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## June Focus

THE central problem of primary care, and what makes it so rewarding, is illustrated by this month's *BJGP* and the emphasis on deprivation. Our patients need us to concentrate all our attention on them and their personal, particular concerns, but such attention will be of little help to them unless we can bring to bear our understanding from large scale studies so that we simultaneously see them as individuals and as members of different groups. When we deal with the poor and dispossessed, if we fail to remember this aspect of their lives, we risk blaming them for the problems over which they have so little control. Somewhat to our surprise, we have managed to capture some of the difficulties of such questions within this month's .

The scale of deprivation and its consequences are described by Kath Moser on page 438, who suggests that there would be large reductions in the rates of mental illness, coronary heart disease and diabetes if all groups had the same rates as those of the least deprived. Think of that next time you are working at targets of coronary disease reduction. Possible links between deprivation and illness appear in Debbie Lawlor's editorial on fuel poverty on page 435 and Sikorski *et al's* paper on breast feeding on page 445. Such explanations tantalise as much as they illuminate: when the middle classes smoked more than their poorer compatriots they still had lower rates of coronary heart disease, and it's not so long in the past that middle class babies were the ones less likely to be breast fed.

In the introductory editorial on page 435, Iona Heath and Liam Smeeth plead for general practice to 'become part of the solution, not part of the problem'. The painfully honest paper from the West of Scotland by Stirling *et al* on page 456 illustrates their point, with the most deprived groups getting shorter consultations despite higher rates of psychological distress (but why are the over-90s in the West of Scotland so cheerful?). It isn't obvious what we have to do to become part of the solution, and the discussion papers by Norman Beale on page 478 and Farmer *et al* on page 486 set out some of the problems of definition and classification from different perspectives. Directing more resources to deprived communities must be correct, even if we have little faith that it will achieve measurable improvement, and we should applaud the efforts of the UK Department of Health to improve the crude system introduced in 1990, as Alves *et al* show. The more privileged articulate groups may complain that they are being discriminated against, but AC Grayling recently quoted Aristotle in the *Guardian*: 'Injustice arises when equals are treated unequally, and when unequals are treated equally.'

When it comes to injustice however, one article in this issue dominates the landscape, namely Iain Bamforth's long essay in the Back Pages on Anton Chekhov's journey to Russian penal colonies on the island of Sakhalin in the 1880s (page 510). He recorded conditions for prisoners that were frankly bestial. This is not Chekhov the dramatist or peerless writer of short stories, but Chekhov the doctor, methodical observer, and humanitarian. (And also, surprisingly, Chekhov the owner of a pet mongoose that 'used to chew hats', but that's another story ...) Bamforth shows us that Chekhov's experiences moulded his mature style. Of greater benefit to the wretched convicts, however, was that he managed to accelerate reform, worth remembering as we survey our own patients and communities and see all that is unfair. Maybe we need not always be impotent.

For those readers who find such discussions too irrelevant, difficult or disturbing, there are other matters to consider. This month's case report from Steven Hunyi on page 466 is a different microcosm of primary care, discussing the difficulties of distinguishing physical and psychological causes of common symptoms. The systematic review of treatments for conjunctivitis by Aziz Sheikh and Brian Hurwitz on page 473 confirms what many would expect: topical antibiotics are effective, but the condition would mostly resolve without them.

DAVID JEWELL  
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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>

## 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](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](http://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 Livingstone, 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 than 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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