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<th>Non-attendance at outpatients departments. More information was needed for non-UK readers</th>
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<td><strong>Author(s)</strong></td>
<td>Castan-Cameo, S; Johnston, JM; McGhee, SM</td>
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We suggest that using appropriate treatment to prevent iatrogenic exacerbation of a disease that is distressing, disfiguring, and difficult to treat is entirely consistent with Ahlquist’s philosophy of first do no harm.

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Authors’ reply

Editor—Ahlquist suggests that the adverse effects of corticosteroid treatment outweigh the beneficial effect on the course of thyroid eye disease after radiiodine treatment. With regard to patients without pre-existing ophthalmopathy we agree, as the study of Bartalena et al showed a low risk (1%) of severe eye disease developing de novo. Of 72 patients with mild ophthalmopathy at baseline (defined as mild conjunctival oedema and periorbital inflammation) who were not treated with steroids, however, 17 (24%) showed a deterioration in their eye disease after radiiodine treatment. Although in many cases this was transient (lasting two to three months), it is nevertheless likely to have caused distress to those who were affected. Even more importantly, seven (10%) patients had an exacerbation requiring orbital radiotherapy and high dose steroid treatment. Adjuvant steroid treatment substantially reduces the risk of exacerbation of thyroid eye disease to < 1%.

We believe that a 24% risk of a short term deterioration in thyroid eye disease and a 10% risk of a more prolonged and severe exacerbation justify the risks of adjuvant, moderated dose corticosteroid treatment. We do not underestimate the problems that some patients experience from preiodoselone treatment at a mean dose of 20 mg daily for three months, but similar doses are widely used to treat conditions such as polymyalgia rheumatica and ashenia, with few long term adverse effects over this period.

Limiting treatment to patients with mild eye disease (and avoiding radioidine treatment in patients with moderate, severe, or active eye disease) means that only one patient with Graves’ disease in five who are referred for radiiodine will require cortico- steroid treatment. At the very least, the 24% risk of exacerbation of thyroid eye disease needs to be fully discussed with the patient. Trials to see if lower steroid doses are effective would be desirable but, in view of the number of patients required, would prove a major undertaking.

Non-attendance at outpatients departments

More information was needed for non-UK readers

Editor—The trial by Hamilton et al examining the effect of giving patients a copy of their referral letter on non-attendance at outpatients departments raises several interesting and controversial issues, but it is difficult to assess for an international audience who may not be familiar with the British healthcare system. This issue of being international has been raised by others, and surely if the BMJ aspires to be an international journal, the research setting needs to be clarified for international readers.

For example, what is the usual referral procedure in the United Kingdom? In Hong Kong a referral letter is always given to the patient and is required for access to secondary care. Patients make their own appointments. Hamilton et al also fail to establish the justification for the research under discussion.

What was the rationale for this randomised controlled trial? They hypothesise that a lack of communication between the doctor and the referring doctor is the cause of non-attendance. If so, how will a copy of the referral letter be expected to improve this communication or guarantee attendance? An explanation of the topic antecedents and justification of the research question are required together with a discussion of the cost implications of this intervention.

Although Hamilton et al quote a national (England or United Kingdom) non-attendance rate of 12%, their own study had a much lower non-attendance rate. The situation in Hong Kong is very different, despite patients receiving a referral letter, and such low rates would be welcomed in Hong Kong. The authors offer no explanation to account for the difference between the study and the national non-attendance rates. This may be due to the study selection criteria. Excluding patients because of severity of disease, previous suboptimal care, or patients’ attitude or lifestyle may have biased the sample and led to an incorrect estimate of the non-attendance rates. The intervention was intended to reduce non-attendance and it did not target the appropriate population, the non-attenders. As the authors have not specified the reasons for patients’ non-attendance, the reader does not know whether the intervention is appropriate.

The BMJ is a widely read journal, and to reach an international audience enough information should be provided to facilitate the assessment of the research and its potential for application elsewhere.

