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October Focus

How will future medical historians view current events? Do generalists remain the key to delivering high quality medicine to today's sophisticated, informed patients, or is the objective of remaining skilled across the entire range of modern medicine a valiant but ultimately doomed dream? Medical research continues to expand the range of what is theoretically possible, and fuels the secondary industry of research to find out how to make such advances available to all.

Take, for instance, osteoporosis. The advances of both diagnosis and treatment of this common condition, together with the increasing prevalence accompanying an ageing population, means that there is the possibility of programmes to reduce the severe burden of its morbidity, for both individuals and populations. On page 806 Versluis and colleagues have explored a method for identifying a population at high risk of osteoporosis that might enable us to focus our efforts on a narrower front. They have devised a model that works in a rough and ready way, with the ability to pick out 76% of those with osteoporosis out of 32% of the population. Unfortunately, as so often happens in such research, this still looks too blunt if it fails to pick out the remaining 24% of those at risk. Another big field looming is that of the new genetics. A randomised controlled trial carried out in Oxford and Northampton by Watson *et al*, and reported on page 817, underlines the need for general practitioners to improve their level of knowledge about the inheritance of two common cancers. Oddly, and to undermine the teachers among us, the trial failed to find any substantial difference between the group who received the information pack alone, and those who had the information pack together with a specific educational pack. Can this be right?

The expanding range of conditions and possibilities that we should be engaging with doesn't mean that we can afford to divert attention from any more traditional areas. In an editorial on page 787, Young issues a trenchant challenge to primary care teams to deliver achievable high quality care to those affected by stroke. Such questions have been exercising the UK's Department of Health for many years, and this is now being manifest in the form of the National Service Framework. The suspicion among clinicians that when managerial attitudes hold sway, then science may be disregarded is emphasised by the discussion paper on page 834. The authors contend that part of the NSF document on coronary heart disease amounts to a screening programme, but it is one with a poor evidential base. Rouse and Adab argue that the NSF document is likely to become a 'futile and costly exercise'.

Let's finish with a study of health service use. Missed appointments are either intensely annoying or a relief, depending on temperament and mood, but they may not be our fault. On page 830 Neal and colleagues show that the best predictors are the age, sex and social disadvantage of the patients. With the danger that much of this month's content merely serves to heighten doctors' sense of under-achievement, it's important to remember that we are not responsible for every last shortcoming of the service. The UK's Department of Health wants, quite rightly, to improve the quality of care that patients get, but we do not need to share their implied view that we are always to blame for the deficiencies. Chris Burton, on page 866, would argue that it that we are applying the oversimplified 'paradigm of linear external control – do x to the system and y will happen'. Emerging complexity theory would suggest that 'trying to understand the system by reducing it to its constituent parts will always fail'. For the last, non-medical word on a holistic view of the world turn to page 868 for a review of the Bosch exhibition running in Rotterdam until mid-November. Scholarship is changing our view of Bosch as a painter of grotesques. 'He drew no distinction between religious and secular subjects or between elite and popular visual culture'.

DAVID JEWELL
ALEC LOGAN

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

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 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).

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 Livingston, 1997). They should be approximately 800 words in length, excluding references, and may include photos.

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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 that 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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Authorship

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