Clinical Rehabilitation
Further Information for Authors and Reviewers

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Acceptance information to authors: outlines actions required by authors after acceptance of an article

The following section provides information for authors of an accepted paper. Areas highlighted by a box should be considered carefully.

Your paper has now been accepted for publication in *Clinical Rehabilitation*. This section explains what will happen next, to ensure a smooth path to publication, avoiding delays or extra work. **With your help**, your paper will be available ‘online’ (to subscribers) within 8-12 weeks. **Please read this section fully and carefully.**

Your paper has already been given an estimated month for publication in the paper journal. However it will be published as soon as it is ready as an **online publication**. The publication process will be outlined here.

1. The original files of the final, accepted version that you submitted have been sent to the publisher.
2. **You need to complete all the actions outlined in this section.** Further progress depends upon you undertaking this work.
3. *** You will have received an email about the formal copyright agreement; please complete the contributor agreement form immediately. Any delays in returning the form will result in delays to your paper being published online first ***
4. You should also ensure that you have completed the author information at the end of This section

**No action will occur until the corresponding author returns the copyright (on the website)**

5. The publisher will send the final copy of your paper including the title page, author details etc to a copyeditor for checking and corrections and editing if needed. The paper is then sent to the printers to make a proof. Once the proof is made, only corrections of differences between your submission and the proof can be made and you cannot correct errors in your original submission.
6. There are no further opportunities to correct the paper. Please double check now that your submission is completely accurate and complete. The “PDF Proof” attached to your acceptance email is what has been sent to the publisher and should be double checked using the checklist given later.
7. **A final proof** will then be emailed to you for you to check. Delays in your proofreading will delay publication; please ensure that a colleague can cover prolonged periods away from your email.
8. Once you have confirmed that you have read the proof, identifying any corrections needed, the final paper will be prepared for putting online.
9. The ‘online’ papers are uploaded in batches, usually once a month but sometimes more frequently. Your paper will appear online within four weeks of receipt of your proof corrections, provided you have returned the contributor agreement form. You will be notified when it is available online. It is found in “**Online First**” on the journal’s web-site ([http://cre.sagepub.com/](http://cre.sagepub.com/)) and is only accessible to subscribers unless you have chosen to use “Open Access”, when it is available to anyone freely. If you wish to use “Open Access”, contact the publisher.
10. In due course your paper will be published in the paper version of the journal. The actual date will be notified to you, but you already have an estimated month. In the meantime you can refer to it as “**in press**” and you can give the DOI for the web access version once it is on-line.
11. You cannot correct or alter the paper at all once it is published online. The journal is a record of actual publication. If a serious error is noted, a note may be published in the journal to draw attention to the error and its correction.
Please note

Contact
We need to make contact with the corresponding author during the publication process. Please fill in the table below and ensure that:

- You have made it explicit who is the corresponding author
- You have given at least two contact routes to that person, or at least one alternative author (Difficulties with emails, especially spam filters, often makes contact difficult):
  - Two email addresses on different servers, and/or
  - Email address and fax number, and/or
  - Two people with separate emails (preferably on separate servers)
- Any prolonged time out of contact is notified to sarah.taylor@sagepub.co.uk

Permissions

Copyright and permission to publish are vital. Please

- Ensure you have written permission to publish any:
  - Photographs of people
  - Figures or substantial chunks of text already published
  - Please return written permission from the original publishers or patient consent forms to the production editor at: sarah.taylor@sagepub.co.uk
- return copyright form

Your responsibilities

By submitting the paper all authors are also accepting and agreeing that:

- The work is original:
  - not published elsewhere
  - no significant pieces of text copied from elsewhere without due acknowledgement and indicating it by quotation marks.
- Any methods described are described accurately and honestly
- Any data reported are reported accurately and honestly
- Any relevant interests have been disclosed
  - Not simply financial interests, but anything that may influence your writing and interpretation and is not apparent from the paper itself

If you have any concerns, contact the editor immediately
**Author’s Checklist of final submitted text (as attached to email)**

The following checklist is provided as guidance for authors in checking the final submission of their paper (attached to acceptance email) for correctness and consistency throughout. Please read and act on This section fully and carefully.

<table>
<thead>
<tr>
<th>Item</th>
<th>Comment</th>
<th>Tick</th>
</tr>
</thead>
</table>
| Title page                  | Please ensure that:  
  - The title is correct  
  - Each author's name and address is present and correct  
  - The order of authors is clear and correct                                                             |      |
| Corresponding author        | Check that the corresponding author’s name and contact details are correct                        |      |
| Text                        | Please ensure the text is accurate, do all numbers add up correctly?  
  Please check:  
  - Any statistics cited in the text in relation to tables/figures are correct  
  - Check the consistency in the use of any mathematical symbols in the paper                          |      |
| Tables                      | Please check that:  
  - Each table is numbered and has a title (legend)  
  - Each table is mentioned in the text somewhere  
  - Each table mentioned in the text is given the correct number, and is present                      |      |
| Figures                     | Please check that:  
  - Each figure is numbered and has a title (legend)  
  - Each figure is mentioned in the text somewhere  
  - Each figure mentioned in the text is given the correct number, and is present  
  - Figures are in black and white and that the text does not refer to colour                          |      |
| References                  | Please check:  
  - The references in the text against the reference list, noting any inconsistency in spelling, dates etc  
  - Each numbered reference in the text refers to the correct reference  
  - Each reference given is complete and correct  
  - References are cited in numerical order in the text  
  - All references in the references list are cited in the text                                           |      |
| Permissions                 | Please ensure you have written permission to publish any:  
  - Photographs of people  
  - Figures or substantial chunks of text already published  
  - Please note, you must send written permission from the original publisher of work taken from other sources or patient consent forms to the production editor at: sarah.taylor@sagepub.co.uk |      |
| Contributor agreement       | No progress will occur until the contributor agreement form has been completed and returned to the production editor |      |
# Information about paper and all authors (please complete and email to publisher immediately)

<table>
<thead>
<tr>
<th>Title of paper</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Corresponding author</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Backup contact</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

For each author please fill in the details below. **Copy the table as many times as needed.**

<table>
<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Name</th>
<th>Post</th>
<th>Address</th>
<th>Telephone</th>
<th>Fax</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

- **Title**
  - Please indicate how you wish to be addressed
  - E.g. Mr, Mrs, Ms, Dr, Professor

- **Name**
  - Please give your first name and last (family) name (in that order)

- **Post**
  - Please give your job title

- **Address**
  - Please give your full postal address, starting each new line on a new line

- **Telephone**
  - Please give your phone number, with the international code if needed and with extension number if appropriate (direct dial is preferred)
  - E.g. +972-7-987-6778 ext 6534

- **Fax**
  - Please give your fax number, again with the international code

- **Email**
  - Please give your email. This is vital because this will be the preferred means of communication. Please double-check that it is correct and clear.
**Authorship:** guidance for articles submitted to *Clinical Rehabilitation*

This section gives some guidance on who should and should not be included as an author. The journal might occasionally question the authors, but primarily expects the authors and their employing organisations to monitor adherence to this guidance which is based on the “Uniform requirements for manuscripts submitted to biomedical journals: writing and editing for biomedical publication.” ([http://www.icmje.org](http://www.icmje.org)).

The uniform guidance states:

“Authorship credit should be based on

1) substantial contributions to the conception and design, or acquisition of data, or analysis and interpretation of data;
2) drafting the article or revising it critically for important intellectual content; and
3) final approval of the version to be published.

Authors should meet conditions 1, 2, and 3.”

The remainder of This section attempts to help people decide on who should and should not be an author. It should be stressed that this is guidance based on an internationally agreed code of practice; it is not a set of absolute rules. The extent to which someone fulfils all three major criteria is a matter for local discussion, and it would be unrealistic to expect all authors to have contributed equally in all three domains.

The table on page seven identifies some activities needed to produce a paper, and the table on page eight is a template that people might use to facilitate discussions concerning authorship:

- a) whether someone warrants being an author and
- b) the order of authors.

But it does not allow any conclusion on actual importance of contributions made.

The approach suggested is:

- List all people who have been involved to any significant degree
- For each person summarise the different activities that they undertook in relation to the study
- Then consider only those people who undertook one or more of the activities given in the first table
  - The other people should be considered for formal acknowledgement if they helped sufficiently
- Ask each person to estimate their contribution on a general level in each domain
  - None (0), minor (1), moderate (2), major (3)
- Then possibly use the second table to assess whether each person has contributed enough to warrant being a named author
  - They should have at least some contribution to domains A and B and C
    - If not, give an acknowledgement
- Then debate order of authors if necessary

Notice that the initial focus is on the activities undertaken by someone; what did they do that contributed to the project?

Once the identity of authors has been agreed, then each author should individually agree and affirm that:

- The author list is appropriate
  - no-one who should be an author has been left out
  - he/she has contributed to the paper
  - all other authors have contributed to the paper and should be authors
  - he/she is content with the order of authors given
- The content submitted is correct and complete
  - he/she agrees with all of the content of the paper, especially the conclusions
  - he/she believes all factual statements and data reported to be accurate
  - he/she has declared all competing interests
  - all other authors have declared all competing interests fully as far as known
  - the paper discloses all relevant information appertaining to the study and analysis reported
  - he/she has no concerns about the ethical aspects of the study or its reporting
<table>
<thead>
<tr>
<th>N</th>
<th>Activity</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Intellectual</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Specifying the question</td>
<td>This encompasses the initiation of the study, framing and then refining the questions asked and answered.</td>
</tr>
<tr>
<td>2</td>
<td>Designing the study</td>
<td>This encompasses both writing the protocol and, more importantly but usually at the same time, considering the most appropriate study design.</td>
</tr>
<tr>
<td>3</td>
<td>Identifying data needed</td>
<td>This includes both specifying what data items and data domains are needed, and also deciding on the data collection tools and collection strategy to be used.</td>
</tr>
<tr>
<td>4</td>
<td>Analysing the data</td>
<td>This refers primarily to the analytic strategy to be used. It does not specifically refer to the actual analysis (usually done by a computer).</td>
</tr>
<tr>
<td>5</td>
<td>Interpreting the data analysis</td>
<td>This refers to the meaning attributed to the results of the analysis, showing how the data answered the questions, and including any emphasis on continuing uncertainty etc.</td>
</tr>
<tr>
<td>B</td>
<td>Practical</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Translating a protocol into practice</td>
<td>This includes all the practical matters needed to carry out a study such as: obtaining approval from an ethics committee, setting up processes to identify, recruit and follow-up participants, gaining cooperation of other parties, ensuring that randomisation processes work, etc.</td>
</tr>
<tr>
<td>2</td>
<td>Collecting and handling data</td>
<td>This refers to using data collection tools to obtain data from participants, recording the data and entering them into storage such as onto a computer.</td>
</tr>
<tr>
<td>C</td>
<td>Producing the paper</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Writing – lead authorship</td>
<td>This refers to writing and revising drafts of the whole paper. Sometimes this may be shared, or started by one person and passed on to another.</td>
</tr>
<tr>
<td>2</td>
<td>Writing – contributing significant text</td>
<td>This refers to writing paragraphs of text, contributing to a section or adding a significant new idea.</td>
</tr>
<tr>
<td>3</td>
<td>Reading, editing, checking</td>
<td>This refers to lesser degrees of writing such as clarifying the text, correcting errors etc.</td>
</tr>
<tr>
<td>4</td>
<td>Identifying relevant references</td>
<td>This refers to undertaking searches to identify appropriate references. It does not refer to choosing references already known or used in the design phase.</td>
</tr>
</tbody>
</table>
Table two
A template for considering project contributors and authorship

1 List all people involved and their contribution

<table>
<thead>
<tr>
<th>Person</th>
<th>Relevant activities contributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
</tr>
</tbody>
</table>

2 For anyone who contributed one or more of activities in first table, indicate contribution below:
- 0 = None, or trivial (0% - 5%)
- 1 = Minor (5% - 25%)
- 2 = Moderate (25% - 75%)
- 3 = Major (75%+)

Sums down indicate relative total contribution of contributor, **but** these are unweighted and should only be used to stimulate discussion; they do not rank order importance of contribution.

<table>
<thead>
<tr>
<th>Contributor:</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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<tbody>
<tr>
<td>Domain:</td>
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</tbody>
</table>

3 Authors must have something in each domain (A, B, and C); the remainder should be acknowledged.

4 Discuss order
Clinical Rehabilitation overview: a brief overview of key matters about the journal

Clinical Rehabilitation is a leading peer-reviewed scientific journal that publishes original research, systematic reviews, and other evidence-based articles that concern the clinical practice of rehabilitation. It should be of relevance to all members of the rehabilitation team, whatever their profession and whatever their particular clinical interest.

Aims and scope
The goal of the journal is to improve the effectiveness and efficiency of rehabilitation services for people with disabilities, whatever their age, and whatever the causes of their disability.

To this end Clinical Rehabilitation undertakes to publish articles that:

- report scientifically sound original research of direct relevance to rehabilitation
- discuss or debate topics, basing their content on good evidence and using sound argument
- educate those undertaking rehabilitation and inform clinical practice, again being based on good evidence and sound argument

All published articles have been subject to peer review and editorial review to ensure that they are both accurate as far as this can be ascertained, and easily understood.

The scope of the journal is broad. Articles may concern:

- any aspect of the rehabilitation process
- patients of any age, including both paediatric and elderly rehabilitation
- disability arising from any cause
- rehabilitation delivered in any setting – home, hospital, residential care etc
- theoretical, philosophical, sociological and other aspects of rehabilitation

Editorial process – selection and improvement of articles
All articles are read by the editor on submission. About 50% are rejected at that point because they are not of sufficient priority to have any prospect of acceptance. The remainder are sent out for peer review. Eventually 25% are accepted for publication (2010).

The peer review process is optionally double-blind. The target is to complete it within eight weeks; the average is less than eight weeks but some take longer.

The author is encouraged but not required to submit a version that does not have identifying information on its front page (i.e. without a full title page), but the author is not encouraged to remove other identifying material.

The identity of the reviewers is not disclosed by the journal to the author, but reviewers may place their names on their review if they wish; the journal does not remove them.

Guidance on writing, submitting, reviewing and other aspects of the journal
The web page has extensive guidance available. If ever you need help, contact the Editor who is happy to help.
Competing interests: guidance on competing (or relevant) interests

All publication is subject to bias. Everyone will have an opinion and a point of view about any matter that interests them, and to be an author and researcher one naturally will be interested in the topic. Other factors may also bias data analysis and presentation such as funding sources, a commercial or personal interest in a saleable good, belonging to an organisation etc.

