The rise of the medical McJob:
why we *should* turn the clock back

When Aneurin Bevan, William Beveridge, and Ernest Bevin proposed a National Health Service in the mid-1940s, the idea was met with considerable resistance from the medical profession. It was eventually accepted in 1948 with the promise of sweeteners which were, for consultants and GPs respectively, the right to continue private practice and independent contractor status (whether working single-handed or in partnership). This prototype has survived over six decades and is the one within which most GPs still work. However, in recent years there has been a noticeable trend towards recruiting doctors who work in other ways, and current vacancies are most likely to be advertised as salaried posts. In this essay I will argue that, far from being a laudable choice, the erosion of the GP principal concept is a worrying trend undermining the interests of patients, GPs, and the wider medical profession.

The trend for new recruits in general practice to work in posts other than principals has been a gradual evolution rather than a revolution. However, the mid-1990s — the time of my entry into general practice — appear to have signalled a pivotal point, which begs the questions: how and why did this occur?

Without doubt, much of it was to do with a generational change in attitudes, as values such as security, authority and tradition became less revered. Douglas Coupland, in his novel *Generation X*,[1] observed trends in young adults seemingly intent on an extended adolescence, unable to visualise a future either personally or professionally. Easily bored, they opted for a series of 'McJobs' — low paid work in service industries with poor prospects, although many came from comfortable, if not actually privileged, backgrounds.

It was at this time that two important trends conspired to sustain Generation X. Firstly, this was the era of the populist politician,[2] none more successful than Tony Blair. The recent Prime Minister was adept at eulogising 'choice' and 'change', yet despite the populist rhetoric, the last decade has been characterised by a paucity of public debate on major issues, and a tendency to dismiss the concerns of those holding a contrary opinion — woe betide anyone who challenged the prevailing orthodoxy by, for example, suggesting that a spending spree financed by irresponsible levels of personal debt was not sound economic planning. Secondly, a coarser form of capitalism spawned an economic system where corporate profit relied on a flexible, ultimately dispensable workforce, especially in sectors such as catering, hence the soubriquet McJob. Not that politicians had a wish to dismantle it, on the contrary, for it was the capitalists whom they courted for party funds and who would wine and dine them in their lucrative semi-retirement. The first Generation X, now in early middle age is, by contrast, still flipping burgers, pulling pints, and often living with their parents. They exercised their choices, and discovered their folly.

Inevitably, an attenuated version of Generation X arrived at medical school, less directionless than the prototype, but neither yearning for the good old days because they didn't have any good old days to remember.[3] They clamoured for flexibility in their working lives,[4] and general practice, already perceived to be a family-friendly specialty, became a popular choice for such graduates. There was no shortage of more experienced colleagues to help them through the options. In 1997 a guide for non-principals appeared in the *BMJ*,[5] describing salaried partnerships (surely an oxymoron), retainers, associates, assistants, locums, and working for the London Initiative Zone: a bewildering array of alternatives.

Another important factor in changing working patterns has been the rise in the number of female medical graduates. This hitherto taboo subject has recently been the subject of discussion.[6] There is no doubt that historically there has been discrimination against women for entry into medicine; however, all UK medical schools now have more women than men, and in some the proportion of females exceeds two-thirds.[7] With this, an emerging body of opinion is concerned that the pendulum has swung too far the other way.[6] Women have brought much to medicine, including better performance in exams[8] and more patient-centred consultations.[9] Nevertheless, after four decades of feminist rhetoric, society still expects women to do the majority of childrearing, leading to most opting to work part-time.[10] General practice therefore bears a disproportionate burden of the fallout, such as maternity leave and loss of continuity of care.[11] There is a potential time bomb for general practice provision, currently cushioned by the fact that most doctors over 45 years of age are male and full-time, while most younger colleagues are female, working part-time, and are unlikely ever to work differently.[12] If any discrimination is currently taking place it is affecting men who intend to work full-time, something that can only be justified were this group unlikely to make a significant contribution to the profession, which is plainly nonsense.

