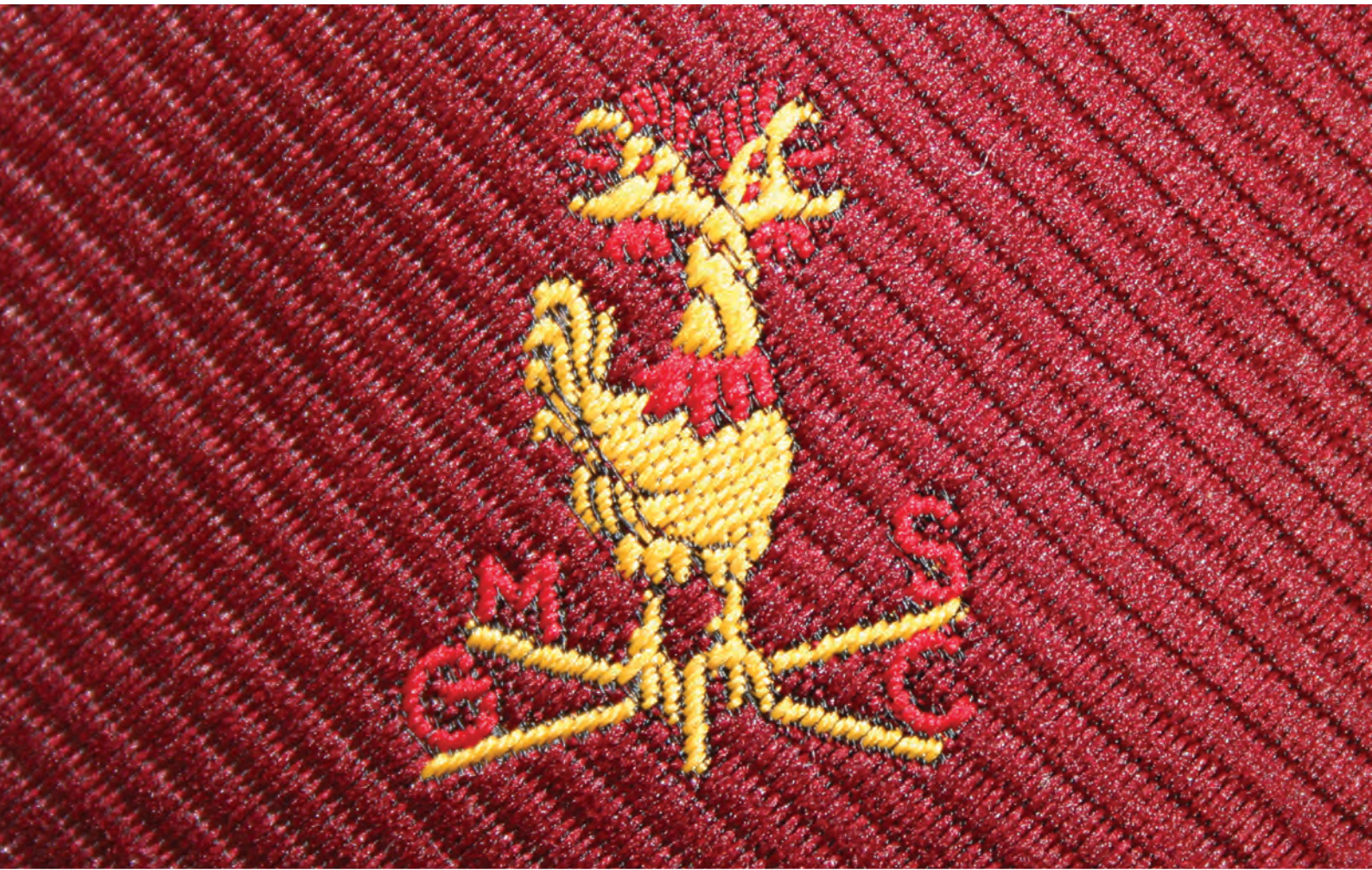


Continuity in a changing world

100 YEARS OF GP REPRESENTATIVE BODIES



JOHN EVERSLEY



Acknowledgements

Thanks are owed to a number of people.

All the people who agreed to be interviewed: twenty one in all. They were generous in their time, very frank and thoughtful in their reflections. Their contributions are anonymised. Some of the interviewees requested this. However, particularly for people who were not closely involved in the events described and analysed, it may also be easier to follow if they are identified by their roles. Where individuals are named in documents that are publicly accessible, their names are used.

- BMA staff were extremely helpful in gathering data and arranging interviews. In particular:
- Jon Ford in the Health Policy and Economic Research Unit
- Lee Sands in the BMA Archives
- Holly Trotman in the GPC Secretariat.
- Lesley Baillie of the Office for Health Economics was also very helpful in providing data.
- The advice and insight of Norman Ellis and Tony Stanton were very much appreciated.
- John Canning, Treasurer of the General Practitioners Defence Fund was a very understanding commissioner of this history.
- John Chisholm was a very thorough proof reader and 'fact checker'. Despite his and others' efforts, the author is solely responsible for the contents.

About the author

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Contents

1. Setting the scene	3
Background.....	3
A time for reflection.....	3
Writing history	5
Policy analysis.....	5
What is general practice?.....	7
General practice as a level of care.....	8
A set of activities.....	8
A strategy for organising health services	10
A philosophy for a healthcare system	12
Understanding the context.....	12
The organisation and technology of primary healthcare.....	13
The social context	16
The political environment.....	20
The economic context for general practice.....	24
The legal, regulatory and ethical context.....	29
2. Why has general practice needed defending	32
3. Whom has general practice needed defending against?.....	35
The relationship with the state: General practitioners and the state an unequal struggle?.....	35
Fighting cockerels: Conflict and cooperation within general practice	38
‘The farmer and the cowman’: Relationships between GPs and other doctors and doctors’ organisations.....	40
Relationships with other professions and interests.....	43
4. How has general practice been defended?.....	44
Strategies	44
Tactics	46
5. Conclusion: Defending general practice – a British success?.....	53
Appendices	59
A: Chronology 1979-2005	62
B: Relationships between representative bodies.....	67
C: Sanctions.....	68
D: Chairmen of GMSC/GPC 1964-2004	69
E: Bibliography	70
References	74

1. Setting the scene

Background

A time for reflection

Between 1911 and 1913 a number of bodies emerged which have formed a major part the 'family' of organisations promoting and defending general practice. The original organisations include:

- the Insurance Act Defence Fund (now the General Practitioners Defence Fund, GPDF)
- Local Medical Committees
- the Annual Conference of Local Medical Committees
- the State Sickness Insurance Act Committee (now the General Practitioners Committee, GPC).

The chronology of the early years is set out in Figure 1.

The General Practitioners Defence Fund decided to commission an updated history of the GPC and its associated bodies. There has been one previous substantive history written by John Marks, who was a former member of the committee and later Chairman of the Council of the British Medical Association (BMA). It was originally written as a doctoral dissertation, first published in 1972, and updated in 1979.¹

The GPDF wished to:

- update the history of the GPC to the current time
- include a historical review of the GPDF
- provide an historical perspective of the Funds in place prior to 1980.

It was agreed that the updating would start around 1980 with the formation of the GP Defence Fund and finish in 2005, just after the last major negotiation of the GP contract. It seemed appropriate to finish the history on 7 July 2005. When the bomb went off in Tavistock Square, the GP negotiators were meeting. Of the two dozen or so doctors who created an ad hoc Casualty Clearing Station, seven of them were members of the negotiating committee and other GPs and other doctors in or near BMA House also joined the team.² It is important to note that this kind of emergency care is not 'just doing a GP's job'. The origins of the term 'Primary Care' are in the First World War experiences of Bertrand (later Lord) Dawson who made a distinction between the emergency care provided by First Aiders in the trenches and in field stations, immediately behind the lines.³ Nevertheless, the training that GPs have may have been a lifesaver in that, used to managing risk and uncertainty, they 'almost instinctively grasped the "do the most for the most" philosophy of emergency care... making do and mending'. It has also been suggested that the experience of working together as a negotiating team meant that 'notoriously independent minded' colleagues were prepared to accept the guidance and discipline of an expert leader.⁴

In 2004, at the time of two reviews of the negotiations that had recently finished, the then Treasurer of the GPDF, Brian Keighley wrote that this is 'an appropriate time to give consideration to the future strategy of the business...not simply "doing more of the same" but more about

challenging what the Company did and why and how it did it'.⁵ This is evocative of Rudyard Kipling's Six Honest Friends:

I keep six honest serving-men:
(They taught me all I knew)
Their names are What and Where and When
And How and Why and Who.^{6,a}

The structure of this history is broadly built around these six questions but before exploring them, a brief explanation of why this approach has been adopted is given.

Figure 1

The early years		
1905		Contract Medical Practice BMA
1910		Report of the Poor Law Reform Committee
1909	April	Lloyd George introduces People's Budget
1911	May	National Insurance Bill introduced
	May/June	BMA Representative Body draws up Six Cardinal Points Insurance Act Defence Fund established
1912	21 February	BMA Representative Meeting agrees to make arrangements for provisional Medical Committees (later LMCs)
	28 February	First meeting of the "State Sickness Insurance Committee"
	April	Provisional Medical Committees receive pledges from 33,000 doctors to resign from Friendly Society and similar contracts to take effect from the date of implementation of the Insurance Act
	December	BMA Representative Meeting agrees GPs should not enter the service
	December	National Insurance Act Practitioners Association formed
1913	January	BMA Representative Meeting agrees to release practitioners from pledge
	April	BMA Council refuses request for a conference of Local Medical Committees
	July	Brighton Division of BMA hosts first Conference of LMCs
	July	First meeting of the Insurance Act Committee (later GMSC, now GPC)

^a Perhaps significantly this was related to the story about why the elephant got its trunk. The elephant's child had its nose pulled by the crocodile. The trunk is then found very useful and the elephants never spanked anyone again.

Writing history

Institutional histories, particularly for the recent past are difficult to write in an accessible way to appeal to a range of audiences. The parties to the events know a lot of the background but may not agree about its significance and often have a shorthand language which is not more widely understood. It can easily descend into a calendar of dates, an alphabet soup of initials and a library of constitutional details. Some protagonists may recall or want to recall the 'dates, kings, queens, soldiers and battles'. However, the audience for a blow-by-blow history is probably very limited. The present account is designed for a wider audience of people, both past and present insiders and outsiders to the GP bodies. Some people may want to use it to answer the question 'What did the BMA do for us?' [or indeed 'to us?'] and others may want to look towards the future: 'You don't need a crystal ball; you just need a good set of wing mirrors'.⁷

In doing this there will inevitably be arguments about the relationship between people and circumstances: do circumstances and events determine what happens or do people make events? Others will be more interested in the significance for the present or the future. In doing this it is easy to slip into history as either progress or decline. Some people may be interested in whether there is anything to learn to apply to other contexts. It is important not to be simplistic about 'learning the lessons of history' or 'history repeating itself'. As Mark Twain said 'The past does not repeat itself, but it rhymes'.^b On the other hand, we might want to be wary of dismissing history as a recent Prime Minister did: 'There has never been a time when...the study of history provides so little instruction for the present day'.⁸

In trying to understand how a study of the past can be useful to the present and future, the approach adopted here is to use the tools analysing public policy to review the past. In the following section the main tools used will be outlined.

Policy analysis

Policy analysts suggest that policies (the principles underlying action) are made by settlements made between different parties with a stake in an issue (stakeholders). The visible positions of the stakeholders, their underlying interests and needs interact to be forces and drivers of policy.⁹

It is necessary to understand the relationships between individual people, groups, institutions and environments. Stakeholders may be individuals – the 'nano' level. This might include the personal and political styles of ministers or the personal experience and qualities of GP negotiators. Relationships may be at the micro level of how teams, such as negotiators operate. At the macro level the concern is how institutions interact: professions or branches of a profession (doctors or GPs) and organisations (the GPC, a political party). Finally, at the meta level, the players may be a cohort of a certain age or background or living at a particular time in a particular country or in a global context and influenced by that.

The context needs to be studied systematically to understand the wider forces at work. However, the context alone does not explain why particular things did or did not happen. For this the concept of 'path dependency' is useful.

^b Perhaps another saying of Twain might also be appropriate to general practice: 'The report of my death was an exaggeration'.

The Future Shaped by Tradition^c

'Path dependency' is a concept used by social scientists (including economists and historians) to explain why '*What Happened Then Matters Now*'.¹⁰

There are two significant levels of path dependency. The first is what actually happened and whether that may shape future events, such as whether the QWERTY layout of a typewriter keyboard in the 1870s continues to influence the design of computers in 2012. Charles Webster described the task of translating the NHS legislation into practice in 1948 as 'entering a house haunted with ghosts from 1911'. Both the Government and the BMA remembered or thought they remembered what had happened in 1911 and were intent on 'learning the lessons' and concerned about whether 'history would repeat itself'.^{11,d}

In relation to general practice, this kind of path dependency can be seen very clearly in the continuities between the GP contracts with the NHS of the late 20th century and the contracts with nineteenth century with Clubs and Friendly Societies and Poor Law Unions.¹² However, as well as recognising the continuities, it is important to identify the breaks and the turning points and avoid a mechanistic or determinist view that everything is inevitable.

The second level is what people believe to have happened. Thus politicians' interpretation that the appeasement of Hitler in the 1930s hadn't worked was important in justifying British intervention in Suez in 1956.¹³ Both politicians and GP negotiators have been influenced by ideas of whether confrontation or compromise has or has not been the right thing to do in relation to general practice. In 1975 the GMSC decided to collect undated resignations from GPs. John Fry who was active in the RCGP criticised 'over-militant postures'. John Marks, then Deputy Chairman of the GMSC, replied reminding Fry what appeasement had led to in the past.¹⁴

Evolution or transformation

Anne Digby's history of general practice in the UK between 1850 and 1948 uses the metaphor of evolution to describe the constants and the changes and why they have happened. She highlights three processes by which organisms change:

- Mutation: diversity may happen by accident or design (such as ecological niches) but also there may be pressures to converge as well
- Selection: through competition and cooperation, through being fittest and fitting or adapting; and
- Replication: Digby notes that in the period which she studied, in the absence of much formal education or regulation, the influence of peers on how general practice was replicated was very powerful.¹⁵

As well as the idea that organisms including GP representative bodies evolve, it is also helpful to think of them as bodies with emergent properties – always changing and with the potential to change in response to internal and external stimuli. The idea goes back to the ancient Greek philosopher Heraclitus that everything is always changing.¹⁶ This is particularly relevant to consideration of what general practice is, to which we now turn.

c The strap line used in a car servicing advert!

d The idea of path dependency has also been used by Bevan and Robinson (2005) to explain why the internal market and competition have been so hard to establish in the NHS.

What is general practice?

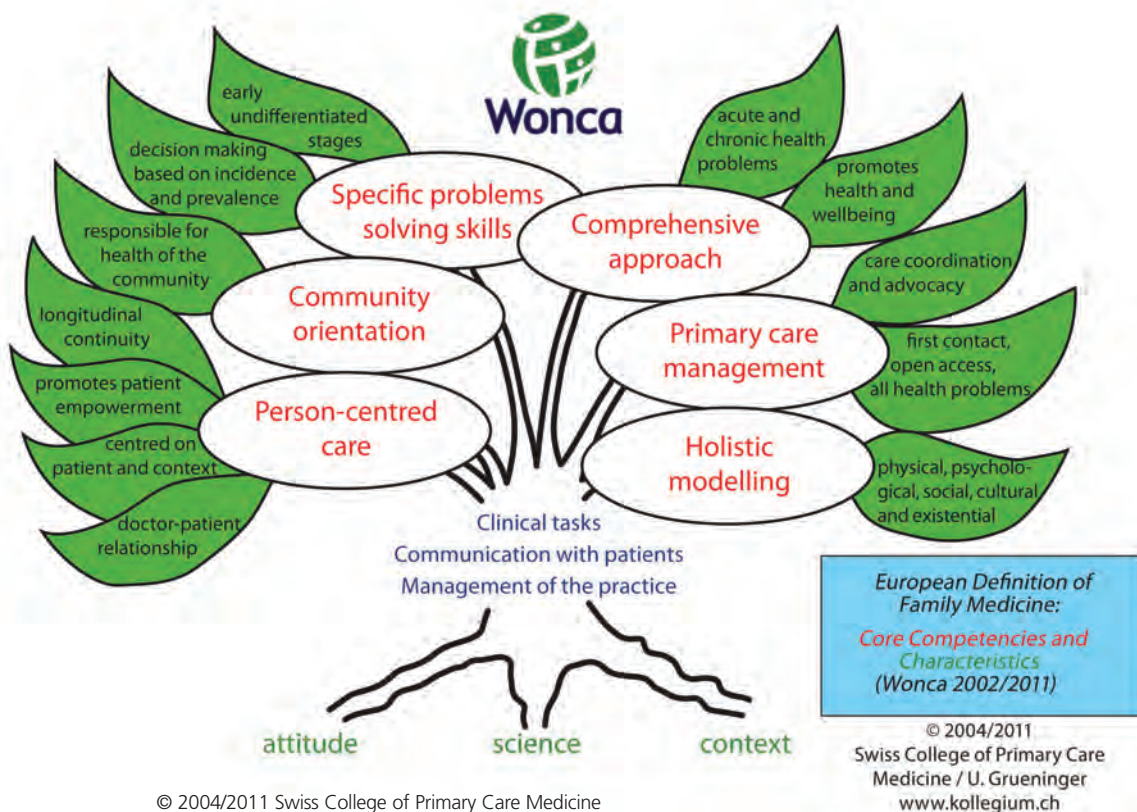
The term general practitioner has been in wide use since at least 1850, superseding terms such as surgeon apothecary.¹⁷ Other terms have not had the same currency or longevity. The term ‘family doctor’ was promoted in the 1960s, in effect to raise the status of general practitioners as specialists.¹⁸ The idea that general practice is ‘primary care’ stems from the Dawson report in 1920 based on his First World War experience referred to above, page 1.¹⁹

In understanding what is to be protected or promoted, we need to understand that general practice has multiple as well as changing meanings. It can also be different things at the same time, not just in different places but within localities and even within practices. There are, however, waves that pass through general practice.

Vuori suggested that primary care is:

- a level of care
- a set of activities
- a strategy for organising health services
- a philosophy for a healthcare system.²⁰

In the documents studied and interviews undertaken for this history all four meanings have been referred to. The WONCA^e definition encompasses all of these elements:



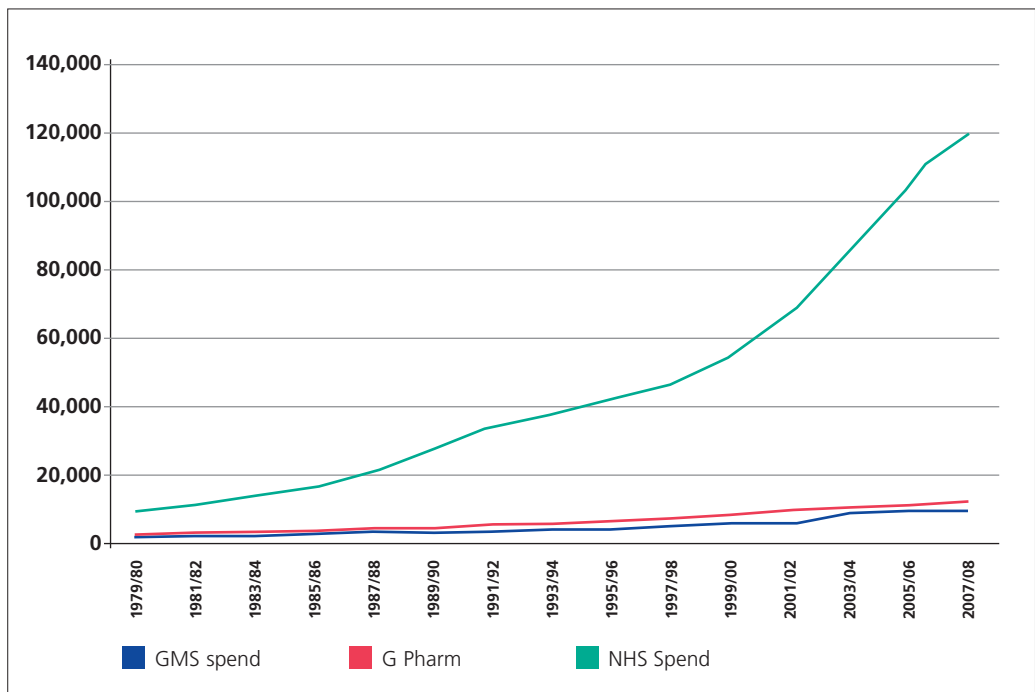
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e The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

General practice as a level of care

Following on from Dawson's war experience the view that general practice is the first tier of care is widely held: the 'first port of call' for patients who are ill or think they are is widely held.²² General practice is seen as 'dealing with 90% of NHS contacts for 10% of the budget'.²³ The evidence for this in terms of expenditure over the life of the NHS is set out in Table 1.

