Advice to a new editor

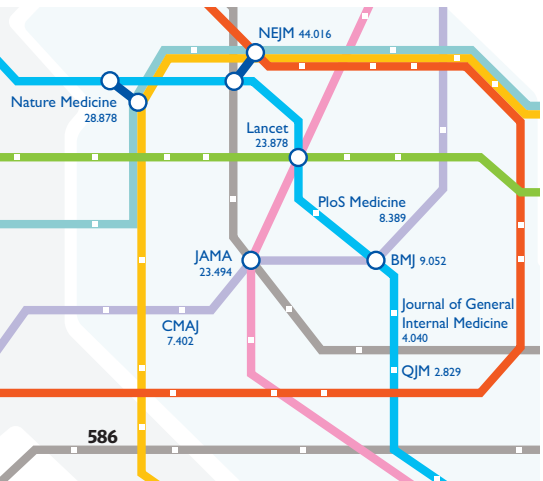
PERSONAL VIEW **Christopher Martyn**

Dear Hermione,

Congratulations on your appointment as editor of the *Journal of Amazing Medical Advances*. I'm sure that you have already gathered an enthusiastic new editorial team and that you're bursting with ideas for improving the journal. The last thing that I want to do is to dampen that enthusiasm but, as someone who has played the publishing game for a while, I felt a word of warning might be useful.

You'll find, if you haven't done so already, that the first thing potential authors ask you about the journal you edit is: "What's its impact factor?" Indeed, it will usually be the only thing they ask you. If you can reply with a double digit figure, they'll immediately try to interest you in a manuscript they are writing. If you have to admit a low number, your plans to liven up the book reviews and to redesign the journal's website won't be enough to compensate. Potential authors will make an excuse and walk away. If you think I exaggerate how much notice authors take of impact factors, take a look at the trouble some journals take to make them known. The *Lancet* makes a feature of its impact factor on its home page. *Brain*'s website gives its impact factor to three decimal places.

Forget most of your current plans. The redesign and book reviews can wait. You need to concentrate on raising your impact factor, and there's no time to lose. Impact factors are updated annually by Thompson Scientific, and they are derived from citations of papers published two and three years earlier. It will be 2009 before anything you've done as editor begins to have an influence.



You probably already know that the impact factor is calculated by dividing the number of citations that your journal receives by the number of citable papers that you published. Increasing the number of citations, of course, raises the impact factor. But so can reducing the number of citable papers. You should think about both approaches.

Concentrate on raising your impact factor . . . there's no time to lose

The most reliable way of increasing the number of citations is to do it yourself. It's easy to find ways of citing papers in your own journal. You can, for example, write an introductory article, under a title such as Editor's Choice, for each issue. It's not much effort to make a few banal remarks about the papers published that month and, if you flag the articles you mention with superscripts and a list of references underneath, Thompson Scientific's search engine will pick them up and count them as citations. Commissioning commentaries on papers and encouraging correspondence also helps because this too provides an opportunity for self citation. Some editors have gone so far as to ask authors of papers that they are about to accept to add papers previously published in their journal to the list of references. But I don't recommend this; it's just too obvious.

The other part of your strategy should be to reduce the denominator of citable papers. Unfortunately, Thompson Scientific doesn't publish the criteria they use to decide what constitutes a citable paper. It's not even clear if there are explicit criteria or if they are applied consistently. Nevertheless, if articles are short, lack abstracts, and don't contain too many references they probably won't be counted as citable themselves. This is why you can publish commentaries and editorials.

Don't publish case reports. I know that readers like them and find them both educational and entertaining, but they are rarely cited and they are usually counted as citable by Thompson Scientific. And try not to publish papers in areas where there is little research activity. Resist any sympathy you feel when a paper is submitted on an unfashionable condition such as deafness or itch. You may admire the researchers for tackling common, unromantic illnesses, but there aren't many scientists working on these conditions so the constituency available to cite them is too small for you to bother with.

On the other hand, if you can pull it off, it's an excellent idea to publish a paper in a well researched area that contains a serious mistake. People will seize on the error, referring to it in their own papers and writing refutations that you can publish in your correspondence columns. The trick is in ensuring that the mistake isn't so obvious that publishing the paper reflects on your competence as an editor.

Now, it's well known that, as a measure of a journal's worth, the impact factor is seriously deficient. Perhaps you'll take the view that editors ought to have better things to do than spend time and effort trying to influence such a flawed indicator. Perhaps you would rather concentrate on producing a journal that is useful to your readers instead of grinding away at stratagems to raise your position in a league table that no one but a fool would take seriously. You might even feel that journal editors as a species have been involved in a collective dereliction of duty in the way they have allowed this malignant number to dominate biomedical publishing. I do hope not. Although you'll probably produce a journal that's widely read and enjoyed, you'll never impress the sort of people who prefer a number to thinking for themselves.