Medical education is also being adversely affected by the number of doctors reducing their clinical practice. At medical school and in our postgraduate education, the memorable pearls of clinical wisdom were invariably delivered by tutors who were frontline clinicians, whether in the consulting room, on the ward round, in the operating theatre, or even in the post-mortem room, allowing theoretical knowledge and its practical application to marry up. I contrasted this favourably with nursing education where a clear dichotomy is in place: theory taught by tutors no longer in clinical practice, while ward and practice-based tutors, though providing the vital training in practical skills, often lack academic recognition and support.[13] The last century has produced many outstanding teachers: John Fry and Julian Tudor Hart in general practice, Hamilton Bailey and Harold Ellis in surgery, and Maurice Pappworth and Sheila Sherlock in medicine, to name but half a dozen. This was a diverse group — Pappworth and Sherlock, for example,

publicly disliked each other — but they did share one other thing in common, in that they each had a large and diverse clinical practice. By contrast, and worryingly, many medical deans now oversee postgraduate education having relinquished all contact with patients. Can we really do no better than a bureaucrat pointing students to the latest web-based toolkit?

Does this all matter? I believe that the trend to move gradually but inexorably from partnerships to working under other contracts is damaging across a wide spectrum, adversely affecting patients, doctors, and potential future recruits into medicine, as well as the standing of general practice both within the medical profession and in comparison to other professions.

Beginning with patients, it is well recognised that chronic illness in an ageing population is the greatest driver of healthcare need.[14] In this respect, the UK is similar to other countries of comparable wealth; however, factors more specific to our population may serve to exacerbate pressure on health care. Our population is easily the most ethnically diverse in Europe, while enthusiastic adoption of the free market has led to a widening gap between rich and poor.[15] The deleterious effects of deprivation on health have been well chronicled,[16,17] but it is only recently that excess demands generated by wealth have been debated.[18,19] I needn't look too far for an obvious example. The prosperous areas of Hertfordshire and Buckinghamshire in which I practice have long been coveted by migrating Londoners, for whom economic pragmatism dictates they can stretch but not sever their links with the capital, into which the majority of working age residents commute. But look beyond the cloying 'best of both worlds' clichés beloved by local estate agents, and the downside is obvious. Given the cost of living, the entertainment and cultural amenities are lamentable. Public transport is negligible, and virtually all journeys apart from the commute to London are done by car — not much in the way of fresh country air when the roads are choked by 4-wheel drives and German gas-guzzlers. Varying degrees of social isolation are rife and support structures poor, as people trade their previous networks for a stressful environment of competitive materialism, despite the limitations of wealth as a source of happiness.[20] Whichever way one looks at it, the pressure on primary care continues to rise, and against this backdrop, selection into medical education of a large proportion of graduates likely to spend most of their careers working part-time, and employment opportunities commensurate with this ambition, seems unwise. We must keep a sense of perspective: what gain is there in fretting over the quality of out-of-hours services[21] or advancing the cause of easy patient access to their health records[22] when we cannot guarantee reasonable daytime continuity of care? The risk to general practice is that patients may conclude that their care lies elsewhere, and the Darzi plan will succeed by default.

Moving onto doctors, if the mood in the current workforce was hale and hearty my argument could cease at source. This is not the case. Concerns are being voiced about the emergence of a two-tier workforce, with salaried doctors forming an unhappy underclass.[23] More importantly, registrars in general practice are despairing of ever finding a substantive post.[24] Established GP principals may have tried to recruit new partners only to find applicants less committed than in previous generations, and it is indeed churlish of any doctor to expect equal pay and status for a less onerous week. The result was that established principals began recruiting younger colleagues on fixed salaries, lower than share partners were earning. While this was obviously economically advantageous to the former, from a strategic viewpoint I fear this is flawed. If they make no attempt to offer partnerships, this fails to reach out to the younger colleagues, even if only a minority of which wish to make a traditional commitment to the workplace, and they risk having nothing worthwhile to hand over when they retire, killing off the concept of partnership forever. Neither side in this argument can have it both ways.