Table 1 General Medical and Pharmaceutical Services Spend as a Proportion of NHS Expenditure



That being said, GPs have never been the only starting point for healthcare. The eighteenth-century dispensaries staffed by apothecaries are the ancestors of pharmacists as well. It was the increasing use of outpatients in the 1870s which led to the division of labour between hospitals and GPs discussed below.²⁴ The role of Accident and Emergency Departments, Minor Injuries Units and latterly Walk-In Centres and NHS Direct may be seen by some people as unnecessary or wasteful; nevertheless they provide a significant service quantitatively. A study in 1995 found over 40% of A & E attenders were there for primary care problems.²⁵ An evaluation of Walk-In Centres found that they saw some patients who traditionally under-consult general practices.²⁶

A set of activities

In describing general practice as set of activities, there is a problem that the same words mean different things at different times and in different places. This was precisely the intention behind the 1858 Medical Act when it did not spell out what a doctor should do. This formed the basis for the famous description of general medical services in the 1966 contract as 'all the necessary and appropriate personal medical services of the type usually provided by general medical services'.^f

^f This has often been described as the 'John Wayne' principle. What Wayne actually said, in Hondo in 1954, is "A man ought'a do what he thinks is best." "A man's gotta do what a man's gotta do" may have been said first by Fred MacMurray in *The Rains of Ranchipur* in 1955 but the closest to the requirement for GPs is Charlton Heston in the 1956 film *Three Violent People*: "A man must do what he must do".

Until the 1990 contract was introduced, it was the basis for describing what GPs had to do even if many did more and some did less. The 1990 Contract introduced specific requirements. However, even then it was more like a musical score which could be played in different ways using different instruments rather than a dictionary with precise definitions.²⁷

The main activities over the last hundred years can be summarised as:

- diagnosis
- prognosis
- treatment
- obstetrics

Thus in 1951 a GP described the role as 'diagnosis, prognosis and treatment most suitable to the patient's way of life'.²⁸

However, the level of sophistication implied by each of these terms varies. In 1972 the Royal College of Practitioners said diagnoses were 'composed in physical, psychological and social terms; intervening educationally, preventively and therapeutically to promote his patient's health'.²⁹ This was aspirational rather than a description. The tools which GPs had at their disposal both in terms of their training and technical aids before the 1970s made accurate diagnosis and prognosis more often arts carved out of experience than a science. Similarly treatment might be by trial and error. Although making up proprietary drugs – still had some place in general practice in the first half of the twentieth century it was declining in favour of standard drugs and Sulphonamides in the 1930s and Penicillin 1940s were transforming what treatments were possible. Below we will review the advances made since the 1960s in diagnosis, treatment and prevention.

Some people have argued that GPs are 'specialist generalists' but in addition in 2002 a scheme for encouraging GPs with Special Interests was introduced with an initial target of 1,000. Even before that there were practices and practitioners with particular interest or expertise in specific conditions, interventions or populations. As Digby points out, this has often been an 'ecological niche', fitting in with the needs of a (potential) practice population, contributing to diversity in practice but central to the survival of practices as well as perhaps meeting patients' needs.³⁰

A number of people interviewed for this history felt that general practice activities had changed for the worse. For one 'a holistic, socio-medical family practice was being replaced by a technocratic, public health relationship'.³¹ Like others he was not sure 'what was driving what' in terms of whether it was a deliberate intention of the contracts of 1990 and 2004 or a by-product of pressure to improve quality by rewarding what was measurable. Others felt that general practice should move further in the direction of a commitment to public health: 'one of the relative failings of general practice is to adequately grip the public health agenda. We are relatively good at caring for individuals and poor at caring for populations. Community Oriented Primary Care needs to be practised if GPs are going to be involved in commissioning'.⁹ However, the same interviewee regretted that the profession as a whole had moved to being a job from being a vocation. He argued that in general practice they had sought to create opportunities for young GPs who did not

⁹ Community Oriented Primary Care was originally developed in Israel and was promoted by the King's Fund in the UK in the 1990s (Pollock and Majeed, 1995).

want to be involved in the business side of practice but [this has turned out to mean that these] doctors don't have to be involved in the development of practices... Practice-based contracts mean that you can share out more resources by having fewer doctors, [creating] a gap between aspirations and opportunities.³²

A strategy for organising health services

The former Health Minister, Lord (Norman) Warner has said: 'Over 90% of the annual public contacts with the NHS are with GP surgeries. GPs and their staff are their portal into the NHS for most people'.³³ As one interviewee put it, the role of a GP as a gatekeeper being economically efficient and in the best interests of patients has been an 'article of faith'.³⁴

However, the idea that GPs are independent and disinterested gatekeepers to hospitals but not allowed beyond the gates themselves oversimplifies the reality in the past and present.

First, as Digby says, the boundary between specialists and generalists is permeable.³⁵ GPs have not had a monopoly of referral: in the nineteenth century outpatients and dispensaries were very important. As Loudon says '...the principle of referral, now enshrined as one of the best aspects of British medicine for the patient, was originally introduced to protect the livelihood of the general practitioner. The impetus behind its introduction came from general practitioners, and the voluntary hospitals were, if not hostile to the idea, in many respects ambivalent. For the voluntary hospitals the hordes of outpatients, although a cause of inconvenience, provided a large pool from which 'suitable inpatients and cases for teaching could be selected; they also provided useful statistics for advertising purposes in order to raise the level of subscriptions'.³⁶ Secondly, GPs were never completely excluded from specialist work. Although the numbers declined after the inception of the NHS, they started to rise again. In 1964 23% of GPs held a hospital appointment. By 1977, the proportion had risen to 40%.³⁷ One of the GP negotiators in the late 1970s and 1980s remembers 'a lot of difficult discussions with consultants about the Hospital Practitioner Grade'.³⁸

When GPs were encouraged to move from referring individual patients to purchasing services on behalf of all their patients – Fundholding – many felt that this undermined GPs' ability to make referral decisions solely in the best interests of their patients. However, the problem was not totally new: as Digby points out, back in the nineteenth century and up to the foundation of the NHS referral was '... rationing, a form of medical policing creating conflicts of interest and inescapable professional dilemmas. Was the doctor's prime loyalty to the patient or the employing organisation?'³⁹ Although many GPs saw it as being made to do the government's dirty work of rationing, the Treasury at the time had the opposite concern: that it was an opportunity to lobby for additional health spending.⁴⁰ It is perhaps this discomfort with the rationing role which makes some GPs prefer the term 'gate opener' to gatekeeper.⁴¹ For some GPs, when the Labour government replaced Fundholding with Commissioning so that a 'person wouldn't personally gain' it took the ethical dimension out of the issue.

An adviser to the 1997-2010 Labour Government in answer to whether commissioning is gatekeeping on a grand scale, said 'commissioning is referral on a grand scale and referral is the

result of gatekeeping'. He also pointed out that gatekeeping isn't just an economic role but is about making sure the patient is in a safe place (managing clinical risk) and starting the patient on a road to complete knowledge of their disease.⁴²

A leading negotiator and an NHS manager made a similar point. The manager pointed out that general practice manages both financial and clinical risk for the NHS and that independent contractor status is relevant to both:

- it contains healthcare costs but because GP principals are personally responsible for their income, practitioners are more accountable for the decisions they take
- general practice absorbs clinical risk by a high degree of acuity.^h If GPs fail to diagnose, treat or refer, the personal responsibility is clear.⁴³

The assertion that GPs' control of referrals contributes to the cost-effectiveness of the NHS is widely shared but it is hard to provide hard evidence, other than that most healthcare systems that do not have such an arrangement cost more.⁴⁴

However, another change was also impacting on GPs' role in navigating patients through the healthcare system: in the past 'Mrs Smith was referred to Mr or Doctor Jones with a letter but now we are expected to refer to the orthopaedic clinic and she will be seen by the person with the shortest list. Economic and efficient but it has lost something personal'.⁴⁵ The question of whether GPs have vested interests in referrals also applies to the size and nature of workloads. Patients may be 'interesting' and rewarding if GPs continue to see them or they may impose additional work, costs and risks. This has been reflected in issues about cost-shifting between hospitals and practices as the NHS has exerted more control over prescribing.

The 'independence' of GPs has been an organising principle of the NHS. It was a central condition of both the 1911 and 1946 legislation. Executive Councils and their successors simply had the duty to ensure that GPs provided 'all the necessary and appropriate personal medical services of the type usually provided by general medical services'. It meant both the quantity and the quality of what was at the discretion of the practitioner. In his unflattering picture of general practice in 1950 Collings said: 'There are no real standards for general practice. What the doctor does and how he does it, depends almost wholly on his own conscience'.⁴⁶

Kenneth Clarke said of the 1990 changes 'We took away from doctors the total licence to do what they liked'.⁴⁷ It was not simply that the 1990 Contract specified what GPs must do but also the move from Family Practitioner Committees to Family Health Services Authorities was a move from 'administration' to 'management'.⁴⁸ The process of increasing the specificity of the contract continued when the 1997 changes introduced Personal Medical Services (PMS) contracts. The 2004 Contract further detailed what activities GPs had to undertake to be paid. The 2004 Contract also moved from contracts with individual doctors to practice-based contracts.

^h Acuity in the sense of prioritising the patient's needs – triage.

ⁱ See Appendix B for an explanation of what these bodies were.

A philosophy for a healthcare system

Providing cradle to the grave care used to be a widely used term⁴⁹ but one interviewer rendered it in contemporary management-speak as 'providing longitudinal care but also said it was 'Being an interpreter' between the patient and 'complicated medicine' and "'If you were my mother" advice in the context of a continuing relationship'.⁵⁰ Another interviewee said everything flows from being 'a personal doctor to the individual patient'.⁵¹ In 1972 the RCGP said that a general practitioner is 'a doctor who provides personal, primary, and continuing care to individuals and families'.⁵²

There are more abstract versions of the philosophy of general practice which also touch on general practice as a strategy.⁵³ These include:

- a model that starts with the patient's experience of the disease and stresses the importance of listening to the patient⁵⁴
- a scientific model that stresses the expertise of the clinician in identifying the problem and effective interventions
- a public health model which emphasises the importance of preventing ill-health and promoting good health including by tackling the wider determinants of health.⁵⁵

If in practice perhaps GPs manage to reconcile these versions, when it comes to representing GPs, the multiple and changing meanings matter a lot. From the anti-vivisectionists of the 1930s and 40s to the proponents of evidence-based medicine, people have argued about whether the state should direct GPs to act or not to act in certain ways, and if so, why or why not. One example serves to illustrate how the issues are bound up. In February 1990 the GMS Defence Fund considered a letter from a GP in which he argued that the new Contract meant a 'substantial increase in clinical work and administration for GPs; unacceptable ethical problems (reporting to the FPC why a woman should be removed from the target population for smears and the names of patients attending health promotion clinics; coercing women to have a smear; intrusive and offensive elements (The 3 yearly check asking about social factors and lifestyle); scientifically unproven procedures (over 75s check and health promotion clinics and triennial medicals), clinics which may increase anxiety'.⁵⁶

Understanding the context

Policy analysts often use frameworks for analysing context such as PESTLE (Political, Economic, Sociological, Technological, Legal and Environmental) or STEEPLE (Social, Technical or Technological, Economic, Ethical, Legal and Environmental or Ecological).⁵⁷ To use such frameworks mechanically is not necessarily illuminating so here they are adapted for the context of general practice representative bodies.

Drawing on Digby's evolution metaphor, we can identify a number of ways in which the context, general practice and its representative organisations interact:

Changes may be initiated by forces within and outside the profession:

- they may simply adapt to the external environment – opportunities and threats presented by demographic change, new technologies or the political environment
- at the level of the individual professional or practice or at local, regional and national level

organisations, practitioners may change the environment through developing new practice, research or education, organisational leadership, or notoriety in the case of Harold Shipman. The biographical element in change is significant. For example, John Marks's autobiography reveals the many personal and sometimes accidental reasons his work took the course it did including for example an interest in dermatology arising from teenage acne.⁵⁸

- frequently there is interplay between the two: an individual turns into a movement and an organisation – the first few women doctors become the Federation and women move towards becoming a majority in general practice with external forces such as contraception and legislative change playing their part.

The organisation and technology of primary healthcare

The general practice workforce⁵⁹

The number of GPs in the UK has risen over the last forty years from a headcount of just over 25,000 in 1975 to over 40,000 in 2006. Expressed as full-time equivalents the figure was 33,384 in 2006. Because many GPs work part-time and the population has also risen, this exaggerates the availability of GPs. Even so, the number of GPs per 100,000 people has gone up, or to put it in another way the number of patients per GP has reduced. The average length of surgery consultations with GP partners increased from 8.4 minutes in 1992/3 to 11.7 minutes in 2006/7 though list size is only one factor in consultation length.⁶⁰ The number of practices has declined sharply to about 8,300 by 2006. At the beginning of the period, about half of GPs worked in practices of two or three doctors; by 2006 nearly half of GPs were working in practices of six or more doctors, and the proportion is now more than half. At the beginning of the period almost all GPs were GMS principals but by 2006 only 51.8% of GPs were on GMS contracts and 45.6% were on PMS agreements. Given that some GPs paid through GMS are sessional GPs employed by other GPs it means that GMS principals are now a minority of GPs.

The proportion working in single-doctor practices in the same period fell from 17% to under 7% to something over 2000 practices. Perhaps surprisingly the number of dispensing doctors has been rising, though the number of dispensing practices has gone down to just over 1000 in 2006. About one in eight doctors is a dispensing doctor. It does not mean they have a monopoly of dispensing in their area. By 2006 over 40% of GPs were women. The number of staff employed by practices rose to 119,642, or a full-time equivalent population of 76,977.

78.8% of GPs in 2006 trained in the UK, 5.1% elsewhere in the European Economic Area and 16.1% in the rest of the world, of whom three-quarters (12.1%) were from Asia.

These figures need to be seen in a longer historical context. GPs in the late nineteenth century were beginning to work together, sometimes as equals, sometimes families – parent and child, siblings, sometimes with one GP employing another doctor. However, in general GPs competed with each other fiercely. Digby argues that the introduction of state health insurance may actually have slowed the move towards partnership by increasing financial security.

Purpose-built accommodation away from the doctor's residence or an adapted building used as a branch or lock-up surgery was not a regular feature of general practice until the late 1960s despite

the fact that it was argued from the Dawson Report in 1920 onwards that teams of GPs working in purpose-built centres were desirable. Apart from a few well known examples such as the Woodberry Down, Peckham and Finsbury Health Centres the move into multi-partner purpose-built premises did not really take off until after the 1966 contract brought in systematic reimbursement for premises costs. The pattern of physical development of practices varied across the UK. In Scotland there was an extensive programme of health centre building in the first twenty-five years of the NHS.⁶¹ In Northern Ireland health centre building stopped in the 1960s. More recently health and social care centres have been promoted there.⁶²

Women started working in general practice in the nineteenth century. Under the National Insurance Acts, there was limited scope for women doctors to develop a practice for women and children, which some women GPs did. In the first half of the twentieth century a disproportionate number of GPs in England came from Scottish universities. In 1946 the BMJ said 'the export of university graduates had long been a feature of Scottish life' and in the period 1911-48 only one-third of Scottish medical graduates practised in Scotland.⁶³

Although small numbers of GPs came from Asia, the Caribbean and Africa from the last quarter of the nineteenth century, significant numbers of Asian GPs arrived only from the 1950s onwards. Staff in general practice in the earliest days of general practice were usually family members but by the late nineteenth century accountants and bookkeepers were employed to keep the books, collect debts and prepare tax statements; solicitors too were used for the business side of the practice. For the service side of the practice, dispensers, coachmen and later chauffeurs and, from the early twentieth century, receptionists were employed. As one of the GP negotiators pointed out, it is not at all uncommon for practices to have fifty people in a practice and for the first port-of-call not to be a doctor (and not necessarily in a face-to-face consultation).⁶⁴

*Technology*⁶⁵

GPs have been innovators and entrepreneurs in adopting new technologies. They started off using horses and carts but were early adopters of bicycles, motor-bikes and cars. They were among the first users of telephones and later faxes. The first British general practitioner to use a computer in his consulting room was John Preece at Whipton near Exeter in 1970. By 1996, 96% of general practices were computerised, and about 15% ran "paperless" consultations by 2002.^{66, j}

Computerisation has been used for both the business and clinical sides of practice. Computerisation in Wales may have advanced more quickly than in England. Wales did not adopt the English Big Bang approach of Connecting for Health and, for example, integration of care records between practices and out-of-hours providers has not been the same problem in Wales.⁶⁷ The miniaturisation of diagnostic equipment meant that much more equipment could be used in general practice.

The first half of the twentieth century saw the arrival of drugs and other interventions to prevent, manage and cure a wide variety of conditions including tetanus (antitoxin), diabetes (Insulin), bacterial diseases (Sulphonamides – the first antibiotics – and Penicillin), tuberculosis (first BCG,

j The BMA and GMSC acquired their first computers in 1979. The Fund agreed to spend no more than £14,500 to purchase a word processor with 2 work stations and a printer. (GPDF Minutes, Agenda and Documents 15/11/79).

later Streptomycin). The second half of the century has seen massive expansion of vaccines to prevent illness, drugs to treat hypertension and heart disease, a number of mental health conditions, malignant disease and many long-term physical conditions, to control fertility and multipurpose drugs such as steroids.

*Education and knowledge*⁶⁸

The ability to use the technologies available was just one part of a transformation in the knowledge of GPs, largely brought about by increases in the quantity and quality of education for general practice.

The earliest training for general practice was apprenticeships. The apprenticeship model goes back to the sixteenth century and reflected a distinction between 'gentlemen who are educated and tradesmen who are trained'. This was often parallel to a distinction between learning a science and learning a craft. Until the beginning of the twentieth century the dominant model was 'See One, Do One, and Teach One'. Not only that but it was oriented to hospital medicine. At the start of the NHS general practice failed McWhinney's four tests: no literature, no scientific journal, no university chair, and no academic organisation. A survey by the College of General Practitioners in 1953 found only two universities and two medical schools which involved GPs in teaching or provided very short periods of teaching about general practice.

In the 21st century general practice is a branch of medicine recognised in the undergraduate curriculum and with compulsory postgraduate vocational training and Continuing Professional Development. The process by which this change has come about starts perhaps with an external intervention: criticism of the standards of general practice by the Australian Joseph Collings in an article in the *Lancet* in 1950. This was followed by a more complacent response by Hadfield for the BMA and another study by Taylor but the seeds were sown for establishing the College of General Practitioners. The College can be seen as having played a crucial role in defining the standards and the processes whereby education would be provided and standards assessed. However, funding to enable practitioners to undertake education and to develop the skills requires the state and the profession's negotiators to make it happen. Postgraduate education and training for general practice was overseen by a Joint Committee of the College and the BMA. Resources for training became part of contract negotiations.

There had been isolated examples of research in general practice before the NHS going back to Edward Jenner, followed by people like James Mackenzie and William Pickles. Its growth from the 1960s reflects the same combination of professional, academic, state and personal contributions. The early adoption of computers in general practice and the move towards larger practices made it much easier to do population-based studies. Knowledge of needs and what works is not always translated into routine practice in any context. Both creating the conditions for research in general practice and turning research into action involved the representative bodies.

*Organisation of responsibility for Primary Care*⁶⁹

Even though the number of general practices has reduced, the fact that there are over 8000 autonomous units populated by 160,000 GPs and staff demands a particular kind of change management and decision-making. Within a general practice, historically there might be a senior partner, but even she or he would not have the role of, say, a managing director of a similarly sized business. Larger practices, professional practice managers and a wider variety of contractual conditions for not only GPs but other staff mean that new styles of management and leadership within practices have evolved. They have managed more or less successfully transformations in the mix of skills and activities in individual practices. Historically competition between practices was very strong. However from the earliest out-of-hours rotas in the 1950s through to out-of-hours cooperatives, research and teaching networks, Multifunds and Commissioning Groups there has been growing cooperation at the local level. Nationally practices with similar interests have collaborated to promote the interests of, for example, dispensing or inner urban practices. There have also been important differences between the four nations of the UK. For example, out-of-hours services in Northern Ireland were not generally run by deputising services – GPs largely organised their own rotas. As early as the mid 1980s, GPs in Northern Ireland eagerly embraced the idea of cooperatives, initially against the opposition of both local politicians and managers.⁷⁰

The common characteristic of these developments is that they reflect a self-organising system – bottom-up or inside-out rather than one which is based on command or control or a predisposition to believe that they should do what their peers are doing. As is frequently said, trying to control GPs is like 'herding cats'.^k The fact that practices and practitioners are autonomous also has major implications for GP representative bodies. Within any organisation there is question of whether members will follow their leaders or whether leaders have to follow their members. The kinds of mechanisms for leading or being led – include the ability to communicate in both directions directly, rewards for unity and sanctions for dissenters and opportunities to forge common views on ends and means. The means and the desire to use such mechanisms may not always be there.

The social context

General practice exists in a changing society and the impact of social changes on it has been profound.

