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Effecting change in frequent non-attenders

Sir,

In 1992, 4.9% of appointments were defaulted in our 12 000 patient practice. A pilot study was therefore carried out over a 12 month period to try to improve the default rate of the frequent non-attenders by sending them a letter asking them to cancel appointments if they were unable to attend. A frequent non-attender was defined as someone missing three or more appointments within a 12 month period.

Over a six month period, frequent non-attenders were identified and randomized to receive a letter or no letter (controls). Patients were excluded where appropriate, for example those suffering from a terminal illness. Doctors were blind to the allocation. Details of all appointments were recorded on the practice computer. Cancelled appointments were not included in the analysis. The numbers of missed and kept appointments were recorded for the six months before the letter was sent out and up to nine months afterwards. Results are reported as geometric means with 95% confidence intervals. Analysis was by the Mann-Whitney test and a two sample *t*-test on the transformed results ($\log_{10}$).

Eighteen patients received a letter and there were 19 controls. All the patients reached six months follow up and 30 reached nine months (15 in letter group, 15 controls). No patient left the practice. There was no significant difference between the groups in mean age (letter group 30.1 years and control group 26.8 years) or sex. In the six months before the letter the mean number of booked appointments in the letter group was 6.0 (95% CI 4.8 to 7.4) and in the control group 5.8 (95% CI, 4.4 to 7.6). Half of these appointments were missed (letter group mean 2.9 (95% CI 2.3 to 3.6), controls 2.8 (95% CI 2.3 to 3.5)). These differences between the groups were non-significant.

In the six months after the letter was sent defaulted appointments were reduced by over a half in the letter group (mean 0.5, 95% CI 0.2 to 0.8) compared with controls (mean 1.2, 95% CI 0.7 to 1.8, $P<0.05$). The difference was still significant at nine months (letter group mean 0.6, 95% CI 0.2 to 1.2, versus controls 1.7, 95% CI 0.9 to 2.7, $P<0.05$). The letter group made fewer appointments over the nine month follow-up period than controls (mean 4.5, 95% CI 2.9 to 6.8, versus 6.3, 95% CI 3.6 to 10.4, difference not significant) and their default rate was less (mean of 19% of appointments missed (95% CI 4% to 36%) compared with mean of 25% (95% CI 13% to 39%)); this difference was non-significant.

Cosgrove[1] reported that defaulting patients had a higher consultation rate than average and were also more likely to default again. The results of this study show that frequent non-attenders also seem to have a high consultation rate (approximately six a year, practice average 3.4), and thus appear to be high users and abusers of the appointment system. It is interesting to note that the control group also reduced their default rate over the study period. This may be explained by the fact that to be included in the study they had had to have failed to attend for at least three appointments in a 12 month period. This is obviously an unusually high level of activity and it is likely that they would tend towards the mean in the following six months.

This study suggests that the default rate of frequent non-attenders can be reduced by sending a simple letter, the effect lasting at least nine months. The subsequent number of booked appointments may also be reduced. However, this is a small study, and a larger study is under way.

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Reference

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Depression among cancer patients

Sir,

There has been increasing interest in the psychological well being of patients who have received radiotherapy for malignant disease. Several studies have shown raised levels of depression in patients who have undergone radiotherapy[1-4] and that symptoms of depression were not detected.

Many cancer patients are in regular contact with their general practitioner, but it is often difficult to ascertain which patients are suffering from symptoms of depression and which are sad and anxious about their illness.

In 1992–93 a small study was conducted in a radiotherapy outpatient clinic at Leicester Royal Infirmary using the hospital anxiety depression scale,[5] which is a self completed questionnaire. It consists of 14 statements, seven relating to anxiety and seven to depression and the subscales can be used independently. A score of nine or more on the depression subscale is indicative of a patient having symptoms of depression.

Eighty eight consecutive adult patients who had completed a course of radiotherapy were asked to take part. Two declined and one was excluded as her eyesight was not adequate for her to complete the scale unaided. Patients who had received a course of palliative radiotherapy were excluded, as were those who had received radiotherapy to the cranium and those who had suffered from a mental illness in the past or were currently receiving antidepressive medication.

Of the 85 who participated 28 (33%) scored nine or more on the depression subscale. The patients ranged in age from 23 to 75 years. Eleven of the 28 were men. Of 31 men sampled 35% had symptoms of depression compared with 31% of the 54 women.

