Editorial Office: 14 Princes Gate, London SW7 1PU (Tel: 020 7581 3232, Fax: 020 7584 6716).
E-mail: Journal@rcgp.org.uk
Internet home page: http://www.rcgp.org.uk

Published by The Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.
Printed in Great Britain by Hillprint Ltd, Prime House, Park 2000, Heighington Lane Business Park, Newton Aycliffe, Co. Durham DL5 6AR.

January Focus

'EVEN the quiet backwater of public health has become a battleground between those who argue that we are autonomous individuals free to choose what we think is best for ourselves and our children, and those who believe that immunisations such as MMR should be obligatory', writes John Gillies, reviewing Marshall Marinker's book on *Medicine and Humanity* (page 80). Rest assured, this is not reopening the debate on MMR, but on the tension between medicine for populations and medicine for individuals. David Keene, in a Viewpoint on referrals (page 71) makes the same point, describing his efforts to draw general conclusions from a collection of decisions made between doctors and patients. He concludes with a plea for us to concentrate on quality of life measures, rather that crude referral rates, implicitly favouring the individual care end of the spectrum (but then he too is a general practitioner). Ken Menon's letter on page 56 presents an impassioned plea for single handed practice using the same arguments, although he sees no conflict between best care for individuals and best care for the whole practice.

Of course, we might all set out to practice patient-centred care, but are frustrated by the inadequate methods available. On page 5, Nicholas Summerton argues for better and earlier diagnosis of cancer but reminds us of how misleading it is to apply the prior probabilities derived from secondary care populations. A paper by Freeman *et al* on page 36 has looked at a counter-intuitive finding of previous research involving patients from ethnic minority groups and showed that good care is better — and more quickly — achieved when patients and doctors share a common language, and presumably a common culture. Such a conclusion might appear to be self-evident, and so obvious, that it is further validation of the method rather than a new finding in itself. But generalising to the context of every consultation is a reminder to find the right language to communicate with all our patients — an absolute pre-requisite for patient-centred care.

There are more pointers elsewhere. The study on page 24 by Dowell *et al* presents a project to try to get 'non-adherent' patients to take drugs as prescribed. This was clearly an exercise consuming a lot of time and energy for each patient involved (although in this instance the clinical task should get simpler and quicker with practice), and it only benefited a proportion of the patients. However, the benefits were real enough in terms of improved adherence to regimes, and this has the potential to generate real long-term benefits. Unusually for this journal, this is even an example of an enhancement in patient-centred care that general practitioners could apply to their own practices tomorrow. On page 9, a paper by Wilson *et al* reporting the findings of a 'hospital at home' scheme sheds some light on patients' reasons for preferring it: that they appreciated more personal care and better communication. Predictably, this was balanced by some of the participants stating that they would have felt safer in hospital. In contrast, a review by Mair *et al* (page 47) of exercise training for patients with heart failure fails to come up with clearly applicable conclusions. This is partly because the primary research has tended to concentrate on physiological, rather than quality of life outcome measures; in other words, an area where patient centredness has not been the main concern of investigators.

For another take on the utilitarian balance between care for individuals and care for the populations, there are three accounts of learning from primary care systems in other countries. The model from the Former Soviet Union, copied throughout almost all of Eastern Europe for most of the past 50 years and which allowed for very little personal care, is described by Peter Toon and Robert MacGibbon on pages 74 and 76. In contrast, French patients get (or used to get, a few years ago) the ultimate in patient-centred care, with little or no interference from authorities. One result, as Stefan Cembrowicz describes it on page 78, is doctors having what appeared to outsiders to be very easy relaxed lives, free from any requirement to constrain expenditure, but resulting in high rates of prescribing and investigation. Travelling to see how doctors in other cultures care for patients is one way to encourage reflection on how we do it here, and this article could encourage a few others to arrange similar exchanges.