*Demographic changes*⁷¹

The growth in population in the UK in the twentieth century largely came from people living longer and only secondarily from net immigration and in some areas high birth rates. Since the NHS began, the population has grown by ten million people and since the mid 1970s by five millions. The patterns of growth mean that there is generally an ageing population (with clusters of younger populations) and that years of good health have not risen as fast as years of life.⁷² There is greater diversity in national origins, ethnicity, cultural and linguistic backgrounds. A higher proportion of the populations live in urban areas and in England as a proportion of the United Kingdom. The different characteristics of the four countries of the United Kingdom have posed problems for GP negotiators about how to balance UK and country interests.

^k The whole of the analogy is 'to herd cats: all you need is to show them the food'.

In the 1970s Welsh doctors noted four problems of special concern in Wales that may be found individually in other parts of the UK but are only found in combination in Wales, namely:

- 1) exceptionally high morbidity especially in the industrial/urban south
- 2) depopulated central areas
- 3) massive fluctuations in the population allied to tourism
- 4) education and service links to England necessary to avoid excessive duplication.⁷³

These changes can have very direct implications for the workload and pay of GPs. For example, the pool system worked by calculating Target Average Net Earnings and expenses for doctors and multiplying it by the number of doctors. This worked well for doctors when the number of doctors was rising faster than the number of patients but not when the trend was reversed.⁷⁴

The composition of the population is also significant. Before the NHS, GPs found ecological niches: Irish-Catholic and Jewish GPs catering for populations of people from similar backgrounds, for example.⁷⁵ Since the inception of the NHS, GPs have continued to select their patients and their patients select them on the basis of demographic as well as other characteristics. In Wales this is a particular issue. Generally the GP representative bodies have argued that Welsh-speaking patients and doctors have been able to find each other and that insistence backed by law that GPs in some places should be Welsh-speaking is unnecessary. The debate has gone on for over thirty years.⁷⁶ General practice 'politics' in Northern Ireland clearly took place in a context of enduring sectarianism and for much of the last forty years, violence. In 2004 the UK BMA presented the Chairman of the Northern Ireland BMA Council (a former GP negotiator) with an award to reflect the fact that Northern Irish doctors 'raised themselves above the troubles and acted impartially and at times heroically in both community and hospital settings'.⁷⁷

Rising standards of living have brought changes in patterns of illness and health⁷⁸ but also on how and where people can access healthcare, as have increasing levels of literacy. Improved access to education has also, of course, affected the supply of doctors.

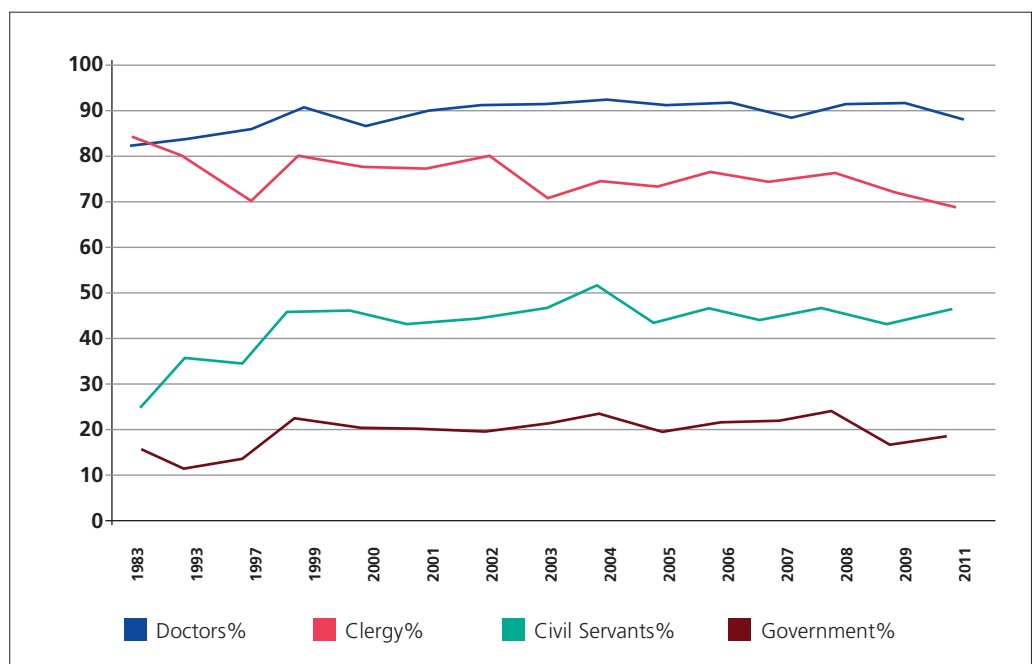
The status of GPs

In the late nineteenth century Lady Warwick was clear that 'Doctors and solicitors might be invited to garden parties, though never, of course to lunch or dinner'.⁷⁹ In the 1960s the complaint was heard that 'Things had gone downhill: the GP no longer enjoys the prestige of being one of a very small number of educated men in the local community and the problems of the GP are 'those of the middle class generally'.⁸⁰

Perhaps they need not have worried about status too much. The evidence on the public's trust in doctors is that it remains fairly stable whatever else is going on. Although the Ipsos MORI survey is about doctors generally, it is reasonable to assume that the perception of doctors will be strongly influenced by the perception of GPs. Although a dip is visible around 2000, when Harold Shipman was accused and convicted of mass murder, 'trust to tell the truth' remains high.

Nicholas Ridley, a Conservative Minister said that that the medical profession had replaced vicars in the community. More recently the (secular) Norman Warner said that some see GPs as replacing priests as personal confidants.⁸¹ The evidence suggests doctors are more trusted. When John Marks talked about the struggle between general practitioners and the state being an unequal one (weighted in the state’s favour) he was clearly not referring to the public’s trust in civil servants and politicians.

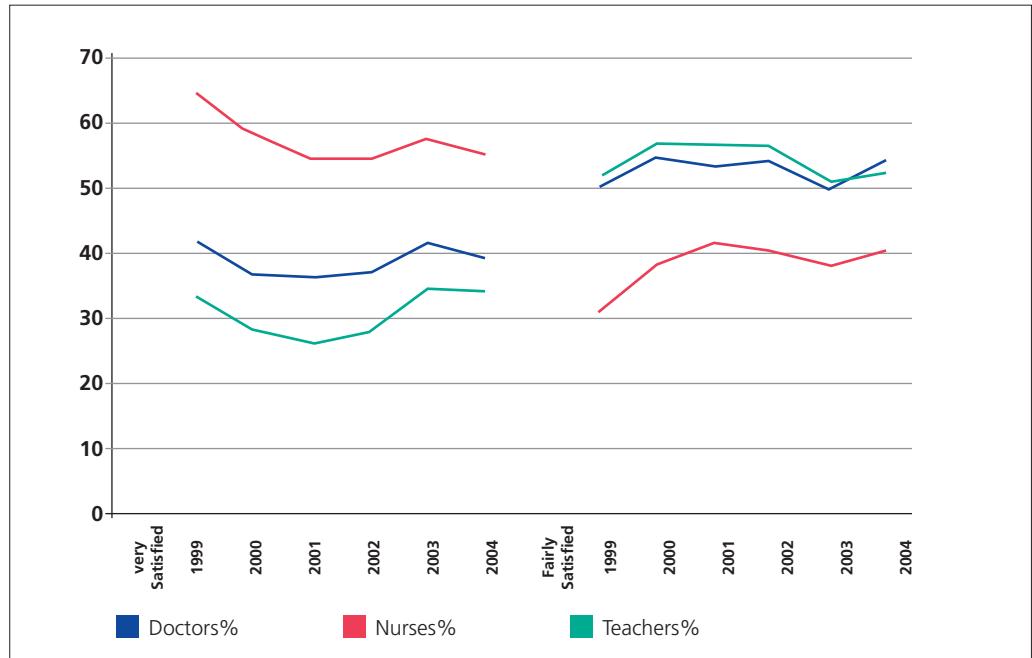
Table 2: For each, would you tell me whether you generally trust them to tell the truth or not?



Source Ipsos MORI (online)

There may be more subtle changes in patients’ perceptions which are reflected in satisfaction levels. Below, levels of satisfaction with doctors, teachers and nurses are compared:

Table 3: Satisfaction levels with selected professionals



Source Ipsos MORI (online)

Although the same surveys show that generally people are satisfied or very satisfied with the job that doctors do, dissatisfaction with waiting times is evident.^{82, 1}

When it comes to asking whether doctors and nurses are underpaid, the differences are even more revealing:

Table 4: Which, if any, of the types of people on this card, do you feel, are underpaid for the job they do?

	Nurses %	Doctors %
8-12 January 1999	91	23
3-7 February 2000	84	27
1-6 March 2001	86	30
7-13 February 2002	85	32
6-10 February 2003	81	25

Source Ipsos MORI (online)

¹ The introduction of a patient survey including general practice did not begin until the end of the period covered here.

The political environment

Doctors as self-interested, resisting change

Most of the attention to the relationship between politicians and GPs focuses on the relationship between government and the BMA. While this is understandable, it is important to remember that as well as local contacts, relationships with members of both Houses of Parliament are also important. From the late 1970s onwards the BMA paid increasing attention to cultivating relationships with MPs.⁸³ Nevertheless, right up to the present time observers could detect and 'underlying antipathy between MPs and GPs about who is representing who', with MPs resenting the idea that GPs represent patients or taxpayers.⁸⁴

The data above suggest that if it comes to a popularity contest between politicians, civil servants and doctors, the latter would generally win. However, there is a long history of governments portraying doctors and in particular their representatives as acting in their own interests and not those of patients or the taxpayer. This tradition can be traced back to Lloyd George and the 1911 Act through Bevan to the period which is the main focus of this history. In 1982 while accepting the Presidency of BMA on its 150th anniversary Prince Charles said he had a letter from a doctor saying BMA stood for bigoted, moribund and apathetic.⁸⁵ Although Kenneth Clarke apparently acknowledged that the BMA was no longer the British Money Association as he perceived it when 'Docker' Stevenson was its Secretary,⁸⁶ he had a clear strategy: 'the one thing we had to do was knock the BMA off its pedestal...so long as the BMA emerged as the spokesman for the savers of lives and healers of the sick, and the people whose only concern was for the welfare of the poor and elderly, we were in a no-win situation ...we had to pull them into the mud with us and make it clear that this was just another trade union, actually one of the nastiest I had ever dealt with, and battle it out'.⁸⁷ He believed that they had always been against any kind of change.⁸⁸ His strategy was followed up with an equally clear tactic: 'I commended the rules of a certain Rugby Club – get your retaliation in first'.⁸⁹ His most famous pre-emptive (and premeditated) strike was at the RCGP Dinner in March 1989, when he said 'The medical profession had always resisted change ... I do wish the more suspicious of our GPs would stop nervously feeling for their wallets every time I mention the word reform'. Later Clarke said it was like a batsman's silly stroke that he regrets instantly [but which] took years to live down.⁹⁰

In 1999 Tony Blair let it be known he was thinking specifically of doctors' resistance to change when he said 'I bear the scars on my back after two years in government' while talking about public sector reform during a speech to venture capitalists.⁹¹ Ten years later, in his autobiography, he said 'It always makes me hoot when the polls are trotted out showing how respected and trusted are doctors' opinions on the NHS...when it is so obvious that those who are running a service have self-interest as well as a public interest to serve, and when for most of the politicians, there is no reason other than the public interest for taking them on'. However he also blamed senior civil servants for inertia: 'They tended to surrender, whether to vested interests, to the status quo or to the safest way to manage things ... they were in thrall ... to a time and a way and an order that had passed, a product of the last hundred years of history'.⁹²

Underlying both the Thatcher/Major and Blair administrations was a view that public services were too provider-driven and would probably have agreed with Shaw that all professions are conspiracies

against the laity.⁹³ Whether it was through the creation of an internal market, privatisation or plurality, there was an idea that providers had to be made to be more responsive to consumers.⁹⁴

However, GPs were in a peculiar position in developing this narrative, for a number of reasons including that they were running small businesses in contract with the government and popular with the public. Simple statements about the dangers of faceless bureaucrats, out of touch with economic realities and public sentiment might not work. Norman Warner expresses the difficulties: on the one hand 'monopoly service providers and powerful vested professional and union interests – combined in the British Medical Association – cause particular problems for a tax-funded healthcare system with free patient access on the basis of clinical need'. On the other 'because they are businesses as well as doctors GPs also present an opportunity. They understand money...they can be enterprising'.⁹⁵ Given the relative costs of general practice and hospital services, GPs might be seen as the sprats to catch the mackerel.

Significantly there was an element of path dependency involved in challenging a laissez faire attitude to GPs. To do so would be at odds with very long-standing arrangements between government and general practice that suited both of them.

The concordats

A settlement between the state and GPs about how the state controlled the overall budget and GPs controlled how it was spent goes back to 1911. In 1948 this understanding was maintained. Bevan said: 'My job is to give you all the facilities, resources and help I can and then leave you alone as professional men and women to use your skill and judgement without hindrance'.⁹⁶ Doctors legitimised the rationing of health care on the basis of clinical need – which they determined – using the referral system between general practitioners (GPs) and specialists, and hospital waiting lists. In return they were given huge professional autonomy, particularly freedom from external clinical scrutiny by NHS management.⁹⁷

As Klein points out (even) Margaret Thatcher accepted the 'implicit concordat between the state and the medical profession forged by the creation of the NHS, whereby the former accepted the autonomy of the medical profession in decisions about the use of resources while the latter accepted the right of the state to set the budgetary constraints within which it worked'.⁹⁸ Or, as Kenneth Clarke put it 'the tradition of the Department was based on allowing all these interest groups just to run the whole damn thing'.⁹⁹

It was fundamental to both the 1911 and 1946 Acts that GPs would not be told who to treat or not treat beyond general eligibility. Although it might be seen as a concession to GPs to allow this independence, it also suited politicians to distance themselves from rationing decisions.

Symmetrically, while it suited GPs to resist state interference, the financial security of state payments was augmented by protection from competition within and outside the profession – by control of where practices could be set up and what roles other healthcare practitioners could perform.

Strategies or crisis management

In understanding the government's attitude to general practice it is important not to exaggerate the coherence and forethought that has gone into policy. Clearly successive governments have seen general practice as a successful strategy for delivering healthcare (see above) but in terms of what to maintain and what to change, blueprints or road-maps are hard to discern. The events leading up to the GP Contract of 1966 can be seen as a response to crises more than an attempt to think strategically. The start of the process leading to the 1990 Contract was a mixture of planning and crisis management. In 1979, GPs produced the New Charter. The Government did not respond directly but did commission the Binder Hamlyn report, study which looked at ways of controlling the costs of family practitioner services.¹⁰⁰ It is not clear what precisely the report said – copies appear to have been shredded – but whether this was because of its sensitivity, its radicalism or because it was not useful is unclear.¹⁰¹ In any case, on the day Binder Hamlyn were commissioned, the GMSC went to Coopers and Lybrand, unsuccessful bidders for the government work, to commission their own study on the cost-effectiveness of general practice which resulted in *General practice – A British Success*.¹⁰²

In 1982, a report on the welfare state by the Downing Street Central Policy Review Staff was leaked to *The Economist*. The main thrust of the report was that healthcare should move to a private insurance based scheme but included the idea that patients should pay for visits to the doctor. There was strong reaction against it even within the cabinet. Margaret Thatcher agreed to 'shelve it' and in public made her famous statement that the NHS was 'safe with us'. The Health Secretary Norman Fowler had not been involved in the report and was furious.¹⁰³ The following year, he and his minister Kenneth Clarke launched their Primary Care Review. Although, superficially, that proceeded in a relatively orderly way to a Green Paper and a White Paper, two crises – over deputising services and the Limited List – both soured short-term relationships between Government and GPs. They also had a long-term impact on Kenneth Clarke's perceptions of how to deal with GP representatives.¹⁰⁴ However, these crises paled into insignificance compared to the crisis which began with Margaret Thatcher unexpectedly announcing a Review of the NHS in response to adverse publicity in the winter of 1987/8.¹⁰⁵ The crisis in 1989 -90 was a mixture of content and process: the combination of the Fundholding element of the Reforms, the unwanted elements of what became the 1990 Contract was coupled with Clarke's determination not to be defeated by the BMA.^m

The events leading up to the 2004 Contract can also be seen as a mixture of crisis management and identifying a common agenda and seeking a 'win-win' negotiation. This is explored further in the Conclusions.

Constitutional politics

If the politics above identified who the actors were and what the dramas have been, another facet of politics has been on what stages issues have been debated. Over the last 100 years there have been Royal Commissions, Working Parties, Review Bodies and variations. Aneurin Bevan said he would not negotiate with GPs but would consult them on implementation and generally health ministers have tried to avoid to be seen to be negotiating with doctors. In general the Thatcher government was antagonistic to the medical profession and its representative bodies.¹⁰⁶ Kenneth Clarke's marathon meeting with the GMSC in May 1989 was almost unprecedented and rarely repeated. The reasons why it took place are probably a reflection of the fact that Clarke had come to the view that

^m See Chronology in Appendix A.

responsibility for the Contract was with him as Secretary of State –not the civil service or an employer-union council – but also that politically he had to get it done. No one involved expected it to last so long – ten hours. Paradoxically, the fact that Kenneth Clarke was supposed to be at a dinner to celebrate the tenth anniversary of Margaret Thatcher’s premiership may have helped prolong the meeting – he couldn’t be seen to stop negotiating for a cabinet dinner!^{107, n} Under the Major government, ministers were more willing to meet professional representatives. When out-of-hours arrangements were being renegotiated in the mid 1990s, Stephen Dorrell understood that the GP negotiators had to be seen to have tried everything including meeting the Secretary of State.¹⁰⁸ In the negotiations between 2001 and 2004, not only did the Secretary of State not get significantly involved in the ongoing negotiations but politicians and the civil servants devolved responsibility to NHS Employers. This did not mean that politicians were not keeping a close eye on the negotiations. They intervened from time to time.¹⁰⁹

Devolution in the more formal sense has also impacted on the GP representative bodies. In particular, Scotland was always seen as potentially different and important. This may be partly because of the export of Scottish practitioners to England, referred to earlier, so that there were a number of Scottish GPs active in medical politics. There are many examples of Scottish practitioners playing a significant role. Kuenssberg’s role as ‘second fiddle’ to James Cameron in the mid-60s is one example.¹¹⁰ The BMA Public Affairs team in the 1980s were famous for advising ‘Don’t forget to mention patients and Scotland’.¹¹¹ In 1998 the Scottish Parliament, National Assembly for Wales and Northern Ireland Assembly were established by law.

In 1998 the General Practitioners Committee for England was created. The GPDF agreed to support a one-off meeting of a Scottish Forum along the lines of the Conference of Local Medical Committees to complement the Scottish GMSC which had existed since 1949. The remit of the GP Representation Task Group was expanded to consider devolution issues. In 1999, it was agreed to support Scottish and Welsh Conferences of Local Medical Committees. Northern Ireland already had a conference of LMCs.

After devolution, as Greer and Trench point out, there was no legal reason to have a single UK-wide contract. They say the decision was, in large part, due to a failure of devolved nerve, the newness of devolved institutions, to the size of England and its potential effects on their systems, and to the power of the health unions including the British Medical Association. Nevertheless, devolved policy-makers have complained that these very expensive new contracts for doctors reflect problems of London and south-eastern England in both providing services and recruiting staff, and are inappropriate to their budgets, priorities and management strategies.¹¹² While recognising the important differences which exist between the four countries, it is important to recognise that the position of the negotiators from the smaller countries has often been that they are stronger by working with the other countries. As a Northern Ireland negotiator put it: ‘We are stronger ... being part of a four nation process ... we have been facilitated. We can punch above our weight. One voice for a thousand GPs is heard disproportionately. It is like a chair with four legs, if one leg falls off...’. He suggested that what happens that UK philosophies and principles are “shamrockised”. After the Northern Ireland Assembly was restored, the Health Minister did attempt to assert a distinctive view but it was not strongly supported by either the rest of the government or her party.¹¹³ In some cases, contracts covered different nations of the UK but were simply not taken up by doctors

n Though he went to the dinner for pudding!

such as Personal Medical Services in Northern Ireland or were not included as an option such as APMS outside England and Wales.

