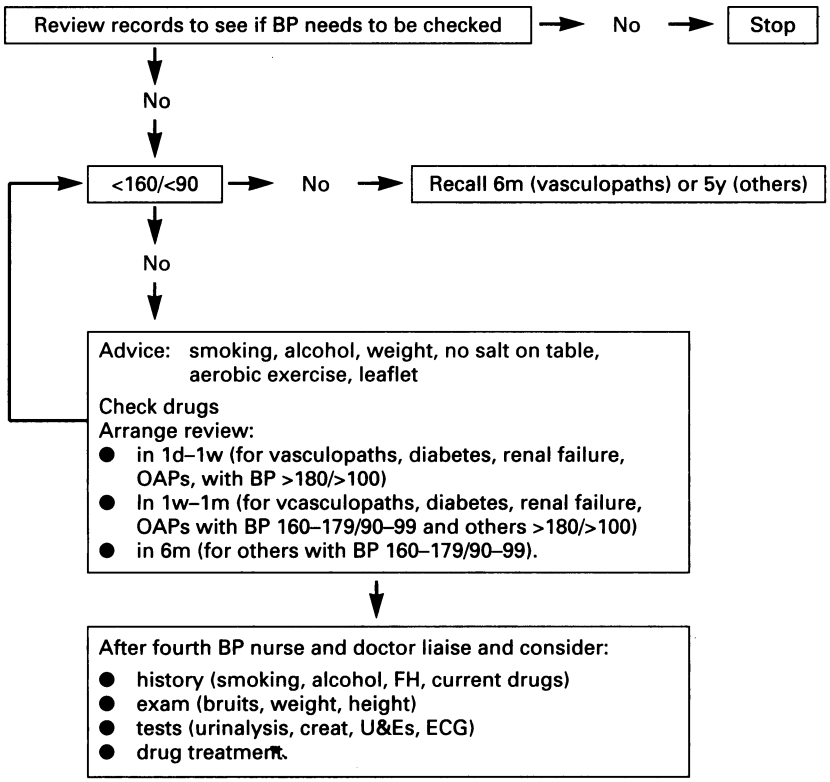

Figure 1. Framework for opportunistic risk-based blood pressure monitoring.

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

be needed to prevent one NTD.[4] In England there were almost 9 million prescription items for contraceptives in 1996 (personal communication: Department of Health, Statistics Division 1E, Prescription cost analysis system, 1996). Since the vast majority of women planning a pregnancy will have previously been using contraception, a message on the proven effectiveness of folic acid in reducing the risk of NTDs with each contraceptive prescription issued, and on the packaging of oral and barrier contraceptives, may be an effective and economical method of informing women who may conceive in the future of the benefits of folic acid supplementation.

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One-to-one teaching with pictures

Sir,

What a shame that Patel and Smith (Letter, October *Journal*) should be so hidebound by their Western medical education that they find the use of flashcards in health education patronizing.[1] After all, what are advertizing posters if not flashcards, and are they not found all over Britain? There was no racial stereotyping of the whole Asian community in the above study, as the ethnic community taking part was precisely identified as Pakistani Moslems with Type 2 diabetes and living in Manchester.[2] Innovative ideas that work and are acceptable to patients should pass in any direction, rather than in a technological hierarchy.

The paper they take issue with stated that 35% of the 200 patients attending consecutive appointments, both at a hospital clinic and the 10 GP practices that were entered into the study, had received no formal education. This means that they had never been to school and could not read or write in any language. It also discussed the importance of viewing the 'whole' intervention of flashcards, one-to-one education, and reinforcement. It made no claims that the cards alone would be educational, except perhaps as a reminder following the intervention. This was amply stated in the full title, but not by the selective reporting of Patel and Smith.

The linkworker took patients through each flashcard, explaining the pictures and using interactive techniques to get patients to participate and ask questions. There did not appear to be any problem with recognizing the contents or message in the flashcards, which had been piloted within the community for acceptability and comprehension. The guidelines mentioned by Patel and Smith had not been published at the time the study was conducted,[3] and some are inappropriate for your purposes since they are aimed at improving maths and reading skills. Development of the flahscards in our study was based on research into pictorial flashcard education in the Third World, and is referenced in the paper.

Patients at six-month follow up expressed their satisfaction with this method of health education, with only two asking for other methods such as audiotape or video. Many asked if they could keep the cards to put on their kitchen walls. Numerous health professionals in the diabetic field working with South Asian communities over Britain have expressed interest in this method, also suggesting its adaptation for white diabetic patients. This must be proof of its acceptability as a method to patients and workers in the field.

We were already aware of the work done by McBean, but it is of little relevance to our research since it studied a very different community with much higher levels of illiteracy and very little exposure to visual aids or pictures.[4] Our pilot studies showed that omitting background details made no difference to patients' comprehension of the pictures and they aesthetically preferred photographs with a background. South Asian communities vary tremendoulsy in Britain regarding their diet, customs, religion, degree of Westernization, and literacy rates. In addition, there is a dynamic state within each community, changing as the population ages and younger generations grow up. Our paper emphasized that prior pilot studies were necessary to identify educational levels within a community before introducing health education that may otherwise be inappropriate.[5]

The reality is that the bulk of South Asian patients in Britain do not have the luxury of access to a well-informed linkworker. They have to make do with practice nurses, who are predominantly white. Communication can be a real issue here. The method we describe shows how one linkworker can be adequately shared between a busy hospital oupatients' clinic and ten local general practices to provide important health education for an otherwise neglected community. This method of health education is widely used in India and Pakistan, where its success is due to the inexpensive technology, acceptability of the linkworker, and the flexibility of the method, which can be adapted by the linkworker to suit the recipient.[6]

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Blepharitis

Sir,

We are writing to report the findings of a psychological assessment, carried out in a general practice, of 20 consecutive patients suffering from blepharitis. There were 14 women and six men, with ages ranging from 27 to 81. Recent studies[1,2] have strongly suggested that some eye disorders are associated with various emotional difficulties, a frequent one being grieving. The 20 patients in this series had suffered from blepharitis continuously or recurrently for anything from three weeks to as long as they could remember.

In 12 cases, the first attack of blepharitis