their name and address, and the purpose of the study.

While we appreciate Dr Scriven's concerns about confidentiality, our research was aimed at developing and improving patient care by investigating integrated (or shared) care for asthma patients. Such developments must be properly evaluated, and the cooperation of general practitioners and patients is required in these investigations.

SUE ROSS

Health Services Research Unit
Department of Public Health
University of Aberdeen
Drew Kay Wing, Polwarth Building
Foresterhill
Aberdeen AB9 2ZD

Response rates in general practice studies

Sir,

Baker has recently noted that 'There is a depressing reduction in the proportion of general practices taking part in research' and suggests that increased pressure of work and changing attitudes among general practitioners towards research may explain this trend (letter, July *Journal*, p.307). There are a number of pertinent questions that should be raised by those of us working in university departments of general practice in an attempt to explain low response rates in general practice studies.

First, when requiring their participation do we fully consider general practitioners' work commitment? Bowling and colleagues have noted a reluctance by general practitioners to answer questionnaires because of the volume they receive.[1] Surveys carried out during the past five years may have experienced low response rates because of the new contractual changes that have occurred in general practice. These changes have increased general practitioners' workload[2] and have had effects upon their stress levels, job satisfaction and mental health.[3] There is also evidence that there is resentment by service general practitioners, the 'miners', towards their academic counterparts, the 'geologists', and this may limit their willingness to participate.[4–7]

Secondly, are our studies always adequately funded? Response rates to mailed questionnaires are dependent upon the level of funding available. Low budget studies are least likely to follow up non-respondents and therefore cannot expect adequate response rates.[8]

Thirdly, can we assume that all general practitioners want to participate in our research? Cockburn and colleagues found that general practitioners may be opposed to the methods used, hostile to or uninterested in research or may be reluctant to participate following discussions with practice partners.[9] They found that there were no significant differences in practice size, general practitioners' sex and number of postgraduate qualifications between respondents and non-respondents, but reported a non-significant trend whereby response rates decreased as age and general practitioner experience increased. Subjects will have the motivation to respond only if they are involved in the subject matter of the survey[10] and general practitioners will not complete questionnaires if they disagree or dislike the topic being investigated.[11]

Fourthly, is our work perceived as a threat by general practitioners? While carrying out a quality of care study, Borgiel and colleagues realized that general practitioners were highly individualistic and were resentful of any interference in their activities.[12] They found that the best method of approach was to encourage personal contacts between the recruiters and the general practitioners. Cartwright and colleagues explored the reasons why a study that intended to analyse doctor–patient relationships attracted a response rate of only 18%.[13] They concluded that the proposed study encroached on the confidential nature of these relationships and was perceived by general practitioners as being threatening and was also seen as a potential disruption to the work of the practice.

Lastly, is the information about the study we give to general practitioners enough for them to be tempted to participate? Two research teams have suggested that raising the quality of the information given to general practitioners about proposed studies will not only improve response rates but also enhance the value of the data collected.[14,15]

Richard Baker is correct in saying that the reasons for the decrease in general practitioner participation in research should be analysed. Yet, it is also important to scrutinize the manner in which researchers seek their general practitioner participants.

PAUL MCDONALD

Department of General Practice
University of Nottingham
Queen's Medical Centre
Nottingham NG7 2UH

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Diabetic non-attenders

Sir,

I read with interest the paper by Thomas and colleagues discussing the targeting of long-term non-attenders in general practice (July *Journal*, p.285) and, although agreeing that this is often a fruitless occupation, I feel some groups warrant such action.

Diabetes mellitus is a common condition, non-insulin dependent diabetes affecting up to one in 10 of us before we die.[1] Non-attendance rates in hospital diabetic clinics are high,[2,3] and the view of some hospital doctors that these patients can always be screened by their general practitioner may be misleading. In the same issue, Tunbridge and colleagues discussed an approach to auditing health care for non-insulin dependent diabetic patients and found that up to 14% of their diabetic patients were non-attenders at both hospital and general practice clinics (July *Journal*, p.291). In view of the high prevalence of complications in these patients (diabetic retinopathy is present in 38% of patients at diagnosis[4]) an aggressive approach by both hospital physicians and general practitioners must ensure that screening is carried out regularly. Non-attenders will always exist, especially with diseases such as diabetes where major lifestyle changes may be needed, but we

are all responsible for making their numbers as small as possible.