The NHS and general practice in particular form part of the battle ground about what is 'United' about British society and about who makes decisions. Gordon Brown gave many speeches that clearly identified 'the NHS' as a vehicle and exponent of 'Britishness'.¹¹⁴ Greer argued in 2004 that although faced with common problems of rationing and provision and political imperatives to get value for tax money, the four countries of the UK 'placed their bets' on different policy trajectories. He argued that England had bet on markets, reflecting the strength of think tanks promoting free market solutions and the strength of Thatcherite politicians. Scotland had bet on professionalism, reflecting the closeness of political and professional elites and the strength of the latter in Royal Colleges and universities. Wales bet on localism reflecting a strong tradition of local government and public health inputs into health policy. Northern Ireland bet on permissive managerialism reflecting the reality of direct rule and fragile devolution in which politicians either didn't want to or were unable to have much impact on health policies.¹¹⁵ It is important to note that this analysis was made shortly after devolution. Some of the initial 'bets' have changed. In Wales the 'extreme' localism has been partially reversed.¹¹⁶ In Northern Ireland, interventions by politicians in devolved government seemed to reverse 'permissive managerialism' but then a combination of civil servants, the profession and other local politicians encouraged a reversion to it.¹¹⁷

When Tony Calland stood down as chairman of the Welsh GPC, in 2002, he noted that devolution had exposed office-holders to much more political scrutiny: 'every last word, phrase and inflection has to be carefully considered before opening one's mouth'.¹¹⁸ However, relationships with almost all politicians in the Welsh Assembly Government were felt to be 'hugely better' than with most Westminster politicians, though trust in civil servants was not strong.¹¹⁹

The economic context for general practice

Economic issues have been central to the concerns of the GP representative bodies since they began. Three levels of concern can be seen:

- Micro: what GPs are paid and the costs of running general practice
- Meso: how spending on general practice is doing relative to the NHS generally and other branches of the medical profession
- Macro: public spending on health and healthcare generally and the value added by general practice

Homo Economicus?

As was suggested above, politicians and commentators have often presented GPs as mercenaries. One of the officials who negotiated with the GPs quoted the view attributed to Aneurin Bevan that 'the only way to get a message across to a doctor is to write it on a cheque'.¹²⁰

It is clear that a primary function of many of the representative bodies is the protection and promotion of pay and conditions, but the relationship between the vocational or professional concerns and material interests is a complex one.

As Digby pointed out about the pre-NHS era, therapeutic standards and procedures in general practice are ultimately grounded in economics.¹²¹ The relationship between what economists call intrinsic rewards (which might be satisfaction and are often associated with altruism) and extrinsic rewards (which are generally the material rewards) is fiercely contested. Richard Titmuss argued that incentives (to give blood) could undermine altruism.¹²² Subsequently others, including Julian Le Grand, Titmuss's successor at the LSE, have argued that incentives are necessary and desirable to deliver services that are responsive to the public and reflect the needs, particularly of the most vulnerable.¹²³ Le Grand was Senior Policy Adviser to Tony Blair between 2003 and 2005 though he does not seem to have been substantially involved in discussions about the 2004 GP contract. The debate continues. The health economist Alan Maynard has argued that doctors' self-interest is undermining the NHS and that 'by moving away from traditional non-financial interests to payment by results, the NHS may have undermined public service values'.¹²⁴ Recent research published by the Office of Health Economics on implementation of the Quality and Outcomes Framework for GPs in Scotland suggests that by increasing financial incentives, non-financial motivations may be 'crowded out'. The research treated activities not specifically measured in the QOF as 'unpaid work' (which is not literally true – it is simply not incentivised). They found increases in the rate of QOF payment had a negative effect on GPs' supply of unpaid work. Only observations from GMS contract practices were used in the empirical analysis. It assumes that the QOF reflects rewards for individual doctors but with practice-based contracts this is not necessarily the case. Also, if salaried doctors were to deliver the same outcomes, it would undermine the argument.¹²⁵

Another difficulty in understanding the economics of general practice is that, particularly since the 1966 Contract, costs have been a substantial part of what is agreed between general practice and the government. The relationship between costs, productivity and profits is not clear.

The pay system

The way that GPs are paid is certainly an example of path dependency. The key features can be traced back to the nineteenth century or even further back.¹²⁶ Although the proportions from each source change, the concept of a mixture of elements has endured.

Capitation

For some GPs the core of the GP contract is 'the list'.¹²⁷ It may have moved from being a personal list to being a practice list effectively, but it gives the GP independence from the funder – whether it is the state or, before the NHS, employers and insurance companies. The GP can choose who to take on and whether and how to treat them. In economic terms it shifts risk from purchasers to providers.¹²⁸

Before the NHS it encouraged fierce competition between practices for patients. When the number of doctors rises faster than the number of patients, that competition intensifies. Capitation fees have always created an incentive to have excessively large lists and the question of how and at what level to cap list size has been ongoing. From the 1950s, basic capitation was modified to encourage partnerships and to recognise that some categories of patients were likely to be heavier users of healthcare.¹²⁹

Fee-for-service

What in other sectors would be called 'piece work' also has a long history in general practice. It has the advantage to both provider and funder of a close relationship between work done and the pay received. However, it will be bad for the provider if the amount of pay (the 'quantum') is less than the value of the time, effort or risk involved. From the funder or purchaser's point of view, the risk is that of over-rewarding activity, with the possibility of encouraging low priority or unnecessary activity.

Incentives/target payments

Fees for services are flat rate payments. Graduated rates encourage the achievement of higher levels of activity which are either more desirable or hard to reach. Thus, target payments for immunisation in the 1990 Contract recognised that achieving cover of 90% of eligible children was harder than achieving 70%, so only achieving the lower target or less was paid at a lower rate. This example illustrates one of the problems with such a system. Achievement of a target may be helped or hindered by factors beyond a practitioner's control – the 'Andrew Wakefield effect' in reducing MMR uptake and the 'Jade Goody effect' in increasing cervical cytology uptake.

Allowances/costs

Some allowances were introduced in the 1950s such as the Initial Practice Allowance to encourage young practitioners to enter general practice and incentives to encourage partnerships. However, it was the 1966 contract which really extended this element introducing reimbursement of premises and staff costs in particular. In 1990, reimbursement of computer costs was added. The list grew longer and longer as particular circumstances were addressed. This included an Isles of Scilly Boat Allowance and an allowance for GP trainees which enabled the purchase of a bed headboard. Some of the allowances became less relevant as circumstances changed such as provision for message-takers' accommodation. Any 'expenses' system runs the risk of encouraging people to incur unnecessary costs or their suppliers to overcharge for goods and services. On the other hand, if levels of reimbursement do not match actual costs, it can act as disincentive to spend money on necessities.

Salaries

Hostility to the principle of salaries for general practitioners was at the heart of arguments between GPs and the government in the run up to the creation of the NHS. However, salaried doctors were always there – in the early days of the NHS as Assistants, more recently as sessional doctors in GMS and PMS practices. Although rates of pay have often been locally negotiated, national pay levels have influenced and been influenced by levels of pay for salaried doctors. In addition, of course, most GP staff have been salaried.

The American economist James C. Robinson has said: 'There are many mechanisms for paying physicians; some are good and some are bad. The three worst are fee-for-service, capitation, and salary. Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoding of visits and procedures, and the churning of "ping-pong" referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem'.¹³⁰

General practice within the NHS

The systems of payment predate the NHS. Between 1911 and 1948 many GPs earned some of their money from National Insurance but only a minority received the bulk of their income from that source. Other public appointments included Poor Law unions and hospital appointments. Despite the fact that the initial setting-up of the NHS scheme was seen by the representative bodies as a defeat and a trigger for a number of bitter disputes about pay, they achieved a lot more financial security than they had previously. From the state's point of view the outcomes of general practice were cost-effective, if not always clinically very effective.¹³¹

Under the NHS, GPs have maintained but not greatly increased their proportion of NHS spend, even when prescribing drugs is taken into account.

Table 1 (on page 7 above) shows the substantial increase in NHS spending in the NHS from 2003 to 2008, following 'the most expensive breakfast in history' when Tony Blair made a commitment to match health spending to EU averages.¹³² A minister of the time said that the contract agreed in 2003 cost more than the Department expected and 'rewarded GPs far too generously for what patients and taxpayers received in return'.¹³³ Even within the BMA, there was a feeling that 'Alan Milburn put all the money on the table and said "here you are boys"'.¹³⁴ However, as the table shows, compared to the rest of the NHS, general practice did not do disproportionately well.

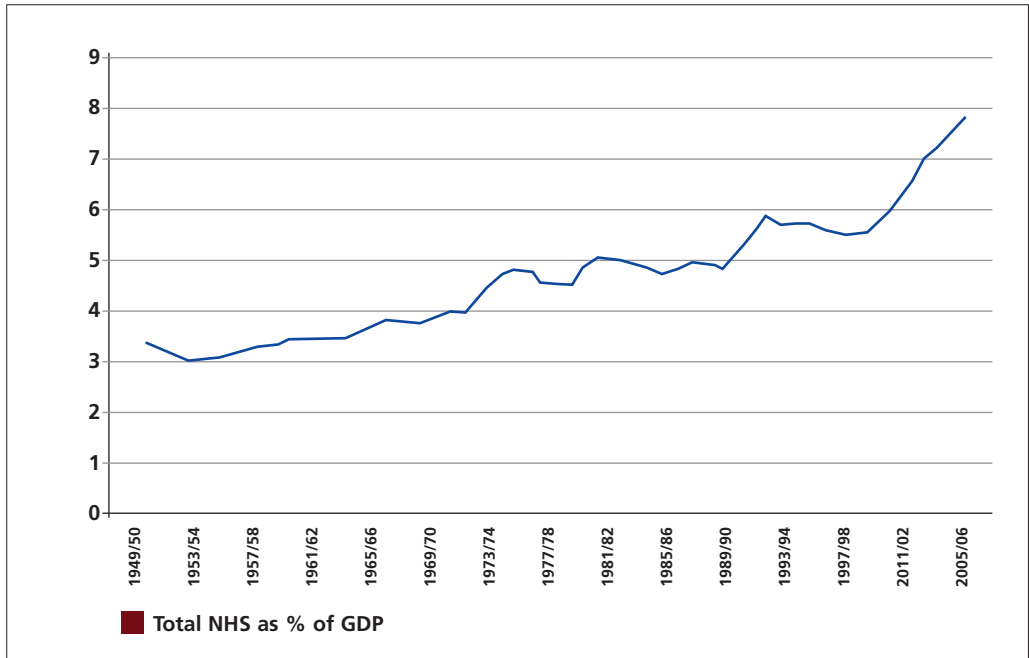
However, there has been a perception that Family Health Services, specifically General Medical Services, have not borne their share of the pain when actual cuts in spending or in the growth in spending have been made. This perception certainly underpinned the Binder Hamlyn report referred to above and Treasury concerns about GPs' non-cash limited budgets being used to supplement cash-limited budgets. In particular this applied to the drugs budget and it was the effort to reduce that which led to the Limited List in the mid-1980s. Later on, GPs' concerns about GMS being 'raided' by cash-strapped Health Authorities led to a series of legal cases supported by the GMSDF to stop the practice.¹³⁵

As well as the debate about the primary care share of NHS spend there have been more specific arguments about the relative pay of GPs and hospital staff. The BMA's practice has been to submit evidence to the Doctors' and Dentists' Review Body jointly from the different branches of the profession. This has meant that often arguments about pay differentials, priorities or negotiating tactics have been (more or less) made in private.¹³⁶

The NHS in the economy

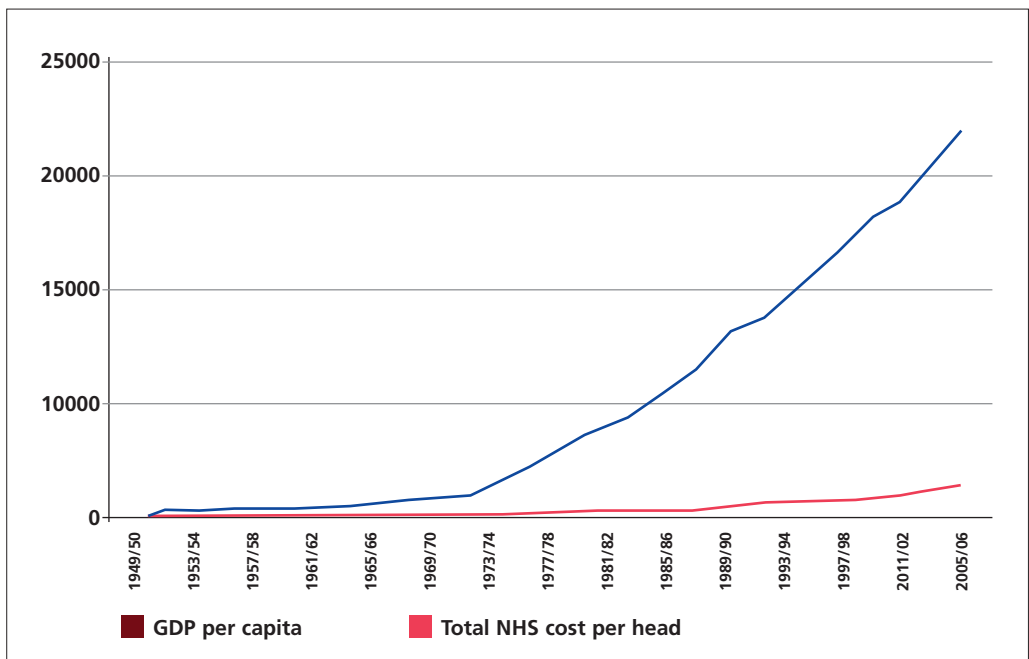
Table 1 illustrated the General Medical Services share of rising NHS spend but the ability of GPs or any other group to achieve better terms and conditions is clearly influenced by how well the economy is doing overall, attitudes to public spending generally and to spending on the NHS. Table 5 shows NHS spend as a proportion of overall Gross Domestic Product (GDP). Table 6 shows how NHS expenditure and GDP per capita have risen within the BMA.

Table 5: Total NHS Spend as % of GDP



Source: OHE

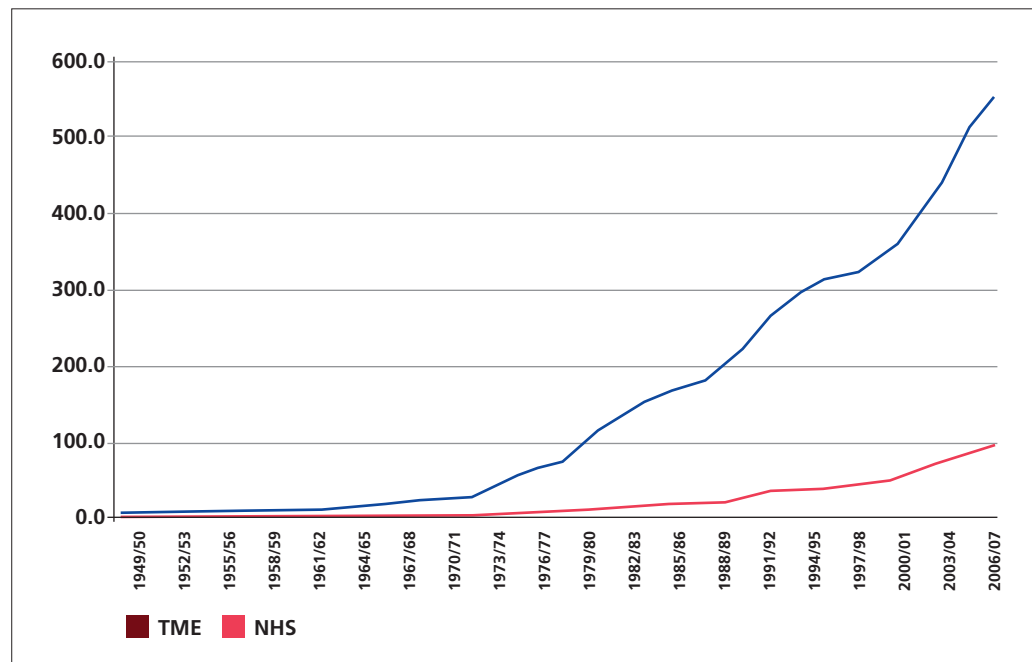
Table 6: NHS spend and GDP per capita



Source: OHE

The Institute of Fiscal Studies has shown the spending on the NHS has grown significantly – both as a share of public expenditure and as a share of national income. Between 1949–50 and 2006–07 it went from 9.3 per cent of Total Managed Expenditure to 17 per cent.

Table 7 NHS Spending as proportion of Public Spending (Total Managed Expenditure)



Source Institute of Fiscal Studies

The legal, regulatory and ethical context

What doctors must, can and can't do is governed by professional, general national and international regulations, ethics and law.

The GP Contract

For all that has been said and written about the GP contract, its legal basis until 2003 was 'fragile'. It was known to both government and the GMSC that it was not a contract as might be generally understood. It was statement of government intentions set out in schedules of fees and allowances.¹³⁷ The case of *Roy v Kensington, Chelsea and Westminster FPC* found that the rights and duties of the doctor and the FPC were based on statute with 'deceptive contractual echoes'.¹³⁸ This led to a lack of clarity about whether the Secretary of State could impose a new contract. The GMSC received conflicting advice from Lord Denning, former Master of the Rolls and the Chairman of the Bar Council, Anthony Scrivener.¹³⁹

Legislation specific to doctors

Comprehensive national legislation specific to doctors began with the Medical Act of 1858 (though there were rules about who could practice in London, for example).

Some of the key developments specific to the regulation of doctors in the last twenty years are set out in Figure 2.

Figure 2 Developments in regulation affecting doctors 1994-2006

1994	LMC Conference adopted a policy of compulsory, confidential, and personal 'reaccreditation'
1995	Publication of the GMC's "Good Medical Practice", which set out, for the first time, a "code" of practice which included the duties of a doctor.
1996-2001	Concerns led to removal from GMC Register of children's heart surgeons and a medically qualified manager at Bristol Royal Infirmary
1999	Introduction of clinical governance
1999 -2004	Accusations, conviction and Inquiry into murders of patients by Dr Harold Shipman
2000 onwards	Discussions on how revalidation will be introduced
2006	Publication of Chief Medical Officer for England's. " <i>Good doctors, safer patients. Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients.</i> "

NHS legislation

There have been a large number of Acts relating to reorganising the NHS. From the GP perspective the impact of changes on the administration, later management, of Family Health Services have been of particular significance. Through various changes of name, GPs held on to arrangements separate from Hospital and Community Services until 1995. They attached great importance to separate administration and up to 1992 the arrangements included substantial GP representation.¹⁴⁰ A civil servant's perspective was that general practice needed to be brought into the mainstream, highlighting that only small number of civil servants and NHS managers knew much about general practice but also that it was 'extraordinary... that GPs could make or break Family Practitioner Committees'.¹⁴¹ After 1995, Family Health Services became integrated with management of Hospital and Community Health Services.

As well as legislation impacting on information and confidentiality affecting everybody, GPs have been bound by specific legislation on patient information. The 1967 Abortion Act did not apply in Northern Ireland which created tensions between GMC and BMA guidance and the legal situation. Different mental health legislation created similar if less intense tensions.¹⁴²

General legislation affecting GPs

The range of legislation which could affect GPs is vast but a few examples illustrate some of the different types:

- Equality legislation: for example, the 1975 Sex Discrimination Act put an end to (formal) medical school quotas and advertisements for partners of a specified gender. It and the Race Relations Act also applied to recruitment of GPs and their staff. One GMSC negotiator found himself in trouble for a comment which he had not fully thought through about recruiting White male doctors.¹⁴³ In Wales, the Welsh Language Act of 2001 raised particular issues for the BMA as a body and for general practices about whether they were public bodies with obligations to produce bilingual information and appoint bilingual doctors and practice staff, for example.¹⁴⁴
- Trade Union legislation: the BMA had to change its constitution to reflect trade union legislation in the 1970s.¹⁴⁵
- Data Protection and Freedom of Information Acts.

Ethical issues for representative bodies

Discussions in representative bodies about the right thing to do have often been expressed as ethical issues. One of these issues has been whether it is legitimate to take industrial action. Some have argued that it can never be. Others have argued that it can be. For example, John Marks said 'Whether it is ethical for doctors to take industrial action: I still maintain that doing nothing in certain circumstances such as the crisis in general practice in the mid 60s would do far more damage than doing nothing in certain circumstances'.¹⁴⁶

In discussions of the gatekeeping role there have been arguments about when gatekeeping becomes rationing and becomes unacceptable and/or if there is financial advantage to the GP in making clinical decisions. The issue of the proper use of fundholding savings was one of the more contentious arguments within the GMSC.¹⁴⁷

Despite the scepticism of the government side, most GP negotiators stoutly defend the position that they have never negotiated anything which is of advantage to [them] but detrimental to patients. Some negotiators express concern that they sometimes rationalise something as in patients' interests when it is really in practitioners' interests such as seeking in the 1990 contract negotiations the removal of the proposed retirement age so that 'patients could grow old with their GPs'.¹⁴⁸

2. Why has General Practice needed defending?

Some interviewees for this history were uncomfortable with the term 'defence'.¹⁴⁹ For some it was because they wanted to use a more positive term such as 'promotion'. For one it was because of the potential confusion with defence bodies for individual doctors.¹⁵⁰ Nevertheless there was a wide degree of consensus that there have been a wide variety of threats to general practice. In this chapter, we briefly review the nature of the threats. In Chapter Three we consider who the threats have been from and in Chapter Four how general practice has been defended.

