General practitioners and the independent contractor status

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SUMMARY. Primary medical care can be provided either by a bureaucratic hierarchical organization or alternatively by independent contractors. Most members of the caring professions in medicine, nursing, and social work are employed in bureaucracies, whereas general medical practitioners, general dental practitioners, opticians, and pharmacists are independent contractors.

The independent contractor status has recently been heavily attacked from within the medical and nursing professions, and also from outside. It has been suggested that contracting for services is an inappropriate and anomalous way of arranging medical care, which should now be stopped. However, this process of contracting for services can be analysed, using perspectives from some of the behavioural sciences, to reveal hidden depths in the independent contractor status which suggest that the provision of primary medical care is best carried out by independent contractors.

Introduction

THERE are two main ways in which people in modern urban industrial societies can work. First, they can be employed either by another individual or by an organization. Secondly, people may provide a service for other people but not be employed by them. This broad distinction is true not just in the UK but throughout the world.

People in the first group are called employees and have the following characteristics: they are engaged or hired, paid by their employers, are responsible to them, and are dismissed by them. These arrangements are governed by a contract *of* service and are often described by lawyers as a "master/servant relationship" (Court of Appeal, 1977).

By contrast, individuals may negotiate their own arrangements of work and agree to provide services, usually through a contract *for* services. Such a contract may be quite specific and detailed or it may not be written at all.

The second group contracts separately and independently. These 'independent contractors' include all businessmen who own their businesses, shopkeepers, many skilled workers, for example, plumbers, and members of the professions such as general practitioners, accountants, quantity surveyors, architects, veterinary surgeons, and dentists. Legally and for tax purposes they are 'self-employed'.

The independent contractor status can be examined from the perspectives of the behavioural sciences: medical sociology, psychology, political science, and social administration.

Medical sociology

Sociology can be seen as the study of the structure and function of society. It analyses the way people behave in relation to the way they organize themselves in a society.

Three technical terms, which have been introduced by sociologists, are currently of special relevance to doctors in the British NHS:

1. Bureaucracy.
2. Spiralists.
3. Burgesses.

1. Bureaucracy

Bureaucracy has been defined as "a system of offices arranged in a hierarchy of authority, with those at the top having more authority than those at the bottom" (Susser and Watson, 1971). This is the usual system for all departments of central and local government and most nationalized industries. Common examples in the

UK are: the civil service, local government, the armed forces, the police, and the administrative and hospital doctor sections of the NHS. Many large businesses also organize themselves in bureaucracies.

Weber regarded the bureaucracy as the most efficient method of administration and called it the "rational/legal" system. He saw it as the logical process of arranging men according to their abilities and ensuring a disciplined control of decision-making (Gerth and Mills, 1946).

Its characteristic features are:

a) A hierarchy of officers.

b) Rules and regulations (usually in writing) of the functions of each rank (limited competence).

c) Uniformity of pay and conditions:

i) Almost always by salary, and pensions.

ii) Terms of conditions of service and holidays.

d) Competitive promotion, dependent upon ability and the opinions of superiors in the hierarchy.

e) Anonymity of its members from the point of view of those outside the system ("all correspondence should be addressed to the head of the department and not to any official by name"). Relationships between staff and clients are controlled and tend to be discouraged.

f) Lack of choice for consumers of the individual with whom they have to deal and often difficulty if they wish to change to another individual or department (civil service, local government, police).

2. Spiralists

Some of the people who work in bureaucracies are classified as 'spiralists'. They tend to move home and posts during a career which characteristically spirals upwards through a hierarchy. Such people are often administrators or scientists, and usually have professional or technical qualifications.

Whilst on the hierarchical ladder spiralists commonly take further examinations as a prelude to promotion. Such promotion usually depends on approval of either the immediate superiors or others of similar grade/rank on selection boards or committees.

3. Burgesses

Burgesses are characterized by long-term residence in a particular place with responsibility for providing a service within an area. They are shopkeepers, businessmen, or professional men who largely depend on the personal recommendations of customers, clients, or patients and hence tend to be sensitive to the local community and its needs.