DAVID JEWELL
Editor

INFORMATION FOR AUTHORS AND READERS

These notes supercede those published in January 2001. The information is published in full in each January issue of the Journal *with a brief summary published in each issue thereafter. They are also available on the RCGP website at http://www.rcgp.org.uk/rcgp/journal/info/index.asp*

Editorial policy

The *British Journal of General Practice* is an international journal that publishes articles of interest to family practitioners worldwide. Priority is given to research articles asking questions of direct relevance to the care of patients. Papers are considered on the basis of this alone; the professional background of the authors (and whether or not they are members of the Royal College of General Practitioners) is of no importance. It is published by the Royal College of General Practitioners, based in the UK, but has complete editorial independence. Opinions expressed in the *Journal* should not be taken to represent the policy of the Royal College of General Practitioners unless this is specifically stated.

Papers

We consider contributions in a number of categories. Detailed guidance is given below for original articles. Much of this (for instance, length of title, styles of references) applies to all types of contribution and further guidance is given under each heading.

Original articles

Title. The title should be a clear description of the research and should not exceed 12 words. Ideally, it will include both the topic and the method of the study. This will appear on the contents on the front cover of the *Journal*. If it is essential, we are willing to have a longer title for the leading page of the article.

Authors. If you put your name to an article you must fulfil the standard requirements for authorship (see later).

Abstract. All research articles should have a structured abstract of no more than 250 words. This should be set out with the following headings: 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 short 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 figures. Generic names of drugs should be used wherever possible. We strongly discourage the use of non-standard abbreviations for medical terms, except where it would otherwise render the text unwieldy.

The **introduction** should be a succinct review of the key articles that have informed the intellectual background to the study. It does not need to be a systematic review but it should avoid obviously selective quotation of the literature.

The **methods** section should include a description of setting, patients, intervention, the time that the study took place, instruments used to measure outcomes, and the statistical tests applied (and software used for analysis). It should also include details of approval from a Research Ethics Committee, and any arrangements for data oversight.

The **results** section should contain all the information required by referees and readers to assess the validity of the conclusions. For quantitative studies, the section should include details of the response rates and numbers lost to follow-up. Further information is given in the section on statistics. Results of statistical tests should be reported with confidence intervals as far as possible in order to provide an estimate of precision. Where probabilities have been calculated, the correct figure should be quoted down to $P = 0.001$; any figure less than this can be quoted as <0.001, i.e. $P = 0.08$ or $P = 0.04$ but not $P = 0.0005$.

A decision was made in October 2001 to encourage authors to write structured conclusions in the **discussion** section. Authors should be reassured that acceptance will not depend on their following this advice, but we think it is likely to help both authors and readers. Whether you choose to use the subheadings or not, you should think in terms of a discussion covering the following:

- summary of main findings;
- the strengths and the limitations of this study;
- how and why it agrees or disagrees with the existing literature, in particular including any papers published since the study was designed and carried out;
- the implications for future research or clinical practice.

Up to six **tables or figures** are permitted in an article. Close attention should be paid to ensure clear presentation of data to help readers understand with the minimum of effort. This will normally mean keeping the data in each table (and the number of tables) to the minimum possible. The same rule applies to figures. We encourage use of graphical representation of data, if the original data is also included for the purpose of redrafting where necessary. Pie charts are strongly discouraged. All figures and tables must have a caption.

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. References to personal communications in the text should include the date. Please do not use the footnote/endnote facility on word processors to indicate references.

Authors should include an **acknowledgement** of those who have helped with and contributed to the study (including the patients) who are not authors of the paper, as well as the bodies responsible for funding the study. Individuals should only be acknowledged with their express permission.

Specific guidance for original articles. Authors submitting **randomised controlled trials** (RCTs) should follow the revised CONSORT guidelines, including a completed CONSORT checklist and flowchart of participants in the trial. Guidance can be found at http://jama.ama-assn.org/info/auinst_trial.html or *JAMA* 2000; **283:** 131-132. Authors should also note the difficulty outlined in making statements about an intention-to-treat analysis. We acknowledge that this is a difficult area and ask that authors are honest about handling the data of patients lost to follow-up.

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**. Illustrative quotes should be included in the results section of the text where the themes are described. Since the quotes are, in a sense, equivalent to the tables and figures of quantitative papers, they should be excluded from the word count. In other words, the limit of 2500 words applies to the text with the quotes removed.

