

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 construction 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 spe-

cialist 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 B₁₂ 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

view of the side effects of the drug it is important that it is used appropriately.¹

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Critical reading

Sir,
I agree entirely with Tom Fahey and colleagues' response to my discussion paper (February *Journal*, p.83). They emphasize the importance of the review article in critical reading (letter, June *Journal*, p.284). A thoroughly researched review article presenting a measured summary of current literature could be an indispensable decision making resource for the busy general practitioner, obviating the need to read the original studies or background literature. There are, however, few review articles which meet the criteria suggested by Mulrow¹ or Sackett and colleagues,² and until editors demand and authors write reviews which conform to these ideals the review article is in danger of remaining little more than someone else's opinion.

There are two factors which may hinder prospective authors from writing such a review. Cochrane pointed out the lack of a database of randomized controlled trials,³ hence the evolution of the eponymous Cochrane collaboration which aims to provide ready access to reviews of available evidence of effectiveness in health care.⁴ Secondly, evaluating results from a number of studies may require a more detailed understanding of statistical methods than normally found among general practitioners, and the use of formal epidemiological tools such as meta-analysis. These two points highlight the need to marry the science of epidemiology with the art of general practice.

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Information feedback

Sir,

In a similar manner to that reported by Voss and Old (letter, June *Journal*, p.282), we have also developed our software (management awareness profiles — MAPs) so that it can be used to display comparative information at practice level, drawing on family health services authority, child health and practice data. The final software is easy to use and provides great flexibility so that the individual user can choose which combination of indicators to display on the same profile.

Subsequent to our original study,¹ we have recently completed a research project which has evaluated the benefits of co-ordinated audit across a large number of practices. This project used MAPs software, which we would expect to be equally useful to medical audit advisory groups.

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Computer programmes for statistics

Sir,

Among the problems facing a doctor when trying to plan scientific research, are the statistical ones. Today, it is considered unethical to perform a medical study with a smaller number of patients, or with a larger number of patients, than is strictly necessary.

The statistical rules for determining study size, at least when the study is a simple comparative one, can be readily

mastered. However, the computations may be burdensome, although convenient short-cut methods are available. Decisions also have to be made about statistical test methods. Should one use student's *t*-test or the Wilcoxon rank test? Should the chi square test for a 2 x 2 table be performed with or without Yates' correction? In general practice, statistical expertise is not always available. I have, therefore, written two computer programmes which may be of assistance in the simplest of such cases. The programmes are: *Study size determination (SSD)* and *Power assessment by simulation (PAS)*.

The programmes have been developed over the last year in cooperation with colleagues in Norway and Denmark. They may be run on IBM compatible (DOS) personal computers with a hard disk. Both programmes, together with documentation files and references, will be mailed (against a nominal charge to cover expenses) to anyone who would like to try them. Interested readers should contact me at the address below.

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Auriscopes examination

Sir,

Examination of the tympanic membrane is usually done with an auriscope. Dim illumination from a weak battery in an auriscope can confuse even an experienced eye and sometimes a normal tympanic membrane may appear dull and serous otitis media may be wrongly diagnosed. The situation can also arise that, although illumination is adequate, the auriscope bulb in out of alignment and the spot of light is not quite in the lumen of the speculum, but is reflected from the sloping inner surface of the speculum in to the lumen, resulting in not only reduced, but also uneven illumination of the tympanic membrane, for example, the upper half of the tympanic membrane may appear brighter than the lower half.

Awareness of these pitfalls should help the examiner in general practice or other similar situations.

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