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## EDITORIAL

THE INTERNATIONAL JOURNAL OF  
**CLINICAL PRACTICE**

# What IJCP authors think about open access: exploring one possible future for publishing clinical research in a general and internal medicine journal



This editorial shares the questions that IJCP is, at the time of this publication, asking research authors about 'open access'. It aims to prompt discussion about open access, and explains some of the challenges that switching to open access presents to a general and internal medicine journal like IJCP. It invites you to share your insights, using the approaches described below. It explains how you will be able to read the results of our research.

## An important trend

Open access publishing has changed, perhaps forever, the way readers access articles in some high-quality, peer-reviewed journals.

The benefits to authors are derived from removing the 'pay to read' barriers that traditionally sit between published articles and the readers who want to read them. Arguably this gives greater exposure for authors' work. Replacing traditional copyright attribution with Creative Commons-based licensing – another component of publishing open access – means that authors' work is arguably more straightforward to re-use [for example, Figure 1 (1)]. Also, although this is controversial, there may be a possible citation advantage (2,3).

The cost to authors, though, is real. Whereas there are frequently no publication costs for authors who publish in traditional subscription journals, publishing in open access journals commonly involves a mandatory publication fee. Sometimes, this fee is

paid by research funding bodies (some of which make unrestricted access a condition of their funding), such as Wellcome Trust, US National Institutes of Health, UK Medical Research Council and some corporations, including pharmaceutical companies. Other times authors pay from their own pockets.

The cost to publishers is also real. The open access model means that publishers can no longer collect the subscription revenues that traditionally sustain their journals and may mean that they instead switch to reliance on authors paying.

Equally critical, publishers who make the switch from a subscription to an open access approach run the serious risk of alienating their authors, who may

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**Figure 1** Open access logo as an example of these authors re-using work published by the original authors using one of the Creative Commons licenses (1)

not believe that the benefits of open access outweigh the costs, and who instead take their articles to different journals, which continue with the traditional approach.

### Hybrid: nice but (unless something changes) suboptimal

Some journals, like IJCP, continue to offer authors a hybrid option: open access for individual articles within a journal where all other articles are available via subscription. This approach was developed to explore the possible transition between models, from subscription to open access. While showing some signs of success, the hybrid approach is (and may remain) suboptimal for some research funders, and the spectre of 'double dipping' raises its head (4).

### Full open access: what IJCP authors think

At the time of this publication, and for another 6 months, we will ask all authors who submit papers to IJCP to answer two questions about open access (Table 1). The answers to these questions will tell us whether or not these authors believe the possible benefits of open access publishing might outweigh the costs.

Then, using these answers, the IJCP team will consider whether or not IJCP should become an open access journal. If we decide to take this course, IJCP would start requiring payment of open access fees from authors for every article we agree to publish, although we would have a fee-waiver option for certain cases. We would no longer collect subscription revenues for the articles we publish online and these articles would become free to read by anyone. We would calculate our open access publication fee in such a way as to replace our current subscription revenue.

### Discussion: letters, Twitter

We wrote this editorial to explain our approach, and to extend discussion to a wider audience beyond those authors who happen to submit to IJCP in the next 6 months. We encourage you to share your thoughts and join the debate, by submitting to IJCP a 'Letter to the Editor' (approximately 200 words, at our usual submission website) explaining what you think about open access, and/or the traditional subscription model, and why. We will review all letters, as is normal, and publish in the journal those that add insight. We also encourage those readers who are Twitterers to discuss open access with us on Twitter: @ijcpedi-

**Table 1** The questions that we are, at time of publication, asking all IJCP authors to answer

Question	Statement	Format for answer
Do you agree or disagree with this statement	'I would still choose to submit my work to IJCP if IJCP in the future required all authors to pay an open access fee for publication and then made all its content open access and free to read online'	Yes/No
	We welcome your general comments (e.g. you may want to comment on what you think a suitable open access fee might be, considering our benchmark of \$3000)	Free text
Do you agree or disagree with this statement	'I would not publish my work in any open access journal (including IJCP if IJCP required me to pay an open access fee) because the costs to me or my research funder would outweigh any benefits'	Yes/No
	We welcome your general comments	Free text

tors. And we will also be happy to receive communications by email.