Brief reports

These are a useful method for reporting circumscribed research where the study or the results may not justify a full report. It does not imply a lower standard for the quality of the work reported. 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 two figures or tables.
- 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. We welcome reviews on areas of interest and importance to primary care workers. They should be written in a style suitable for the *Journal* but should aspire to the quality standards set by the Cochrane Database of Systematic Reviews. Authors may find it helpful to consult the instructions for systematic reviews given on the Cochrane Collaboration website (http://www.update-software.com/ccweb/cochrane/hbook.htm).

Reviews should include a statement of the question that you are attempting to answer and a description of the search strategy used to answer it. Researchers should justify their decisions over whether or not to synthesise results of primary care research either quantitatively or qualitatively.

Discussion papers

These are approximately 4000 words in length. They need to be a statement of a new idea or controversial matter where the opinion being expressed is at least partly based on published evidence. Unlike reviews, there is no obligation for authors of discussion papers to try to be impartial in citing the available literature.

If you are considering submitting a discussion

paper you should be aware that we receive a great many of these submissions and usually only publish one each month. This means that discussion papers may have to wait much longer than other types of paper between acceptance and publication.

Case reports
We are keen to encourage publication of case reports. The purpose is to use everyday experiences to stimulate debate and education. They should describe a patient or patients with common diagnoses where the presentation or management has prompted a question likely to interest the *Journal*'s readership. The format should be a brief description of the problem accompanied by a discussion informed by published literature, citing up to six references. Where possible, the text 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. It is essential to obtain permission from any patients whose story is to be used as the basis for a case report (see http://jama.ama-assn.org/info/auinst_req.html#patients for full requirements of informed consent) and to maintain patient confidentiality.

Editorials
These are statements of informed opinion and not short systematic reviews. Some are commissioned, but we also welcome unsolicited editorials. However, authors considering submitting an editorial should either contact the Editor via the *Journal* office and discuss it or send in an outline so that we can advise you whether it is going to be worth spending time and effort completing the editorial and how it can be fitted in to the publishing schedule. Editorials should be up to 1200 words in length and have no more than 12 references. We are happy to hear from authors who believe that there are topics we should be covering in an editorial.

Letters
Letters can be used to respond to published articles, report original research or raise any other matter of interest to the primary care community. The best letters are brief, lively, and provocative. They may contain data or case reports but in any case should be no longer than 400 words.

Feasibility and pilot studies
We are happy to consider feasibility and pilot studies. They should only report on the acceptability of study designs and methods, and validity of outcome measurement. We have decided that it would be misleading to report substantive results unless there are compelling reasons (which must be included in the text) to believe that they would apply to the general population.

Papers that are discouraged
The Editorial Board has decided that the *Journal* should not, in general, publish reports of audits or straightforward reports of postal questionnaires assessing professionals' views. All research papers will be judged by the same criteria, whatever field of primary care they concern.

The Back Pages
Viewpoints
These are short editorials. Some are commissioned, but spontaneous offerings are particularly welcome. We welcome forthright expression of opinion. Articles should be around 600 words and up to five references are permissible. Viewpoints should have an original slant and *must* be topical, though we welcome every standpoint. Do not feel the need to be constrained by the requirements of standard scientific writing. Viewpoints will be peer reviewed, openly, but only to ensure factual accuracy and not to alter the message.

Essays
We welcome expansive essay writing on significant topics. Speculation, hypothesising, and debunking are encouraged. They should be no more than 2000 words long. References should be limited to fewer than 20 in number whenever possible. Submissions will be subject to open peer review. Shorter essays are also welcome; in cases where a 2000-word essay may be inappropriate, 800–1000 words will often suffice.

Personal Views
We welcome unsolicited Personal Views. An ideal length would be approximately 400 words; contributors may include one or two references if appropriate. We especially welcome the eclectic, the international, and the polemical, and will help with translation difficulties whenever possible. We want to ensure that there is a place in the Journal's pages for anecdote-based medicine, reflecting that general practice touches all of life's variety. It is essential to obtain permission from any patients whose story is to be used as a basis for a personal view (see http://jama.ama-assn.org/info/auinst_req.html #patients for full requirements of informed consent).

