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August Focus

WALKING around the Thackray Medical Museum in Leeds is a reminder of how much we take for granted today. It portrays the health of the Leeds poor in the early 19th century and the reforms that transformed it: clean water, universal sewage, and better housing. In one of our 'Postcards from the 21st Century' on page 688, Tom Knowlands reminds us that this remains as true now as it was then. More important is the bureaucratic paradox that all of these services, and many others that are vital for health, are all now the responsibility of local authorities and aren't really seen as part of the health services at all.

Back in the official world of medicine, the drive to attain high standards of care and to be able to demonstrate it to funders and patients is likely to be a major preoccupation for the foreseeable future. General practitioners in the UK have been somewhat wary of this subject in the past, and Martin Roland in his editorial on page 611 explains why: it is the concern that, if we are to be measured, then we should be measured against standards that reflect the true nature of primary care. The study on page 644 by Campbell *et al*, which explores the effect of practice size on different indices of quality, illustrates the problem beautifully. While small practices performed less well on some easily collected indicators, such as immunisation rates, they performed better on personal continuity of care and access. The study emphasises the importance of involving patients' voices in determining how primary care is to be judged. These two points are taken up in papers from Northern Ireland: the first paper, by O'Reilly *et al* on the working of out-of-hours co-ops (page 625) suggests that access deteriorates the further you live away from the centre. Should we be limiting the size of co-ops to ensure equitable access? (Answer: probably not until the study is replicated) The second paper by Gilliland and co-workers on page 661 is a study of patients being removed from doctors' lists, where the patients' voice is definitely not being heard. A more sceptical view of measurement and what it can achieve is given by columnist Saul Miller on page 696, but then the Back Pages has always provided a refuge for those who find numbers unsatisfying: there are lots of book choices this month (pages 686–687) and even a 'top ten favourite ten paintings'.

One of the collective habits to have attracted criticism is our slowness to incorporate research findings into practice. A study by Hickling *et al* on page 615 tries to find out why, given unequivocal research findings, we have been slow to investigate heart failure with echocardiograms and treat it with ACE inhibitors. The answers are predictable, but are worth reflecting on: first to test against your gut feeling ('did they really think that?') and second to work out how these doctors could have dealt with the barriers they have identified. Where the evidence for best practice exists, other contextual and psychosocial factors may have enormous influence on what happens in everyday practice. The paper by Mowle and co-workers on page 658 reports on the use of benchmarking to take such well known influences into account. Many will find the approach attractive, but applying it for a large number of different clinical problems will clearly take an enormous commitment in time and money. Unfortunately, the evidence for many problems is either lacking or based on secondary care, as the review by Hanley *et al* of the causes of vertigo illustrates (page 666).

Not that we should continue to castigate ourselves too vigorously. General practitioners can sometimes be shown to perform to very high standards, such as their ability to make clinical diagnoses of influenza with impressive accuracy, as found by van Elden *et al* (page 630). A second paper from the Netherlands by Lewin-van den Broek *et al* is a tough read — the kind of paper that makes *BJGP* readers groan, but which will repay the effort. It is a pragmatic trial of different strategies in dyspepsia. It is able to come up with some practical recommendations at the end, particularly that endoscopy is of little value in uncomplicated dyspepsia at all ages (in contrast with echocardiography).

The final contribution from the Netherlands on page 635 by Eekhof and co-workers suggests that we can also do without sophisticated treatments to soften earwax. Perhaps we can start to put the olive oil back where it belongs — in the salad.

DAVID JEWELL

INFORMATION FOR AUTHORS AND READERS

These notes supercede those published in January 2000. The information is published in full in each January issue of the Journal. A regularly updated version is also available on the RCGP website at http://www.rcgp.org.uk/rcgp/journal/info/index.asp

Original articles

All research articles should have a structured abstract of no more than 250 words. This should include: Background; Aim; Design of study; Setting; Methods; Results; Conclusion; Keywords. (Up to six keywords may be included, which should be MeSH headings as used in *Index Medicus*.)

'Where this piece fits'. Authors are asked to summarise, in no more than four sentences, what was known or believed on the topic before, and what this piece of research adds.

Main text. Articles should follow the traditional format of introduction, methods, results and conclusion. The text can be up to 2500 words in length, excluding tables and up to six **tables or figures** are permitted in an article. **References** are presented in Vancouver style, with standard *Index Medicus* abbreviations for journal titles. Authors should try to limit the number of references to no more than 25. Authors submitting **randomised controlled trials** (RCTs) should follow the revised CONSORT guidelines. Guidance can be found at http://jama.ama-assn.org/info/auinst_ trial.html or *JAMA* 2000; **283:** 131-132. Papers describing **qualitative research** should conform to the guidance set out in: Murphy E, R Dingwall, D Greatbatch, *et al*. Qualitative research methods in health technology assessment: an overview. *Health Technology Assessment* 1998; **2(16): 1-13**.

Other articles

Brief reports

The guidance is the same as for original articles with the following exceptions: the summary need not be a structured abstract; Authors should limit themselves to no more than six references and one figure or table; and the word limit for the summary is 80 words and for the main text it is 800 words.

Reviews These are approximately 4000 words in length. They should be written according to the quality standards set by the Cochrane Database of Systematic Reviews. (www.update-software.com/ccweb/cochrane/hbook.htm).

Discussion papers

These are approximately 4000 words in length.

Case reports

Where possible, case reports should follow the evidence-based medicine format (Sackett DL, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based medicine*. Edinburgh: Churchill Livingston, 1997). They should be approximately 800 words in length, excluding references, and may include photos.

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Authors considering submitting an editorial should either contact the Editor via the *Journal* office or send in an outline for an opinion. Editorials should be up to 1200 words in length and have no more that 12 references.

Letters

Letters may contain data or case reports but in any case should be no longer than 400 words.

The Back Pages

Viewpoints should be around 600 words and up to five references are permissible. *Essays* should be no more than 2000 words long. References should be limited to fewer than 20 in number whenever possible. *Personal Views* should be approximately 400 words long; contributors may include one or two references if appropriate. The *Journal* publishes five regular columnists and we rotate these periodically. *News* items have a word limit of 200–400 words per item. *Digest* publishes reviews of almost anything from academe, through art and architecture.

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