Pisanje in predstavitev znanstvenih besedil

Marija Petek Šter

Vsebina

- Namen znanstvenega besedila
- Elementi in struktura znanstvenega besedila
- Predstavitev rezultatov znanstvenega dela

Namen znanstvenih besedil

- **Namen znanstvenega besedila** je predstavitev izvirnih znanstvenih rezultatov, ki prispevajo k porastu že obstoječega znanja.

- **To work, to finish, to publish (Michael Faraday)**
- Če dela nismo objavili, to ne obstaja!

Preden začnemo s pisanjem znanstvenega besedila

- Koncept pisanja:
  - Razmislek o pisanju (če gre za originalni znanstveni članek se vprašamo: ali naši rezultati prinašajo pomembne znanstvene informacije)
  - Pregled obstoječe literature
  - Priprava načrta pisanja za posamezna podpoglavja članka

Elementi in struktura znanstvenega besedila

- **Pisanje nam olajša »šablona« za pisanje znanstvenih besedil**
- **Običajna struktura znanstvenega besedila:**
  - **Naslov:**
  - **Izvleček:**
  - Ključne besede:
  - Uvod:
  - Metode:
  - Rezultati:
  - Razprava:
  - Zaključek:
  - Zahvala:
  - Literatura:
  - Priloge:

Naslov

- **Zelo pomemben** – naslov vodi/odvrne od nadaljnjega branja
- Naj označi bistveno vsebino prispevka
- Popoln, nedvoumen, jedrnat
- Dolžina: max 100 znakov (s presledki vred)

- Primeri:
- Kam plovemo? (slab naslov)
- Pomen CRP testa pri bolnikih s kašljem v družinski medicini (bolje)
- Pomen testa CRP pri bolnikih s kašljem in negativnim testom D-dimer v družinski medicini (bolj specifično)

Izvleček

- **Zelo pomemben** del znanstvenega dela: na kratko pokaže bistvene podatke iz članka
- Omejen po obsegu: 250 besed
- IMRAD struktura: (**I**ntroduction, **M**ethods, **R**esults **A**nd **D**iscussion)
- Piše se v tretji osebi ednine ali množine, dopusten je pasiv, pretekli čas

Izvleček

- Vsak od delov izvlečka po **IMRAD** strukturi naj ima **do tri stavke**
- Zadnji stavek razdelka **Izhodišča** naj predstavi **namen raziskave oziroma ključno raziskovalno vprašanje**
- Predstavite le ključne metode in rezultate
- V prvem stavku razdelka D (Discussion) podajte odgovor na zastavljeno raziskovalno vprašanje, nadaljujte z uporabnostjo rezultatov oziroma idejo za nadaljnje raziskovanje

Ključne besede

- Najbolj označujejo vsebino članka
- Navadno do pet
- izbrane iz:
  - standardiziranega geslovnika – tezavrusa. Primer takega geslovnika je MeSH® (angl. Medical Subject Headings)
  - Prosta izbira

- Npr: Kašelj, negativen D-dimer, CRP, diagnostična vrednost, družinska medicina

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PLOS ONE

Prevalence, Determinants and Patterns of Multimorbidity in Primary Care: A Systematic Review of Observational Studies

Concepció Violan[1,2], Quintí Foguet-Boreu[1,2], Gemma Flores-Mateo[1,2], Chris Salisbury[3], Jeanet Blom[4], Michael Freitag[5], Liam Glynn[6], Christiane Muth[7], Jose M. Valderas[8]*

1 Central Research Unit, Institut Universitari d'Investigació en Atenció Primària Jordi Gol, Barcelona, Catalunya, Spain, 2 Universitat Autònoma de Barcelona, Bellaterra (Cerdanyola del Vallès), Spain, 3 Centre of Academic Primary Care, School of Social and Community Medicine, University of Bristol, Bristol, United Kingdom, 4 Department of Public Health and Primary Care, Leiden University Medical Center, Leiden, The Netherlands, 5 Institute of General Practice and Family Medicine, Jena University Hospital, Friedrich-Schiller-University, School of Medicine, Jena, Germany, 6 Discipline of General Practice, National University of Ireland, Galway, Ireland, 7 Institute of General Practice, Johann Wolfgang Goethe University, Frankfurt/Main, Frankfurt, Germany, 8 Health Services & Policy Research Group, School of Medicine, University of Exeter, Exeter, United Kingdom

Abstract

Introduction: Multimorbidity is a major concern in primary care. Nevertheless, evidence of prevalence and patterns of multimorbidity, and their determinants, are scarce. The aim of this study is to systematically review studies of the prevalence, patterns and determinants of multimorbidity in primary care.