Publishers try to counter bias by ensuring that all potential bias is disclosed. Indeed they have a responsibility to ensure that all potential bias is disclosed. Readers can then consider the bias associated with anything that is disclosed. The publisher is not implying that bias has or has not affected the publication; the reader makes his or her own decision.

There are several particular sources of bias. First, authors (or reviewers) may have a personal bias in favour of or against something or someone that cannot be deduced from the text and associated information. Generally this is difficult to discern, and is not easy for someone to disclose.

Second, the authors may directly or indirectly benefit from the contents of the article being published. The benefit is often financial, and may be direct or indirect. Other benefits are relevant: funding of research assistants or journal subscriptions, support to attend conferences, donation of goods, attracting patients who pay directly, taking out a patent or copyright on the product etc. This information can and should be disclosed.

Last the act of publication is itself advantageous (in the current academic system where publication determines merit and promotion). This does not need disclosure, but must be remembered by readers.

To reduce hidden bias of the second type, we ask all authors to disclose any competing or otherwise relevant interest and, because funding is a common competing interest, we ask all authors to disclose the source of funding and any other support received.

Our guidance is as follows.
If you feel that there are any interests that readers should be aware of, please state them; competing interests will not affect the decision to publish.

Competing (or relevant) interests are wide. They obviously include the source of funding and support for the reported work (which must be stated, together with a statement on what influence the source had over the analysis, interpretation and reporting of data) and any financial interests that any author may have in the results. However they also include any other influences that others might believe could affect the way you set up the study, collected and analysed the data, interpreted the results or wrote the paper.

The easiest way to make a judgement is to ask yourself, in relation to the paper, “would I be embarrassed if this fact became known?” If so, report it.

If you do not think there are any competing interests that readers should know about, state “none declared”.

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**CONSORT non-drug checklist:** a checklist for papers describing RCT or CCT of a rehabilitation intervention

### Checklist of Items for Reporting Trials of Nonpharmacologic Treatments*

<table>
<thead>
<tr>
<th>Section</th>
<th>Item</th>
<th>Standard CONSORT Description</th>
<th>Extension for Nonpharmacologic Trials</th>
<th>Reported on Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title and abstract†</strong></td>
<td>1</td>
<td>How participants were allocated to interventions (e.g., “random allocation,” “randomized,” or “randomly assigned”)</td>
<td>In the abstract, description of the experimental treatment, comparator, care providers, centers, and blinding status</td>
<td></td>
</tr>
<tr>
<td><strong>Introduction</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Scientific background and explanation of rationale</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participants†</td>
<td>3</td>
<td>Eligibility criteria for participants and the settings and locations where the data were collected</td>
<td>When applicable, eligibility criteria for centers and those performing the interventions</td>
<td></td>
</tr>
<tr>
<td>Interventions†</td>
<td>4</td>
<td>Precise details of the interventions intended for each group and how and when they were actually administered</td>
<td>Precise details of both the experimental treatment and comparator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4A</td>
<td>Description of the different components of the interventions and, when applicable, descriptions of the procedure for tailoring the interventions to individual participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4B</td>
<td>Details of how the interventions were standardized</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>4C</td>
<td>Details of how adherence of care providers with the protocol was assessed or enhanced</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Objectives</strong></td>
<td>5</td>
<td>Specific objectives and hypotheses</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>6</td>
<td>Clearly defined primary and secondary outcome measures and, when applicable, any methods used to enhance the quality of measurements (e.g., multiple observations, training of assessors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sample size†</strong></td>
<td>7</td>
<td>How sample size was determined and, when applicable, explanation of any interim analyses and stopping rules</td>
<td>When applicable, details of whether and how the clustering by care providers or centers was addressed</td>
<td></td>
</tr>
<tr>
<td><strong>Randomization–sequence generation†</strong></td>
<td>8</td>
<td>Method used to generate the random allocation sequence, including details of any restriction (e.g., blocking, stratification)</td>
<td>When applicable, how care providers were allocated to each trial group</td>
<td></td>
</tr>
<tr>
<td><strong>Allocation concealment</strong></td>
<td>9</td>
<td>Method used to implement the random allocation sequence (e.g., numbered containers or central telephone), clarifying whether the sequence was concealed until interventions were assigned</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Implementation</strong></td>
<td>10</td>
<td>Who generated the allocation sequence, who enrolled participants, and who assigned participants to their groups</td>
<td></td>
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<tr>
<td><strong>Blinding (masking)†</strong></td>
<td>11A</td>
<td>Whether or not participants, those administering the interventions, and those assessing the outcomes were blinded to group assignment</td>
<td>Whether or not those administering co-interventions were blinded to group assignment</td>
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<tr>
<td></td>
<td>11B</td>
<td>If blinded, method of blinding and description of the similarity of interventions†</td>
<td></td>
<td></td>
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<tr>
<td>Statistical methods†</td>
<td>12</td>
<td>Statistical methods used to compare groups for primary outcome(s); methods for additional analyses, such as subgroup analyses and adjusted analyses</td>
<td>When applicable, details of whether and how the clustering by care providers or centers was addressed</td>
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<tr>
<td>Results</td>
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<tr>
<td>Participant flow†</td>
<td>13</td>
<td>Flow of participants through each stage (a diagram is strongly recommended)---specifically, for each group, report the numbers of participants randomly assigned, receiving intended treatment, completing the study protocol, and analyzed for the primary outcome; describe deviations from study as planned, together with reasons</td>
<td>The number of care providers or centers performing the intervention in each group and the number of patients treated by each care provider or in each center</td>
<td></td>
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<tr>
<td>Implementation of intervention†</td>
<td>New item</td>
<td>Details of the experimental treatment and comparator as they were implemented</td>
<td></td>
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<tr>
<td>Recruitment</td>
<td>14</td>
<td>Dates defining the periods of recruitment and follow-up</td>
<td></td>
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<tr>
<td>Baseline data†</td>
<td>15</td>
<td>Baseline demographic and clinical characteristics of each group</td>
<td>When applicable, a description of care providers (case volume, qualification, expertise, etc.) and centers (volume) in each group</td>
<td></td>
</tr>
<tr>
<td>Numbers analyzed</td>
<td>16</td>
<td>Number of participants (denominator) in each group included in each analysis and whether analysis was by “intention-to-treat”; state the results in absolute numbers when feasible (e.g., 10/20, not 50%)</td>
<td></td>
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<tr>
<td>Outcomes and estimation</td>
<td>17</td>
<td>For each primary and secondary outcome, a summary of results for each group and the estimated effect size and its precision (e.g., 95% confidence interval)</td>
<td></td>
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<tr>
<td>Ancillary analyses</td>
<td>18</td>
<td>Address multiplicity by reporting any other analyses performed, including subgroup analyses and adjusted analyses, indicating those prespecified and those exploratory</td>
<td></td>
<td></td>
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<tr>
<td>Adverse events</td>
<td>19</td>
<td>All important adverse events or side effects in each intervention group</td>
<td></td>
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<tr>
<td>Discussion</td>
<td></td>
<td></td>
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<tr>
<td>Interpretation†</td>
<td>20</td>
<td>Interpretation of the results, taking into account study hypotheses, sources of potential bias or imprecision, and the dangers associated with multiplicity of analyses and outcomes</td>
<td>In addition, take into account the choice of the comparator, lack of or partial blinding, and unequal expertise of care providers or centers in each group</td>
<td></td>
</tr>
<tr>
<td>Generalizability†</td>
<td>21</td>
<td>Generalizability (external validity) of the trial findings</td>
<td>Generalizability (external validity) of the trial findings according to the intervention, comparators, patients, and care providers and centers involved in the trial</td>
<td></td>
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<tr>
<td>Overall evidence</td>
<td>22</td>
<td>General interpretation of the results in the context of current evidence</td>
<td></td>
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</table>

*Additions or modifications to the CONSORT checklist. CONSORT = Consolidated Standards of Reporting Trials.
†This item was modified in the 2007 revised version of the CONSORT checklist.
Criteria for acceptance: outlines the factors that influence whether a paper is accepted

Acceptance is competitive. We can only publish a limited number of articles each year (about 110 at present, out of about 400 submissions each year). Consequently the editor has to prioritise submitted articles. Some will be rejected even if they are sound scientifically and of relevance to the readership. This page outlines some of the factors that influence the decision (it is assumed that the study is ethical). However, ultimately the judgement is made by the editor. You may question the editor’s decision if you wish, and the editor has occasionally changed his mind. This section outlines some of the factors influence the editorial decision.

The editor will generally ask the following questions.

1. **Is the study scientifically sound?**
   The journal is keen only to publish material that is academically sound. This takes into account such factors as:
   - Study design and logic; is the study systematic and reproducible?
   - Appropriateness of data collected; are the data collected complete and necessary?
   - Analytic procedures used; are they appropriate and justified?
   - Use and interpretation of evidence; are they fair and justified?

2. **Is the topic appropriate?**
   The journal focuses on the **clinical practice of rehabilitation**. In principle everything published in *Clinical Rehabilitation* should be of direct relevance to practicing clinical staff. For example we do not publish data from studies on animals, and rarely publish data from studies of healthy people. However given the large range of studies that may inform the practice of rehabilitation this is difficult. Ultimately the question the editor asks is: “Is it likely that someone who sees and manages patients in rehabilitation would find this interesting and/or useful?”

3. **Are the arguments used & conclusions drawn logically sound?**
   Assuming that the data are secure, and the analyses are sound, then the editor will assess how sound the general conclusions are. Most people over-interpret their data, and draw conclusions that are not warranted; they will usually be asked to change them. However if the design and/or data cannot allow any useful conclusions to be drawn, the paper will be rejected.

4. **How does this article fit into our ‘balanced portfolio’?**
   *Clinical Rehabilitation* is read by people with many different interests, and it is important that the journal maintains a wide spectrum of articles. If we have already accepted a very similar article that is as good as or better than the one under consideration, it is unlikely to be accepted. On the other hand sometime a complementary study may gain priority.

5. **Type of study**
   As any reader will realise, we generally give highest priority to randomised controlled trials and systematic reviews because they are probably the soundest types of study. However we also give priority to good qualitative studies. Studies on data collection tools have a lower priority and will rarely be accepted if they are not on the relevant patient population. The priority of other exploratory studies is dependent on their content.

6. **Novelty**
   All journals like to publish ‘ground-breaking’ research. However *Clinical Rehabilitation* tries hard to publish negative studies, studies that question accepted practice, studies that do not show an intervention to be effective. It also wants to publish confirmatory research, provided that it is still worth confirming an earlier study; replication is very important in science.

7. **Readability, interest etc**
   Articles that are a pleasure to read, that excite, interest or challenge, or that make me think will always have a slight edge; all other things being equal, they get accepted.

8. **Note**
   Most authors seem intent on getting their paper rejected through sloppy writing and presentation, failing to read guidance, and in many other ways. While the Editor tries hard to determine the potential of a study, you increase your chance of acceptance by reading and adhering to guidance.
**Editorial Board Members**: lists members of the editorial board and contact details

### Editor

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Email contact</th>
<th>Profession</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor</td>
<td>Derick Wade</td>
<td><a href="mailto:clinical.rehabilitation@sagepub.co.uk">clinical.rehabilitation@sagepub.co.uk</a>, <a href="mailto:derick.wade@ntlworld.com">derick.wade@ntlworld.com</a></td>
<td>Doctor</td>
<td>Oxford, UK</td>
</tr>
</tbody>
</table>

Major interests: Neurological rehabilitation, data collection tools, evaluative studies.

### Associate Education Editor

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Email contact</th>
<th>Profession</th>
<th>Location</th>
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<tbody>
<tr>
<td>Dr</td>
<td>Diane Playford</td>
<td><a href="mailto:d.playford@ion.ucl.ac.uk">d.playford@ion.ucl.ac.uk</a></td>
<td>Doctor</td>
<td>London, UK</td>
</tr>
</tbody>
</table>

Major interests: Neurological Rehabilitation, goal setting, education, rehabilitation process and pathways, vocational rehabilitation.

### Editorial Board

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Email contact</th>
<th>Profession</th>
<th>Location</th>
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<tbody>
<tr>
<td>Associate Professor</td>
<td>Louise Ada</td>
<td><a href="mailto:L.Ada@usyd.edu.au">L.Ada@usyd.edu.au</a></td>
<td>Physiotherapist</td>
<td>Sydney, Australia</td>
</tr>
</tbody>
</table>

Major interests: Testing neurological rehabilitation interventions – particularly after stroke, contribution of motor impairments to disability, design of rehabilitation environments.

| Professor         | Jules Becher       | jg.becher@vumc.nl, jg.becher@hccnet.nl | Doctor       | Amsterdam, The Netherlands |

Major interests: Pediatric Rehabilitation, Orthotics, all kinds of spasticity management.

| Dr                | Audrey Bowen       | audrey.bowen@man.ac.uk | Neuropsychologist | Manchester, UK |

Major interests: Cognitive aspects of stroke rehabilitation. Systematic reviews.

| Dr                | Robert Cooper      | Robert.G.Cooper@manchester.ac.uk | Doctor – Rheumatologist | Manchester, UK |

Major interests: Idiopathic inflammatory myopathies.

| Associate Professor | Avril Drummond     | avril.drummond@nottingham.ac.uk | Occupational Therapist | Nottingham, UK |

Major interests: Neurological Rehabilitation, falls, RCTs, Occupational Therapy.

| Professor         | Jan Geertzen       | j.h.b.geertzen@rev.umcg.nl | Doctor       | Groningen, The Netherlands |

Major interests: Amputation, prosthetics, orthotics and shoes. Specific and non-specific pain syndromes.

| Professor         | Maria Stokes       | m.stokes@soton.ac.uk | Physiotherapist | Southampton, UK |

Major interests: Physiological mechanisms of neuromusculoskeletal function, dysfunction and recovery – including development of investigative techniques.

| Professor         | Alan Tennant       | a.tennant@leeds.ac.uk | Health Services Researcher | Leeds, UK |

Major interests: Psychometrics; Epidemiology; Health Services Research.
Editorial processes: explains the process from submission to final decision for all articles

This section outlines and discusses the editorial processes that occur after you have submitted a new paper, a ‘letter to the editor’, or other material such as Omniana to Clinical Rehabilitation.

Some general principles

Before giving details, some general principles concerning the editorial process will be outlined.

