diagnosis of dementia. Families regularly complain that they wish their general practitioner would either make the diagnosis or refer the patient to hospital if in doubt.[1] Secondly, general practitioners have little information about voluntary organizations and what they do. This is partly a problem of voluntary organizations who are not communicating to general practitioners what it is they do. However, it is also a problem for general practitioners who may not appreciate that voluntary organizations have an important part to play in offering information and support to patients and their families. There is now a relevant voluntary organization for virtually all chronic diseases which serves as a source of information and support for sufferers. Obviously, organizations vary in their aims and in the quality of service they provide. For example, among the many other things it does, the Alzheimers Disease Society publishes a regular newsletter which many carers find helpful as it gives advice on legal, financial and social problems. The value of the Alzheimers Disease Society was well expressed in a letter (February *Journal*, p.109).

Given that our society has an ageing population and there is an urgent need to raise awareness of alzheimers disease and other dementias, the issues of diagnosis of dementias and information about voluntary organizations could be included as part of general practitioners' continuing medical education.

When general practitioners have a patient with a diagnosed chronic disability, they should not ask themselves 'Shall I refer to a voluntary organization?' but rather 'To which voluntary organization should I refer?'.

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Shared care for hypertension

Sir,

Dr Snowise is correct in his observation (letter, February *Journal*, p.110) of the similarity between our shared-care scheme for patients with hypertension (October *Journal*, p.441) and a scheme reported earlier.[1] Indeed, these have a common origin in shared care systems for patients with thyroid disease[2-4] and diabetes mellitus.[5] However, as far as we are aware, our study was the first randomized controlled trial of shared care to be carried out in the United Kingdom. Our study provided strong evidence for the first time that the approach was feasible, acceptable and cost effective.

We stand by our claim that this is shared care. The term does not necessarily imply equally shared care but rather care which is shared as and when appropriate and matched to the patient's needs. The patients in the shared-care scheme for hypertension are not looked after solely by their general practitioner. Careful review of their clinical status by a specialist and appropriate advice are offered at least annually, as well as an appointment at the specialist clinic at short notice, if required. A recent article has emphasized that there are several models of outpatient shared care and that the traditional outreach clinic approach has many shortcomings, not least in cost effectiveness.[6] Our model has distinct advantages in that respect and also in ensuring that responsibility for overall care of the patient remains firmly in the hands of the general practitioner. We do not claim that shared care is suitable for all patients or their general practitioners. It should be seen as an option available in the hierarchy of care plans for patients with hypertension and other chronic conditions, an attractive option compared with continuing attendance at an outpatient clinic.

Dr Snowise misunderstands the implications of our cost-effectiveness analysis. The outpatient costs quoted in the paper are the direct costs of outpatient services used, allowing direct comparison with calculated costs in general practice. These are only a fraction of the costs likely to be charged by a provider hospital, which they were not intended to represent.

Fundholding general practitioners would surely prefer to have the assurance that their patients are receiving an appropriate level of care and hence that limited resources for outpatient care are being used efficiently. In addition to current fundholding issues there is an important and much wider public health dimension to this problem for whole populations of patients. It concerns quality, efficiency and continuity of care and should be urgently addressed. Shared care schemes offer one prospect for improvement in standards and appear to be just as relevant now, after evaluation, as they were when our experiment was started several years ago.

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Managing violence in the practice

Sir,

Drs Kidd and Stark comment in their letter (February *Journal*, p.109) about the paper on general practitioners' fear of aggression at work (September *Journal*, p.390). They argue that the responding doctors were too biased a sample and 'can carry little weight in the argument for a change of practice'. They also state that 'no details of the non-respondents' were reported.

The first paragraph of the discussion section fully acknowledged the question of the response rate to the original questionnaire and therefore the potential limitations of the findings. A reference was also provided for readers who wanted to explore the question of representativeness of the sample in more detail.[1] The paper Kidd and Stark comment on was confined to exploring the continued feelings of intimidation by doctors who had suffered a previous episode of aggression at work. There had to be a retrospective method that identified such a group and it was the original survey which explored prevalence of aggression, which was used as the tool. In fact, all of the respondents who had suffered abuse did complete at least some of the questions on their level of intimidation at work.

It is possible (although not likely) that the abused doctors who responded to this questionnaire were not representative of other abused doctors not identified for this study by their not having completed the initial questionnaire. However, data were provided on 611 previously abused doc-