The majority of these patients (25/28) had regular monthly contact with their general practitioner and this study highlights the need for general practitioners to be aware of the increased psychological morbidity in this group of patients. The use of a self assessment scale such as the hospital anxiety depression scale may be useful in the general practice setting as a method for screening these patients.

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Abnormal menstrual bleeding in perimenopausal women

Sir,

Irregular menstrual bleeding and menorrhagia occur frequently among perimenopausal women[1] and are common reasons for consultation with a general practitioner.[2] Recommendations from specialists are that any woman over the age of 40 years with menorrhagia or other forms of increased vaginal bleeding should undergo endometrial biopsy in order to detect atypical endometrial hyperplasia and endometrial carcinoma.[3] The incidence of malignant neoplasms of the uterus increases rapidly in women over the age of 40 years.[4] A study was undertaken to investigate the frequency with which general practitioners refer women over this age who present with a new episode of abnormal menstrual bleeding.

The study involved 11 general practitioners in four surgeries. All the practices were fully computerized and contributed research data to one of two bodies (VAMP research or the Royal College of General Practitioners weekly returns unit). Women aged over 40 years who had consulted a general practitioner with abnormal menstrual bleeding were identified by a computer search of their records. Computer records and written records were then analysed.

The study was designed to observe the management of new episodes. Women who had consulted before full computerization of the practices and/or who had first consulted when aged 40 years or less were excluded. In addition, women who had had a hysterectomy, were post menopausal, had consulted only with postoperative bleeding or pregnancy-related bleeding and those that had undergone endometrial biopsy within the previous three years were also excluded. In order to ensure adequate follow up, women with a new episode within nine months of the search were excluded and therefore so were women referred more than nine months after the onset of the new episode.

The diagnosis classification system used by the computer contains 28 terms which may involve increased menstrual bleeding. Some of these terms are specific, reflecting excess menstrual loss (for example, menorrhagia) and others are non-specific (for example, dysfunctional uterine bleeding). The diagnoses were divided into four groups. Of 110 women with excess menstrual loss, 38 (34.5%) were referred to a consultant gynaecologist; of 28 women with irregular menstrual loss, six (21.4%) were referred; of 15 women with intermenstrual loss, 10 (66.7%) were referred; and of 41 women with non-specific loss, 12 were referred (29.3%).

The rationale for endometrial biopsy in menopausal women who complain of abnormal menstrual loss is to detect endometrial abnormality yet only 34.0% (confidence interval 27.3%–40.7%) of such women were referred by their general practitioners.

If endometrial carcinoma is to be detected earlier then it would appear that either general practitioners need to refer more often and quickly or there needs to be more specific criteria for referral which reflect the issues within primary care. The new devices for endometrial sampling[5] may provide a means of performing endometrial biopsy in general practice according to current specialist recommendations.[6] The cost effectiveness of each approach needs to be evaluated.

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Non-attenders for cervical screening

Sir,

Although the achievement of cervical smear targets has been part of general practitioners' workload for some years, it is useful to examine the reasons why some women do not attend for screening.

Immediately prior to recent media scares concerning the taking of cervical smears,[1] a survey of call and recall non-attenders was carried out in a semi-rural practice with two men general practitioners. Although the practice achieves the higher uptake target (80%), it has a considerable group of non-respondents to requests to attend screening sessions.

An anonymous, postal questionnaire, sent to patients' homes with a stamped, addressed reply envelope, was used so that patients responding to the questionnaire could not be followed up. More than half of the 77 patients surveyed (53%) replied. In common with previous studies[2] reasons for non-attendance included a stated preference for the smear to be taken by a woman (24 respondents), and fear generated by the perceived lengthy waiting period for results (mentioned by six women). However, there were two other important findings.

Seven of the women reported feeling pressurized to attend for cervical screening in some instances to a degree where they were actively avoiding their doctor. Although the group considered themselves to be well informed on the importance of the smear test, three quarters (31 women) responded positively to a question offering their removal from the recall register until they themselves requested to be reinstated.

The study involved a small number of women. However, more than half of the group not responding to cervical screening requests were prepared to complete the questionnaire and return it to the practice and their replies to the questionnaire raise important issues. Where does health promotion end and undue pressure begin? Does the fact that doctors receive cervical screening target payments lead to the pressurization of patients? How would allowing a group of non-respondent to opt out of the programme affect such target payments? As there is a direct relationship between a regular cervical smear programme and reduced mortality from invasive cervical neoplasia,[3,4] what are the ethical considerations in allowing vulnerable women to opt out?

It would be valuable to learn whether these feelings are present in non-attenders at cervical smear programmes in other practices and whether or not the more