- All decisions and actions should be justified and explained. This is done using personalised letters or emails.
- All authors are sent a copy of all emails. (Just in case the submitting author has not informed all authors about the submission. This has occurred.)
- All decisions and actions are open for questioning. Authors (and indeed reviewers) may contact the editor at any point for clarification, or to debate and to dispute any action or decision. The editor has changed his decision on occasion.
- Decisions should be made as quickly as compatible with being fair and thorough. The process should adapt to the circumstances, not wasting the time of authors, reviewers or the editor.
- Reviewers and authors should be treated with respect, recognising the work that they undertake.

ORIGINAL ARTICLES

This term includes the great majority of submissions: research papers, systematic reviews, Rehabilitation in Practice papers and any other articles with the sole exceptions of Letters to the Editor which are discussed at the end.

Registration

You will have registered your paper when you submitted it, and you will have received notification by email that it has been registered. This notification is automatic, and it gives you a reference number (which you should use whenever corresponding about the paper), but it does not imply that anyone has read or seen the paper.

First read by editor

The editor reads all papers as soon as he can after submission. However this may not be immediate: the editor has holidays from time to time, there may be a large number of papers to be read, and other factors may delay the process. Nonetheless he hopes to read most submissions within 7 days of submission although it may be up to 21 in case of holidays.

The editor’s first read will determine the next step. There are three options:
- Immediate rejection
- Return for revision before review
- Review by others

Selection between these options is based upon:
- Suitability; is the topic appropriate?
- Potential of the study/paper; could a good paper be achieved eventually?

1 Suitable?

The editor’s first decision concerns suitability of the paper for Clinical Rehabilitation – is the topic and content appropriate for the journal? Is it relevant to the practice of rehabilitation?

It is sometimes difficult to know what is relevant to the practice of rehabilitation, because the practice of rehabilitation varies between countries, between different professions, and between individuals. If you feel that the Editor has rejected a paper as not relevant when you think it is, please say so. The journal is international and multi-professional, and the Editor cannot know what might be considered relevant everywhere. However the editor still reserves the right to consider a paper as not sufficiently relevant to a sufficiently large part of the readership to be accepted.
A small number of papers are almost always not suitable. Examples include:

- most non-systematic reviews (see guidance on types of articles accepted)
- any study on animals (because not applicable to rehabilitation)
- most studies on healthy controls without any patients (not applicable to rehabilitation)
- studies where the topic is not relevant to the practice of rehabilitation or rehabilitation research

If judged not suitable, the editor will reject the paper, sending an email and an attached letter explaining why.

2 Potential publication?
The next decision concerns the potential of the paper – after due revision and improvement, is it likely or at least possible that we would publish this paper?

A large number of papers are rejected at this point. The paper’s priority is assessed against various criteria (see separate document) although this is not done in a formal way (i.e. the editor does not have a system of allocating specific scores).

The common reasons for rejection include:

- difficulty in generalising from the paper because of small sample size, an unrepresentative sample, bias and other similar factors
- difficulty in drawing any conclusion because of poor design, small and/or biased sample, poor data sets used
- the topic has already been well researched with many other papers published

If the paper’s priority (after taking into account any potential improvements) is judged to be low (i.e. less than 40% probability of final acceptance) then the paper will usually be rejected immediately, without further review.

This approach is taken for two reasons:

- the author has a reasonably quick response, and is not kept waiting for reviewers when eventual rejection is almost certain
- the reviewer is not ‘wasting’ time and effort on a paper that is very likely to be rejected.

The authors are informed by email and a personal explanation given in an accompanying letter.

Sent out for review
If the paper is considered at least to have potential, the editor will then undertake a more detailed review, and will record his initial impressions which will later be sent to the authors.

Then the editor selects two reviewers (rarely three reviewers will be approached if there is a specific reason). These are identified in various ways:

- from the editor’s own memory and knowledge
- from the data-base of authors who have previously submitted papers
- from a data-base of previous reviewers
- from the references in the paper itself
- searching the Internet, including medical data-bases
- from the reviewers suggested by the author at submission, if any are suggested (be re-assured that we do use suggested reviewers as we assume authors to be honest in their recommendations).

The reviewers are chosen on various criteria:

- not known to be closely associated with the authors
- considered to have an interest and/or expertise in at least some aspect of the paper
- known or considered to be able and willing to give some time to the review process

The reviewers are then contacted by email seeking their help and, if they accept they are given access to the version of the paper which does not include the title page detailing the authors and originating institution (unless the author has left the title page in the submitted version for review).

Reviewers are given guidance. This guidance is also available to anyone, on our website.

Return of the reviews
The editor generally waits for reviews to arrive; authors are encouraged to contact the editor eight weeks after the paper has been sent out for review if they have not heard from the journal, and this then stimulates action.
Once all reviews are returned (or when reminded that eight weeks have passed) the editor reads the reviews and the recommendations, and re-reads his own initial opinion and the paper. He then decides on the next step:
- immediate acceptance, with no further action from authors (this has not yet occurred, but is possible)
- acceptance after revision (this editor does not distinguish between major and minor revision)
- rejection

All of the authors are informed by email, and with this email the editor usually includes:
- the reviews received and scores given. These are anonymous, and may be edited if considered impolite which is in fact very rare; almost all reviewers provide thoughtful comments politely phrased.
- a copy of the editor’s initial comments
- a letter explaining either why it was rejected or what major areas need revision
- a standard document enlarging on either rejection or the next steps
- additional guidance documents as appropriate

The reviewers are sent a copy of the same email and attachments (blind to each other’s identity and without disclosing their identity to the author) so that they may learn of the decision and so that they may read the opinion of others.

The author is informed that they may contact the editor if they want further advice on revisions or, in the case of rejection, if they wish to make any comments or ask questions.

**Return of revised paper.**
When the author resubmits their revised version, the editor reads any covering letter provided outlining their response to comments and changes made, and reads the revised paper. The editor may make one of three decisions:
- Acceptance. This is the usual decision. Minor editing may be undertaken to improve presentation.
- Return for further changes. This is sometimes necessary.
- Rejection. This is rare, but would arise if the revision makes it clear that in fact the original paper so misrepresented the study that it no longer reaches priority for publication.

It is worth noting that papers are not routinely returned to the reviewers. However the editor obviously reserves the right to do this if he considers it necessary.

The author will be informed of the decision by email, with an accompanying letter if needed to explain the decision.

**LETTERS TO THE EDITOR**
These are welcome, but usually they should be in response to published material. Letters should be as short as possible, but they may be up to 1000 words if necessary.

Letters are not subject to peer review. They are read by the editor who will usually decide immediately on further actions, though rarely he may seek advice.

Any letter that comments significantly on a published article will be sent to the author of that article inviting a comment or reply. The author will be given a short time to reply (usually 14-21 days).

The editor will:
- amend or edit letters, including any reply
- choose whether or not letters and replies will be published
- always inform authors of any significant changes to their material

Generally letters will be published as soon as practical after receipt.
Editors competing interests: explains the competing interests of the Editor in Chief

The editor makes final decisions on the acceptance or otherwise of a submitted paper, and he also may suggest changes in emphasis, or removal of material or other changes. He hopes that all decisions are explained and justified. However because we now ask both authors and reviewers to disclose any competing interests, the editor is also disclosing his competing interests here. If you believe that the editor’s actions have been influenced sufficiently to be unfair to you, or if you have any other concerns about the editor, please see our document on how to express those concerns.

A competing interest is any factor that might affect judgement or decisions that is not intrinsic to the decision making process and framework; it may bias advice given or the decision made. The existence of a competing interest does not mean that bias occurs, has occurred or will occur. However it is appropriate that others should be aware of potential biasing factors.

Financial
My income comes primarily from my NHS post. I do not have any ongoing, long-term contract with any other health care organisation. I have however over the last 20 years undertaken work on behalf of various organisations that have paid me. These include:

- Pharmaceutical companies (Ipsen, Glaxo-Smith-Kline, Eaton pharmaceuticals, GW pharmaceuticals)
- Law firms (medical expert reports)
- Government health organisations (expert reports)

Academic and research
I do not propose to list all my areas of research interest; they can easily be discovered through internet searches. I have many friends and colleagues in the academic and clinical world who may submit papers to the journal. I have relatively formal connections with various universities:

- University of Oxford, UK
- Oxford Brookes University, UK
- University of Maastricht, The Netherlands
- Zuyd University, Heerlen, The Netherlands
- Kings College, University of London, UK

Authorship and this journal
I am obviously concerned to promote the journal, and to increase its influence. To this end it is possible that the following factors may influence my decision.

- Profession of authors/topic of study. I am keen to encourage some professions into publishing in the journal (e.g. nurses) and to encourage publication relating to some particular topics (e.g. aphasia research, spinal injury research, visual or auditory impairment)
- Country of origin. I am keen to foster rehabilitation research in countries that do less rehabilitation research (for economic or other reasons)

Personal
I have no direct personal interest in any aspect of rehabilitation, but I am committed to improving care for disadvantaged groups of people.

Other
There are other connections that I believe are unlikely to cause bias, but are disclosed here.

- Close association with several disease-specific organisations such as the MS Trust, MS Society, Parkinson’s Disease Society, Headway
- Honorary membership of the College of Occupational Therapists
- Training in and continued clinical interest in neurology and psychiatry
**Ethical position:** explains the ethical stance of the journal in relation to content and conduct of the research, its behaviour towards authors and others, and stands on malfeasance

*Clinical Rehabilitation* aims to act within a moral framework. This has three aspects:
- First, we wish to ensure that papers published are based on work that has treated every participant with respect—the activities of the researchers should have been morally acceptable.
- Second, we ourselves wish to treat submitting authors with respect, and to behave towards them in a morally acceptable way.
- Third, we wish to be responsible members of society, and if we come across morally unacceptable behaviour then we will raise the issue with the organisation concerned, usually the organisation responsible for the study or the organisation employing the authors.

This section enlarges upon the ethical approach used by the journal.

**Research ethics**

When a study is submitted and reviewed, we ask reviewers to consider the ethical aspects of the study and the editor also does so.

It is our view that formal ethical committee approval does not automatically ensure that the study was morally sound, and that failure to obtain approval from an ethical review committee does not necessarily mean that the study was morally flawed. It is a common observation that different ethical review committees take different views on what does or does not need their opinion, quite apart from differences of opinion between committees on the morality of the same project.

Consequently, we certainly take into account any opinions obtained from ethics committees, and we would prefer most projects to be reviewed independently in relation to their morality, but we also consider the study itself. Ultimately, of course, the morality depends upon the actions of the researchers during and after the study, rather than the review committee, and we cannot monitor their actual behaviour.

People interested in considering the ethical aspects of any study might find the Table of questions below forms a useful starting point. Note that it applies to all studies and reports, not simply those labelled ‘research’.

The journal is willing to include some (brief) discussion of the ethical aspects of a study within a paper if this is necessary and appropriate.

In the event (thankfully rare) that a reviewer or the editor has some ethical concerns about a paper, regardless of whether it has formal ethical committee approval, it will be sent to a minimum of three members of the Editorial Board for their opinion on the ethical issue, and what action (if any) we should take. A decision will be made on the basis of their comments. The authors will be informed about the process and its outcome.

**Publication ethics**

We try to treat authors with respect. This means that:
- We respect the confidentiality of submitted material, and ask reviewers to do so (the only exception being when public interest requires disclosure, which has never happened yet)
- We make decisions that we can justify, and that are not biased by (unacknowledged) prejudices
- We communicate as quickly and clearly as we can
- We will respond to reasonable comments, criticisms and questions about the editorial process

We also recognise our responsibility to the readership and wider public. To this end we will try to ensure that all publications are accurate, and that errors are corrected. Furthermore we will try to ensure that any potential major biasing factor, such as funding by a commercial company that might have an interest in the results is acknowledged within the published paper.
Public ethics
Finally we have a responsibility not only to the readers and the scientific (rehabilitation) community but also more widely. This relates largely to reporting on behaviour by any researchers or authors who submit papers to us that is morally unacceptable in relation to the research or writing (i.e. we are not considering their behaviour in other spheres).

The types of behaviour that may come to the attention of a journal include:
- Research fraud
- Publishing data twice without acknowledging it
- Claiming responsibility for work undertaken by others without acknowledgement
- Undertaking research or other activity that is ethically unacceptable (and/or illegal)
- Publishing material as original that is in fact reproduced from other studies or is in other ways fraudulently misrepresented

We hope that this type of behaviour is unusual and will rarely come to our attention, but equally we hope that we would take action if we do become aware of such behaviour. Please also see our document on malfeasance.

Questions to consider in relation to the ethics of a study

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment</th>
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<tbody>
<tr>
<td>How great was the change in clinical practice?</td>
<td>Almost every study worth reporting will involve some change from normal clinical practice. This applies to audit, research, and even case reports.</td>
</tr>
<tr>
<td>What extra burden was imposed upon the patient(s)?</td>
<td>Burden includes time, mental or physical effort, thinking, emotional strain, pain etc. It includes additional investigations, answering questions, travel etc.</td>
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<tr>
<td>What additional risks did the patient(s) (or other participants) face?</td>
<td>Risk covers not only direct, physical risk to health and well-being but also risks in terms of direct additional knowledge (e.g. of discovering that one has an untreatable condition) and in terms of information becoming available that would not otherwise have been known. It includes the risk of others becoming aware of (new) information.</td>
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<tr>
<td>What benefit might accrue to the patient (or other participants)?</td>
<td>This might include access to a higher quality or quantity of care, more rapid treatment, a better standard of information becoming available about the patient’s own health etc</td>
</tr>
<tr>
<td>What benefit might accrue to Society?</td>
<td>This will include reduction of some clinical uncertainty, gaining information to guide later research (i.e. pilot work), and training clinical staff to undertake better projects. Within this question one can also consider whether the project design is adequate to deliver the supposed benefit.</td>
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<tr>
<td>Was each participant informed about the study and able to choose whether or not to participate?</td>
<td>Participant must always be treated with respect, and this involves giving them sufficient relevant information about the options, and risks and benefits so that they can make the choice not to participate. This applies equally to daily clinical practice, to ‘audit’ and to ‘research’. Many acceptable studies will not involve giving each participant full information and obtaining signed consent, but the failure to do so needs justification which will usually be in terms of: (im)practicality, for example if in coma or with aphasia, or difficult to contact low risk of harm to person, and/or high chance of significant benefit from study</td>
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<tr>
<td>Was the method of recruiting participants fair and appropriate?</td>
<td>From a moral perspective it is important that there is no selective exploitation of vulnerable people. This means that the investigators should have considered and approached all potential participants regardless of social or demographic characteristics. However this question also covers the risk of scientific bias, such as excluding a relevant population, and the risk of disenfranchising a population who might benefit from participating in research.</td>
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**Letters to the editor:** outlines nature of these and the processes involved

*Clinical Rehabilitation* welcomes letters to the Editor for publication. This section gives some information on what is generally included in the phrase ‘letter to the editor’, and how to write and submit them. Primarily letters are a way of commenting on published articles and they are not a way of publishing new data.

