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 recently[1] 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 MRCGP/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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3. Heath MCD, Sims PA. The general practitioner in the inner city: a survey of a London health district. *J R Coll Gen Pract* 1984; **34:** 199–204.
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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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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

long term administration because of its lack of side effects. Clearly a formal trial of DSCG in children with chronic cough whose history suggests cough variant asthma is needed. Naturally, disabling side effects on the parents of these children should not be neglected.

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Reference

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Focus on Women at 35

Sir,

Several years ago our practice compiled an age sex register, but now that it is complete, what should we do with it?

Late in 1982 we decided to offer all our women patients reaching their 35th birthday a comprehensive health check, which would include a cervical smear and thus make use of the fact that smears taken from that age attract a fee every five years. We considered that most women had completed their family by 35, had a settled lifestyle and might even think of themselves as middle aged and so welcome a check-up. Our aims were to establish a simple positive health care trial and we hoped to catch those patients who might otherwise not be seen in surgery for such checks. We also hoped that husbands might be encouraged to attend for simple health checks as a result of the screening programme offered to their wives.

We drew up a list of 29 questions designed to assess the general health and lifestyle of the patient. From the age sex register we found that 96 women would have their 35th birthday during 1983 and we sent most of these a letter wishing them a happy birthday, explaining the scheme and offering them an appointment. The nurse made the bookings, then each letter was scrutinized by the patient's own general practitioner and signed before being sent out timed to arrive on the patient's birthday.

At her appointment, which was within normal surgery hours, the patient was seen by the nurse who explained the procedure, discussed the questions and checked weight, blood pressure and urine. The doctor then went through the answers to check details before carrying out a full pelvic check and smear and any other examination that appeared to be necessary. Finally, the patient signed the claim form, which allowed her yet more time for informal chat when additional worries often emerged.

The scheme has now completed its first full year and has been generally welcomed by the patients and considered a success by both doctors and nurses. 85 of the 96 eligible women were sent letters and 61 attended. Five of those sent letters could not be traced and nine were new patients who will be followed up at their first attendance, leaving ten who did not respond. Forty thought it was a good idea, but eleven did not appreciate the approach on their birthday and eight confessed that they were worried and suspicious of our motives or findings.

A wide variety of minor ailments was reported and 13 were taking medication at the time of questioning; but 38 felt on top of everything.

We took cervical smears from all but two of the women, of which 26 per cent were reported as showing no endocervical cells. One examination revealed a large ovarian dermoid the size of an orange, which was later removed. No abnormalities were discovered on testing urine samples or blood pressure. Only one husband is known to have taken up the nurse's offer to check his blood pressure, although others could have been spurred to attend their own doctors. Several of the questions were of a social nature which turned up some interesting answers.

It was pleasing to find that most of our 35-year-old women patients were healthy and were not suffering from unsuspected problems. However, it is those who do not turn up for such screening programmes who cause the most concern; perhaps we should mark their notes accordingly and take special interest when they do turn up for ordinary consultations. On the whole, however, it seems to have been a sensible way to use our age sex register; to look positively at the general wellbeing of one small section of our patients. The chance of finding unsuspected pathology appears to be very low, but 59 × £5.70 = £336.30 additional income is welcome. We shall continue to send invitations to our 35-year-old women.

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Cardiac Rehabilitation

Sir,

A symposium on cardiac rehabilitation organized by the Research Panel of the Society of Occupational Medicine[1] laid stress on the beneficial effects of early return to work after myocardial infarction or cardiac surgery. A recent leading article in the *British Medical Journal*[2] drew attention to the fact that many patients can get back to normal activity and return to their previous jobs within a few weeks, and warned of the permanent damage to the well being of the patient that can ensue from inadequate or incorrect medical advice given in the recovery period in limiting physical activity.

Indeed, at the symposium the opening speaker, Dr Celia Oakley questioned whether perhaps the imposition of a rehabilitation programme may in some cases in itself give rise to iatrogenic disease. Following appropriate investigation a decision should be made on whether cardiac surgery or further medical treatment is indicated, and where this is not the case, there can be no justification for keeping a patient away from work. Physiological demands which physical exercise makes upon a patient will be less severe after training, producing according to Professor Fentem a beneficial 'sparing' of the heart. A vigorous exercise programme with running, swimming and circuit training up to 80 per cent of maximum heart rate has been in operation at the Queen Elizabeth Military Hospital, Woolwich, for the last four years, and beneficial effects were found, in particular on indices reflecting anxiety and depression.

The psychological consequences following a 'coronary' were outlined by Dr Elizabeth Cay, and the ensuing loss of confidence was dramatically brought home by a contribution from a patient who had suffered a recent infarction. He considered return to work would have taken longer, if he would have returned at all, without a course of rehabilitation. The post coronary rehabilitation programme at Northwick Park Hospital, aimed at the restoration of maximal physical function and confidence in the performance of daily activities includes both occupational therapy and physiotherapy and this was briefly described.

Two thirds of the patients undergoing cardiac surgery at the Queen Elizabeth Hospital, Birmingham, returned to gainful employment, and were thus able to contribute to the society which underwrites the considerable cost of their treatment.

Return to work after infarction or cardiac surgery was also discussed from the viewpoint of the doctor working in industry. While the value of a formal course of rehabilitation was considered controversial, all were agreed that maximal restoration of function for the patient who has suf-