1990–1995

Regarding my editorship

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I was the third appointed editor of the *New Zealand Family Physician* (*NZFP*) and my watch was from 1990 to 1995. That makes my opinions on editing somewhat dated considering the changes since in communication, sources of information, and the availability of the Internet and its multiple uses. To have heard Dr Tony Townsend describe himself as the 'dinosaur' of his practice at the 2007 College conference makes me wonder what my label would be when I remember attending a postgraduate course in 1958 with his father!

Being editor was a time of learning the skill of clarifying medical journal expression without distorting the personal style of authors.

In 1992 I attended the WONCA World Conference in Vancouver and gave a paper at the Editors' meeting, which was attended by the representatives of the British, US, Australian and Canadian Family Medicine (FM) journals, the staff of a Norwegian paper and quite a few doctors of non-English speaking colleges. My paper was *'Defining content policies for a Family Practice journal'* in which I compared our FM journals according to 10 elements such as original papers, therapeutics, correspondence, College news, and medical education. Original papers took up from 10 to 74% of the pages in the issues checked, correspondence 0–10%, medical education 0–32% and, as a distinct departure from the rest, our Journal Review section of 21% had no similar section in any other FM journal. There was considerable variation between issues of the same journal and I failed to find out whether journal committees make any policy decisions in that regard, especially concerning original papers, specialist areas of practice and commercial advertising. I felt that original papers and reviews of journals (the Journal Review Service), both carried out by general practitioners themselves, were of high value.

At that time the content of *NZFP* was complemented by the free distribution of two substantial journals financed by pharmaceutical companies. Their articles were written on subjects of current clinical interest by specialists in that field and this reduced the need to cover them in the *NZFP*. I suspect that the same influences affected FM journals elsewhere. In the same way the electronic information sources may well be modifying present needs. I would be interested to know how our readers manage best now. Medico-political subjects were also a feature of separate publications here.

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The question before and at my time was whether to make our journal an expanded in-house College newsletter growing up from the first of these in New Zealand, put out by the Auckland Faculty of the RCGP in January 1962. It contained 20 small pages, of which seven reported three lectures by specialist physicians at a Wairakei College meeting. Also at that time we had the Medical Recording Service of the College which distributed 12" disks of lectures and interviews – some I remember being recorded to a very high standard in the radio station studios.

The alternative to the expanded in-house newsletter was to have a world-class journal available to the world via Index Medicus. We have requested inclusion at intervals in the past until very recently, when Dr Townsend regretted our exclusion. In 1992 I sent four copies of the *NZFP* off as requested by the Literature Selection Technical Review Committee of the (US) National Library of Medicine and had a similar response to the 1989 letter, which stated *'the New Zealand Family Physician was not recommended by the societies as being useful to family practitioners.'* The professional societies were not named, nor were the judgement criteria. I regretted having to advise doctor authors who wished to have international listing to publish with the *New Zealand Medical Journal* rather than with us.

I took the path between these extremes so that papers that might not have met Index Medicus approval could be published for one's peers here while copies would be despatched to the libraries of sister Colleges. In my time as editor the FAMLI Index was listing papers of FM interest in a more limited circulation. Publication by *NZFP* allowed us to keep in touch with aspiring authors without too many hurdles, although GP referees reported on the quality and interest in submissions. Between 1990 and the present time the proportion of pages of original papers

has doubled, with some credit due to the development of university departments of General Practice with research capabilities. For the journal's sake I hope it will remain in the full control of general practitioners.

Another influence on our FP publications I have classified as 'health politics and economics.' From the late 1960s I was a member of the Central General Practitioners Committee of the New Zealand Medical Association (NZMA), becoming Chairman for some years. We had a liaison with the Royal New Zealand College of General Practitioners in its early years and our policy was to keep medico-political matters for another publication and to refer matters concerned with education, standards of care and practice organisation to the College. The NZMA and the College are now both active in both fields to the extent that recent copies of the *NZFP* and the *British Journal of General Practice* had 27% and 10% respectively on health economics subjects. Does that give us two voices or opportunity to divide us?

I must commend the modern section of the journal devoted to Problem-Oriented Evidence that Matters (POEMs). Careful scrutiny of the scientific evidence for practical medical decisions would have been of great value in my practice.

I would like to think that the *NZFP*, even under a new title, should remain a medical journal by and for doctors but accessible to practice and district staff and allied health workers. The collegiality of doctors, here or overseas, is founded on a long, common medical education, experience and dedication, with a common cause. I have greatly enjoyed reading the papers on 'continuity of care' in the *NZFP* of February 2008 and the Pickles (RCGP) lecture of 2007 by Professor Sean Hilton on 'education and the changing face of medical professionalism'.[1] It is a reminder of the ethos that we aspire to and of the respect paid to us and for us to live up to. May our journal always remain deeply embedded in our College.

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One of the challenges of my editorial role, which included business management, was to earn financial revenue from advertising and sponsorship of the Journal Review Service. These were not guaranteed indefinitely and the College had to pick up the residual expense. We had discussions which threatened *NZFP*'s existence, or parts thereof, at the same time as we were sending the *NZFP* to all doctors working in general practice – not only the subscription-paying Members. It was very rarely that we had to object to any advertising, but some trading sometimes affected placement within issues. As with other countries' journals, advertising in ours has dropped from 34% of space to just 5%, and apart from its classified sections, that of the *Br J Gen Pract* to just 1%. I was very thankful for the advertising by pharmaceutical firms in my day.

As when I relinquished the editor's role in 1995, I remain grateful for the help of my assistant editor, Dr Gordon Jenner, the authors, referees and reviewers, the contributions of the College officers and staff, and our printers and publishers who helped an amateur produce a professional journal.

I wish the journal a great and fruitful future. I hope it remains the journal of our general practitioners in every sense. (Do you think some day we could challenge the 'Back Pages' of our mother College?)

References

1. Hilton S. Education and the changing face of medical professionalism: from priest to mountain guide? Br J Gen Pract. 2008; 58(550):353-61.

How to change the world

'There is no single strategy that will transform the U.S. health care system, Davis argues, but a series of coordinated policy changes could bend the curve of projected spending – up to $1.5 trillion over a 10-year period. One option is to create a system for generating information about the effectiveness of medical treatments to compare their costs and benefits, as Britain and Australia have done. Additional strategies include adopting health information technologies, developing a system of patient-centered medical homes for primary care, negotiating pharmaceutical prices, and moving to a bundled episode-of-care payment system that combines hospital and physician services for episodes of acute care.'

Davis K. Slowing the growth of health care costs — Learning from international experience. N Engl J Med 2008; 359:1751-1755.