There are two kinds of burgesses: those who have emerged at or near the top of a hierarchy and have no further ambition for promotion, who 'settle down' in a local community, even though they remain a salaried employee of the organization; and those who do not work within a bureaucracy at all, are not salaried, and contract independently to provide a service or sell something. These are the 'independent contractors'.

Independent contractors. Independent contractors have much more freedom to choose the way they organize themselves than members of bureaucracies. A butcher can decide the kind of shop he wants, the number of staff he wishes to employ, the conditions of work, and when and where he buys his meat. He is responsible for his own stock control, may largely choose his hours of work, and often works longer hours than his salaried counterpart in a supermarket.

If he makes the right decisions he will make a profit, part of which he will probably retain as capital in his business and part of which will form his income. He accepts the personal risk of making a loss and should his decisions prove unwise, even through no fault of his own, he will bear the loss himself and may ultimately be declared bankrupt. Part of his profit can be seen as a reward by society for bearing the risks of uncertainty.

The independent contractor is self-employed by definition. He works for himself and will therefore usually be responsible for arranging a replacement when he is ill or away on holiday, for organizing his sick pay insurance, and for making his own superannuation arrangements. It follows that his income is often by item-of-service payment, commission, by a profit from selling or, in medicine, by fees, whether through private practice or the NHS.

Independent contractors who are professionally qualified work by providing a service; they will similarly decide about premises, mortgages, staff, equipment, and loans. They too bear personal responsibility and may ultimately be liable to bankruptcy. The independent contractor thus usually accepts greater responsibility than his equally well qualified opposite number in a bureaucracy.

The consequences of the independent contractor being able to choose his conditions of work and being responsible to himself are variety and flexibility. From the consumer point of view this may be a good feature, in that it provides a wide freedom of choice and flexibility of provision of the service; however, the standards of service may vary from the very good to the very bad.

Variety is closely associated with the scale of organization, independent contractors tending to be involved in smaller organizations and bureaucracies in larger ones.

The independent contractor system emphasizes the personality of the operator and his relationship with the client or patient, whereas bureaucracy tends to diminish it. The local shopkeeper and the local general practitioner are known as individuals. In most practices the doctor's name, personality, family, car, and characteristics are well known to his patients, whereas in the hospital service patients often do not know the name of the doctor they see, especially if he is a junior, let alone his or her family or interests. Because he is settled in one place the general practitioner is able to establish long-term relationships not only with his patients but with colleagues and other residents in the community. As he

is not seeking promotion in a hierarchy within a bureaucracy he tends to feel responsible to his patients rather than to superiors.

Independent contractors often work in partnerships, a concept not found in a bureaucracy. They will characteristically be negotiators. They may provide a service or they may sell something, but they share the common characteristic of independence.

It thus appears that spiralists and burgesses in many ways have contrasting characteristics (Table 1). The order, uniformity, and regulated anonymity of the bureaucracy contrasts with the variety, lack of order, flexibility, freedom, and emphasis on personality of the burgesses.

History. The first formal arrangement for the provision of medical services by Government in the UK was the Health Insurance Act of 1911. General practitioners then chose a capitation system of payment, which created a list or 'panel' of patients, instead of a salary.

The intense resistance to a salaried service by general practitioners in 1948, when the full NHS was introduced, has not always been fully understood. Even today it is often regarded as an anomaly. Recently, evidence has been submitted to the Royal Commission on the NHS by many other health workers which has suggested that the independent contractor status of general practitioners ought to be "brought into line" (Royal College of Midwives, 1977) because it is a minority arrangement in Britain and "their specially favoured financial and working position" (Health Visitors' Association, 1977) removed. Similarly, the Trades Union Council (1976) considered, "All people providing health care within the NHS should be salaried."

In both 1911 and 1948 general practitioners chose an arrangement which enabled them to preserve their independence and identify themselves with the other professional independent contractors in the community.

General practitioners eschew bureaucracy and therefore do not look to the hospital for an organizational model. They see themselves more in relation to the local accountant or solicitor, who are independent contractors. Dentists have a similar status. In short, they see themselves as burgesses.

