erees who review manuscripts are blinded to the identity of the authors.[2] They found that only 18.6 percent of the responding journals currently blind referees. Two family medicine journals were surveyed: *American Family Physician* does not use blinded referees, whereas *Journal of Family Practice* does. Other pertinent journals that do not blind reviewers include the following:

American Journal of Diseases of Children
Annals of Internal Medicine
British Medical Journal
Geriatrics
Journal of the American Medical Association
Journal of Pediatrics
New England Journal of Medicine
Pediatrics
Southern Medical Journal

Some of the largest and most influential journals are on this list.

In their classic study, Peters and Ceci evaluated 10 psychology journals that used nonblind review by resubmitting manuscripts that previously had been published in the same journal 2 years before, changing only the names of the authors and their institutions. Only 2 out of 14 reviewers believed that the previously published papers were suitable for publication.[3]

It seems that it would be easy to blind reviewers to an author's identity by removing the author identification page before sending a paper out for review. As pointed out in the editorial, this will not guarantee anonymity, but it may help. Decisions made by reviewers and editors affect careers, funding, and the course of medicine. The process of publication is as important as the data published, and this process should be made as objective as possible.

Allen F. Shaughnessy, Pharm.D.
Saint Margaret Memorial Hospital
Pittsburgh, PA

References

1. Young PR. A case for refereed journals. J Am Bd Fam Pract 1989; 2:77.
2. Cleary JD, Alexander B. Blind versus nonblind review: survey of selected medical journals. Drug Intell Cin Pharm 1988; 22:601-2.
3. Peters DP, Ceci SJ. A manuscript masquerade. The Sciences 1980; 20(7):16-19, 35.

Bibliographic Databases

To the Editor: As Shearer, et al.[1] correctly note, a number of excellent systems are available for computer access to MEDLINE and related databases. Any of those mentioned are suitable for use by medical librarians and researchers with high levels of sophistication and extensive experience in working with MEDLINE. In my view, however, the system of greatest value to practicing physicians and residency programs was mentioned last and without the attention it deserves.

Its somewhat frivolous name notwithstanding, "Grateful Med" provides rapid, easy access by less sophisticated users to MEDLINE, AIDSLINE, and other MEDLARS databases.[2] This system is particularly useful when one wants information quickly or lacks ready access to medical library services. The price is right, the instructions are lucid and reasonably simple, and a computer-based tutorial program is supplied. Informative monthly bulletins are published, and annual system upgrades have been provided without additional cost.

One potential pitfall with self-administered literature searches, whether using "Grateful Med" or another approach, is the definition of search terms. It is important to have access to a copy of the *Medical Subject Headings* (*MeSH*) book, and a telephone call to a medical librarian or other source of advice will be needed occasionally until one becomes familiar with the system.

The software can be ordered for $29.95 plus $3.00 for shipping from National Technical Information Service, 5285 Port Royal Road, Springfield VA 22161.

Robert D. Gillette, M.D.
St. Elizabeth Hospital Medical Center
Youngstown, OH

References

1. Shearer B, McCann L, Crump WJ. A primer for users of medical bibliographic databases. J Am Bd Fam Pract 1989; 2:191-5.
2. Gillette RD. Software review: Grateful Med. Fam Med 1987; 19:475.

Editors' Comment

Ms. Shearer and colleagues have written a companion article, "Grateful Med: Getting Started," which will be published in the January – March 1990 issue.

Effort Thrombosis

To the Editor: I read, with great interest, Aquino and Barone's article, "Effort Thrombosis of the Axillary and Subclavian Vein Associated with Cervical Rib and Oral Contraceptives in a Young Woman Athlete," (July – September 1989). I was surprised that they had found only 52 cases in which effort thrombosis was related to sports participation. I wish to add a similar case that presented to our family practice residency program in March 1989.

A previously healthy 24-year-old woman presented with abrupt swelling and discoloration of her right hand and arm, which had became progressively worse during the 6 days prior to admission. She denied any trauma to that extremity but had been taking oral contraceptives for 6 years. She had increased her athletic activities 3 weeks earlier, participating in aerobics 3 times a week and volleyball twice a week. Her history was otherwise negative. Family history was negative for any thromboembolic diseases.

On admission to the hospital, her blood pressure was 140/90 mmHg, pulse 88, heart rate and rhythm were regular with no murmurs, and her chest was clear. Her right upper extremity, from the shoulder down was swollen and had purple-bluish discoloration. It measured 2 to 3 cm greater in circumference than the left upper extremity at the hand, forearm, and arm.

