high as almost to make the procedure unwarranted. He mentions several contributing factors, among which is that high-altitude natives have higher-than-normal CSF pressures. Could the suddenness of the symptoms in the present case be attributed to rapid decompression with a transient lower pressure in the epidural space compared with the subdural space, and subsequent loss of spinal fluid via a dural leak? A slow loss of spinal fluid would not cause symptoms, but sudden accentuation of the loss might, or were these merely coincidental factors? Other thoughts on the matter are welcome.

Why What You See is What You Get

To the Editor:—Although the intent of this letter is to dissect our Journal, I believe it should probe further than that and consider the separation between academic and clinical practice of anesthesiology. Each year I see bright, talented young men who do not choose academic practice. The reasons are several, including attitude, personal desire, and interest and income. Some reasons are based on misunderstanding. The cliché that academic practice is a life of leisure is just as false as the one that the private practitioner daily carries home a wheelbarrow of money. What I would like to see is a healthier relationship between these two broad divisions of our professional society. This can come about only through mutual respect, understanding, and communication. In this latter area, communication, I think Anesthesiology can do more than it is now doing to bridge the gap.

Recently I made it my business to talk to a number of our best young academicians. In their answers to questions about the Journal, there seemed to be a number of recurring thoughts. I offer these in the hope that they may be helpful.

A young instructor stated that unless an article concerned MAC, ballistocardiography, or computers, it would not receive serious consideration for publication in the Journal. Another believed that many authors have standard methods of study set up in their laboratories, whereby they could crank out many repetitive articles, differing only in one aspect, such as a drug or dose tested. Most agreed that the clinical value of the Journal has decreased greatly in recent years, with the major emphasis being on basic science areas, and the Clinical Workshop supplating, for the most part, the former purely clinical articles.

Another interesting comment concerned the originality and value of the articles. For instance, a short (two-page) article on drug dependence in the goldfish was done by a relatively unknown worker, but possessed great originality and significance. It proved simply and eloquently that dependence is pretty much a metabolic affair and not something mystical. I have been asked, why doesn’t Anesthesiology publish more of this original, illuminating, provocative work, rather than the more repetitive articles that we see so frequently? An English transplant to our country feels that the American literature suffers greatly from the hash-and-rehash type of article, in which a prominent figure says the same thing repeatedly in different forms, serving only to increase the size of his bibliography.

In summary, I suspect the Journal reflects fairly accurately the present estrangement that exists within our society. I could, of course, answer many of my own questions, but would rather present these to you, unfiltered, from various individuals of instructor and assistant-professor rank with whom I have spoken. I must admit that most of these “academicians” are primarily interested in clinical or applied
research. Uniformly, they are not basic researchers. The essence of their contentions is that our Journal is becoming the forum of the basic research rather than that of the clinical investigator. On whether this is true, I seek your comments.

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To Dr. Nagel:—The Editorial Board and I are deeply appreciative of your thoughtful comments relating to ANESTHESIOLOGY. As you probably suspect, yours has been a recurrent criticism, recurrently answered by previous and present Editors in much the same form. Please excuse me, then, for a cliché answer to a cliché complaint, since neither you nor I offer any new, bright or promising solutions.

Except for Editorials, Medical Intelligence and Reviews, most of which are written by invitation, our Journal can only select for publication from among those articles submitted to it. What is submitted depends upon what research is supported. If research money goes to goldfish, MAC, computers, and metabolism, that is what appears in Original Articles. If 1972 research money goes to acupuncture, that will appear in 1973. As a scientific journal, we report the research that has been done—not the provocative, original, and brilliant research we wish had been done. Granting agencies, not editorial boards, control directions in research.

Our Journal does, however, make a significant contribution to the clinically-oriented reader—in some issues almost 50 per cent of the pages—in the form of clinically relevant Editorials, Reviews, Medical Intelligence, Case Reports, and Correspondence. Despite criticism, I believe we have achieved a nice balance in most issues—a comfortable bias I sustain.

Of course, our Society could decide not to publish a scientific journal, but one of some other sort. What would you like? Something not too mind-taxing and, as a bonus, include the hobbies of authors? Or we could accept every manuscript submitted, as is the custom with some journals. We just don’t have the talent in our specialty to produce a New England Journal of Medicine. What is it our people want?

They want more clinical research, more clinically-oriented articles, answers to their real-life questions, somebody to look into the problems that concern them and to provide clear information they can readily use. Splendid! Good clinical research is vastly more difficult than laboratory research, but uniquely can be done only by clinicians, who are also uniquely the only ones who complain about the lack of clinical research. Do they really believe the goldfisher will do it for them? Why don’t the complainers become the doers?

To me this is the heart of the problem. All journals are anxious to publish good clinical research. It will not, however, come from the Editorial Boards, or the laboratory workers, but from the clinician-complainers. The fact is that good clinical research in anesthesiology is still hard to come by.

The problem of rehash articles or laboratories which crank out more of the same with a new agent or new dose, or a new number in the article title, is a continuing one, and our Board is not of unanimous mind as to a solution. What you see this year is therefore my responsibility. I accept your criticism.

My best overall answer to our critics, I believe, is to ask what they see published in other journals which they wish had been published in our Journal. I scan widely; I find some things, but they add up to very little. And most of what I find would not satisfy the clinician, only the researcher. What do you find? Perhaps if the persons whose views you summarized so conscientiously answered this question and made us privy to their answers, we might then know what each other was talking about. Is this a new idea to improve “communication”? Why not offer them the bait? What is published elsewhere that should be in our Journal?

Again, I deeply appreciate the concern which led to your letter. I believe the next move is yours.—A. S. K.