WITHOUT PREJUDICE

At the beginning of this year that tireless quartet of general practitioners led by Dr. J. C. Cameron had before it the advice in the Family Doctors' Charter that the pricing of the new contract should be negotiated directly with the Government. But the Minister of Health insisted on sticking to the Review Body as the mechanism for deciding how much. Dr. Cameron told the special conferences in March that the setting up of the Review Body had been "a turn . . . in the right direction"; Mr. J. R. Nicholson-Lailey stressed its "integrity and impartiality." And so in the long run the implied advice was followed.

The advice was to stick with the Review Body. It was sound advice. Yet to look at recent correspondence in the *B.M.J.* it appears that one or two or more have only just heard the news. This does not really surprise me, as so many medical men these days deafen themselves with their own shibboleths.

What a mess the profession has got into in the past with direct negotiation with the Minister of Health on pay! It was only when this was removed to arbitration that the famous Danckwerts Award was made in 1952. This was based upon the interpretation of the Report of the Spens Committee.

Mr. Iain Macleod, the then Minister of Health, took fright at the size of the sum and determined to bury the Spens Reports for ever and a day. He didn't find this difficult. After some shilly-shallying the profession agreed to fall in with the Royal Commission on Remuneration of Doctors and Dentists in the N.H.S. set up in 1957 and reporting in 1960. Thus was side-tracked the general practitioners' demand for an increase first of 24% and then of 29%. The myth of Spens was kept alive but the corpse had a decent burial. "It's no good trying to keep it alive," I was told by the cleverest—and perhaps the wisest—brain I have come across in medical politics. "The Government just won't have it. They're determined never to have another Danckwerts." And it was a Conservative Government he was referring to.

The Royal Commission came out with its report and its recommendations that an increase of 21% should be made and that a Review Body should be set up to make periodic adjustments in the pay of N.H.S. doctors, relating this to changes in the cost of living, changes in the earnings of others, recruitment, and the National Interest.

All this was wrapped up in a package, and the medical profession in effect had to take it or leave it. The package deal was accepted and with it the Review Body of seven men.

I am sure the profession's leaders believed they would get a fairer deal out of the neutral Review Body than out of the other interested party, the Ministry of Health. A reasonable assumption to make.

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"Just but not generous" was the verdict on the 14% award of the Review Body in 1963. But when the cheques came in general practitioners found that the 14% appeared to have shrunk to as low as 6%. It took them a long time to realize that the 14% was applied to net earnings and not gross. But what was much more difficult to swallow was the fact—and it was a fact—that by the time of the award they had already had some of it on account. A woman scorned has shown no such fury in the hubbub that arose, reaching the full volume of the *vox humana* in a meeting of the Panel Conference in Church House, Westminster, in March 1964.

Overnight the Pool became a dirty four-letter word, and strong men were even ready to forgo the security of the capitation fee.

Back to the charge they came with a new weapon called S.C.7 with a price tag of £18m. on it. The Review Body riposted with an offer of £5½m. complete with strings. It seemed they were getting as difficult as Ministers of Health used to be. But the tenacity of those who sit regularly in Committee Room A of B.M.A. House was that of a hungry leech. The Family Doctors' Charter was produced and priced at, I believe, £42m. more than was in the current Pool.

In spite of the setbacks those representing general practitioners didn't take much persuading to carry on with the Review Body—on the assumption, I suppose, it wasn't going to let them down by resigning. In their quieter moments they probably also reflected that consultants and hospital doctors also had a say in this, and an important say too.

What sticks out in all this is that the organized medical profession have acquiesced in and accepted each of the successive steps taken since 1946. It can't turn the clock back, especially a clock it has itself been so busy winding up. Whatever may be the drawbacks of the present system of adjusting pay, doctors would find direct negotiations with Ministers of Health very much worse, because they're hemmed in by the Treasury. We may not like the results up to date. But we helped to draw up the rules and should stand by them.

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Some years ago I listened to a discussion between American and Norwegian doctors in which it emerged that general practitioners could and did earn bigger incomes than consultants and specialists. At least I heard this statement made by a prominent specialist in Oslo. The Americans were horrified, and horrified, too, to discover that Norwegian doctors weren't rich and didn't want to get rich, quick or slow. The Norwegian specialist said, "Why shouldn't the general practitioner get more than I? He works longer hours in often appalling conditions, whereas I work in a hospital where everything is provided for me. I have expert help from assistants and nurses, and *x*-ray and pathological facilities. I have reasonable hours and do the work I love."

The other day I read that in Norway, too, young doctors are avoiding general practice and prefer to work in hospital. So there, it appears, it isn't the money but the nature of the work, and conditions, that control the drift from general practice.

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From what I glean in a most interesting recent series of articles in the *B.M.J.* doctors who work in groups with colleagues of their own choosing prefer it this way. In particular, I was struck by the egalitarian nature of payment in some of these groups. Whatever each man earns goes into the common pool, which is shared out equally at the end of the day. Apart from the advantage of common services and purpose-built accommodation, men in such groups consult freely among themselves, to their own mutual advantage and to the benefit of the patient. But the overriding obstacle to the full development of this type of practice is lack of money for the full employment of auxiliaries and for proper premises.

I would not say I am quite certain just how a Group Practice differs from a Health Centre. Both embody the same type of practice—doctors working in the same premises adapted to modern conditions and aided by auxiliaries, with adjacent facilities for expert investigation.

The fundamental difference is, it appears, in ownership. The local authority owns the Health Centre. The group owns the Group Practice. This gives the doctors in the group a sense of freedom and a spur to enterprise. It's not freedom to earn more money, but freedom to be free that they value.

The group reaches its most satisfactory evolution when its members have a good working relationship with the local medical officer of health. Conflict between the Health Centre and the Town Hall can spoil a great deal. It's no good blinking the fact. The general practitioner *should be* the leader of the health team, but this is not necessarily the way all medical officers of health would see it, especially if the place the general practitioner works in is owned by the local authority. I now begin to understand why Aneurin Bevan preferred Group Practices to Health Centres.

PERTINAX