

routinely. Bartalena et al did not go so far as to advocate routine glucocorticoid treatment for all patients with mild ophthalmopathy who receive radioiodine, 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.

James Ahlquist *consultant endocrinologist*
Endocrine Unit, Southend Hospital SS0 0RY
drahlquist@southend-hospital.thenhs.com

- 1 Walsh JP, Dayan CM, Potts MJ. Radioiodine and thyroid disease. *BMJ* 1999;319:68-9. (10 July.)
- 2 Bartalena L, Marcocci C, Bogazzi F, Manetti L, Tanda ML, Dell'Unto E, et al. Relationship between therapy for hyperthyroidism and the course of Graves' ophthalmopathy. *N Engl J Med* 1998;338:73-8.

Authors' reply

EDITOR—Ahlquist suggests that the adverse effects of corticosteroid treatment outweigh the beneficial effect on the course of thyroid eye disease after radioiodine 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.¹

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 radioiodine 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 at a substantially lower dose reduced 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 prednisolone 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 asthma, with few long term adverse effects over this period.

Limiting treatment to patients with mild eye disease (and avoiding radioiodine treatment in patients with moderate, severe, or active eye disease) means that only one patient with Graves' disease in five who are referred for radioiodine will require corticosteroid 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.

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.

John P Walsh *consultant endocrinologist*
Sir Charles Gairdner Hospital, Nedlands,
Western Australia 6009, Australia

Colin M Dayan *consultant senior lecturer*
University Division of Medicine, Bristol Royal
Infirmary, Bristol BS2 8HW

- 1 Bartalena L, Marcocci C, Bogazzi F, Manetti L, Tanda ML, Dell'Unto E, et al. Relation between therapy for hyperthyroidism and the course of Graves' ophthalmopathy. *N Engl J Med* 1998;338:73-8.

Non-attendance at outpatients departments

More information was needed for non-UK readers

EDITOR—The trial by Hamilton et al¹ examining the effect of giving patients a copy of their referral letter on non-attendance at outpatient 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,² 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 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 speci-

fied 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.

Susana Castan-Cameo *demonstrator*
sccastan@hkusua.hku.hk

Janice Johnston *coordinator, expert subcommittee on grant applications and awards*

Sarah McGhee *director of health services research group*

Department of Community Medicine, University of Hong Kong, Hong Kong

- 1 Hamilton W, Round A, Sharp D. Effect on hospital attendance rate of giving patients a copy of their referral letter: randomised controlled trial. *BMJ* 1999;318:1392-5. (22 May.)
- 2 Smith R. Avoiding becoming the English Medical Journal. *BMJ* 1999;318:1158-59. (1 May.)

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.¹ 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 departments 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%.²⁻³ 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. Influences on attendance may also vary as the rates change, and qualitative research to generate further hypotheses is probably needed.

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

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.

Debbie Lawlor *visiting lecturer in public health medicine*

Barbara Hanratty *visiting lecturer in public health medicine*
hssbh@leeds.ac.uk

Nuffield Institute for Health, University of Leeds, Leeds

- 1 Hamilton W, Round A, Sharp D. Effect on hospital attendance rates of giving patients a copy of their referral letter: randomised controlled trial. *BMJ* 1999;318:1392-5 (22 May).
- 2 Andrews R, Morgan JD, Addy DP, McNeish AS. Understanding non-attendance in outpatient paediatric clinics. *Arch Dis Child* 1990;65:192-5.
- 3 Partridge JW. Consultation time, workload, and problems for audit in outpatient clinics. *Arch Dis Child* 1992;67:206-10.

Authors' reply

EDITOR—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,¹⁻³ 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 appointment² 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 (3.6%) 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),⁵ 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.

William Hamilton *general practitioner*
12 Barnfield Hill, Exeter EX1 1SR
barnfield.hill.research@which.net

Alison Round *consultant in public health medicine*
North and East Devon Health Authority,
Southernhay East, Exeter EX1 1PQ

Deborah Sharp *professor of primary health care*
University of Bristol, Bristol BS8 2PR.

- 1 King A, David D, Jones HS, O'Brien C. Factors affecting non-attendance in an ophthalmic outpatient department. *J R Soc Med* 1995;88:88-90.
- 2 Stone C, Palmer J, Saxby P, Devaraj V. Reducing non-attendance at outpatient clinics. *J R Soc Med* 1999;92:114-8.
- 3 Andrews R, Morgan JD, Addy DP, McNeish AS. Understanding non-attendance in outpatient paediatric clinics. *Arch Dis Child* 1990;65:192-5.
- 4 Pal B, Taberner D, Readman L, Jones P. Why do outpatients fail to keep their clinic appointments? Results from a survey and recommended remedial actions. *Int J Clin Pract* 1998;52:436-7.
- 5 Hamilton W, Round A, Taylor P. Dictating clinic letters in front of the patient. *BMJ* 1997;314:1416.

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."¹ 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 should be obtained for any procedure which carries a material risk. The working party noted 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 are 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.

Alan Aitkenhead *professor of anaesthesia*
University of Nottingham, Nottingham
Alan.Aitkenhead@nottingham.ac.uk

- 1 Dobson R. Anaesthetists do not need separate consent before surgery. *BMJ* 1999;319:142. (17 July.)

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 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.²

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.

Amanda Bisset *specialist registrar in radiology*
Southampton General Hospital, Southampton
SO16 6YD
106265.1352@compuserve.com

Gabor Libertiny *specialist registrar in surgery*
Royal Berkshire Hospital, Reading RG1 5AN