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February Focus

STOP press ... the next big idea is — wait for it — Community Hospitals! Are they heading for a revival? As we have witnessed increasing specialisation of consultants and concentration of facilities into larger units the case for intermediate facilities has gained strength and support. The problem has always been persuading the planners that this is a serious argument and not simply a nostalgic yearning for a lost golden age. As Seamark *et al* reports on page 125, plenty still exist. They identified more than 450, so that 20% of general practitioners have access to community hospital beds. One surprise is that the numbers have remained steady over the last 25 years. The other is that, on the face of it, general practitioners know how to use them appropriately (Donald *et al*, page 95). Geoff Meades's editorial (page 91) points out that these hospitals can also be more sensitive to local needs and interest groups and be a powerful agent for decentralisation.

At medical school we were taught that diagnosis is the most important thing in medicine, and diagnosing common conditions, such as asthma, should be bread and butter. Unfortunately, the reality may not be as good as it should be. This month, two papers report the use of scoring systems to help diagnosis. One shows the doctors apparently missing one-quarter to one-third of childhood asthmatics (Frank *et al*, page 117). The other uses a computer-derived score (filled in by children themselves or by their parents) as a screening tool and is a reminder that there are no simple cut-off points when screening (Kable *et al*, page 112). In any case, it seems unlikely that there will be an explosion of practices providing patients with computers for self-diagnosis when we remain so ambivalent about IT, as argued in the Back Pages by Steven Ford (page 161) and Neville Goodman (page 167).

However, another challenge is to spot the rarities when they turn up. Good general practitioners are nature's hoarders of knowledge, throwing nothing away, having minds like dusty attics stuffed with half-remembered bits and pieces. Elsewhere in the Back Pages, Peter Sims recounts his successful diagnosis of leprosy in Zambia (page 157) and Graham Worrall talks about dealing with frostbite and swile finger — although these appear to be everyday occurrences where he works (page 165). The review from Finland, examining the success at diagnosing cancer of the tongue illustrates the difficulty: the patients where, by implication, the diagnosis was not considered at first presentation were at increased risk of death (Kantola *et al*, page 106). What rate of diagnostic error is acceptable?

Old favourites crop up again, in the form of timely reminders. John Bain (page 132) repeats that it may be difficult to apply the results of research directly to clinical practice. John Millar (page 130) estimates that 2% of all general practice consultations concern side-effects of prescribed drugs. Vedsted and his colleagues (page 121) from Denmark find that frequent daytime use of doctors is associated with frequent use out of hours. Here, however, there is a half-empty glass: more than half of the daytime frequent attenders don't use out-of-hours services at all. Spitzer *et al* (page 101) shows once again that rates of streptococcal carriage can be higher in closed communities, surprisingly in this case among the orthodox Jews of Hackney.

The most impassioned prose in this month's *BJGP* comes in two letters from doctors replying on the subject of school pupils sitting in general practice surgeries. Both find the idea completely unacceptable, and Richard Vautrey calls on the medical schools to take a stand. To their arguments should be added the very strong one that if it does carry any weight with admissions committees then it is likely to work to the advantage of pupils from middle-class families. Perhaps general practitioners have been carried away by their success in medical education over the past 30 years. The separation of undergraduate and postgraduate teaching organisations, for historical reasons, has always looked anomalous, and on page 135 Roger Jones and Nigel Oswald pursue the elusive goal of a curriculum to draw the parts together. With the increasing confidence of the past 30 years has also come a willingness to listen to voices from a much wider range than the traditional experts. Our understanding has been enriched by contributions of, for instance, social scientists and economists, as well as specialists and epidemiologists. In the Back Pages we introduce a new series of Postcards from non-medics with one from a geographer (page 158), and on page 160 we announce the eagerly awaited result of the columnists competition.

DAVID JEWELL
Editor

ALEC LOGAN
Deputy 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 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 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*.)
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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.
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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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