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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Reference

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.