Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). All letters are acknowledged on receipt, but we regret that we cannot notify authors regarding publication.

Fortress general practice

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Sir,

I was interested in Andrew Potter's letter (May *Journal*)[1] contrasting his recent experience as a patient in general practice in this country with the system within which he works as an expatriate doctor in Benin. I have also needed medical attention in this country while on leave from overseas missionary service, and know that it gives a rather disorienting feeling. However, I make no apology for the fact that Dr Potter might have identical comments if he attended the inner-city practice where I now work (though we would not offer and then refuse registration with a doctor whose list was closed!). We value our multidisciplinary team highly.

What surprises me is his description of the open-access system that he operates in his own clinic. When resources are in short supply, whether in the Third World or in the NHS, it is imperative that all members of the team are utilized to the full. Surely, an ophthalmologist should not see every patient with an eye condition. A nurse, medical assistant, infirmière, or ophthalmic technician could screen and treat those who did not need specialist attention. This not only builds up the skills of local colleagues but also would ensure that there is continuity of care when Dr Potter himself is on leave. When I worked in rural general practice in Asia, it was not long before my interpreter could ask the right questions and give out the routine treatments without my supervision — though he would quickly ask advice if something was out of the ordinary.

In my present practice I could do all routine new patient health checks myself, I could do all the travel vaccinations, I could answer all the letters, as Dr Potter obviously feels I should. If I did, however, at least half the patients who now see me when they need to consult a doctor would have to go elsewhere: I would be too busy to help them.

Reference

1. Potter AR. Fortress general practice. [Letter.] *Br J Gen Pract* 1999; **49:** 399-400.

Sir,

Dr Potter exhibits such obvious signs of 'reverse' culture shock that it would perhaps have been kinder not to respond to his letter (May *Journal*).[1] My motivation for doing so is to express my uneasiness at his expression of irritation towards a partnership that I recognize could be very similar to my own. We thought we were improving our service for patients — I suspect that Dr Potter would wish we hadn't bothered.

But what is the substance of his annoyance?

- He wasn't able to get an appointment the next day. Unfortunate that he used the formula about 'waiting' or 'being slipped in', as only the phrase 'it will only take a couple of minutes' was missing to complete the triad. But was he actually feeling unwell? Presumably not, as the receptionist did leave that option open. I would suggest that if he did indeed faint or froth at the mouth he would have had a doctor or two, a practice nurse, and full resuscitation facilities appearing from within the fortress within a few seconds — one of the benefits of modern general practice that may have allowed Dr Potter to remain alive if such an unfortunate episode were to occur. Could his problem not have waited until the day after when there was time to discuss it properly — and with the benefit of not feeling that someone else with an equally or more urgent problem was being short-changed?
- Why was his introduction to the practice so inauspicious? I would like to address a few questions to Dr Potter. Will you not accept that to complete a form detailing medical history could be useful? Personal lists are often thought to be a good idea — what is wrong in asking someone to see another well-qualified doctor if a particular list is full? What is wrong with having a basic medical check performed by a 'very pleasant practice nurse'? We have surprisingly often picked up unexpected pathology on this check and it is well validated; it is not just the practice statistics that benefit. Did you give the receptionist any reason why she should suggest you see a doctor? Room for some criticism perhaps if such a suggestion would have been relevant, but as a doctor yourself she was perhaps expecting some initiative on your part. Why was the form for the travel clinic so upsetting and worth mentioning as an issue? I would recommend even to seasoned travellers that they ring MASTA for up-to-date advice, and most general practice forms have nothing on this for complexity and thoroughness.
- And, in return, in reply to Dr Potter's questions and comments, many thousands of patients do manage to penetrate the system. They make appropriate appointments or are seen quickly if they inform us they are presently unwell and unable to wait. This is borne out by the consistently high regard in which the profession is held, which the polls confirm.

I have been qualified for more than 20 years, but I find it in no way demeaning to either sit in a waiting room with other patients or consult a colleague of less experience. I understand that others may feel differently on this issue but 'subaltern' has an unfortunate ring to it. The words, 'I do not suppose that I am differ-

ent from anybody else' are not consistent with the remainder of his letter.

Of course the profession has its faults, but I do not recognize 'fortress general practice', as pictured by Dr Potter, with regard to this partnership. I do not know where this practice is, but have every sympathy with them and am not at all surprised that they went no further than their terms of service when responding to a complaint of this nature. I am quite sure they read his letter.