Methods: Systematic review of literature published between 1961 and 2013 and indexed in Ovid (CINAHL, PsychINFO, Medline and Embase) and Web of Knowledge. Studies were selected according to eligibility criteria of addressing prevalence, determinants, and patterns of multimorbidity and using a pretested proforma in primary care. The quality and risk of bias were assessed using STROBE criteria. Two researchers assessed the eligibility of studies for inclusion (Kappa =0.86).

Results: We identified 39 eligible publications describing studies that included a total of 70,057,611 patients in 12 countries. The number of health conditions analysed per study ranged from 5 to 335, with multimorbidity prevalence ranging from 12.9% to 95.1%. All studies observed a significant positive association between multimorbidity and age (odds ratio [OR], 1.26 to 2.27.46), and lower socioeconomic status (OR, 1.20 to 1.91). Positive associations with female gender and mental disorders were also observed. The most frequent patterns of multimorbidity included osteoarthritis together with cardiovascular and/or metabolic conditions.

Conclusions: Well-established determinants of multimorbidity include age, lower socioeconomic status and gender. The most prevalent conditions shape the patterns of multimorbidity. However, the limitations of the current evidence base means that further and better designed studies are needed to inform policy, research and clinical practice, with the goal of improving health-related quality of life for patients with multimorbidity. Standardization of the definition and assessment of multimorbidity is essential in order to better understand this phenomenon, and is a necessary immediate step.

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Uvod

- **Kaj je že znanega in kaj še ostaja odprto**
- Sedanji čas za raziskovalno vprašanje
- **Struktura lijaka:** Od širšega, bolj znanega, k ožjemu, manj znanemu in še odprtemu

- **Zadnji odstavek uvoda:** Natančno oblikovano raziskovalno vprašanje, na katerega smo v raziskavi želeli odgovoriti, ter z nedvoumno oblikovanim problemom, ki smo ga želeli rešiti (predstavitev razloga, da smo se raziskave lotili in njenega namena)

Uvod: Pogoste napake

- Raziskovalno vprašanje ni jasno:
- Npr. Želeli smo ugotoviti povezavo med kašljem in CRP

- Bolje:
- Namen raziskave je ugotoviti, ali povišana vrednost CRP pri bolnikih s kašljem, pri katerih smo izključili pljučno embolijo, kaže na okužbo.

Association of Conituity of Primary Care and Statine use.
Warren JR et al. PLOS ONE, 10 (10): e0140008, oktober 2015

Introduction

Poor adherence (also known as *compliance*) to long-term medication is a major issue undermining effective delivery of healthcare.[1] It is frequently overlooked by prescribing physicians when intensifying treatment.[2, 3] Statins, as a case in point, are effective in primary prevention of cardiovascular disease (CVD)[4] and are a central element of CVD risk management guidelines.[5]·[6] The rate of failure to maintain statin therapy for 12 months after initiation is high,[7] even following acute coronary events.[8] Poorer levels of statin adherence are associated with higher rates of long-term mortality after acute myocardial infarction[9] and in coronary artery disease generally.[10] Risk factors for poor adherence to statins include dispensing for primary (as compared to secondary) prevention[11, 12] and being a new statin user.[11] In terms of strategies to improve adherence to lipid lowering drugs, reinforcement and reminder have the best evidence.[13]

The relationship of continuity of care (CoC) to medication, including statin, adherence is unclear. Brookhart et al.[14] found that physician visits–either to the physician who initiated statin therapy, or to another physician–as well as cholesterol tests, myocardial infarction or other CVD-related hospitalisation, were all associated with return to statin adherence. Adding to the complexity, there is a 'healthy user bias' in statin adherence; that is, those who adhere to statins tend to pursue other healthy practices, including seeking out preventative health services in the form of screening tests and vaccinations,[15] and being more likely to be non-smokers.[12, 16]

The present study utilised data from a large prospective study of Australians aged 45 and over linked with national health databases to estimate the association of CoC on statin adherence when adjusting for a range of patient characteristics.

