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Sir,

We were disappointed to see how unwilling the group of GPs surveyed by Deehan *et al* (November *Journal*)[1] were in their responses to managing drug misusers. We believe, however, that with the right intervention GPs can change their behaviour towards drug misusers if not their attitudes.

We, in South London, have, for the past three years, run a consultancy and liaison service for the GPs in Lambeth, Southwark and Lewisham Health Authority (LSLHA) offering what we believe to be a comprehensive model of shared care, which includes face-to-face contact, easily accessible telephone advice, and training for primary care health staff. Within the past year, the Consultancy Liaison Addiction Service team (three nurses and one part-time GP consultant) has worked with 29 surgeries, providing help in managing their alcohol and drug-dependent patients. In this group are GPs who, prior to our service, were not managing dependent patients at all, quoting lack of resources and back up from colleagues as reasons for non-involvement.

Like Deehan *et al,* though unlike Gruer *et al* in Glasgow,[2] we would accept that money is not the main incentive to change. Within LSLHA additional funds for GPs caring for opiate users within a shared care model were made available. The numbers of drug misusers treated by GPs in LSL has not increased. Perhaps success is due to shared care, and additional resources should be put into expanding this way of working. Now is the time for GPs in all areas to get off the fence and positively participate in the care of this needy group of patients.

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Nurse practitioners

Sir,

The editorial by Koperski *et al* (November *Journal*)[1] on the subject of nurse practitioners (NPs) seems to suggest that there is an inevitable progression towards NPs taking an increasing role in general practice. I do not agree that this is necessarily a good thing.

The principle of 'practice makes perfect' has already led to the emergence of many different roles and specialties within the health care professions. NPs in general practice represent another new nursing specialty. The impetus behind their emergence is the continuing identification of new areas where it is those who perform tasks most often whose patients have the best results; often it doesn't seem to matter whether a doctor or a nurse performs these tasks.

General practitioners traditionally feel that the strength of their position hinges on their being the last true generalists in medicine. In defence of this they look to develop others' roles, to delegate, when changes are needed. This is a dangerous tactic.

If NPs are more successful than doctors in certain roles,[2] it is not because they are nurses per se, but because they are using skills that doctors are not. Perhaps GPs should consider learning some of these skills. And if the skills are simply those derived from frequent practise of a task, that is an argument for sub-specialization by GPs.

The demonstration of the worth of NPs seems to be mainly by those who are already ideologically committed to the concept. In fact, there are other solutions to the problems NPs apparently help to solve. However, those solutions will mostly involve GPs having to become more flexible about their own role.

There is a continuum from absolute specialist to absolute generalist. Perhaps GPs should try sliding a little further along from their end of it.

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Management of hypertension

Sir,

From Oxfordshire it emerges that factors other than recommendations in hypertension guidelines appear to be responsible for the variation in hypertension control between practices;[1] and from The Netherlands comes evidence that one of these factors appears to be organizational: an important finding is that only 5% of practices have protocols.[2]

In our practice, we decided that, with our high consultation rate, high non-attendance rate, and already large administrative burden, a recall system[2] would not be appropriate. We therefore devised a framework for opportunistic risk-based blood pressure monitoring, adapted from local[3] and national[4] guidelines and simple enough to be held on half a sheet of A4. For patients aged 30-79 (and older if not housebound), feeling generally well and neither pregnant nor terminally ill at the time of their consultation, the nurse (or doctor) will follow the flowchart (Figure 1).

The simplicity of this framework may make it attractive for other practices and help overcome organizational barriers to vascular disease prevention.