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Reference

1. Potter AR. Fortress general practice. [Letter.] *Br J Gen Pract* 1999; **49:** 399-400.

Mental health services

Sir,

May I make a point regarding the letter from Burd *et al* (May *Journal*)?[1]

As a practice counsellor with more than 11 years experience, my observation is that both people with severe and enduring mental illness, and those with perhaps less devastating, but still real, psychological distress, quite reasonably attend general practices for help, and both groups deserve the best service we can offer. It seems unhelpful to suggest that primary care groups might wish to choose between them.

In Suffolk we have recently surveyed the opinions of patients who have taken part in practice counselling in the past two years. We found that, when patients were offered a 10-point scale where 10 = 'I certainly would recommend this kind of counselling to others', 96.2% of them circled 7 or above. When asked to choose a number on the scale where 10 = 'your problems are solved' (following counselling), 80.1% of patients chose 7 or above. Clearly patients see counselling as useful to them.

I agree that to overmedicalize this (much larger) group is to do them a disservice. Nevertheless, these patients do come to their general practices for help. Are the authors seriously suggesting that primary health care teams should turn away patients struggling with the effects of, for example, bereavement, relationship problems, living with chronic illnesses in themselves or a loved one, or early life abuse, when we have effective pharmacological and psychological help to offer them within our practices?

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Reference

1. Burd M, Chambers R, Cohen A, *et al* Mental health services – primary concerns for the future. [Letter.] *Br J Gen Pract* 1999; **49:** 399.

Sir,

Burd *et al* (May *Journal*)[1] are right to be concerned about the future of mental health services, and perhaps these concerns could be alleviated by discarding the centrally driven policy of distinguishing between patients with a severe mental illness and those without, with mental resources only available for the former. For it could be argued that it is this policy that lies at the root of the many tensions that currently exist between primary health care and secondary care mental health services, with GPs perceived as inappropriately referring the so-called 'worried well', and mental health teams seen as not picking up those patients who are in need but who do not have a diagnosis of a severe mental illness.

In a commonly used definition of severe mental illness put forward by the Audit Commission,[2] groups 'A' and 'B' both require a diagnosis of a psychotic illness as one of their criteria. However, the recent British psychiatric morbidity survey identified a high prevalence of neurotic illness, 'some of which is extremely severe and associated with suicidal risk' and 'high levels of social disability'.[3]

If primary care groups, together with mental health services were able to commission care for patients on the basis of functional disability, and not artificial and often tautological definitions of what is or is not a severe mental illness, many of the tensions that Burd *et al* are concerned about may cease to exist.

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2. Audit Commission. *Finding a place: a review of mental health services*. London: HMSO, 1995.
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Management of heart failure

Sir,

The paper by Horne *et al* (May *Journal*)[1] is timely given the recently published SIGN guideline, which concerns best practice in the treatment and follow-up of heart failure patients.[2] Barriers to change identified will clearly be of importance in the implementation of this guideline. General practitioners are said to be receptive to guideline initiatives, although more investigation of the concept of 'use; is required.[3] Prior knowledge, beliefs, and individual working practices are thought to be important.[4]

While attitudes are important, practical barriers to implementation are an area requiring further attention. A practice-based case-note survey of 55 patients with 'heart failure' indicated some of the difficulties that exist. These included inability to accurately identify cases using Read codes and incomplete baseline investigation profiles (Table 1) — of the 55 patients, 85.5% (47/55) had undergone five or more of the eight baseline tests, and a 16.7% (4/24) rate of suboptimal ACE-1 therapy.

Furthermore, there is confusion over what comprises optimal treatment (particularly in the elderly) and lack of an evidence-based approach to monitoring (EG U/E, echocardiography or ECG). This is in a practice that is highly computerized, has undertaken the RCGP Quality Practice Award and actively undertakes an evidence-based approach to care.

Our results demonstrate a conflict between knowledge and behaviour. Realities of workload and economics cannot be ignored; however, these should be balanced against any gains from reduced patient morbidity. We intend to expand the study to include these areas to provide a more balanced view to guideline implementation.

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1. Horne R, Coombes I, Davies G, *et al*. Barriers to optimum management of heart failure by general practitioenrs. *Br J Gen Pract* 1999; **49:** 353-357.

