Another reason that Type Two Errors have been all but ignored is because they are often unimportant. In the social sciences there is usually considerable debate over the meaning of true-positive results (valid statistically significant differences). Social scientists tend to be at even more of a loss over true-negative results. So it is rare that a false-negative result impedes progress. However, when the conclusion at hand is that two drugs have similar effects, or that one drug has no effect because its observed effect is not statistically different from control, the most important question that can be asked is: "How hard did you look?"

Glantz and others have made suggestions for improving the quality of published analyses, and all of the suggestions we have seen should be taken. The problem is that they seldom are taken. The suggestion, "submit all analyses to expert reviewers," is editorially impractical. We would like to make a suggestion in this regard: require that an appendix containing all raw data be submitted with any article that contains a statistical inference—with the understanding that a copy of that appendix will be sent by the journal to any reader willing to cover copying and handling costs. The logic here is that raw data usually belie unjustified inferences. Authors would be more careful if they knew that anyone would be able to perform a truly independent analysis of their results. Anesthesiology could be the vanguard of such a revolution.

Use of the Left-entry Laryngoscope Blade in Patients with Right-Sided Oro-Facial Lesions

To the Editor—Malformations and tumors that deform the right side of the face and oropharynx usually render the visualization of the larynx with a regular laryngoscope more difficult. One frequently has to resort to fiberoptic instrumentation or blind nasal intubation. We have found the "left-entry" laryngoscope blade* also clinically useful in these patients with right hemifacial lesions.

This blade was originally designed for the left-handed anesthesiologist. It actually is a mirror image of the standard Macintosh or Miller blade, in that the ridge or curve is placed on the right. Thus, when the laryngoscope blade is introduced on the right side of the mouth, the tongue is pushed to the right, towards the lesion. A better exposure of the larynx is obtained and an endotracheal tube, introduced from the left, is positioned more easily.

* The "left-entry" laryngoscope blade is made in different sizes and configurations by the Foregger Company, Hauppauge, New York 11788.

References


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