A venogram showed right subclavian thrombosis. Urokinase was infused intravenously, and by the 4th hospital day, a third venogram showed that most of the thrombosis had cleared. At this time, her right upper extremity was much improved clinically with decreased swelling and less tenseness and tenderness. She was able to move her fingers freely. The urokinase drip was discontinued, and she was continued on heparin drip and subsequently discharged on oral warfarin for 3 months. After 3 months of oral therapy, she was reevaluated by vascular surgeons. At that time, she underwent a first rib resection to prevent further injury. She is currently asymptomatic.

Robert J. Darios, M.D.
Sparrow Hospital
Lansing, MI

Pap Smear Adequacy

To the Editor: Thanks for the relevant and clear article on "Papanicolaou Smear Adequacy" (July – September 1989). Certainly, the suggestion of more aggressive use of available collection technology is very well taken. Not only do reports of "no endocervical cells" strain followup systems and cost extra money, but they cause needless anxiety.

When I did a study of 600 samples obtained by 20 practitioners in our HMO in 1983, I found that, aside from a correlation of endocervical cells and blood (presumably because of more aggressive scraping, because relation to menses, etc. was not a factor), the most important single factor that correlated with the presence of endocervical cells was the technician involved! Unfortunately, 4 technicians were used in my study, and their percentages were 63, 68, 83, and 90 percent, with a significance of $P < 0.001$ between the latter three (unpublished data). The laboratory representatives, when questioned, said they did not find such variability, but there is no other simple way of explaining my data.

Dr. Noel notes that 2 technologists were used in the study. I believe this might affect his data. More to the general point, I believe that laboratories have a much greater variance between technologists than they realize, and this may affect the "adequacy" of Pap smears more than any other factor.

Alan Steinbach, Ph.D., M.D.
Berkeley, CA

The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: I appreciate Dr. Steinbach's letter regarding my study. As he states, reports of "no endocervical cells" do strain followup systems, cost extra money, and cause anxiety. Most importantly, though, these reports potentially indicate that a cervical carcinoma has gone undetected.

In his unpublished study, Dr. Steinbach apparently has found significant variability among technicians in reporting the presence of endocervical cells. This problem of intertechnologist variability has been reported previously, and knowledge of this problem was incorporated into the planning for the study published in *JABFP*. In my study, although 2 cytotechnologists were used, 1 cytotechnologist screened all of the slides for the first 5 months of the study and the other cytotechnologist screened all of the slides for the last 2 months. Thus, only 1 cytotechnologist was screening the slides at any given time. The potential confounding variable of inter-rater reliability was controlled for by randomizing patients to either one of the two techniques and using a single cytotechnologist who was blinded to the technique used. For this reason, inter-rater reliability did not affect the data. Even though there may have been some variability among the cytotechnologists, I still found that there was a true difference in the adequacy of Papanicolaou (Pap) smears attributable solely to the instrument used.

Based on this data, I am confident that using the cervical cytobrush for Pap smears increases the rate of recovery of endocervical cells, which improves the detection of cervical dysplasia.

Michael L. Noel, M.D.
Baylor College of Medicine
Houston, TX

Any More Cordials to the Drooping Spirit

To the Editor: I read and re-read your recent editorial (July – September 1989) and thought it was *excellent*. Your presentation of the modern doctor-patient relationship was a perfect image placed in context.

As chairman of our hospital Ethics Committee, I plan to make your (to me) stinging question, "Can they [values] be nourished by the ideals of competence and accountability in a market economy?" the topic of our next meeting. Also, because some of your discussion was about patient autonomy, I wonder if you would agree that the transition from medical paternalism to autonomy to state paternalism is not necessarily an advance?

John Davenport, M.D., J.D.
Irvine, CA

Editor's Comment

Thank you for your letter. Your last sentence poses a question that goes beyond my editorial, a question about the relative merits of differing ethical values, in this case, patient autonomy versus two varieties of beneficence. (I interpret paternalism to be an authoritarian form of beneficence.) Such a question, as I understand it, belongs to the metaphysics of morals rather than to normative ethics or to metaethics. (See Rakel RE, Conn HF, eds. *Family Practice*. Philadelphia: W.B. Saunders, 1978:Chapter 17.)

You imply that substituting patient autonomy, as a higher ethical value, for physician beneficence is not necessarily a bargain; moreover, that patient autonomy is already being displaced by another form of beneficence that is even less virtuous. Whether you are correct in this opinion I cannot say, but I agree with your pointing out that the next round of debate about medical ethics will include analyzing the ethical status of what we have already decided to be ethical.