delivery—food was not, nor bus fares; why should an exception be made for medical care? While he believed very firmly that private practice could be the salvation of primary care in the inner cities he did not think doctors were avaricious—indeed he could not believe that any of them had entered medicine with the intention of making money.

Some way had to be found to reward effort, he believed, so that the better GP doing better work would get paid more. In British Columbia, for example, he recalled going to a post-graduate lecture at 7 am and finding it packed. The reason was simple: doctors were eager to acquire higher qualifications because that meant better fees and better hospital privileges.

Quality control should, thought Dr Lefever, be in the hands of one's professional colleagues. Doctors in Britain were not self-disciplining. On the whole local medical committees did not give a damn about the quality of the work done by their constituents. In fact, they would jump to the defence of any doctor at any time—"if he's a doctor then he must be in the right." Surely it was healthier to take the attitude that if the medical community included some bad doctors then it should actively seek them out and get rid of them?

Solutions

If he were asked to find a solution for the problems of inner city practice within the NHS, his first change would be the encouragement of more single-handed practitioners. "I don't think the health centre or the group practice model works in inner London," he commented. "It is ideal for a rural setting; but it doesn't work in the inner cities with their high turnover of population. I found that when I was senior partner in a group of three with 10 000 patients I was becoming just a prescription-writing machine. My colleagues who are still running that practice would not say the same thing; they find their work satisfying and believe they are doing a good job. It is personal to the doctor. What I am arguing is that the system should not be designed on the assumption that there is one best way of organising primary care. There are tremendous advantages in the city centre for single-handed practice. It is much easier to provide continuity and personal care for patients—especially

those who may not find it easy to come to terms with an appointment system. The secretarial work is necessarily simpler with only 3000-4000 patients, and much tighter controls can be maintained." There were further advantages, too. Fewer things and patients got lost: and less paperwork was generated, satisfying and believe they are doing a good job. It is personal to Furthermore, a single-handed GP could still arrange to be in a rota for out-of-hours cover—and he was himself in such a rota.

Nevertheless, since few city doctors lived on the premises there was a tendency to hand over out-of-hours care to deputising services. What did he think of suggestions that city hospitals should provide a primary care service at nights and weekends? Dr Lefever simply did not believe that junior hospital staff were the right people to provide primary care—any more than he believed that GPs were the right people to cope with surgical emergencies. On the whole he was very impressed with the quality of London deputising services and was not convinced that they were the bogeys they seemed to be from comments in the press. Doctors used deputising services for various reasons, and the main one was not laziness but simply that they could not afford to live where they practised.

Why, however, did inner city GPs have a poor reputation among hospital doctors—and, indeed, general practitioners in small towns and country practices? Their poor standing was often justified, said Dr Lefever. Partly the explanation lay in the drop in the population of the inner cities in the past 20 years. As families had been rehoused in new towns and dormitory suburbs their doctors had stayed behind, getting older; but the drop in population meant that as GPs died or retired their remaining patients were allocated among their colleagues and few young recruits came in to replace them. Furthermore, young doctors just could not afford the investment required to set up new practice premises or modernise old ones. Local authorities regarded general practice as a business; they looked at planning requests and made rating assessments on that basis. A GP who spent nothing on ancillary staff could earn a lot. "I'm not saying you become a good GP by having lots of ancillary staff but there is no way you can be a good doctor without them." Everything was stacked against doctors who wanted to practise good medicine in the cities, he concluded. "Britain is the only country where a doctor can earn a lot of money while being pretty indolent."

Personal Paper

What does a subeditor do?*

JANE SMITH

British Medical Journal, 1978, 1, 222-223

Doctors can get almost anything published somewhere if they only persevere. Clearly this is bad because it provides writers with little incentive to raise their standards, readers are forced to be unnecessarily discerning, and poor articles harm medicine.

*Based on a paper given at the BMJ ELSE workshop for medical technical editors held at Winchester on 17-18 November 1977.

British Medical Journal
JANE SMITH, BA, subeditor

Medical editors and subeditors therefore have what amounts almost to a moral obligation to discipline the careless approach of some writers. In short, they must publish only good material and they must edit it intensively.

Intensive editing is necessary for several reasons (all for the benefit of the reader): to ensure clarity, accuracy, and some sort of uniformity of style and appearance. Some authors, for example, are surprisingly unconcerned about accuracy. To take a rather frivolous, but representative, example, a subeditor might ring up the author and point out that his diagram had 188 black circles whereas it should have had 199 to be consistent with the text and ask where the missing 11 should go. The reply might be: "Oh, I didn't think you would check things like that. Does it matter?" There is also plenty of evidence to suggest that

authors make many statistical errors, which present even more difficulties for subeditors, who are not usually statisticians.

For these reasons, therefore, and also because a British scientist's literary education virtually stops after about the age of 15, the author is not necessarily the best person to prepare his paper for publication. There comes a point when it is just a waste of time to keep asking the author to cut, condense, or restructure his article or to redesign tables and charts. Then the editorial staff must take over. They will have more interest and more time than the author, and for tables and charts will have a better understanding of the typographical tools at their disposal. Arguably an author is never the best person to condense his own writing: it is standard journalistic practice that someone else should edit a writer's copy.