I wish you the best of luck whatever you decide.

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A film that has a lot to teach all doctors p 589

REVIEW OF THE WEEK

Celebrating the medical past, again

Do we need another 400 minute radio series on the history of medicine, however excellent this one is, asks **Balaji Ravichandran**

The history of medicine, it seems, must always be progressive and be celebrated. Recently, though, it has become fashionable to write accusatory histories—consider, for example, *Bad Medicine* by David Wootton (review *BMJ* 2006;333:606). Yet the common thread of progressivism binds them all, and Andrew Cunningham's radio series is another case in point.

Modern medicine, the argument usually goes, is scientific. For most of human history, it wasn't: from the days of Hippocrates and Galen, the patient centred approach to medicine was more of an art than a science, and this viewpoint dominated medical thinking till the late 18th century. But in the aftermath of the French Revolution scientific discoveries, particularly microbiological ones, were slowly yet systematically adopted by practitioners of Western medicine. Medicine, therefore, has moved from strength to strength, and is likely to move on in the same direction in the foreseeable future.

Accusations of viewing the medical past through rose tinted spectacles abound—often, rightly so. Dissenters reject this and have suggested that doctors have done much more harm than good. Undoubtedly, most advances weren't medical at all, but scientific; refusing to embrace new scientific discoveries, doctors continued to favour treatments that had nothing more than a placebo effect.

David Wooton says that the history of modern medicine begins with the discovery of antisepsis by Joseph Lister and its incorporation into surgical procedures. Since then, of course, medicine has progressed, as scientific advances have gone hand in hand with advances in medical education and practice. Other historians, like Roy Porter (and including Andrew Cunningham), may not exactly agree, but they would urge readers to view the past in its own context and to interpret events with empathy.

Ironically, the works of dissenters have more in common with celebratory histories of medicine by Porter and Cunningham than one would think. The working formula behind dissenting writings is woefully familiar. Divide 2000 years of history into discrete, convenient periods; give each its own discoveries and heroes (or villains); and show that from humble (and even repugnant) beginnings, medicine has progressed farther than anyone could have predicted.

No prizes for guessing the heroes of Cunningham's story—Hippocrates, Galen, Paracelsus, Vesalius, Harvey, Sydenham, Jenner, Pasteur, Koch, Magendie, Morton, Lister, Nightingale, and Fleming—nor for the milestones and the background themes that define each of his episodes: anatomical progress, establishment of hospitals, clinical medicine, experimental physiology, microbiology, anaesthesia, tropical medicine, nutrition, antibiotics, and transplantation. As a welcome relief, there are episodes on the entry of women into medicine, the development of clinical medicine, and the establishment of the UK's National Health Service.

Cunningham's series richly enjoys the benefits of hindsight and charitable interpretation. He also says that modern scientific medicine is superior to all other practices of medicine, past or present. Wootton, also progessivist in distributing praise and allocating blame, would largely agree, though Cunningham tries to make sense of the past in its own terms. He is not entirely successful, but he makes a genuine case for understanding why doctors of the past behaved the way they did.

The problem with most celebratory accounts of medical history is that they are largely unreflective. They might make you feel good and might throw in some interesting facts and legendary stories. In this radio series, which, with its great many quotations, sounds rather like the reading of a popular history textbook, you have familiar anecdotes about Morton's discovery of anaesthesia and the etymology of vitamins and tuberculosis, as well as Osler's aphorism on the clinical importance of syphilis.

In tune with modern medicine, Cunningham even talks at length about sanitation and tropical medicine, at the expense of cutting edge medical technologies involving radiology, biotechnology, and pharmacology. Again, the dichotomy between reflective academic (unreadable) history and unreflective popular celebratory history looms large.

Length matters. More and more medical history hits the market every year, whether in books or in radio and television programmes. So, why make another 400 minute series on the history of medicine that differs little from its predecessors, unless to inspire the few who might consider a career in medicine?

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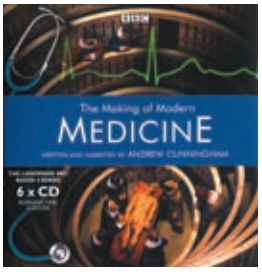

The Making of Modern Medicine

Written and narrated by Andrew Cunningham

BBC Audiobooks, £25

Broadcast as 30 part series on Radio 4, weekdays at 3 45 pm, starting 5 February 2007

www.bbc.co.uk/radio4/science/medicine

Rating: ★★★☆

The problem with celebratory accounts of medicine is that they are largely unreflective

The poverty of expectation

FROM THE FRONTLINE
Des Spence

My father went bankrupt in 1972. My family was sent tumbling down into a black financial abyss. We fell, but rather than hit the bottom, we were caught in a safety net—the welfare state. This educated me, fed me, clothed me, housed me, paid for my university education, and supported my studies. A debt of gratitude to society lives with me everyday. There is nothing that I would not do to protect our welfare state—for me it is what passes as my faith.