Existential crises

The idea that general practice faces a life or death crisis has been raised so often that more recent negotiators from time to time even mock their colleagues for its over use.¹⁵¹ The earliest period of the representative bodies and the run-up to the creation of the NHS are the two most obvious examples of threats to what many GPs see as the cornerstone of their identity – independence. As the analysis of context above suggests, there are distinctions to be made between organisational autonomy (independent contractor status), management autonomy (e.g. having discretion over patient lists) and clinical autonomy (over prescribing, for example). Threats to any may be seen by some as a threat to the existence of general practice. In the early 1980s the Limited List was seen by a leading representative as 'the end of the NHS as we know it'.¹⁵²

Process issues

Many times GPs have been angry about a failure to consult or being consulted but then ignored. Lloyd George was criticised for not consulting on the 1911 Act and Bevan on the 1946 Act. The Limited List proposal came as a complete surprise to GPs' representatives and later they were angry about their views being ignored.¹⁵³ On the other hand, Kenneth Clarke, the junior minister at the time, had a different interpretation: 'they just tried to veto everything [and this] led to determination to do it differently next time'.¹⁵⁴ Since PMS contracts were first proposed negotiators on both sides have been aware that the GMSC/GPC has had no formal negotiating rights in respect of PMS contracts and more recently APMS contracts.¹⁵⁵ Nonetheless, the GMSC/GPC has managed to maintain de facto sole national (UK) negotiating rights during the period studied.

Competition

Various sources of competition have been a regular source of concern:

- Entry and exit to general practice: having too many or too few GPs was one of the earliest concerns about the 1911 Act. Too many meant an economic threat. Too few meant excessive workloads. After the introduction of the NHS, GPs wanted both limits to where new practices could be set up and permission to start and merge practices and the Medical Practices Committee was set up to oversee this. The GMSC worked with the RCGP and GMC on entry standards for general practice and on professional misconduct. It also worked on when NHS contracts might be terminated and fought to have the retirement age for GPs to be removed.
- Within the medical profession: territorial disputes between hospital doctors and GPs pre-date the representative bodies (see above page 10). In the run-up to the introduction of the NHS there were tensions with public health doctors about maternity services and immunisation and in the 1980s about child health surveillance. More recently there have been arguments with Occupational Health doctors about sickness and disability certification and with dermatologists about minor surgery.

- With other professions: with pharmacists over dispensing, with Health Visitors and District Nurses over whether nursing teams should be attached or aligned to general practices and what tasks nurses should or should not do.¹⁵⁶

Reputation and standards

Representatives have felt there were threats to their reputation when they have felt they were being asked to do too much, too quickly or something which might harm their relationship with patients. An example of the latter would be the introduction of the Police and Criminal Evidence Act in 1984 – which concerned all branches of the profession.¹⁵⁷

Perhaps even more important has been the threat to the reputation of general practice from poorly performing doctors. While one former Chairman of the GMSC may or may not have said 'There is no such thing as a bad doctor'¹⁵⁸ some of his successors regard unacceptable doctors as 'the Achilles heel'¹⁵⁹ and the actions of Harold Shipman as catastrophic. Reports of poor deputising services in the 1980s became the basis of a national change in policy. One interviewee suggested that every individual failure becomes an excuse to micro-manage or to make the issue a corporate problem.¹⁶⁰ This perception has led some GP representatives to argue that they 'have to put their own house in order' on the grounds that self-regulation is preferable to external control.¹⁶¹

Reputation and status may not be the same thing though they are often related. Clearly poor behaviour by some GPs is likely to harm their collective reputation but social and professional status is wider than that. For example, the status of GPs with their medical peers: Moran's (in)famous comment about 'doctors who had fallen of the ladder' was said in the specific context of whether Merit Awards should be paid to GPs but in the wider context of pay differentials between consultants and GPs.¹⁶²

The neglect of general practice by medical education, although particularly an issue taken up by the College of Practitioners, had been raised by the representative bodies before the NHS was founded.¹⁶³

Managing threats: the theory

Policy analysts (and others) advise that management of risk has three components: probability, severity and mitigation.¹⁶⁴ In the following chapters we analyse what the representative bodies have done enough to anticipate and manage the threats. Here we briefly outline the theory.

- Probability: many of the threats were foreseeable and foreseen. Specific threats such as the Limited List in the 1980s might not have been foreseen but the general danger of external cost-control was anticipated in the commissioning of the Coopers and Lybrand report on the cost-effectiveness of general practice, for example.
- Severity: the representative bodies have probably not been 'guilty' of underestimating the seriousness of what were perceived as threats but it may be argued that some things were not seen as threats but as opportunities. It is clear that a number of negotiators in retrospect think that the opt-out from out-of-hours commitment, even though it was clearly what the membership wanted, has in fact harmed the profession.¹⁶⁵

- Mitigation: risk management involves weighing up the cost and effectiveness of measures. Clearly each case is different. In Chapter Four we consider how general practice has been defended – in effect the cost – and in Chapter Five, how effective that defence has been. However, before that, we consider who it has needed defending against. This reflects another insight from risk management.

Mitigating threats

A report on high security prison escapes in the 1990s highlighted the categories of Physical/ Environmental, Procedural and Relational Security.¹⁶⁶ These concepts have wider applicability and it only slightly over-simplifies the strategies of the representative bodies to suggest that they have followed these three paths:

- Environmental: to control the environment by the pursuit of independence and involvement in the oversight or management of general practice at local and national levels
- Procedural: to have (sole) representation rights
- Relational: to ensure that representatives were aware and in dialogue with all the parties who were potential threats.

In this context we look at the relationships that the representative bodies have had to manage.

3. Whom has general practice needed defending against?

The relationship with state: General practitioners and the state an unequal struggle?¹⁶⁷

John Marks's portrayal of GPs as the underdog in a struggle with the state needs to be refined in two ways: firstly the state is not homogenous and secondly, the relative power and influence of the profession and the state depend on what is at issue, among other things. It has been observed that the power of the medical profession is in inverse proportion to the size of the stage on which a specific health issue is fought out.¹⁶⁸

The state as government

The state can be narrowly seen as the Ministers of the government of the day. From Lloyd George (as Chancellor of the Exchequer) to Patricia Hewitt who was Secretary of State for Health at the end of the study period, it is possible to identify individual, party and government ideologies and political styles which were drivers of their attitudes and behaviour.

Some Secretaries of State have been innovators and others consolidators; some ideologues and others pragmatists; some confrontational and others bridge-builders. Between 1976 and 2005 there were thirteen of them. The longest lasting of them was Norman Fowler but among those who had the most impact on general practice are Kenneth Clarke who lasted a little over two years and Alan Milburn who spent just under four years at the Department. Not all Ministers welcomed being sent to the Health Department. When John Reid was offered the post in 2003, he is reported as having said 'Oh F***, not Health'.¹⁶⁹

When Labour was elected in 1997, they thought that they would have a very different relationship with the BMA to the previous administration: 'We were bright eyed, we weren't going to make the same mistakes...We scoffed at the idea that we would argue with the BMA'.¹⁷⁰ It is not surprising that New Labour politicians did not think they were following in the footsteps of Enoch Powell who wrote: 'The unnerving discovery every Minister of Health makes at or near the outset of his term of office is that the only subject he is ever destined to discuss with the medical profession is Money'.¹⁷¹

It is also important to remember that both the Prime Minister and the Chancellor of the Exchequer play a crucial role too: not only did Margaret Thatcher put the Central Policy Review Staff paper on a Cabinet agenda without consulting health ministers in 1982, but in 1988 she announced the Review of the NHS, again without consulting health ministers.^{172, o} In the run-up to the 1997 election Stephen Dorrell felt that not only was it a disadvantage that the Chancellor and Chief Secretary to the Treasury had both been at Health, 'knew where the bodies were buried...knew all the arguments because they'd used them before' and within the government there was a view that health 'is never going to win us any votes anyway'.¹⁷³

In 2000 Tony Blair took health ministers and civil servants and even his closest Special Adviser on Health by surprise when he announced an increase in health funding on the Frost programme on television.¹⁷⁴

^o David Willetts says that Thatcher thought she was announcing an External Review not a government review, which would be chaired by Lord (John) Vaizey who had in fact died in 1984. He also says the background to the review was the Primary Care Review which in an early draft had what he called 'the lunatic chapter' proposing 100% Fundholding (in Isom and Kandiah, 2002).

Civil servants

With a relatively rapid turnover of Ministers, it might be expected that civil servants would have considerable responsibility if not power. However, it is important to note that very few civil servants have made a career working in primary care, numbers have generally been small compared to other aspects of health and not all welcomed the opportunity. One civil servant is said to have described working on primary care as 'like going to the Russian Front in World War II: it fought to rules no one understood and no one cared much about'. It was seen as a 'Second Division' operation.¹⁷⁵ Another civil servant remembers being told that 'once you were there, it was quite difficult to get out if you got on the wrong side of GPs because the GPs would ask for you to be moved and the Department would resist on principle'.¹⁷⁶ At one stage the primary care part of the Department was physically moved away from the main location of the Department. Furthermore the 'concordat' (see p.20 above) meant there was a 'hands off' tradition. As Kenneth Clarke put it: 'the tradition of the Department was based on allowing all these interest groups just to run the whole damn thing'.¹⁷⁷ On the other hand, another civil servant felt primary care was 'a place where you could make a difference' and liked working with GPs, partly because of their willingness to innovate in the interests of patients e.g. through computerisation or out-of-hours cooperatives.¹⁷⁸

Medical advisers

Medical advisers can play an important role in health policy. However, when Margaret Thatcher became Prime Minister in 1979 she is reported to have told Patrick Jenkin, her new Secretary of State for Health, that one of his first objectives should be to send many of them 'back to the NHS to do proper medical jobs'. Throughout the period numbers were reduced and their roles limited.¹⁷⁹ One of them however was present at many of the negotiations on the 1990 Contract and has written extensively about the period.¹⁸⁰ Medical advisers were also active, mostly behind the scenes, during the 2001-03 negotiations. The view of the medical advisers held by many of the GP negotiators was often quite negative with 'duplicitous' being a regular epithet.^{181, 182} It is perhaps inevitable that there is a degree of mistrust both among the representative bodies and on the government side of people who are both doctors and civil servants: their role includes 'to keep the other side honest, to put them at their ease and make them believe we were honest and to look for holes in their argument'. The idea that the two roles are incompatible goes to the heart of the attachment to 'independent contractor' status. However, one of the advisers suggested that many of the medical advisers (not just in relation to general practice) are 'refugees from reality'.^{183, p}

Policy advisers

Ministers have had policy advisers for a long time. In the first couple of decades of the NHS, academics such as Richard Titmuss and Brian Abel-Smith played significant parts in shaping health, social services and social security. In the period of the 1979-97 Conservative Government advisers to the Secretaries of State do not seem to have played a very significant role in making policy as opposed to presentation and consideration of the political implications. The role of the Downing Street policy staff (see p.38) seems mainly to have encouraged the health ministerial team to take a more proactive role. David Willetts, who had been in the Downing Street Policy Unit, was Director of the Centre for Policy Studies in the late 1980s, a Health Authority and Family Practitioner Committee member who as he put it 'kept in touch'.¹⁸⁴ Under the Labour Government elected in 1997, Policy Advisers both in the

p On the election of the Labour government in 1997, the structure and style of professional advice changed again. A number of National Clinical Directors or czars were appointed, including one for primary care. It may be that their role is more strategic, open and independent and causes or reflects less tension.

Department and Downing Street were more actively involved in policy with Simon Stevens evidently particularly involved in shaping policy impacting on GPs. Stevens in Downing Street and colleagues in the Department articulated the motive: increasing the capacity of primary care to take on work previously done in secondary care to deliver the policy priority of reducing waiting lists and times. He also identified the proposed means – incentivisation – and the opportunity: the GPs’ enthusiasm for renegotiating contracts ‘to change general practice for ever’. The plan for how to do this however was left to Ministers, advisers and civil servants in the Department to develop. The Downing Street adviser continued to keep an eye on it as did the Prime Minister’s Delivery Unit. One of the advisers said that when he started work he was given a list of 27 things to do of which one was the GP contract. However, the GP contract was a ‘big ticket item’ which demanded the attention of Ministers.¹⁸⁵

The state as NHS managers

If the Departmental politicians and civil servants did not necessarily want to intervene too much in general practice, GPs had ensured that the structures set up to administer general practice embraced the principle of ‘partnership with GPs’.

From the Insurance Committees (1911) to the Executive Councils (1948) and the Family Practitioner Committees (1974) – and in equivalent structures in Scotland, Wales and Northern Ireland – GPs were guaranteed representation on all the local decision-making bodies. Not until the Family Health Services Authorities were created (1991) did representation diminish. In the mid 1990s, the separate administration of Family Health Services appeared to end – although ‘provider’ and ‘shared services’ agencies actually maintained a degree of separation. Many of the GPs who became involved in national representation began their medico-political careers in either cooperative or antagonistic relationships with local NHS Administrators (until 1992) or managers.¹⁸⁶

In 2001, it appeared that the government had devolved negotiations on the new contract to the NHS Confederation but the civil service and Ministers were closely involved in the background which the GP negotiators knew.¹⁸⁷ A Minister felt that though the Department/Confederation split caused some confusion and the mechanism for coordination was ‘clunky’, the Confederation delivered Ministerial priorities.¹⁸⁸

The state as regulator

The state has a regulatory role which may or may not be at arm’s length but, if only in creating the structures and approving the procedures, has an influence. In the last forty years among the ways it has manifested itself in relation to GPs are:

- 1970s Industrial Relations legislation, which led to the BMA registering as a trade union and thereby precipitated a review of the constitution which led to tensions about the relationship between the BMA as a membership organisation and the GP representative bodies which included non-BMA members but had negotiating rights for all GPs – the so-called Chambers crisis¹⁸⁹
- changes to the constitution and membership of the General Medical Council
- inquiries, notably that of Dame Janet Smith into the Shipman case.

GPs as politicians

Throughout the history of the representative bodies party or election activity by GPs has been part of the relationship with government. When individual GPs have been active members of the ruling party this can be an advantage. When they have been of opposing parties, the relationship has been trickier. Examples of some of the potential relationships are:

- *Promoting and extending government plans:* Henry Brackenbury: Chairman of the Insurance Acts Committee between 1915 and 1924 when he had to deal with a Conservative /Liberal, Coalition, Conservative and Labour governments as well as an LCC Councillor who stood for parliament as an independent Liberal
- *Opposition:* Christopher Tiarks, a GMSC member, stood as an independent 'Protect the Health Service' candidate in the 1989 Vale of Glamorgan by-election. He later became the Secretary of Berkshire and Buckinghamshire LMCs
- *A potential ally or opponent:* John Marks says that a Gallup poll in 1989 claimed that only 16% of GPs would vote Conservative in a general election compared with 61% who had at last election.¹⁹⁰ Stephen Dorrell described the consternation in the Whips' office when it was announced that Kenneth Clarke was going to impose the Contract in 1990¹⁹¹
- *Party advisers:* In relation to the 1990 Contract and reforms, critics claimed that the Conservative Medical Society, including the GPs Michael Goldsmith and Clive Froggatt played a significant role. Froggatt says his role has been exaggerated and also describes the 1990 Contract as 'wretched'.¹⁹² Sam Everington was a Labour Adviser in the 1990s.¹⁹³
- *Non-aligned:* Other GP representatives have felt that however strong their political opinions are that it is a disadvantage to be a member of a political party when potentially dealing with changing political contexts.¹⁹⁴

Fighting cockerels:^q Conflict and cooperation within general practice

A fundamental challenge for GP representative bodies has been whether and if so how to maintain unity in the face of great diversity of interests and attitudes and how to manage the relationships between various different bodies. A description of those different bodies is given in Appendix B.

Differences in practice

As Digby says, the 1858 Medical Act created a united national structure for doctors but general practice was not uniform.¹⁹⁵ The National Insurance Act and later the NHS created the possibility of convergence but differences have remained, for example between rural practices, some depending on dispensing and urban practices, or between small practices and increasing numbers of large practices.

Differences in contractual status

Dispensing doctors, trainees/GP registrars, non-principals (or sessional doctors), PMS doctors and salaried doctors have been included in Local Medical Committees and other representative bodies. A number of questions have often accompanied their presence:

- How many are there and therefore what level of representation should they have? For example, in 2000 the number of non-principals was estimated at 3500 by the NHS Executive but at 7000 or more by the non-principals themselves.¹⁹⁶ Dispensing doctors have traditionally had representation reflecting the numbers with the right to dispense rather than the numbers who are sole dispensers

q The late John Ball made the comparison in respect of the GMSC, leading to the tie design on the cover

in their area. In 1996 there were 4000 dispensing doctors but the numbers without any competition from any pharmacy was reported to be a little over 100.¹⁹⁷

- What is the role of the representative bodies in relation to them? The perception may be that the bodies are mainly concerned with representing GMS principals.¹⁹⁸ The difficulty for those who are not GMS principals is that their terms and conditions may either be negotiated with GP principals – in the case of GMS salaried or sessional GPs creating a potential conflict of interest - or for PMS GPs, negotiated with local NHS managers rather than through the national structures and processes.
- If those who are not GMS principals get less from representation and often earn less, should they pay a lower levy?

Attitudes to major policy issues

In 1911, LMCs included GPs opposed to state involvement in general practice. In 1948, GPs who had bitterly fought the legislation were representing GPs alongside others who had been more enthusiastic. In the 1990s GPs who had been strongly opposed to Fundholding worked alongside Fundholders. However difficult having differences within bodies might be, a more difficult issue on many occasions has been large numbers of GPs in the middle who switch sides. GPs voting for opposition to government proposals but signing up to operate the system before the representative bodies have concluded negotiations is a tradition which goes back to 1913.^r The representative bodies have often had to beat a hasty retreat. Kenneth Clarke used this in the latter part of 1989, for example.¹⁹⁹

How have representative bodies managed differences within general practice?

There are several characteristic ways in which the main representative bodies have handled differences within general practice:

1. continuing to represent all GPs no matter what conflicts of interest or tensions are involved
2. discouraging other groups from emerging to fill the vacuum. Where other groups have emerged, there have often been efforts to embrace them or to undermine them – for example by having a lower voluntary levy for non-principals than the subscription of the National Association of Non-Principals²⁰⁰
3. sticking very closely to ‘mandates’. Whatever the leadership have thought of the feasibility and desirability of decisions of the Conference of LMC, Representative Meetings or the GPC, they have largely worked within the letter of the policy²⁰¹
4. reflecting the morale of GPs: Charles Webster described the BMA opponents of the creation of the NHS as being Adullamites.²⁰² In the case of GPs it might be more accurate to say that the GP leaders have reflected rather than led discontent and also that the discontent has often reflected or created unrealistic expectations of what negotiation can achieve^{203, s}
5. managing militancy: recognising that it could be doused by prosperity, to paraphrase Klein²⁰⁴
6. paying attention to relationships: perhaps most importantly, to adapt another phrase of Klein’s: it is the physiology not the anatomy that matters.²⁰⁵ The system could be made to work by good communication, overlapping memberships, trust or goodwill or poisoned by their absence.

^r See Appendix C on Sanctions.

^s David, when he had been expelled from the court of King Saul, there gathered together "every one that was in distress, and every one that was in debt, and every one that was discontented" (1 Samuel 22:2). 1.



The LMC Conference in the Great Hall in 1983 (BMA Archive)

'The farmer and the cowman': Relationships between GPs and other doctors and doctors' organisations

The branches of medicine

One of the interviewees quoted the musical Oklahoma! in discussing the relationship between GPs and other doctors:²⁰⁶

Oh, the farmer and the cowman should be friends.
One man likes to push a plough, the other likes to chase a cow,
But that's no reason why they cain't be friends.

Territory folks should stick together,
Territory folks should all be pals.

From the beginning of the representative bodies, this has not been easy. At the first Conference of LMCs in 1913 the proposal that there should be 'fusion' with the BMA was changed to 'cooperation'. There are many reasons for the difficulties.

Perceptions of unequal status

There have long been perceptions of unequal status, from Lord Moran's 'doctors falling off the ladder' to a residual feeling among GPs that consultants think they are Lancelot Spratt and GPs are Dr Finlay.^{207, t}

Differences on clinical issues

There have been a number of issues where different branches of the medical profession have disagreed about who should appropriately do what. These include minor surgery, obstetrics, child health surveillance, dermatology and 'AIDS testing' (as it was called in 1987).

^t Even though becoming a Dr Finlay was an inspiration to at least one GP who became prominent in GPC and BMA affairs (Tony Calland in Jenkins, 2008, p.302).

The constitution of the BMA

Although the BMA has a clear principle of ‘full delegated authority’ – that if an issue only affects one branch of the profession, it has authority to deal with it – big issues may involve risks to and resources from the whole Association and the BMA Council or its executive may have differences in approach to the GPs and intervene accordingly. Something of this sort happened with the Limited List.

The fact that LMCs and the GPC represent doctors who are not members of the BMA (See Appendix B).