**Purpose and content**
The primary purpose of letters is to comment on articles published in the journal. They offer an opportunity for readers to make constructive criticisms, to draw attention to important aspects of the paper that may have been missed and generally to debate the topic.

Letters may introduce new (unpublished) data if the author wishes to use this as part of their comment. However letters are not (at present at least) a mechanism for publishing short articles concerning research that is not relating directly to some previously published article.

Letters will rarely be concerned with political matters – the journal is international and political matters are usually specific to an individual country or region.

**Style and length**
Letters should refer in their title and/or in their first paragraph to the article concerned, giving it as a reference at the end of the letter. Otherwise they can follow the most appropriate structure to the content provided that they are:

- As succinct and short as possible
  - There is no absolute word limit, but anything over 1000 words is really a separate article. 300-500 words will be an approximate, median length.
- Polite in tone, and well reasoned
  - Strong disagreement and strong opinions are welcome, but the letter must be both courteous in its style and well argued in its content (the editor will check and edit the letter if necessary)
- Referenced appropriately
  - It is possible to have up to six references, though more than four (including the original article) will be rare.

**Submission and editorial handling**
Letters should be submitted through the web site [http://mc.manuscriptcentral.com/clinrehab] choosing ‘letter to editor’ as document type.

All will be read and a decision made on whether of not they can be published. The author will be notified, usually within 14 days.

Some will be published without asking the author of the original article for comment. This will be relatively rare but may be appropriate on occasion (for example if it is the author him- or herself who is writing).

Most will be shown to the author of the article being commented on, and that author will be asked if they wish to comment. They will have two or three weeks to reply. The same considerations on style and length will apply to their reply.

The reply of the original author will also be scrutinised for publication (usually it will be accepted).

All letters may be edited to:
- Shorten them if necessary
- Clarify any points that are unclear
- Remove any personal or unpleasant comments (easy to make unintentionally if English is not an author’s first language)

The authors will have an opportunity to review and check their letters.

**Publication**
The intention is to publish letters as soon as possible.
Malfeasance: discusses nature of malfeasance (authorial, scientific, moral) and our response to issues such as duplicate publication and plagiarism

Malfeasance is practice that falls below an acceptable moral standard, and/or is illegal. Legality is generally specific to the country where it occurs. Clinical Rehabilitation cannot know the detailed laws of all countries, and can only consider legality in broad terms. Morality is a human matter, and is generally not specific to any country or culture although there may be practices on the boundary that might be considered immoral in some countries or cultures but moral in others. Clinical Rehabilitation will generally respect cultural and geographic differences provided participants are always treated with respect and dignity. This section gives:

- More detail on what might or might not be considered malfeasance
- What you should do if you suspect any malfeasance
- What we will do once suspicion has been raised

Clinical Rehabilitation has a responsibility to maintain a standard of science and authorship that complies with any legal requirements that apply (in the home country of the authors) and that is of a high moral standard. We will be alert to:

- Authorial malfeasance
  - Plagiarism and duplicate publication
- Data-related malfeasance
  - Alteration or even fabrication of original data
  - Manipulation and analysis of data knowingly to achieve results that do not reflect the truth
  - Failure to report known data or results that would materially alter the conclusions
- Moral (and legal) malfeasance
  - Breaking the laws in the country where the research occurred
  - Treating participants without due respect for their well-being and autonomy

Initial suspicion

Malfeasance might become suspected:

- By the editor, on reading a submission
- By a reviewer
- By a reader (after publication)

Whenever it is suspected, the editor should be informed. Any concerns will be treated confidentially. The person raising the concern will always be consulted about and informed of any actions and decisions, and their identity will not be disclosed unless they request it.

Our response – general

Our response upon suspecting malfeasance will depend upon the circumstances, but at a minimum we will always contact the author seeking clarification and explanation.

Our first goal will be to collect as much relevant information as possible, primarily from the author. We must always treat the suspected author fairly, and authors will be considered innocent unless proven otherwise. The author will be supplied with as much specific information about the concern as we are able to give without disclosing our sources, and will be invited to respond. Depending upon the circumstances and seriousness of the suspicion we may also inform the author that a failure to reply will require us to contact their employer or some other higher authority.

The author’s explanation will be considered, and further clarification sought if necessary.

The matter will always be considered by the editor, and usually advice will be sought from at least two other members of the editorial board.

We recognise that there is often uncertainty and ambiguity in these matters and we believe that most cases of apparent malfeasance will be due to misunderstanding or ignorance, or mistakes rather than an act of deliberate planning. Consequently in most cases we will simply be trying to educate the author(s) about the nature of their mistake and how to avoid it in future.
Rarely it may be apparent that malpractice was deliberate, and serious. Before coming to a final conclusion the evidence will be considered by at least four members of the editorial board who will also be asked for their advice on the most appropriate next steps which we believe should be proportionate to the circumstances.

Generally Clinical Rehabilitation believes in exposure of malpractice to:
- Warn others that work by the author may be invalid
- Deter people from being dishonest

Consequently, once we feel that malpractice may have occurred we will (with due legal advice and consideration) undertake one or more of the following:
- Write to the authors with our conclusion, and state that further papers will not be accepted from them; and/or
- Notify the organisation(s) that are involved in employing and/or funding the authors; and/or
- Notify any supervisory professional bodies in the country of our concerns; and/or
- Publish our concerns in the journal

Obviously in practice our level of evidence will usually only be sufficient to allow the first option.

Specific aspects of each domain are now discussed.

**Plagiarism**

Plagiarism is “the practice of (dishonestly) claiming or implying original authorship of material which one has not actually created, such as when a person incorporates material from someone else’s work into his own work without attributing it.” ([http://en.wikipedia.org/wiki/Plagiarism](http://en.wikipedia.org/wiki/Plagiarism)) (accessed October 8th 2006)

Plagiarism (in the context of articles submitted to this journal) will usually involve stealing lengths of text. Plagiarism of ideas is also possible, but it is the nature of science to use and develop methods and ideas first put forward by others. However even then it is at least polite and honest to make reference to someone who has previously used the method, or to the person who originated the idea.

To avoid plagiarism you should:
- write your article using your own words
- never claim originality if you know that someone else has already published the idea
- identify any significant use of the words of others (more than four words) through:
  - placing the text in quotations, and
  - giving a reference to the source.
- acknowledge the source of any important new ideas through a reference

If someone submits (or publishes) an article that includes text that we think may be plagiarised, Clinical Rehabilitation will (after due checking and correspondence with the author) publish the original text and the submitted text, to allow others to see the nature of the possible plagiarism and to see the identity of the authors submitting the text. Judgement on whether the copying can be termed plagiarism will be left to each reader.

If an article claims originality for an idea that is discovered not to be original where it is also implausible that the author was unaware of the earlier source, then the author will be contacted and asked to acknowledge the earlier source.

**Duplicate publication**

Publication of the same or very similar data twice constitutes duplicate publication. Any authors discovered to be deliberately attempting or to have knowingly undertaken duplicate publication will be disallowed from future publication in Clinical Rehabilitation and will have their names published, which may well preclude publication in other journals.

In order to avoid this authors should:
- only submit data or analyses of data that have not been published (or accepted for publication or still being considered for publication) elsewhere;
- state that the data or at least this specific analysis of the data has not been published elsewhere before;
- not submit the same article to two journals simultaneously. (Please confirm with any other journal that you may have submitted to that it is no longer considering your article.).
There is no absolute rule about how much original data or new analysis is needed to make an article original and not duplicate, but if 50% has already been published then originality must be in doubt.

**If you are in any doubt**, tell the Editor and submit one copy of the possible duplicate article.

Duplicate publication can include the incorporation of data that has already been analysed and published within (as part of) an enlarged data-set, for example if data from a pilot project is also included in a later paper reporting on the definitive trial. Under these circumstances it is vital that the editor and the reader is specifically informed that the data reported and analysed includes previously reported data. At a minimum this ensures that people undertaking meta-analysis do not accidentally inflate their analysis. It is also vital that the two sets of data are reported separately.

In practice there are no good reasons for incorporating the two data-sets into one, and the editor will usually ask for the published set to be removed from the analysis.

The editor is frequently asked about the status of ‘conference abstracts’ and duplicate publication. Generally a conference abstract will not constitute duplicate publication because the methodology and data presentation lack adequate detail. However some ‘conference abstracts’ are excessive (the longest I have come across was about 2000 words!). Any abstract over 250 words is not an abstract.

Sometimes submitted articles concern and refer to data already published elsewhere, perhaps presenting a subgroup analysis or a different outcome or a different analysis. In this case the authors should always submit previously published papers (or the accepted version if not yet published) to the editor so that:

- the editor can judge whether there is significant duplication
- the reviewers can, if necessary, see the paper if that is essential to judging the submitted paper.

**Data-related malfeasance**

This is very difficult to detect. We expect authors to be honest. Authors should consider the following.

First, they should always check that their data-sets are correct and that the programmes used appear to be working correctly, and that selected data-sets are selected correctly.

Second, they should double check for transcription errors (copying from the output of the statistical package into text or tables in the paper).

Third, they should consider whether they have reported all the relevant data that might influence a reader’s interpretation; ‘inconvenient’ data should not simply be ignored and not reported.

Fourth, if they have undertaken secondary (post-hoc) analyses they should report all analyses undertaken (or at least that they were undertaken) and not simply report a selected group that show interesting results.

**Legal and moral matters**

We expect all authors to work within the legal requirements of their country and organisations.

Moral and ethical aspects of projects will often be considered locally by duly appointed bodies (Ethics committees, Institutional Review Boards and similar); this is often but not always also a legal requirement. However *Clinical Rehabilitation* notes that:

- some people may not have access to any reviewing organisation
- sometimes committees may decide that a project falls outside their remit and does not need review
- different committees take different views and given different opinions

*Clinical Rehabilitation* also notes that traditionally audit is not considered to need ethical review (though the editor believes there is no distinction between audit and research; see Wade DT, British Medical Journal 2005;330:468-473 and Wade DT, British Medical Journal 2007;334:1330-1331).

Consequently we will consider the ethical aspects of all research papers offered, being guided by the opinions of any reviewing body but always being prepared to make our own decision.

If we have any concerns about ethical aspects of a study, especially if there has been no external review, we may ask the author to add a paragraph discussing ethical aspects of the project.
Provisional acceptance: explains nature and meaning of ‘provisional acceptance’ of an article

This section discusses the nature of provisional acceptance and what you need to do next.

When you receive this your paper will have been reviewed by the Editor and, usually, two reviewers. With the email you should receive:

- A letter from the editor and, separately, his comments written on initial reading (i.e. before seeing the reviews), outlining areas where he thinks changes are needed.
- Copies of the comments submitted by reviewers, and the scores they gave (the score sheet is attached).
- And sometimes, as needed, a copy of specific written guidance we have on some types of report such as randomised controlled trials or other general advisory documents.

Please read the letter and comments carefully. You do not have to make changes in response to every comment, but please consider them carefully as they represent the impression and questions that readers are likely to have. You may always contact the editor for advice or clarification, or if you have any specific questions or concerns.

Revising your paper – please read and act on this

When revising the paper please check that:

- The abstract is no longer than 250 words, and has structured headings.

- You have 2-4 clinical messages in no more than 50 words, these messages being derived from the study itself.

- All means (averages) are accompanied by a standard deviation (SD), best presented as, for example “mean (SD) age was 45.8 (6.4) years”.

- All percentages are accompanied by actual numbers, as (for example) “There were 45 (30%) men” or “70% (n = 56) were alive”.

- You have no abbreviations; those for statistical tests such as SD, ANOVA, IQR are usually allowed and ADL is allowed.

- You have turned off track changes, have removed all tracked changes, and have removed all highlighting etc leaving plain text

- You have read and followed our advice on writing; see: http://www.sagepub.com/journalsProdManSub.nav?prodId=Journal201806

- You submit the revised file preferably as a single file with the title page and abstract included (anonymity is not necessary).

- You attach or give a letter outlining major changes made or why you have not made major changes suggested (if you have not); you do not need to detail every small change.
Resubmission process – please read
You will need to undertake the revision on the copy of the originally submitted paper that you have on your computer, and then to upload it again on the website. When resubmitting please:

- note that you must delete old files
- alter the title, if this is being changed
- ensure that the abstract is submitted as part of the text file, as well as on the web
- put the title page as part of the submitted text
- ensure that you categorise the resubmitted text files as ‘for review’

To resubmit you need to go to the web site (http://mc.manuscriptcentral.com/clinrehab), enter your author area, select your paper that you submitted and follow the instructions on resubmission:

- Select ‘manuscripts with decisions’
- You will then see all manuscripts awaiting action. On the right you will see a column headed ‘actions’ and text saying ‘create a revision’
- Select ‘create a revision’, and be prepared to upload
  - Your revised article (which does not need to be anonymous) with title page and abstract included
  - A letter outlining your changes and response

When your paper is resubmitted, the editor will read it to check it. He will then make one of three decisions:

- The improvements and changes are sufficient to allow publication. He may make some small editorial changes to your electronic version.
- The changes and/or the replies to questions are such that he thinks the paper should not after all be published and he will reject it. A full letter of explanation will be sent
- The changes and or answers are not sufficient, but he still thinks the paper should be capable of reaching an appropriate level. He will write explaining what further actions are needed.

Very rarely he may decide that the paper should be reviewed externally again, which will delay a decision.

After acceptance:

- The editor allocates a provisional publication date
- He informs the publisher of acceptance and the suggested/anticipated publication date.
- He will inform you if significant editorial changes have been made. Please recheck your paper if so.
- You will be asked to transfer copyright and to confirm details about the title and authors

Further matters are handled by the publisher, and all further communication should be with them.

Finally please read this quote from an author, Dr James Cauraugh:

"Dr. Wade, while revising our paper, a quote by the writer/poet, Antoine de Saint-Exupery came to mind: “If anything at all, perfection is finally attained not when there is no longer anything to add, but when there is no longer anything to take away.”"
Raising concerns about editorial and other matters: what to do if you have concerns about the Editor’s decisions or other behaviour

This section outlines what you should do in the event of any concern about the editorial and publication processes of Clinical Rehabilitation. It does not discuss commercial concerns or other matters such as distribution.

Everyone involved with Clinical Rehabilitation is committed to achieving a high quality journal which behaves ethically. As part of this concern we genuinely welcome feedback and comment, particularly if it is constructive. We also recognise that occasionally someone may feel that our standard of behaviour is poor in some way, and this section primarily discusses that situation.

