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December Focus

THE College is 50 years old. A time to take stock and reflect on what has and has not changed in that time. Start at the back, where we are publishing a collection of articles looking back to 1952 and forward to 2052. Students of history will not be surprised to be reminded how much has changed in the last 50 years, as described in Irvine Loudon's essay on page 1031, while on page 1032 the atmosphere of crisis in the NHS today is simply an echo of events in 1952. Two contrasting visions of the next 50 years are offered. George Davey Smith sketches out two possibilities, one of increasing life expectancy and widening health inequalities, the other of a return of diseases we thought had been eradicated. On page 1034 Paul Hodgkin gives an apocalyptic vision of technology driven culture, while suggesting how primary care might adapt to cope with it. For a more optimistic answer, turn to the outsider's perspective that Kurt Stange brings to bear in this month's editorial on page 963. Or, like John Frey on page 1033, ask the taxi driver.

What do the research papers tell us about our current concerns? In contrast to the embattled pioneers of 1952, we know there is a huge range of activities we can perform to a very high standard, given enough support. For instance, transferring responsibility for anticoagulation to primary care is very cost-effective, but, according to Parry *et al* on page 972, only when two conditions are met. First, the primary care workers have to maintain a minimalist approach to the problem, and, second, the economic analysis only comes out with this answer if the societal perspective is taken, not that of the NHS alone. Acknowledging the importance of health economics is one aspect of health care that differentiates us from primary care 50 years ago. The grandiose view of health economics is that it will deliver precise costings that will enable policy makers to take coherent, transparent rationing decisions, but those who understand the value laden world of medicine may be less surprised that the reality is so much less clear.

Over the course of the past 50 years, research in health care has become an increasingly complex activity, depending on the cooperation of a range of people with different skills. The pair of papers by Little *et al* on high attending adults (page 987) and children (page 977), are a case in point. These two complex studies examine a comprehensive range of factors to identify which ones influence high consulting rates. Higher attenders were more likely to have, or to believe that they have, poor physical health. But they also had high rates of medically unexplained physical symptoms, which may be a marker for somatisers. Among children, higher attendance was associated with anxiety in parents and their willingness to tolerate uncertainty. The authors feel there is scope here for helping patients understand minor symptoms better and reduce consultation rates. However, a qualitative study of women presenting with breast cancer sets out clearly why moves to reduce consultation rates pose major difficulties. This study by Burgess *et al* on page 967 identified a group of women who delayed significantly before presentation and explored their reasons for doing so. The authors here suggest that women have to experience a symptom which 'matches their expectation of breast cancer'. It's a reminder that there are likely to be just as many patients who consult late or not enough, as those who consult earlier and excessively. These are the kind of questions that would have concerned general practitioners as much in 1952 as they do now, a modern glimpse into the eternal verities of primary care.

So, for another look at the eternal verities, turn back to the translation of Miguel Torga's diaries. These moving extracts from the diary kept by a doctor in a remote, poor part of Portugal, could have been written at any time from ancient Greece to our own times. Indeed, in one entry of 14 October 1963, he wonders whether we still have the wisdom of doctors of the past. The 'everything is getting worse' line may appeal to some, but his humanity and understanding are an example to us all.

In this anniversary issue, we have not indulged in a lot of congratulation to say what a wonderful institution the College is. It exasperates many of us for all kinds of reasons, and its tendency to self-congratulation is one of them. On page 1025, Denis Pereira Gray reminds everyone of the visible achievements. However, like Adam Smith's 'invisible hand', it does its job best when it is not obvious. It is the College's covert influence in so much of what has changed in the past 50 years that really matters.

DAVID JEWELL
Editor

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.

Editorials

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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Authorship

All authors should satisfy the requirements set out in 'Uniform requirements for manuscripts submitted to biomedical journals' (www.jama.ama -assn.org/ifo/auinst _req.html or *Med Educ* 1999; **33:** 66-78). Please supply full details of the names, addresses, affiliations, job titles, and academic qualifications for all authors.

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Correspondence and enquiries

All correspondence regarding research papers should be addressed to The Editor, *British Journal of General Practice*, at the College address (e-mail: **journal@rcgp. org.uk**). Contributions to the Back Pages should be addressed to the Deputy Editor at the same address. Letters to the Editor concerning items in the Back Pages should be copied to the Deputy Editor.

Opinions expressed in the Journal should not be taken to represent the policy of the RCGP unless this is specifically stated.