Welfare reform is back on the agenda. Entrenched opinions have already started shelling each other with insults. This is nothing new.

When I first started as a general practitioner I tried to limit medical certification. But this compromised my relationship with patients, who simply sidestepped me. I eventually resigned myself to signing people off, even if they were capable of work. I rationalised that I was not an instrument of the benefits system and was not equipped to police incapacity benefit.

Currently, some 2.7 million people claim incapacity benefit. Welfare reform, therefore, is important and overdue. This is not an economic debate, but fundamentally a medico-social issue. For incapacity benefit is a key ingredient in the speedball that is social deprivation.

We might all hate work at times—lying under our duvets scheming how to use our medical knowledge to feign the kind of sickness that brings early retirement. But we get up and go. It is the very drudgery of work that gives our lives shape, camaraderie, and purpose. Work and routine are the elixir of a contented life.

I see generations of poor families who have never worked. Their material deprivation pales in comparison with the absolute poverty of expectation that is killing them. They are disarticulated from broader society and trapped in a cycle of subsistence benefits.

The welfare state is failing our most deprived populations and needs to be reformed for the health of our nation. We must get people back to work using both incentives and sanctions. Doctors can play an important role but must be ready to wrap up against the wind that will surely blow.

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Hidden extras

DRUG TALES AND OTHER STORIES
Ike Iheanacho

Last weekend *The Food Magazine* published research on over-the-counter medicines for young children (www.foodcomm.org.uk/latest_medicines_Mar07.htm). Its conclusion that some of these treatments contain inappropriate additives has caused understandable anxiety among parents and healthcare professionals. But this has overshadowed wider issues about the content of medicines, particularly those less safe than over-the-counter treatments.

Every working day, a doctor may unknowingly prescribe dozens of substances. This represents neither incompetence nor carelessness. Far from it: each prescription might be wholly appropriate and accurately documented. Nevertheless, it may still obscure exactly what the patient is being invited to take.

This is because of the ragbag of other substances incorporated in a prescribed medicine with the so-called active ingredient. Possibilities include coatings, colourants, printing inks, preservatives, sweeteners, flavourings, fillers, agents to facilitate binding or disintegration, lubricants and flow-enhancers—a non-exhaustive list. These excipients (and even this umbrella term may be unfamiliar to some prescribers) are typically an under-recognised part of treatment. Until something goes wrong, that is.

A common misconception is that excipents are completely inert substances not worth worrying about. In reality, these supposedly innocent bystanders can cause significant casualties. Such effects may well be highlighted in a medicine's product literature or other guidance; but, even so, a lack of awareness may prevent the prescriber from averting or promptly spotting them. Clinical reactions are not the only problem. People with specific religious or lifestyle principles can feel justifiably aggrieved if not forewarned of, or offered alternatives to, medicines that contain animal derivatives such as pork or beef gelatin.

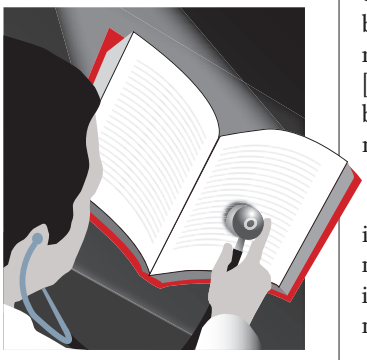
None of this should undermine the importance of excipients. They may be crucial in making, stabilising, distinguishing, storing, and taking medicines. And there is clearly a balance to be struck between avoiding unjustified paranoia in the prescriber and patient, while ensuring both are well informed about the therapies they use. But achieving this compromise is difficult, not least because doctors are usually taught little or nothing about excipients. This knowledge gap can leave them hamstrung to critically appraise a medicine's content, as they would clinical data about the treatment.

Oddly enough, another type of prescriber is better placed to make this sort of assessment. The development of prescribing by pharmacists in the UK has been greeted rather sniffily in certain quarters. Yet their training and experience of may confer advantages over doctors in some prescribing decisions. It is hard to believe this differential expertise will not have tangible benefits for patients. It might do something for the sniffing, too.

Ike Iheanacho is editor, *Drug and Therapeutics Bulletin* iiheanacho@bmjgroup.com

The foul taste of medicine

BETWEEN THE LINES
Theodore Dalrymple



The healthfulness of the unpleasant is a metaphor for the human condition

I was one of the many middle class children whose tonsils were sacrificed to the need of ear, nose, and throat surgeons to increase their incomes. I am not in the least bitter about it because of the ice cream I was given to eat after the operation, though I did dive down to the bottom of the bed and spit out the foul tasting medicine I was also given.