The general principles are to contact:
- the person concerned in the first instance if you feel able to do so
- another senior person if dissatisfied with the initial response or if unwilling to contact the person concerned

In practice most concerns will be about the editor, and this will be assumed from here on.

If you feel that the editor has acted in a way that is biased, irrational, unfair, discriminatory or in any other way wrong then you should first raise your concerns with the editor. If you feel unable to do this, then choose one of the editorial board; their names, contact details and professional interests are published on the web site to allow you to choose who ever you feel most appropriate.

A copy of any letter or other correspondence (e.g. email) should also be sent to the senior journal editor at the publisher (Sage publications).

The letter should summarise your main concern, and then give as much supportive detail and information as you can.

You should receive a reply within seven working days, at least acknowledging arrival except when the person is on holiday or otherwise unavailable.

The definitive reply should consider and respond to your concerns. If you are unhappy with the response you may continue the correspondence or contact the senior journal editor at Sage directly.
Rejected papers: explains in general why papers might be rejected (not always because they are ‘bad’)

This section gives some brief information about the rejection of papers by Clinical Rehabilitation.

Acceptance for publication is competitive. The journal can only publish about 110-120 papers each year at present, but has about 400 submissions each year. The intention is to publish all papers within a reasonable time of acceptance, and so we can only accept about a limited number of papers each year at most; the remainder have to be rejected.

Various factors influence the decision:

- Relevance to the reader; is the topic within the broad remit of the journal?
  - Clinically based, relevant to the practice of rehabilitation

- Interest to the reader; will a reader want to and enjoy reading it
  - Does the article stimulate, inform, and/or challenge the reader?

- The nature of the study design; can it achieve the objective?
  - Generally RCTs, systematic reviews and larger/epidemiologically sound studies will have higher priority

- Importance, and novelty; to what extent is the information new or important?
  - Replication of studies is very important, but after a topic has been researched several times it is less important to continue unless there is continuing uncertainty

- Relationship to recent or ‘in press’ papers in Clinical Rehabilitation (or other journals):
  - If the Journal itself has already published other similar papers (or they are about to be published) then sometimes the paper’s priority is reduced
  - Alternatively if this paper complements or contrasts with another paper then its priority may be increased

- Clarity and style of presentation
  - Papers are not rejected on account of their presentation, but if the editor or reviewers fail to understand the paper then they will not be accepted

- The opinions of and advice given by reviewers (for those papers sent for review)
  - The editor reads these and takes them into account but the editor makes the final decision.

Immediate rejection

All papers submitted are read initially by the editor. At this stage the first decision is whether the paper has the potential to be accepted. In other words, the Editor considers whether the paper can be improved sufficiently to achieve publication. (Note: no paper is perfect at the time of submission.)

It is not fair on the author to impose a wait for reviewers if it is already obvious that publication will not happen. It is not fair on reviewers to ask them to spend time and effort if the editor is already reasonably certain that the paper will not be published. (Note: reasonable certainty is about 90% or more.)

Therefore papers may be rejected by the editor before any review. This occurs in about 50% of submissions at present (2010). It will usually be because the editor has decided that the content of the paper (i.e. the study data or topic) will not reach sufficient priority to allow publication, even after revision.
Later rejection

About 30% of papers sent out for review are nonetheless rejected. These fall into two groups.

The first group are papers where the editor considered the paper to be doubtful, but wanted further advice before confirming rejection.

The second group are papers where the editor’s first impression was that the paper would be sufficiently important or good to warrant publication, but the reviewers find flaws or weaknesses that the editor did not notice, or they use their knowledge of their field to point out that the study is actually not that important.

In both situations the opinion of the reviewers is important, but the final decision still lies with the editor who may take into account other factors.

Comment

The decision to accept or reject a paper is, obviously, personal to the editor and currently the editor writes to each author, justifying or explaining the decision.

If you feel there has been a major misunderstanding of your paper, or that someone has made a seriously flawed judgement, or that someone’s comments are factually incorrect or exhibit marked bias, or if you have some other significant concern then you may write to the editor raising your concern. Please try to ensure that your letter or email explains clearly the nature of your concerns so that the editor can consider them and reply.

The editor undertakes to treat your comments and concerns seriously. He does not undertake to change his mind, but he has done so (about once or twice each year).
Reporting a systematic review: guidance on reporting a systematic review; links to appropriate web sites

Clinical Rehabilitation will generally only publish systematic reviews. This section gives some specific guidance, but much more detail is available on the Internet.

A **systematic review** is one that has a specified method underlying the identification and selection of the papers from the specified data sources that are being used. A systematic review may or may not include a **meta-analysis**, which is the use of a statistical method to combine data, usually summary data from several separate studies. A meta-analysis always depends upon an initial systematic review, and so the methodology advised for meta-analytic studies is also advised for other systematic reviews.

Authors are strongly recommended to read the PRISMA statement and checklist for improving the quality of systematic reviews and reports of meta-analyses of randomised controlled studies (see [http://www.prisma-statement.org/](http://www.prisma-statement.org/)).

The abstract should use the following headings:

| Objective | State what the goal of the review was; what questions are being asked. |
| Data sources | Define the data-bases searched, and any secondary sources of data |
| Review methods | Summarise search and selection strategies, including patient population, study type and design selected, how studies were selected, any quality criteria used |
| Results | Give some results – actual data (e.g. number of studies and patients included, percent showing some specified outcome) |
| Conclusion | This should relate back to your objective; the question should be answered (or the fact that it cannot be answered made clear) |

The paper itself should follow the usual structure (Introduction, Methods, Results, Discussion), and will often have tables to present data. Some points are worth making.

Please always check (before starting!) that there are no identical reviews. If there is one similar to yours, explain why yours is necessary; how does it differ?

The title should include the fact that it is a systematic review (and a meta-analysis if so).

The introduction should explain why a systematic review is needed.

The results section should try to summarise data efficiently; it should not simply be a sequence of summaries of each paper.

The discussion should not only discuss the limitations of the studies included, but should also discuss the weaknesses and limitations of the review itself. It should also place the review in the context of other systematic reviews of the same topic, or of the same topic in different diseases, or in some other context.

It is helpful to include, as an appendix, a copy of the computer data-base search strategy for one data-base.

The journal will consider putting large tables or appendices as ‘web-only’ parts of the paper if appropriate.

If a meta-analysis is undertaken, then presentation of the results using figures such as produced by the Cochrane Collaboration’s Review Manager (RevMan) are useful (see [http://www.cc-ims.net/RevMan](http://www.cc-ims.net/RevMan)).
**Reporting an RCT**: guidance on reporting randomised controlled trials; links to appropriate web sites

*Clinical Rehabilitation* wishes to comply with the highest standards, and wishes to facilitate use of study information by others especially for meta-analysis and for use by the Cochrane Collaboration. These notes are intended to help any author who is reporting a Randomised Controlled Trial (or study); the advice will also apply to other, non-randomised designs of Controlled Clinical Trial.

Randomised controlled studies remain the strongest experimental design for investigating the effects of any action; they allow a causal relationship to be established. The best source of help is a web site - [www.consort-statement.org](http://www.consort-statement.org) - which includes several specific papers which should be read. The most important is:

Extending the CONSORT statement to randomised trials of non-pharmacologic treatment: explanation and elaboration.


**An important note on randomisation.**

One common error is to abuse (or misunderstand) the word, *randomization*. Many people submitting papers confuse *randomisation* with *allocation*. *Allocation* is executing the choice; *randomisation* is a process for determining the choice (other processes exist, such as alternate allocation).

The essence of randomisation is that when a choice is made (allocation to a group, timing of a treatment, order of events etc) the outcome of that choice cannot be predicted or known. For example, when patient is recruited and registered with a study it is not known and cannot be known what group the patient will allocated to even with all the information available.

Randomisation **is not the same** as:

- **Arbitrary**, where other factors determine choice (e.g. which team or hospital took the patient)
- **Consecutive, alternate allocation** (i.e. first patient group A, second group B, third group A and so on)
- **Choice determined** by day of the week, birth date, hospital number etc.

**An important note on analysis and interpretation**

A second common error is to misunderstand the logic of the design and to misinterpret the data. Parallel group RCT designs **compare** the effects of two (or more) interventions. They cannot and do not show any **absolute** effect and if both change by the same amount one cannot conclude that they are both effective (or ineffective). Thus the analysis should focus on comparing the two groups, and not on studying change over time within groups.
**Check List for any paper describing an RCT**

<table>
<thead>
<tr>
<th>Heading</th>
<th>Component</th>
<th>Comment</th>
</tr>
</thead>
</table>
| **Title & Abstract** | | Should identify the paper/study as a randomized study  
Use structured abstract (see later)  
Give total number of participants in whole study, and each group |
| **Introduction** | | Justify the study. Refer to any relevant systematic review or meta-analysis. Indicate previous relevant research, and gaps/weaknesses, but do not undertake a long narrative review.  
State main hypothesis/hypotheses and any prospectively planned subgroup or covariate analysis. |
| **Methods** | **Protocol** | Describe what you actually did (so that it can be replicated):  
How were patients recruited? (What was the pool of potential patients?)  
How were patients selected? Planned study population: inclusion/exclusion criteria  
Planned interventions, and timing. *Clinical Rehabilitation* will accept a reasonable description of any intervention, often published as an appendix if it is long.  
Primary and secondary outcome measures, and clinically significant difference if possible. Give names and references for measures, but only describe them in any detail if new, or if difficult to get other information easily.  
Statistical analyses - why, how, whether 'intention-to-treat' |
| **Assignment** | **Unit of randomization (usually a patient)** | Method of randomization (give actual details of link from randomization process to allocation of a patient to a group). This is the weakest link in most papers.  
Describe how a patient was allocated to a group.  
Blinding. Were patients blind as to (treatment) group – often difficult in rehabilitation trials. |
| **Masking** | **Masking is blinding of observers collecting data after randomisation. How was group allocation hidden from observers?** | |
| **Results** | **Flow** | Describe what happened.  
Use a flow diagram; account for all registered/randomized patients (see later)  
Analysis | Estimate confidence intervals on any effect or difference  
Always give absolute numbers (with % if wished)  
It is extremely helpful, and much preferred if all studies report mean and standard deviation of change scores in each group (allows meta-analysis)  
Note that main concern is not whether one group shows 'significant' change and the other does not, but whether the change in one group is significantly different from the change in the other (or whether the absolute levels are different between the groups)  
Give as much summary data as possible  
Describe prognostic variable in groups, and any adjustments undertaken in analysis |
| **Discussion** | | First paragraph should summarise main findings.  
Discuss areas of weakness:  
• Bias  
• Measures: Relevance/validity, sensitivity and reliability  
• Sample selection/generalisability  
Discuss strengths |
| **Tables** | | Tables should be used to present most data  
Give mean (SD), and other summary statistics for each group at each time point, indicating numbers with valid (used) data if it changes. |
| **Figures** | | Figures are a poor way of presenting most data, with the exception of relationships that change over time (in a graph) or relationships between two sets of data (in a scatterplot) |
### Structured Abstracts (especially for RCTs)

<table>
<thead>
<tr>
<th>Heading</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective</strong></td>
<td>The purpose of the study; what did you hope to discover? Specifically, in an RCT, what intervention/factor were you investigating?</td>
</tr>
<tr>
<td><strong>Design</strong></td>
<td>How was purpose achieved? Specify (as appropriate) randomized, non/single/double blind, parallel group, cross-over etc.</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Where was study undertaken? Not especially geography, but type of setting (home, hospital, primary or secondary care etc)</td>
</tr>
<tr>
<td><strong>Subjects</strong></td>
<td>Who was studied? Diagnosis(es), any selection, etc</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td>What was done? What was main treatment or factor differentiating groups.</td>
</tr>
<tr>
<td><strong>Main measures</strong></td>
<td>Outcome measures and other measures used. Give names and/or domains (activity or impairment) measured</td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Main data. Please always give number of patients, and some hard facts such as mean (SD) scores on main measure in both groups. Please focus on the comparison between groups as this is the primary purpose of this design. Change within groups is less important. Please give an estimate of the mean difference between groups with a 95% confidence interval if possible.</td>
</tr>
<tr>
<td><strong>Conclusions</strong></td>
<td>These should be related to the objective. Ensure conclusions follow from information presented in the abstract. Do not speculate here!</td>
</tr>
</tbody>
</table>
Flow diagram for randomized studies

Total number of patients that potentially could have been recruited
*This may not always be available.*

**Exclusion**
N, and reason
N, and reason
....
*If known*
Group as appropriate

**Registered but Not randomized**
N, and why

Total number of patients registered (N(t))
*This is all those registered, and all should be randomized.*
*If not all randomized, state how many not, and reasons*

Name groups as in text

**Group A**
N(1) =

Received allocated intervention = n
Did not receive allocated intervention = n

Losses (N3):
Account for all not having follow-up data.
Na; reason a
Nb: reason b; etc

**Group B**
N(1) =

Received allocated intervention = n
Did not receive allocated intervention = n

Losses (N3):
Account for all not having follow-up data.
Na; reason a
Nb: reason b; etc

**Outcome data**
Time
N(2) with data
Number excluded from analysis, (if relevant)
Data...

**Outcome data**
Time
N(2) with data =
Number excluded from analysis, (if relevant)
Data...

Repeat on down if multiple follow-up points

Note:
N(1) should equal N(2) + N(3) for each group,
and N(t) should equal sum of two groups.
### Example tables of data presentation

This page shows some possible ways of presenting data. They are to help you. They are not the only ways, and not necessarily the best for every study. However giving mean and standard deviation change scores facilitates meta-analysis and should be given wherever possible for this reason.