### Results: to be published

By answering our questions or by joining in the conversation, you will be taking part in an interesting and highly topical debate (in the publishing world, at least), as well as playing an active role in helping decide how IJCP approaches open access in the future. We will aggregate and analyse the responses that we receive from authors (Table 1), and will share those results with you in a future editorial. Like this editorial, we will publish the results in an article that is free to read online. To receive this news as soon as it is published, please register with IJCP online to get new content alerts (5).

### Disclosures

CG is employed by John Wiley & Sons, and as such benefits from the success of the company's publishing programme. CG publishes clinical and research journals including a number for Societies and Royal Colleges in Australia and New Zealand, the International Journal of Clinical Practice, the global Wiley open access journals in health sciences, is the treasurer of the Committee on Publication Ethics (a UK registered charity), and leads the Wiley-Blackwell publication ethics programme.

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## EDITORIAL

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# Silent cerebral embolism after catheter ablation of atrial fibrillation

Editor's  
Choice

## Silent cerebral embolism after catheter ablation

Stroke prevention is a cornerstone of the modern management of atrial fibrillation (AF), and the most effective way is oral anticoagulation (OAC) (1). However, the drawback of the approach is the need for lifelong therapy often with cumbersome monitoring if the Vitamin K antagonist class of drugs (e.g. warfarin) is used. Indeed, failure to cure AF and achieve long-term rhythm control, as well as the growing incidence of AF in the ageing population poses a major burden to any healthcare system (2). From this point of view, the development and improvement of the interventional strategies to achieve sinus rhythm control can potentially be both cost-effective and improve patients' quality of life.

A number of non-pharmacological therapies has been developed and clinically tested for rhythm control in AF. Among these, pulmonary vein catheter ablation or isolation is currently used widely (3). The intervention is usually performed in patients with symptomatic paroxysmal AF, which cannot be controlled by antiarrhythmic agents. The utility of the catheter ablation for patients with persistent AF or permanent AF with heart disease is less established.

The procedure is considered as generally safe and efficient, but the long-term benefits of catheter ablation are still debated. Indeed, recent meta-analyses of trials conducted in patients with AF, mostly with the paroxysmal form of the arrhythmia, have revealed a much better sinus rhythm control with the catheter ablation than with antiarrhythmic drug therapy, at least in the short-term (4,5). However, long-term analyses tend to show the opposite with a higher rate of successful maintenance of sinus rhythm on antiarrhythmic agents and a substantial number of late AF relapse after the intervention (6).

Given that one of the main reasons for rhythm control with catheter ablation is the prevention of the most feared AF complication, cerebral thromboembolism, what do the facts show in this respect? The updated worldwide surveys estimate that catheter ablation *per se* may be responsible for symptomatic cerebral thromboembolism in 0.23% cases for stroke to 0.71% cases for transient ischaemic attacks (7). However, it is increasingly recognised that highly symptomatic and often immediately disabling cerebral events represent only the tip of the iceberg of all AF-related cerebral thromboembolism. In addition to clinically evident strokes and transient ischaemic attacks, many patients suffer recurrent 'silent' cerebral embolism.

The phenomenon of 'silent' cerebral embolism is well described for patients with permanent AF, particularly in the context of progressive AF-related dementia. Various studies have demonstrated cognitive impairment in subjects with long-standing AF, presumably due to recurrent release of microthrombi from dysfunctional atria (8–10). In fact, such microthrombi correlate with symptomatic cerebral infarcts in patients with AF perhaps indicating the presence of a 'thromboembolic continuum' with the bigger thrombi leading to the symptomatic cerebrovascular events (11). Whilst postprocedural thromboembolism is well documented for different cardiovascular interventions, it is only becoming more apparent that the problem is highly relevant to the procedures of the catheter ablation (12,13).

Although the incidence of the postprocedural 'silent' thromboembolism is not precisely known, a recent report found that 11% of patients with AF suffered new postprocedural (i.e. after externally irrigated radiofrequency ablation) cerebral embolism within 1 day as revealed by diffusion-weighted mag-