EDITORIALS

Free Medical Publications or Scientific Medical Journals?

The three physician-editors of the Medical Journal of Australia resigned a few months ago over the issue of editorial freedom. The Lancet reports that the appointment of a lay publishing manager, who was given ultimate authority for the contents of the journal, created an intolerable situation for the medical editors. Apparently, this radical administrative move was effected in an effort to increase income from advertising. Pharmaceutical advertising had been inadequate for the needs of the journal and the Lancet staff correspondent notes that one of the reasons was: "successful competition for large slices of the cake from so-called free medical publications. These periodicals are extremely well produced and illustrated, easy to read, and buttressed by an impressive list of editorial consultants. On the debit side, they publish no original research, have no correspondence columns in which dissenting views can be expressed, discourage critical reading, and inhibit recourse to primary data sources by the virtual elimination of references."

The Lancet concludes their analysis with the following admonition: "Medical educators and researchers in Australia are particularly anxious, in case the restructured MJA, attempting to solve its besetting financial problems by trying to attract pharmaceutical advertising, becomes more like the 'free' publications. If that were to happen, Australia would have lost not just its most experienced medical editor, but its only general medical journal as well. The costs of a cheaper journal may be very high indeed."

The circumstances may have been far more complex than those described by the Lancet staff correspondent, and, of course, the publication scene in Australia may not be comparable to that in other countries. Turning to the United States, one may ask: In this country, what are the characteristics of journals of clinical investigation vs controlled circulation periodicals? The latter are wholly depend-
an understanding of the discipline of clinical research and this should be a particularity of the well-trained practitioner. Editors of scientific medical journals choose to encourage critical reading rather than to offer pre-digested algorithms of diagnosis and therapy. Their aspiration is to modify clinical behavior by encouraging an understanding of mechanisms in health and disease rather than by providing a laundry list of steps in diagnosis and therapy. Let us not be deluded; a brief self-assessment quiz at the end of an article or series of articles (surely one of the most pervasive fads in controlled circulation circles) is of limited educational merit. A common practice is to append these superficial quizzes to "practical" digests of patient management. This is a poor substitute for the development of a study plan which characterizes a well-balanced editorial curriculum.

These observations are not meant to denigrate the contributions of the non-scholarly medical magazine. Yet, we must acknowledge that physicians require the maintenance and encouragement of intellectual curiosity and that these surely are intimately related to habits of critical reading. There are priorities in medical documentation; first among these priorities is the primacy of journals of original studies. This conclusion must not be accompanied by academic smugness because an increasing number of physicians assert that some editors are negligent in providing a sufficient number of papers with immediate clinical relevance. This serious omission can be corrected with more clinical commentaries that synthesize, criticize and interpret. Scientific clinical periodicals so constituted are uniquely suited to encourage a dialogue between authors and readers, and it is this type of medical journalism which can make of our journals extended classrooms for life-long students of medicine.

Alfred Soffer, M.D., FCCP
Park Ridge, Illinois

References
1 Lancet correspondent: Journal in trouble. Lancet 1981; II: 801
2 Soffer A. What is a 'practical' clinical journal? Arch Intern Med 1980; 140:1419
3 Soffer A. The unique solo of peer review journals. Chest 1980; 78:547-48

Sexual Dysfunction and Chronic Obstructive Pulmonary Disease

Sexuality is generally necessary to human wellbeing. Just as chronic illness interferes with normal nutrition and the ability to earn a living, it frequently impairs sexual performance. The effects of sexual dysfunction range from minor adjustments to catastrophes for the patient and the family.

In this issue (see page 413), the description by Fletcher and Martin of sexual dysfunction in men with moderate to severe chronic obstructive pulmonary disease (COPD) offers important insights for the medical professional involved with treating COPD patients. They use a spectrum of the new techniques available to evaluate erectile function which have made it possible to distinguish between psychogenic and "organogenic erectile impotence" (OEI). In alerting us to the problem of sexual dysfunction in selected COPD patients, the authors offer the first evidence that impotence correlates with the severity of COPD and may stem from organic causes in a notable proportion of such patients.

A normal penile erection requires effective interaction between a complex of inputs from the central nervous system, peripheral nerves, endocrine glands and blood vessels, as described in an excellent review. Recent discoveries on the physiology of erection made it clear that organic causes of impotence are more common and psychogenic impotence correspondingly less common than was formally believed. The incidence of OEI in part depends upon patient selection; the incidence of organic versus psychogenic sexual dysfunction in unselected patients with COPD is unknown. In one investigation, the authors describe a 19 percent rate of impotence among male COPD patients attending a chest rehabilitation program, but emphasize that many men with advanced disease continue sexual function. Certainly, psychologic factors contribute to the sexual dysfunction in many patients with severe COPD. Depression, a frequent cause of sexual dysfunction, is often significant in persons with severe COPD. Although sexual problems are potentially reversible through individual counseling, group therapy or educated advice by the physician, when impotence is due to a combination of depression and impaired libido, the response to therapy may be poor.

It is important to emphasize that sexual dysfunction cannot be treated until a proper history defines the problem. This is a major hurdle for patients and physicians alike since recording a history of sexual function may be neglected or avoided. Health professionals are sometimes poorly trained for taking a sexual history compared to their expertise in obtaining information about physiologic functions. Publications yield no evidence to indicate what percentage of physicians offer sexual counseling for patients with severe lung disease, but nearly half of patients recovering from myo-