

## EDITOR'S PAGE

# Of Editors and Dilemmas

The principal role of the Editor-in-Chief and Associate Editors of a medical journal is to select content. The most important responsibility relating to content is to determine which of the many original research articles submitted for review should be accepted for publication. As indicated previously, in the average week the editors of *JACC* will consider approximately 100 manuscripts, of which about 10 can be accepted for publication. Obviously, selecting these papers is a grueling task that requires not only assessment of the novelty and accuracy of the work, but judgment about the potential impact upon practice. The process is imperfect and papers frequently present issues that convey a degree of uncertainty and stress to the process of reaching a decision. In this regard, there are a few special issues that constitute particularly difficult dilemmas.

The most common quandary encountered is when the reviewers disagree in their assessments. As has been reported in these pages previously, in nearly 40% of cases the critique of one expert external reviewer places the manuscript in the highest priority category, whereas that of the other places it in the lowest. This represents something of a dilemma because there is a danger of either missing a potentially very important paper or accepting one with a serious flaw. When both referees make cogent agreements for their recommendation, we often seek a third opinion. Our resolution usually favors giving the author the benefit of the doubt. Nevertheless, it is always difficult to override the advice of a respected reviewer who unequivocally advocates rejection of a manuscript.

The most difficult dilemmas, however, often occur when the facts are not in question and two reviewers are in complete agreement. In fact, the Associate Editor usually concurs as well in such instances. The most common scenario for such dilemmas involves manuscripts that contain significant imperfections but address a prevalent and very important clinical issue for which virtually no data are available. Typically, such studies entail large patient groups but are retrospective and uncontrolled. Accordingly, they are susceptible to important variables whose influence cannot be assessed. Such studies often apply propensity analysis in an attempt to deal with the uncontrolled variables, a maneuver that greatly strengthens the paper but is ultimately limited and not definitive. The editors are left with a paper that provides some useful data regarding the clinical issue, but no clear direction for clinical action.

While not discussing specific manuscripts, a few examples can illustrate the dilemma clearly. Imagine a common chronic cardiac condition for which periods of stability are interrupted by episodes of decompensation. When stable, the patients are often treated with agents that may be detrimental (or beneficial) during periods of decompensation. However, no data exist as to whether one should discontinue the agents during decompensation. A manuscript is received that reports the retrospectively analyzed outcomes of a large group of patients in whom the agents were either stopped or carried on. The paper provides useful information regarding the end results of patients so managed, but it cannot eliminate the variable of why the individual patients received the treatment



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that was given. As another example, consider two prevalent conditions that not uncommonly occur in the same individual. Each disorder warrants prophylactic treatments that may lead to adverse effects in combination. However, no data exist as to whether one (or other) of the therapies should be discontinued when the two conditions coexist. A manuscript is received that reports the outcome of a large number of patients in whom one, or the other, or both agents were administered. Again, the variable of why the management was selected in any individual case prevents preferable management strategies from being derived. Many other illustrations could be given.

The common denominator of the foregoing examples is imperfect data regarding common clinical problems for which little or no evidence is available as to optimal management. The editors are confronted with the dilemma of whether some information is better than none. On the one hand, the observational data can provide some guidance for decision making, at least in regard to relative safety. On the other hand, the data are clearly not capable of resolving the issue, and may be misinterpreted to be more definitive than they are. To complicate the matter, such papers often provide the only available data for common clinical problems and thus are likely to be frequently cited and reflect well on the *Journal*. As might be expected, these manuscripts stimulate some of the longest and most spirited discussions of the editors.

There are, of course, other dilemmas that often confront the editors. One of the most difficult relates to manuscripts that are similar to others published by the same authors, so similar in fact that they raise the issue of duplicate publication. Such papers are never identical, and always differ in at least some small aspect. However, they typically originate from the same database and provide substantially overlapping findings. More than just rejection, the issues include the consequences to the authors if

duplicate publication is determined to be present. The editors tread very cautiously here, and try to give the authors every benefit of the doubt. Another cause of quandary is the manuscript reporting findings that are absolutely predictable, but have never before been published. Do we serve our readers well by documenting the obvious? In the same vein, the paper with incremental findings also creates a predicament. Should we reject a manuscript that is well done and accurate but advances the field only a small amount? Unfortunately, our page limitations often dictate that we do so.

Nevertheless, all of these other dilemmas pale compared to the potential positive (or negative) impact of papers presenting the solitary data on common unresolved clinical issues. I wish that I could say that after 5 years and over 20,000 manuscripts we had evolved a clear pathway to reaching decisions on these papers. In fact, it is still a case-by-case process. In general, however, we have tended to put the data out there and let the readers decide for themselves. Still, it is a bit disappointing to realize that, despite all the work and efforts of the authors, reviewers, and editors (alone and in combination), uncertainty and ambivalence often exists regarding whether the decision to publish was correct. Editors are sometimes thought to act "like God" in deciding whether a manuscript will be published or not. It is clear to me, however, that with regard to the dilemmas with which we deal, we still lack omniscience.

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