twenty chapters, divided into three parts, provide a clear, detailed overview of research on peer review, current practices, and possible changes that might make it better in the future. The chapters are sensibly organized with well-deployed subheadings, and most of them end with a concluding section that summarizes the main points or offers recommendations for action.

An especially useful feature of this book is that it also considers peer review in settings other than "international" primary journals, with chapters that examine the process in grant applications, economic studies, the pharmaceutical industry, and in smaller, society-sponsored journals that may publish in a language other than English. One chapter is devoted to ways in which using the Internet for peer review might help to make it faster, fairer and more effective; there is also a chapter on statistical peer review.

A chapter aimed specifically at editors advises on how to set up a peer review system; another explains to reviewers how to provide useful feedback on a manuscript; and a most welcome contribution written for authors recounts the main stages in scientific peer review and publication, and divulges how to communicate effectively with editors and reviewers. This chapter should be required reading for anyone who plans a research career in the health sciences.

A theme that is repeated throughout the book is the need for further research, and for efforts to design studies that will overcome the methodological limitations of much of the work done to date. Readers who may wish to investigate peer review from outside the medical research community (for example, sociologists, psychologists, managers, translators, and experts in English for special purposes) may be put off by the emphasis on study designs that attempt to imitate the quantitative methods of prospective, randomized, controlled trials. After all, peer review is essentially a human process, and attempts to understand and improve it may well benefit from input by other academic disciplines that use descriptive methods and other strategies to identify variables, outcome measures, and potential confounders.

People who are already familiar with the ongoing debate on peer review will find in this book a useful compendium of information and sources, although they will notice that a few general medical journals, i.e., *British Medical Journal*, *The Lancet* and *JAMA*, dominate most of the lists of references provided at the end of each chapter. For people who may wish to use this book as a starting point for their own research on peer review, the index will unfortunately let them down. Many potentially useful entries are missing, and many others refer the curious reader to a just one page of this 258-page work. Because of inadequate cross-referencing between chapters, important information on specific points of interest may be overlooked.

Like any other research problem, peer review will never be completely "solved". It will evolve as the technology of scientific publication changes, and as authors increasingly demand accountability, fairness, speed, and the right to appeal. As noted in the final chapter, peer review is entering a period of rapid change which follows a few hundred years of complacency grounded on unproved assumptions of editor and reviewer competence and objectivity. This book, along with the international congresses on peer review (the fourth to be held in Barcelona in 2001), marks a historical change in attitude by both the producers and the gatekeepers of biomedical knowledge, who now recognize that the biases inherent in peer review need to be identified and, if possible, removed.

Karen Shashok
Translator and Editorial Consultant
C/ Comp. Ruiz Aznar 12, 2-A
18008 GRANADA, Spain
fax +34-958-132354
email kshashok@ctv.es

Meetings of Interest

The following list is presented as a service to EMWA members and is not meant to be complete. EMWA does not endorse these meetings in any way. Those having the **[EMWA]** symbol include presentations from EMWA members. If you would like to have something listed here to share with other members, please contact Barry Drees (details on back cover).

Date	Meeting/Sponsor	Location
Dec 6-7	**Centralised and Mutual Recognition Procedures** IBC Global Conferences Ltd. Gilmoora House, 57-61 Mortimer St., London, W1N 8JX, UK Tel: (+44) 171 453 5496; Fax: (+44) 171 636 6858; www.ibc-uk.com/LY1169	London, UK
Jan 19-21 May 8-10	**Effective Pharmaceutical Project Management** Rostrum Personal Development Mildmay House, St Edwards Court, London Rd, Romford, Essex, RM7 9QD, UK Tel: (+44) 1708 776 016 or (+44) 1708 735 000	London, UK
Feb 9-10	**Being Assertive in Your Role** Rostrum Personal Development Mildmay House, St Edwards Court, London Rd, Romford, Essex, RM7 9QD, UK Tel: (+44) 1708 776 016 or (+44) 1708 735 000	London, UK
Mar 8	**Interpreting Clinical Laboratory Data** Rostrum Personal Development Mildmay House, St Edwards Court, London Rd, Romford, Essex, RM7 9QD, UK Tel: (+44) 1708 776 016 or (+44) 1708 735 000	London, UK
May 2-3	**Effective Medical Writing** Rostrum Personal Development Mildmay House, St Edwards Court, London Rd, Romford, Essex, RM7 9QD, UK Tel: (+44) 1708 776 016 or (+44) 1708 735 000	London, UK
May 4-5	**Beyond Electronic Document Management** Drug Information Association Postfach 4012, Basel, Switzerland Tel: (+41) 61 386 9393; Fax: (+41) 61 386 9390; www.diahome.org	Edinburgh, UK

EMWA's Winter Workshop Meeting

Leander Club, Henley-on-Thames, England

December 13, 1999

Presenting:

- **Writing the Final Report of a Clinical Trial**
- **Punctuation for Clarity and Style**
- **Bibliographic Resources**
- **The Biomedical Paper**

Coming next issue . . . (Winter 99/2000)

☞ NEW FEATURE!

