prognosis for improvement is poor. Thus, for back pain, a longer duration of pain is a predictor of poor outcome.[5,7]

If a patient is not improving then he or she is more likely to be dissatisfied and seek alternative therapy. Pringle and Tyreman showed this is true: those who had previously attended their general practitioner were more dissatisfied, had significantly longer duration of symptoms (over six months) and had a worse outcome. I would suggest the same is also true for those who seek osteopathic help first, do not get better, and then seek help from their general practitioner. It can be concluded that patients fare better by being seen promptly but the type of practitioner does not matter.

M J B WILKINSON

249 Boldmere Road, Sutton Coldfield
West Midlands B73 5DL

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Colour blindness in doctors

Sir,

The paper by Spalding (January *Journal*, p.32) has prompted me to write regarding the practicalities of my colour vision defect, red blindness and green weakness. It must be remembered that loss in some areas may produce gain in others. People with red–green defects often see yellow and blue better than people with normal colour vision.

I am aware that I can detect jaundice more easily than contemporaries with normal colour vision. Urine dipstick reading does not present problems as the changes in hue and depth of colour compensate (besides, there is no harm in asking the patient to help). Despite having good blue vision, cyanosis presents a problem, presumably because people with normal red vision detect the lack of redness, rather than the presence of blue in blood. My greatest problem has been the 'pink' ear of otitis media. Other clues are used instead, for example, the eardrum looks darker, more shiny or opaque and there may be traction or bulging of the eardrum. Also there may be a clear history of earache following an upper respiratory tract infection. I call this a 'pink' eardrum and teach students such, not knowing what pink actually is.

Colour blind doctors cope by using other clues and experience, but teaching may present problems about which they should be aware. Perhaps the only task for which partially defective colour vision should be prohibitive is in the reading of computer assisted colour coding, such as in reading isotope scans or mammograms.

JOHN D FLETCHER

Wallacetown Health Centre, Lyon Street
Dundee DD4 6RB

General practice in deprived areas

Sir,

I was interested to read the editorial by Adrian Hastings and Ali Rashid (February *Journal*, p.47). As the authors emphasize, deprivation is a significant factor in the excess morbidity and mortality noted in many areas of the United Kingdom and as a result represents a very real challenge to those primary health care teams working in those areas.

Unfortunately the editorial fails to dismiss the myth that deprivation is solely a manifestation of urban areas or post-war housing estates. Deprivation also affects populations in non-urban and rural areas. These deprived populations seem largely ignored because the total population in any one area will be small when compared with the compact deprived populations in large cities or towns. Nonetheless, the total affected population nationwide is large. These populations not only face the difficulties of those living in inner city areas but also a lack of services, for example geographically convenient health care (both hospitals and general practice surgeries), social service provision (offices, child care facilities and so on), post offices, shops, unemployment offices, and perhaps most importantly public transport.

In Leicestershire most of the public monies, for example for child care facilities, are directed toward the inner city areas all too familiar to Hastings and Rashid. However, when parameters of deprivation such as unemployment, single parent families, child abuse, social work intervention and so on are considered one comes up against the uncomfortable fact that deprivation is at least as bad, if not worse, in some of the rural areas of Leicestershire (personal communication). Talking to colleagues in similar rural areas nationwide it would appear that this is far from being an unusual experience.

I do not wish to devalue or belittle the problems of deprivation in inner city areas but rather to ensure that the issue of growing rural and non-urban deprivation is given the coverage it deserves.

DAVID SOWDEN

18 Tower Gardens, Ashby de la Zouch
Leicestershire LE65 2GZ

Sir,

I read the editorial by Hastings and Rashid (February *Journal*, p.47) with great interest as I work in a deprived area of central Preston and know only too well the sense of frustration experienced by health care professionals. I was somewhat surprised, however, to learn of their ideas for involving the doctor in community issues such as visiting day nurseries and talking to school children. They talk of salaried general practitioners, able to 'concentrate on using their medical skills without having to devote time to financial concerns' — a perfect description of a clinical medical officer.

There exists within the school health service a highly motivated team of medical officers and nurses. For these health professionals the community issues described above are but a fraction of their daily work. Their work in community child care clinics is already being eroded by general practitioners taking on developmental checks and immunizations but they still have a great deal of expertise and time to offer patients, without any financial axe to grind.

Since working in this field I have discovered how little many general practitioners know of the school health service. It would seem prudent to avoid duplication by encouraging general practitioners to use an existing service and skills, thereby freeing themselves for other work.

BERNITA LLOYD

Geoffrey Street Health Centre
Off New Hall Lane
Preston PR1 5NE

James Mackenzie

Sir,

Godfrey Fowler's James Mackenzie lecture (February *Journal*, p.78) contained a