

Table 1. Reported psychological well being among those with familial hypercholesterolaemia and those found to have a raised cholesterol level on screening.

Problem resulting from knowing cholesterol level raised	% of respondents			
	Familial hypercholesterolaemia group experience problem		Screened group experience problem	
	Never/rarely	Sometimes/often	Never/rarely	Sometimes/often
Sleeplessness (n = 44/31)	77	23	77	23
Depression (n = 45/29)	53	47	79	21
Feelings of:				
No power over life (n = 45/29)	78	22	97	3
No control over health (n = 44/29)	55	45	76	24
Dependency on doctors (n = 20/10)	15	85	50	50
Current anxiety (n = 45/42)	36	64	60	40

n = total number of respondents in familial hypercholesterolaemia/screened group.

worried about having a raised cholesterol level one year after diagnosis. Being diagnosed as having hypercholesterolaemia increased feelings of vulnerability to disease generally. Following diagnosis 28 patients from both groups (31%) felt at risk from diseases both related and unrelated to coronary heart disease, compared with 10 patients (11%) before diagnosis ($P < 0.05$). Worries about health since diagnosis had stopped 12 of the familial group (29%) ($P < 0.01$) and eight of the screened group (18%) (not significant) from engaging in activities that they had engaged in prior to diagnosis, and 39 of the sample (43%) believed that a raised cholesterol level meant that they were unhealthy.

The results confirm the findings of other studies which have shown that positive screening results for risk factors such as hypertension are associated with reduced social activities,² increased subjective perceptions of poor health,² increased depression and tension,³ lower scores on self-reported measures of well being,⁴ and increased absenteeism and social morbidity⁵⁻⁷ irrespective of whether any treatment has been prescribed.

Recent government initiatives have ensured that screening for risk factors will remain high on the health care agenda.⁸ Informing asymptomatic individuals of the presence of a risk factor which may give rise to premature death might also give rise to adverse psychological consequences. Further research is called for into the psychological consequences of screening for raised cholesterol levels, and a role for counselling following the screening and diagnosis of hypercholesterolaemia may be indicated.

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Thyroxine prescription

Sir,

In the paper by Parle and colleagues, 48% of patients were receiving inappropriate dosages of thyroxine,¹ whereas other studies have reported inappropriate doses among 39%² and 32%³ of patients.

One of the aims put forward by Parle and his team was to investigate indications for thyroxine prescription in the United Kingdom. This was achieved by examination of the patients' notes and has obvious sources of potential error. The first is that such recording can be incomplete, inaccurate or missing. Secondly, only those patients receiving thyroxine as recorded on the practice computers were investigated. We are not told whether this included all patients taking thyroxine.

Although Parle and colleagues are to be congratulated on showing unequivocal

primary hypothyroidism (low total serum thyroxine level or low free thyroxine and raised thyroid stimulating hormone level) in 113 out of 146 patients receiving thyroxine (77.4%), the low percentage of all patients receiving thyroxine (0.8% compared with 1.9% found by Tunbridge and colleagues⁴) almost certainly means that at least the same number of patients again could be taking thyroxine in these practices. A study carried out by Swansea general practitioner trainees³ showed that older patients not on the computer, who had been taking thyroxine for many years often had no thyroxine stimulating hormone level recorded. The fact that the mean duration of thyroxine replacement therapy quoted by Parle was seven years for men and eight years for women lends further credence to the argument that older patients taking thyroxine were probably missing from the study.

A further possible source of error arises when thyroxine is inappropriately used following transient hypothyroidism. This is known to occur after surgery,⁵ radioactive iodine ablation,⁶ pregnancy⁷ and viral thyroiditis.⁸ The Swansea study not only identified patients who were taking inappropriate doses of thyroxine but also used a withdrawal test⁹ to test the appropriateness of having thyroxine replacement therapy. The withdrawal test over 21 days identified 28% of the studied sample who did not require thyroxine at all. The test was safe, provided that those who were truly hypothyroid and needed to return to treatment were recommenced slowly. The commonest reason in 1984 for commencement of thyroxine was its use by surgeons before local trauma to the gland had been allowed to settle³ (I suspect this happens much less frequently these days, if at all).

