should be careful when generalizing beyond the specific sample of cases in this study'. Indeed in his experiments (in which accidently J-J R was one of the doctors studied) Hobus showed that contextual factors are important in diagnosis.[2] However, Hobus also confronted the doctors with new patients.[2]

Jolly and Southgate ask what performance is. We define performance as what a doctor actually does in day to day practice, preferably in a setting where doctors are unaware they are being studied.[3] Also, performance (and thus its assessment) may be divided in several aspects (for assessment thus several methods) as for example the personal interaction between doctors and patients, the medical technical content of a consultation and the record (clinical notes) of a consultation. Indeed we believe that our correlations should be regarded in the same way that multiple choice questions and clinical scores correlate in formal assessment systems. Therefore we state that 'the use of clinical notes to rank doctors according to those who perform many or few actions... may be justified' and, indeed, criterion validity is not addressed here. Jolly and Southgate suppose that a correlation coefficient of 1.0 would imply that every action would have been recorded, irrespective of its importance and ask whether this is sensible. No, it is not sensible. We do not believe (and thus we agree with them) that every action has to be recorded or that a record has to be verbatim of the consultation. However, that is not what a correlation of 1.0 is about, since if all doctors noted 20% (or 30% or 50%) of their actions and thus presumably took quality of actions into account, then the correlation would still be 1.0.

So, indeed from the range in mean content scores in our study little can be concluded from records about what doctor actually do during consultations. If however, records are being used as one in a series of performance assessment methods, records review may well prove to be valid, since it may correlate with other aspects of performance. For example, to study recording habits (as an aspect of performance), clinical notes may well be studied. However, to look at the actual content of consultations clinical notes, with the restrictions from our discussion section in the paper, should not be used.

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### References

1. Rethans J-J, Martin E, Metsemakers J. To what extent do clinical notes by general practitioners reflect actual medical performance? A study using simulated patients. *Br J Gen Pract* 1994; **44:** 153-156.
2. Hobus P. *Expertise van huisartsen: praktijkervaring, kennis en diagnostische hypothesevorming* [Expertise of general practitioners: content in diagnostic hypothesis formation, PhD thesis]. Maastricht, Netherlands: University of Limburg, 1994.
3. Rethans J-J, van Leeuwen Y, Drop R, *et al.* Competence and performance: two different concepts in the assessment of quality of medical care. *Fam Pract* 1990; **7:** 168-174.

## Counselling children in general practice

Sir,

I entirely agree with Wright and Cottrell's reply (August *Journal,* p.380) to an editorial on counselling.[1] Unfortunately, most counselling and psychotherapy training in the United Kingdom does not address the training issues of working with children and families.

Traditionally, most medical child psychotherapists worked from an analytical and psychodynamic perspective and their training is long and expensive. However, this is slowly changing as family systems theory is beginning to inform effective practice. Unfortunately, the number of trained therapists is tiny and only a very small proportion work in general practice in the UK.

Until training improves, it is probably wise that counsellors continue to work with patients aged 16 years and over, in order to prevent harm and be cost effective. Also, the picture many general practitioners share of traditional child guidance clinics with their long waiting lists may colour their attitude to providing such a service in-house.

To work effectively with children and their parents demands great skills and sensitivity together with the ability on the part of therapists to build up trust with their patients. General practice, with its tradition of continuing care lends itself ideally to the establishment of such services. Interested general practitioners running child health surveillance programmes, and skilled health visitors, are at present carrying much of the burden, often uncontained, unsupported and inadequately supervised.

All this will change as more counsellors working in general practice are trained to work using a family systems perspective and have in their tool box of skills cognitive behavioural strategies that they can apply successfully, as well as the wider counselling perspective that their training brings.

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### Reference

1. Salinsky J, Jenkins GC. Counselling in general practice [editorial]. *Br J Gen Pract* 1994; **44:** 194-195.

## Occupational therapy

Sir,

In Cambridge, the National Health Service community trust (Lifespan Healthcare) has not only undertaken to raise awareness of the full potential of occupational therapy for primary care, but has also recently received a grant from the Headly Trust to develop a model occupational therapy service based in general practitioners' surgeries and accessible by direct referral from any member of the primary care team. While the College of Occupational Therapists[1] and many fundholding practices[2] are considering new roles for these therapists, the benefit of any specific service offered is unknown. We hope to evaluate systematically the contribution NHS occupational therapists could make in this new setting, based on our experience with outcomes of occupational therapy for inpatients[3] and day patients.[4] However, before framing our intensive evaluation (involving a limited number of practices) it would be invaluable to have comments from general practitioners on their experiences of working with occupational therapists in the surgery. We would be most grateful if readers could send such comments to the address below.

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### References

1. College of Occupational Therapists. *Who makes doctors better?* London: College of Occupational Therapists, 1993.
2. Ingram S. Reference guide — occupational therapy. *Fundholding* 1994; **3**(8): 25-28.
3. Harries P, Caan W. What do psychiatric inpatients think about occupational therapy? *Br J Occupational Ther* 1994; **57:** 219-223.
4. Rutherford J, Caan W. User satisfaction with a psychiatric day hospital. *Psychiatr Bull* 1993; **17:** 627-628.