patients and the increasing depersonalization that patients experience in hospitals have produced a move on the part of certain consumer groups in the US to push for home care, particularly for childbirth and terminal illness. Unfortunately, the physicians are 'not following' patients to their homes and these people are undertaking this care themselves—a sad return to the situation of the last century.

It seems that family physicians have an enormous and perhaps insurmountable task ahead of them—to reconcile and implement the scientific, managerial, and pastoral roles of medicine, the last of which, as Dr Gray points out so well, is slipping slowly and perhaps inevitably away.

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TREATMENT OF MINOR RESPIRATORY ILLNESSES IN GROUP PRACTICE

Sir,

General practitioners see patients complaining of a cough about three times a day all their working lives. Usually there are no physical signs and the cough is predominantly nocturnal. The pathology is probably a widespread necrosis of ciliated respiratory epithelial cells due to a viral infection. This produces a relative stasis of bronchial secretions which is aggravated by the low ambient humidity in bedrooms. The only treatment required is to restore the normal humidity to the bedroom atmosphere by the use of an electric kettle or some similar device which produces 70 ml (2-3 oz) of atmospheric moisture every hour.

So far so good; now for the snags! Explaining this mechanism is a lengthy business and patients are often sceptical. They have been brought up to expect at least a bottle of medicine. There is an implied transaction of trading a symptom for a treatment and the refusal of treatment in some concrete form is an implied accusation of malingering. Furthermore, in a group practice colleagues vary considerably in their philosophies and patients compare the treatment prescribed by the different partners in a practice. Under the same roof there may be doctors who do not prescribe anything, others who prescribe antibiotics either prophylactically or as sedatives, or even prescribe 'Karvol', 'Calpol', mist. expect., and a eucalyptus chest rub on the same prescription form.

It is difficult to refrain from prescribing antibiotics when the patient storms out of the room and demands to see another doctor, particularly when by such tactics the patient receives a prescription for an antibiotic, admittedly given as a sedative!

The most difficult treatment to administer is nothing, and to make it palatable requires considerable time and patience to explain the reason for so doing. It is refreshing that recently patients are becoming more receptive to this advice and sometimes are even relieved to discover that they do not require treatment at all.

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PRE-SCHOOL DEVELOPMENT SCREENING

Sir,

I was interested to read the letter from Dr Evans (March *Journal,* p. 181) concerning pre-school development screening and the general practitioner.

Having been both a general practitioner and a clinical medical officer, I feel that it is not important whether the doctor doing the screening is called a general practitioner or whether the screening is done in a building called a surgery or a clinic ("A rose by any other name . . .").

However, it is of supreme importance that whoever does it is prepared to devote much time to it, that he or she has had full and specialized training, and is backed by a consistently efficient organization.

I feel Dr Evans's letter, much concerned with financial reward, might have been more in place in a journal devoted to medical politics than in one dedicated to raising academic standards in general practice.

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COMFORTER FOR CHILDREN

Sir,

One of the most pleasant aspects of general practice is the licence each one of us has to observe and record even the most simple behaviour of our patients.

It is well known that many children, usually those aged between three and five, when stressed or ill, place a special piece of material close to their face as a comforter. The comforter is chosen by the child himself and may be anything from a favourite toy to a small piece of discarded blanket or clothing. It is also named in a charming way by the child and it becomes his constant companion for a while.

What has struck me particularly is that when brought into action the comforter does not go into the mouth, where one might expect a breast substitute to go, but straight to the very centre of sensitive touch, that soft area between lip and nose, the philtrum.

This observation may be of no great significance, but that such a comforter should be the most important possession of a developing person in his early years is none the less exquisite.

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INDEPENDENT CONTRACTOR STATUS

Sir,

As a junior hospital doctor completing vocational training for general practice, I was intrigued by Dr Pereira Gray's article (December *Journal,* p. 746) plumbing the "hidden depths in the independent contractor status".

Its only claim to credibility rather than anecdote is a rather crude sociological formulation, using a bit of Weber here, Parsons there, and Frankenberg for good luck, while neglecting both the historical and contemporary complexity of the rise and changes in the medical profession. Indeed, it completely omits to remind us that a majority of younger doctors and those returning from the forces were in favour of a salaried service for general practitioners in 1946 (Foot, 1973), and seems unaware that one of the major achievements of the NHS (and the Royal College of General Practitioners) has been to rescue primary care from the vagaries of the market place, and a style of care that has more in common with the practice of a corner grocer than that of a modern health practitioner. Indeed, he views this as a positive