Your new-look *Journal*

THIS month sees the first issue of the new-look, expanded *British Journal of General Practice,* heralded in an earlier editorial.[1] We hope you will have noticed the bulkier package and approve of our new cover and layout. The appearance of the scientific section is largely the same, as this layout permits the maximum amount of text per page consistent with legibility and enables us to publish as many of the acceptable papers sent to us as possible. However, in the new section we have allowed ourselves more scope for the imagination and hope that you find the new layout less formal and condensed but more eye-catching and attractive. This is in keeping with our aim to present thoughtful, stimulating writing that reflects daily practice but also allows a wider range of opinion and even the flying of 'kites'. Alec Logan introduces the new 'Back Pages' on page 673 of this issue and gives guidelines for contributors to the new section.

Medical journals have to change to reflect the needs of their readers. General practice is now a complex activity requiring business and managerial aptitude in addition to clinical skills. Quantitative research, though vital in strengthening the evidence base for patient care, cannot address the whole of general practice; it cannot cover the complexity of the individual problems general practitioners deal with every day,[2] let alone explore the nature of the professional judgement on which clinical practice depends.[3] Qualitative research can open up topics not answerable by traditional quantitative methods,[4] so we have long welcomed good quality qualitative as well as quantitative research and continue to do so. The increasing popularity of qualitative approaches was evident from papers presented at the recent conference of the Association of University Departments of General Practice in Dublin, so we may be seeing more such papers in the *BJGP* in due course. In medicine we are constantly dealing with case histories: stories that are biographical accounts of illnesses. Such stories can provide insight into medical practice that science never can,[5] and learning from anecdotes is an important feature of medical education.[6] Our extra pages now give freedom for less conventional writing on general practice: essays, digests, anecdotes, and more space for the views of readers with a reflective approach to practice.

The *Journal* team has been strengthened by the appointment of a deputy editor, Dr Alec Logan, who will be managing the new material. We also welcome four new members to the editorial board: Drs Tom Fahey, Surinder Singh, Lindsay Smith, and Blair Smith. The board will be active in advising on the research-based papers and the extra material, helping us to maintain high standards in both.

The *British Journal of General Practice* will continue to meet its primary responsibility to publish original work relevant to general practice and primary health care,[7] and to comment on factors affecting the health and well-being of patients. We are deeply grateful to the unsung heroes of this process: our referees. They receive no monetary reward for their time, their expertise, or their patience and flexibility. I am pleased to say 'thank you' to them all in this editorial and to publish annually a list of names of those who have helped in this way during the previous year. We are currently revising our list of referees, updating the information on place of work, qualifications, and current expertise. Reviewers' reports are continuously audited and scored in order to offer authors objective and, we hope, constructive, criticism of their work. These reports are passed on to authors whether their work is accepted or not. We now receive more papers that involve economic evaluations or describe qualitative research and we wish to be able to offer authors the best possible feedback in these areas also. Reviewers of qualitative research papers are supplied with separate guidelines relevant to this type of research, and we would be happy to supply a copy of these guidelines to interested authors. Our policy on anonymous reviewing remains unchanged. While, on specialized topics, it is sometimes possible to guess authorship of papers or identify reviewers from their opinions, we believe that anonymous reviewing helps referees to look more objectively at papers and is usually fairest to all concerned.

It is not possible to publish everything we receive that is worth publishing. Priorities are determined on originality, scientific value, our perception of relevance to primary health care, and our understanding of the interests of readers. Our aim is to reflect the growing edge of general practice. We are unlikely to accept papers that simply describe what has been well described before, or reports of educational courses without objective evaluation. Work that is relevant locally, but that does not have implications for the wider community, is less likely to be of interest to the majority of readers. Baseline data alone are rarely sufficient to justify a paper: we expect to have an assessment after an intervention or over time. Well-presented papers with references in the Vancouver[8] style and a summary in the *BJGP* format are particularly appreciated by reviewers and can be handled more quickly. It is especially important to number each page of the manuscript clearly: a running header or footer is ideal. Accepted papers are subedited on screen so we ask for a disk file together with two printed copies of revised manuscripts. We are increasingly concerned to avoid researchers and readers being overwhelmed by redundant material. Duplicate and 'salami' publications reduce the space available for new findings. Authors who submit papers containing data that overlap with data published or submitted elsewhere should state this clearly in their submission letter and send us a copy of such overlapped papers. We wish to make up our own minds on the degree of overlap during the peer review process.

