

expected their general practitioner to withhold sensitive information.¹ Do we just ignore this? When we write these reports do we really have the fully informed consent of our patients? Hamilton's statistics are interesting, but the ethical problems remain as great as ever.

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References

1. Lorge RE. How informed is patients' consent to release of medical information to insurance companies? *BMJ* 1989; **298**: 1495-1496.

Assessing elderly people

Sir,

I am concerned by a statement made by McIntosh and Power in their paper on elderly people's views of an annual screening assessment (*May Journal*, p.189). It is their opinion that 'the substantial numbers in the study who perceived themselves to be in good health when rated objectively as having medium or high health risk scores must cause concern, especially when the high risk group has been shown to have a greater probability of dying in the next six months than people in the other two groups.¹ Unfortunately, they do not go on to make the obvious point that these deaths would probably not be preventable in most instances. Surely most medical practitioners would prefer their elderly patients to regard themselves as well and thus enjoying good health, rather than as unwell and suffering ill health. The ineffectiveness of screening elderly people has been recognized for a number of years and is at best controversial.²

It is morally indefensible to carry out screening when the effect on the group whose diseases the investigators are intending to uncover is simply to make them aware of their ill health without necessarily offering the benefits of a cure. Wilson and Jungner laid down the criteria for screening in 1968 and included the requirement of successful intervention upon detecting a disease discovered by screening.³ Medical practitioners should be suspicious of those advocates of screening who regard it as acceptable to change the enjoyers of good health into the sufferers of ill health without offering them the hope of a cure.

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References

1. Young M, Chamone A. Screening evaluation of the elderly. *Scott Med J* 1989; **9**: 10-11.

2. Tulloch AJ, Moore V. A randomized controlled trial of geriatric screening and surveillance in general practice. *J R Coll Gen Pract* 1979; **29**: 733-742.
3. Wilson JMG, Jungner G. *Principles and practice of screening for disease. Public health papers 34.* Geneva, Switzerland: World Health Organization, 1968.

Formative and summative assessment

Sir,

Philip Tombleson's editorial (*May Journal*, p.183) is a fine summary of the various issues relating to formative and summative assessment. Sadly, it does not indicate how progress should be made. For instance, should we be allowed to continue in the present confused state of paying lip service to the notion of formative assessment, or should the Joint Committee on Postgraduate Training for General Practice be permitted to prescribe a national package of formative assessment for regions to implement?

More interestingly, the editorial fails to address the thorny issue of what form summative assessment should take. Bearing in mind the haphazard approach to formative assessment, is there not a case that the MRCGP examination (with some modifications) would be the most appropriate means of testing achievement of competence at the end of vocational training? After all, it has the unique advantage of being a national test with a national standard. It has also been the subject of long and thorough research and refinement. It might also be worth noting that, in the current climate of change, particularly with respect to the Calman report,¹ the introduction of the membership examination as the summative form of assessment, would bring our discipline firmly into line with the other medical specialties.

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References

1. Department of Health. *Hospital doctors: training for the future. The report of the working group on specialist medical training (Calman report).* London: DoH, 1993.

Practice nurses

Sir,

I was disappointed to read the letter by Noreen Gilhespy (*May Journal*, p.219). As a general practitioner my impression from talking to practice nurses is that they

find it much easier working outside a hierarchical structure, that their professional development has been greatly enhanced and that they have found it much easier to obtain education and relevant qualifications for practice nursing.

In my area general practitioners and practice nurses have joint educational meetings. Nurses employed by the health board are not allowed to perform tasks such as venepuncture, as they are apparently not covered to perform such tasks. Health board employed district nurses and health visitors are allocated to a practice without having the opportunity to meet other members of the primary care team they will be joining, unlike practice nurses who are interviewed by practice doctors and therefore have an opportunity to select the doctors they will be working with. It may be that district nurses and health visitors are less involved in practice decisions and forward planning.

It seems improbable that in the present financial climate health boards and family health services authorities will want to reimburse 100% of practice nurse salaries as suggested by Gilhespy. Gilhespy's suggestion of the appointment of nursing administrators to supervise practice nurses would further increase financial costs and remove more nurses from providing direct patient care. The money spent on these proposals would result in less being available for other essential aspects of the primary care budget.

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Retired doctors required for research work

Sir,

After working for 10 years in the cardiac department at St Bartholomew's Hospital, London and finishing my University of London degree in cardiac research with Professor Camm, I moved to Harley Street where I set up a company involved only in cardiac research. The Medical Centre for Cardiac Research Limited was created six months ago under the directorship of Duncan Dymond, consultant cardiologist at St Bartholomew's Hospital. Owing to expansion we are looking for five retired doctors who are interested in being involved in an enthusiastic research team on a part-time basis.

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