APPROPRIATE CONTENT FOR DISCUSSION

To the Editor: A particular issue of concern to authors is what the *Journal of the American Geriatrics Society* considers appropriate content for the discussion section of a manuscript.

In general, it seems that social science journals expect authors to interpret and discuss their findings in the context of the previous literature and attempt in some way to advance our general understanding of a particular area. A paper must tell a story and have a take-home message. Basic science journals, on the other hand, seem to want little beyond methods (technical rather than design/statistical) and results. Thus, some journals expect the results to speak for themselves and let the reader do his or her own speculation, whereas others will not accept papers that do not attempt to develop or advance a theoretical model or discuss implications for society or public health.

Presumably, clinically oriented journals have to fall somewhere in the middle, but there seems to be considerable disparity even among such journals with respect to how much discussion is allowed or desirable or necessary. Some journals seem to limit discussion to address the problem of publication costs by imposing page limits and/or charges on the author, thus encouraging the submission of Least Publishable Units. Although the correct answer to "How long should the discussion be?" is "Long enough," the question that concerns me is "What does the journal want to see discussed?"

The attractiveness of *JAGS* to a wide range of both authors and readers is that it is a journal intended to address issues relevant to clinicians who take care of older adults and that it publishes papers from a variety of settings and disciplines. However, different disciplines encourage different writing styles and approaches. It would seem likely that papers reporting research from non-clinical studies, such as epidemiological surveys, would be required by *JAGS* to describe in the Discussion what their findings might mean to clinicians and how their findings are potentially relevant to the care of patients. Some manuscript reviewers may ask for all the "speculation" to be deleted; however, they seem to regard as idle speculation anything other than the results and simple comparisons of results with those of other studies. It could be argued that any attempt to explain/interpret results and go "beyond the research"[1] is necessarily speculative. The question then is about the extent to which the reviewers' perspective reflects editorial policy. Although *JAGS* allows authors to rebut reviewers' comments, authors are generally eager enough to gain timely acceptance that they accommodate points of view with which they actually disagree, with which a different reviewer may have disagreed, and which may not even be consistent with editorial policy. An articulation of editorial policy would be helpful.

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REFERENCES

1. Ekerdt DJ. Write This Way (editorial). J Gerontol 1996;51B:S51–S52.

Editors note: The above letter was referred to the editors of the *Journal,* and their reply follows.

In reply: We appreciate Dr. Ganguli's constructive letter about the appropriateness of including speculative content in the Discussion section of *JAGS'* manuscripts. Dr. Ganguli has increased our awareness that all reviewers do not display a consistent philosophy about speculative content, so a statement of *Journal* policy is in order.

JAGS' editors discourage speculative content in the Discussion section of the Abstract for several reasons — including space limitations, speculation's being too easily mistaken for findings, content priorities, etc. — and we encourage relevant speculation in the Discussion section of the manuscript.

Peer reviewers' encouragement or discouragement of speculative content in Discussion may vary, both individually and across disciplinary/subspecialty boundaries. Thus, it must always be the author's responsibility, in revising, to incorporate reviewers' comments judiciously, as appropriate, and to provide a reasoned rejection/rebuttal for those comments judged to be inappropriate. As editors, we agree with Dr. Ganguli's comments with regard to placing any findings published in the *Journal* in an appropriate clinical context.

Marshall J. Graney, PhD, Deputy Editor
William B. Applegate, MD, MPH, Editor

FELLOWSHIP TRAINING

To the Editor: The Metropolitan Area Geriatrics Society (MAGS), a regional affiliate of the American Geriatrics Society (AGS), was founded 10 years ago to serve the educational needs of a cornmunity that currently offers 12 fellowship programs responsible for 48 fellowship positions in Geriatrics. It represents the majority of the fellowship positions in Geriatrics in New York State and at least 30% of the fellowship positions in Geriatrics in the United States.

On April 24, 1996, our Executive Board heard from our representative to the Council Of State and Affiliate Representatives of the AGS (COSAR) that the AGS had endorsed a recommendation that Fellowship training requirements for a Certificate of Added Qualification (CAQ) in Geriatrics would be reduced to 1 year. This information was shared with our membership at our annual business meeting the following week. It is fair to say that the change in training eligibility was not favorably received.

In open discussion at both meetings, it became evident that none present, including the program directors, had been consulted about their views on the proposed decision, nor were they in favor of it. That such a decision would be made without our knowledge, let alone opinion, is difficult for us to understand or accept.

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