Metode

- **Kaj smo naredili, da bi lahko odgovorili na vprašanje, zastavljeno v uvodu**
- Pretekli čas
- Opis mora biti do te mere natančen, da je mogoče našo raziskavo po opisu v metodah ponoviti (opis preiskovance in uporabljenih metod)

Preiskovanci

- Vključitveni/izključitveni kriteriji
- Način izbora
- Število

Tip raziskave (uporabljene znanstvene metode)

- eksperimentalna ali deskriptivna
- kvalitativna oz. kvantitativna
- Natančnejši opis:
  - kvalitativne (grounded theory, fenomenološka analiza)
  - kvantitativne raziskovalne metodologije (npr. presečna, kohortna, randomizirana kontrolirana…)

Opredelitev spremenljivk in opis merilnih orodij, intervencije…

- Opredelitev odvisnih in neodvisnih spremenljivk
- Opis merilnih orodij (npr. vprašalnikov, lestvic…)
- Opis intervencije

- Pojasnitev kratic in pojmov

Statistične metode, etika

- Navesti je potrebno **uporabljene statistične metode** in mejo pri kateri zavrnemo ničelno hipotezo (p-vrednost – običajno $p < 0.05$)
- zgolj navedba programskega paketa s katerim smo izvedli statistično analizo!
- Navesti je potrebno številko in datum **soglasja etične komisije!**

Metode - Pogoste napake

- Posamezni elementi manjkajo
- Metodologija ni zadosti natančno razložena
- Spremenljivke niso definirane
- Opis uporabljenih statističnih metod ni jasen/zadosten
- Manjka podatek o etični odobritvi raziskave

Deckx L. Loneliness in patients with cancer: the first year after cancer diagnosis. Psyho-Oncology 2015.

loneliness frequency changes throughout different phases of cancer survival, and none of the studies included in the review distinguished between social nal loneliness.

In this study, we aim to answ wing research questions: How often is loneliness (and its subtypes) considered a problem in OCP? Are the frequency, severity and evolution of loneliness different in OCP compared with younger cancer patients (YCP) and older people without cancer (ONC)? Are common cancer-related and ageing-related problems such as fatigue, cognitive impairment and functional impairment risk factors for loneliness? The advantage of these problems is that they show limited overlap with loneliness, and they are actionable.

Although this study is largely descriptive, results will have important implications for healthcare workers who are confronted with cancer patients (e.g. nurses, general practitioners, oncologists and psychologists). For example, results of this study will increase awareness for the problem of loneliness in the affected subgroups and will show who is especially at risk of becoming lonely and whether loneliness is especially important during the first phases of disease or after initial treatment.

Methods

Design and study population

The data for this study were collected as part of the KLIMOP study [13], a cohort study of OCP (≥70 years), YCP (50–69 years) and ONC (≥70 years). The current study included cancer patients with a new diagnosis of breast or colorectal cancer and cancer stages I–III. They were recruited through seven hospitals in Belgium and the Netherlands. ONC were recruited through general practices and home nurses in the same regions.

Exclusion criteria for OCP, YCP and ONC were the inability to speak Dutch, a formal diagnosis of dementia and an estimated life expectancy of less than 6 months.

Data collection

Data were collected through personal interviews or self-administered questionnaires at baseline (T0) and at 1-year follow-up (T1). The baseline interview took place between cancer diagnosis and a maximum of 3 months after diagnosis. In one hospital, baseline data collection was integrated in a routine geriatric assessment and was therefore slightly different. It did not include the same measurement tools for fatigue and cognitive functioning. Hence, this information was unavailable for patients recruited in this hospital.