Justifications

All this has two corollaries. Firstly, if a subeditor is to do a lot to an author's manuscript then he must be able to justify all the changes he makes—not only on the general level that he is making it easier for the reader but also at a very specific level. The subeditor must be able to justify the small changes or sets of changes that he makes—on grounds of clarity, accuracy, conciseness, tough-mindedness, or even on grounds of house style, though house style tends to be more an excuse than a justification.

But you cannot prescribe a set of justifications in advance, except in general terms, because you cannot prescribe a way of subediting: every subeditor will do it slightly differently. There are, for example, many ways of making an ungrammatical sentence grammatical, many ways of making something unambiguous. And one of the factors that may affect it will be the author's own style, or at least the words he has used. If a subeditor does his editing skilfully enough and if an author does not check back with his original copy (though, of course, he should) then the author may not realise that his article has been changed fairly substantially, though piecemeal. But it should be much clearer, sharper, and probably shorter.

Making things shorter though without leaving anything unsaid has its own justification. If an article is reduced to two-thirds or half its original length then that leaves more space for another article in the journal; and it leaves more time for the reader to read another article or to see some more patients or to go yachting. In that sense at least intensive subediting is not a luxury.

Confrontation

The second corollary of intensive editing is less welcome. If a manuscript is subedited fairly heavily and without much consultation with the author there is a danger of producing a confrontation when the author sees his proofs. For example, a paper is edited in the normal way, and the author does not like what has been done. So instead of thinking that there might have been a reason for the changes—that the original might have been unclear or ambiguous—he puts it down to editorial bloody-mindedness and carefully puts back on the proof all the words and phrases that the subeditor had so carefully excised and rewritten on the copy. The editor is then presented with only two possibilities: to give in to the author or not to give in to him. On a weekly journal it may be too late for compromise: the author may be in America or Aberdeen and it is difficult to argue about a whole article on the telephone. All too often the editor gives in—for possibly less than rational reasons. Here the advantages of earlier consultation with the author are clear, though for most journal articles constant consultation tends to be a waste of time. The educational effect is minimal; and only a small minority of authors complain bitterly at what the editorial staff have done to their papers. Most say nothing or make only minor amendments, and a few are very grateful.

The reason why some journals edit intensively and others do not has more to do with practical considerations than with ideological ones. The editor who refuses to edit on the grounds that word-by-word editing according to a canon destroys an author's style is just wrong-headed. No style manual can lay down a word-for-word guide on how to edit; if it could, then all subeditors could give up their jobs to computers and word processors. More crucial to whether things get edited intensively or not are considerations of time, money, and tolerance.

The production rate of subeditors is not high, and the problem constantly gets worse: the more articles are condensed the less space they fill, and so the harder the subeditors have to work to fill the space they have created. Certainly, the shortest articles, such as Short Reports in the *BMJ*, often demand an amount of work that is totally disproportionate to the amount of space they fill. Someone—the subscriber, advertiser, or learned society—has to pay for this.

Tolerance

There are also constraints of tolerance. Authors may be prepared to put up with substantial revision when they submit their article to a general journal because they realise that it has a wide readership that they are not in a position to assess. On a specialist journal, where articles may be longer and more detailed and where authors may feel that they know the readership better, they may be less prepared to put up with revision, though their articles may well need it.

Many of the subeditor's problems stem from the fact that doctors as authors are badly disciplined. Language in science is often thought of as a tool of expression rather than a tool of thought—a means for describing and not as a vehicle for generating and clarifying ideas—and is therefore considered to be a bit peripheral, though, of course, it is not. These authors' articles need intensive editing but usually do not get it, and when they do the authors often take it as a personal affront, which it is not.

Why are combinations of streptomycin and sulphonamides recommended for prophylaxis against travellers' diarrhoea when antibiotic treatment of established diarrhoea is discouraged?

Controlled trials have shown that combinations of streptomycin and sulphonamides do reduce the incidence of travellers' diarrhoea when taken prophylactically,^{1,2} but antibiotic treatment of established diarrhoea presents two problems. Firstly, the attack is self-limiting, lasting about five days, so that the effect of any antibiotic is difficult to prove. Secondly, no single organism is responsible for causing travellers' diarrhoea, and different areas probably have different pathogens. One study³ found a probable agent in 63%: enterotoxin producing *Escherichia coli* of different, non-enteropathogenic serotypes was the commonest, but other possible pathogens were salmonellae, invasive *E coli*, shigellae, *Vibrio parahaemolyticus*, *Giardia lamblia*, and the human reovirus-like agents. Obviously, antibiotics would be effective only against some of these organisms.

¹ Turner, A C, *British Medical Journal*, 1967, **4**, 653.

² Baron, G H, *Lancet*, 1976, **2**, 143.

³ Merson, M H, et al, *New England Journal of Medicine*, 1976, **294**, 1299.

Were the words "general paralysis of the insane" used on death certificates around 1900 a euphemism for syphilis?

General paralysis of the insane was the name given to syphilitic lesions of the central nervous system because the combination of dementia and paralysis distinguished the condition from other forms of dementia. Such a designation implied that syphilis was the cause, though in rare cases the clinical picture could be mimicked by cerebral arteriosclerosis and certain intoxications of the brain.