tual clues have been shown to be paramount in the diagnosis and management of clinical disorders in general practice.[1] Hence the conclusions about records are restricted to scenarios in which the context is limited to that provided only by the encounter. In such a situation doctors might reasonably choose one of two approaches to the contruction of a record for the new patient, either to be very thorough or to jot down what, in their view, were the essentials of the case with the expectation that the patient would be returning. Hence the consultations studied were biased both in type (new) and in content (lacking important contextual attributes).

The second reason is more complex and concerns the extent to which records are performances in their own right as well as reflections of another activity — the clinical encounter. The paper begs the question what is medical performance? Rethans and colleagues regard it as just what went on in the consultation, the interaction between doctor and patient. Of course medical performance is more than this. So what exactly is the performance being investigated, and upon which the notion of validity is founded; what is the record valid for?

To answer this question it is helpful to consider what type of validity is being investigated here. If content validity is being investigated, then surely the appropriate questions are either: is the content of the consultation, in terms of discrete descriptions of all actions, reflected in the record? (representativeness) — plainly it is not; is the record nevertheless accurate for what it did record? (fidelity) — these data are not presented.

The record is clearly content valid from the point of view that it exists (although many were missing), and also from the point of view that things get recorded in it as part of the performance of the doctor's duties. Perhaps the correlations should be regarded in the same way that multiple choice question, essay and clinical scores correlate in formal assessment systems. That is, they are different aspects of performance and contribute to the construct validity of clinical assessment. Looked at in this way the coefficients reported in the study are of an appropriate order of magnitude.

Criterion validity would be estimated, not by measuring how many of the whole number of events taking place were recorded, but by measuring how many of those events taking place in the consultations which should be recorded (according to standards) actually were. This is not addressed in the study because the standards were set for the interaction not the recording.

Furthermore, records may be used to assess the quantity of performance (for which they are plainly invalid), but they may also have a relationship to the quality of performance. Suppose, for example, that the correlation coefficient (index) calculated had been 1.0 or 0.9. This would mean that every or almost every action performed was recorded irrespective of its importance. Is this an indicator of high quality performance? Moreover, is it sensible, plausible or efficient?

The authors summarize that 'The finding that the mean content score for all the categories of actions ranged from 0.25 to 0.36 shows that little can be concluded from records about what doctors actually do during consultations'. This may be true but does it invalidate the record as an aspect of performance to be assessed? Does the record have to be verbatim to be an accurate reflection of the consultation? We would think not.

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Counselling children in general practice

Sir,

We were interested to read the editorial by Salinsky and Jenkins (May *Journal,* p. 194) discussing counselling in general practice. It is encouraging that practices are developing this service, but to date it has been directed mainly towards adults. Despite the fact that bereavement, adjustment to disability and anxiety are not exclusive to adults, some surveys of counsellors' functions in general practice make no mention of children.[1,2] Although counselling of adults is likely to be of indirect benefit to their children, counsellors must address the impact of adult mental health problems on parenting if this benefit is to be maximized. It is well known that mental health problems are common and underdiagnosed among children presenting in general practice.[3] While some of these children will require referral to specialist services, others may be helped in the primary care setting.

Dowrick's extensive review of mental health provision in primary care says little about children, but alongside a call for more cooperation between primary and secondary care in the field of mental health, he calls for a comprehensive audit to be carried out.[4] If we are to ensure that children's needs are adequately addressed, child mental health workers should make sure that they are part of this process.

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Detecting patients with alzheimers disease

Sir,

Dr Cross (letters, June *Journal,* p.283) expresses concern about additional work that would result from screening for dementia.[1] Checks for patients aged 75 years and over are being carried out already as part of general practitioners' terms of service, and screening for dementia is included in these. Deterioration of mental function should therefore be detectable as the checks are carried out annually and results can be compared with those of previous years. Early intervention can avoid crisis management and may save work in the long term. Some causes of dementia are treatable, for example, vitamin B_{12} deficiency, and it must be part of a general practitioner's function to detect these problems as early as possible.

Furthermore, Wilcock had expressed concern that tetrahydroaminoacridine (tacrine) might be used without discriminating clearly between those patients who would benefit from its use and those who would not. He also surmised that the number of patients who would benefit would be small. Our study proved him correct. In