**Baseline data: mean (SD) or n(%)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Control</th>
<th>Trial</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>29</td>
<td>31</td>
</tr>
<tr>
<td>Age</td>
<td>56.8 (4.6)</td>
<td>57.3 (5.1)</td>
</tr>
<tr>
<td>Female</td>
<td>14 (48%)</td>
<td>16 (52%)</td>
</tr>
<tr>
<td>Initial Barthel ('/20)</td>
<td>13.4 (3.2)</td>
<td>13.5 (3.4)</td>
</tr>
<tr>
<td>Type of MS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Progressive</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Secondary progressive</td>
<td>25</td>
<td>28</td>
</tr>
<tr>
<td>Relapse-remitting</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

**Outcome data at six months: mean (SD) or median (IQR)**

<table>
<thead>
<tr>
<th>Group</th>
<th>Control</th>
<th>Change</th>
<th>Trial</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>26</td>
<td>26</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Barthel ('/20)</td>
<td>16.1 (2.2)</td>
<td>2.9 (1.1)</td>
<td>18.2 (2.4)</td>
<td>4.6 (2.0)</td>
</tr>
<tr>
<td>RMI Median, IQR</td>
<td>10 (4,11)</td>
<td>0 (0,1)</td>
<td>11 (2,13)</td>
<td>1 (0,1)</td>
</tr>
<tr>
<td>RMI (mean, SD)</td>
<td>9.6 (4.5)</td>
<td>1.0 (1.3)</td>
<td>10.5 (2.4)</td>
<td>1.5 (1.3)</td>
</tr>
</tbody>
</table>

RMI = Rivermead Mobility Index  
IQR = interquartile range

If the number of subjects contributing data is different at different points or is different for different measures, please indicate the numbers for each analysis.

### Statistical analysis

Finally a brief note on appropriate and inappropriate analysis. Randomisation allows comparison between groups, or time intervals, or whatever is randomised. Thus the main statistical analysis should be comparing two or more groups. The usual situation (two parallel group RCT) will be the comparison of change over time in patients in group A with the change in patients in group B. One may simply compare absolute values at each time point, and one may control for important prognostic variables using analysis of covariance. It is also helpful to give 95% confidence intervals.
Reporting qualitative research: guidance on reporting qualitative research

**Note:** The Editor would welcome improvement and constructive criticism on this section

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*Clinical Rehabilitation* is keen to publish high quality qualitative research concerning any aspect of rehabilitation. This section gives some guidance on the presentation of qualitative research. It is derived from published material but should not be seen as a definitive text. Advice (the so-called RATS aimed at reviewers but a useful checklist for authors) can be found at: [http://www.biomedcentral.com/info/ifora/rats](http://www.biomedcentral.com/info/ifora/rats)

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The introduction - appropriateness

As usual the introduction should establish the need for the research through reference to existing research and clinical practice.

However the introduction should also establish why a qualitative approach is necessary and appropriate, and should if appropriate establish why the particular method used is the best approach. Reasons might include lack of data on:

- The content of a treatment or therapy
- The phenomenology and content of some particular experience (e.g. spasticity), clarifying a construct
- What really matters to patients (or others); opinion

Generally qualitative research will answer questions about what or how or why.

The method – data range

Any research project should collect data from the whole spectrum of people it concerns; this helps in generalising the results to other people.

Generally qualitative research studies a small number of people and so more effort is needed to cover the range. Thus, in contrast to much quantitative research, a deliberate policy of selecting participants is required to ensure that data comes from a representative range of people. Furthermore a deliberate policy of collecting a full range of data from each individual is needed, because relying on spontaneously generated information risks missing important data.

The method – data collection

Any research project should ensure that all data available are collected for analysis; selective loss of data can bias findings, and random loss (if known to be random, which is rarely the case) increases the uncertainty associated with any results.

In qualitative studies the data are the words and ideas generated by individual participants. These are usually spoken, and it is improbable that an interviewer will be able to remember and record all ideas expressed. Furthermore the interviewer will inevitably introduce bias into their immediate record. Consequently it is usually preferred that interviews are recorded electronically (on tape) and are then transcribed onto paper for further analysis.
The method – data handling and analysis
As stated above, recorded speech should be transcribed preferably by an unbiased person who is unlikely to introduce systematic errors (e.g. mishearing ambiguous words).

Analysis consists of abstracting information from the words recorded. This obviously depends upon the researcher and she or he inevitably will have some initial hypothesis that might bias analysis. The usual method for overcoming this is ‘triangulation’, a process whereby one interpretation of the dataset is compared with another interpretation of the same dataset, and/or interpretation of a different dataset appertaining to the same person and topic. Discussion with final agreement on an interpretation is usually needed. Further validation of the interpretation may be gained by asking the person or people who provided the data whether the abstracted ideas are consistent with their intention.

Once the core ideas have been abstracted it may additionally be necessary to group these. This could be considered the qualitative analogy to factor analysis. Again, this should be done independently by at least two people, and again it should be validated against the opinions of the subjects if at all possible.

The results
Presentation of the results takes two forms. First there is the result of the data analysis. Second there is presentation of example data items that characterise the main themes or ideas reported.

Presenting results takes expertise, balancing detail against space. However the results are presented, authors should ensure that a reader can gain an overview early on, and that they can understand what the themes or ideas are. Quantification may be helpful in terms of relative importance between ideas, but it cannot be interpreted as the actual frequency in any other population.

The results section usually includes quotations from participants, and it is usual to identify the participant in some way such as age, gender, group or whatever.

The journal suggests that quotations are best presented in italics within the text.

“The man, .. I mean the nurse .. who came was helpful. He. We talked about my arm.” [F, 68]

Please be careful that no individual participant can be identified.

Quotations should be used to illustrate important points. They are data items.

Discussion
This should be structured around the same headings as any other article. It is especially important to emphasise that qualitative research cannot usually comment on the relative importance or the relative frequency of ideas in the general population precisely because the sample has usually been deliberately selected to cover the whole range which means that ‘statistical outliers’ will be over-represented. Consequently the implications of the research must take this into account.

Please always discuss the weaknesses and limitations of qualitative research in general and your project in particular.
Reporting single case studies: guidance on reporting single case studies

This section gives outline guidance on reporting single cases experimental studies. It is not concerned with case reports (i.e., just reporting a case; Clinical Rehabilitation rarely publishes case reports). Authors should consider reading the two references at the end.

A single case experimental study aims to investigate some aspect of rehabilitation through controlling some factors. It is attempting to show cause and effect.

The paper written needs to:

- **Introduce** the study
  - What is the question to be answered?
  - Why is a single-case experimental study most appropriate?
  - What other relevant work is there?

- **Describe the context**
  - nature of patient, clinical factors etc
  - the phenomena being studied and the data that measure it
  - the intervention(s) being studied
  - any other measures used

- **Describe the design** which should:
  - Establish a stable or predictable base-line
  - Have an element of randomness in choosing or starting a change
  - Establish stability after change (before introducing further change)
  - Establish that data collection is as free of bias as possible

- **Present results** clearly
  - Visual presentation of data is often best
  - Analysis should be simple, and clearly described

- **Discuss** the study
  - How do the findings relate to other studies?
  - How should they be interpreted and used?
  - What cautions are there?

**References**

Tate RL, McDonal S, Perdices M, Togher L, Schultz R, Savage S
Rating the methodological quality of single-subject designs and n-of-1 trials: Introducing the Single-Case Experimental Design (SCED) Scale.
Neuropsychological Rehabilitation 2008;18:385-401

Single Case Experimental Designs. Strategies for studying behaviour for change.
Barlow D, Mock M, Hersen M
Reviewing articles guide: guidance given to our reviewers, including our score sheet

Clinical Rehabilitation aims to publish articles of relevance to the day-to-day practice of rehabilitation. It is a peer-reviewed journal, and thus depends crucially upon the quality of the reviews of submitted articles made by a large number of independent reviewers. Your work given freely(!) is crucial to this process. You have been approached to give an unbiased opinion. This section gives some guidance.

The three aims of peer review are:
- to help select articles for publication in the journal, selection being based on:
  - the scientific merit and validity of the article and its methodology;
  - the relevance of the article to the clinical practice of rehabilitation;
  - the interest of the topic to the clinical reader; and
  - the understandability of the article itself.
- to improve the articles wherever possible.
  - which data and analyses should be presented, including suggesting further analyses
  - structure and presentation of the article (detailed comments are not necessary)
- To check against malfeasance within the scientific and clinical community.
  - writing; plagiarism, duplicate publication etc
  - data; fabrication or alteration
  - ethical and legal; not respecting participants (undue risk or inducement)

You have three responsibilities: to the author, to the reader, and to the journal.

The author
The author will have worked hard to carry out and write up the research. A referee should:
- give a reasonably quick reply (preferably within four weeks). If this is not possible please inform the editor as soon as possible. Authors are naturally impatient.
- give adequate, clear reasons for any comments, suggestions or recommendations. References are not necessary but may occasionally help.
- avoid personal bias, reading the paper for its own content.
- be constructive, not destructive, suggesting ways of overcoming any criticisms made, or of otherwise improving the paper
- read the paper as if blind to its origin if you (think you) know who wrote it

The reader of the journal
The readers of the journal will (or should) expect articles to have been scrutinised for major errors. Clinical Rehabilitation is read by a very wide range of professions from a wide range of cultures and countries, with varying levels of expertise. Readers depend upon informed experts reviewing the paper. Therefore the referee should check that:
- the work is original (if it claims to be);
- the background information given is correct, reasonably complete and covers most relevant issues without undue (hidden) bias;
- the design of the study, and the logic of the arguments made are coherent;
- the authors discuss any weaknesses openly and adequately;
- the results are credible and internally consistent;
- the conclusions can reasonably be drawn from the results, and are credible;
- the references are appropriate and accurate (as far as you know or can judge).
The journal
The journal publishes articles ‘free’, and so the authors must be encouraged to be as succinct as possible (it also make it more likely that the article will be read). Please comment if:

- you think that the article can be shortened,
- you think that tables or figures are unnecessary,
- you have any other suggestions to shorten or improve the article.

Secondly, the journal wants to retain its reputation. It should avoid publishing articles that:

- are scientifically invalid,
- are duplicate publications,
- seem to include or condone illegal or unethical behaviour,
- are disrespectful of others in any way
- are misleading or simply without content.

An approach to reviewing a paper
Each reviewer develops their own approach to the task, and this editor does not wish to constrain his reviewers to any fixed format. Some suggestions are given here especially for those new to the job.

Your comments are anonymous, in that only the editor knows your identity. This allows you to be honest, but requires you to be polite and unbiased. Unless you request otherwise, your comments will usually be sent to the authors with a covering letter. You and your co-reviewer will receive copies of my letter to the author and of each other’s review (anonymously).

When reading the paper please consider two perspectives:

- as a representative reader, considering whether you would read it and understand it.
- as a scientist, considering the validity of statements, and of the conclusions.

Both the author and the editor appreciate free-text comments because they draw attention to matters that concern you. It is helpful to start your free-text comments with a short summary (1-4 sentences; 2-5 lines) of the main message of the paper. This means that the editor can get a quick overview of the content of the paper, and it can also reassure the author that you have understood the article.

After that you may choose the approach that you find best both for yourself and given the paper and its content. When making comments please draw attention to any major ambiguities or errors in writing, but you do not need to make detailed editorial comments on grammar, spelling etc.

In order to help you, a series of specific questions are given below. These may help you in thinking about the paper. They offer you a structure that probably applies to most papers, though certainly not to all papers. They also offer you the opportunity to score the paper on different aspects (and our web system offers an easy method for recording scores). However you are not obliged to use either these headings or the scoring system. It is for guidance only.

<table>
<thead>
<tr>
<th>Scoring (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If giving a score, note that:</td>
</tr>
<tr>
<td>- For each question the default is ‘99’ which means that you think the question does not apply, or you do not want to give a score for that question.</td>
</tr>
<tr>
<td>- Otherwise please choose a number between 0 and 10, where 0 is the worst and 10 the best.</td>
</tr>
</tbody>
</table>
Some questions to consider

1 What is your overall advice?
   I would appreciate your view on the value of the paper assuming that your suggestions are carried out. In other words, what is the potential outcome for the paper.
   
   0 = reject totally; the paper has no merit and might even be misleading
   10 = must accept; an outstanding study

2 How easy was the paper to read and understand?
   This refers to your opinion as a reader of the journal. Any difficulties you experienced were not your fault; they indicate a need for better writing or presentation. It does not specifically apply to the actual use of words if the author is clearly not a native speaker of English. However if particular sentences or paragraphs are unclear or ambiguous, please draw attention to them.
   
   0 = appalling presentation; the paper needs almost completely rewriting, structure poor
   10 = well constructed, logical flow of ideas, easy to read and understand

3 Is the abstract a reasonable summary?
   The abstract should give all the vital information, including some actual results (data, in studies reporting data). If unstructured, we will ask for a structured abstract.
   
   0 = inaccurate, misleading, seriously incomplete
   10 = full, clear, accurate

4 Is the introduction satisfactory?
   The introduction should explain why the study is needed, and set it in the context of existing work largely through references. Introductions should be succinct. They will usually end by posing the question(s) or hypotheses being explored.
   
   0 = incomplete, illogical, biased or otherwise unsatisfactory introduction
   10 = justifies study well, and refers adequately but not excessively to existing work

5 Are the methods described clearly?
   The methods section should in principle allow full replication of the study. Could you follow it? Was it complete? Did you understand what was done? Is there unnecessary discussion?
   
   0 = poorly structured, unclear, missing information
   10 = well structured, complete yet concise, no significant omissions, not excessive

6 Are the methods used appropriate?
   This refers to the design, measures and analytic procedures actually used. Was the design appropriate? Were the measures used or data collected appropriate? Have the data been analysed in the most efficient way possible, not too complex but utilising the data to their full extent. Comments on statistical analyses are helpful, but not essential (if you have specific concerns mention them; we can obtain specialist advice).
   
   0 = inadequate or faulty method used, not allowing any conclusion to be drawn
   10 = best possible methods used

7 Are the results presented clearly?
   This primarily refers to the structure of the results section (its ordering and flow), and the appropriate mix of text, tables and figures. It also refers to the data presented in the text.
   
   0 = incomplete data, poorly ordered, not well presented, obvious errors
   10 = well set out, logical ordering, easy to understand, results relate to questions posed
8. Are the **tables and figures** appropriate and accurate?
   This refers to the data presented in tables or figures. Are they easily understood? Should more or less data be put in tables? Are the figures helpful?

   - 0 = tables and figures add nothing or are misleading or inaccurate
   - 10 = best use of tables and figures, no major changes needed

9. Is the **discussion well structured**?
   A discussion should have a reasonably logical flow. Could you follow it? Did it cover all main points concerning you? Were conclusions reasonable, and not too ambitious given the study?

   - 0 = poorly written discussion, difficult to follow and making unwarranted claims
   - 10 = well written discussion, balanced and drawing reasonable conclusions

10. Does the discussion cover the **main limitations and weaknesses** of the study?
    This is vital. The authors should be more aware than most of the flaws in their study. No study is perfect!

    - 0 = does not mention or acknowledge any weaknesses or limitations
    - 10 = covers all the main limitations, and gives reasonable weight to them

11. Is the **extrapolation and speculation** reasonable, balanced and relevant to rehabilitation?
    The readers are interested primarily in the clinical practice of rehabilitation. Any discussion should at least mention how the study might influence clinical practice.

