practice records remain confidential, while others fear that personal revelations may affect future relationships with their doctors.) They should have debriefing sessions with their own counsellor at least monthly and should have a commitment to audit and reaccreditation.

Some practices may balk at this degree of rigour, especially given the relative scarcity of trained counsellors. We would be wise, however, to move slowly. Every family health services authority should enter into discussions with its general practitioners to establish guidelines for the employment of counsellors. It is important that the current demand for counsellors does not lead to a lowering of standards and that all counsellors in primary care are properly trained, supervised, and supported.

MIKE PRINGLE

Senior Lecturer,
Department of General Practice,
Nottingham Medical School,
Nottingham NG7 2UH

JOHN LAVERTY

Community Care Manager,
Lincolnshire Family Health Services Authority,
Lincoln LN4 2HN

1 Balint M. *The doctor, his patient and the illness*. London: Pitman, 1964.
2 Rowland N. Counselling and counselling skills. In: Sheldon M, ed. *Counselling in general practice*. London: Royal College of General Practitioners, 1992.
3 McLeod J. *The work of counsellors in general practice*. London: Royal College of General Practitioners, 1988. (Occasional paper 37.)
4 Mullen PD, Tabak ER. Patterns of counselling techniques used by family practice physicians for smoking, weight, exercise, and stress. *Med Care* 1989;27:694-704.
5 Sanders D, Fowler G, Mant D, Fuller A, Jones L, Marzillier J. Randomised controlled trial of anti-smoking advice by nurses in general practice. *J R Coll Gen Pract* 1989;**39**:273-6.
6 Slama K, Redman S, Perkins J, Reid ALA, Sanson-Fisher RW. The effectiveness of two smoking cessation programmes for use in general practice: a randomised clinical trial. *BMJ* 1990;**300**: 1707-9.
7 Townsend J, Wilkes H, Haines A, Jarvis M. Adolescent smokers seen in general practice: health, lifestyle, physical measurements, and response to antismoking advice. *BMJ* 1991;**303**:947-50.
8 Murphy PS. Effect of nutrition education on nutrition counselling practices of family physicians. *Acad Med* 1989;**64**:98-102.
9 Shute PA. Patients' alcohol drinking habits in general practice: prevention and education. *J R Soc Med* 1988;**81**:450-1.
10 Robertson C. Alcohol—a public health problem. Is there a role for the general practitioner? *J R Soc Med* 1990;**83**:232-5.
11 Holden JM, Sagovsky R, Cox JL. Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *BMJ* 1989;**298**:223-6.
12 Anderson S, Hasler J. Counselling in general practice. *J R Coll Gen Pract* 1979;**29**:352-6.
13 Holtedahl KA, Doumenc M, Steinert S, Roghell PK. Patients with sexually transmitted disease: a well-defined HIV risk group in general practice? *Fam Pract* 1991;**8**:42-7.
14 Clarke M. Sex and health promotion: the need for a new primary care initiative. *J R Coll Gen Pract* 1987;**37**:555-6.
15 Ashhurst PM, Ward DF. *An evaluation of counselling in general practice*. London: Mental Health Foundation, 1983.
16 Martin E, Martin P. Changes in psychological diagnosis and prescription in a practice employing a counsellor. *Fam Pract* 1985;**2**:241-3.
17 Robson MH, France R, Bland M. Clinical psychologist in primary care. *BMJ* 1984;**288**:1805-8.
18 Teasdale JD, Fennell MJV, Hibbert GA, Amies PL. Cognitive therapy for major depressive disorder in primary care. *Br J Psychiatry* 1984;**144**:400-6.
19 Earll L, Kincey J. Clinical psychology in general practice. *J R Coll Gen Pract* 1982;**32**:32-7.
20 Cade J, O'Connell C. Management of weight problems and obesity: knowledge, attitudes and current practice of general practitioners. *Br J Gen Pract* 1991;**41**:147-50.
21 Corney RH. Counselling in general practice—does it work? *J R Soc Med* 1990;**83**:253-7.
22 Waydenfeld D, Waydenfeld SW. Counselling in general practice. *J R Coll Gen Pract* 1986;**36**:671-7.
23 Corney RN. Marriage guidance counselling in general practice. *J R Coll Gen Pract* 1986;**36**:424-6.
24 Martin E. Counsellors in general practice. *BMJ* 1988;**297**:637-8.
25 Rowland N, Irving J, Maynard A. Can general practitioners counsel? *J R Coll Gen Pract* 1989;**39**: 118-20.
26 Shepherd S. Can general practitioners counsel? *J R Coll Gen Pract* 1989;**39**:304.
27 Gray PG. Counsellors in general practice. *J R Coll Gen Pract* 1988;**38**:50-1.
28 Gonzalez-Willis A, Rafi I, Boekeloo M, Bowman M, Sardeson K, Taggart V, *et al*. Using simulated patients to train physicians in sexual risk assessment and risk reduction. *Acad Med* 1990;**65**:S7-8.
29 Rudner HL, Bestvater D, Bader E. Evaluating family counselling skills training for family practice. *Med Educ* 1990;**24**:461-6.
30 Nickless S, Mathers D, Fender E, Garner J. Appointing counsellors in general practice. *Br J Gen Pract* 1990;**40**:478.
31 Sibbald B, Addington-Hall J, Brenneman D, Freeling P. Counsellors in English and Welsh general practices: their nature and distribution. *BMJ* 1993;**306**:29-33.
32 British Association for Counselling. *Invitation to membership*. Rugby: British Association for Counselling, 1989.
33 Newman CV. Advice on the appointment of psychologists and counsellors within general practice. *Br J Gen Pract* 1990;**40**:388-9.
34 Stott NCH, Pill RM. 'Advise yes, dictate no'. Patients' views on health promotion in the consultation. *Fam Pract* 1990;7:125-31.