Table 1. The number of tests needed to complete baseline profiles for 55 patients previously diagnosed with 'heart failure'.

Test	Number of tests (patients)	Percentage
Full blood count	1 (55)	1.8
Urea and electrolytes	1 (55)	1.8
Liver function tests	13 (55)	23.6
Serum cholesterol	41 (55)	74.5
Thyroid function tests	34 (55)	61.8
ECG	6 (55)	10.9
Chest X-ray	8 (55)	14.5
Echocardiogram	22 (55)	40.0

2. Scottish Intercollegiate Guidelines Network. *Diagnoses and treatment of heart failure due to left ventricular systolic dysfunction – a national clinical guideline.* Edinburgh: SIGN, 1999.
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Computer use in the GP consultation

Sir,

The article by Watkins *et al* (May *Journal*)[1] addresses an interesting area on the use of computers during the consultation. While high numbers of responders had a desktop computer and used it during the consultation, no mention is made of whether the patient is encouraged to 'consult' the computer also.

As a trainer of general practice registrars, I am frequently looking at the consultation both by direct observation and the use of videotapes. One area that is commonly addressed is whether we use the computer in partnership with the patient; they are encouraged to look at the screen and check the information held is up-to-date and correct (a prerequisite of the data protection act[2]). This process allows the development of a triangular consultation between the doctor, patient, and the computer.

With increased computer usage in the consultation, it would be a fertile area to address whether the patient'' satisfaction with the consultation is enhanced by actively encouraging them to 'own' information held about them on the computer.

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1. Watkins C, Harvey I, Langley C, *et al*. General practitioners' use of computers during the consultation. *Br J Gen Pract* 1999; **49:** 381-383.
2. HMSO. *Data Protection Act.* London: Stationery Office, 1984.

Repeat prescribing management

Sir,

We welcome the publication of McGavock *et al*'s paper on repeat prescribing (May *Journal*),[1] and agree with much of its contents, in particular, comments about the lack of evidence in this important area. Unlike McGavock *et al*, whose paper set out what GPs 'thought they did' rather than what they actually did, we investigated GP prescribing with reference to the duration of prescription issued and the relationship of this parameter to prescribing costs.

We examined the prescribing of 59 practices from the Fourth National Morbidity Study for a one-year period between 1991 and 1992. We used defined daily dosages (DDDs) to determine the mean prescription duration of each prescription issued. For combined groups of drugs (cardiovascular, asthma preparations, psychotropic drugs, dopaminergic drugs, oral hypoglycaemics, thyroxine, allopurinol) there was an inverse relationship between mean prescription duration and cost (R_s = -0.17), although this did not achieve statistical significance. In other words, practices that issued longer prescriptions were not more expensive prescribers.

It is the frequency and quality of patient review that is paramount. Unlike McGavock *et al*, who advocate two-monthly prescriptions, we would favour three-monthly ones. Longer prescriptions would reduce dispensing fees to pharmacists. For patients with stable non-psychiatric conditions, three-monthly prescriptions, with review at consultation on alternate occasions, means that patients are seen every six months and receive just two repeat prescriptions a year. Patients, GPs, and the government would know what was expected. Risks associated with accidental poisoning are scarcely different if patients receive a three-month as opposed to a two-month supply, and are counterbalanced by the assessment at alternate prescriptions. We believe there would be considerable benefit to patient management if this routine were adopted, though we emphasize that these recommendations should only apply to persons with stabilized non-psychiatric chronic conditions.

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Reference

1. McGavock H, Wilson-Davies K, Connolly JP. Repeat prescribing management – a cause for concern? *Br J Gen Pract* 1999; **49:** 343-347.

Assessment of teaching practices

Sir,

Increasing numbers of medical schools are devoting more curriculum space to community-based teaching. As Murray and Modell (May *Journal*)[1] rightly acknowledge, there must be systems in place to ensure that this teaching is of the highest standard, especially with hot competition from other specialties for SIFT resources.

For many years, postgraduate departments of general practice have been in the vanguard of teacher assessment and have developed considerable expertise. It seems sensible to harness these skills when devising methods to assure quality when teaching undergraduates.

There has been enthusiasm here in Oxford to forge a closer working relationship between undergraduate and postgraduate departments, firstly by writing a joint document for the accreditation of teachers (trainers and tutors) and teaching practices (training and universities).