- **Loneliness**

questionnaire, the five positively worded and six negatively worded items correspond to social and emotional loneliness, respectively. The loneliness score is computed as the sum of all the items [15]. We present loneliness as the mean score (severity) and the proportion (frequency) of loneliness. We used a score of ≥3 as a cut-off for total loneliness and a score of ≥2 as a cut-off for emotional and social loneliness [15,16].

- **Fatigue**

We used a unidimensional visual analogue scale for measuring fatigue. Patients were asked, 'On a scale of 0 to 10, how would you rate your fatigue over the past 24 hours?' We used the most commonly used cut-off of ≥4 to define increased fatigue [17]. Change in fatigue was operationalized as follows: not fatigued (<4 at T0 and T1), was fatigued (≥4 at T0; <4 at T1), became fatigued (<4 at T0; ≥4 at T1) and persistently fatigued (≥4 at T0 and T1).

- **Cognitive functioning**

Cognitive functioning was measured with the cognitive functioning subscale of the quality of life questionnaire developed by European Organization for Research and Treatment of Cancer (EORTC QLQ-C30) [18]. Based on the EORTC QLQ-C30 manual, cognitive functioning was recoded to a score ranging from 0 to 100, with higher scores representing better functioning [19]. We used the lowest functioning quartile (<67) as a cut-off for cognitive impairment. Change in cognitive functioning was then operationalized as follows: not impaired (≥67 at T0 and T1), was impaired (<67 at T0; ≥67 at T1), became impaired (≥67 at T0; <67 at T1) and persistently impaired (<67 at T0 and T1).

- **Functional status**

Functional status was measured as activities of daily living (ADL) using the Katz Index (six items) [20] and as instrumental ADL (IADL) using the Lawton IADL scale (eight domains in women and five in men) [21]. Each item was coded as dependent/independent. Functional impairment was defined as dependence on at least one domain of ADL or IADL. Change in functional status was operationalized as follows: not impaired (independent at T0 and T1), was impaired (dependent at T0; independent at T1), became impaired (independent at T0; dependent at T1) and persistently impaired (dependent at T0 and T1).

- **Socio-demographic information**

We recorded sex, age, ethnicity (Caucasian or other),

Rezultati-1

- **Navajanje ugotovitev (jih ne komentiramo!), do katerih smo v svoji raziskavi prišli**
- Pretekli čas
- Predstavitev naj bo točna, jasna in razumljiva
- Najprej predstavimo bolj splošne in enostavne rezultate, šele nato bolj kompleksne in podrobne rezultate:

Npr.

najprej opišemo populacijo sodelujočih bolnikov in predstavimo deskriptivne podatke, sledijo analize povezanosti in odvisnosti med spremenljivkami

Deckx L. Loneliness in patients with cancer: the first year after cancer diagnosis. Psycho-Oncology 2015.

Medical information

Medical information included cancer type (breast or colorectal cancer) and stage (I, II or III).

Ethics

The study was approved by the ethical review board of Katholieke Universiteit Leuven and Universitair Ziekenhuis Leuven (S52097-ML6279) and the Maastricht University Medical Centre (NL31414.068.10). All patients signed informed consent.

Analysis

Persons were excluded from analyses if they were deceased, lost to follow-up or skipped data collection at T1, had missing data for loneliness at T0 or T1, or received a diagnosis of cancer during follow-up.

Characteristics of the study population are presented as the mean and standard deviation for continuous variables. Comparisons were performed using the Wilcoxon–Mann–Whitney test for continuous data and the chi-squared test for categorical data. Comparisons within groups were performed using Wilcoxon signed-rank test for continuous data and the McNemar test for categorical data. A p-value of <0.05 was considered statistically significant.

The relationship between loneliness at T1 and changes in fatigue, cognitive functioning and functional status was tested with multivariate logistic regression analyses. All analyses were adjusted for age, sex, marital status and educational level (consistently shown to be important risk factors for loneliness [22]), baseline loneliness and cancer stage.

We used backward stepping and a p-value of <0.10 as a cut-off to enter a variable. The fit of each model was tested with the Hosmer and Lemeshow goodness-of-fit test.

