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December Focus

HANDS up everyone hosting some research in their practice. Now keep your hand up if you are completely sure that the research is ethically sound on every count. On page 1007 Rogers and Schwartz discuss research ethics as it particularly affects primary care. Balancing the interests of the patients being invited to participate with the gains to them or future patients may not be easy, and then there are the other considerations, such as consent and confidentiality. Both generally accepted ethical practice and the regulations keep changing. For instance the 1998 Data Protection Act restricted access of researchers to general practitioners' patient lists in a way that made some planned studies more difficult to carry out. One aspect of research governance that is long overdue is the involvement of participants in the planning and commissioning of research (see page 971). But there is a final message to all doctors: we can't simply leave it to the research ethical committees but have to satisfy ourselves that all is as it should be.

The increasing regulation of research ethics seems to have worked well, however irksome the bureaucratic structure can be for researchers. The same cannot be said of numerous other regulations that have come the way of UK general practitioners in the past few years. This month, several authors are dissecting bits and pieces of such initiatives. On page 1035 it's the unseen costs of so-called advanced access schemes, and on 1047 the conflict between the quantity and quality agendas. There was the directive to offer an annual check-up for all those aged over 75 years, including a test of mental function. On page 1002 the MMSE is shown to be not that helpful in diagnosing dementia. Of course it's designed to be a screening instrument, not a diagnostic one, but the paper is a reminder of how careful clinicians have to be when using any measuring instruments, especially those taken out of context. Another well-intentioned piece of guidance was that we should advise smokers to give up at every opportunity. The paper on page 997 reports that general practitioners are ignoring that and taking the pragmatic line of concentrating their efforts where they think they are most likely to be effective.

All of this preoccupation with the NHS's constant change detracts from our efforts to develop a more international vision, and must try the patience of readers outside the UK. So lest anyone thinks that things are uniquely bad here, turn to the translation of Martin Winckler's writings on medicine in France on page 1051. The recent verdict that France provides the best system in the world may look a little less rosy.

Time seems to remain a preoccupation with doctors the world over, hence the blunt approach of advanced access. A paper on page 981 challenges some of the assumptions. Using a qualitative approach they develop a concept of practice-centred time, describing the ways in which some of the familiar features of 'modern' practice organisation can hinder access to doctors. Many readers will take issue with the analysis in this paper, but it is a reminder of how much we create our own problems. One of the barriers identified in the Buetow paper is 'inadequate consultation lengths'. The review of consultations on page 1012 has tried to identify the differences in consultations between doctors who consult at different rates. The authors are guarded in their conclusions but in the end come down in favour of longer consultations, on a variety of indices (including, with reference to the comment above, slower doctors requesting fewer follow-up consultations). Step back from this review for a moment, however, and another conclusion tentatively emerges from the text. Look at the various markers of being assessed. None of them is controversial, yet many have been accepted for only a few years. No wonder we are all working so hard. The image of the hamster exhausting itself on a rotating wheel, with which the *BMJ* characterised the medical profession a short while ago, comes instantly to mind. But perception is all. The paper on page 1004 neatly suggests that it is the perception of consultation duration, more than the objectively measured duration that predicts patients' satisfaction. So the challenge for the modern general practitioner is, as we always knew, to give our patients the impression that they have all the time they need with us, while at the same time rushing harder than ever to do all the work we want to as well as tackling all the Department of Health's latest diktats. 'Stiffen the sinews, summon up the blood and imitate the action of …' certainly not a tiger, nor equally a hamster, but perhaps a swan.

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 *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*.)

'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** (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**.

Other articles

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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.

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Letters

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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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