200 consecutive patients with various malignancies (83 men, mean (SD) age 62.6 (1.5) years; 117 women, mean age 63.7 (1.3) years). Thirty five of them had lymphoma, nine leukaemia, 15 bronchioalveolar carcinoma, 32 breast cancer, 28 urogenital carcinoma, 19 gastric carcinoma, 22 cancer of the colon, and 40 other carcinomas.

Only in the 51 men with weight loss (mean weight loss 8.0 (0.9) kg) was the mean cholesterol concentration (4.68 (0.21) mmol/l) lower than Wannamethee and colleagues' limit of 4.8 mmol/l. The cholesterol concentration was 5.50 (0.35) mmol/l in the 32 men who did not lose weight, 6.43 (0.40) mmol/l in the 62 women who did not lose weight, and 5.35 (0.33) mmol/l in the 55 women who did lose weight (mean weight loss 6.2 (1.2) kg). When the patients were divided according to the stage of cancer the mean cholesterol concentration was higher than 4.8 mmol/l in all groups, being 5.19 (0.38) mmol/l in the men with a localised tumour, 4.88 (0.21) mmol/l in the men with metastases, 6.30 (0.35) mmol/l in the women without metastases, and 5.61 (0.40) mmol/l in the women with metastases.

These data support Wannamethee and colleagues' conclusion that a very low cholesterol concentration is associated with only a slightly increased risk of cancer and that there is no causal relation. Our data also show that preclinical cancer is not likely to be responsible for low cholesterol concentrations because even clinically overt cancer produces low cholesterol concentration only in men with weight loss. Even in patients with advanced cancer (metastases) the cholesterol concentration was higher than 4.8 mmol/l. Therefore, there must be other factors (chronic ill health, smoking, and heavy drinking, as Wannamethee and colleagues suggest) that lead simultaneously to an increased risk of cancer and to low cholesterol concentrations in some subjects.

A C SÖNNICHSEN
Senior house officer
C OTTO
Junior house officer
W O RICHTER
Professor
P SCHWANDT
Professor

Klinikum Großhadern,
Ludwig Maximilians Universität,
81377 Munich,
Germany

1 Wannamethee G, Shaper AG, Whincup PH, Walker M. Low serum total cholesterol concentrations and mortality in middle aged British men. *BMJ* 1995;311:409-13. (12 August.)

Beware of the distorting interpreter

EDITOR,—Michael Phelan and Sue Parkman's article on the problems that arise when an interpreter is used during clinical work is instructive.¹ A small point that I would like to add concerns personal feelings and overt or covert interests or prejudices. Phelan and Parkman mention this as an important issue when one is counting on "friends or relatives" of the client, but it can also be important when interpreters are used, as I found when interviewing a young widow from an Asian culture.

I first met the family when I saw both parents about their son's behavioural problems at primary school. The father was much older than his wife, and it was clear that he thought that his son was perfect and that the mother was supposed to serve the boy, whatever issue was involved.

When the father died of a sudden heart attack we heard reports of the mother's grief and of the boy's intense distress. Because the mother was supposed to speak little English (the father's good knowledge of English had meant that this was not a factor in earlier meetings), we organised the services of an

interpreter for a meeting with her and her son.

After considerable discussion of the widow's feelings, and after we had asked the son to leave the room, I felt justified in verbalising my impression that the widow was experiencing not only pain but also relief at her husband's death. When I asked the interpreter to convey this to the mother he laughed and told me that my idea was plainly wrong. After some discussion he said something to the mother, but her facial expression suggested that she had not been told my views, and I had to argue this further with the interpreter. Finally, he said something to the widow that must have been closer to my interpretation, since she smiled, nodded vigorously, and said—in English—that perhaps it was wrong that she should harbour such feelings but that she certainly did so.

A H BRAFMAN
Consultant child psychiatrist

Roehampton Child Guidance Clinic,
Queen Mary's University Hospital,
London SW15 5PN

1 Phelan M, Parkman S. How to work with an interpreter. *BMJ* 1995;311:555-7. (26 August.)

Critique of fundholding study contained errors

EDITOR,—We wish to correct three errors that Jennifer Dixon and Howard Glennerster make in their article on fundholding when they discuss our comparative study of fundholding and non-fundholding practices.¹

Firstly, they state incorrectly that in our study in Oxford fundholders' prescribing costs decreased while costs in non-fundholding practices increased. In fact, costs increased in both groups, although the increase was slightly less steep among the fundholders (13.2% compared with 18.7%).² Further follow up of the practices showed that fundholders were unable to sustain this advantage two years later.