We performed a sensitivity analysis to assess the influence of missing values, making worst-case and best-case scenarios by imputing missing values as either a normal or abnormal score. We assessed the influence of sex and type of cancer by stratifying the analyses for these variables.

Statistical analyses were performed using the STATA statistical software package version 11 (StataCorp LP, College Station, TX, USA).

Results

Follow-up of the population

Until August 2012, 772 persons were included in the KLIMOP study. During 1-year follow-up, 19 (2%) people died, 166 (22%) were lost to follow-up and 47 (6%) skipped data collection at T1 (Supporting Information). The percentages of OCP and YCP ($p=0.79$) and OCP and ONC ($p=0.21$) lost were comparable. Persons available for analyses were comparable with those lost to follow-up with respect to loneliness, socio-demographic and clinical characteristics. Only for OCP was the proportion of exclusions with cancer stage II lower and that with stage III higher, compared with OCP ($p<0.01$). The final number of people with full data included in our analyses was 475.

Baseline characteristics

All patients but two were Caucasian. OCP and ONC were comparable at baseline except for a higher proportion of women in OCP compared with ONC, due to the high number of breast cancer patients ($p<0.01$). OCP differed from YCP with respect to age, marital status, living conditions, age at leaving school, cancer treatment, cancer stage and functional status (Table 1).

Severity and frequency of loneliness

Figure 1 shows the severity and frequency of total, emotional and social loneliness in the three groups at T0 and T1 (see Supporting Information for more detail). At baseline, 22% of OCP, 21% of YCP and 39% of ONC were lonely. At T1, 35% of OCP, 30% of YCP and 41% of ONC were lonely. At baseline, OCP were less lonely compared with ONC ($p<0.001$), while OCP and YCP were comparable ($p=0.67$). For OCP and YCP, the severity of loneliness significantly increased between T0 and T1 ($p<0.001$), while it remained constant for ONC ($p=0.71$). Results for emotional and social loneliness were largely similar (Figure 1). However, the increase in loneliness in OCP and YCP was mainly due to an increase in emotional loneliness.

Influence of fatigue, cognitive functioning and functional status

In univariate analyses, fatigue, functional status and cognitive functioning were associated with loneliness at T1 (Supporting Information). However, in the multivariate model, functional status did not contribute significantly to explaining feelings of loneliness at T1 (Table 2). The multivariate model shows that people who were persistently fatigued were approximately three times more likely to be lonely at T1 (odds ratio (OR) 2.83, 95%CI: 1.46–5.50). Similarly, for cognitive functioning, people who became impaired (OR 2.78, 95%CI: 1.35–5.72) or were persistently impaired (3.09, 95%CI: 1.41–6.76) were almost three times more likely to be lonely at T1. Also, loneliness at T0 (OR 7.37, 95%CI: 4.27–12.73) and having no partner at T0 (OR 2.69, 95%CI: 1.54–4.69) were significantly associated with loneliness at T1.

Risk factors for emotional and social loneliness were similar, with the exception of marital status and fatigue in multivariate analyses (Table 2).

Rezultati-2

- Del rezultatov lahko predstavimo v obliki tabel in grafov, pazimo da se podatki ne ponavljajo – vsak podatek predstavimo le enkrat!
- Izogibamo se enostavnim grafičnim prikazom – npr. prikazovanje populacije po spolu z tortnim diagramom (pie diagram)
- Navajajte **vrednosti p** na tri decimalke natančno ali $p<0,001$ (če je $p<0,000$)