Auditing *BMJ* decision making

We are setting targets and publishing how often we meet them

This is the age of accountability, and editors of medical journals must be as accountable as anybody else. When bodies as diverse as hospitals, railways, schools, and dust carts are having to publish data demonstrating their performance, medical journals need to join in. Editors might argue that because we live in a highly competitive world in which authors, readers, and advertisers can all go elsewhere with ease we are already sufficiently accountable. But we can do better: we can set ourselves targets and then let readers know if we reach them.

We are setting ourselves targets for the time we take to make decisions on papers submitted to us and then to publish the papers. We aim to make a decision within eight weeks on papers that go through our full peer review process and within two weeks for the papers that we reject in house. Most papers should then be published within eight weeks of acceptance, although short reports, drug points, and lessons of the week may sometimes take longer. Starting in July, every six months we will publish our median time to make a decision and publish original papers and the proportion of cases in which we have met our targets.

To the many *BMJ* readers who never submit a paper this may seem to be limited accountability, but the time that editors take to make decisions on publication is critical to authors. Borrowing an idea from the editors of the *Annals of Internal Medicine*, we have, in addition to setting targets for decision making and publication, developed what we call the "vital signs" of the *BMJ*. These signs include data on circulation; the number of papers and letters submitted for publication, pages published, and advertisements placed; data from readers on which papers they read and what they like and dislike; citation data; "influence data" (like mentions of the *BMJ* in parliament or the *New York Times*); and financial data. These data matter much more to us than they do to readers or authors, and so we don't plan to publish them regularly—unless readers tell us that they want them. For now we will restrict ourselves to data on decision making and publication times.

By the end of 1992 the *BMJ* had received about 4350 papers and 3500 letters for publication during the year (exact data are not available because this editorial was written before Christmas). About half of the letters are published, usually without external peer review as we publish as letters only those that relate to matters raised in the journal within the past six weeks. "Out of the blue" letters are considered as papers and submitted to full peer review.

About half of the papers are rejected after being read by two editors without being sent for external peer review. Papers are rejected at this stage because they are insufficiently original for the *BMJ*, carry no useful message for a general medical audience, or are seriously flawed scientifically or completely incomprehensible. If we think we see even the glimmering of an original, important, and scientifically sound message then we will give authors the benefit of the doubt and send the paper to an external referee. We don't send more papers out to external referees because we don't want to exhaust this

valuable resource (even though we have about 2500 referees on our database) and because we are the best judge of issues like whether the paper belongs in the *BMJ* or another sort of journal. Our target is to reject the papers not sent to external referees within two weeks, and we hope that this information may lead more authors who have scientifically sound papers but are worried that they may be too specialist for a general audience to let us see them. They will have lost little time if we do decide that they are too specialist.

The 2500 or so papers that are sent out go to one or more referees, and we ask the referees to return the papers within two weeks. Most of our referees are extremely busy, and they don't always manage to return the papers in time, although most of them do. This is the weakest link in the chain, and we have a system for chasing referees and eventually going elsewhere. One factor here is that we are increasing the number of referees we use outside Britain, and this may sometimes increase delay, although electronic communication is shrinking the globe fast.