Columnists
The *Journal* publishes five regular columnists and we rotate these periodically. We shall call for new volunteers periodically.

News
The *Journal* has limited space available for announcements, news, and reports on conferences and meetings. We welcome submissions, but warn contributors that space limitations necessitate brevity. The word limit is normally 200–400 words per item. We encourage contributors to supply URL addresses where interested readers can explore the topic discussed in more detail.

Digest
The *Journal* commissions reviews of books relevant — though often only loosely — to general practice. However, we are very receptive to suggestions from readers and welcome unsolicited reviews. We welcome reviews of almost anything from academe, through art and architecture, to soap opera. The *Journal* will also publish poetry occasionally, and is very keen to promote adventurous photography.

Publishing ethics
The *Journal* supports the ethical principles set out by the Committee on Publication Ethics (COPE) available on their website (http://www.publicationethics.org.uk/). It is important that authors understand the need for the research undertaken to conform to the Helsinki declaration. You will normally have to confirm that the study has been approved by a Research Ethical Committee to be considered for publication. In addition you must ensure that there is no risk of your being charged with duplicate publication. All authors of any kind of article submitted must declare any competing interests by completing a standard form which will be sent to all authors at the conclusion of the peer review process. This should be returned with the revised manuscript. COPE has given guidance on the definition of competing interests: that they may influence the judgement of author, reviewers, and editors; that they may be personal, commercial, political, academic or financial. As a rough guide, they have been described as those which, when revealed later, would make a reasonable reader feel misled or deceived. In addition, all authors must declare that, where relevant, patient consent has been obtained and that all reasonable steps have been taken to maintain patient confidentiality (see http://jama.ama-assn.org/info/auinst_req.html#patients for full requirements of informed consent).

Submission of manuscripts
We are working towards handling manuscripts entirely by electronic means. We therefore request that all submissions should be sent via e-mail (to **journal@rcgp.org.uk**) or on a floppy disk in the first instance, provided they meet the submission requirements as set out below. If electronic submission is not possible, then authors should submit four copies of the manuscript with a formal letter of submission. It should be pointed out, however, that the Editor never reads the letters before making decisions, as a matter of principle. The letter does not need to be signed by all the authors (see below).

Authorship
The list of authors should include all those who can legitimately claim authorship. We do not require all the authors to state what contribution they have made to the work. However, all those who claim authorship should satisfy the requirements set out in 'Uniform requirements for manuscripts submitted to biomedical journals' (http://www.jama.ama-assn.org/ifo/auinst_req.html or *Med Educ* 1999; **33:** 66-78):

- *Each author should have participated sufficiently in the work to take public responsibility for the content.*
- *Authorship credit should be based only on substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content; and final approval of the version to be published.*

All of the above conditions must be met. Acquisition of funding, the collection of data, or general supervision of the research group by themselves do not justify authorship. We do not require all authors to sign the letter of submission; however, all authors must sign the declaration form sent with the Editor's response at the conclusion of peer review. In addition, at least one author should be designated as the guarantor for the integrity of the data on which the paper is based. This will normally be the author for correspondence.

Please remember to supply full details of the

names, addresses, affiliations, job titles, and academic qualifications for all authors.

Manuscript
An electronic version of the paper on disk should accompany the manuscript for the purpose of electronic peer review, currently under development. The paper should be saved as an MS Word document and/or Rich Text Format (.rtf) document. Please label the disk with the name of the first author as well as the title of the paper.

The manuscript should be double-spaced, with tables and figures on separate sheets. It is not essential that the first submission conform to these instructions in every particular. However, where there are obvious major breaches (for instance, if your paper is much longer than recommended) it may be rejected without being sent out for peer review. Normally, we shall only insist on strict adherence to the Instructions for Authors in revised manuscripts, and the Editor's letter will give further instructions to help you achieve this.

