QUALITY IN HEALTH CARE

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Instructions for authors

Papers should be sent in triplicate to the editor, *Quality in Health Care,* BMA House, Tavistock Square, London WC1H 9JR (tel 071 383 6204). They should be prepared according to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (Vancouver agreement) (*BMJ* 1991;**302**:338–41).

General

- All material submitted for publication is assumed to be submitted exclusively to the journal unless the contrary is stated.
- All authors must give signed consent to publication. (Guidelines on authorship are given in *BMJ* 1991;**302**:338–41.)
- The editor retains the customary right to style and if necessary to shorten material accepted for publication.
- Authors should submit questionnaires not established and well known.
- If requested, authors shall produce the data on which the manuscript is based for examination by the editor.
- Type all manuscripts (including letters) in double spacing with 5 cm margins at the top and left hand margin.
- Number the pages.
- Give the name and address and telephone and fax numbers of the author to whom correspondence and proofs should be sent.
- Do not use abbreviations.
- Express all scientific measurements (except blood pressure (mm Hg)) in SI units.
- Permission to reproduce previously published material must be obtained in writing from the copyright holder (usually the publisher) and the author and acknowledged in the manuscript.
- Keep a copy of the manuscript for reference.
- An acknowledgement of receipt of the manuscript will be sent.

Specific points

ARTICLES

Articles report research and studies relevant to quality of health care. They may cover any aspect, from clinical or therapeutic intervention, to promotion, to prevention. They should usually present evidence indicating that problems of quality of practice may exist, or suggest indications for changes in practice, or contribute towards defining standards or developing measures of outcome. Alternatively, they should contribute to developing approaches to measuring quality of care in routine practice. The journal is interprofessional and welcomes articles from anyone whose work is relevant, including health professionals, managers, practitioners, researchers, policy makers, or information technologists. Papers are usually up to 2000 words long with up to six tables or illustrations. Shorter practice reports, which may not be original in concept but must contain information sufficiently novel to be of importance to other units, are also invited. Articles of a discursive or debating nature, which do not conform to the criteria for original papers given above, will be considered.

- Give the authors' names, initials, and appointment at the time of the study.
- Articles should generally conform to the conventional format of structured abstract (maximum 250 words; see *BMJ* 1988;**297**:156), introduction, patients/materials and methods, results, discussion, and references.
- Give up to three keywords/phrases.
- Whenever possible give numbers of patients/subjects studied (not percentages alone).
- Articles may be submitted to outside peer review and assessment by the editorial board as well as statistical review; this may take up to ten weeks.
- Manuscripts rejected for publication will not be returned.

LETTERS

- Should normally be a maximum of 400 words and 10 references.
- Must be signed by all authors.
- Preference is given to those taking up points in articles published in the journal.
- Authors do not receive proofs.

Tables

- Should be on separate sheets from the text.
- Should not duplicate information given in the text of the article.
- Should have a title.
- Should give numbers of patients/subjects studied (not percentages alone) whenever possible and relevant.

Figures

- Should be used only when data cannot be expressed clearly in any other form.
- Should not duplicate information given in the text of the article.
- Should be accompanied by the numerical data in the case of graphs, scattergrams, and histograms (which may be converted into tables).
- Should include numbers of patients/subjects (not percentages alone) whenever possible and relevant.
- Legends should be given on a separate sheet.

LINE DRAWINGS

- Should be in Indian ink on heavy white paper or card or presented as photographic prints. One original and two photocopies of each must be submitted.

HALF TONES

- Should usually be submitted as prints, not negatives, transparencies, or *x* ray films.
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- Should be trimmed to remove all redundant areas.
- The top should be marked on the reverse in pencil.
- Labelling should be on copies, not the prints.
- The identity of patients in photographs should be concealed or their written consent to publication obtained.

References

- Should be numbered sequentially in the text.
- Should be typed in double spacing.
- Should give the names and initials of all the authors (unless there are more than six, when the first six should be given followed by *et al*); the title of the article or chapter, *and* the title of the journal (abbreviated according to the style of Index Medicus), year of publication, volume number, and first and last page numbers *or* the names of any editors of the book, title of the book, place of publication, publisher, and year of publication, and first and last pages of the article.
- Information from manuscripts not yet in press, papers reported at meetings, or personal communications should be cited in the text, not as formal references.
- Authors are responsible for the accuracy of references.

Proofs and reprints

- Corrections to proofs should be kept to a minimum and should conform to the style shown in *Whitacker's Almanack.*
- Corrections other than printers' errors may be charged for.
- Justification for corrections, if necessary, should be given in a letter and not on the proof.
- Reprints are available; an order form and scale of charges are included when the proof is sent out.

EDITORIAL AIMS

The direction, scope, and readership of the journal were discussed by the editorial board of Quality in Health Care *at its first meeting in April 1992. The readership and aims were agreed and are printed below.*

Readership

Quality in Health Care is for all health care staff and those whose work is related to health care. Though the primary readership may be working practitioners from all health care professions and managers, other important audiences include researchers, policy makers, and health economists.