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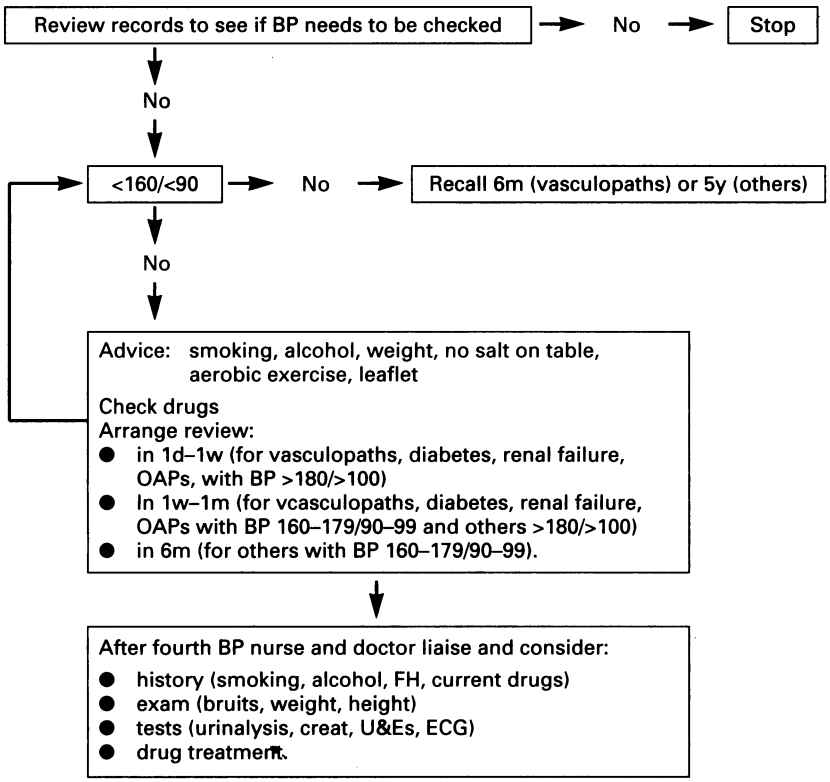

Figure 1. Framework for opportunistic risk-based blood pressure monitoring.

Summative assessment

Sir,

The leading article by Pereira Gray (October *Journal*)[1] summarizes the lengthy and tortuous process by which we have arrived at summative assessment. Although we believe he is right to celebrate many of the achievements in education attained by our discipline, we do not believe summative assessment to be one of them. Pereira Gray refers in passing to the critiques of summative assessment, but his editorial does not do justice to the very real concerns that are now becoming apparent as this new model of end point assessment is implemented universally. Rhodes has reported[2] that, in line with standard assessment theory, the 'high stakes' minimum competency assessment was narrowing the curriculum and affecting standards for the GP training year. We would concur with Neighbour[3] that it is not easy to define competence, and this is certainly not achieved with the current summative assessment package.

We have now completed our first full year of summative assessment, and our results, as with professional groups,[4] have shown that minimum competency testing is inefficient. In North Thames (West), of the 80 who have been assessed we found one registrar who would not otherwise have been recognized as needing two months remedial training. A huge effort was needed by GP registrars, assessors, and deans to find this, and we have had many worried, angry, or distressed GP registrars contacting the office during the year. The cost to the taxpayer for the 80 registrars in running summative assessment has been £62 000 — money we believe could have been more effectively spent in promoting formative assessment systems associated with adult, reflective learning.

As Pereira Gray points out, we are the only medical specialty that allows those with only 'minimum competence' to practise. By allowing entry into general practice of those with only minimum competence (whatever that means), rather than the MRCGP, we are neither 'protecting the public' nor advancing our discipline. The new modular MRCGP, as described by Haslam,[5] is set well above minimum competence. It will have the desirable effect of preventing those who have not received competence from practising, and at little cost to the taxpayer.

We are in total agreement with Haslam when he states:

> Assessment should not simply be a means of assessing minimum competence...it is becoming clear that other Health Service professionals are expecting that GPs should have reached a high rather than minimum standard of competence. There can be no logic in accepting lower standards in the medical specialty that is least supervised, hardest to do well in, and easiest to do badly.[5]

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Folic acid supplements

Sir,

The paper by McGovern *et al* (October *Journal*)[1] shows disappointing results in the proportion of women taking folic acid supplements before conception, with only 21% of postpartum women in Glasgow reporting having done so. The retrospective nature means that even this low estimate may be subject to recall bias. Fifty-eight per cent of the women in their study group had planned their pregnancy; thus 64% of those women who could have benefited from the reduced risk of a neural tube defect (NTD) that can be achieved with folic acid supplements did not do so. These results are consistent with recent similar surveys in Leeds[2] and Birmingham,[3] where 30.1% (1996) and 26% (1996) of women respectively reported they had taken folic acid prior to conception.

As the Health Education Authority's £2.3 million, three-year campaign to promote the benefits of folic acid draws to a close, we must look to new ways of improving the uptake of this important health message.

It has been estimated that over 35 000 pieces of GP advice on folic acid, given during contraception consultations, would