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In the *Journal* this month:

Editorials

Yvonne Carter looks at the lack of funding for research in primary care and asks whether the Culyer report has the answers. Brendan Sweeney notes that continuing advances in genetic knowledge mean that the medical world is on the brink of a revolution, but asks what the ethical implications are.

Measuring morale

Over the years, a variety of tools have been used to examine doctors' mental well-being in a range of psychological and sociological studies. In this study, Grieve's main aim was to investigate the effect of practice area deprivation on mental well-being using a questionnaire in an anonymous postal survey. She found that well-being was not associated with practice area deprivation, but that help for small primary care teams, and measures to reduce time stress, should improve morale.

Fundholding in the South Thames Region

In this paper, Corney and Kerrison monitor the changes occurring in a sample of fundholding and non-fundholding practices. Their results show that most fundholders had developed 'outreach' clinics and increased the range of diagnostic services in their surgeries. However, despite these advantages, there are disadvantages associated with these clinics; for example, they may lead to a fragmentation of services, causing a fracture in the links between practitioners and hospital services.

Specialist outreach clinics

Specialist outreach clinics in general practice are one example of a shift in services from secondary to primary care. Black *et al* focus on two specialties, dermatology and orthopaedics. They describe these specialist clinics from the perspective of the patient, GP, and consultant, and estimate the comparative costs of these clinics and equivalent hospital outpatient clinics. The results suggest that a cautious approach should be taken to the further development of outreach clinics as studied, as the benefits may be modest and their costs higher.

Drug therapy changes

Munday *et al* note that, owing to the increased emphasis on seamless care, patient education, and increased accountability for drug costs, GPs and community pharmacists may consider the receipt of information on the reasons for drug therapy changes incurred during hospital admission to be an essential requirement. They found that the existing hospital discharge prescription requires modification to facilitate the completion of this information, which will ease the continuity of patient care and counselling and help to control costs.

Green prescriptions

This study, carried out in New Zealand by Swinburn *et al*, was part of a randomized controlled trial of the effects of written exercise advice (green prescriptions) versus verbal advice among sedentary patients, and describes the qualitative research carried out with participating GPs to assess their attitudes and perceptions towards using the green prescriptions, and the feasibility of incorporating them into everday practice. Overall, the GPs were very positive about the concept, believing it to be beneficial for patients and achievable within general practice.

GPs' views on the services to which they refer patients

Horobin *et al* undertook a survey of the opinions of Fife GPs on the quality and availability of a selection of services to which GPs refer their patients, as an important part of the planning and development of such services. They discovered that far more GPs rated services as poor for availability than for quality. The response to both the questionnaires and the invitations to

meetings highlights the difficulty of obtaining the views of GPs, even regarding the services to which they refer patients.

The Dundee out-of-hours cooperative (DDOC)

Bain *et al*'s report describes the setting up of an out-of-hours cooperative in the city of Dundee, and illustrates the main findings during the first year of operation. The key features of the cooperative were that two doctors could deal with the large majority of out-of-hours calls for a population of almost 100 000 patients, only one-third of calls required a home visit, most calls were handled within an acceptable time period, most patients rated the service as equal to or better than the previous service, and there were extended opportunities for GPs to meet with other colleagues during out-of-hours work.

Magnetic resonance imaging (MRI) of the lumbar spine

The use of MRI for the investigation of back pathology is now well established for hospital specialists, but no data are available on its use by GPs. In their report, Chawda *et al* attempt to rectify this by comparing referrals for MRI from GPs and hospital outpatient doctors, and assessing GP patient management following receipt of the scan report. The results show that there was no difference in the diagnostic rates for disc herniation and spinal sternosis, but that GP direct access to MRI shortens investigation time, which potentially reduces waiting lists and allows GPs to make more informed management decisions.

Stress management strategies

Recent surveys have highlighted sources of stress for UK GPs. In this article, Sims systematically reviews the existing evidence for the possible benefits of stress management interventions to see if any findings might be relevant to GPs and their patients. Results so far suggest that relaxation and cognitive behavioural skills are helpful and that group methods are both more cost-effective and more beneficial than individual counselling. Sims also suggests possible avenues for future interventions to alleviate stress.

Prevention of psychological morbidity following perinatal death

Hammersley and Drinkwater note that in recent years a significant volume of hospital-based literature has been produced about the management of women and their families after perinatal death. In this paper, they document the evidence for high levels of psychological morbidity following perinatal death, review a variety of interventions designed to reduce morbidity, and make some tentative proposals about the key elements of an effective community-based support programme.

Improving the treatment of depression in primary care

Richard Moore observes that previous work has succeeded in improving the recognition of depression by GPs. He explains that this is only likely to be of benefit when it results in effective treatment. Factors compromising this effectiveness include non-compliance, non-response, and relapse of depression. Psychological therapies may prevent the latter, but are not available to the majority of depressed patients seen in primary care; however, Moore argues that existing evidence demonstrates that primary care staff can be trained in effective psychological interventions for depression, but that these interventions need to be sufficiently brief to be incorporated into routine treatment.

Letters to the editor

Letters this month include correspondence concerning evidence-based medicine, the antibiotic management of sore throats, GP training in dermatology, questionnaire response rates, and the spread of HIV from non-drug user to non-drug user.

International digests

This month's digest items, compiled by Douglas Garvie, comment on independence in the elderly, osteoporosis in males, electronic medical records, and acute sinusitis in adults.

INFORMATION FOR AUTHORS AND READERS

Papers submitted for publication should not have been published before or be currently submitted to any other journal. They should be typed, on one side of the paper only, in double spacing and with generous margins. A4 is the preferred paper size. The first page should contain the title only. To assist in sending out papers blind to referees, the name(s) of author(s) (maximum of eight), degrees, position, town of residence, address for correspondence and acknowledgements should be on a sheet separate from the main text.

Original articles should normally be no longer than 2500 words, arranged in the usual order of summary, introduction, method, results, discussion and references. Letters to the editor should be brief — 400 words maximum — and should be typed in double spacing.

Illustrations should be used only when data cannot be expressed clearly in any other way. Graphs and other line drawings need not be submitted as finished artwork — rough drawings are sufficient, pro-vided they are clear and adequately annotated.

Metric units, SI units and the 24-hour clock are preferred. Numerals up to nine should be spelt, 10 and over as figures. One decimal place should be given for percentages where baselines are 100 or greater. Use the approved names of drugs, though proprietary names may follow in brackets. Avoid abbreviations.

References should be in the Vancouver style as used in the Journal. Their accuracy must be checked before submission. The figures, tables, legends and references should be on separate sheets of paper. If a questionnaire has been used in the study, a copy of it should be enclosed.

Four copies of each article should be submitted and the author should keep a copy. Rejected manuscripts will be thrown away after three months. Two copies of revised articles are sufficient. A covering letter should make it clear that the final manuscript has been seen and approved by all the authors.

All articles and letters are subject to editing.

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More detailed instructions are published in the March issue.

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