Of the schizophrenic patients 86% had been seen within six months, and 97% within 12 months, compared with 69% and 76%, respectively, for the controls.

There were 15 serious physical problems (including congestive heart failure, epilepsy, chronic obstructive airways disease, and an un-united fracture) and 29 non-serious problems (including varicose veins and arthritis) identified among the schizophrenic patients, compared with seven serious and 16 non-serious problems among the controls. Of the schizophrenic patients, 76% were on oral psychotropic drugs and 41% were receiving antipsychotic medication by depot injection. Despite this, there were few recordings of mental state (short comments in the notes of five schizophrenic patients). Employment was recorded for 26 out of 29 patients in each group: five patients with schizophrenia were in employment outside the home compared with 18 controls. There was virtually no record of financial problems or benefits received in either group (financial problems were recorded for two schizophrenic patients; there was no record of benefits received).

Risk factor recording, apart from cholesterol level, was good in both groups (Table 2). However, there was no evidence of action taken to reduce risk factors among the schizophrenic patients.

Of the schizophrenic patients 24% had seen a psychiatrist within the last two years, and 38% were in contact with the community psychiatric nurse.

We intend to improve the care of patients with schizophrenia in the areas of continuity, recording of mental and social problems, modification of risk factors, and specialist drug review. A recall system has been introduced together with special record cards for patients with schizophrenia which have a grid of possible problems to be explored every six months (copies are available on request).

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Urine sampling technique

Sir,

Over the past three years our family practice residency training programme has organized a weekly critical appraisal seminar attended by residents (trainees), teaching practitioners and any other interested people. The seminar deals with one or more particular medical articles which are likely to have an impact on general practice in terms of diagnosis, prognosis and management.

Recently we held a session on a *Journal* article on urine sampling techniques.[1] The message from Baerheim and colleagues was that holding the labia apart was an effective way of obtaining a clean specimen, and that using the midstream technique and cleaning the perineum added little to reducing the contamination rate. Since the practice processes about 142 specimens a month, the relevance to our practice was considerable, and it was decided to implement the suggestions from the study. In the changed preparation technique, women were instructed simply to part the labia while obtaining the specimen and not to use the benzalkonium chloride pads that were part of the standard cleansing procedure used normally.

Over a two day period, 22 urine samples were collected of which eight were from obstetric patients. Both analysis and culture were carried out for 11 specimens. Of the 22 samples 12 (55%) were grossly contaminated by vaginal elements (debris, cellular material) and of the 11 culture specimens eight (73%) were similarly contaminated. Patients with contaminated specimens had to be recalled for a repeat sample and culture, and the practice had to absorb the cost of doing this. The contamination rate for urine specimens collected during a one month period before the intervention was 12.4% (in 185 specimens) and during a one month period after the intervention ended it was 14.7% (in 177 specimens).

Reasons for the poor outcome in our study are first, that women might vary greatly in their ability to spread the labia and obtain a urine specimen, particularly if they were overweight or had objections to touching themselves, and secondly obstetric patients may have great difficulty performing the procedure, especially in the third trimester. In Baerheim and colleagues' study, the subjects were healthy women college students studying nursing or medical technology, a group likely to have an athletic shape, manual dexterity and a bias towards success in a medical procedure — their mean age was 22.6 years and their mean weight 61.3 kg. Our practice sees a much greater variety of patients including women who weigh up to 100 kg. Though the technique recommended seems simple and the average healthy woman may be able to perform the procedure with little difficulty, it seems inappropriate for obese or pregnant or frail, elderly women.

Though Baerheim and colleagues' study was relatively well designed and was relevant to general practice, it has

Table 2. Risk factors recorded among schizophrenic and control group patients.

	No. of schizophrenic patients			No. of control patients		
	Factor recorded	Problem found	Evidence action taken	Factor recorded	Problem found	Evidence action taken
Blood pressure (within 5 years) (n = 29/29)	26	2	0	24	4	2
Smoking (ever) (n = 29/29)	24	12	0	21	4	2
Alcohol (ever) (n = 29/29)	17	2	0	17	1	0
Weight (ever) (n = 29/29)	19	4	0	19	2	1
Cholesterol level(ever) (n = 25/25)[a]	4	0	–	2	1	1
Cervical smear (within 3 years) (n = 8/10)	7	0	–	10	0	–
Mammography (ever) (n = 7/7)	4	0	–	3	0	–

n = no. of schizophrenic/control group patients eligible for inclusion. [a] Patients over 65 years of age not considered eligible.

little generalizability for the range of patients in our practice.