Aims and scope

(1) Fundamental to all health care, including the debate about quality of care, are the views and needs of patients. The purpose of the journal is to contribute actively to the debate about the quality of health care by exploring subjects and ideas (from both routine clinical and managerial practice and research) which concern and inform this debate and which focus on benefit to patients.

This will be achieved through publishing a range of papers and articles.

(i) Those with an academic base which increase and clarify the understanding of the wide range of issues pertinent to continuous quality improvement in health care;

(ii) Those which describe practical and applied studies or audits of routine practice which are of wide applicability;

(iii) Those of a more discursive nature which contribute to discussion about quality in health care;

(iv) Series and commissioned papers which address specific issues or look at the quality of health care from particular perspectives;

(v) Appropriate letters, book and conference reviews, and précis of national effectiveness bulletins.

(2) The journal will be easily accessible to a broad readership. Language and style will be clear and the use of "quality" jargon minimised. There will be editorial insistence on "translation" of unnecessary jargon.

(3) The board considers that the communication and collaboration between the different health care professions is of central importance for the improvement of quality in health care. This will be promoted by publishing papers which address a wide readership, which are written by authors from the different professional groups, which specifically address collaborative or interdisciplinary work and also by involving referees from different backgrounds in the assessment of each submitted paper. Studies or quality improvement reports which take account of the views of users of health care will be encouraged.

(4) The importance of considering the consequences of the quality debate on clinical education and management training is recognised. The huge gap between undergraduate medical education and the problems and concerns of practitioners is an area of interest. The papers published in the journal will be a potential source of educational material. Submitted papers that address this directly will be encouraged; when relevant, authors of other papers may be asked to comment on the educational aspects of research findings.

(5) The value of reporting and reflecting the experience of health professionals and researchers from the rest of Europe, North America, and other countries is recognised. Papers and other contributions about research into, and practical experience of, quality improvement in health care will be encouraged from those working outside the United Kingdom.

(6) The board believe that the publication of this journal should aim to create an environment which will encourage or inspire research and practical quality improvement work consisent with the journal's objectives.

Editor

et al, by asking who are the experts in diabetes care, showed the different emphasis that patients and professionals assign to various aspects of care.[8] Such work should influence those designing services for particular types of care. Other groups of patients whose views have been the direct focus of papers published in the journal include survivors of stroke[9] and patients who have complained formally about the care received in hospital.[10]

Clarity and style

Many authors write with a clear style. But, when necessary, we have had to insist that authors exchange heavy, sometimes impenetrable, jargon for plain English. Of course, jargon may help to convey quickly technical information or complex ideas. And one person's technical language is another's jargon. But the message to authors is simple. If what you have to say is worth communicating then it is worth ensuring that it is accessible to as many people as possible. If the work on quality of health care is to give patients a better deal, it is crucial that it can be easily understood by all those who work in health care and does not become the provenance of a group of specialists who have their own jargon.

Authors from different healthcare professions

One of the aims of the journal is to publish papers by people from all groups within health care and to encourage a wide readership. Quality improvement depends on good communication between the various professional groups within health care. But these groups tend to work closely within themselves, and this is reflected in their reading – different journals for each profession and specialty. So far, only a few healthcare professionals other than doctors have submitted papers to *Quality in Health Care*. Nurses, therapists, and other healthcare professionals are responsible for much work that focuses on quality of care but are reluctant to write about it.[11] And, so far, few managers have contributed to this journal.

presents this information in a clear, logical, and structured manner, with explicit reasoning for pursuing each line of inquiry.

Arranged in eight chapters, the book largely follows a thesis format. The first three chapters provide excellent in depth literature reviews; the first chapter gives a useful summary of the physical implications of multiple sclerosis from biomedical and social sciences sources, the second and third chapters are particularly valuable in bringing together broader concepts such as chronic illness as a socially defined condition and "insiders' perspectives" based on reports of people with chronic illness themselves. In particular, the third chapter outlines two predominant approaches (qualitative versus quantitative) and argues the need to bridge the language and academic barriers between the two. The project itself, as discussed in the remaining chapters, seeks to do this by integrating both approaches to help gain a fuller understanding of how people with multiple sclerosis live with their illness.

As it becomes clearer that multiple complementary research approaches provide the most illuminating data when studying the human condition, this book presents a much needed, explicit example for others of how this research can be done to good effect. The study provides an in depth consideration of how 40 people with multiple sclerosis in Northern Ireland, community and institutionally based, perceive their lives, their illness, and their means of coping. Although necessarily limited in its application, the study provides a valuable insight into the sufferer's perspective, an area often neglected by healthcare professionals. In this respect, not being a "recognised professional in the field" may have been a significant asset to the author. The study is of interest to clinically based researchers, particularly in rehabilitation and community settings. The findings are especially relevant to clinical practice and are of interest to therapy and nurse teachers, as well as students.