Divide and rule

The medical profession’s external adversaries are not above seeing opportunities to divide and rule the profession. In 1989 Kenneth Clarke decided that a battle with the consultants when he was already at loggerheads with the GPs might be one battle too many. In same speech as the reference to ‘wallets’ he tried to appeal to GPs, saying that said ‘Fundholding would ensure that some consultants would pay more attention to GPs than they do now. It put the boot back on the other foot, with consultants needing the money that GPs’ patients would bring ... By December 1991 it would be consultants sending GPs Christmas cards, and not the other way round’.²⁰⁸

Competition for resources

With finite resources available for public spending, in general and on the NHS in particular, inevitably different branches of medicine could see themselves in competition. In June 1981, the Welsh Council of the BMA asked the Welsh GMSC ‘to consider and examine the scope for economy within its craft in order to secure a better distribution of the limited funds available under the system of cash limits’.²⁰⁹ As a statement of relationships at the time this is interesting, but also for what it shows about the level of understanding of how GPs were paid. Later in the decade the Department and the NHS became increasingly concerned that the acute sector was shifting costs, of drugs in particular, precisely because they were not cash-limited.

Relationships with other organisations within the craft

One of the most important relationships has been between the GMSC/GPC and the (Royal) College of General Practitioners. John Fry’s biographer describes the relationship between the College of General Practitioners as a David and Goliath one. He asserts that the College was compromised by the BMA’s support for its creation in 1952.²¹⁰ Fry argued that the BMA’s pursuit of better pay and conditions was at the expense of quality in general practice: it protected the inefficient and the incompetent. In an Editorial in *Medical Care* in 1965 he argued that ‘medical rage was holding the NHS to ransom. Greed was exceeding common sense...the NHS had propped up general practice in Britain, not short-changed it. On the basis of competence, many GPs were lucky belonging to a state-protected species...Too few had raised standards an iota since 1948’.²¹¹ Even more controversially he was quoted in a *Daily Express* article in July 1965, at the height of the Family Doctor Charter negotiations as saying ‘GPs are not grossly overworked or harassed by hordes of demanding patients as they claim, and most run their practices inefficiently, do mainly trivial work, have stick in the mud mentality and only feel busy!’²¹² He argued the 1966 Contract put the ‘the cart before the horse’ – creating opportunities for GPs before improvements in competence. He was also advising the Ministerial team unofficially.²¹³ In the late 1980s he was close to the ‘gang of four’ associated with the RCGP who broadly supported

the new Contract and again Fry advised the Department.²¹⁴ It is still felt by many people involved in the GMSC during the 1990 Contract that the RCGP leadership (but not necessarily the College's membership) were in league with the government. Marshall Marinker, one of the four, denies that they were in cahoots and also that the new contract was 'Stalinist command economics' - which does not sound like fulsome praise.²¹⁵ However, Kenneth Clarke described the RCGP leaders as 'very good and very supportive'.²¹⁶ On the BMA side, they were seen as 'treading on turf that was not theirs'.²¹⁷ Civil servants and politicians were not above using the Honours system to reward those they had found helpful and RCGP leaders found favour.^{218, u} The Department also deliberately funded work by the College and also posts at the National Association for Primary Care and NHS Alliance to 'divide and rule and poke the BMA in the eye' in the 1990s.²¹⁹

Fry's role is highlighted here for three reasons. First, much of the tension between the College and the BMA relates to events in which he was directly involved and the College did not necessarily know or condone what he did – they disowned him over the Express comments. Secondly, his criticisms go to the heart of the complexity of what is 'academic' and what is 'medico-political'. Thirdly, even in Fry's most belligerent moments, he was well aware that BMA negotiators could be concerned with quality. One of his friends and a close collaborator in the RCGP was Ekke Kuenssberg who was part of the group who drew up the 1965 Family Doctor Charter and negotiated the 1966 Contract, often staying at Fry's home while he did so.²²⁰

Fraser Rose, co-founder of the College, was a member of the GMSC. He and Kuenssberg were followed by many other doctors in combining roles in the GMSC/GPC with active participation in the RCGP. The Joint Committee on Postgraduate Training for General Practice and later the RCGP Postgraduate Training Board have seen the BMA and Royal College working closely together or at least keeping their battles in private and resisting external 'divide and rule'.²²¹ Sometimes an 'honest broker' has been necessary to resolve problems.²²²

One of the civil servants interviewed felt some of his doctor colleagues in the Department had seen the College as 'Shining Knights' and been 'charmed' by the College but he felt that the GMSC was more down to earth and reflected the real world of its members.²²³ Another observer felt he understood the relationship between the College and the BMA once he understood it as the difference between the Eighteenth and Nineteenth Centuries – between the guilds and the trade unions.²²⁴ The GP representative bodies were a creation of the first half of the twentieth century and the College of the second half. Especially given the overlapping memberships, it might be more accurate to see it as more like the relationship between the craft unions of the nineteenth century and the 'new unionism' that was born in the last ten years of the nineteenth century.^v One negotiator was adamant that it was right that the College should exist as a separate body. He compared it with the Royal College of Nursing, a trade union, an educational and professional body and the Royal Pharmaceutical Society of Great Britain which was not only an educational and professional body but also a regulatory body until recently.²²⁵

In the 2001-3 negotiations the roles of the Department medical advisers and the College were less prominent and contentious. (But see page 41 above on the medical advisers). Advice on the Quality

u The general rule is said to be that GPs get MBEs, consultants get OBEs, and Professors get CBEs (BMA Archive B/55/10/16/1). Of the 'Gang of Four, two got knighthoods, and two OBEs. Fry got a CBE.

v This has the added elegance of the fact that one of the (possibly unwitting) midwives of the new unionism was Annie Besant before she became a Theosophist and commissioned the building which is now BMA House.

and Outcomes Framework came from Dr Tony Snell representing the NHS Confederation, Professor Martin Roland at the University of Manchester and Dr Colin Hunter of the College, as well as Dr David Colin-Thomé, the National Clinical Director for Primary Care.²²⁶

Relationships with other professions and interests

GPs' relationships with other professions have at times been a major preoccupation of representatives. The underlying theme could be said to be that however overworked GPs have been, no one could or should replace GPs' central role. 'Rivals have sometimes been dismissed as 'shop keepers' or would be 'noctors'. In general if GPs couldn't control them, the strategy has to been 'hug them to death''.²²⁷

Pharmacists

The tensions between emergent general practice and pharmacy go back to the seventeenth century. Until the twentieth century most GPs would have made up at least some of their own medicines. As pharmaceutical products became standardised and mass-produced pharmacy also became more specialist. As more drugs became available and the drugs bill for the NHS became more significant, the government's wish to control NHS dispensing but also to encourage over-the-counter purchases exacerbated tensions.

GP representatives have sometimes felt that pharmacists have been unduly sympathetically listened to by Ministers. In the case of Kenneth Clarke, not only did he have a constituency interest in pharmacy (Boots headquarters until 2008) but according to one of the civil servants who worked with him, the pharmacists used to give him cigars and entertained him 'in the style to which he would like to grow accustomed'.²²⁸

Community Nurses

The Cumberlege report in 1986²²⁹ which proposed among other things that community nurses should be zoned rather than attached to practices and be able to prescribe, highlighted some tensions with GPs. 'We like nurses, not Noctors' as one negotiator said.²³⁰ The strategy adopted by the GMSC was to work closely with the Royal College of Nursing.²³¹

Midwives

As with the pharmacists, the history of tensions between GPs and midwives goes back to the seventeenth century. GPs only stopped using the title 'Male Midwife' in the 1950s. GPs being able to claim Maternity Medical Services payments while not necessarily providing direct care continued to be a source of discontent to midwives.

4. How has general practice been defended?

Strategies and tactics

In theory 'strategy' and 'tactics' ought to be distinguishable. From their linguistic origins, strategies are about how to win a war and tactics about how to win a battle. In practice they are not always so distinguishable and strategies are often implicit rather than explicit.

In 2003 and 2004 there were at least three inquiries into the 2001-2004 contract negotiations.²³² They all carry valuable insights in how to carry out tasks effectively 'Doing the Thing Right' but do not explore what the underlying rationales about 'Doing the Right Thing' are or how to decide what the 'Right Thing' is.²³³ At the time the Secretary of the GPDF highlighted 'a lack of clarity regarding a strategy to meet its corporate objectives'.²³⁴

In order to explore what the strategies have been, the kinds of choices that the representative bodies have had to make are outlined. In the abstract, it is possible to do 'both' in each case but in specific circumstances, representative bodies and individual GPs have done one thing rather than another.

Strategies

Root and branch opposition or improvements

In the spring of 1912 33,000 GPs made pledges to have nothing to do with the National Insurance Act. The position was reaffirmed by a BMA Representative Meeting in late December but it was apparent that many GPs were in fact signing up. Similar sequences have happened repeatedly since – see Appendix C. Part of the explanation is that as improvements are agreed, opposition is diluted. However, GPs have clearly signed up to changes because they saw the consequences of opposition for themselves and patients.

Partnership or opposition

The way that GPs have had representation on bodies administering and managing Family Health Services has already been outlined. Even though Ministers have generally expressed unwillingness to hold discussions on whether to introduce changes they have decided on, they have in most situations been willing to discuss how to implement them with representatives.²³⁵ At the same time, often GPs have challenged plans or actions either through legal cases or through threats of sanctions. 'Undated resignations' have been regarded as the most serious of these sanctions.

Relationships based on contract or status and trust

Particularly since 1966, GPs have been drawn into more and more arrangements which are based on formal rights and responsibilities. This is obviously part of a wider social change. However, it has reduced the bargaining strength of doctors. As Kenneth Clarke put it: 'so long as the BMA emerged as the spokesman for the savers of lives and healers of the sick, and the people whose only concern was for the welfare of the poor and elderly, we were in a no-win situation'.²³⁶ The BMA as a whole has been very conscious of the advantages of being seen to be concerned about patients' well-being.

Knowledge

It generally follows from relationships based on contract that detail and complexity will increase. GPs have used their knowledge of how general practice works and understanding of the detail to their

advantage. Although complexity seems to have been fostered, it has been rather like Palmerston's view of the Schleswig-Holstein question: "Only three people...have ever really understood the Schleswig-Holstein business — the Prince Consort, who is dead — a German professor, who has gone mad — and I, who have forgotten all about it."²³⁷ There has been a danger that knowledge has been lost in information.^w Some of their negotiating partners have resisted the absorption in detail. (Sir) Joseph Pilling famously intervened in one negotiation to offer Occam's razor: 'The contract has become so complex that even those who understand it best are aware that it is itself a problem' – if NHS managers, Local Medical Committees and educationalists don't understand the rules 'it is incumbent on others to tell them'.²³⁸



Occam's razor cartoon by John Ball

There is a contrast between the concise "The Six Cardinal Points" in 1912 and the Family Doctor Charter in 1965 on the one hand and the rather more detailed report of the 1979 New Charter Working Group.

Defence of the status quo or visions of the future

Articulation of principles may be part of either a 'bottom line' about things which GPs are not prepared to give up or a vision of the future. Strategies of demands or aspirations have been used at various times. Especially in the last forty years, a 'proactive' stance to set the agenda has been tried through such initiatives as 'Your choice for the Future' and 'Core Services – Taking the initiative'.²³⁹

^w 'Where is the wisdom we have lost in knowledge? /Where is the knowledge we have lost in information?' (Eliot, 1972)

^x Occam's razor: the principle that "entities must not be multiplied beyond necessity" – in effect that simpler explanations or hypotheses are usually better than more complex ones. The cartoon is by John Ball

Defending the weakest or putting the house in order

GP bodies have been conscious of the need to maintain unity and to make all GPs feel that they are represented. As Kenneth Clarke's biographer puts it: 'Circling the wagons, trying to protect the strength of their profession by defending even their weakest members'.²⁴⁰

Against that strategy has been the view that GPs need to put their own house in order because of the damage done to the reputation of general practice by unacceptable practice. Local Medical Committees and the Industrial Relations Officers of the BMA have been particularly involved in this work.

Money or satisfaction

To maintain commitment to and from the representative bodies, being able to demonstrate tangible achievements is important. Winning financial gains fulfils that function but surveys of GP opinion show that such winning is important to GPs in its own right. Government policy has assumed that GPs are sensitive to financial incentives²⁴¹ but so has the GMSC/GPC. However, it is also clear that increased pay isn't always accompanied by higher levels of satisfaction. GPs' dislike of their out-of-hours commitment could not easily be overcome with money.

Macro and micro levels

Defence of general practice has operated on two levels. The macro level has been the gathering and deployment of time, skills and money to negotiate, research, communicate etc – mainly at the national level. The micro level of working with individual practitioners and practices is inevitably mainly local but where legal cases, for example, have been taken up, it can occur at the national level too. At the macro level the difficulty of representing two sides of disputes e.g. between partners or between partners and assistants or sessional GPs has been a problem. This has been addressed by Industrial Relations Officers and sometimes by LMCs by ensuring different individuals provide support to the different parties with appropriate confidentiality. However, as more and more GPs are not principals in GMS practices it is increasingly a macro problem too.²⁴²

Tactics

We now turn to how the representative bodies have used the tools they have had at their disposal.

Negotiation

Negotiation has been part of the 'arsenal' since the beginning.

The reputation of the BMA largely founded on the GP negotiators is a formidable one:

Kenneth Clarke said: 'I did find them more difficult to deal with than the Rail Trade Unions, and then the Police Federation later, a very unionised public service. They thought of themselves as different and unbeatable. ..they are brilliant negotiators, I did not leave it to my officials to deal with the people that I then had to deal with; you had to deal with them yourself, and it was rough going. They really are brilliant negotiators.'²⁴³

One ex-Minister said ‘A harder nosed bunch of negotiators you’ve never met. Enormous respectability – “only representing interests of patients”. No, sorry, only representing themselves’.²⁴⁴

It is also worth remembering the government of Margaret Thatcher had taken a very tough line on negotiations. One of the GP negotiators was mindful of the fact that ‘a certain individual had sat out thirteen hunger strikers’.²⁴⁵ The government had also survived a sustained confrontation with the miners. In this context it is remarkable is that the Secretary of State not only sanctioned negotiations with GPs by civil servants and junior Ministers but personally took part in the marathon session in May 1989.



Kenneth Clarke and Michael Wilson outside BMA House (BMA Archive)

Civil servants and NHS managers who were more involved in day-to-day negotiations had a less resentful view of the skills of the GPs. One said that ‘the better the other side are, the better the results are’.²⁴⁶ Another had a ‘Road to Damascus’ moment when he realised that neither he nor his opposite number had the skills to get out of an impasse and tried to muddle through. He realised that successful negotiation depended on [both sides] being good at what they do and went on negotiator training.^y However, this negotiator as others on the government side questioned whether the GP negotiators’ experience of general practice was typical of general practice, with disproportionate representation of more rural and smaller practices.²⁴⁷ Although from the late 1980s both sides were trained in and negotiation leaders were committed to ‘Principled Negotiation’, each side had its metaphorical ‘attack dogs’ too.^{248, z}

Some of the enduring themes have been:

- *Maintaining sole negotiating rights*: This has been achieved by a willingness to represent a very wide range of interests. The downside of this is that it can promote ‘particularism’ in which specific narrow interests become the currency of negotiations instead of encouraging convergence. It also raises problems of conflicts of interest, (see page 53 above).

^y The same incident is remembered by one of the GP negotiators for the inappropriate attacking behaviour of one of his colleagues. (GPDF interview 017)

^z Indeed the GMSA sometimes had a real dog in meetings too (GPDF interview 017)

- *National negotiations*: Until 1997, local contracts were fairly well resisted. Having a national contract helped avoid particularism but also carried dangers of not responding to local circumstances and of having a single paymaster. The former meant that if there was a specific issue to be addressed, there was not necessarily a forum and process for dealing with it. An example of this might be London in the early 1990s when, following the Tomlinson Report, there were substantial sums available for investment in primary care but some uncertainty about who would decide what it could be used for. Having a single paymaster has meant that that anything agreed had to be affordable for the whole country and it was bound to be high profile, which could potentially embarrassing to either or both parties.
- *GPs as negotiators*: Since the very beginning, face to-to-face negotiations have been undertaken by GPs. The Annual Conference has often questioned this and called for ‘professional’ negotiators but there have been significant advantages in the arrangements:
 - o ‘my patients wouldn’t like it...’ or the empathy resulting from a negotiator saying they had been up the previous night delivering a baby,²⁴⁹ though some civil servants were sceptical about the claims of negotiators to be bleary-eyed from their clinical responsibilities.²⁵⁰
 - o detailed knowledge of the consequences of proposals, which the negotiators encouraged by introducing greater complexity, which gave them further advantage but was also seen as valuable by their negotiating partners²⁵¹
 - o a connection to and understanding of their peers.

Concerns about how people came to be negotiators and whether they had the necessary skills for the job led to the introduction of training for negotiators - from the 1980s, at first carried out by BMA staff with trade union experience and later by external trainers – including ones used (apparently coincidentally) by the civil servants with whom they were negotiating. In the late 1990s job descriptions for negotiators were introduced. The training and job descriptions reflected increasing sophistication in understandings of what makes negotiations successful. The paper proposing job descriptions said ‘the time commitment required is now of a sufficient quantum that it is wholly unacceptable to adopt it for the “honour and glory” approach’ and ‘It has been well said by many members of the GMSC that we not only get the negotiators we deserve but we get the negotiators whose partners will let them become negotiators’.²⁵²

The financial arrangements during and after periods of service as negotiators have recognised the material implications. However, it is worth noting that the commitment to being a negotiator may have a personal and professional cost from being away from home and the practice for a substantial amount of time.

Doctors and BMA staff who have seen how negotiations in other branches of the BMA are conducted are very clear that GPs are much more obviously in the driving seat than in other crafts.²⁵³ However, it is also important to recognise that GPs do not operate alone. One of them pointed out that in addition to GMSC/GPC secretariat staff he worked with a lawyer, a communications expert, a health economist, a pensions expert and an actuary.²⁵⁴

Sanctions

There have been long-running discussions about what sanctions GPs have if negotiations don't succeed or whether the threat of sanctions can be used to reinforce negotiations. There has been much discussion about whether there is a physical list of 'lesser sanctions' which is maintained by the GPC Secretariat. The list with fifteen measures that GPs could take was maintained until the early years of the 21st century. Many of the specific measures are no longer relevant because of legal and contractual changes. The 'tool out of the box' approach to defending or promoting general practice is perhaps no longer seen as a useful one: more bespoke instruments are perhaps seen as more effective. Evaluating proposed actions as 'red, blue or green' in terms of their advisability in law has also been used.²⁵⁵ Historically, the sanctions which have been threatened or used include:

- *The threat of resignation*: although this is termed the nuclear option or deterrent by some negotiators, it is the one that has been threatened most often – see Appendix C. It was the original reason for setting up the Defence Fund – to hold the undated resignations from Friendly Societies and other bodies. It has not been put into effect on a large scale although in 1965 about twenty fairly well-off GPs in various practices in central Birmingham actually did resign from the NHS. A GP fighting fund was established with many of those who tendered undated resignations giving money to the fund.²⁵⁶ In 1966 and 1990 the BMA was worried that if large numbers of GPs were to resign, it would backfire on the Association. John Marks, as Chairman of the Council of the BMA, said he was 'petrified' that the GPs would resign.²⁵⁷ 'The government would have yodelled from the rooftops [about] the grasping GPs reaching for their wallets.'²⁵⁸ In 2001 the Chairman of the GPC was known to his team to have been uneasy about a resignation ballot, but the strategy was initially devised while he was out of the country.²⁵⁹ Politicians and civil servants have generally been sceptical about resignation as a real threat: 'they have mortgages',²⁶⁰ many GPs benefit from premises funding, and because the prospects of making a living from private practice are small for GPs in any numbers. This view is reinforced by the fact that even a government as ideologically predisposed to market solutions as Mrs Thatcher's ruled out making private health insurance tax deductible for most people.²⁶¹ It was recognised on the government side that the threat of the sanctions was an expression of serious discontent but it was also noted that if the doctors did resign 'the government would just look to what other professions could do.'²⁶² In 2001 the Chairman had said openly that it was inadvisable to hold a resignation ballot – it was too confrontational. It did indeed antagonise the Secretary of State.²⁶³
- *Working to contract*: in 1970 77% of GPs refused to sign sick certificates.²⁶⁴ In 1990 the BMA Annual Representative Meeting (ARM) discussed a 'work to rule' proposal which was the policy of the NHS Supporters Party and supported by some leading negotiators. It was opposed by others, including John Marks on the grounds that it would have been seen as putting doctors' self-interest before patient welfare. A crisis was avoided by not taking a definitive vote.²⁶⁵
- In 1997 the GMSC advised GPs to *refuse to provide non-core services* but when one of them asked for legal support if he was taken to court, the GPDF (sic) replied that the GMSC could not undertake to support every doctor who was taken to court by the Department for refusing to provide non-core medical services.²⁶⁶
- *The veto*. Events in 1989 demonstrated two problems with vetoing proposals: first, leaders could not count on their constituency to follow their lead; secondly, the veto did not stop the introduction of changes. If 1989 is not an example of its success in relation to the contract, a refusal to take part in

relation to Fundholding had more effect. The profession was deeply divided on this issue. The description of Fundholding as unethical by leading GMSC negotiators clearly put some GPs off taking part. Although many GPs did eventually become Fundholders, many did not and some of those who did refined the concept by the creation of Multifunds, for example to mitigate what they saw as some of its flaws. By the GMSC being clearly on one side, many GPs including some on the GMSC felt unrepresented and the position made the GMSC's negotiating position more difficult.²⁶⁷

Legal cases

A significant tool which GPs have had at their disposal is the ability to fund legal advice and cases through the General Practitioners Defence Fund and through the BMA. After the costs of negotiators, the cost of legal advice has been the largest item of GPDF expenditure – in 2004 over 20% of spending – although much of that cost related to contract negotiations rather than legal cases. Many of the cases have been Judicial Reviews of NHS decisions. Such cases have included the rights of dispensing doctors, reviews of cost-rent schemes and the use of GMS money by local health authorities. Other cases have been taken up where there have been disputes between GPs.