Tabela

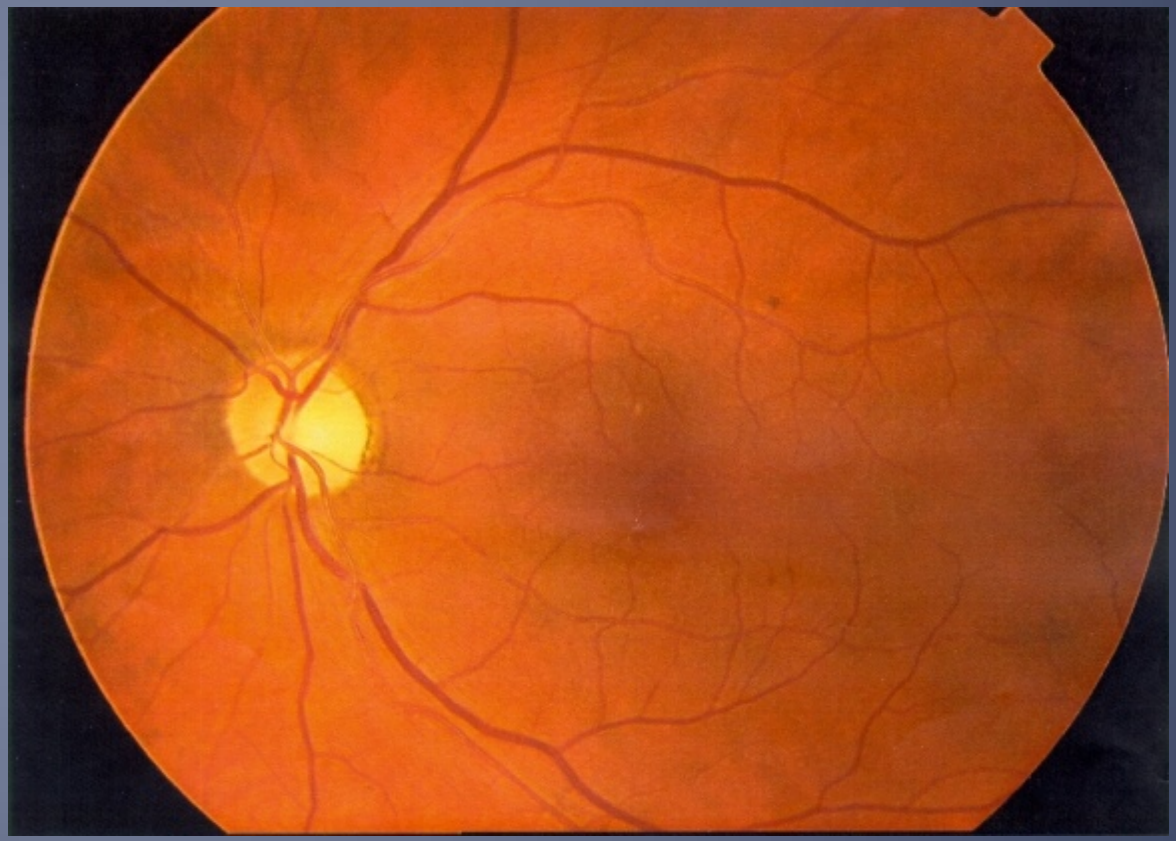
Tabela 1. prikazuje ocenjeno kakovost življenja…

Tabela 1. Ocenjena kakovost življenja bolnikov po posameznih dimenzijah EQ-5D vprašalnika

	Mobility (percentage) N=778	Self care (percentage) N=773	Ussual activities (percentage) N=771	Pain-discomfort (percentage) N= 769	Anxiety/depression (percentage) N=764
I have no problem	460 (59.1)	734 (95.0)	500 (64.9)	250 (32.5)	503 (65.8)
I have some problems	318 (40.9)	36 (4.7)	254(32.9)	476 (61.9)	353 (33.1)
I am unable	0	3 (0.4)	17 (2.2)	43 (5.6)	8 (1.0)

Slike (grafi)

Slika 1 prikazuje aterosklerotične spremembe na očesnem ozadju.



Slika 1. Aterosklerotične spremembe ožilja na očesnem ozadju.

Rezultati: pogoste napake

- Predstavljeni so % brez absolutnih številk
- Prikazana je le vrednost p, brez vrednosti testa, ni intervalov zaupanja
- Isti rezultati so predstavljeni večkrat (v tekstu, tabeli, grafu)
- Prikazovanje rezultatov v tabelah, ki ne odgovarjajo na ključna raziskovalna vprašanja
- Tabele niso samopovedne
- Med rezultati (dejstvi) se nahaja tudi interpretacija rezultatov!