The prompt publication of monographs in this way greatly increases the accessibility of research. Unfortunately the ease of use as a reference source is appreciably limited by the lack of an index system, making many valuable discussion points inaccessible without rereading much of the book. Nevertheless, the book provides a much needed perspective for professionals in rehabilitation.

JANE JOHNSON
Clinical Nurse Specialist in Rehabilitation

If you wish to order the titles reviewed or require further information, please contact BMJ Bookshop, PO Box 295, London WC1H 9JR (tel 071 383 6244; fax 071 383 6662). Books are supplied free of postage in the UK and to BFPO addresses, overseas customers should add 15% for postage and packing. Payment can be made by cheque in sterling drawn on a UK bank account or by credit card (Mastercard, Visa, or American Express) stating card number, expiry date, and full name. (The price and availability of titles are occasionally subject to revision by the publishers.)

COMMENT

Hormone Replacement Therapy: A Critical Review of Current Practice and the Way Ahead. Clinical Resource and Audit Group and Scottish Office. (pp 76; free). Edinburgh: CRAG Secretariat.

Although the benefits of hormone replacement therapy are well recognised, views differ widely as to how it should be prescribed and to whom, hence the decision by the Clinical Resource and Audit Group to hold a conference to assess the benefits and risks of hormone replacement therapy and to recommend sensible prescribing policies. The subsequent consensus statement summarises the papers presented at the conference and comprises chapters covering identification of women who would benefit, which preparations to prescribe, the risks and benefits of long term therapy, and areas for future research and for audit.

The need for greater education among doctors and patients is highlighted by the fact that, although all agree that women who have a premature menopause have most to benefit from hormone replacement therapy, only 30% of this group is currently taking the therapy. The greater availability of computerised general practitioner records should enable easier identification of women who should be offered hormone replacement therapy, such as those who have had a hysterectomy. Poor compliance is still a major problem – in the United States 20% of women discontinue therapy within nine months and 30% of those prescribed therapy fail to collect the prescription. Outdated ideas about contraindications to therapy, such as thromboembolism, are still commonly encountered.

The agreed approach when hormone replacement therapy is being started is that the cheapest, effective type of preparation should be prescribed in the first instance, although the individual requirements of each patient should be considered. Different routes of administration are discussed in the statement, together with their influence on patient compliance. The risks and benefits of long term hormone replacement therapy are discussed in detail, and, clearly, more research is needed about the effect of the progestogens used in opposed hormone replacement therapy on the risk of ischaemic heart disease and breast cancer.

Although there is some overlap between the chapters this is an extremely useful booklet for all those who prescribe hormone replacement therapy. It emphasises the need for research of the effects of modern opposed therapies and the need for greater awareness of the benefits of hormone replacement therapy among both women and clinicians

LESLEY REGAN
Consultant Gynaecologist and Obstetrician

DIARY

27 April
London: Royal Society of Medicine. Evaluating clinical audit: past lessons, future directions. A joint conference of the RSM Forum on Quality in Health Care, CASPE Research, and *Quality in Health Care*, sponsored by the Department of Health, on the progress and impact of clinical audit in the NHS. (£45, RSM fellows and forum members; £85 others, including all conference materials, lunch, and VAT.) Further details from Miss Lisa Spicer, RSM, 1 Wimpole Street, London W1M 8AE (tel 071 290 2900 ext 4936; fax 071 290 2989).

14 April–14 May
London: Barbican Centre. Helping to heal. A national touring exhibition of new photographs by Jerry Hardman-Jones focusing on the work of Arts for Health, a national charity based at Manchester Metropolitan University. Further information about the exhibition, review copies of the catalogue, and photographs from Sheeran Lock Fine Art Consultants (01422 844642; fax 01422 845443).

29 June
London: Royal Society of Medicine. How to change practice: strategies and solutions. A conference on the problems and opportunities of changing and influencing clinical practice with an emphasis on practical and working approaches. (£25, RSM fellows and forum members; £35 others.) Further details from Miss Lisa Spicer, as above).

QUALITY QUOTES

Ideals are like stars. You will not succeed in touching them with your hands; but, like the seafaring man, you choose them as your guides, and, following them, you will reach your destiny

– CHARLES SCHURZ

I knew very well what I was undertaking, and very well how to do it, and have done it very well – SAMUEL JOHNSON

Excellence is to do a common thing in an uncommon way

– BOOKER T WASHINGTON

Certainly a leader needs a clear vision of the organisation and where it is going, but a vision is of little value unless it is shared in a way so as to generate enthusiasm and commitment. Leadership and communication are inseparable

– CLAUDE I TAYLOR
(Chairman Air Canada)

Amusing or erudite items relating to quality – including examples of "quality speak", cartoons, etc – are welcomed for publication and should be addressed to the editor