LETTERS

Note to authors of letters: Please note that all letters submitted for publication should be typed with *double spacing*. Failure to comply with this may lead to delay in publication.

Cancellation and default from appointments in primary care

Sir,

Cancelled and defaulted appointments have important implications for the running of our practices. The pressure of the new contract is for us to provide a hospital-type outpatient service with a variety of clinics. It seems likely that patients attending clinics for ongoing problems such as hypertension or diabetes will be invited to book an appointment from one clinic attendance to the next. On the evidence available, doctor initiated and advanced booked appointments have a poorer record of attendance than patient initiated ones in primary care.[1] While the reasons for patients defaulting from appointments have been extensively documented[2] relatively little is known about cancelled appointments.

With this in mind a record was kept of the number of patients who cancelled or defaulted, with cancellations arbitrarily divided into those giving less than half an hour's notice, one half to two hours' notice, two to six hours' and over six hours' notice in October 1988 and 1989. This record was kept at our two premises, one in suburban Glasgow and the other in a village, each of which serves approximately 3000 patients. In addition a retrospective analysis of the attendances in October 1987 was carried out at the suburban surgery by inspecting the notes of all the patients who had appointments and ascertaining as far as possible who had attended and who had not. The 17 patients whose records had been withdrawn were assumed to have attended.

The results were given in Table 1 along with the total number of consultations for the periods involved. Three patients actually called after the scheduled appointment to cancel. Fifteen patients appeared to have defaulted from the suburban surgery in 1987 but this number almost certainly included some who cancelled at short notice.

The number of patients defaulting is not increasing but those who do cancel have more than doubled at our village surgery. The latter may seem to have defaulted because their names appear on the doctor's appointment list and their records on the consulting room desk indicating that they cancel after consulting has started. Such appointments are wasted, since shorter notices lessen the likelihood that the appoinmtent can be reallocated. These late cancellations represent an increased workload for our reception staff, involving more patient/staff contacts as these patients make (and break) further appointments.[2] Habitual defaulters or patients prone to cancelling could be given appointments at the end rather than the beginning of a surgery or unpopular appointment times could be double booked, as happens in the United States of America. This would help the doctor to use the time more efficiently[3] but it presupposes that these patients would accept appointments at the time which the practice allocates to them rather than the time they choose. It also presumes that our staff have a knowledge of the vagaries of all our patients.

The introduction of more health promotion and disease management clinics would result in patients finding it increasingly difficult to book an appointment for the day and time of their choice. The new contract encourages general practitioners to provide a structured service rather than a demand led one. The result may well be unattractive to patients if this means less time for 'ordinary' appointments.

Table 1. Duration of notice given of cancellation of appointments and number of defaulted appointments.

	Number of appointments			
	1988		1989	
	Sub-urban surgery	Village surgery	Sub-urban surgery	Village surgery
Patient defaulted	10	5	4	5
Patient cancelled with notice				
<0.5 hrs	6	4	6	9
0.5–2 hrs	7	6	10	14
2–6 hrs	6	5	0	18
6+ hrs	16	9	11	16
Total	35	24	27	57
Patient attended	644	628	634	666

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General practice research in the *Journal*

Sir,

It is interesting to note the change in the origins of the first/main authors of papers in the *British Journal of General Practice* over the last 10 years. The majority of first authors of papers published now come from academic units, other disciplines and other countries, while contributions from mainstream UK general practice have fallen from one half to one third. Still fewer now originate from general practice trainees. The source of some papers is open to interpretation, particularly in the early years of this decade; however, the data in Figure 1 shows a clear trend in the proportion of papers having an 'ordinary' general practitioner or general practitioner trainee as main author.

Although academic departments have much to offer in methodology and breadth of thought, general practice, at the grassroots, is becoming underrepresented in the *Journal*. This could be due to lack of motivation, lack of ideas, or lack of ability, but whatever the reason,

