

DEPARTMENT OF HEALTH,  
P.O. BOX 5013,  
WELLINGTON.

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## CLINICAL SERVICES LETTER NO. 105

### TO MEDICAL PRACTITIONERS

Dear Doctor,

#### SALARIED GENERAL PRACTITIONERS?

The Royal Commission on Social Security asked for the comments of the Department of Health on a submission received from a private individual. The submission in question included a proposal for "Social Service Centres", where general practitioners would work alongside social workers and educationists.

In commenting on this proposal, the Department made it clear that it was not prepared to support such a scheme if it involved the use of salaried general practitioners.

You may be interested to read the Department's explanation of its reasons for taking this view:

"The present writer\* has often asked himself why the system of salaried professional men (and women) subject to regular inspection and assessment of efficiency which has proved so successful in the educational field should not be extended to general practice. The reason is bound up with the relationship between teacher and pupil as compared with that between general practitioner and patient. The first is sometimes a personal relationship, but usually it is not; the second is essentially a personal relationship of a very intimate kind.

A teacher can impart knowledge to scores (or hundreds) of pupils at a time. Keen pupils can still benefit from the ministrations of people they regard as poor teachers or lecturers—as frequently happens in a university setting. The teacher's effectiveness can be gauged by results; it is not difficult to distinguish between good teachers and bad. Teaching can be programmed and fitted into regular hours; the teacher, not the pupil, decides when and for how long at a time his services will be made available.

The doctor, on the other hand, must give personal attention to each patient, and deal with him as an individual. A great part of his work is effective only to the extent that the patient has confidence in him as a doctor and as a man. It is exceedingly difficult to classify general practitioners on any kind of efficiency scale; in practice, no solution to this problem has ever been found. The efficiency of a general practitioner's work cannot be measured by results. The patient decides when he needs medical attention, and illness ignores the calendar and the clock.

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\*This paper, originally drafted by the Director of Clinical Services, was endorsed as an official departmental submission and presented as such.

In 1938 Drs J. P. S. Jamieson and P. P. Lynch gave a written explanation of their contention that the standard of practice must fall under a 'contract system' in general practice\*.

'The relationship which is established immediately a patient summons a doctor has been and always will be, a strictly personal relation of a very special sort—independent of fee or of the standing of the patient. Medical service has a personal and confidential character which is as many sided as human nature itself and touches at every point in people's lives. The confidence of the patient implies corresponding responsibility on the part of the doctor and no limit can be set to what may be required of it. Consequently, medical practice does not lend itself readily to terms of contract like the supply of a definite number of standard articles, or the giving of so many hours of specified work. Contract necessitates limitation of responsibility. There would be the tendency for the doctor's services to be limited by the terms of contract rather than by the exigencies of the case.'

They went on to say:

'It has been questioned why, if what we contend be correct, medical officers of institutions and of public services maintain standards on the salaried basis. The reason is that their responsibilities and the scope of their work are in fact limited and differ essentially from ordinary practice. They have chosen a field of work and a mode of life which appeal to them individually and which they are free to change if they choose. Further, they do not set standards. Their standards are maintained by competition with officers in similar institutions throughout the world.'

Although much that the doctors' representatives had to say in 1938 would today not be said at all, or would receive different emphasis, these particular principles are as soundly based now as they were then.

The scheme in question could be made to work, of course. In Eastern Europe (and elsewhere) salaried general practice is common. It has some advantages, but the medical profession in this country would never agree that these outweigh what would be lost if it were to be adopted here. It is, I repeat, a question of the personal relationship between doctor and patient, and the personal touch in dealing with him. The second can be illustrated by the way patients are received in the outpatient departments of public hospitals, as compared with even a mediocre private practice. In the first they are so many 'cases', differing in urgency and severity, but without individuality; in the second they are regarded as ill people. The private patient, whether he realizes it or not, wants 'his' doctor, a doctor he knows and believes in, who knows him (or so he believes) and is interested in him as a person. On the doctor's part, one of the essential satisfactions of general practice depends on his feeling that to his patients he is not just another doctor, but a man with a name and a personality, who has something special to offer to the patients who seek his help.

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\*Lovell-Smith, J. B., *The New Zealand Doctor and the Welfare State*, page 73.

Even in private group practice there is a danger that patients may become 'patients of the group', and then experience shows that much is lost both to patients and doctors. But this can be avoided or corrected if the doctors are aware of the risk. In a salaried clinic service some loss of the personal relationship would be inevitable and universal, and its extent would be proportional to the 'efficiency' with which the system was run. In well administered organizations nobody is indispensable, efficiency is judged on punctuality, turnover of so many units of various kinds, economy of time and materials. What the good general practitioner gives to his patient cannot be measured that way. Today it is true that certain types of treatment are scientific and impersonal, but at least 30 percent of patients still suffer from neuroses, and psychological factors play a prominent part in most, if not all, illnesses.

The important difference between a private GP and a salaried GP is not that the one takes a fee from the patient and the other does not. Even if the patients of salaried doctors paid fees the situation would still be the same; essentially, it is not a question of fees at all. The point is that the private doctor enters voluntarily into a relationship with his patient which is governed by the ethics of his profession, with no possibility of direction or interference from a third party, whose authority may be invoked by the patient to coerce the doctor into doing what the patient, and not the doctor, thinks should be done. In short, the private doctor practising on fee per service is not under contract, the salaried doctor is. The one has moral and professional obligations only, the other is subject to control from outside, and his advancement in the service may depend on factors which have little or no bearing on the kind of personal attention he gives to patients.

In the foreseeable future a salaried service in general practice, particularly in a clinic setting, would be totally unacceptable to the medical profession in this country."

Yours faithfully,



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Director,



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