KEVIN SHOTLIFF
Diabetic Retinopathy Unit
Royal Postgraduate Medical School
Hammersmith Hospital
Du Cane Road
London W12 0NN

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Complaints procedure

Sir,

May I congratulate Alastair Donald on his editorial (July *Journal*, p.270). It is reassuring to see the president of the Royal College of General Practitioners come to the aid of a member, Colin Waine, who has by all accounts been unjustly treated. The present complaints procedure is unjust and it would be of benefit to the profession if the RCGP turned its attention to addressing some of the problems inherent in it.

Though the system undoubtedly has faults, there is I believe a deeper malaise. That a complaint about a self-limiting condition should ever reach the stage of a formal hearing seems absurd. We have as a profession, over the past 20 years, been reluctant to define our limitations. The effect of this is that general practitioners are now presumed to be competent at dealing with everything from thrombolysis to school refusal 24 hours a day, seven days a week.

By not defining our professional responsibilities more clearly, by not stating what we consider to be practicable and desirable general practice, by not limiting our professional competence to areas we can deal with efficiently and effectively, we have attempted to become all things to all people. We have set ourselves up as curers of all ills and providers of all services. We have consequently created expectations, both from the public and the government, that we are unable to meet. Two phrases 'The general practitioner is ideally placed...'[1] and 'general practitioners should...'[2] often appear in articles by general practitioners or specialist doctors who attempt to define the role of general practice. It is only a matter of time before as general practitioners we will find ourselves in breach of our terms and conditions of service for not providing services that the public expect but which we know from scientific studies to be worthless. Alastair Donald rightly states that fear of litigation is a major deterrent to young doctors entering general practice.

Perhaps it is an opportune time for the RCGP to do two things. First, it could review the complaints procedure and, with the General Medical Services Committee, make strong and consistent representations to the Department of Health for the procedure to be altered. Secondly, it could look again critically at its own role in promoting what many general practitioners consider unreasonable, unnecessary and unproven obligations on general practice. A redefinition of our generalist role, that bears a relationship to the day to day expectations of working general practitioners is long overdue.

D BLANEY
Laggan Leigheas
Killin
Perthshire FK21 8TQ

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Who will guard the guards themselves?

Sir,

I am disappointed that the president of the Royal College of General Practitioners should give the title in Latin of his sensible editorial about complaints (July *Journal*, p.270).

Many current general practitioners graduated at times when Latin was not a requirement to enter medical school. Perpetuating its use in the *Journal* in this way seems to me to alienate such doctors from the RCGP.

Latin is also used as a secret code between health professionals that alienates patients. It can deny patients information about their health to which they are entitled. The journal of a specialty that prides itself in communication between doctor and patient should abandon its use.

ADRIAN ELLIOT-SMITH
Health Centre
Queensway
Billingham
Cleveland TS23 2LA

Colour blindness in doctors

Sir,

John Fletcher's letter (June *Journal*, p.262) describes some of the difficulties a doctor can have in clinical work if suffering from inherited defective colour vision. There have been other reports of these problems.[1,2] Doctors would be better able to adjust if they knew the type and severity of their defect, but commonly they do not. It seems clear that testing and advice for the defect should be a part of student health services.

However, more evidence is needed about when difficulties occur and how they are best overcome. It is to this end that I ask doctors with inherited defective colour vision to contact me, and to do this even if they believe that their defect is mild. I would then ask them to complete a questionnaire about their observations. Their names will not, of course, be included in any publication and will be in complete confidence. Their cooperation would go a long way towards helping doctors and medical students with this defect who at present receive little or no advice.

J A B SPALDING
5 Curzon Road
Weybridge
Surrey KT13 8UW

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College plane trees

Sir,

Some 30 or so years ago the then College of General Practitioners distributed seedlings which were described as descendants of the plane tree on Cos under which Hippocrates taught. I visited mine recently and despite two transplantings and spending most of its life some 600 feet above sea level in West Yorkshire in a garden facing the east and sloping to the north it has achieved a height of some 40 feet and a girth at three feet above the ground of two feet six inches. I should be interested to hear how others have fared.

D A MACLEOD
49 Plantation Road
Harlow Hill
Harrogate
North Yorkshire HG2 0DB