The ward sister rebuked me sternly for my bad behaviour, but I had my revenge when my mother gave me a box of chocolate letters that I distributed to all the staff with the conspicuous exception of the ward sister.

Medicine has always tasted foul, of course; indeed, the fouler the better. Joseph Hall, DD (1574-1656) reflected on this in one of his Occasional Meditations, which he entitled "On a medicinal potion":

"How loathsome a draught is this! How offensive, both to the eye, / and to the scent, and to the taste? Yea, the very thought of it, is a / kind of sickness: and, when it is once down, my very disease is / not so painful for the time, as my remedy. How doth it turn the / stomach, and wring the entrails; and works a worse distemper, / than that, whereof I formerly complained?"

Reading this, I confess, I thought of my time in a malarious country in Africa, where I recommended proguanil as prophylaxis and grew angry when my patients did not take it, although I did not take it myself because it nauseated me so.

Better, I thought, malaria than a life of gastritis; and to this day, 20 years later, yea, the very thought of it is a kind of sickness.

The Right Reverend Dr Hall expressed a general pessimism about the gustatory quality of medicines that has, on the whole, been borne out by experience: "And yet [the potion] must be taken, for health: neither could it be / wholesome, if it were less unpleasing; neither could it make me / whole, if it did not first make me sick."

For the good bishop, it is divinely ordained that what is good for us can only be unpleasant, at the very least a denial of our fleshly inclinations. The healthfulness of the unpleasant is a metaphor for the human condition: "Why do I not cheerfully take, and quaff up that bitter cup of / affliction, which my wise God hath mixed for the health of my / soul?"

The reaction of Lord Bishop of Exeter (later of Norwich) to his medicine was precisely mine 50 years ago: "Why do I then turn away my head, and make faces, and shut mine / eyes, and stop my nostrils, and nauseate and abhor to take the / harmless potion for health?"

Why, he goes on to ask, make such a fuss when "we have seen mountebanks, to swallow dismembered toads, and drink the poisonous brother after them, only for a little ostentation and gain?"

At the time of my tonsillectomy I had a friend who used to drink the water in puddles and swallow earthworms, only for a little ostentation (to appal the adults) and gain (we paid him three pence to do it). I certainly wasn't prepared, then, to swallow foul tasting medicine for that most trivial and uncoupling of all reasons, my own good.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

The Doctor

Film released 1991

This film is a classic portrayal of a doctor's transformation as a result of his own experience of illness. Like a lot of Hollywood movies, it shows the hero overcoming adversity and coming out a better person; it also a reflection on the different aspects of being a doctor.

William Hurt plays Dr Jack McKee, a cardiac surgeon, who is lively and technically competent, but also arrogant, and who has appalling doctor-patient communication skills. Why is it always the surgeons that seem to be this way? Maybe there is some truth in what Dr McKee says on his ward round with his subservient junior staff, that a surgeon needs to be quick and decisive, and that concentrating on the patient's agenda can be distracting. His big fear seems to be that if he becomes sensitive to the patients' needs and fears, he will be paralysed into inactivity.

Dr McKee develops an irritating cough, and eventually after coughing up blood he goes to see an ear, nose, and throat surgeon in his own hospital, the glamorous Dr Lesley Abbott. There is brilliant acting here by William Hurt, as he portrays a patient having a laryngoscope shoved down his choking throat and then being told bluntly by Dr Abbott, "You've got a growth, doctor." She, rather like Margaret Thatcher, seems to feel that she has to be as tough as the men to survive in her professional world.

We follow Jack McKee trying to come to terms with his illness, while also carrying on his work as a heart surgeon, and we see just how difficult it is to be both a doctor and a patient, especially when you are playing both roles in the same hospital. The best scenes show the powerlessness and frustrations of being a patient, from nearly being given a barium enema intended for a neighbouring patient, to the endless waiting around and poor staff communication.

Transformation: Hurt as McKee

SNAP/REX

The film is much less effective when straying away from the medical arena to portray Jack's close relationships. Finding difficulty communicating with his wife, he seeks solace with a fellow radiotherapy patient, who is dying from a brain tumour. Despite being terminally ill, she is beautiful and elegant with her shaven hair, and they run away together, dancing into the sunset in the Nevada desert. Pure Hollywood schmaltz!

Jack discards his female ENT surgeon for a more sensitive male colleague whom he had previously ridiculed for being a nerd, but now clearly recognises as the sort of doctor he needs. He survives surgery and the temporary loss of his voice, and is finally reconciled with his long suffering wife. He returns to work as a much more caring and effective doctor, able to successfully combine the technical and human qualities of being a doctor.

I use this film extensively when teaching medical students, but it has a lot to teach all doctors, at all stages of their careers.

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