For and against

Should we fight to preserve the independent status of general practitioners?

Roger Chapman, Helen Groom

Primary care in Britain is set to change again from 1 April. England, Wales, and Scotland have different sets of reforms, but general practitioners in all areas will soon be working together in new groupings that could lead these doctors into salaried rather than independent contracts with the NHS. Here, two members of the BMA's General Practitioners Committee argue the pros and cons.

FOR The special status that most general practitioners have enjoyed in the NHS for 50 years is under threat. Until now most general practitioners have contracted independently with health authorities and their predecessors to provide primary care, rather than being salaried employees. Working together as principals in practices has not affected this independence. But from April all general practitioners in England and Wales, and some in Scotland, will join together in large local groups that could signal the end of the independent contractor.

Many general practitioners feel that their independence is increasingly illusory and believe, despite protestations to the contrary, that governments have always resented the freedoms and privileges of this special status. The general practitioners' revised contract in 1990 ushered in an increasingly managed service. The Primary Care Act 1997 enabled alternative models of primary care, often where traditional practices no longer met the needs of local people, and encouraged salaried options.

The move to primary care groups and the prospect of rapid progression to primary care trusts signal a big shift in that direction. Despite the protective conditions negotiated by the General Practitioners Committee in June 1998, the introduction of cooperative working, clinical governance, and unified budgets could render independent contractor status unsustainable. Finally, the relatively few young doctors aspiring to be general practitioners and the large but unknown number of fully trained general practitioners choosing to work in general practice without becoming principals are cited as evidence that doctors are rejecting independent contractor status.

Does the threat to contractor status matter?

General practitioners value the uniqueness of their position. Responsible participation in the NHS and personal commitment to the development of primary care characterised the golden years of general practice

in the 1970s and '80s. The initiative, enthusiasm, and energy of that period, facilitated by the family doctors' charter of 1965, led to rising standards, evolving practices, and developing services.

General practice undoubtedly faces considerable problems, yet many general practitioners still enjoy their work. Part of that enjoyment is the relative freedom afforded by independent contractor status. The ability to plan and organise the working day is a privilege that allows general practitioners to control their working environment. The freedom to speak publicly about issues of concern without the fear of sanction by managers cannot be given up lightly.

The new primary care structures will increase the focus on quality, but budgetary pressures will lead to difficult debates on prioritising patients' needs. Yet general practitioners have already learnt to negotiate budgets and manage them responsibly; cash limits are nothing new to general practice, and debates about rationing have become part of the job for many general practitioners.

What can general practitioners do?

General practitioners cannot assume that independent contractor status will continue to suit all circumstances and all individuals. One model of general practice is no longer applicable in all parts of the United Kingdom. Imminent retirements and recruitment difficulties in, for example, inner cities require the introduction of a range of alternatives. The differing aspirations of a new generation must be valued and respected.

Yet the practice comprising independent contractors as the unit of delivery of primary care continues to deliver a highly cost effective service. General practitioners who value their present status must work to maintain that position and tell younger colleagues about the good bits of general practice and the advantages of their position. Nothing will deter potential recruits more than the unremitting diet of doom and gloom that currently fills the pages of much of the

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medical press. General practitioners who participate fully in the new primary care structures and embrace clinical governance can secure the position of independent contractors while arguing for the resources needed to continue the development of general practice.

There is nothing in the new NHS arrangements that necessarily finishes off the independent contractor. Any government could do it more directly by abolishing the independent contractor status and imposing a salaried service. General practitioners must ensure

that this does not happen by default or through apathy or misunderstanding.—Roger Chapman

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AGAINST Despite our independent contractor status, general practitioners are public servants in the public sector. As a profession we have enjoyed the respect and gratitude of our patients. Most general practitioners enjoy stable, well rewarded, lifelong jobs. In return general practitioners have worked hard, increasingly hard. We have provided a “cradle to grave” service, 24 hours a day, 365 days a year, while maintaining the professionalism and dedication required to give patients the best services possible. Unfortunately, that unwritten contract between general practitioners and the public is no longer enough for either party. The general public will no longer blindly accept the word of doctors. Patients quite rightly expect their general practitioners to have up to date knowledge of them and their problems and of appropriate solutions supported by evidence.

Our independent contractor status does not define us. The essence of being a general practitioner is the ability to listen and to hear what patients are saying and to investigate, prescribe, refer, and manage patients who are, or believe themselves to be, ill. Our awareness of local variations and, most importantly, our knowledge of individual patients within the context of their families and communities are our defining attributes. This is why we are important advocates and allies for our patients. We can be an important source of information to the new primary care structures and the wider networks of health and social care. We and the public should defend these attributes rather than the holy grail of independent contractor status. Attributing too much importance to contractor status could imply that the many non-principals,

assistants, and salaried doctors, who increasingly provide high quality care in many practices, are second class general practitioners.

Together with the BMA's General Practitioners Committee, the Royal College of General Practitioners, and the public we seek to serve, the profession should define for itself the art of being a general practitioner. We have to negotiate for satisfying and high quality training, a new career structure, and appropriate rewards. We have to accept and welcome the checks and balances in our practice demanded by both government and public. We face working with a new system of revalidation, a national institute for clinical excellence to dispense direction through clinical guidelines, and a commission for health improvement to check that we follow that direction. At the same time, the profession is trying to stem a drop in recruitment to training schemes and a perceived fall in general practitioners' morale.

Whether we like it or not, the world of general practice is changing. Fighting too hard to protect our contractual status may mean that we lose sight of the real essence of generalist practice that is so valued by general practitioners, the NHS, and the general public.—Helen Groom

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Observing patients Deaf wife

Years ago in my consulting room I was seeing an old patient for his regular six monthly review, and was pleased when my receptionist sent in his wife as I had never met any of his relatives. During the usual questioning I addressed odd remarks and questions to her which elicited no response. In his notes I then wrote “deaf wife.” After a physical examination, an electrocardiogram, and an x ray examination I bade him goodbye and noted that the wife remained seated. I inquired if she was not going to accompany her husband? She then spoke up to say, “I am not his wife, but your next patient. I was fascinated to see the whole procedure, but have one complaint. Next time could you provide a better male specimen, someone like Paul Newman?”

Edwin Besterman, consultant cardiologist, University of the West Indies, Kingston, Jamaica

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for “Endpieces,” consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.