As shown by Parle, thyroxine stimulating hormone level measurement is a good indicator of adequate thyroid replacement, as free thyroxine measurements can be affected by other drugs.

The authors rightly conclude that regular review of thyroid function tests should take place to ensure optimal control. There are currently several regional centres which now allow regular automated follow up and these include the Scottish and Welsh automated follow-up registers which should also provide us with important and useful follow-up data.

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Formative and summative assessment

Sir,

We would like to comment on the editorial by Tombleson (May *Journal*, p.183). He points out that formative assessment is attractive to teachers because it measures improvement. Although true, there is a theoretical danger that trainees who are good at the commencement of training may be penalized because they show less improvement than colleagues who are poorer initially but then attain a similar standard of achievement. Furthermore, the trainer's eagerness to show improvement in a trainee's performance may bias his or her judgement.

The problem of assessor bias is a potential disadvantage of 'in house' assessment by trainers since poor trainee progress can pose a potential threat to the trainer who may feel that it reflects on his or her competence as a teacher. A potential solution to this problem is to separate the role of assessor from that of the trainer or mentor.

Formative assessment can be valuable but can prove threatening to a trainee if it is regarded as a series of mini-examinations to be negotiated during vocational training. Since its purpose is primarily educational, would it not be better to call it formative education rather than formative assessment? The same tool could be used for the purpose of summative assessment, provided the change in purpose was recognized.

General practitioners who are involved

in training at any level must accept responsibility for making assessment decisions. They should be aware that these decisions could profoundly affect the careers of those whom they assess and so must feel confident that the assessment tools they use are valid, reliable and in the public interest. However, even an imperfect assessment procedure can be used to introduce a sense of value. This must surely be better than an almost casual transition from traineeship to principalship?

In summary, summative assessment of competence for entry to general practice is necessary and is best conducted by a doctor who is not the trainee's mentor. Assessment of competence in order to identify learning needs should be formative. The assessment tools may be identical, but the different purposes must be clear to both the assessor and the person being assessed.

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24-hour cover

Sir,

As a former general practitioner, I am well acquainted with the burden which 24-hour cover places on doctors. However, I was surprised to read that relatively little progress has been made in providing alternative or supportive services (apart from the deputizing services) in the period since I left practice in 1984 (editorial, June *Journal*, p.226).

Most practices, I understand, are now group practices and operate from health centre-type premises. In addition, the support services provided therein have also been widened and increased. Practice nurses have, at last, made their presence felt and are now accepted as valuable members of the team. However, the practice nurse is only the first step on the way to a better and more efficient use of paramedical staff at the point of first contact with the general public. The suitably trained nurse practitioner and the general practitioner could work in tandem on a shift basis to provide 24-hour cover.¹ This would ensure that, out of hours, all patients were treated by staff from the group practice.

It was stated in the editorial that 'whatever arrangements are made, it is impor-

tant that primary medical care be provided by trained general practitioners at all times', but is this necessarily the case, and is it in fact necessary?²

In 1978, I asked 'is the general practitioner really necessary?'³ and in a series of articles, I pointed out that suitably trained paramedical staff could provide a general practitioner type service, with the general practitioner acting in the role of specialist generalist.⁴

Reading the editorial by Maxwell and Toby, it does not appear as if there has been much movement in this direction. With the proper use of paramedical staff working with general practitioners, 24-hour cover could be provided, care remaining within the practice which would be to the mutual benefit of all concerned.

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Voluntary Service Overseas

Sir,

Enclosed with the December 1992 copy of the *Journal* was a leaflet issued by Voluntary Service Overseas and the Royal College of General Practitioners encouraging doctors to enquire about medical posts abroad. I am a medical volunteer and have been working in Malawi for the last two years and I am concerned that some of the information in the leaflet is not strictly accurate.

Under VSO terms and conditions volunteer doctors are not paid a national wage in Malawi; they receive an allowance which is considerably less than that paid to a Malawian doctor in a similar position. It is supposed to cover basic living costs and is the same amount for every volunteer in Malawi, whatever their profession or level of responsibility. To maintain a reasonable standard of living the medical volunteer will have to be prepared to spend his or her own money.

Most VSO doctors are posted as district medical offices and spend much of their time with administration. At the end of two years they usually have reached some