

THE JOURNAL OF CLINICAL ETHICS

NOTE REFERENCE STYLE

Do not use software functions that automatically number notes and/or embed the notes in the text; instead type the text of the notes at the end of the article.

A fact not generally known or easily checked should receive a citation in an endnote, as should a direct quotation. *The Journal of Clinical Ethics* uses a modified version of *The Chicago Manual of Style* notes and bibliography system, in which full citations are provided in endnotes, and a bibliography is not included. See *The Chicago Manual of Style*, chapter 14. Scholarly comments are made in endnotes. Footnotes are not used in the journal.

A brief description of the system used by the journal follows. Note reference numbers in the text are set as superior (superscripted) numbers. In the endnotes section, the note numbers are full size and not superscripted. Note reference numbers appear at the end of a sentence, unless this would reduce clarity (for example, when two separate statements in a sentence are supported by different sources).

Note reference numbers run consecutively through a manuscript, that is, the first note reference number is 1, the second is 2, and so on. No number is used more than once. This may require that the same source be included several times in the endnotes. When this happens, a shortened version of the citation is used (see note 3 below). When a statement is supported by more than one source, all of the sources are included in the same endnote (see note 2 below), with the sources separated by a semicolon. Only one note reference number is used at a time (that is, do not use ^{1,2} or ¹⁻⁴).

The full titles of journal are used in endnotes (that is, use *The Journal of Clinical Ethics*, not *JClinEthics* or *JCE*). For sources with more than four authors, only the name of the first author is provided, followed by “et al.” (see note 2 below). Authors are listed by first and middle initial and last name. Examples follow.

NOTES

1. J.L. Smith, R.M. Miller, Jr., and W.C. Callahan, “The Therapeutic Misconception: Where Are We Now?” *IRB Topics* 124, no. 6 (June 2012): 1147-59.

2. L. Greene and W.K. Nelson, “The Ethics of Care,” in *Principles of Nursing Science*, vol. 2, ed. W.K. Nelson (Plano, Tex.: Nursing Administration Press, 2011), 122-4; T.M. McCall et al., “Six Sigma in the Small Urban Hospital,” *Health Care Administration Quarterly* 6, no. 2 (Summer 2012): 150-6; E.G. Howe, *Military Medicine* (Hagerstown, Md.: University Publishing Group, 2012), 14-44.

3. Smith, Miller, and Callahan, “The Therapeutic Misconception,” see note 1 above, pp. 1147-8.

4. *Ibid.*, 1148.

5. Greene and Nelson, “The Ethics of Care,” see note 2 above.

6. M. Biondolillo, “Informational Briefing on Proposed Amendments to 105 CMR 130.000, 105 CMR 140.000 and 105 CMR 150.000: Provision of Information on Palliative Care and End-of-Life Options,” 16 October 2013, <http://blog.mass.gov/publichealth/wp-content/uploads/sites/11/2013/10/End-of-Life-Care.pdf>, accessed 21 May 2014.

When a table or figure includes notes, the notes appear at the end of the table or figure, not in the endnotes (see table 1 below). A table or figure that is not the original work of the author must be acknowledged, and, when appropriate, the author must obtain written permission from the owner of the material to include it in the author’s article in *The Journal of Clinical Ethics*.

For blinded peer review, authors must blind or remove all material in their article that may identify them, including the endnotes.

TABLE 1. Respondents’ characteristics (N = 1,196)

Characteristic	n	Weighted proportion, %
Gender		
Female	593	49.7
Age group		
23-35	733	61.2
36-45	269	22.4
46-55	171	14.3
56-	25	2.1
Specialty		
Internal medicine	212	17.7
Surgery	310	25.9
Obstetrics/gynecology	126	10.5
Pediatrics	150	12.5
Other	400	33.4
Overseas education experience	230	19.2
Practice organization*		
Level 3	1,020	85.2
Level 2	152	12.6
Level 1	26	2.2

* Hospitals in the PRC are assessed by the PRC Ministry of Health based on the number of beds and ability to provide comprehensive healthcare. Level 3 is the best, then Level 2 and Level 1. At each level, hospitals are classified into three grades: Grade A is the best, then Grade B and Grade C. Level 3 hospitals have at least 501 beds, provide top-quality comprehensive healthcare, and have high-level research capacity. Level 1 hospitals include most community-based hospitals providing disease prevention and primary medical care for residents. Level 2 hospitals are local, provide comprehensive care to multiple communities, and have some research capacity, generally in the county or city.