Razpravljanje

- **Najpomembnejše poglavje** vsakega znanstvenega besedila
- Odgovoriti mora na vprašanja iz uvoda
- Pojasniti mora rezultate (**ne pa jih ponovno navajati**), njihov pomen in ujemanje z obstoječim znanjem
- Pišemo jo v sedanjem času

Struktura razprave

Razprava o rezultatih

- Kratek povzetek rezultatov v povezavi z hipotezo (ami)
- Predstavitev rezultatov v luči argumentov predstavljenih v uvodu in pojasnitev nasprotujočih si rezultatov
- Pojasniti pomen rezultatov za praktično delo in/ali nadaljnje raziskovanje

Razprava o metodah:

- Slabosti in omejitve naše raziskave

Bauwens et al. Systematic screening for distress in oncology practice using the Distress Barometer: the impact on referrals to psychosocial care. Psyho-Oncology 2014; 23;804-11.

a referral. Of the patients with elevated distress but no reported need for more support, 19 patients (35%) accepted a referral.

Discussion

This study clearly indicates that self-reporting of distress, using the DB, leads to both increased numbers of referrals to psychosocial professionals and more actual acceptances of these referrals. However, analysis of the referral process demonstrates that using the DB does not, by itself, guarantee distressed patients' access to additional support. Rather, it seems that using the DB may facilitate the communication about referrals among oncologists and their patients, and to a lesser extent helps patients to overcome hesitations about an actual referral.

Detection of distress

At first sight, the overall percentages of detected elevated distress are quite similar in both conditions, but further analysis reveals a different picture. The central tendency response style as observed in the oncologists in the UP condition corresponds to reports on such bias in previous studies [36,37], where oncologists tended to report an intermediate rate of distress, possibly resulting from their uncertainty in assessing patient distress. Oncologists possibly recognise some notion of distress in their patients but find it difficult to appraise its severity and need for additional care.

Referral problems

Oncologists, when they indicated distress in their patients in the UP condition, seem to find it difficult to assess the necessity of psychosocial referral. Distress may be disregarded as 'understandable' and not 'avoidable'. It remains difficult for doctors to decide if and to whom patients suffering from distress should be referred. In the experimental condition, it seems that using the screening instrument with indication of the nature and intensity of complaints and the wish/needs of the patient may not only help oncologists to decide the necessity of a referral, and also helps them to effectively carry out the referral. Possibly using a screening instrument facilitates the communication with the patient about a potential referral. In the UP condition, reasons that a referral judged as necessary did not result in an actual referral were not systematically questioned, but often, doctors added spontaneously reasons as 'too early' and 'maybe next time'. This observation suggests that the use of a screening tool may accelerate the referral process, which could confirm the

Acceptance of referral and need for help

In line with previous research [38,39], this study indicates that although elevated distress and the wish to talk with someone about problems were positively related, 53% of distressed patients reported no need to talk and 20% of the non-distressed patients reported a need to talk. However, a significant number of distressed patients without reported needs accepted a referral. Both findings confirm that patient's needs for psychological support cannot be satisfied solely by screening for distress, nor can such screening guarantee willingness to accept referral. This study confirms Baker-Glenn [38] who claimed that additional screening for needs may highlight those who are willing to accept referral for additional support, but it also demonstrates that such screening cannot replace negotiation and consultation about referral.

Limitations of the study

This study has some limitations. First, no full structured interview was carried out to assess symptoms, so it was not examined in this study whether each patient was a true positive case or not. However, a previous study on the DB showed its relatively high sensitivity (0.79) and specificity (0.81) [33] and because oncologists in the UP condition showed a central tendency response style with as consequence a low specificity, we do not expect a larger proportion of false positive and false negative patients to be included in the experimental group than in the UP group. A further limitation is our ignorance about patients referred and supported by the PST in terms of outcome, which is the ultimate criterion to evaluate the usefulness of screening. Third, participants were typically many months from diagnosis at the time of the study, which may have influenced patterns of referrals, but in this study, no statistical evidence was found for this. Fourth, although the sample of cancer patients was large in this study and the feasibility and acceptability of the DB was shown in a previous study, a period of 2 weeks may be too short to evaluate the impact of a screening instrument on the referral process. However, the positive impact of the routine use of a screening tool on the referral process has by now been demonstrated in other studies with longer screening periods. One study [30], with a 6-month screening programme showed no higher proportion of patients with major depressive disorder or adjustment disorder being referred to Psychiatric Services, but the screening seemed useful for introducing psychiatric treatment at an earlier stage. Another study [29] with a 1-year screening programme indicated a higher and more accurate referral of patients. A further limitation was that reasons that a