The threat of legal action has sometimes been used to encourage the Department to negotiate but the Department has been reluctant to give something for nothing. Where for example there was a dispute between doctors and a pharmacy which could be resolved by an amendment to the regulations the Department was 'unwilling to make an amendment without the doctors giving something in return being pressured by the pharmacists in this respect.'²⁶⁸

The Defence Fund and its legal advisers have noted a number of issues with pursuing legal cases:

- Judicial Reviews essentially challenge the process by which decisions have been made, rather than the outcome of the decision itself, so they may simply delay a decision
- In disputes between practices the doctors asking for financial support are not necessarily on the 'right side' as far as the wider profession is concerned
- The benefits of winning and/or the costs of losing may not be proportionate to the legal costs
- The danger of the 'wrong principle' being decided
- Arguments about whether the issues are private law matters
- Whether they are more appropriately cases for Medical Defence Organisations to take up.

The Defence Fund has tried to address these difficulties by having criteria for deciding whether to take up cases, including the probability of success and whether a principle of general significance is at stake. In fact in the early years of the 21st century a substantial amount of money was spent on resolving disputes with the Inland Revenue about National Insurance liability in respect of LMC officers and national negotiators.

Maintaining unity

The representative bodies have had a number of tactics for maintaining unity among general practitioners:

- identifying external enemies: part of the reason for warning of 'existential' threats is the value for encouraging unity; however, 'crying wolf' can lead to scepticism or cynicism

- including special interests in negotiations, although this has the dangers of particularism (see p. 55).
- proactive initiatives. These have other advantages and disadvantages and so are considered separately
- it may be a little exaggerated but it could be argued that GPs have also maintained unity by following the principle that George Bernard Shaw identified: 'the truth is, there would never be any public agreement among doctors if they did not agree to agree on the main point of the doctor being always in the right'.²⁶⁹

Proactive initiatives

The programme from 1994 to 1997 identifying core services, including the production of 'Core Services; taking the initiative' is one example of a proactive initiative.²⁷⁰ Such initiatives have definite advantages in terms of rallying GPs around a positive vision rather than being reactive or simply defending the status quo. However, there may be problems with the approach:

- the process of arriving at a 'manifesto' may highlight how little practitioners agree on and therefore express only vague aspirations rather than 'SMART' objectives
- it may focus only on 'economistic' demands – 'food for cats'
- it tells the 'other side' what they need to offer practitioners to get what the government want. As one of the civil servants involved in negotiations said, 'Once you name your price you are shafted'.²⁷¹
- representative bodies may be set up to be reactive rather than proactive. Executive bodies are used to taking decisions, usually about operational matters rather than long-term planning.²⁷² Plenary sessions in large-scale meetings are rarely places for critical reflection. Survey questionnaires also have a conservative bias to them.

Public relations

Although the BMA has had public relations advisers for even longer, since the 1970s it has increased its capacity for influencing public opinion including through work with politicians and journalists.

Conscious decisions were taken to combat negative press attitudes: as Marks put it the press thought doctors were 'Charlatans in 1776...avaricious in 1912 and entirely self-interested in 1948'.²⁷³ Instead the BMA needed to be seen as a professional scientific body interested in the well-being of patients and the community.²⁷⁴ Campaigns on smoking, boxing and safety belts were part of this campaign but they also attracted criticism - from the Daily Express for 'pontificating' in 1984 and from within the BMA at the Annual Representative Meeting in 1984 for 'Banning things' and from the then Chairman of the Welsh BMA Council for spending too much time on Board of Science and Education matters in 1987.²⁷⁵

Specific campaigns such as that against the 1990 Reforms also got a mixed reaction. On the one hand it was said that the issue attracted more letters to MPs than the Poll Tax did.²⁷⁶ On the other hand, the specific advert in 1989 showing Kenneth Clarke with the caption 'What do you call a man who ignores medical advice?', while at the time attracting a lot of publicity and some approval, in retrospect is seen by BMA insiders, by Kenneth Clarke himself and analysts as unproductive or counter-productive.²⁷⁷

Resources, structures, processes and representation

Finally in analysing how general practice has been defended it is necessary to look at the resources and organisation the representative bodies have had their disposal.

Resources

The availability of money from both an LMC levy and BMA membership subscriptions has meant that GPs have had access to resources that other branches of practice have not had. As most of the other branches are representing employees of the NHS, they have perhaps needed less bespoke support. The fact that GPs have paid the levy reflects their recognition of its value. In the 1970s there was period when it was very difficult to collect subscriptions from some LMCs. More recently some PMS doctors have been unwilling to contribute. Almost all the income of the Defence Fund comes from the levy and the money is then used for paying for negotiators' time and legal advice, for example. After a renegotiation of the shares of the costs between the BMA and GMSC, most of the core costs of the GPC secretariat are now met from BMA funds. The levy covers the costs of the negotiators, meetings of GPs, some campaigns, commissioned special surveys and the like and many legal costs. For a long time the GMS had external legal advisers but now in house BMA lawyers provide most of the initial advice.

In addition to the GPC Secretariat and BMA Law, the representative bodies can draw on specialist teams within the BMA. Given the complexity of GP finances, the Health Policy and Economic Research Unit plays an important role. The Public Affairs and Parliamentary teams work to get messages across to wider audiences.

Representation and accountability

Sidney and Beatrice Webb expressed admiration for the BMA's constitution as a model of democracy. On paper, it is very clearly a model of democracy in which representatives are elected by the membership, have to justify their actions to them – normally by only acting within policies that have already been decided – and are removable by them.²⁷⁸ There are strengths and weaknesses of this model in both theory and practice. In theory it is very responsive to the membership, which works well when conditions and opinions are stable, but at times of flux or confusion can be more difficult. At key turning points such as 1911-13, 1946-8 and 1989-90, it is not so clear that the model has worked well: Special Meetings have been called but then been rapidly overtaken by events. or failed to make decisions or did so by narrow margins.²⁷⁹ Alternatives to this 'mandate' model of democracy are models in which representatives are elected with licence to exercise wide discretion. This is in effect what the GPDF provides, but it does not fit comfortably within the BMA's culture for some people. The problem can be compounded if elections are not based on the policies or skills of candidates but on horse-trading or patronage. Descriptions of BMA elections suggest this has sometimes happened.²⁸⁰

5. Conclusion: Defending general practice – a British success?

A former government Special Adviser described the BMA as the most powerful trade union in the country [which represents] petty bourgeois individuals and small businesses.^{281, aa} The position of being small businesses almost entirely financed by central government and negotiating their incomes directly with government at the highest levels makes the GPC and its associated bodies unique and remarkable. Yet despite this uniquely powerful situation, GPs remain, as Rudolf Klein has put it, ‘richer but not happier’.²⁸² Why are they not happier? Has the defence of general practice not been a success?

Many doctors in the early 2000s would have identified with the doctor’s hardships described by Shaw in the 1900s: ‘The real woes of the doctor are the shabby coat, the wolf at the door, the tyranny of ignorant patients, the work-day of 24 hours, and the uselessness of honestly prescribing what most of the patients really need: that is, not medicine, but money’.²⁸³ Yet clearly conditions and the ability to improve the lives of patients have dramatically improved.

As one observer noted ‘without the state GPs might well be penniless but they continue to be deeply ambivalent about both about it but also the market’.²⁸⁴ John Ball’s cockerel lives on! The fact that the GP representative bodies have even survived for a century in a society in which health and healthcare have been transformed is in itself extraordinary.

The changing relationship between general practice and the state

The ways in which the system has both adapted to change and also made changes can be seen in what might be described as the rise and fall of the GP as independent contractor. Since 1911 GPs have gone from being a disparate group of private and voluntarily funded independent businesses through a phase of nearly all GPs being on the same contract, which they did largely by a process of hard bargaining at the national level and control over the administration of the contract at the local level which was made possible by the twin structures of Local Medical Committees and the GMSC/GPC.

Even though PMS and devolution opened up the possibility of regional and local negotiations the UK GPC has maintained its pre-eminent role.^{bb} Although leading figures on the government side and on the GP side thought that the 2004 contract would be the last to be negotiated UK-wide, the lack of appetite and capacity for separate negotiations in the smaller countries make this far from certain.²⁸⁵ However, in a context where only a minority of general practitioners are principals on GMS contracts, the GPC may well have to reinvent itself, perhaps emphasising its expertise and its value as a national voice rather than its right to represent practitioners.²⁸⁶

Be careful what you wish for, you may receive it²⁸⁷

The representative bodies have engaged in both defensive and proactive actions. At times it has seemed to outsiders^{cc} that they have defended the indefensible. However, there have also been problems with what they have wished for. In 2004 negotiators achieved what members asked for in relation to abolition of the retirement age and out-of-hours commitment. The rationales for doing what members wished for were more than ‘give them what they want’ but in retrospect a number of negotiators regret their success both as specific issues and because they have paid a price in less

aa Perhaps an echo of George Bernard Shaw, who wrote ‘Trade Unionism is not Socialism: it is the Capitalism of the Proletariat’ (Shaw, 1937, Chapter 46)

bb So much so that meetings of meetings of GPC England were discontinued not long after the creation of GPC UK and the GPCs for the other nations because so many issues were of UK significance (GPDF interview 017)

cc And perhaps sometimes to insiders!

desirable developments in the same packages. Some of the key areas of negotiations and reflections on them from the parties are revealing.

The content

Control over entry and exit to general practice

One of the principal ways in which any occupational group can control its terms and conditions is by managing the numbers of people in it. Keeping the numbers down can add a premium to pay but increase workload. On the whole, the representative bodies have opted for the strategy of controlling numbers.

The list

Although the personal list has now effectively been replaced by a practice list, the aspiration of universal registration of patients with NHS GPs has been maintained. There are alternative means of getting primary care – for specific conditions, for minor injuries and relatively straightforward ill-health episodes. It is possible to access secondary care in emergencies without going through GPs but GPs continue to dominate primary care. GP negotiators argue that the list contributes to cost-effectiveness, continuity and research.²⁸⁸

24/7

A civil servant who was no longer involved in primary care when it happened said he was gobsmacked when he read that GPs had walked away from the 24/7 commitment – it was the GPs' 'moral high ground'.²⁸⁹ A minister said 'we sold the out-of-hours commitment too cheaply and didn't develop a new model of contract for it'.²⁹⁰ A number of GP negotiators had regrets about it: 'it started to destroy general practice', one said. He felt that out-of-hours cooperatives could have solved the problem at much lower cost.²⁹¹

Independent contractor status

Although, as noted on page 13 above, approximately half of GPs are now salaried with various different kinds of employers, independent contractor status remains the organising principle which characterises UK general practice. It certainly poses problems about having employers and employees represented by the same body. It may have a downside too, as one of the civil servants noted that it exacerbated the isolation of GPs from local government, the voluntary sector and the NHS. The personal contract reinforced GPs' individuality.²⁹²

The relationship between income and clinical practice

Rudolf Klein has described the great achievement of the NHS as separating the practice of medicine from the income of doctors.²⁹³ At the beginning of the twentieth century it was what critics like George Bernard Shaw were most concerned about – that doctors had a vested interest in ill-health and treatment whether necessary, safe or effective or not: by making doctors virtually tradesmen, we compel them to learn the tricks of the trade'.²⁹⁴ However, the government in both the 1990 and 2004 Contracts was intending to link pay to performance.²⁹⁵

Winning and losing

In relation to the introduction of the National Insurance Act the Westminster Gazette remarked in 1912 'we all admire people who don't know when they are beaten. The trouble with the BMA is that it doesn't know when it has won.' In 1948, Alfred Cox, the former Secretary of the BMA repeated it. Possibly the representative bodies also don't always know when they have lost particularly if increased pay has anaesthetised the pain.

Klein has described the 1990 Contract as a humiliating defeat for the BMA. Specifically: 'the leaders could summon their troops to battle but they could not make them fight...'²⁹⁶ There is no doubt that many GPs felt that the 1990 Contract was a defeat in that it was imposed on them. However, in substance it was what had been negotiated. In material terms GPs were better off. In 1990, the leaders did not expect their troops to fight, which is why they reached agreement, but the 'troops' still blamed them. The voice of Ministers over the century has often been that leaders were more militant than members – a view which not only helped win battles with the doctors but also encouraged public perception of the strength or radicalism of the politicians.²⁹⁷ However, the members were certainly known on occasion to be more militant than the leaders. In 1990, David Mellor said to the GP negotiators 'What would be the point of making more concessions, you can't deliver anyway'.²⁹⁸

The possibility that GPs have won but not realised it may be linked to a general feeling of vulnerability or insecurity – that things or will get worse. The fear that GPs might be losing status vis-à-vis the government, other branches and the profession is an enduring theme. In 1938 it was said 'At present there is a tendency for this branch of the profession to sink lower and lower in the estimation both of the public and of the student body from which the profession itself is recruited. The practice of medicine itself has been brought into disrepute by the indiscriminate administration of medicines'.²⁹⁹

If the BMA does not always know when it has won, perhaps it does not always know when it has lost, nor necessarily do its negotiating partners see what they have achieved. There is a conventional wisdom that the 2004 Contract was victory for the GPs and policy failure for the government.^{dd} Tony Blair says 'We paid more for the Consultants' and GPs' contracts than strictly necessary ... but in the long run, I considered it worth it. We set in place tracks of reform that in time would carry the system to transformational change. GPs' contracts were generous, but ... we inserted the right to open up local GP monopolies to competition'.³⁰⁰

On the other hand Lord (Norman) Warner^{ee} says the GPs outsmarted the department negotiators.^{ff} 'The new contract undoubtedly cost a lot more than expected... The out of hours opt out only cost GPs average of £6k a year but cost £300m to provide with new providers, same providers at higher rates with concerns about quality. The Quality and Outcomes Framework cost more than planned because GPs performed at a higher level than expected. In other words the initial indicators were too easy.' However he goes on to say it 'ended up being something of a pyrrhic victory for the BMA but a costly change for the NHS'.³⁰¹

dd It is reported as a policy failure in a forthcoming book by Professors Sir Ivor Crewe and Antony King.

ee Norman Warner was a junior Minister at the time of implementing the 2004 contract.

ff They weren't actually Department negotiators, they were from the NHS Confederation and they do not agree with this assessment.

Simon Fradd, a negotiator of the 2004 contract, said in relation to the out-of-hours commitment 'We got rid of it for effectively 6% of the value of the contract. It was just stunning. Nobody in my position had ever believed we could pull it off but to get it for 6% was a bit of a laugh'.³⁰² A civil servant said 'the cat got away with the cream'.³⁰³

This won-lost interpretation is not a view shared by many of Fradd's colleagues or their negotiation partners in the NHS and the Department of Health. Hamish Meldrum has said that he and Alan Milburn agreed that 'it was a real win-win contract. What's happened, and what is a catastrophe, is the way it has been handled since, and the fact that actually going from a 'win win' we have gone to a 'lose lose', where the Government don't feel happy, the doctors don't feel happy, and that's not good for patients'.³⁰⁴ A government adviser felt that there was a difference between the two sides about whether the contract negotiated was a 'thank you' (i.e. a reward for coming into practice and staying) or a 'please' (an incentive to do more and better). Either way it was a different mood to the period of the 1990 contract when a government minister said 'It's their bloody job; they should just be doing it'.³⁰⁵

One of the politicians involved said 'it is too early to tell whether it is a policy cock-up. It was multilayered – trying to address the concerns of the BMA, to recruit more GPs, to shift work from secondary to primary care and to shift to a system of paying GPs by results. He felt that partly because of poor data – 'flying without instruments' - they had got 'minutiae' wrong ... They didn't appreciate the financial risk, especially on the Quality and Outcomes Framework – they didn't expect 75% of GPs would achieve the QOF standards'.³⁰⁶

Another of those closely involved in the negotiations on the government side felt there were a number of missed opportunities to incentivise better quality.³⁰⁷

The 2004 contract has probably done more to break the pattern of general practice as both a contract (from individual to practice) and as a set of activities (24/7 commitment) than any other negotiation in the last 100 years. On the other hand if success criteria are cost-containment and whether it improved standards, clearly it was less immediately successful from the government's point of view. However, for the GPs too it may be a problem. As a former Minister put it, they went from angels to fat cats in weeks and newspapers picked up stories about doctors earning vast sums which even GP negotiators found 'close to indefensible'.³⁰⁸ A former civil servant noted that by dropping the out-of-hours commitment they 'lost the moral high ground'.³⁰⁹ It has also weakened their strength as near monopoly providers of primary medical care.

The inverse scare law

Charles Webster suggested that in the 1940s the BMA's attitude to the proposals for the NHS was conditioned by the leadership's fear of members 'lapsing in to defeatism and complacency that had proved their downfall in earlier times'. This anxiety could turn vigilance into overreaction.³¹⁰ James Willis described the 'Inverse Scare Law' as the principle that the more unlikely a danger is, the more we worry about it'. He was talking about clinical concerns but he might have a point about medico-political matters. The threats to general practice are not necessarily the ones that get the loudest, longest airing or attention.

Representativeness

In echoing Julian Tudor Hart's phrase³¹¹ it is also a reminder that one of the questions about success for the GP representative bodies must be how inclusive have they been. Certainly some inner city GP representatives would argue that the GP representative bodies have been more sensitive to the needs of a small number of relatively affluent dispensing practices and smaller practices than they have been to urban practitioners and larger practices.³¹² Although there is some evidence that many financially successful practices also have the highest standards of quality, GPs who are poorer are not necessarily poorer GPs and richer GPs are not necessarily better GPs. The composition of the GPC and the negotiating team has not kept pace with the changing make-up of practices in terms of size, location or the age, sex and ethnicity of practitioners.

Physiology not anatomy

The relationship between structures, functions and outcomes in relation to health and healthcare has exercised politicians, civil servants and academics.³¹³ It is also relevant to the GP representative bodies.

To see the various GP representative bodies as separate organs functioning independently is as mistaken in relation to organisations as it is in relation to human bodies. In the case of the organisations, they might work together out of common interest or because of overlapping membership and just as 'divide and rule' might be used against them, they have been quite capable of playing 'good cop, bad cop'.

The issue of the sum being more than the parts also applies to the government side. There may have been tensions and failures in communications between politicians, civil servants and NHS managers in relation to both the 1990 and 2004 contracts but it worked better for both sides when they worked in concert.

Different kinds of leadership

There have been a number of debates about what the appropriate style of leader is within the GP representative bodies.

The structure of the representative bodies and the processes of elections encourage leaders who 'represent' GPs in the sense that they 'take the temperature', reflect what members say they want and success is achieving what they want and stopping what they don't want. 'Leading' by articulating a strong vision and persuading the constituency to follow is much more difficult. For example, in the mid 1990s the then Chairman of the GMSC proposed a practice-based contract but the GMSC decided not to pursue the idea.³¹⁵ A decade later, it was strongly promoted by the government side and the GPC accepted it.³¹⁶ Whether leaders are visionaries or delegated representatives, they may be 'Big Picture' and/or 'Detail' people. It has been suggested that the GPC has been at its best when the leadership has had two people working together but focusing on the different perspectives.³¹⁷ While this sounds rational, there is another factor to take into account which is the style of the 'other side'. In the negotiations before the 1990 contract, the styles of the Secretary of State and the Chairman of the GMSC were clearly very different. One former Chairman recognised his own good fortune that the other side wanted to negotiate during his time but felt that at other times GP leaders simply had to prevent things from happening.³¹⁸

A third issue in leadership is how 'teamwork' is understood. Leaders may feel that 'the buck stops with me' or that negotiating teams have 'collective responsibility'. However in the BMA culture, the members have a record of blaming Chairmen rather than teams and there has been a history of Chairmen resigning in the face of criticism, including more or less openly within the negotiating teams. There are also intellectual and emotional approaches to developing and maintaining team solidarity: either by developing statements of principles or by having regular meals together, for example.³¹⁹

So!