It is essential that you send us an electronic version of the paper when it has been revised, following the instructions as above. Most papers are accepted subject to revision. If it is a revision of a previous paper (as opposed to, for instance, a major rewriting of a full article into a brief report) then *you must also send us a version of the paper showing where alterations have been made*. This can be done most simply by using the 'Track Changes' command on your word processing package. You should also show in the accompanying letter where you have and have not responded to referees' comments. We ask you to give us a word count of the abstract and main text (excluding tables and figures).

Peer review
Almost all the original articles, brief reports, reviews, discussion papers and case reports are sent to two expert reviewers. Reviewers are currently blinded to authors' identities; however, we are moving towards a system of open peer review. An electronic version of the assessment form which referees are asked to complete is available at http://195.224.175.21 /rcgp/journal/assessors/index.asp. Papers are assessed on a number of criteria, including:

- Is it clear what question is being asked and, if so, is it important and interesting?
- Have the authors designed a study that is capable of answering the question (i.e. is the methodology appropriate for the question being asked; is the sample size adequate, etc.)?
- Are the data appropriately reported and analysed?
- Are the findings of the study being discussed in an impartial, critical way?
- Do the findings have any relevance to primary care beyond the local or national setting in which the study was conducted?

The Editor's decision draws on the advice given by the referees, but he is not bound by their recommendations.

Appeal
The Editor's decisions are not infallible. If your paper has been rejected and you feel that a mistake has been made you may appeal. You should write to the Editor *within six months of receipt of the Editor's decision*, setting out where you think the referees' report or the editor's letter is incorrect. You should not, at this stage, make any revisions to take account of the referees' comments. The appeal process will operate if a referee or the Editor could have made a mistake with the technical aspects of a study or if bias could have entered into the referees' comments. The process is less likely to be used where a paper has been rejected on the basis of editorial policy. If the Editor feels that there are grounds for challenging the original decision then the paper will be sent out to a new referee and the Editor will be guided by this referee's report. Referees used in the appeal process will often be members of the Editorial Board.

Editorial standards
You will receive formal acknowledgement of your paper soon after it is received in the editorial office. You should receive a response to the initial manuscript within 13 weeks of its receipt, whether or not the paper is likely to be accepted for publication. Most papers will require some form of revision and we ask you to submit the revised version to the *Journal* office within three months of receiving the Editor's letter. We aim to respond to revised submissions at a standard of one month from receipt. We are also working to decrease the delay from acceptance to publication, and we therefore undertake to publish no more than four months after final acceptance of a paper. Performance figures will be published annually in the *Journal.*

Preliminary screening
All papers are initially read by a member of the office staff. Any that are thought likely to be rejected whatever the result of peer review are sent to the Editor for screening. The aim is for al such papers to be seen within a month of submission. If authors are unsure whether a paper may fall into this category and wish to find out without going through the full peer review process, then they are welcome to ask for their paper to be handled in this way. Please mark the paper 'For preliminary screening'.

Fast tracking
Being a monthly journal, the *BJGP* cannot respond with a major degree of urgency to requests to 'fast track' papers. However the Editor has discretion to move papers up the queue if there are good reasons to do so, and get them into print quicker than our routine procedures would allow. The authors must supply compelling arguments to accelerate their paper in the covering letter to the Editor and mark the paper 'urgent'.

Publication of articles
All articles and letters are accepted subject to editing, which may be considerable. Proofs are sent to authors, who are asked to check them for errors and return them promptly. However, the exact month of publication can be decided only when all the articles have been returned and collated with other sections of the *Journal.* On request, authors will receive 25 offprints of their article free of charge. Order forms for extra offprints are sent to authors with the proofs and should be returned with them together with payment. Orders received after publication are more expensive.

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Correspondence and enquiries
All correspondence regarding research papers should be addressed to The Editor, *British Journal of General Practice*, at the College address. Tel (office hours): 020 7581 3232. Fax (24 hours): 020 584 6716. E-mail: **journal@rcgp.org.uk**. Contributions to the Back Pages should be addressed to the Deputy Editor at the same address. Letters to the Editor concerning items in the Back Pages should be copied to the Deputy Editor.