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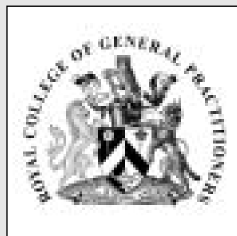

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January Focus

SOME years ago, I found myself in a meeting discussing a different set of contract changes, and arguing that the bullying approach of the time was not an appropriate stance to have adopted towards a group of knowledgeable and experienced practitioners. The response was 'but you general practitioners never change of your own accord. This is the only way that we can get you to change.' I didn't then have the necessary reply, that we change all the time, but it is the speed at which we change, and the gradual and organic way we do it, that renders it almost imperceptible. Periodically it's good to take a longer view and remind ourselves of this truth. As another year turns, this month's *BJGP* performs just such a role.

The approach towards back pain has done a complete about-turn, from the 'stay in bed' 30 or so years ago. The educational trial to improve the adherence to modern guidelines, reported on page 33, didn't detect any differences between the intervention and control groups. One explanation suggested by the authors was that the newer guidelines had already been widely adopted. Some of the changes are adaptations to changes in social technological spheres. The actions taken by men on detecting testicular swellings illustrate both some of the traditional male habits of denial in some, as well as some much less traditionally male willingness to consult early in others (page 25). The report of having patients examining their own records was both welcome and useful, with 70% finding at least one error (page 38). Many readers, some of whom may already have incorporated this kind of activity into everyday routines, will simply shrug at this study and wonder why we bother to publish it at all, but can anyone imagine it happening 20 or 30 years ago? However, the need for a cautious, gradualist approach is also illustrated by the letter on page 59 suggesting that 'modern' electronic sphygmomanometers are still not accurate enough to carry the weight of responsibility for the decisions to be made on diagnosis and treatment. Forget, for the moment, the 'white coat' problem applying to any readings taken by doctors using any method. Too late, says Neville Goodman on page 77. Partly in response to European concerns about toxicity, traditional mercury sphygmomanometers have already been retired from hospital practice. He bemoans the further loss of touch between doctors and patients that will result — another of those mysterious aspects of medicine that we find hard to quantify and may in consequence fail to value (especially in an Anglo-Saxon culture). On page 60 one doctor is keen not to embrace the gizmos of modern technology, again valuing human contact over the beguiling attractions of the modern world. Saturday morning surgeries are vanishing, too. The patients don't seem to mind much. As we have published elsewhere, they have become sophisticated enough to distinguish between seeing their own doctor for something long term and any doctor for more urgent problems (page 47).

Slow change is also discernible in the approach to respiratory tract infections and the use of prescribed antibiotics. This seemingly everlasting preoccupation is at last yielding to some really useful research that liberates primary care from the inappropriate conclusions derived from the populations of patients admitted to hospital. This month we publish a scoring system for adults on page 20, and a less formal set of criteria for children on page 9 — application of these rules could help to reduce antibiotic prescription, up to 30% in adults. That such reductions are possible is illustrated by the findings on page 15: the pathogenic organisms causing lower respiratory tract infection were the usual suspects, but 39% were viruses. These are only pointers towards changing clinical practice. The questions listed on page 5 remain to be answered. As the authors point out: 'The lack of a standard definition makes it difficult to compare and synthesise information across the studies.'

If it's difficult to discern professional changes, losses of secular knowledge can be completely invisible. Benny Sweeney makes a heartfelt plea for the pleasures to be had from fine art. He points out that the loss of shared knowledge about the classical world, and ignorance of the symbolism in Dutch genre paintings has made the exercise more difficult (page 70). I did know the story of Icarus (still a powerful metaphor that will do service in our own age for overweening ambition) but the lute symbolising lust? News to me.

DAVID JEWELL
Editor

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These notes supersede those published in January 2003. The information is published in full in each January issue of the Journal. *Small changes may take place during the year. The definitive version is available on the RCGP website at http://www.rcgp.org.uk/journal/info/index.asp*

Editorial policy
The *British Journal of General Practice* is an international journal publishing articles of interest to family practitioners worldwide. Priority is given to research articles asking questions of direct relevance to patient care. 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 our 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*.)
'*How this fits in*'. 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, particularly focusing on the relevance to clinicians.
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, 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 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.

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 $P = 0.0005$. Giving probability values in this way enables readers to make a judgement concerning significance. However, in general terms we apply stringent standards to significance testing. P values of 5% are accepted as significant for primary outcomes; for secondary outcomes or where multiple testing is concerned the general rule is to insist of $P<0.01$ to count as significant. Please note that we always want 95% confidence intervals, and they should not be adjusted to 99% confidence intervals where multiple tests are involved. This is, strictly speaking, inconsistent, but we feel is most likely to be helpful to readers.

We strongly encourage (but do not insist on) authors to write a structured **discussion** section, using the following subheadings:

- 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** (RCT)s 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/ifora_current.dtl 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 **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).

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.

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/ifora_current.dtl 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 likely to be welcomed, and whether someone else is already working on that topic.

Editorials should be up to 1200 words in length and have no more that 12 references. We are happy to hear from readers with suggestions for 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/ifora_current.dtl 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 file. 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#patients for full requirements of informed consent).

'Salami' publication. Medical editors generally are concerned with the practice of generating numbers of related papers from the same study. This is not a matter of unethical behaviour, but bears on best publication practice. When considering whether to publish findings separately or together, authors might wish to consider the degree of overlap according to the following questions:

- Is this the same, related or a completely different question?
- Is it using the same or different methods to answer the question?
- Is it assessing the same, overlapping or a completely different population of participants?

Authors should discuss with the editor the extent to which submitting a more complete report will require the word limit to be extended. In order to enable the editor to make a judgement, authors should include with the submitted file abstracts or full copies of other papers published, in press, submitted or planned, that have come from the same study.

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 files

All files should be submitted in electronic format. 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 file 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 file. If electronic submission is not possible, then authors should submit four copies of the file with a formal letter of submission. It should be pointed out, however, that the Editor rarely reads the letters before making decisions. The letter does not need to be signed by all the authors (see above). In the course of 2004 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 file should be double-spaced. Tables and figures 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 file 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 files, 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 file 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).

Processing submitted files

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 in line with 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 file soon after it is received in the editorial office. You should receive a response to the initial file 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.*

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.

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 Department (Tel: 020 7581 3232; Fax: 020 7225 0629).

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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.

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Electronic version only	£133 + 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: 020 7581 3232; Fax: 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.