By contrast in Britain well over half of those in the medical profession are salaried employees, including all hospital doctors. The grades from the most junior pre-registration house office to senior registrar level are all spiralists, and the consultants form the top rank of the medical bureaucracy of the NHS. In addition, all the medical administrators of all ranks in the central government service and all the community physicians are salaried medical bureaucrats as defined by Susser and Watson (1971).

Many of the doctors in the most senior grades of these branches of the profession have never known employment under any other system. They may sometimes find it difficult to understand why the intricacies of the more complex and subtle independent contractor system may be more appropriate for general medical practice in the community.

Susser and Watson (1971) stated:

"Typically the staff consider the patient in hospital with necessary if concerned detachment as a case and an object of scientific study. Decisions about management of the case must display technical competence and be justifiable to colleagues on scientific grounds. The hospital 'encapsulates' the patient, whose set of associations and ideas are thereby strictly limited, and the behaviour expected from him is accepting, submissive, and dependent. His needs tend to be assessed within this restricted framework. Thus decisions about him are often made with perfunctory attention to the latest roles he has relinquished in the world outside, in family, work, and leisure, and he cannot appeal to those outside for support."

On the other hand, Susser and Watson continue:

"The pressures in the community situation of the practitioner direct his attention to the personal needs of his patients, but they may isolate him professionally and preclude constant reference to the scientific judgement of colleagues."

They conclude:

"The pressures in the hospital situation of the specialist maintain his technical competence and divert his attention from the personal needs of patients . . . The mistakes of general practice often seem to arise from technical failures, the mistakes of hospital practice often do so from failures of communication."

Since this analysis leads to a conclusion that would be broadly accepted by many doctors both in hospital and general practice, it illustrates how sociological analysis can aid understanding.

Psychology of human relationships

Balint (1964) suggested that the most important 'drug' in general practice was the doctor himself. He focused attention on the doctor/patient relationship and showed that the outcome of care depends substantially on the personality of the doctor as well as on the personality of the patient.

By emphasizing for the first time the importance of the doctor's personality, a new factor was introduced in considering the best method of organizing medical services for primary care doctors. If the personality of the doctor is important, then the system should take this into account, which the independent contractor system does. It emphasizes individual personality, whereas the salaried hierarchical structure of a medical bureaucracy systematically diminishes it.

If a personal system of medical care is desired, then there are good reasons for ensuring that it is provided by burgesses, and not through a bureaucracy. It is therefore logical that suggestions should recently have been made that other members of the primary health care team might adopt this status (Hart, 1977). For example, if it is considered important that clients/patients are to have an effective choice of service, then

bureaucracies should be avoided. Consumers/clients have little or no choice in deciding the individual who will provide a service in most big bureaucracies, for example, local government or the police. Even in medicine patients normally have no choice of hospital nurse or hospital doctor in any grade below consultant, and relatively little choice of consultant. Similarly it is difficult for clients to change a hospital nurse or hospital doctor.

Patients can, however, change general practitioners, as independent contractors, at any time without stating a reason. General practitioners have a reciprocal right.

Paradoxically this freedom of doctors and patients to change each other strengthens doctor/patient relationships, and many surveys, including Cartwright (1967), have reported a high percentage of satisfaction of patients with general practitioners.

Negotiating relationship

From the patient's point of view the ideal arrangement for obtaining a medical service would be to have a choice in deciding from whom and where it is supplied and to be able to negotiate management and treatment with a skilled local doctor who is easily and continually available.

Stimson and Webb (1975) have discussed the use of power and authority in the consultation. Certainly, at their worst, consultations in general practice degenerate into authority-laden 'doctors' orders' (Byrne and Long, 1976). At their best, however, a true negotiating relationship occurs. Patient and doctor contribute information and opinions which are shared, discussed, and assimilated until a jointly negotiated plan of management emerges. The counselling process, which is increasingly being used in general practice, can be seen as a form of negotiating relationship. One of the commonest examples is in contraceptive consultations, where the doctor provides a list of possible methods and the particular choice is negotiated with each individual patient with the patient playing the main part in the final decision.

