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April Focus

The need to develop new methods, not only of treating the patients but also of analysing the problems and researching the answers, is reflected in Barbara Starfield's NAPCRG 2000 lecture on page 303. It sets out with great clarity the reasons for developing new methods of assessing health care interventions and finishes in a paean to primary care, arguing (convincingly to the already converted) that it is uniquely well placed to address these problems. One of the recent drivers for change has been the recognition that we cannot decide for patients and that they need to understand the balance of risks and benefits to make their own decisions. On page 276, David Misselbrook and David Armstrong revisit the question of how to present the information, but on this occasion show how it will affect the decisions that patients may make. Adrian Edwards and Glyn Elwyn have written the accompanying editorial on page 259, reminding us that general practitioners have to be good listeners, and of the need to develop new methods (again) of communicating risk. David Misselbrook is in the overexposure league this month, in a coincidence that results from the *Journal* being edited from opposite ends of the country. In the Back Pages, he resurfaces with a version of the Flanders and Swan classic 'The gasman cometh', rendered for the acronym-infested modern NHS. (Our younger readers, unfamiliar with F&S, are strongly advised to go back and sample these geniuses of the comic song from the 1950s. Their writing is just as fresh and funny now as it was then. Unusually for them the music for 'The gasman cometh' is itself derived from 'Dashing away with the smoothing iron', but you need the F&S version to get the words to fit beyond the first two lines).

The biggest innovation in recent times was fundholding, and on page 264 Ann Bowling and Matthew Bond evaluate the outreach specialist clinics that were a prominent feature of the scheme. They come up with an admirably clear answer. If clinics are small and close the service is perceived to be better, quicker, more acceptable, and less efficient. Better local commissioning to make practices share clinics would make them more efficient, and presumably less acceptable, and slower.

The *BJGP*'s own contribution to innovation is less a new idea than the resurrection of an old one. On page 297 we include a case report from Mukerjee and Butler, the first of many, we hope. At best, when they follow the evidence-based medicine model, they can give clear answers to common questions. Even without that approach they can stimulate education and ideas and be the starting point for research projects. If nothing else they should encourage us all to make use of the many opportunities for learning that clinical practice throws up every day.

Is there anyone to speak up for the old fogey? As so often the Back Pages provide some timeless wisdom as counterweight. Andrew Spooner reminds us what traditional general practice can achieve, if only we were given the time. James Willis, reviewing *The Tyranny of Health* by Michael Fitzpatrick attacks some of modern medicine's orthodoxy, finishing with an eternal truth, and Gillie Bolton ventures into the more difficult territory of spirituality in medicine.

Other personal ghosts were stirred by this month's *BJGP*. On page 270 Helen Smith and colleagues report general practitioners' views of what constitutes appropriate out-of-hours calls. In the abstract it describes them having well developed classification. However — surprise, surprise — it rests not only on the nature of the problem but also on the politeness (and other characteristics) of the patients and whether they were able to get the timing of the call right. It reminded me of a story told by the late and much-missed Martin Lawrence whose friend had trays marked, not 'in', 'out', and 'pending', but 'too early', 'too late', and 'too difficult'. In the daytime, of course, few doctors handle calls, and the paper by Morris Gallagher and colleagues on page 280 explores how receptionists do it. When as an undergraduate I went to Aldeburgh to learn from John Stevens, a great postgraduate teacher and my own personal mentor, now dead many years and also much missed, I was dumbstruck to hear him describe the receptionists' job as the most difficult in the building. They emerge from Gallagher's papers once again as the unsung heroes of modern primary care, deploying arcane (and underpaid) skills to manage the system in a parallel universe.

DAVID JEWELL
Editor

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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*.)
'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**.

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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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