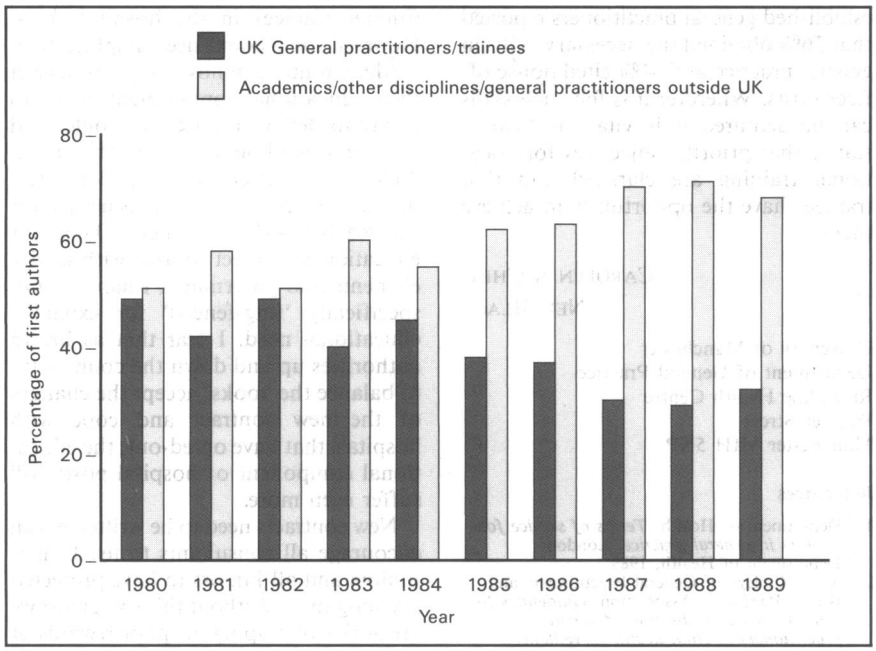

Figure 1. *Proportions of papers in the* British Journal of General Practice *with UK general practitioners/trainees or academics/others as first author.*

the relevance of the *Journal* to the 'ordinary' UK general practitioner is now being questioned. This is happening at a time when the role and relevance of the Royal College of General Practitioners itself is under scrutiny. A great deal is learned from research and audit within practices but a change in editorial policy away from strict quantitative methods, and towards a section where ideas could be floated could go some way to redressing these issues.

Without some form of committed support and encouragement, and with the increased workload of the imposed contract, this trend is likely to continue.

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Training for the new contract

Sir,

The paper by Dr Kearley (October *Journal,* p.409) and letter from Dr Castle (October *Journal* p.430) were particularly timely.

The trainee sub-committee of the north west England faculty of the Royal College of General Practitioners are concerned that general practitioner trainees may not be equipped to deal with many aspects of the new contract.[1] We are aware of problems that have arisen over inclusion of general practitioners on the new minor surgery and child health surveillance lists. We therefore carried out a study in April 1990 to assess trainees' confidence, training and experience in these areas.

Questionnaires were distributed by course organizers and completed by trainees in general practice on their day release course. Questions were included on the nature of the training scheme (organized or self-construct), additional qualifications and previous hospital posts held. Respondents were asked whether they felt they had received adequate training, had experience and were confident in particular child developmental examinations and minor surgery procedures. The questions were structured with yes/no alternatives and there was a section for respondents' comments. Data were analysed using the SPSSX statistical package.

Seventy four out of 137 trainees completed the questionnaires, a disappointing response rate of 54% possibly due to poor attendance at day release courses and preoccupation with the forthcoming MRCGP examination. Thirty four of the respondents (46%) were on organized vocational training schemes with the remainder constructing their own scheme, a pattern characteristics of the north west region. Fifty nine respondents (80%) had held senior house officer posts in hospital paediatrics but only four (5%) had worked in community paediatrics. Nine respondents (12%) had held senior house officer posts in general surgery. Eleven trainees (15%) possessed a diploma in child health; no one had a higher surgical qualification.

There was a wide variation in trainees' perceptions of the adequacy of their training in child health surveillance examinations (Table 1). While 89% of the trainees reported adequate training and experience and expressed confidence in neonatal examination, only 30% were confident about the pre-school examination. Only 17 respondents (23%) reported confidence in all procedures. There was no significant difference between trainees on organized as opposed to self-constructed schemes. The trainees who reported experience and competence in the pre-school examination were also more likely to have held a community paediatric post ($P<0.05$ and $P<0.05$ respectively) or to have obtained the diploma in child health ($P<0.01$).

So, how many trainees would be eligible for inclusion on child health surveillance lists? If confidence in all examinations is required then only 23% of trainees would be eligible. If family health services authorities demand the diploma in child health examination then only 15% are eligible. If the guidelines of the Royal College of General Practitioners and British Paediatric Association[2] which have since been revoked had been adhered to, possibly none would be eligible. If the MRCGP qualification is acceptable, then the 29 who obtained this in summer 1990 may be eligible.

How can this situation be improved? It seems evident that more community paediatric experience is required for general practitioner trainees. This could be provided at the senior house officer level with mandatory time in a community paediatric post; alternatively, experience during the general practitioner trainee year could be provided either by secondment to the same or by a compulsory requirement for training practices to have regular child health clinics.

A similar wide variation in trainees' responses to questions on minor surgery was seen (Table 2). Responses ranged from 80% who felt they had received adequate training and were confident in draining abscesses, to 3% who had received training, experience and were confident in ligation of varicose veins and injecting haemorrhoids. No trainees were confident in all procedures listed: only two trainees reported training in eight of the procedures (but confidence in carrying out only seven).

Even with the recent removal from the minor surgery list of the requirement to be competent in the ligation of varicose veins, applying the current Department of Health criteria, none of these trainees