We formed a working party with representatives from both departments and reviewed all local assessment material in current use. Lively discussion ensued. Inevitably there are differences in teaching objectives — medical students are primarily placed to learn clinical medicine in a general practice setting, GP registrars to

learn the craft skills, and knowledge to become a practising GP. The length of attachment differs considerably — GP registrars stay for up to one year, medical students for six weeks. There is variance of emphasis between teaching within consultation and by tutorial.

Despite these differences, we found enough common themes to produce a final draft document from which we shall jointly be able to accredit teachers and teaching practices. Practices will be able to be approved for both types of teaching at one visit, keeping the burden of being visited to a minimum. This will have a number of advantages: university tutors learning assessment skills from experienced trainers, the development of universal standards within student teaching practices, the encouragement of trainers to participate in medical student teaching, and opportunities to organize joint teaching courses aimed at improving the quality of teaching.

We strongly advocate the mutual benefit from close cooperation between undergraduate and postgraduate departments when devising teaching assessment criteria.

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Reference

1. Murray E, Modell M. Community-based teaching: the challenges. *Br J Gen Pract* 1999; **49:** 395-398.

Detecting psychological problems in primary care

Sir,

While reading the article by Scott *et al* (June *Journal*)[1] on detecting psychological problems in primary care (to shorten the title), I was again struck by how hard it is to write up results in a readable way: the wealth of detail sometimes obscures. But jumping to the discussion or merely reading the summary does not always give the true picture.

Although it is understandably overlooked by the authors, given their presumed hypothesis and all the effort this study took, I see there was no difference of any significance in patient satisfaction ratings between those of the study GPs and those consulting the control group of GPs, despite what was written in the summary. As patient-centredness was an important part of the consultation, it must be just as important in assessing the outcome and not ignored, even if it leaves a sense of discomfort. I have every sympathy with the authors' premise, but a sense of objectivity is vital, and convenience should not distort the facts.

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Reference

1. Scott J, Jennings T, Standart S, *et al*. The impact of training in problem-based interviewing on the detection and management of psychological problems presenting in primary care. *Br J Gen Pract* 1999; **49:** 441-445.

The detection and treatment of psychological problems

Sir,

The paper by Jan Scott *et al* (June *Journal*)[1] reiterates the message that anything that alerts GPs to the psychological problems of their patients is worthwhile. Improving listening skills, teaching doctors to use cognitive behavioural approaches and solution focused approaches to be used in everyday consultation have broadly similar effects.

However, recognition is one thing, managing is another. To claim that management of patients with psychological distress is improved merely because these patients were more likely to receive psychotropic medication does not necessarily mean that they were managed 'better'.

In fact, it is worrying that problem-based interviewing (PBI) trained GPs were more likely to offer pharmacotherapy than control GPs. Have the authors any evidence that the patients were made better or that their psychological functioning improved after their medication stopped? Surely that should be the desired outcome if the PBI intervention should be more widely taught and used in the future. I suspect that, on this test of credibility alone, the shortcomings of a psychopharmacological solution to psychological distress problems will show that it is nor a solution. Instead, it creates drug dependency, causing prescribing costs to rise and increased patient consultation rates. In addition, as other such well-meaning projects have discovered, the effects do wear off as the professionals concerned become victims of burnout and disillusion as their efforts in case findings are not matched by patient health gains.

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Reference

1. Scott J, Jennings T, Standart S, *et al*. The impact of training in problem-based interviewing on the detection and management of psychological problems presenting in primary care. *Br J Gen Pract* 1999; **49:** 441-445.

Clinical skills assessment

Sir,

In their paper 'Clinical skills assessment, (June *Journal*),[1] Kelly, Campbell, and Murray must be taken to task for the possibility they are masquerading subjective and non-validated stations as objective 'gold standards' against which all other forms of assessment must be measured.

Eight assessors ('experienced' GPs, trainers/examiners) performed the stations and declared them 'satisfactory' for 'realism'. However, the fact that three registrars failed to wear gloves, and one did not perform a vaginal examination, may suggest other than 'realistic' circumstances to the participants.

Seven separate objective assessments are given for station 4 as an example, we are not told the marking plan constituting a 'pass'.

