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<th>Non-attendance at outpatients departments. More information was needed for non-UK readers</th>
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Bartalena et al did not go so far as to advocate routine glucocorticoid treatment for all patients with mild ophthalmopathy who receive radioactive iodine, and with good reason. Clinical trials showing that a treatment is effective are immensely useful but need to be supported by further, balanced evaluation of the risks and benefits of treatment before the original demonstration of efficacy is translated directly into routine clinical practice—a message for all clinicians, not just endocrinologists. First do no harm.

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Non-attendance at outpatient 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 out-patient 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 not be familiar with the British healthcare system. This issue of being international has not be familiar with the British healthcare system. This issue of being international has not be familiar with the British healthcare system. This issue of being international has not be familiar with the British healthcare system.

Firstly, the setting may affect 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 patient 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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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 radioactive iodine. 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 radioactive iodine 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 of their disease that is distressing, disfiguring, and difficult to treat is entirely consistent with Ahlquist’s philosophy of first do no harm.

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 adjunct, moderated dose corticosteroid treatment. Adjuvant corticosteroid treatment at a substantially lower dose reduced the risk of exacerbation of thyroid eye disease to < 1%.

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commented, and as the patients were not approached directly these views may not be representative. The third key point, that it may be possible to apply interventions from primary care to reduce non-attendance, is intuitive but cannot be deduced from any of the data presented.

This study used a practical intervention to address an important problem, but we would like to see it repeated in a different setting before the copy letter is dismissed as ineffective.

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Barbara Hanratty visiting lecturer in public health medicine

1 Hamilton W, Round A, Sharp D. Effect on hospital attend-
ance rates of giving patients a copy of their referral letter: randomised controlled trial. BMJ 1999;318:1392-5 (22 May).
3 Partridge JW. Consultation time, workload, and problems from the randomisation and only four non-attendences were well researched, 3.6% of these failed to attend. Reasons for non-attendance are well researched, but it is difficult to establish acceptability, this has been having the pilot study (when patients were directly approached), 3 our study confirmed that patients and doctors seemed satisfied with the process. Finally, we consider that the trial did establish the feasibility of applying interventions from primary care to reduce non-attendance because this is what we actually did. It is a pity that it did not work.

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Authors’ reply

Editor—Castan-Cameo et al comment that international readers may be unsure of 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, 1-3 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 1 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 from the randomisation and only four (3.0%) of these failed to attend. Reasons for non-attendance are well researched, 4 such as forgetting or not receiving the appointment or getting better.

Lawlor and Hanratty consider our key points unrepresentative of the paper. However, it is incorrect to say that the setting affects the ability of a randomised controlled trial to produce valid results. Validity depends on the design and conduct of a trial. Perhaps what they intended to say was that the results of a trial in one setting may not be applicable in another—we agree with this. Our study was representative of patient behaviour in one geographical area. Although the trial was not primarily designed to establish acceptability, this having been tested in the pilot study (when patients were directly approached), 3 our study confirmed that patients and doctors seemed satisfied with the process. Finally, we consider that the trial did establish the feasibility of applying interventions from primary care to reduce non-attendance because this is what we actually did. It is a pity that it did not work.

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Anaesthetists need consent, but not written consent

Editor—Dobson’s article concerning information and consent for anaesthesia appeared under the headline “Anaesthetists do not need separate consent before surgery,” and stated that “New guidelines on obtaining consent for anaesthesia recommend that consent from patients specifically for a general anaesthetic is not needed.” These statements are incorrect, and I believe that they may mislead readers.

The guidelines issued by the Association of Anaesthetists of Great Britain and Ireland state that express consent may be obtained orally or in writing. As Dobson indicated correctly, the working party saw no virtue in getting the patient to sign a separate consent form for general anaesthesia. However, we indicated explicitly that, if oral consent is obtained, then an entry should be made in the clinical records indicating the advice which was given and that consent was provided. In the final section of the recommendations, we made the following statement: “The anaesthetist should make a record of the anaesthetic techniques (e.g. general anaesthesia, regional anaesthesia, local anaesthesia, or a combination) which have been discussed with and agreed by the patient, and should list the material risks which have been explained.”

The working party believed that discussion with and provision of information to patients about anaesthesia is vitally important. We wished to emphasise that two way communication is more important than merely obtaining a signature on a consent form and were keen that anaesthetists should not be misled into believing that a signature on a consent form is evidence that valid consent has been obtained. It is regrettable that Dobson’s article equated consent with written consent and failed to acknowledge the clear signal in the document that competent patients must be given appropriate information, and must give consent, before any anaesthetic procedure.

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Risks 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 passenger 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. 2

Further research is necessary. In the meantime superficial comparisons worthy 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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