Once returned the papers are considered by an internal editorial committee, and the 800 or so that may merit publication are passed on to one of our two "hanging committees" (named after the committee at the Royal Academy that decides which pictures to hang in the summer exhibition). Both hanging committees comprise two practising clinicians, a statistician, and two medically qualified editors; for the "general practice hanging committee" both clinicians are general practitioners. These committees make the final decision on publication, although we ask for almost every paper to be revised before publication. About 13% of papers submitted to us are published, and we aim to make this decision within eight weeks.

We expect that our median time to this decision will be less than eight weeks, and we have, in exceptional circumstances, peer reviewed papers and published them within a fortnight of submission. But just as all doctors have patients who consume disproportionate amounts of time so we have papers that slow us down. Sometimes we have problems finding a referee, or the perfect referee has gone to sea for a month, or the referee loses the figures and takes three weeks to ask for copies, or we have a furious debate over a paper at the hanging committee and decide that we need another specialist opinion. Authors can imagine for themselves how our process may stall, and we obviously have to balance the quality of the decision making against its speed.

The time to publication depends partly on how many papers we accept. All editors live between the Scylla of having insufficient papers in the system to allow efficient publication and the Charybdis of taking too long to publish. We must balance how many papers we accept and how many pages we have available. Our target is to publish original papers within eight weeks of final acceptance.

If targets are to have any meaning then they must be neither too easy nor too hard. The data we have at the moment suggest that we should reach our targets about 80% of the time, but our aim over the years will be not only to reach the targets in a higher proportion of cases but also to make the targets more difficult.

RICHARD SMITH

Editor, *BMJ*

Laser treatment of portwine stains

Newer lasers bring better treatments

A decade ago the argon laser was hailed as a "new ray of hope for portwine stains."[1] Was this optimism justified, and what of more recent rays of hope?

Portwine stains are composed of networks of ectatic vessels in the outer dermis under a normal epidermis. These birthmarks do not fade but mature and darken with age, with the relatively normal vessels of a juvenile mark undergoing degeneration with dilatation and stasis. About three per thousand children are born with a portwine stain. Regarded as untreatable before the advent of the argon laser, these stains almost always have a devastating effect on the person's quality of life.[2]

Many different argon laser techniques have been described,[3,4] but after analysis these are essentially the same, with laser-tissue interaction times that exceed the ideal (see below) by at least one order of magnitude. Success rates of 60-85% (subjectively assessed) have been reported for the treatment of mature portwine stains on the face in older patients.

The results in children, particularly younger than 10, are much less favourable. Severe atrophic or hypertrophic scarring occurs in at least 2% of adults and up to half of children.[3] Minor changes in the texture of the stain occur in half.[5] Histologically, the skin heals with a dermal scar[6] due to the non-specific accumulation of heat. Various computer assisted scanning devices have improved the results, and the European Community Haemangioma Working Party has stated that an argon laser should not be used without one of these devices or to treat children.[7]

Ideal treatment, by selective photothermolysis,[8] requires a wavelength that is minimally attenuated by epidermis and dermis and strongly absorbed by blood. Wavelengths of 577-590 nm are predicted as optimal, depending on the dermal blood content, and 585 nm is a good compromise.[9,10] Pulse durations of 0·5-5 ms produce only transmural injury to the vessel wall, by heat conduction from the hot red cells,[9] and hence prevent non-specific dermal injury. The spot size should be at least 3 mm and energy density 5-8 J/cm^2 to ensure deep injury of ectatic vessels.[9]

The argon laser cannot produce these ideal parameters, and neither can any of the recently introduced lasers such as the copper vapour,[11] the continuous dye,[12] and the frequency doubled neodymium yttrium aluminium garnet lasers.[13] Despite a limited, well documented depth of vascular injury[14] the argon laser in combination with automated scanning devices is often still considered the treatment of choice in mature portwine stain.

So far only the pulsed dye laser produces parameters that approach the theoretical ideal, and even then it is at the lower limit of the ideal pulse duration; Tan *et al* have shown that this laser can successfully treat children of any age with a negligible chance of scarring,[15] and our experiences confirm their findings. Although the pulsed dye laser is often considered of limited value in mature portwine stain, Tan has recently reported excellent results.[16]

Although the argon laser offered the best available treatment for a time, newer lasers have now superseded it. With output parameters within the ideal boundaries, the pulsed dye