Of particular importance, especially for the future, are consultations in which general practitioners are becoming involved in practical preventive advice about patterns of behaviour, especially about the so-called 'diseases of lifestyle'. McKeown (1976) has cogently argued that such behavioural factors form one of the main ways of improving health care. Helping patients to alter their habits in eating, drinking, smoking, and exercising cannot be achieved by authoritarian methods and requires sensitive and skilled negotiation with each individual. General practice can in fact be seen as a continuous series of individual negotiations with patients.

Furthermore, general practitioners, as personal doctors, have an important role as independent medical advocates negotiating for their patients (Gray, 1970), a role that is being increasingly recognized and accepted (BMA, 1976; RCGP, 1977).

It therefore seems logical that the doctor's own experience and professional relationships should encourage a negotiating outlook rather than an authoritarian one. This is just what the independent-contractor status achieves. The general practitioner negotiates his contract for services and has a choice, for example, whether or not to provide maternity services, immunization services, or contraceptive services. In this way he or she negotiates his or her own role.

Partnership

Furthermore, most general practitioners now work in partnership. This intimate legal relationship has no parallel in the hospital or administrative services. General practitioners in partnership are legally tied together in a contract that resembles a professional marriage.

Partners have to share not only money but responsibility for staff, premises, timetables, and off-duty hours. General-practitioner partners are, among doctors, uniquely dependent on each other and vulnerable to the opinions of their partners. Legally they are even responsible for each other's professional debts and 'jointly and severally' responsible for each other's income tax payments. Partnership forces them to accept the feelings and priorities of their partners. They have to negotiate all the time.

Doctors who thus have to adopt a negotiating relationship with both the authority which uses their skills and their colleagues are more likely to adopt a similar negotiating style with their patients.

Authority in hierarchies

In a hierarchical structure, in contrast, the essential feature is authority: orders are transmitted down a line. Because human behaviour is infectious (Gray, 1978), those who work in a system in which they receive orders will tend to give orders in their turn. This impinges on professional relationships. The relationship between junior hospital doctors and patients is classically authoritarian. Junior doctors who are at the bottom of the hospital hierarchy may tend to treat their patients as a new, lower member of the hierarchy. This will tend to happen because patients in hospital are particularly vulnerable—they are undressed, in foreign territory, separated from their families, and therefore relatively helpless.

Political science

From a political point of view, the independent contractor status has several features which are theoretically attractive to both political philosophies.

Those politically to the right of centre favour independence, freedom of choice for the consumer, and the concept of 'standing on one's own feet'. The right could therefore be expected to favour increasing the number of independent contractors in society.

On the other hand, those politically to the left of centre favour the concept of equality, the elimination of

Table 1. Comparison of characteristics of independent contractors and salaried employees in bureaucracies.

Characteristic	Independent contractor	Salaried employee
1. General characteristic	Variety Self-employed Administratively untidy Variable standard of service	Uniformity Employee Administratively tidy "Master/Servant" Order
2. Sociological classification	Burgess	Some are spiralists
3. Authority	General—often employs staff Can never be given orders Negotiators	Specific—accountable upwards and authority over subordinates "Officers/Supervisors"
4. Philosophy	Flexible and great freedom to negotiate local arrangements	Rules, often nationally determined Consistency and standardization of policy
5. Personality of operator	Individuality encouraged Use of names and relationships with clients valued	Individuality discouraged Anonymity of staff Correspondence to junior members of hierarchy discouraged
6. Contract	Contract *for* services	Contract *of* service
7. Pay	Usually not incremental salary scale Often some element of fee for service or commission	Salary by definition Usually incremental scale

authority and the master/servant relationship and its replacement by a negotiated contract for services. The left have recently emphasized the importance of social democracy and participation by all is more easily achieved and is indeed inevitable with independent contractors, who cannot be ordered about and inevitably participate in and negotiate their working arrangements. The left could therefore also be expected to favour an increase in the number of independent contractors in society.

