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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2. Pal B, Taberner DA, Readman LP, 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.

AUTHORS' RESPONSE

doi 10.1308/003588409X392009

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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

doi 10.1308/003588408X301109

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.

doi 10.1308/003588409X392027

Rationing of treatment for varicose veins

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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.

Reference

1. Lindsey B, Campbell WB. Rationing of treatment for varicose veins and use of new treatment methods: a survey of practice in the United Kingdom. *Eur J Vasc Endovasc Surg* 2006; **32**: 272.

AUTHORS' RESPONSE

doi 10.1308/003588409X392036

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We owe Professor Campbell an apology for our failure to quote his electronic paper on varicose veins treatment rationing; despite that, we quoted two of his papers as an incentive for us to conduct our study. Regrettably, the keywords used for our search did not retrieve the electronic publication. We tried to search for Professor Campbell's article, after receiving his comments, using Medline and the NHS National Library for Health resources, but we hit a blank search results even by trying the search using both the authors and the full article title. Only when we 'googled' the full title did we find the reference (a drawback of electronic publishing?).

We can still claim that our survey was the first survey to paper publish rather than electronically publish, but we agree with all of Professor Campbell's other comments. However, despite the similarities between the two articles, our article remains unique in highlighting the huge regional variations existing in the UK, which was the main aim of the article.

COMMENT ON

doi 10.1308/003588408X318165

MM Hoosein, H Towse, G Conn, DL Stoker. Consenting practice for open inguinal hernia repairs – are we failing to warn patients of serious complications? *Ann R Coll Surg Engl* 2008; **90**: 643–6

doi 10.1308/003588409X392018

Inguinal hernia repair – trends in litigation

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Hoosein and colleagues have correctly identified gaps in the consenting process for inguinal hernia repairs. Analysing

Table 1 Aetiological analysis of complaints and litigation costs associated with hernia surgery during period 2002–2007 (NHS Litigation Authority)

Causes	Closed	Paid	Paid/ closed (%)	Mean comp'n/ case (£)
Haemorrhage/haematoma	5	2	40.0	50,396
Visceral injury	21	10	47.6	42,150
Operation failure	19	11	57.9	33,981
Ischaemic orchitis	35	14	40.0	25,633
Infection	17	8	47.1	22,938
Chronic pain	18	2	11.1	13,750
Other (non-specific)	29	10	34.5	13,146
Wrong side operation	2	1	50.0	6,500
Venous thrombo-embolism	3	1	33.3	6,000
Wound complications	10	5	50.0	5,320

Comp'n = Compensation. The 'paid/closed' ratio indicates the likelihood of a claim to lead to compensation.²

data from the NHS Litigation Authority reveals a total of 223 claims following inguinal hernia repair made during the period 2002–2007.¹ At the time of analysis, 159 of these cases were closed, representing 5.4% of the total closed cases relating to general surgery during that time period. Damages were paid in 64 cases ('paid/closed' ratio² of 40.3%), summing up to a total of £1,636,510 (range, £600 to £170,000). Interestingly, 13 patients based their claim exclusively on 'failure to be warned on the potential complications of the procedure'. Six patients had fatal outcome and another 11 patients had to undergo orchidectomy as a result of ischaemic orchitis. Further aetiological analysis is presented in Table 1.

It is evident that the current consent process can potentially fail to inform patients effectively on the sinister risks associated with hernia surgery, thus leading to postoperative patient dissatisfaction and litigation with significant costs for the NHS. Junior trainees need to be appropriately educated on the above risks. We further support the move towards procedure-specific consent forms for such commonly performed operations.

References

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