    - 0 = unreasonable, illogical, unjustified or irrelevant speculation
    - 10 = clinically relevant and well justified conclusions

12. Are the **clinical messages** appropriate?
    The clinical messages are, in essence, the bottom line conclusions. Are those given justified? Have any been missed? Has the author drawn conclusions logically, and emphasised the most important ones?

    - 0 = messages not at all justified or consistent with study and data
    - 10 = fully appropriate

13. Do you have any concerns on **malfeasance** (ethical, scientific, authorial)?
    If you have any significant concerns, please let the editor know. You may wish to do this in a confidential letter. The editor will always keep you informed of his responses and actions, and will consult you before disclosing your concerns, and will not disclose your name (unless you request that). See our document on malfeasance on our web-page.

I hope this guidance is helpful.

Anyone interested in the peer review process for *Clinical Rehabilitation* should read an editorial:
*Clinical Rehabilitation* 2004;18:117-124
Reviewing data-free papers: guidance to reviewers on how to review articles not reporting a formal study

Clinical Rehabilitation publishes many papers that report upon studies where data are collected and analysed. The criteria that should be used when reviewing such papers are, at least to a limited degree, agreed and we publish guidance. This section provides outline guidance for all other types of papers. These are generally papers that draw upon evidence to educate, or to stimulate debate, or to develop a new hypothesis. The guidance is necessarily broad, and may not suit every circumstance or every reviewer, but I hope the guidance is useful. It presents a series of headings which might be considered.

Interesting to read?
The journal is of no use if articles are not read. Therefore the first question is “How interesting was this?” To be interesting a paper needs to be:

- written in an engaging style that maintains interest
- well structured and laid out, with a logical flow and appropriate use of headings
- concerned with a topic of some clinical importance to at least a proportion of the readership
- not too long

Evidence-based, justified?
The articles being considered will often consider topics where evidence is relatively scarce. Nonetheless the articles are not intended simply to be an opportunity for an author to reveal his prejudices without further explanation or justification. The reader needs to be reassured, if possible that:

- any relevant evidence has been considered
- any dogmatic statement has some justification
- any biases are made explicit

Well written, focused?
This is another aspect of being interesting.

- Does the article have a clear, coherent structure?
- Do ideas flow logically, one from the other?
- Are there parts that are not really relevant?
- Can you understand it without difficulty?
- Is anything unclear or ambiguous?

Fair, not libellous or inaccurate?
Authors may present any material, provided it is not actually libellous. However it is especially important that we protect readers from being misinformed or given a biased account without open acknowledgement. To this end please consider, as far as you are able, whether:

- Any author or article is being seriously misrepresented or misused
- Any statement or suggestion might actually be dangerously wrong (proof is not needed; simply draw attention to any significant concerns so that the author can justify their stance, or alter it)

In the end I am simply interested in your view on the suitability of the article, expressed in whatever way you consider most appropriate. If you think that the article can not be made suitable, say so. If you think that reasonable changes will make the article good, summarise your main suggestions. Thank you.
What *Clinical Rehabilitation* publishes: an outline for the type of material that the journal publishes

*Clinical Rehabilitation* is an international journal which aims to publish the best scientific research articles and other articles on all aspects of activity limitation (disability) and rehabilitation. Articles must also be readable, enjoyable and easily understood because the journal is aimed at an international and multidisciplinary audience.

Submitted articles are subject to a process of review and selection to ensure that the content is of high standard. The core values of *Clinical Rehabilitation* that guide this selection and prioritisation of submitted articles are that all articles published should:

- Be scientifically sound, either presenting new data and/or analyses, or using evidence to support any opinions or suggestions.
- Be logically sound, using coherent arguments to explore or defend ideas and conclusions
- Avoid bias as far as possible, and acknowledge openly any bias that may be present
- Be useful, of interest and relevant to professional staff working in the field of rehabilitation both clinically and in research
- Be ethically sound both in terms of the underlying research (if any) and in terms of its content and style.

***

All articles submitted are considered for publication, and all articles that are considered by the editor to be potentially worthy of publication are sent out for peer review. The editor does not adhere to fixed rules, and is always happy to be approached by authors for informal advice on potential articles (email an abstract to clinical.rehabilitation@sagepub.co.uk).

Articles published will tend to fall into one of the following groups, but these groups are neither exhaustive nor exclusive.

**Original research/data**

These papers will be reporting on studies undertaken to answer some question. The studies may be:

- **Evaluating an intervention**, usually by a randomised or otherwise controlled study design
- **Evaluating service delivery**, either by ‘audit’ or using more experimental designs
- **Exploring inter-relationships** between different factors. These may be studies investigating prognosis, recovery, responsiveness to treatment, other inter-relationships etc
- **Descriptive**, usually natural history studies in which case epidemiologically-sound studies are much preferred
- **Investigating data collection tools** (assessments and measures). Generally the journal will only publish studies on these if the subjects are patients (not healthy people, unless the data collection tool is for use with healthy people).
- **Qualitative**, usually providing data on the content of treatment or experience of rehabilitation and disabling illnesses.
Reviews
The journal gives high priority to two types of review (see below), but does not generally publish ‘simple’ reviews. The reviews preferred are:

- **Systematic reviews** of published evidence, including Cochrane reviews. These may be longer than the stated preferred word count.
- **‘Position’ reviews** that draw upon published information in a systematic way but use it to develop and support a personal hypothesis or point of view. The position, or view being advocated should be challenging in some way; we are looking for something to challenge the routine and orthodox.

Papers espousing a specific point of view (position reviews) should have a summary that makes explicit the diversity of opinion that exists and the opinion of the authors, and it should also explain how the authors have collated their evidence in support of their point of view. The main article should then expand on the logical arguments and evidence base.

It is not possible to dictate or suggest a specific layout or structure for a position review. However the article will be judged against criteria such as:

- Clarity of writing and lay-out (use tables and figures if necessary)
- Logical coherence, and use of evidence
- How reasonable and sensible it is; dangerous or irrational ideas are unlikely to be published!

Rehabilitation in practice
*Clinical Rehabilitation* started a new type of article in the journal in 2006, entitled Rehabilitation in Practice. The aim is to publish articles that focus on clinical practice and the use of evidence to improve clinical practice. The articles may take many forms but in general they will be between 2000 and 4000 words (no rigid limit applies).

[For further information, see the editorials in *Clinical Rehabilitation* 2006;20:93-96 and 2010;24:291-291]

The primary intention is that articles should in some way synthesise or use available evidence to improve the way that rehabilitation is undertaken in practice (i.e. outside the research context). This will require considerable judgement and expertise on the part of the authors, and the journal (i.e. the editor) recognises that ultimately advice given and conclusions drawn are a matter of opinion. Nonetheless articles should adhere as far as possible to the core principles of *Clinical Rehabilitation*:

- being based on evidence wherever possible;
- avoiding hidden bias; being rational and coherent;
- being relevant to a wide, general readership; and
- being practically useful.

There may be several different sub-types, but authors should not worry unduly about these. Please contact the editor if you wish to discuss your idea.

Description of a therapy
*Clinical Rehabilitation* is particularly interested in publishing descriptions of rehabilitation interventions that have been or are being evaluated. These are difficult to get published. The intention is to give sufficient description of how to do it that a reasonable person with appropriate clinical experience could deliver the rehabilitation. The article should also be readable.

The requirements are that:
- there should be some theoretical and/or evidence-based justification for the intervention’s design
- the intervention must be being evaluated in an RCT, or have been evaluated.
- the description is sufficient to allow someone to deliver a similar programme.

Note that it is not necessary for the intervention to have been shown to be effective.

There is no fixed format, and you should look at published articles for some ideas.

Reports on translating evidence into practice (audit+)
Papers reporting on the translation of some evidence-based practice into routine clinical use, and an audit of the structures and/or processes and/or outcomes associated with this will be welcome.

The paper should have the usual format. It should outline, in the introduction, the evidence being used. The methodology used to collect data and compare against some standard should be described as usual (and should be scientifically sound). Within the method section there should be a description of the service/treatment or whatever is being audited. This may be given as an Appendix. There should then be results and discussion as usual.
Educational and ‘how to do it’ articles; protocols, care-pathways etc
Systematic reviews and research projects can only focus on a limited part of the totality of rehabilitation at any one time. Consequently there are few opportunities to publish articles about, or to read about, care pathways and protocols that cover the overall management of some problem or situation.

Educational papers are likely to start with some reasonably common clinical situation and, using the available evidence, put forward a system for managing it. These may be care pathways, algorithms, protocols etc.

The structure and layout cannot be dictated but the article will be judged against criteria such as:
- The appropriate use of evidence (while it is not necessary to review and give evidence for every step, the article should reference any systematic reviews and other data sources used, and the article will be reviewed to check on the evidence)
- The applicability of the system in different settings (the protocol should be made as generic as possible; refer to a specialist multi-disciplinary out-patient clinic and not to the specific clinic you run!)
- The importance of the topic (this is relative, and does not preclude pathways for rare problems if they are well constructed)
- Clarity and lay-out; simple figures or protocols that can be copied and used will be a strong point.

Reports on development and/or content of services, treatments, data collection tools etc
This type of report will only be accepted if of significant importance and very well presented. Generally research reports should contain details about the development of and/or content of and/or justification for the intervention or data collection tool being researched. Sometimes a separate report may be justified, especially when the development fails; publication of experiments that fail may help others to avoid failing.

These papers should also have a reasonably standard lay-out with an introduction setting the scene. However the methods and results may include how the development was run, and the results of the development.

It is important that the report covers a topic of reasonably widespread interest and it is vital not to concentrate only on factors of local relevance (local to the city, or to the country or health care system concerned).

Other
The journal is also interested in and will publish letters commenting on recently published articles or topical issues. The authors of the original are given an opportunity to read the letter and write a response, if appropriate. The editor will usually select letters without review. [See separate guidance on this topic.]
Writing for Clinical Rehabilitation: a reasonably detailed guide on how to write: style, headings, structure, and many other tips

This section aims to help aspiring authors write an article that is likely to be accepted for publication and that will be read by and influence others. It combines direct suggestions of a practical nature relating to the process of publication with general suggestions that relate to the process of writing effectively. Other documents on this website cover matters such as the submission and handing of documents and the more technical aspects of preparing documents for submission.

The primary messages are:

- You are telling a story, so make it interesting and have a logical sequence
- Your reader is like you, and prefers simple clear sentences using plain language
- Your article should be as short as possible, but as long as necessary

This section discusses:

- **Structure of scientific articles; why and what**
  - The title; make it interesting
  - The abstract; make it informative
  - The introduction; why did you do the study (and why should the reader read it)?
  - The methods; what actually happened?
  - Ethics; were actions morally acceptable?
  - Results; what did you find?
  - Discussion; what does it mean, and what does it not mean?
  - Clinical messages; so what? [This is particular to Clinical Rehabilitation]
  - Accompanying statements; thanks, who influenced us, who did what?
  - References; the historical context
  - Illustrations; tables and figures

- **Writing style**

- **Some (otherwise) unwritten rules;**
  - Length of article
  - Authorship (see also our separate document)
  - Copyright?
  - Malfeasance (immoral or illegal behaviour)
    - Plagiarism
    - Duplicate publication
    - Misrepresenting data or data analysis

- **Where to get help**
Structure
A good story has a beginning (a puzzle is set out), a middle (taking you towards the resolution of the puzzle), and an end (the solution of the puzzle). Scientific articles are no different.

Most scientific journals request a similar structure for their articles. This is not just chance! The structure has evolved to be currently the most efficient and effective way to communicate. Please use the suggested structure unless you have good reasons not to; articles will be considered with other layouts but most readers are familiar with the standard format given below.

A clear structure within each section is also important. Please make the article flow in a logical and coherent way so that the reader can understand both what he has learned so far and where the article is going. The structure should be apparent without excessive use of subheadings.

The title
A book has a title that is aimed to grab your attention and tell you what to expect inside. Do the same with your title. The priority is for the title to be informative, but it should not be too long and if it can also attract attention then that is a bonus.

Title page
Books also give you some boring factual information at the beginning. Your article will start with the title page, which should give the title of the paper; a running title; the names and initials of all authors; and the name and address of the author to whom correspondence, proofs and offprint order are to be sent should be given, together with an email address, telephone and fax numbers if possible. Please make sure that this information is given, is accurate and is up-to-date. We find it impossible to make contact with some authors, whose articles therefore cannot be published.

The abstract
Most books have a synopsis, hoping to entice you to buy the book. Your abstract fulfils that purpose. Your abstract is also going to be available in electronic data-bases and will be subject to searches; Google is now the primary route to articles. Make your abstract as informative as you can. This is achieved by using a structured abstract of no more than 250 words if possible.

The abstract is important for many reasons. Editors often reject papers on the abstract alone, and research shows that this is fair in most cases. Many readers will only read the abstract, especially if undertaking searches of computer data-bases. They help the reader (and the author) establish the main messages. Clinical Rehabilitation requires structured abstracts wherever possible, because research shows that structured abstracts are usually more informative.

A structured abstract involves using some or all of the following headings; not every heading is appropriate in every case, and other headings may be used.

- **Objective.** The purpose of the study; what did you hope to discover?
- **Design.** How was purpose achieved?
- **Setting.** Where was study undertaken? A general not specific description.
- **Subjects.** Who was studied?; what types of patients?
- **Interventions.** What was done?
- **Main measures.** Outcome measures and other measures.
- **Results.** Main data. Please always give number of patients, and some hard facts.
- **Conclusions.** Should be related to the objective.

Sometimes different headings may be used. Some journals use other headings (e.g. Background, Methods, Results, Conclusions). Some types of article require more appropriate headings. For example we give specific guidance on systematic reviews as a different set of headings should be used when reporting a systematic review. A good source of guidance on the appropriate headings to use is to visit the EQUATOR website (http://www.equator-network.org/?t=1001) which has links to most important guidelines and recommendations.

Thereafter most research articles should follow the standard layout and be presented in this order.
Instructions to Authors

Revision: Oct 6th 2010

Introduction - why did you ever start on this study?
This sets up the puzzle; why was this study necessary? The first sentence should attract the reader. The introduction should encourage the reader to continue reading.

The introduction can usually be covered in three or four paragraphs which should:

- Specify the general topic and field of study with a broad brief outline of its relevance
- Outline important earlier work, including any systematic reviews or meta-analyses (but the introduction is not the place for a detailed review of previous work).
- Identify gaps or uncertainties in existing knowledge that require more research.
- Conclude with a brief statement of the main hypotheses you are testing, or your research questions.

