

April Focus

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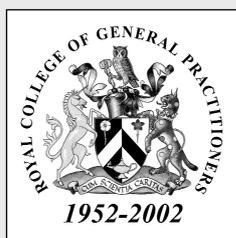
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Published by The Royal College of
General Practitioners, 14 Princes Gate,
London SW7 1PU.
Printed in Great Britain by
Hillprint Ltd, Prime House, Park 2000,
Heighington Lane Business Park, Newton
Aycliffe, Co. Durham DL5 6AR.

MANAGED care versus patient-centred care (continued). On page 343 Eileen Hutton describes the expanding work of the RCGP Patients' Liaison Group, which she now chairs. While impressive in itself, it also marks the start of a series being run in the Back Pages on patient participation. Eileen Hutton's piece opens by quoting the deputy editor, who brings some scepticism to the subject. Two papers in this month's *BJGP* lend some support to his scepticism. The first of these is a paper by Thomson *et al* (page 314) on Babycheck, a scoring system designed to help parents assess (for lovers of politically correct language 'empower' them) the seriousness of illness affecting their children. We learn that very few of those given the system used it, and fewer still used it correctly. Is this a sign that these parents didn't want such help, or were too busy, or wanted more input from the professionals after all?

The second paper, by Elliott *et al* (page 269), is a careful examination of patients' assessments of their pain. Here the authors compared serial assessments with a single assessment made retrospectively, and found poor correlation. I suspect that many readers will put it in the 'Do you mean to tell us someone did a research study to prove *that*?' category. However research sometimes has the role of characterising and quantifying (as well as occasionally disproving) conventional wisdom. The findings may mean more for researchers who have to be very clear precisely what they want to measure when studying painful conditions, but clinicians also need to think about how they discuss pain with patients, as well as how they apply the findings of research.

Elsewhere, there is plenty of material looking at managed care. A large trial by Freemantle *et al* on page 284 on using education to influence practices' prescribing ended with mixed results. With disarming honesty, the authors found the 'high participation rate ... surprising given recent questioning of the use of guidelines as standards of care by which practitioners may be judged.' Is this irrepressible optimism or stark naïvety? On page 322, Lough and colleagues try to demystify clinical governance, and perhaps readers will find it all less frightening. For a practical example, turn to the study of sore throat diagnoses by Marshall *et al* on page 277. In one of several commentaries that happen to be included in this month's journal, Blair Smith sets out some of the problems associated with the use of such data.

For many GPs in the UK the most satisfying aspect of their work is the opportunity it offers for long-term relationships with patients. In the Back Pages, Brian Hurwitz considers the passage of time and takes as his starting point just such a long-term encounter with a single patient. For humility, remember that it all ends the same: two papers look at death, what practices can learn from it (Webb *et al*, page 296) and how we best help our patients cope with it (Elizabeth Lee's editorial). And if that wasn't enough to stop us all being too pretentious, read Roger Neighbour's thoughts on hypocrisy in the Back Pages.

DAVID JEWELL
Editor

© *British Journal of General Practice*, 2002, **52**, 265-268.

INFORMATION FOR AUTHORS AND READERS

These notes supercede those published in January 2001. The information is published in full in each January issue of the Journal They are also available on the RCGP website at <http://www.rcgp.org.uk/rcgp/journal/info/index.asp>

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All research articles should have a structured abstract of no more than 250 words. This should 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 (RCT)**s 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.

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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

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Case reports

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Letters

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

The Back Pages

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