

LETTERS

Let's Use the Independent Contractor Status to Raise Standards

Sir,
The College has started the 'Quality Initiative' at an opportune time in an attempt to raise standards. Patients, government and our hospital colleagues are all demanding that better care be provided by general practitioners.

Of three approaches advocated recently¹ two already have been shown to be of limited value—at least in the short-term. 'The individual general practitioner should cultivate the habit of regular self-audit as part of his (or her) continuing professional development'. Dr Irvine states that the College should 'establish the MRCCP/FRCGP in the public mind as our hallmark of continuing quality'.² Yet to some extent the College is preaching to the converted.

Most doctors now sitting the membership examination have recently completed their vocational training and the majority of these doctors would be expected to have high standards. Older College members, especially those who joined when the College was starting, are probably interested in continuing education and improving standards. The other problem is that we begin to imply to the public that general practitioners who aren't members are inferior doctors, which clearly isn't true.

The 'pay us for what we do' approach already exists and has been shown to fail. Heath and Sims found that a group of general practitioners surveyed in the Tower Hamlets Health District all provided the oral contraceptive pill but one didn't own a sphygmomanometer.³ Kurji and Haines confirmed this lack of standards when they found '35 per cent of 43 patients taking oral contraceptive pills apparently had no blood pressure recordings during the time they were taking these'.⁴

The public understandably won't wait 20–30 years for vocational training and the College efforts to raise standards by osmosis. As most general practitioners jealously guard their independent contractor status it would require too profound a change in attitudes to suggest the introduction of a salaried service. So I would suggest that the status of independent contractor be used to prevent poor general

practice. Minimum standards of care must be established (after full consultation with all parties involved) and these standards incorporated into new contracts between general practitioners and their family practitioner committees. The FPCs must then actively monitor these standards to ensure that their contractors are giving value for money.

For contraceptive services I would suggest that the contract require general practitioners to complete a contraceptive continuation card containing details of relevant history and all examinations which would be kept with the patient's notes. The FPCs would monitor the services by checking 10 per cent (every 2 years) of the records of women for whom the doctor had received contraception fees. General practitioners failing to fulfil their contractual obligations would be heavily penalized financially. None of us would repeatedly employ a builder who gives second rate service so why should we expect our patients to do the equivalent?

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Post-coital Contraception

Sir,
Dr Andrea Hemlock (May *Journal*, p.299) can be reassured that post-coital contraception is effective. It is true that one never knows *which particular* women one has assisted in prevention of pregnancy, but a pronounced anti-fertility effect is not in doubt.

If no treatment were to be given, the best estimate of the chance of conception is about 30 per cent immediately prior to ovulation.¹ The two-dose oestrogen-progestogen combination pioneered by Yuzpe and recently approved by the Committee on Safety of Medicines has a failure rate of about

2 per 100 women treated at midcycle—a markedly reduced pregnancy rate.² The intrauterine contraceptive device is even more effective than morning after pills in preventing pregnancy in this emergency situation, with an almost zero failure rate.³

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2. National Association of Family Planning Doctors, Clinical and Scientific Advisory Committee. Postcoital contraception—notes for doctors. *Br J Family Planning* 1983; **9**: 42–44.
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Chronic or Recurrent Cough in Children

Sir,
I read with interest this short report by Dr Spelman (April *Journal*, p. 221).

Chronic cough as a presentation of asthma has been called 'cough variant asthma' by Hannaway and Hopper.¹ These authors describe 32 children all presenting with chronic cough of more than two months duration. The cough was usually non-productive, nocturnal, exercise or cold air induced and in all patients could be triggered by upper respiratory tract infections. The condition was more likely to occur in the autumn, early winter and spring. A positive family history of asthma was found in 40 per cent and positive skin tests in 55 per cent. In the 20 children who were able to have peak expiratory flow rates tested, none were abnormal. One third of the children demonstrated subtle expiratory wheezes during forced expiratory of deep breathing; the latter was considered to be a neglected clinical sign by the author. All the children responded to oral theophylline. Interestingly 18 patients out of the 24 in the long term follow-up group ultimately developed obvious mild or moderate clinical asthma.

Besides theophylline or beta agonists the authors logically suggested a trial of disodium cromoglycate (DSCG). I have tried this over the past two years and anecdotally I can report success. DSCG is obviously better for