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September Focus

OUR Norwegian Summer continues at the *BJGP*. Last month, it was Fugelli on 'Trust'; this month, on page 699, it's Hjortdahl on another sacred cow: 'Continuity of Care.' A prerequisite for high quality general practice, or barnacled relic from our bygone Golden Age?

As usual, probably both. Kearley *et al* on page 712 explore the value of the personal doctor relationship in Oxfordshire general practice. Two-thirds of patients strongly valued a close doctor–patient relationship, particularly in the management of chronic illness, and especially psychological illness. However, as Hjortdahl points out, nearly one-third of patients did not consider a close and continuous relationship with their doctor as especially important, and, for a large chunk of patient–doctor contact (minor illness, repeat prescribing, to name but two), why should they? As we navigate treacherous waters between the Scylla of discontinuity, and the Charybdis of inaccessibility we should be guided by such work in planning our appointment systems, our disease management, and time on the golf-course. Healthcare management and our political masters should be guided too.

One particular constituency to be considered will be the elderly. Foster *et al* on page 719 embarked on a qualitative study on the views of elderly people on out-of-hours services, and found disquiet. Here a lack of continuity of care was predictably a source of angst, coupled with a distrust of telephones, and suspicion about the quality of nursing advice. If NHS Direct is to sweep all before it by 2004, then these concerns will have to be addressed. Effective communication between doctor and vulnerable patients will, as always, be crucial.

And talking of communication, hands up every reader who has had to write to a patient in the past month explaining that last year's cost-effective switch to cerivastatin might not have been quite such a good idea as it seemed at the time? 'Superb drug … just a pity that one's muscles turn to soup.' On reflection, what motivated many of us when we switched to what was at the time the least expensive statin? And to what extent did we discuss our motives for switching with our patients themselves?

Consider this in the light of the paper by Grime *et al* on page 703. In an elegant piece of qualitative research, the authors explore popular stereotypes around our prescribing of, not statins, but equally fashionable proton pump inhibitors. The numbers are very big; use of PPIs is booming. Are profligate GPs the culprits, or should patients remodel themselves as health economists? Well, neither actually. Under examination, stereotypes disintegrate. Discussing the issues with patients seems to help. Trusting our patients (who, surprise, surprise, aren't actually keen to take excessive dosages of powerful medicaments forever) seems a more rational way forward than stereotyping them as wilful debauchees. And it is not just at the micro level of a consultation that patient involvement can be constructive (though rarely easy). To what extent, for example, did NICE involve patients in considering the use of beta interferons? In his accompanying editorial, Steve Iliffe on page 700 calls for 'professional bodies and academic departments … to strengthen the foundations of medicine-based evidence', and 'to acknowledge that clinicians want guides to action more than … theoretical understanding'.

Patient involvement resurfaces elsewhere in this issue. Ann McPherson describes the DIPEx (database of individual patient experience) project in the Back Pages, and calls for volunteers. However, she was probably not expecting the sort of patient experience described by Martin Scott two pages later. Martin has been a registered drug addict for the past 15 years, and his experiences of primary care and addiction services make sobering and thought-provoking reading. Two further pages later, and Scott Murray and others conclude their two-part presentation of 'Patients as Poets', with the extraordinarily moving account of one patient's diagnosis with lung cancer. And, while involving patients is challenging enough, there is also the small matter of protecting their human rights — read Iona Heath's splendid review on page 778. The book *The medical profession and human rights* made her 'proud to be a member of the BMA'. All in all, a strong line-up this month in the Back Pages, and very few numbers, which will please our columnist James Willis, who has the last word on page 784.

And finally, Martin Vessey, writing from the Institute of Health Sciences in Oxford (where they clearly have too much time on their hands), objects to the Naked Doctor adorning the contents column of the Back Pages (Letters, page 758). He's still there of course, because I like him — it's a 'Lurv Thing'. Perhaps it is time for a new image. Suggestions, and feedback in general, to journal@rcgp.org.uk.

ALEC LOGAN
Deputy 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. A regularly updated version is 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.
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Letters may contain data or case reports but in any case should be no longer than 400 words.

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