In the 1950s Charles Moran, former President of the Royal College of Physicians, stated that 'to end up in general practice is to have slipped off the ladder'. It was one of a number of late-career gaffes he made with which he besmirched his reputation, a more famous one being publishing details of Winston Churchill's health problems (he was Churchill's personal physician) just a year after the latter's death, in breach of confidentiality and of common decency. That remark illustrates, however, that general practice's reputation had once been poor in the eyes of consultant colleagues, and while some may still hold such views, there is no doubt that general practice's stock has risen considerably. Central to this has been academic kudos, beginning with the founding of the RCGP, through to the advent of vocational training, the membership examination, and research platforms. Having fought hard for this position, however, the chances of maintaining it may not be propitious. Unless there is an increase in graduates who are able to commit themselves to the profession properly, and given reasonable opportunities in the job market to do so, general practice may become a Cinderella specialty, a job sufficient to provide a second household income rather than serious professional endeavour. A truly apocalyptic vision is the next generation of GPs being chiefly a part-time, peripatetic group with little stake in the profession or bond with a community, limited opportunities for professional development, and no political clout beyond securing their own existence. They would be, in fact, lifelong McJobbers.

How then can medicine, and general practice in particular, be seen as a worthwhile career for future generations? Despite extensive press coverage of GPs earnings, much of it wildly exaggerated,[25] medicine cannot begin to compete with comparable professions such as law and dentistry for monetary remuneration, let alone working in the City or getting to merely journeyman status in professional sport or showbusiness. A useful and secure job with a reasonable pension and a respectable position in society has proven sufficient, thus far, to allow a cohort of able entrants willing to forsake more lucrative professions for medicine. However, the concern is that general practice is losing its carrots while retaining the sticks.

We are at a crossroads in the profession. Significant gains have been made in areas such as education, as well as the implementation of a contract rewarding good, evidence-based clinical care.[26] However, general practice risks losing its

ability to provide continuity of care for patients or to nurture its future generations if it colludes with the proliferation of transient posts at the expense of traditional partnerships, an experiment that has clearly failed. If this trend is to be reversed, selection into medical school and postgraduate training schemes must ensure a critical mass of entrants likely to be wholly committed to their careers. In addition, rather than accept the demise of the GP partnership as inevitable, we should revive it before it is too late.

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COMMENTARY

When I received this piece from the editor of *Back Pages* I expected to read the usual 'politically correct' opinions one has come to expect from College activists of a certain age.[1] As an older GP I have become used to accusations of exploitation of younger colleagues with many commentators forgetting the experience of a decade ago when a cohort of doctors raised the 'generation X' question as to why they should take on the responsibility of partnership when they could earn just as much in sessional employment or as jobbing locums.

How refreshing, then, to see the honest and penetrating analysis that Dr Lakasing presents as a challenge to current orthodoxy; general practice has a chance of survival if the professional leaders of his generation take heed of his warnings.

I could take issue with his analysis of medical resistance to the NHS in the 1940s, as my suspicions are that the terms of engagement offered by the then Government were initially as doctor-friendly as any offered by their modern counterparts, and that the 'sweeteners' he describes were totally necessary (at the time). Given the command and control environment that most primary care organisations now try to impose upon us, I certainly believe that the independent contractor status works best for us but, more importantly, also for our patients in their survival while floundering within the Byzantine complexity of the 21st century NHS.

Dr Lakasing also has the courage to challenge a relaxed attitude over the 'feminisation' of our discipline by pointing out the dangers that go hand in hand with the obvious advantages of having female partners. Already challenged by the out-of-hours opt out, continuity of care is our strongest feature, especially in dealing with chronic disease, and he is right to point out that such continuity is compromised by part-time working often associated with female doctors and family life.

There is, however, one feature missing from his analysis. There may be a tiny minority of principals who actively exploit younger colleagues by offering only sessional or salaried employment, but the biggest causal factor is financial instability within practices. We still run small businesses and, at a time when we have seen years of rising costs and falling personal incomes, who should be surprised that permanent partnerships as are rare as hens' teeth?

I shall take part-time retirement later this year and will take comfort from this essay that our decision to appoint a partner to replace me will reduce the number of 'McJobs' by at least one.

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