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

References

1. Bowling A, Jacobson B, Southgate L, Formby J. General practitioners' views on quality specifications for 'outpatient referrals and care contracts'. *BMJ* 1992; **303;** 292-294.
2. Hannay D, Usherwood T, Platts M. Workload of general practitioners before and after the new contract. *BMJ* 1992; **304:** 615-618.
3. Sutherland VJ, Cooper CL. Job stress, satisfaction and mental health among general practitioners before and after introduction of the new contract. *BMJ* 1992; **304:** 1545-1546.
4. Bichard A. Working at the coalface: miner or geologist? [editorial]. *Br J Gen Pract* 1991; **41:** 4-5.
5. Pitts J. General practice research in the *Journal* [letter]. *Br J Gen Pract* 1991; **41:** 34-35.
6. Hooper PD. General practice at the coalface [letter]. *Br J Gen Pract* 1991; **41:** 170.
7. Sterland JS. General practice at the coalface [letter]. *Br J Gen Pract* 1991; **41:** 170.
8. Bailey K. *Methods of social research.* Third edition. London: The Free Press,1987.
9. Cockburn J, Campbell E, Gordon JJ, Sanson-Fisher RW. Response bias in a study of general practice. *Fam Pract* 1988; **5:** 18-23.
10. Mayer CS, Pract RW. A note on nonresponse in a mail survey. *Public Opinion Quarterly* 1966; **30:** 637-646.
11. Cartwright A. Professionals as responders: variations in and effects of response rates to questionnaires, 1961–77. *BMJ* 1978; **2:** 1419-1421.
12. Borgiel AEM, Dunn EV, Lamont CT, *et al.* Recruiting family physicians as participants in research. *Fam Pract* 1989; **6:** 168-172.
13. Cartwright A, Lucus S, O'Brien M. Some methodological problems in studying consultations in general practice. *J R Coll Gen Pract* 1976; **26:** 894-906.
14. Murphy E, Spiegal N, Kinmonth AL. 'Will you help me with my research?' Gaining access to primary care settings and subjects. *Br J Gen Pract* 1992; **42:** 162-165.
15. Kocken RJJ, Knottnerus JA, Smeets PELM. GPs as participants in scientific research [letter]. *Br J Gen Pract* 1993; **43:** 305.

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