attribute: "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 . . . If he makes the right decisions he will make a profit, part of which he will 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." This, in a nutshell, is Dr Pereira Gray's basic conception of the modern practitioner—someone who can reduce his relationships both to his patients and the skills he provides to the crude terms of a financial negotiation. This is hardly satisfactory for those doctors who wish to apply their science comprehensively to the population they serve, without distortion by pecuniary considerations.

Dr Pereira Gray has rushed in where, as he states, the College and even the British Medical Association feared to tread, in a confusing attempt to justify the independent contractor status. A simple dichotomy between salaried hospital bureaucracies—impersonal, non-participatory, providing no autonomy —and independent contractors, providing a personal, sharing, and autonomous service, is far from the truth. In his anxiety to reduce a complex situation to a simple polarity, he casts outrageous slurs on the concern and competence of hospital senior and junior staff. He suggests that patients often do not know the name of the doctor they see and that receipt of a salary interferes with the individuality of hospital doctors. Such unsupported anecdote is not born out by Anne Cartwright's study of patients in hospital (1964).

I believe the 'independent contractor status' is more illusory than real. Apart from a self-employed tax status (shared by half the hospital consultants) and a rather complex method of calculating remuneration, there is little to differentiate from salaried hospital colleagues. Where there are differences, they tend to operate to the disadvantage of the general practitioner, particularly those with small list sizes working in deprived areas. And it can hardly be a credit to contractor status that a substantial proportion of single-handed practices remain, predominantly in the most deprived areas (Collings, 1955).

Ancillary staff in general practice have gained little from contracting doctors and are often considerably worse off than their hospital counterparts. Practice accounts can be a time-consuming nightmare in the majority of practices which are not large enough to employ a practice manager.

A more enlightening comparison would have been with dentists, who, with their fee-for-item remuneration, approximate more closely to the model of a medical grocer. The current state of British dentistry does not cast credit on this style of care (Radical Statistics Health Group, 1976).

For those who do not wish to be medical businessmen, a medical equivalent of the corner shop grocer, a salaried service is an attractive and realistic alternative. It would release general practitioners from the unnecessary financial burden of providing and equipping their own practice premises (without losing a decisive voice on planning decisions); it could provide for defined geographical areas of responsibility while retaining the right of choice of patient and doctor; it could provide for those with heavier patient workloads by per capita, age and sex, and consultation rate weightings. It could also provide remuneration for night and weekend working (as is the case with junior hospital staff), and provision of special services (maternity, family planning, etc) could be made within it. Periods of sickness absence, holidays, and night duty could, where required, be covered by salaried locums, paid and administered by the NHS. Ancillary and secretarial staff would benefit considerably by being brought into line with hospital counterparts.

These are the bread and butter questions of terms and conditions of service. The issue of democracy in the NHS is one which concerns all doctors, whether independent contractors or salaried hospital staff, faced as they are with increasing inroads by successive governments into their political and clinical autonomy, as continual cuts in spending necessitate tighter and tighter control over budgets. If 'progressive patient care' and 'the health team' are to take on any real meaning, then doctors must seek new alliances both with their patients and other health service staff, both locally and nationally through patients' organizations and the trade unions which represent health workers.

It is the trade union organization of doctors that will protect the clinical autonomy and interests of doctors, and not some Don Quixote image of an independent contractor riding a dying horse and tilting at windmills. The British Medical Association and Royal College do not provide a justification for independent contractor status, because there isn't one. To plumb "the hidden depths in independent contractor status" is to hold up to the light the unsatisfactory practice of primary care in many inner city and industrial areas. It is not a recommendation.

As salaried staff, general practitioners have nothing to lose but their chains. Correctly negotiated by experienced trade unionists, they could gain not only in democracy and autonomy but also in terms and conditions of service for themselves as well as their staff and patients.

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TRAINERS' COURSES

Sir,

Dr Wayne Smith's letter (March *Journal,* p. 184) prompts me to add my caution to his about the Thames Valley Trainers' Course which I attended 18 months ago. It seems that nothing has changed.

Some of us on that course made our protest loud and clear about the pseudo-intellectual fumblings and abrasive format that the organizers depended on. It is all very well for them to impose periodic courses on the trainers but they appear unwilling to learn from their mistakes.

The 'highlight' of our course was a ghastly hour spent with the trainees in a small circle surrounded by the 40 or so trainers on the course from which a trainee-led discussion was meant to ensue. The result was insulting to the trainees, offensive to the outsiders, and embarrassing to the majority. Nothing useful came out of it and it was entirely predictable.

Perhaps through these columns one may be allowed to entreat the Thames Valley Faculty hierarchy to wake up, to recognize the privileged position to which they have elected themselves, and perhaps, to treat the rest of us with less contempt.

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