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Key messages did not accurately summarise the study

Editor—We should like to suggest two additional “key points” for the paper by Hamilton et al concerning hospital attendance rates. Firstly, the setting may affect the ability of a randomised controlled trial to produce valid results, and, secondly, the BMJ key messages boxes may not provide a reliable summary of the data contained in the paper.

Non-attendance at hospital outpatient departaments wastes resources, frustrates staff, and may result in unmet health needs. However, chance, human nature, and the complexities of modern life make it unlikely that 100% attendance will ever be achieved, whatever measures are used. The authors quote a national non-attendance rate of 12% and studies showing a range from 9.9 to 29%. Yet only 6% of the patients in their pilot study did not keep their hospital appointments; this level is so low that we wonder whether it is possible to reduce it further.

The first key point in the box asserts that copy letters do not reduce non-attendance at hospital outpatient departments. This has been demonstrated in an area where non-attendance was already half the national average, but we know nothing about the effectiveness of the intervention elsewhere. If the underlying hypothesis about the relation between information sharing and non-attendance is true, the low rate in their area may reflect doctor-patient communication that is already optimal.

In Hong Kong a referral letter is always given to the patient and is required for access to secondary care. Patients make their own appointments; this level is so low that we wonder whether it is possible to reduce it further.

The second key point states that the concept of copying letters to patients is acceptable to doctors and patients. The perceived acceptability of the copy letter was investigated in a questionnaire sent to participating practices, and all were prepared to send copy letters if they were shown to be beneficial and the cost could be offset. Ten of the 13 practices received positive comments from patients. However, we do not know how many patients had...
Authors’ reply

Enntror—Castan-Cameo et al comment that international readers may be unused to the United Kingdom’s system of referral. In brief, a referral decision is made between patient and general practitioner; the general practitioner writes to the hospital consultant, and an appointment is sent to the patient by post from the hospital. Our hypothesis was that offering information to patients would perhaps allow them to make a more informed decision on the value of attending. The written summary that the copy letter provided should have allowed patients to reflect on their condition, perhaps increased their understanding, and given an opportunity for further discussion with their general practitioner or family and friends. We expected increased attendances, increased cancellations, and reduced non-attendances.

Both Castan-Cameo et al and Lawlor and Hanratty must have missed our first sentence, which stated that the 12% figure included new and follow up appointments; follow up appointments have a higher non-attendance rate,1,2 but our study only targeted new appointments. They are the appointments most influenced by the general practitioner. It may prove impossible to reduce new patient non-attendance from 6%, but at £65 per appointment even small reductions are worth while. Castan-Cameo et al wonder if the low non-attendance rate was due to exclusions; not so, only 117/2078 (5.6%) were excluded. Cameo et al wonder if the low non-attendance rate, follow up appointments have a higher non-attendance.

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4 Partridge JW. Consultation time, workload, and problems from the randomisation and only four so, only 117/2078 (5.6%) were excluded attendance rate was due to exclusions; not

Risk of medicine and air travel

Editor—Berwick and Leape draw comparisons between the risks of delivering health care to patients and the safety statistics of airline travel,1 with air travel being over 10 000 times safer for the passenger than medicine for the patient. Although nobody doubts the importance of designing safer healthcare systems that reduce adverse effects, serious drug errors, etc, this comparison is fundamentally flawed. It is not simply because old aeroplanes are grounded before they fall out of the sky.

More importantly, if you want to compare health care with aviation then like should be compared with like—that is, care of the patient with the aeroplane itself and not with the individual passenger. If a separate team looked after each patient or, conversely, if the team flying the aeroplane flew twenty or more planes simultaneously, as is the case with patient care in hospitals, safety indicators of these two different fields would be closer. Problems with air controllers over London, a recent hot topic in the media, also illustrate this. On the other hand, in surgery the presence of a well staffed high dependency unit reduces complication rates: where funds are available for an increased number of trained staff to look after patients then complications and presumably the rate of adverse effects are reduced.1

Further research is necessary. In the meantime superficial comparisons worthy more of a tabloid newspaper than the BMJ are best avoided; they may harm patient care by obscuring important contributing factors to current difficulties in delivering health care.

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