A century on from the formation of the first defence body, general practice is a very secure part of the healthcare system of the UK. Practices give better care to many more people. GPs are better paid and better regarded by patients, other doctors and politicians than a century ago. How much can be attributed to the defence bodies? If the bodies had not existed, could general practice have been even better? Has the representative system survived because it has adapted to changing environment or because it has resisted change? It could be that doctors are a conservative profession and change comes very slowly. However, this explanation would be at odds with the fact that general practice itself has been one of the more innovative parts of the health system. Subjunctive history or counter-factual history is probably more entertaining than illuminating.³²⁰

In 1946 *The Economist* said Bevan had proved Lord Dawson wrong and shown that it was possible to create a health service which combined 'socialism in its administration with individualism in its practice'.³²¹ Perhaps the answer to what the GP representative bodies have done and how they have done it is that they have combined collectivism in representation with individualism in practice and this arrangement has both great strengths and serious flaws.

Appendices

Appendix A Chronology 1979-2005

1979	February	<i>Report of the New Charter Working Group</i>
	July	Royal Commission on the National Health Service Report
	December	<i>Patients First: Government proposals for the NHS</i>
1981	February	One-year training for general practice becomes mandatory
1982	July	Binder Hamlyn, commissioned by government, start study of ways of controlling the costs of family practitioner services
	August	Three-year training for general practice becomes mandatory
1983	October	Griffiths Report
	November	<i>The Cost-effectiveness of General Practice</i> (Coopers & Lybrand, commissioned by GMSC)
	December	<i>General practice – A British Success</i> (GMSC)
1983-1984		Deputising Services crisis
1984	April	SoS Fowler and Clarke initiate review primary care
	November	SoS Fowler announced the prescribing 'Selected List' aka Limited list
1985	April	Limited List imposed
1986	April	Green Paper <i>Primary Health Care – an Agenda for Discussion</i>
	April	Cumberlege Report: <i>Neighbourhood Nursing: A Focus for Care</i>
1987	November	<i>Promoting Better Health: The Government's programme for improving primary health care</i> White Paper involving new contract for GPs
1988	Summer	<i>Prescribing Analyses and Cost</i> (PACT) agreed between government and GPs
	July	Access to Medical Reports Act
	July	Department of Health and Social Security splits: Department of Health established
	November	Health and Medicines Act
1989	January	White Paper <i>Working for Patients</i>
	February	<i>General Practice in the NHS – New Contract</i>
	April	<i>Improving Prescribing</i> Government policy statement
	April	Conference of LMCs confirmed opposition to contract but rejected by large majority call for resignations if Government went ahead
	4 May	Ten-hour meeting to hammer out agreement with GPs with K Clarke
	5 weeks later	GP conference narrowly threw contract out Subsequent ballot 82% of GPs rejected contract by three to one Clarke says will impose contract...
1990	March	LMC conference again rejected deal but by 153 to 148; ballot on sanctions against imposition of the contract
	June	National Health Service and Community Care Act
	July	Access to Health Records Act
1991	April	Indicative Prescribing scheme
	April	Introduction of GP fundholding

	October	Patients' charter
1992	March	Survey of GP Opinion
	April	<i>Your Choice for the Future – A Survey of GP Opinion</i> <i>Choices for the Future</i>
	October	Tomlinson Report: <i>Report of the inquiry into London's health service, medical education and research</i>
1993	March	<i>General Practice: Which Way Forward?</i> Implementation of health promotion banding scheme
1993-95		Out-of-hours negotiations
1994		<i>Developing NHS Purchasing and GP Fundholding: Towards a Primary Care Led NHS</i>
1995	June	Health Authorities Act
1996	March	<i>Defining Core Services in general practice –reclaiming professional control</i>
	June	<i>Primary Care: the future Consultation Paper</i>
	October	<i>Primary Care: the future: Choice and Opportunity White Paper</i>
	November	<i>Core services: Taking the Initiative</i>
	November	<i>The National Health Service: A Service with Ambitions White Paper</i>
	December	<i>Primary Care: Delivering the Future White Paper</i>
1997	March	National Health Service (Primary Care) Act
	December	<i>The New NHS: modern, dependable White Paper – proposing Primary Care Groups and Primary Care Trusts</i>
1998	April	Abolition of GP fundholding
	July	<i>A first class service: Quality in the new NHS Consultation Paper</i>
	September	<i>Information for Health: An Information Strategy for the Modern NHS 1998-2005</i>
1999	February	Establishment of National Institute for Clinical Excellence
	April	Establishment of Primary Care Groups
	June	Health Act
	June	Establishment of Commission for Health Improvement
	July	<i>Saving Lives: Our Healthier Nation White Paper</i>
2000	March	<i>Shaping Tomorrow</i> report discussed at special GP Conference
	April	Establishment of first Primary Care Trusts
	June	LMC Conference instructs GPC to prepare proposal for new GMS contract and negotiate with DH
	July	<i>The NHS Plan: a plan for investment, a plan for reform</i> Development of National Service Frameworks
2001	April	Establishment of NHS Modernisation Agency
	May	Health and Social Care Act
	July	<i>Shifting the Balance of Power within the NHS: Securing delivery</i>
	Autumn	National Survey of GP Opinion
2001-2005		Shipman Inquiry
2002	January	Wanless Report: <i>Securing our future health: Taking a long-term view</i>

2002	April	<i>Your Contract, Your Future</i>
	April	<i>Delivering the NHS Plan: next steps on investment, next steps on reform</i>
	June	National Health Service Reform and Health Care Professions Act
2003	February	<i>New GMS Contract: Investing in general practice</i>
	November	Health and Social Care (Community Health and Standards) Act
	December	<i>Delivering Investment in General Practice: Implementing the new GMS contract</i>
2004	December	<i>Building on the best: Choice, responsiveness and equity in the NHS Learning the Lessons</i> and GPC Task Group Review published
	April	Establishment of Commission for Healthcare Audit and Inspection (Healthcare Commission)
	June	<i>The NHS Improvement Plan: Putting people at the heart of public services</i>
2005	March	<i>Creating a patient-led NHS: Delivering the NHS Improvement Plan</i>

Appendix B

Relationships between representative bodies

THE INSURANCE SCHEME.

STATE SICKNESS INSURANCE COMMITTEE.

First Meeting.

THE first meeting of the State Sickness Insurance Committee appointed by the Special Representative Meeting on February 21st was held on February 28th, when there were present:—*England and Wales*: Dr. R. M. Beaton (London), Dr. John Brown (Bacup), Dr. T. M. Carter (Westbury-on-Trym), Dr. S. Hodgson (Salford), Dr. Constance E. Long (London), Dr. R. A. Lyster (Winchester), Dr. E. O. Price (Bangor), Dr. Lauriston Shaw (London), Dr. W. Johnson Smyth (Bournemouth), Dr. D. G. Thomson (Thorpe, Norwich), Dr. D. F. Todd (Sunderland), Mr. E. B. Turner (London), Dr. A. H. Williams (Harrow-on-the-Hill), Mr. D. J. Williams, F.R.C.S. (Llanelly), Mr. E. H. Willock (Croydon). *Scotland*: Dr. J. Adams (Glasgow), Dr. Bruce Goff (Bothwell), Dr. R. McKenzie Johnston (Edinburgh), Dr. J. Munro Moir (Inverness). *Ireland*: Dr. J. S. Darling (Lurgan), Dr. R. B. Mahon (Ballinrobe). *Ex officio*: Dr. E. J. Maclean, Chairman of Representative Meetings; Dr. J. A. Macdonald, Chairman of Council; Dr. E. Rayner, Treasurer.

Apologies for absence for unavoidable reasons were read from the President, Professor Saundby (Birmingham), Dr. F. W. Kidd (Dublin), Dr. R. E. Howell (Middlesbrough), and Mr. R. J. Johnstone (Belfast).

We are enabled to publish the following account of the proceedings in anticipation of the preparation and confirmation of the minutes.

The minutes of the Representative Meeting appointing and instructing the Committee were read.

BMJ 2 March 1912

Administration and management of Family Health Services

Local Insurance Committees were set up under the 1911 Act. In 1948 the Local Insurance Committees became Executive Councils and in 1974 became Family Practitioner Committees (FPCs). In 1979 a Royal Commission recommended their abolition but the BMA fought to retain them and to make them accountable to the Department of Health and Social Security rather than Health Authorities. In 1991 they became Family Health Services Authorities. From 1994 to 1996, FHSAs were merged with Health Authorities. From 1999, and in all areas of England by 2002, the management of contractors moved to Primary Care Trusts. Up until the creation of FHSAs, LMCs had members of the variously named bodies. When FHSAs were formed, the sole doctor required to be on them was appointed by the NHS. The Society of FPCs had an annual conference. The reputation of the conference was that it often reflected the views of family health practitioners as much as or more than those of the NHS administrators though by the early 1970s the BMA felt doctors' influence was waning. A similar gradual waning of doctor influence occurred as the administrative structures in the other three countries of the UK changed – though perhaps in Scotland, GPs retained more influence.³²²

British Medical Association³²³

In 1832 the Provincial Medical and Surgical Association was formed. The name was changed to the British Medical Association in 1855. In 1902 the constitution of the BMA was changed, particularly in response to pressure from GPs who wanted the association to have a more aggressive stance towards the bodies they contracted with – the Clubs and Friendly Societies. The reformers wanted the constitution to include the right to strike but this was not agreed. In 1949 the BMA set up the British Medical Guild to get round the fact that the constitution would not allow it to take industrial action. After the 1971 Industrial Relations Act, the constitution of the BMA was changed again though after a fierce debate, it had very little impact on the representation of GPs. In 1975 the BMA changed its constitution again and became a trade union under the 1974 Trade Union and Labour Relations Act.

The BMA has secretariats for the various committees for the different branches (formerly 'crafts') of the profession, including the General Practitioners Committee. It also has a number of departments and specialist teams such as the Health Policy and Economic Research Unit (from 1976) which provides crucial evidence for negotiations on GP pay and conditions and for evidence to the Doctors' and Dentists' Review Body; the Public Affairs Division; the Board of Science; the Legal Services Department; and an industrial relations team organised through Regional Services.

The proportion of GPs who are members of the BMA and the proportion of BMA members who are GPs vary but the figures are currently 78.5% and 30.2% respectively. Overall about two-thirds of doctors in the UK are members of the BMA.

General Medical Council³²⁴

The 1858 Medical Act established a General Council of Medical Education and Registration. Its name was changed to the General Medical Council in 1951. An amendment to the Act in 1886 allowed general practitioners to elect doctors by postal vote. Lay membership was introduced in 1926. In 1978 the Council was given the power to co-ordinate all stages of medical education. In 1995 the GMC published Good Medical Practice, the first profession-wide statement of standards for doctors.

Currently, twelve of the twenty-four members are doctors and all members of the Council are appointed by the Appointments Commission.

The General Practitioners Committee³²⁵

The State Insurance Committee met for the first time on 28 February 1912. In 1913 it became the Insurance Acts Committee. After 1948 it became the General Medical Services Committee. The GMSC became the General Practitioners Committee in 1998. GPC members do not have to be BMA members. There is a potential conflict between the GPC (and also LMCs) and the BMA because the GPC and LMCs may include non-BMA members who may think, for example, that the BMA is too radical or not radical enough or both. The costs of the GPC are met jointly by the BMA and the GPDF. It has sometimes been a bone of contention with other branches of the profession that the GPC is better staffed than other committees because of the additional resources provided by the GPDF.

The GMSC Scotland started in 1949, the Wales GMSC in 1970 and the Northern Ireland GMSC in 1972.

The General Practitioners Defence Fund³²⁶

The Central Insurance Defence Fund was first established as a Trust in 1911.⁹⁹ Soon after the NHS was created it became the General Medical Services Defence Trust. The objects in the trust deed for the fund dated 28 July 1949 included:

- a) The taking of such action as the Trustees from time to time consider expedient in the interests of general medical practitioners rendering service in England or Wales under the National Health Service Act, 1946 or any enactment amending or consolidating the same or in Scotland or Northern Ireland under any corresponding enactment

- c) financial assistance to or for the benefit of any general medical practitioner or class or classes of general medical practitioner...[who] have suffered or be likely to suffer hardship as a consequence of his, her or their loyalty to any policy sponsored or approved by the Conference of LMCs called by the GMSC of the BMA.

In 1980, the General Medical Services Defence Trust became the General Medical Services Defence Fund Limited. In presenting the annual accounts, the formula for many years has been that 'The company acts to protect the interest of general medical practitioners rendering services in the United Kingdom under the NHS and will continue to do so in the foreseeable future'.

The Fund changed its name to the General Practitioners Defence Fund in 2001. In 2004 it changed its Memorandum and Articles to reflect the view that there was a potential conflict of interest in having directors who were also the principal recipients of the funds disbursed.

Local Medical Committees (LMCs) and Conference

LMCs are the local representation of general practitioners. All GPs providing NHS services are automatically represented. LMCs are usually described at the statutory bodies recognised since 1911. Technically Clause 62 of the 1911 National Insurance Act refers to bodies 'recognised as representing

⁹⁹ This is in Marks, 1979. In 1965 The Deputy Treasurer of the GMS Defence Fund said that the National Insurance Defence Fund was set up in 1918

general practice'. LMCs were elected on a franchise of all practitioners but for example in London the committee consisted of non-panel doctors whose declared intention was to make the workings of the Act as difficult as possible. Almost all the funding for the GP Defence Fund comes from Local Medical Committees. At times some LMCs have been unwilling to pay their (voluntary) levy. The problem was very acute in the 1970s. In recent years it is not LMCs in general that are unwilling to contribute, but their revenues depend on individual members contributing. Some PMS doctors and non-principals have been unwilling to contribute. From the Insurance Act onwards, the state has been required to consult LMCs, in addition to LMCs having the representation on local administrative and later management bodies described above under Administration and management. The GPC also convenes an Annual Conference of Representatives of Local Medical Committees (LMC Conference), which is the principal policy-making body for general practice. In 1968 the GMS Committee proposed the first Conference of LMC Secretaries.

Royal College of General Practitioners

The College of General Practitioners was founded in 1952 following discussions of the highly critical Collings report on general practice and building on both the General Practice section of the Royal Society of Medicine and the General Practice Review committee of the BMA. It also echoed an earlier tradition by holding its foundation meeting at the Society of Apothecaries. The College was incorporated in 1962 and was granted its Royal Charter in 1972. In 1965 the College started examinations for Membership of the College.

Other bodies

Medical Practitioners Union³²⁷

In 1912 The National Insurance Act Practitioners Association was formed by Liberal supporters of the National Insurance Act. Its members later became the founder members of the Medical Practitioners Union. In the 1930s the anti-vivisectionist movement and to a lesser extent the British Union of Fascists became influential in the MPU. The MPU is now part of the Unite trade union and is affiliated to the TUC.

Medical Women's Federation³²⁸

In 1879 the Association of Registered Medical Women was formed to represent qualified medical women in the UK. When the Insurance Act Committee was constituted in January 1913 the Association nominated a member. In 1917, the Association and various regional bodies combined to form the Federation.

British International Doctors Association

The successor to the Overseas Doctors Association, it has a seat on the GPC.

Bodies which no longer exist

Organisations regularly spring up because they feel that existing bodies' policy or practice is wrong or because they think their interests have been neglected. These have included the Association of Panel Committees, the National Medical Guild, the National Association of Doctors in Practice and The General Practitioners Association.

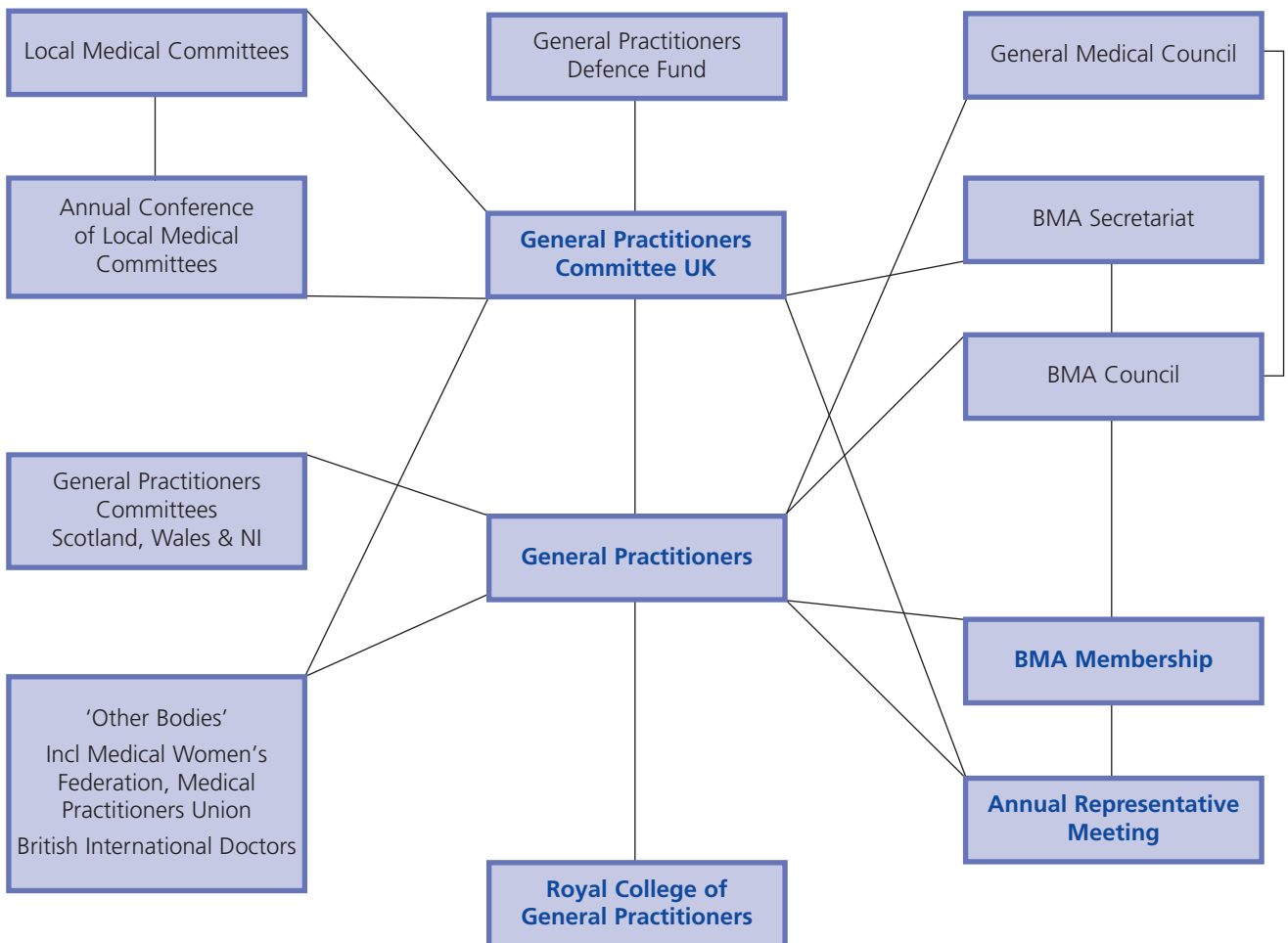
Bodies not included in the formal structures

The Family Doctors Association claims a membership of 1000 GP practices 'that believe in the importance of patients having a named GP'.

The National Association of Sessional GPs (formerly the National Association of Non-Principals) describes itself as 'the only independent lobbying and information service for Sessional GPs' – locums, salaried and retainer GPs.

The National Association for Primary Care (NAPC) believes that clinicians should lead the process of NHS commissioning. It now works closely with the NHS Alliance. The NAPC developed from fundholding and the Alliance from commissioning.

Relationships between GP bodies



Appendix C

Sanctions

- 1912 Provisional Medical Committees receive pledges from 33,000 doctors to resign from Friendly Society and similar contracts to take effect from the date of implementation of the Insurance Act
- 1923 95% of GPs send undated resignations over proposed pay cut
- 1946 Plebiscite: 17,000 GPs against accepting Government proposals for general practice
- 1947 Another plebiscite showed a much smaller number of GPs opposed to the scheme
- 1965 Undated resignations held by Medical Guild. Followed by Family Doctor Charter
- 1970 British Medical Guild recommended that doctors withdraw all cooperation with the administration of the NHS. 77% of GPs refuse to sign certificates
- 1975 60% of GPs in England submitted resignations
- 2001 Ballot on need for new contract and GPC right to represent all PMS GPs. 86% of principals willing to consider resignations

Appendix D

Chairmen of GMSC/GPC 1964-2004

Chairman	Dates	Major events
J C Cameron	1964-1974	Call for undated resignations; Family Doctor Charter; 1966 Contract; 'Red Book'
R A Keable-Elliott	1974-1980	Call for undated resignations; <i>Report of the New Charter Working Group</i>
J G Ball	1980-1984	<i>General Practice – A British Success</i> deputising services; Limited List; abolition of short-term sickness certification; maintaining independence of Family Practitioner Committees
M A Wilson	1984-1990	Limited List; 1990 Contract
I G Bogle	1990-1997	Health promotion; out of hours
J W Chisholm	1997-2007	Introduction of Primary Care Groups and Primary Care Trusts; Shipman murders and Shipman Inquiry; 2004 Contract

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Published by the British Medical Association in partnership with PPRE.

British Medical Association, BMA House, Tavistock Square, London, WC1H 9JP
www.bma.org.uk

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ISBN 0-9544904-6-0