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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Reference

1. Brodaty H, Griffin D, Hadzi-Pavlovic D. A survey of dementia carers: doctors' communications, problem behaviours and institutional care. *Aust N Z J Psychiatry* 1990; **24:** 363-370.

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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References

1. Petrie JC, Robb OJ, Webster J, *et al.* Computer assisted shared care in hypertension. *BMJ* 1985; **290:** 1960-1962.
2. Barker DJP, Bishop JM. Computer based screening system for patients at risk of hypothyroidism. *Lancet* 1969; **1:** 835-838.
3. Lazarus JH. Follow up of thyroid disease: three years' experience of an automated system. *Health Trends* 1978; **10:** 66-71.
4. Jones SJ, Hedley AJ, Curtis B , *et al.* Do we need thyroid follow-up registers? A cost-effectiveness study. *Lancet* 1982; **1:** 1229-1233.
5. Jones RB, Hedley AJ. Patient-held records: censoring of information by doctors. *J R Coll Physicians (Lond)* 1987; **21:** 35-38.
6. Orton P. Shared care. *Lancet* 1994; **344:** 1413-1415.

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-

tors. The wider dissemination of the personal consequences of such a large number of individuals I believe in itself warranted publication. Since no systematic bias was operating in this study, I further believe that the potential unrepresentativeness of the responding abused doctors does not undermine the important questions raised by the data. These 611 abused general practitioners represent 23% of all general practitioners practising in West Midlands Health Authority, and to ignore the implications for their practice would be unreasonable.

The authors of the letter also disagree that other professional groups, such as social workers, have access to more training on aggression. In contrast to general practitioners, the subject of aggression at work is a more recognized issue for social workers and teachers and is more comprehensively managed. Indeed, until the publication of research findings over the past three to four years, there was no training at all on aggression aimed at general practitioners. One of the positive consequences of work being published has been the raised awareness of the problems general practitioners face, alongside other professional groups. This has further led to a number of educational initiatives which are aimed at general practitioners and practice staff.

I would fully concur with Kidd and Stark where they suggest that 'general practitioners can do much to lead this process of turning research findings into practice by carrying out risk assessments of their premises, reviewing their policies on violence and seeking appropriate training for themselves and their staff.' These very recommendations have been consistently stated in my publications of research into aggression within general practice.

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1. Hobbs FDR. Violence in general practice: a survey of general practitioners' views. *BMJ* 1991; **302:** 329-332.

Leicester assessment package

Sir,

Our comments (letter, November *Journal,* p.535) are related to the statement made by Fraser and colleagues that the Leicester assessment package can be recommended for use in summative assessment.[1] We made no comment on its use as an education tool. As with any other formative measure its educational value will be determined by how helpful its users find it educationally rather than how reliable it is. We did not contend, as suggested by Fraser and colleagues (letter, March *Journal,* p.162) that the analysis was based on rank ordering but in the absence of any definitions of what the scores mean what we have is in fact a league table of performance.

We believe that if Fraser and colleagues wish to advance the claims of the Leicester assessment package in the determination of minimal acceptable competence they should address this area specifically. They state in their letter that candidates scoring less than 50% should be regarded as of unacceptable competence. We cannot find a pass/fail mark for summative assessment in the Leicester assessment package. However, the criteria for the package state that a score of below 40% demonstrates a performance indicating that the doctor is not safe to practise independently whereas 40% to 49% raises doubts concerning capability for independent practice and over 50% a satisfactory standard. It is easy to see why we are confused regarding the pass mark for summative assessment.

In addition, the Leicester assessment package scoring system is such that it is possible to be totally inadequate in one component yet still have a score which indicates a pass. There is no system for 'blackballing' a candidate who makes a single gross error.

In the study none of the doctors had an overall mean score below 50%, that is none was of unacceptable competence. The authors are therefore claiming that their system can identify a group of doctors none of whom has actually been tested by the system. When accepting the definition of minimal competence of 50%, two out of six assessors in the study believed that one doctor fell below this level while the other four disagreed. We would suggest that such disagreement must raise doubts about the utility of the method in summative assessment. Although it is not explicit in the text, it appears that this doctor had no experience at all of general practice but still managed to produce 'an acceptable performance in general practice consultations'. If this result is repeatable it must raise questions about the validity of the assessment method and the need for vocational training.

We contend that the paper contains no evidence to support the use of the Leicester assessment package in summative assessment since no evidence is presented that it can do the one thing that is essential in such a system — it has not identified any unacceptable doctors.

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Reference

1. Fraser RC, McKinley RK, Mulholland H. Consultation competence in general practice: testing the reliability of the Leicester assessment package. *Br J Gen Pract* 1994; **44:** 293-296.

Health promotion posters

Sir,

We were pleased to see further interest taken in the hitherto under-researched subject of health promotion in waiting rooms (December *Journal,* p.583). However, Ward and Hawthorne's findings differ markedly from our similar study[1] and the differences suggest that their conclusion that waiting room posters are a useful medium for health promotion may not be justified.

In our study, to avoid the possibility that patients might return to the waiting room to check the display before completing the questionnaire, the questionnaires were handed out in sealed envelopes for completion at home and then returned by freepost mail. Perhaps as a consequence our response rate (55%) was lower than their admirable response rate of 99%. Moreover, the longer delay between sitting in the waiting room and completion of the questionnaire in our study may have been a factor in explaining the much lower proportion of patients correctly naming poster topics (23% in our study compared with between 65% and 92% in Ward and Hawthorne's study). If recollection of topics, let alone their message, is forgotten so quickly it must cast doubt on the effectiveness of such displays in changing behaviour.

Traditional though they are, the value of waiting room posters is not proven.

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Reference

1. Wicke DM, Lorge RE, Coppin RJ, Jones KP. The effectiveness of waiting room notice-boards as a vehicle for health education. *Fam Pract* 1994; **11:** 292-295.