Common mistakes are:

- To make the introduction too long, giving detailed reviews of all previous work, and/or
- To start giving information about the methods used and/or results found.

The introduction should answer four questions:

- What question or topic is this article or research about?
- What is already known?
- What is not known, or still reasonably uncertain and why is this important?
- What particularly is this research investigating?

Methods – what did you actually do?
You now describe how you set about solving the problem posed in the introduction. It is a very necessary if slightly boring part. It should allow the reader to understand exactly what you actually did. This part should describe what you did in sufficient detail to enable replication, at least in principle.

Please ensure that you describe the methods in a logical order. You should cover:

- the design of study,
- how subjects were recruited and selected,
- what data were collected (i.e. the measures used),
- how data were collected (i.e. who did it, where, when)
- how bias was countered (both patient and experimenter bias),
- what types of analysis were undertaken. Describe the statistical methods used.

In addition you should state (if true and relevant) that the study had the approval of local ethical committees.

Flow diagrams are often helpful, and should be given for all studies of interventions. (see Rennie, JAMA 1996; 276: 637-39 or Altman, BMJ 1996; 313: 570-71).

If you are evaluating an intervention (treatment) then Clinical Rehabilitation is happy to give you reasonable space to describe both the experimental and control intervention either within the text or, if long, in an appendix or published as a web addition.

There are some common errors to avoid. You do not need to justify in detail every choice made, nor should you describe in detail every data collection tool used. Use references to allow readers access to details when references are readily accessible. Only give detail if you are using a technique or tool that is new or difficult to find using references.

Results (data) should not be given in the methods section; this is a common error. Data belong in the results section.

But do give detail on all important matters. The commonest failing is a failure to describe accurately what was done, while explaining in tedious detail what was not done, and why, or what might have been done but was not etc.

Ethics – were your actions morally acceptable?
Clinical Rehabilitation only wants to publish ethically sound research. This basically means that the subjects (patients or healthy people) must be treated with respect. They should be informed of the nature of the project, given choices, especially on whether to participate, and subject to as little risk or unpleasant procedures as possible on account of the research. Usually protocols are considered by ethical committee (Institutional Review Boards) before being started, but the journal’s view is that consideration by an ethics committee does not guarantee ethically sound research nor does failure to seek help from an ethics committee inevitably imply
unethical practice. The journal will always consider the ethical aspects of submitted papers. Discussion of ethical issues relating to a project may legitimately be included in an article.

**Results – what did you discover?**

This is where you present your data. This is the denouement, where the reader finds the answers. Of course most people skip over this, but you should try to attract their attention. Relate the presentation of results back to your questions. Present results in a logical order.

Think carefully about how you present your data. Give actual numbers; all percentages should be accompanied by actual numbers. Tables are often a good way to show data. Figures, such as scatterplots and other graphs, are informative but histograms rarely are. Always give a title to each figure and table, and always enlarge upon all abbreviations under the table.

Please place all tables and figures on separate sheets, at the end, but please show in the text where they belong. *(Some journals now suggest incorporating tables and figures within the text, but Clinical Rehabilitation does not, believing that most reviewers prefer to find tables and figures separate)*

The results of complex statistical analysis are not results in themselves. They help the reader understand the data, and inform the reader how much weight can be given to an interpretation. Tables and text should primarily contain summarised data such as means (which should always be accompanied with standard deviations), medians and ranges, modes or whatever. The text can give the results of more complex analysis.

However statistical analyses help in understanding and interpreting data. Therefore they are an important additional set of data.

**Discussion – so was it worthwhile?**

Stories do not have discussions! But story tellers usually try to include a moral within the story itself. You have an opportunity to make that more explicit. Note that research shows that most readers start with the discussion. Therefore your discussion should:

- be interesting and informative
- be fair, and not one-sided
- come to some conclusion

In *Clinical Rehabilitation* it is particularly important that the discussion focuses on the clinical relevance of a study. How should this study influence the clinical practice of rehabilitation teams?

It is also important to structure your discussion. It should have a logical flow moving from topic to topic. A generic structure has been suggested [Smith R. The case for structuring the discussion of scientific papers. *British Medical Journal* 1999;318:1224-1225], and the component parts suggested are:

- Statement of principal findings
- Discussion of strengths and weaknesses of the study itself
- Discussion of the strengths and weaknesses in relation to other studies, discussing particularly any differences in results
- Explanation of the meaning of the study particularly:
  - How it informs about possible mechanisms of illness, or
  - How it might alter clinical practice and/or health care policies
- Highlighting some of the unanswered questions and suggested future research

For *Clinical Rehabilitation* we require the first paragraph to summarise the whole study, explaining what you have discovered and what the major strengths and weaknesses are. It may be all that the reader reads!
You must then discuss:

- **Weaknesses and limitations.** Avoid the temptation to overstate your study. You will, or certainly should know the main weaknesses of your own study. Tell the reader, so that they do not draw inappropriate conclusions. You also have an opportunity to respond to potential criticisms, and to point out any relative strengths. **The major flaw in articles submitted is a total failure to acknowledge any weaknesses.**

- **Context.** Set your findings in the context of other knowledge. You do not need to consider every single other study, but do point out how your findings support, develop, or refute previous research findings. You can point out how your study is better than, or different from other studies.

- **Implications.** You may also take the opportunity to speculate on the consequences of your findings. This should be restrained, and realistic. For this journal, *Clinical Rehabilitation* you should certainly relate your findings to the clinical practice of rehabilitation. You may also consider what next research step is needed. Sometimes there may be implications for theory.

It is not necessary to use subheadings. In general the text should flow logically with relatively short paragraphs that provide structure. However we do not have a fixed rule.

We do not have a section entitled ‘conclusions’, nor do we require a final summarising paragraph. The first paragraph and the Clinical Messages encompass this.

**Clinical message – so what?**

Many readers will simply want to know “Should this research have any impact upon my clinical practice?”

Therefore *Clinical Rehabilitation* would like all authors to provide a series of points encapsulating the main clinical message(s) arising from the article. They should be limited to no more than 50 words and should comprise 2-5 bullet points.

The clinical messages must arise from the study. They should be complete in their own right, and should not depend upon reading the article.

**An example clinical message**

**Clinical messages**

- Three months of cardiac rehabilitation in patients after coronary artery bypass grafting improves heart rate recovery and resting heart rate
- Recovery of heart rate over one minute may be a good measure of the effectiveness of cardiac exercise training

**Accompanying statements**

Unlike novels and short stories, journal articles follow from the work of many people, and often the work is paid for by others. *Clinical Rehabilitation*, in common with many other journals, wants to maximise openness and to reduce the risks of hidden influences.

Consequently, on a new page, we would like to see the following.

**Acknowledgements.** (not essential)

This is your opportunity to say thank you to everyone who contributed to the article. This can include people who have given advice, people who helped in the running of the study, patients and relatives, people who provided resources including money, etc. If you have more than four authors, you could consider whether some should simply be acknowledged instead.

**Competing interests, and source of funding.** (essential)

If you feel that there are any interests that readers should be aware of, please state them; they will not affect the decision to publish. [See separate guidance for a little more detail.]

Competing interests are wide. They obviously include the source of funding and support for the reported work (which must be stated, together with a statement on what influence they had over the analysis, interpretation and reporting of data) and any financial interests that any author may have in the results. However they also include any other influences that others might believe could affect the way you set up the study, collected and analysed the data, or interpreted the results. Ask yourself, in relation to the paper, “would I be embarrassed if this fact became known?” If so, report it.

If you do not think there are any competing interests that readers should know about, state “none declared.”
Contributors. (essential) (See also separate document on authorship)
Please indicate (using the initials of authors) what each author contributed to the study and paper. The activities involved usually include writing the paper itself, initiating the study, designing it, monitoring progress, and deciding on the analytic strategy. One author should be the guarantor, the person who takes ultimate responsibility for the accuracy and honesty of the report and the morality of the study.

References – where can the reader find other parts of the greater story?
References are, in one way, the earlier parts of your story. They put your chapter in a context. They also allow you to avoid repeating information that is readily available elsewhere.

They should always be condensed to those which are relevant; more is not necessarily better.

They should be numbered in the order in which they appear in the text in the ‘Vancouver style’ [1]: for articles, give names and initials of all authors, the title of the article, the journal title abbreviated according to Index Medicus, year of publication, volume number and first and last page number; for chapters in books give authors, chapter title, editor(s) of the book, the book title, place of publication, publisher, year of publication and first and last page number.

It is easiest to place them in the text using square brackets, one for each reference number (e.g. as - [2][5][12]).
This is not compulsory, but it makes life easier!

For examples, see below [2][3][4]:
1 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. JAMA 1993; 277: 927-34.

Illustrations – making it more interesting
Text is informative, but large expanses of text can be off-putting. Most scientific studies have sufficient data to warrant the use of tables or figures both to break the text up, and to allow more efficient presentation of the results.

Tables are rarely needed for a single column of figures. Histograms are very rarely useful or appropriate; avoid overuse of fancy computer packages! Think carefully about how to present your data. Each table should be typed on a separate sheet with an explanatory caption, and be numbered. Indicate in the text where tables should be positioned.

Figures can present data in a clear and informative way, but equally can be badly used. Flow diagrams showing how patients (or papers, in a systematic review) progressed through the study are often helpful. Scatterplots and others graphs are often very informative. Histograms are rarely useful. Photographs may occasionally help (black and white only).

Writing style
Please remember that you are trying to attract and maintain the interest of a busy reader. Make your article interesting. Tell a story. Do not wander from the main theme or focus of your story. Avoid jargon, avoid long words, and avoid long and complex sentences.

Abbreviations are extremely difficult to read, and are usually ambiguous. They should be kept to a minimum and must be clearly defined when used for the first time. We generally tolerate:
• Mean (SD) – for mean (standard deviation)
• 95% CI – for 95 % confidence interval
• IQR – for inter-quartile range
• ADL – for activities of daily living
• FIM – for Functional Independence Measure
We do not tolerate many other abbreviations!

There are also some more technical requirements:
- Please submit the article in double spacing, and with a reasonable font size (font size 12)
- Abbreviations (if used) should be typed with no full point.
Scientific measurements should be given in SI units, but blood pressure should be expressed as mmHg and haemoglobin as g/dl.

All numbers under 10 should be written as words, except when attached to a unit of quantity (e.g. 1 mm or 3 kg), and that numbers of 10 or more should be written as digits except at the beginning of a sentence.

Generic names should be used for drugs. Authors should be aware of different drug names and availability in the UK, North America and Australia, and give alternative names or drugs in the text.

Avoid excessive capitalization. For the titles of books and articles, capitals should be used for the initial letter of the first word only. However, for the titles of journals and series, the initial letter of all principal words should be capitalized.

Use italics for emphasis sparingly.

Please avoid using more than three levels of heading.

Some unwritten rules
There are some unwritten rules that apply to a greater or lesser extent in most scientific journals.

Length of articles
Clinical Rehabilitation does not have any rigid rule. My advice is “Articles should be as long as necessary and as short as possible.” As a guide for ordinary articles, 1,500 words of text is good and 3,500 seems rather too long.

Authorship. (See separate document for more advice)
Clinical Rehabilitation in common with most journals wishes to restrict authorship to those who warrant it. To quote the BMJ (1994; 309:1456-57): “authorship should be based only on substantial contributions to: (a) conception and design, or analysis and interpretation of data; (b) draft an article or revising it critically for important intellectual content; and (c) final approval of the version to be published.” Conditions (a), (b), and (c) must all be met and all people meeting these conditions should be included as authors. Activities such as fund-raising, collecting data, and simple supervision do not qualify for authorship on their own. It is acceptable and best to acknowledge people in the acknowledgement section who have helped in various ways.

Copyright.
Authors must obtain copyright permission to reproduce all maps, diagrams, figures and photographs - forms are available from the publishers. As a rule it is also necessary to obtain permission for single passages of prose exceeding 250 words, or scattered passages totalling more than 400 words from any one work. EU copyright extends to 70 years after the death of the author or 70 years after publication of a scholarly edition, whichever is longer. Please supply the publisher with full information for all work cited, including author, date published, publisher and page references. All text (more than a few words) taken from any other published sources should be clearly identified as such by the appropriate use of quotation marks and a corresponding reference.

Malfeasance (See separate document for more information)
Malfeasance is practice that falls below an acceptable moral standard, and/or is illegal.

Clinical Rehabilitation has a responsibility to maintain a standard of science and authorship that complies with any legal requirements that apply (in the home country of the authors) and that is of a high moral standard. We will be alert to:

- Authorial malfeasance
  - Plagiarism and duplicate publication
- Data-related malfeasance
  - Alteration or even fabrication of original data
  - Manipulation and analysis of data knowingly to achieve results that do not reflect the truth
  - Failure to report known data or results that would materially alter the conclusions
- Moral (and legal) malfeasance
  - Breaking the laws in the country where the research occurred
  - Treating participants without due respect for their well-being and autonomy

The editor asks reviewers to consider every article from this point of view, and considers it himself. No cases have been detected yet, which is not to claim that none have occurred; we simply cannot know. Our response to suspected malfeasance is detailed in a separate document.

Additional sources of help
There are many ways of improving your writing. The best is to read extensively, and outside science. Try novels by Dickens, or poetry, or any good novels. Read many articles and consider how easy you found them, and what features helped you. It is particularly helpful to think about papers (or books) that you found difficult or stopped reading; try to work out why the paper was difficult or why you stopped reading. Then avoid doing the same when you write.
Also it is essential to practice writing. Writing is not easy and (just like rehabilitation) continued practice with continued constructive feedback (from a friend or relative who is outside your immediate research group) is best. You should constantly be reviewing and revising your paper (most of my editorials go through 10-15 versions, often ending quite different from the first version).

Third, read about writing. Amazon have 191 books on ‘how to write a paper’ and 73 on ‘writing plain English’ (searched 15th February 2009), so there is no shortage!

Fourth, use the Internet. The National Health Service in the UK is funding the EQUATOR Network (http://www.equator-network.org/?o=1001) as a resource centre for good research reporting. It is still developing, but it already has links to most important guidelines and recommendations. There are undoubtedly many other such sites. Indeed many other journals have guidance on writing and reporting.

Books that may help:
Oxford Guide to Plain English - *This is the cheapest, and probably the best buy*
Martin Cutts
OUP 2004

Improve Your Writing Skills
Collins 2004

The Complete Plain Words
Sir Ernest Gowers
Penguin books

Fowler's Modern English Usage
R W Burchfield
OUP

Feedback and Suggestions

I hope this guidance is helpful. Please send comments and helpful suggestions to the editor.

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