Regulatory Questions and Answers: the Investigator's Brochure
Douglas Fiebig

As the first offering in our new series, we look at the seemingly irreconcilable goals of making an Investigator's Brochure attractive enough to get the investigators to read it while still keeping it simple enough for the next update and getting it finished on time.

The Changing Face of EMWA
Geoff Hall and Barry Drees

A comparison of the results of EMWA surveys past and present including the best ever response to an EMWA survey, the almost 100 responses to the survey included in TWS last winter.

The Fastest Pen in the West
Adam Jacobs

The man in the white hat returns with a creative surprise for TWS readers to start off the new millenium.

The Medical Translator's Dilemma: Shall I, Shan't I?
Anne Bartz

Some people come to medical writing not from the natural sciences, but rather from a linguistic background, as former translators. Find about the other side of life as an EMWA member expands her horizon from medical translating to medical writing.

We will also have our regular features (From the Editor's Desk, Message from the President, Meetings of Interest, Vital Signs, From the Literature, The Lighter Side, etc.). Until then.

Department of Corrections:
Summer 1999; Vol 8, No. 3

On page 20, in *Vital Signs*, the response to one of the comments from a reader noted, "we did have something from an ethicist in Vol. 7; no. 3 (1988)."

There was not only no journal, but also no EMWA in 1988! The correct reference is Vol. 7; no. 3 (1998).

EMWA Executive Committee

President:
Geoff Hall
58 Church Road, Worcester Park, Surrey, KT4 7RW, UK
Tel: (+44) 181 715 1368 Fax: (+44) 181 715 1369
medwritehall@worldscope.co.uk

Vice-President & Programme Manager:
Keith Veitch
R&D Management (B.60/H315)
SmithKline Beecham Biologicals
Rue de L'Institut 89
B-1330 Rixensart, Belgium
Tel: (+32) 2 656 9632
Fax: (+32) 2 656 8113
veitch@sbbio.be or
keithveitch@compuserve.com

Treasurer:
Barbara Grossman
Covance
7 Roxborough Way
Maidenhead
Berks, SL6 3UD, UK
Tel: (+44) 1628 548 182
Fax: (+44) 1628 547 333
barbara.grossman@covance.com

Membership Officer:
Julia Forjanic Klapproth
Hoechst Marion Roussel
Clinical Development
Bldg. H840
D-65926 Frankfurt, Germany
Tel: (+49) 69 305 82982
Fax: (+49) 69 305 80070
julia.forjanic-klapproth@hmrag.com

Immediate Past President:
Gerold Wilson
Schering AG
Berlin, Germany
Tel. (+49) 30 468 15287
Fax. (+49) 30 468 14768
gerold.wilson@schering.DE

Public Relations:
Jane Stock
97 Ashen Grove
Wimbledon Park
London SW19 8BJ, UK
Tel: (+44) 181 241 1243
Fax: (+44) 181 241 0456
jane.stock@dial.pipex.com

Website Manager:
Marian Hodges
6 Highfields
Ashtead
Surrey, KT21 2NL, UK
Tel: (+44) 1372 275 053
marian@molesoft.demon.co.uk

Education Officer:
Julia Cooper
Parexel International Ltd
River Court, 50 Oxford Road
Uxbridge
Middlesex, UB9 4DL, UK
Tel: (+44) 1895 864 403
Fax: (+44) 1895 864 323
julia.cooper@parexel.co.uk

Journal Editor:
Barry Drees
Hoechst Marion Roussel
Clinical Development, Bldg. H840
D-65926 Frankfurt, Germany
Tel: (+49) 69 305 3834
Fax: (+49) 69 305 80070
barry.drees@hmrag.com

EMWA Secretariat

Phillipa Clow, 10 Batchworth Lane, Northwood, Middlesex, HA6 3AT, UK
Tel: (+44) 1923 842 503 Fax: (+44) 1923 835 077
emwa@dial.pipex.com