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Journal publication times

Sir,

You kindly published my paper on practice nurses (January *Journal*, p.25), and my thanks for that. I have spoken to several colleagues who have published in the *Journal* and found my experiences were similar to theirs. In particular we were concerned with the long delay between acceptance of the paper and publication, and by the requests for major revisions at relatively short notice. The *Journal* seems keen to impose its formal style, and unkeen to create any controversy.

The long delay is hopefully the result of success, but could be reduced by expanding the *Journal*. If general practice is to expand as a hot bed of research, and the *British Journal of General Practice* is to be the lead journal, then strangulation of research at the publication stage is unhelpful. The short notice revisions could be avoided by a revision of work practices. I would suggest that controversy would be of great help in stimulating informed debate, and could be handled with success, given the skills within general practice.

Could I suggest these concerns form the basis for an audit? Do you define your standards, and review your performance? As the journal of the Royal College of General Practitioners I am sure that you do.

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Editor's reply

Thank you for giving us your views as a *Journal* author and to express some concerns which you found were shared by other writers. I am pleased to reply to these concerns and to give some explanation of our procedures in preparing manuscripts for publication.

Minimizing the delay between submission and publication is the perennial concern of the *Journal* team. The time from submission to first reply to author depends largely on the efficiency of the peer review process. We are now able to arrange full statistical assessment of papers which require it. Although this new procedure slightly lengthens the review process, we have been able to minimize delay with the cooperation of reviewers. Before a final decision on publication is made we ask for most papers to be revised in the light of reviewers' comments. Some authors respond promptly, but others are tardy and delays of 30 weeks are not unusual. Author delay at this stage can contribute substantially to the mean time from submission to decision on publication.

After an original paper is accepted, it takes its place in the queue awaiting subediting. The length of this queue depends on how many papers we accept and the balance between the number of accepted papers and how many pages we have available in each issue of the *Journal*. There has been a steady increase in the number of submissions over the last few years (435 in 1991 and 485 in 1992). During this time the number of pages available has remained constant. We had hoped to secure extra pages, but this did not prove possible owing to College budgetary constraints. While we welcome the increase in submissions, reflecting as it does the popularity of the *Journal* with authors and the success of the College in promoting general practitioner research, the inevitable result is an increased rejection rate. We may be guilty, on occasion, of preferring to accept an interesting paper to the detriment of the mean acceptance to publication time.

You mention the imposition of a formal style. Most major journals adopt a uniform house style as this has been found to assist readers by ensuring a logical and standard layout. The purpose is to ensure accuracy in the text and the references, and not to stifle controversy or debate which is the *raison d'être* of editorials, discussion papers and letters to the editor. We see it as part of our job to help authors, especially first authors, to make the best of their material. Most authors appreciate suggestions to improve the clarity of their papers.

Over the years, there has been a gratifying and sustained rise in citation in other learned journals of papers originally published in the College *Journal*. Many authors in other journals refer to original articles in the *British Journal of General Practice* and it is essential that the text, tables and references are as accurate as we can make them. Papers are subjected to detailed and intensive sub-editing and as this process is different from the refereeing procedure many problems only come to light at this stage. If substantial subediting has been done, a manuscript may be returned to an author for correction before proofs are prepared. Having been a general practitioner myself for many years, I appreciate the difficulty of finding the time for revision of a manuscript while carrying a heavy clinical workload including night and weekend calls. Revision is hard work in these circumstances.

The time between acceptance and publication remains much longer than we would like. Dates of submission and acceptance are given on papers when they are published. Like general practice, the *Journal* is a team effort involving all *Journal* staff on behalf of readers and researchers. We will do our best, but continue to depend on authors' cooperation to streamline the process as much as possible.

Osteopathy

Sir,

Pringle and Tyreman conclude that osteopathy has some benefit (January *Journal*, p.15). Justification for their research comes from Meade and colleagues who randomized patients with back pain to receive treatment either at a National Health Service outpatient rheumatology clinic or a private chiropractic clinic.[1] Assessment at two years revealed that patients with chronic pain fared slightly better in terms of disability. However, the validity of the study was questionable, and not all variables were controlled.

Chiropractic therapy is different from osteopathy. Both are based on the theory that all diseases are caused by pressure, either on the arteries (osteopathy) or nerves (chiropractic therapy).[2]

In the study by Pringle and Tyreman the osteopaths were treating patients with musculoskeletal disorders. Symptoms in the majority of these patients will settle with little or no treatment. No conclusion of benefit can be made without comparison with a placebo.[3]

In assigning patients to four diagnostic groups the osteopaths were merely identifying prognostic features. It is known that with back pain a worse outcome is associated with a reduced straight leg raise, sudden onset, radiation of pain and duration of pain of over a week.[4-6]

In 80–90% of cases of back pain, patients recover in about six weeks, irrespective of the administration or type of treatment.[7] Therefore, we can confidently predict that someone seen early will improve. However, after a few months the