Zaključek

- Kratka ponovitev odgovora na zastavljeno raziskovalno vprašanje, prikaz praktične uporabnosti naših rezultatov in/ali idej za nadaljnje raziskovanje na tem področju (ki so nastale na osnovi našega dosedanjega raziskovanja)
- Zaključek napišite preden napišete uvod, pazite, da istih stavkov ne ponavljate v uvodu in zaključku!

Razprava- pogoste napake

- Razprava ni strukturirana
- Posamezni elementi razprave manjkajo (niso navedene omejitve raziskave, ni primerjave rezultatov z izsledki predhodnih raziskav)
- V zaključku ni odgovora na ključno raziskovalno vprašanje
- Zaključek ne sledi rezultatom raziskave (pretirano vizionarski)

- **Priporočila za prakso:**
- Temeljijo na splošno znanih dejstvih, ne sledijo rezultatom raziskave

Zahvala

- Zahvala tistim, ki ne izpolnjujejo pogoja za avtorstvo, so pa pomembno prispevali k nastanku dela (npr. predstojnik, direktor, glavni mentor)
- Zahvala tehničnim sodelavcem, kolegom, ki so zbirali podatke, bolnikom…
- Zahvala financerju (če gre za projekt z navedbo naziva in šifre projekta)

Literatura

- Je seznam vseh v prispevku citiranih del
- Način citranja je prilagojen reviji – SLO (Zdravstveno Varstvo, Zdravniški vestnik - Vancouvrski način citiranja, Obzornik zdravstvene nege – Harvardski način)

Priloge

- Sem sodijo:
- Podrobnosti o metodah raziskave (npr. uporabljeni vprašalniki)
- Podrobnosti o rezultatih (npr. individualne tabele)
- Naj bodo označene z velikimi črkami abecede, po zaporedju pojavljanja : A, B, C…

Za ponovitev

- Namen: Doprinos k novemu znanju
- IMRAD struktura
- Pisanje v preteklem času, namen dela v sedanjem času
- Izvleček: Dober izvleček nagovori bralca, slab ga odvrne
- Uvod: informativen, struktura lijaka
- Metode: Tako napisane, de omogočajo ponovitev raziskave
- Rezultati: od bolj enostavnih, opisnih, do kompleksnih
- Razprava: ključen del znanstvenega dela
- Zahvala vsem ki ne izpolnjujejo pogojev za avtorstvo, pa so pomembno prispevali k nastalemu delu

Predstavitev znanstvenega dela

Značilnosti dobre predstavitve

- Informativna
- Enostavna
- Jasni zaključki, ki temeljijo na rezultatih raziskave
- Predstavitev praktične vrednosti ključnih ugotovitev
- Ne predolga (max. 15 minut, kar pomeni ne več kot 15 diapozitivov)

Struktura predstavitve

- Izhodišča - ozadje, ki je privedlo do odločitve za raziskavo
- Predstavitev namena in ciljev raziskave
- Predstavitev znanstvenih hipotez
- Materiali in metode – opis preiskovancev (kriteriji vključitve/ izključitve, število) in ključnih metod (tip in vrsta raziskave)
- Rezultati – ključni rezultati, s katerimi odgovorite na zastavljene hipoteze
- Razpravljanje: Predstavitev rezultatov v luči drugih raziskav, predstavitev omejitev raziskave
- Zaključki: Kratka ponovitev odgovora na zastavljeno vprašanje in predstavitev praktične uporabnosti dobljenih rezultatov

Razpravo po predstavitvi

- Pomemben del predstavitve raziskovalnega dela
- Bolj je predstavitev jasna, manj dodatnih vprašanj za pojasnitev pričakujte
- Zahvalite se za vprašanja in ne prepirajte se s člani komisije oz. publiko!

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