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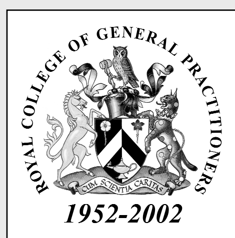

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March Focus

In this month's issue, Helen Lucas in the Back Pages (page 249) describes her frustration with the directives from her PCG on the care of patients with mental health problems. Like the rest of us, she recognises both the need and the scope for better structured care, but at the same time points out that it 'does not play to the strengths of general practice'. Here, in microcosm, is the debate between managed care and patient-centred medicine with which all general practitioners are becoming increasingly familiar, and which is going to be with us for a long time. As in so many other areas of primary care (remembering Iona Heath's lecture of a few years back) we have to be able to respond to both of these forces.

The tension surfaced in the conference on self care, where those representing both sides of the question were engaged in debate (for more details see my report on page 250). However, it figures in the range of papers in this month's *BJGP*. As the story above illustrates, the battle lines will not always be drawn in the same familiar places. For instance, the purpose of managed care will not always be to reduce costs, and patient-centred care will not always be costly. A randomised controlled trial conducted by Lewin *et al* on page 194 reports a reduction in symptoms by implementing a self care for patients with angina. Impressively, they make an attempt to use the kind of outcome measures that are likely to matter to patients. (Perhaps also impressive was that the study was funded by a pharmaceutical company). Of course, the report also shows, by implication, how much more work such an intervention is than the addition of a statin to the evening pre-bedtime drink. On page 206, Meade *et al* report that participants in a trial of cardiovascular prevention were invited after the trial to opt for warfarin, aspirin or both, with more opting for aspirin. However, even here a substantial number opted either to continue or to start warfarin, showing once again that individual preferences, especially when based on the best evidence, are difficult to accommodate within rigid guidelines.

Nor is this a Luddite cry to be allowed to ignore the agenda for managed care altogether. It is up to general practitioners in the UK, more than any other group, to keep the system working within constraints. On page 181 a study by Walker *et al,* more clearly rooted in the managed care agenda, reports the successful implementation of a plan to control prescribing costs. In this non-randomised trial both intervention and control practices succeeded in staying within budget, so the precise contribution of the intervention is uncertain.

Elsewhere, a paper by Little *et al* (page 187) describes a new take on the decision to prescribe antibiotics for throat infections, though here too the paper concludes with a plea to find a way to target resources more effectively; a review of programmes to improve parenting skills by Barlow *et al* on page 221; and statutory obligations about certification for absence from work from Sawney *et al* on page 215. At the risk of repeating myself, we undersell ourselves all the time when others know so little of what our job comprises. Which is why we must continue to retain control over the education and standards for postgraduate education. The Department of Health has just issued a consultation document for reform of the arrangements for postgraduate education in England and Wales. According to Jim Cox on page 179, their implementation would lead to a major of transfer of influence away from the Colleges and towards the Secretary of State. Unless Jim Cox is much mistaken, this is one area where the battle lines are clearly drawn and very easy to interpret.

DAVID JEWELL
Editor

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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 *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 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.*)
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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** (RCT)s 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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These are approximately 4000 words in length.
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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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