60th anniversary of *Thorax*

Thorax 1991–1996

S G Spiro

The only bound volumes that I have of *Thorax* (five in all) were the annual collations of published papers during my tenure as Editor. I noted with some satisfaction that the pagination had risen from 939 pages in 1991 to 1328 pages by 1995.

For me, my short editorial announcing that we had agreed to publish Supplements to be produced with—but not integral to—*Thorax* was a huge leap forward. No, we may not have been pioneers here, but it represented a broadening of the content and it became a vehicle for Society guidelines, symposia summaries, and topical reviews.

The first supplement was the Guidelines for the Management of Asthma (1993;**48**:S1–24). Not only was this publication a great success, reaching a world audience and excellent for the journal's impact factor, it was also a considerable financial success as the pharmaceutical industry bought thousands of copies. These profits were in part transformed into more pages as I adopted a policy of expanding *Thorax* with papers of general interest, perhaps at the expense of the impact factor—always a controversial issue.

I think that, overall, the supplements raised the journal's profile. Other guideline supplements followed, some more successful than others. They have always been independently produced without sponsorship, although industry has often bought copies after publication. While they remain individual gambles, I was pleased to have added supplements to the content of *Thorax*.

Editor, 1991–1996

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60th anniversary of *Thorax*

Thorax 1996–2002

A Knox, J Britton

The year 1996 was a strange one. Dolly the sheep was cloned and Britain was embroiled in an epidemic of mad cow disease. Nottingham Forest football team were in the premier league. Amid this confusion, two different beasts were appointed to the editorship of *Thorax*, one a cell biologist and the other an epidemiologist. This was the first time *Thorax* had joint editors rather than a dictatorial structure. Would it work? How would we run the journal?

The main indicator of scientific quality of a journal then, as now, was the impact factor and, for all its failings, it at least provided something objective which was measurable against comparator journals. At that time the impact factor of *Thorax* was rather low and we were concerned that, as competitor journals expanded, we might be left in their wake. We decided that lean and mean was best. We would concentrate on quality at the expense of quantity and hope that by publishing only the best papers we would improve the impact factor. Hopefully this would then make the journal more appealing to contributors for their better papers, and there would be a positive spiral with this policy increasing the number of good manuscripts received. Interestingly, not all within the publishing house were convinced about this. The spectre was raised of an anorexic journal getting thinner and thinner and then imploding without trace. Another major change we made was to improve the turnaround time on decisions. As investigators ourselves, we had experience of papers being in review for inordinate lengths of time before being rejected. We hoped that a quick decision—especially if it was negative—would allow the authors to send their work elsewhere with speed.

At first life was difficult. Irate authors who were used to getting their work published in the journal were horrified that their papers would have to find a different home. There were protests that papers had been rejected so speedily that we could only have given them a cursory glance. Unfortunately, if the message is not compelling, then no amount of reviewing is likely to turn a paper into something which will have a major impact in the field. We may have made some mistakes, but authors could always turn to other journals. We also suffered from the assumption by the British Thoracic Society that guidelines written by them would automatically be published in the journal, irrespective of quality. These were interesting times.

Initially our policy resulted in a few lean issues of the journal but—lo and behold—as the impact factor of the journal rose, its perception did also and submissions increased steadily. Our ideas had been vindicated. Like Clinton in 1996, we stayed on for an extended term but all good things eventually come to a natural conclusion.

There were the issues of potential scientific misconduct, duplicate publications, ghost writing, etc. The former were often spotted by sharp eyed reviewers. These were inevitably a source of embarrassment to those involved and unnecessary hassle for us.

We were able to publish a number of papers which took respiratory medicine forward in new directions (and probably some which set it back!). Some examples of the former in common respiratory conditions were landmark papers highlighting the relationship between exacerbations and decline in lung function in COPD[1] and papers characterising new phenotypes in asthma.[2] There were also clinical papers with therapeutic implications in a diverse range of therapeutic areas such as a study defining the role of CPAP in mild sleep apnoea,[3] a paper on bisphosphonates in treating osteoporosis in cystic fibrosis,[4] and the occasional interesting anecdotal report such as a paper suggesting that GM-CSF was a novel treatment for alveolar proteinosis.[5] On a more experimental note, laboratory studies suggested a potential for anti-TGFβ strategies in pulmonary fibrosis.[6] These