Secondly, the authors repeat Keeley's erroneous claim that most of the non-fundholding practices in our study were preparing for fundholding in 1991-2.³ This is not true. Some of these practices have now joined the scheme, but they had not done so by the time that data collection for phase 2 of our study ended in 1992.

The third mistake is to suggest that Howie *et al*'s Scottish study and our study produced conflicting findings on the impact of fundholding on referral rates.⁴ The two studies used different definitions of referrals, different denominators, and different methods of collecting data. They are therefore not directly comparable, and the patterns observed in the two studies are at least potentially compatible.

ANGELA COULTER
Director

King's Fund Development Centre,
London W1M 0AN

JEAN BRADLOW
Associate commissioner

Oxfordshire Health,
Oxford OX3 7LF

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2 Bradlow J, Coulter A. Effect of fundholding and indicative

prescribing schemes on general practitioners' prescribing costs. *BMJ* 1993;307:1186-9.

3 Keeley D. Fundholders had a head start. *BMJ* 1994;308:206-7.

4 Howie J, Heaney D, Maxwell M. General practice fundholding: shadow project—an evaluation. Edinburgh: Department of General Practice, University of Edinburgh, 1995.

5 Coulter A, Bradlow J. Effect of NHS reforms on general practitioners' referral patterns. *BMJ* 1993;306:433-7.

The case for student fundholding

EDITOR,—Teaching in medical schools is of variable quality, and I have often pondered how good teaching might be promoted by those who are taught. The answer, in fact, is learnt early by most students: "selective attendance," which is also sometimes disparagingly termed "skiving."

This laudable activity is usually misinterpreted by the medical school authorities, who seek to combat it. Undergraduates are adult learners capable of determining whether an hour is better spent with a textbook or being taught badly. If the authorities fear that the few main selective attenders will pass their examinations but make bad doctors then surely the error is with the examinations and not the students.

Picture the typical scene. The professor of surgery is searching for his students. "Where are those lazy blighters? I'm going to fail the lot of them." But with insight he would say: "Where are those students? Not here? The teaching on this firm must be awful; I'd better do something about it."

A close look at selective attendance, rather than the selective attenders, would provide the medical school with revelatory insights. This time honoured process should be formalised by allowing market forces to operate. Students should be given control over the vast sums of money they bring into the NHS, to spend where they see fit, by a system that I propose to call student fundholding.

The service increment for teaching provides about £40 000 per clinical student each year for the teaching hospitals.¹⁻³ Teaching hospitals, however, have always been more expensive than other hospitals, and the service increment was simply a soubriquet attached post hoc to this additional cost.¹ Since this money is not spent entirely on teaching, the loss of all of it might affect a hospital's patient care. However, students must have control of a sufficient sum to hurt the hospitals to encourage them to improve their teaching to win back the money.

Bad education would vanish with the pressures of open competition. Teaching would have its own kudos. Teaching and research would separate, which would eliminate the paradox of teaching hospitals having staff interested primarily in research. Teaching qualifications would become advantageous or necessary. The ridiculous situation whereby most medical educators know nothing about educating, perhaps having had only a few courses on how to deliver lectures when they began in their post, would disappear. Who would appoint a consultant surgeon with no surgical experience, expecting her just to muddle through after the odd afternoon course on how to repair a leaking aortic aneurysm? Long live skiving.

SIMON WILSON
House officer

Pinderfields General Hospital,
Wakefield WF1 4DG

1 Chantler C. Service increment for teaching and research. *BMJ* 1992;305:71-2.

2 Committee of Vice-Chancellors and Principals of the Universities of the United Kingdom. *CVCP briefing: undergraduate medical and dental education*. London: CVCP Publications, 1994.

3 Wilson S. Student fundholding. *Student BMJ* 1995;3:297-8.

4 Yorkshire Regional Health Authority. *Service increment for teaching and research (SIFTR). Medical: service specification*. Harrogate: YRHA, 1994/5.

Correction

Vitamin D receptor genotype and bone mineral density

Owing to an editorial error, one of the authors was omitted from the footnote to the second of the two letters in this cluster (the authors' reply, 30 September, p 875). The missing name was that of J S Lanchbury, senior lecturer in immunogenetics at the Molecular Immunogenetics Unit, United Medical and Dental Schools, London SE1 9RT.