Social administration—organization of other caring professions

All the caring professions face common problems in organizing their members to provide a service for patients or clients. In analysing the organization of two other caring professions, nursing and social work, it is seen that both now operate within a bureaucracy as defined earlier.

Social work grew up within the framework of local government, which is itself a bureaucracy. The nursing profession, after its reorganization, is now arranged in a classic hierarchy with the upper ranks numbered: for example, ward sister, number 6, chief nursing officer, number 10. It is interesting that the word 'officer' is used only for the upper ranks, who do not directly work with patients.

As a result there has been a diminution of the role of the field worker in both professions. The nurse at the bedside and the social worker in the home are both at the bottom or low in their hierarchies. Promotion in both professions means a move away from the patient or client and upwards into administration. All the main policy decisions in both professions are now taken by people who no longer personally care for patients or clients; in other words, those who actually do the job are under the authority of colleagues who no longer practise.

Administrators in general practice are employed by the doctors and are therefore responsible to the clinicians, whereas clinical nurses and practical social workers serve their (professionally qualified) administrators. Unlike the nursing and social work professions

Characteristic	Independent contractor	Salaried employee
8. Premises and equipment	Usually responsible for providing own premises and equipment	Usually provided by the employing authority
9. Staffing	Usually responsible for own holidays, locum, and pension	Employer responsible for holiday arrangements, locums, and often pensions
10. Retirement	Variable Individual negotiation	Usually compulsory at fixed age
11. Partnership(s)	Common "Jointly and severally" responsible in law and for tax and partners' debts	Rare No responsibility for colleagues taxes or debts
12. Income tax assessed under	Schedule D "wholly and exclusively"	Schedule E, PAYE "wholly and necessarily"
13. Responsibility	Ultimately answerable to client/patient	Ultimately answerable to superior or employer
14. Professional neglience	Professional is solely responsible and alone—can be sued	Employing authority responsible and can be sued (as well as or instead of professional)
15. Degree of choice by client/patient	Usually wide choice and relatively easy to change	Little or no choice of individual or department Difficult to change

the posts with the highest status and pay are not held by those whose main task is to administer.

Through the remarkable and often unsung benefits of the independent contractor status, general practitioners in the UK have successfully avoided many of these pitfalls. They alone have evolved a system which avoids the restricting and enveloping problems of a hierarchy. There is no hierarchy in general practice. Even the traditional dominance of the senior partner is giving way to truly equal partnership. Quite apart from other considerations, full financial parity is normally achieved by all partners in about three years. The most senior practitioner sees his patients, does home visits with his younger partners, and shares with them the responsibility for taking decisions. He therefore remains, willy nilly, in close touch with the everyday problems of the job.

Thus the independent contractor status dignifies the field worker and emphasizes the importance of the role of the person actually facing the patient. Alone among the caring professions, alone even in medicine, the patient meets a professional in the front line at the desk and in the home who is not a junior member of a hierarchy.

Conclusion

This analysis of the independent contractor status using the behavioural sciences suggests that there are strong theoretical reasons why this method of organization is appropriate for general medical practice and should be retained in the future. Although the British Medical Association (1976) and the Royal College of General Practitioners (1977) in their evidence to the Royal Commission on the NHS both strongly support the retention of the independent contractor status for general practitioners, neither has published a theoretical justification for it.

It would be ironic indeed if, just when the considerable advantages of such a flexible system of organization in a caring profession are beginning to be understood, the Royal Commission on the NHS should suggest a salaried service which would encourage yet another medical bureaucracy.

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Clinical pharmacy

For the first time in the history of hospital pharmacy an advertisement appeared in the pharmaceutical and national press for a pharmacist—actual grade, and properly enough, principal pharmacist "for clinical services".

Clinical pharmacy has for some time been discussed and speculated upon as a shadowy entity. Ever since the therapeutic revolution reduced at a stroke the traditional practice of pharmacy to something not far removed from any other branch of the distributive trade, pharmacy, and especially hospital pharmacy, has cast around for a justification for its scientifically trained graduate output.

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