Editorial Office: 14 Princes Gate, London SW7 1PU (Tel: 020 7581 3232, Fax: 020 7584 6716).
E-mail: journal@rcgp.org.uk
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January Focus

THE story is told of the late Hermione Gingold, who was disturbed in the middle of her stage act by a small girl who was sitting in the front row of the stalls asking her mother: 'Mummy, what is that lady *for*?'. The kind of question designed to make any of us stop dead in our tracks. The purpose of the *BJGP* is to publish primary research, some of which may in the future, through a process that none of us understand, influence standard clinical practice. But occasionally we hold a mirror up to the discipline: less 'These are some of the directions you may take in the future'; more 'This is where you are now'. Sometimes we encourage aspirations, and sometimes we support a more cautious approach to what is achievable. For instance, some years ago a landmark paper suggested that general practitioners' interest in the disease was a predictor of the quality of control among patients with diabetes mellitus. Two papers this month take a different line: that on page 47 concludes that no doctor characteristics (including interest in the disease) influenced the quality of glycaemic control; and on page 9 the strongest influence on the variation in prevalence of diabetes mellitus in the North East of England was socioeconomic deprivation. Deprivation remains one of the eternal verities of primary care, as this month's segment of oral history from Paisley reminds us (page 76). We don't, as doctors, have to feel responsibility for everything. The paper from Copenhagen on page 47 leaves us with one uncomfortable question: what is a doctor with an interest in diabetes *for*?

In his characteristically outspoken column on page 87, Neville Goodman points out the danger of setting unattainable targets. Here, too, doctors do not have to feel it's all their fault. The paper on page 15 takes the matter further, trying to define the characteristics of guidelines that influence practice from those that don't. The results are not surprising: those that require less in terms of new skills and knowledge are more likely to be incorporated into clinical work, but here again the effect of the paper is to shift the focus away from blaming the doctors, and towards all the other factors that fix the framework within which doctors work. I suspect that we shall return to this vexed question again and again. More surprising, paradoxically, is the paper on page 31, looking at the predictive value of haematuria for urological cancer. We have become so used to debunking the nostrums we were taught as medical students that coming across one that stands up to modern deconstruction is a real revelation.

It won't do to let all this make us feel ineffective. Some things do change. On page 85, Roger Neighbour looks back on the recent past and pays homage to the changes that have been completely embedded in the accepted wisdom of what counts as good general practice. In the same vein, patients' expectations of antibiotics have moved a long way (see page 43) and the idea of delayed prescribing becomes steadily more acceptable (page 36). But if you are looking for the text to uplift this month, then turn to the accounts of doctoring in the darkest days of the Holocaust (page 78) and modern Lebanon (page 80). When patients, governments, and we ourselves collude to make life difficult and demoralising, then such stories can remind us of the deepest purposes of doctoring, the reasons why we all chose to take on this calling in the first place.

DAVID JEWELL
Editor

INFORMATION FOR AUTHORS AND READERS

These notes supercede those published in January 2002. The information is published in full in each January issue of the Journal *, and is 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 discussion. 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.

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 named 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. 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 adopt structured discussions. We think it will help both authors and readers. It is not essential, but strongly encouraged. The discussion section should cover the following sections, using sub-headings:

- 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 *of the hard copy journal* 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. A rough guide would be no more than five columns and rows in each table. Where the article requires more data to be presented, the larger tables can and should be included in the electronic, and not the hardcopy version. The same general rule applies to figures. We encourage use of graphic 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

We welcome systematic 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). They should be no more than 4000 words in length. Long lists of references, and tables of included and excluded references will normally be published only in the electronic and not the hard copy.

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 be impartial in citing the available literature.

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), including a statement of the question being asked, the search strategy used, and the conclusions drawn from the papers identified. 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#separate 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. We want to avoid you working on an editorial if one is already in the pipeline covering the same topic, or if it is unlikely to be acceptable for policy or other reasons. Editorials should be up to 1200 words in length and have no more that 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#separate 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 named 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 report (see http://jama.ama-assn.org/info/auinst_req.html#separate for full requirements of informed consent).

The Journal is keen to discourage the practice of salami publication. In order to enable the editor to make a judgement in this area, authors should include all abstracts of other papers that have emerged from the same project, both published and submitted.

Authorship
The list of authors should include all those who can legitimately claim authorship. This will be all those who have made a substantial contribution to the concept and design, conduct, analysis or writing up a study. Authors may if they wish supply details of their individual contributions to the work, but we do not insist on it, and the data will not be published. Contributions would be expected to fall into one of the following categories:

Conceiving and designing the study
Obtaining funding and/or ethical approval
Collecting the data
Analysing the data
Interpreting the data
Writing the report in part or wholly
Revising the report

Each author should have participated sufficiently in the work to take public responsibility for the content relevant to their own contribution. We do not require all authors to sign the initial letter accompanying 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.

Submission of papers
All papers should be submitted in electronic format. 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. The paper should be saved as an MS Word document and/or Rich Text Format (.rtf) document. If sending in a disk, please label the disk with the name of the first author as well as the title of the paper. 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). In the course of 2003 we hope to move to submission directly on-line, as part of a move to complete electronic handling of the whole process of submission, peer review, editors response and authors' revisions.

The paper should be double-spaced. Tables and sheets should be saved separate from the text and references, and not included within the text. 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 papers (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).

Processing submitted papers

Preliminary screening

All papers are screened by the editor. Any that are unlikely to be accepted, whatever the result of peer review, are rejected at this stage. The decision to reject at this stage will often be made according to the Journal's overall policy.

Peer review

Original articles, brief reports, reviews, discussion papers and case reports which pass the initial screening test are sent to two or three expert reviewers. Reviewers are currently blinded to authors' identities; however, we are moving towards a system of open peer review. 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 peer review process is widely acknowledged to be imperfect. 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 unlikely 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. Performance figures will be published annually in the *Journal*

Fast tracking

Being a monthly journal, the *BJGP* cannot respond with much 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 copy 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.

Principal authors who are not members of the College will be sent a complimentary copy of the *Journal* in which their article appears. Enquiries about the purchase of additional copies of the *Journal* should be made to the Sales Office (tel: 020 7581 3232; fax: 020 7225 0629).

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Circulation and subscriptions

The journal is published monthly and is circulated to all fellows, members and associates of the RCGP, and private subscribers including universities, medical schools, hospitals, postgraduate medical centres and individuals in over 40 countries. The subscription fee for the *paper* edition for the year 2003 is as follows:

UK resident	£133.00
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Zone I (including EU)	£170.00
Zone II	£190.00
US surface mail	$268.00
US airmail	$306.00

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Electronic edition *only*	£133 + VAT
Combined electronic/paper edition	£180 + £7.30 VAT

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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.