These are exciting times for general practice. Past initiatives are bearing fruit and major new issues are emerging that deserve careful reflection and public debate, not least in the *BJGP.* Issues of quality and public confidence are well to the fore – and does not the latter largely depend on public expectations and perceptions of the quality, not only of the technology but of the human face of medicine in general practice? Patients reasonably expect their doctors to keep abreast of advances in diagnosis and treatment, so a commitment to learning throughout the professional lifetime will give both the satisfaction of a job well done and a protection against ill-founded accusations. The concept of continuing medical education is evolving into that of continuing professional development,[9,10] not only for doctors but for their staff and colleagues in the professions related to medicine. Will practice learning become the norm? Can the traditional inter- and intraprofessional relationships be restructured to withstand the strain of the new evaluation culture?

The strength of a scientific journal depends on the quality of original papers it attracts and publishes. Our commitment to continue to be a means by which original material about general practice can reach a wide audience is in no way diminished, but we are pleased to have extra pages to do more for RCGP members and the discipline. 'The book and the byte are destined to be friends',[11] so we are pleased also to add to the information

on our Internet pages, which are attracting considerable attention from North America as well as elsewhere. I hope that authors will share my enthusiasm for these new opportunities and respond by offering us not only essays, commentaries, and points of view, but more 'why' papers as well as 'how' papers in the traditional scientific mould. We will attempt to balance the new writing with scientific contributions in a reflective and reader-friendly way, cherishing philosophy and literature as well as statistics. I hope also that more readers will come to share my conviction that research questions from general practice can have their own 'fizz and pop'.[12]

The *raison d'être* of all this professional activity is to improve the quality of practice by a clearer understanding of the clinical, psychological, social, and other factors affecting the health and well-being of patients. 'The public relies on the ability of general practitioners to doubt, to question, and to reassess.'[13] We will reflect *caritas* as well as *scientia* but success will depend on feedback from readers. We hope you like our new format. Please join us at the growing edge by reading the *British Journal of General Practice* and contributing to the wider debate on primary health care.

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Summative assessment of vocational training: to be required by law

PARLIAMENT will soon be considering changes to the Vocational Training Regulations 1994,[1] which are likely to make vocational training for general practice necessary by law before a doctor may work in general practice in the National Health Service (NHS). Why is this necessary? Why is general practice the only branch of medicine for which Parliament has felt this to be necessary? What does it mean for the future?

The first general principle that this development reflects is a shift in thinking from competence towards performance. For most of the past century the main emphasis in medical education and in medical assessment has been on the measurement of competence: has the doctor learnt what is required? However, it has become increasingly clear that competence is not enough. Knowing how to act does not necessarily help the patient; what matters to the patient is what the doctor does. An ounce of performance is more important to patients than a ton of unimplemented knowledge.

Once the focus is on performance (defined in terms of what the patient receives), logical thinking becomes easier. It can then be seen that there are always three levels of performance at which professionals may function: the bare minimum, the average or usual, and the excellent. A doctor may function on different levels at different times, but on the whole most doctors operate at the same level for most of the time. Greatly differing proportions of the profession are involved at each of these levels of care. The definition of each level serves fundamentally different purposes: the minimum level exists to protect patients, while the usual and excellent levels have been designed to satisfy the profession collectively and to provide incentives and rewards for good work.

Good performance. Most patients receive good care from most general practitioners. In the interests of the collective reputation of the practising profession, this fact should come first in all thinking about performance in general practice. The current attention being paid to 'poorly performing doctors'[2] must not prevent proper recognition being given to the good work of the silent majority in the profession.

It is a privilege and a responsibility for the professions to determine their own standards and to regulate themselves. Indeed, self-regulation is a defining feature of any profession. In the United Kingdom this is now achieved through three 'competent authorities': the General Medical Council (GMC, established in 1858), the Joint Committee on Postgraduate Training for General Practice (JCPTGP, established in 1976), and the Specialist Training Authority (established in 1996). All three are professional bodies, with predominantly medical membership, and constituted so that the medical profession and the state (which gives all professions their independence) can both be satisfied about the standards of doctors.[3-5]

Excellent performance. There are also many general practitioners whose performance is excellent and who deserve recognition. For these practitioners the award of Fellowship by Assessment (FBA) from the Royal College of General Practitioners was introduced in 1989.[6] The aim was to encourage excellent performance and to acknowledge those who can demonstrate that they achieve it. Fellowship by Assessment made it possible, for the first time, to measure excellent performance objectively and provided professional recognition of it. Already, more than half a million patients in the NHS receive