Even allowing for the stations to be thought of as objective, the conclusions the authors draw become progressively more bizarre. They suggest that the fact that only one out of 29 registrars was 100% successful in all stations means there is a 'major problem in the GP registrars nationwide'. This is a bizarre conclusion. Why should this putative serious competence problem be restricted to GP registrars, particularly as the point is made

that undergraduate and hospital training may be to blame?

I was told that as long as I didn't make a mistake fatal to a patient in my finals, I would pass and my real learning could then begin. Are we in danger here of overlooking lifelong learning and professional development in favour of an unrealistic quest for a 'finished product'? If we do only accept the perfect result, who will be here to see the patients?

One final quibble related to station 4. Had any of the assessors ever experienced a vaginal examination? I would be surprised if anyone receiving one would ever describe it as a 'comfortable' experience, however skilfully performed. How can you assess comfort using a dummy?

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Reference

1. Kelly MH, Campbell LM, Murray TS. Clinical skills assessment. *Br J Gen Pract* 1999; **49:** 447-450.

Sir,

Kelly *et al*'s finding in the June issue[1] fit closely with my own[2] where I showed that trainers felt diffident about making judgements about the clinical skills of their GP registrars for the summative assessment trainer's report. The evidence was that they would do this unreliably, and this seems to have been borne out.

However, there may be other reasons for the apparent alarming failure rate shown in the study that need to be considered. The first is that the standard was too high. The examples given suggest this might be the case. Thus, the trainer's report states a cause for failure would be that a registrar 'repeatedly misinterprets the findings made (including failure to detect signs of major abnormality/illness)' in a vaginal examination. The test described by Kelly *et al* only tested the registrar once, so by definition no conclusion could be drawn. Similarly, a doctor faced with anaphylaxis with only an out-of-date adrenaline ampoule is unlikely to harm and may save a life by injecting it.

Another cause of the high failure rate may be the test itself. At a recent OSCE pilot in another context, only three out of 13 doctors detected the major abnormality on doing a vaginal examination on a mannequin at a station I supervised. These doctors were trainers, lecturers, and senior lecturers in general practice. The conclusion must be that they were not incompetent doctors but it was an incompetent test! I would therefore agree with the authors of this paper that further work is necessary.

This latest revealed deficiency adds to the evidence that summative assessment is having the problems predicted using the standard assessment theory.[3] The recently published national evaluation on the effects of summative assessment on vocational training by Grant *et* al,[4] involving more than 2000 responders, effectively discredits the whole process. It is time that we fell into line with other specialties; the superb MRCGP examination should become the entry requirement into the discipline. For those whose performance gives cause for concern, the robust and extensive GMC procedures should be followed. Summative assessment (apart from a modified trainer's report that concentrates on professional behaviours) should be ditched before it does more of the harm revealed in the report from the Joint centre for Education and Medicine.[4] The large amount of money released could be used more effectively to raise standards.

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4. Grant J, Mountford B, Mack J. *The effects of summative assessment on vocational training in general practice.* London: Joint Centre for Education in Medicine, 1999.

Sir,

As one of the authors of the papers relating to the trainer's report of summative assessment, I welcome the paper by Kelly *et al* (June *Journal*),[1] which provides important data on the concurrent validity[2] of one part of the trainer's report. There are three points that I would like to raise that result from this paper.

First, there are two small factual inaccuracies that should be pointed out to the reader, although they do not alter the overall outcome of the paper. For all clinical skills tested in the trainer's report, it is only possible to test the ability to undertake the examination by means of direct observation; the possibility of assessment by discussion with the registrar is only available for those parts of the assessment that deal with interpretation, and for no item in the report is it acceptable to use the completion of a hospital post as the evidence of appropriate performance. In addition, in the test of inter-rater reliability[3] of the eight registrars referred, only two (and not five) would have been missed by the current system, none of which would have related to the clinical skills component of the trainer's report.

Secondly, the paper by Kelly *et al* does provide confirmation that the standards available in the trainer's report are feasible to use. I would strongly concur with the authors that consideration should be given to ensuring that adequate assessment of performance, using these standards, is taking part during the hospital components of vocational training.

