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

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.

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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.

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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.

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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.

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James Mackenzie

Sir,

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