which not only wastes resources but frustrates staff.^{1,2} However, although the authors suggest that the weather makes no difference in 'did not attend' rate, re-analysis of their raw data shows a highly significant linear trend for worsening attendance with improving weather conditions (13.3% 'did not attend' on raining days versus 30.7% on hot sunny days; $P = 0.033$, chi-squared test for trend).

The other factor that we could not glean from the data was whether positive response to a telephone call influenced 'did not attend' rates; *i.e.* if the 'did not attend' rate was less in those who responded to a telephone call than those who did not, then this would imply that contact with a patient to confirm a booking (like in a restaurant) was actually useful.

Similarly, we have been frustrated by 'did not attend' on the day of surgery, and to reduce this we are taking patients off the scheduled operating list for routine surgery if they have not confirmed their intention to attend in advance – this so-called 'lean theatre' has helped to reduce 'did not attend' for surgery in Charing Cross Hospital, and a similar 'lean clinic' approach might be employed to reduce non-attendance at clinics.

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AUTHORS' RESPONSE

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LORRAINE CORFIELD, ALEXIS SHIZAS, ANDREW WILLIAMS
Department of Colorectal Surgery, St Thomas' Hospital, London, UK

CORRESPONDENCE TO

Lorraine Corfield, Department of Colorectal Surgery, St Thomas' Hospital, London, UK. E: icorfield@doctors.org.uk

We thank Siriwardana and Buchanan for their insightful response to our paper and particularly the re-analysis of the effect of weather on 'did not attend' rate. The telephone calls did not influence 'did not attend' rates in that the overall rate did not improve significantly after attempted telephone reminders. We did not record the 'did not attend' rate in the group who were successfully contacted by telephone but the fact remains that attempted calls (the equivalent of 'intention to treat') were ineffective in reducing 'did not attend' rate.

The suggested 'lean clinic' approach is an interesting proposition and worth considering. We have some reservations that, due to the difficulty encountered by some patients

in our study (9.5%) in successfully contacting the hospital, current systems will not allow for the smooth running of such a service. Patients may also arrive on their appointment day without having confirmed which then creates the dilemma as to whether to see these patients, particularly as notes will not be available.

COMMENT ON

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MK Nasr, JS Budd, M Horrocks. Uncomplicated varicose vein surgery in the UK – a postcode lottery. *Ann R Coll Surg Engl* 2008; **90**: 474–6.

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Rationing of treatment for varicose veins

BRUCE CAMPBELL

Department of Vascular Surgery, Royal Devon and Exeter Hospital, Exeter, UK

CORRESPONDENCE TO

Bruce Campbell, Consultant Vascular Surgeon, Royal Devon and Exeter Hospital, Exeter EX2 5DW, UK
E: bruce.campbell@nice.org.uk

Nasr, Budd and Horrocks will each be embarrassed to learn that their knowledge and search of the literature failed to register our larger, roughly contemporaneous and arguably more successful survey on rationing of treatments for varicose veins.¹ They make more than one claim for originality of their work: I will leave it to others to challenge the 'first published email survey in vascular surgery' and concentrate on the aspect of rationing of varicose vein treatments ('There has been no survey to date').

I have no pique about them missing our publication: it provides a wonderful opportunity to snipe at friends and some comparisons of their survey with ours are interesting. The numbers of surgeons included (from the same pool) were 245 and 411 and the response rates were 44% and 75%, respectively. Based on these observations, one could conclude that:

1. An email survey allows inclusion of a substantially smaller number of people from the same professional group.
2. The response rate to an email survey is grossly less than a postal survey.
3. Publishing a paper in the electronic part of a journal, rather than in full in the paper copy (*i.e.* our paper in the *Eur J Vasc Endovasc Surg*) makes it easy to miss.

Re-assuringly, the main findings of Nasr and colleagues from the 109 surgeons who responded to them about rationing of varicose vein treatments were similar to those from the 307 whose responses we published.