Thirdly, and most importantly, while criticisms can be levelled at the study (particularly the risks of bias, questions about the validity of the stations and the absence of any data on inter-rater or intra-rater reliability), this paper does demonstrate a poor correlation between the results of assessment undertaken by trainers relating to individual registrars and the results of assessments undertaken by trainers working in the capacity of objective assessors, despite using the same standards. Whether or not this is a cohort effect (the cohort of trainers were the first to use the national trainer's report), or whether it is an effect of using trainers as assessors, the paper strongly suggests that one or other form of assessment may produce invalid results. In the long term a predictive validity[2] study is needed to determine which method of assessment is more accurate. In the meantime, I agree with the authors that the clinical skills component of the trainer's report should be revisited. The content of the trainer's report is probably best confined to the assessment of those elements of performance that can only be assessed by the trainer, provided that demonstrably valid and reliable alternative methods for assessing the clinical skills elements exist.

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The future of the *BJGP*

Sir,

The forthcoming appointment of a new editor to the *BJGP* offers a wonderful opportunity for the editorial board, RCGP Council, the college membership, and readers to contribute to an open debate on the future content and direction of the *Journal*.

Under Dr Wright's editorship, the *BJGP* has become the most cited academic journal of general practice in the world. The introduction of the Back Pages has brought welcome diversity, controversy, and even humour to the *Journal*. However, I would like to suggest that the current structure and, to a degree, the content reflects a fading paradigm of primary care: that of applied science as the pre-eminent force driving the profession forward. The huge canvas of general practice needs both art and science, reflection and the application of a body of knowledge, intuition and deduction, left and right brain skills, dealing with the patient and the illness. Perhaps the concept of 'post-normal science'[1] best fits this complex picture. As one of our most distinguished thinkers has pointed out, general practice is therefore very different to other medical specialties.[2] This important difference is not adequately reflected in the *Journal*.

I understand the need for general practice to establish academic credibility at university and national levels, and for research activity to better reflect disease in the community — these processes are well under way, must continue, and should be reflected in research papers of high quality in the *Journal* — however, a general practice journal that confines many original reflective papers to the 'back pages' reflects an inappropriate dichotomy of thought and is out of kilter with modern general practice. It seems odd, for example, to confine an important article by an internationally recognized author on human rights and health,[3] an issue of import to all doctors, to the back pages. In contrast, the *New England Journal of Medicine* had an equivalent article within the main text of the journal.[4] The front–back division of the *Journal* is arbitrary and unhelpful.

I suggest a call from the editorial board for ideas on the future of the *Journal*. The college faculties could be used to take the debate to the membership, distil ideas and feedback. An interactive website, with weekly electronic publication, would be a great asset for this and for discussion of other important issues for the *Journal* and the College in the future. It is time for the *Journal* to build on the academic status that it has achieved, by forging a new identity that better reflects the totality of primary care.

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Alec Logan, Deputy Editor, responds

I welcome Dr Gillies' thoughtful comments. At the *Journal* we are carefully considering how best to integrate material presently published in the Back Pages within the *Journal* as a whole. Such delicate issues will be keenly debated within the *Journal* and the College in the next six months or so, and of course a new editor will be appointed soon. The views of the membership of the College, our readership, are hugely important — comment to Journal@rcgp.org.uk. Constructive dissent especially welcome.

General practice non-attendance

Sir,

Jonathan Inglesfield reports on his pilot study on general practice non-attendance in the June issue.[1] He sent non-attenders the Goldberg General Health Questionnaire (GHQ) and had an excellent response rate of 57%, which is far higher than the norm of 30% for surveys of hospital non-attendance.[2] His main finding was that 37 of 67 responders (54.5%) had a score of 2/3 or more, which he interprets as them 'having mental health difficulties'.

However, this is a considerable over-interpretation of his results. Firstly, the GHQ is designed as a screen for emotional disorders, not a diagnostic instrument. Secondly, the absence of a control group — which he acknowledges — is crucial. A study of 305 general practice attenders from Bristol,[3] also using the GHQ, found 52% with a score of three or more. This suggests that general practice non-attenders are no different from attenders in their GHQ scores.

The study of non-attendance is important. It increases waiting times for patients[4] and causes frustration within the practice. Inglesfield makes a good point in noting that the GP is the person least affected by non-attendance, usually being able to use the time to catch up a surgery running late or to perform an alternative task. I suspect this is why it is under-researched. Almost all research has been hospital-based, showing associations with younger patients,[5] males,[6] and long waits for appointments. Associations with race and socio-economic class have been variable. I fully agree with Inglesfield that more research is needed; however, on the current evidence we cannot add an association between illness and non-attendance to the list.

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