GPs and the Politics of Health Insurance in Britain, c.1900 to 1939

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Abstract

General practitioners (GPs), as family doctors, have been part of the social fabric of Britain for well over a century. In the late nineteenth century, their newly assertive professional identity and desire for the rewards of a comfortable middle-class living brought them into conflict with organisations offering sickness insurance to the working classes. Out of this conflict came a need to create representative bodies capable of defending the GPs' professional privileges and 'articles of faith', which included the maintenance of independent contractor status and the patient's free choice of doctor. The National Insurance Act 1911 heralded the beginning of a new relationship between GPs and the state which began inauspiciously in an atmosphere of recrimination and suspicion, but eventually became one of mutual dependence, founded on 'bargained corporatism', though punctuated by occasionally heated disputes.

Through a series of research questions, this thesis asks how GPs came to support and be involved in the administration of National Health Insurance (NHI) and how their relationship with government took shape in the interwar period. It argues that the development of the GPs' political consciousness was influenced by an overarching desire for professional self-determination and realisation of the 'professional social ideal'. It explains why the relationship between GPs and the state was characterised by alternating periods of harmonious cooperation and mutual distrust and antagonism. It further explains why the professional representative institutions created under NHI became so enmeshed with the culture of British General Practice that they have survived to the present with remarkably little alteration. Particular focus is placed on the role of Local Medical and Panel Committees, hitherto largely ignored by historians, both as instruments of the state's administrative authority, and as the focus of political lobbying and resistance. The thesis contends that National Health Insurance was a qualified success for GPs and their patients. However, GPs' support for its replacement by a more comprehensive National Health Service was conditioned by a continuing desire to protect their sectional interests and freedoms from what many of them perceived to be the widening influence of a centralist and controlling state.

This thesis comprises 83,978 words.

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List of acronyms

APC Association of Panel Committees

BMA British Medical Association

BMJ British Medical Journal

CMWC Central Medical War Committee

GMC General Medical Council

GP General Practitioner

IAC Insurance Acts Committee

LMC Local Medical Committee

LMPC Local Medical and Panel Committee

MAI Medical Aid Institute

MPU Medico-Political Union, subsequently Medical Practitioners Union

MWF Medical Women's Federation

NHI National Health Insurance

NHS National Health Service

NMU National Medical Union

NUT National Union of Teachers

PEP Political and Economic Planning

PHC Primary Health Centre

PMPU Panel Medico-Political Union

PMS Public Medical Service

RAMC Royal Army Medical Corps

RMO Regional Medical Officer

SMA Socialist Medical Association

SMSA State Medical Services Association

TUC Trades Union Congress

Acknowledgements

Introduction

General Practitioners (GPs) are an essential part of the social fabric of modern Britain. Providing a person-centred general medical service which is accessible to the entire population, they mediate between individual patients and the state in matters of health, lifestyle, and access to welfare and other benefits. Yet uniquely among National Health Service (NHS) doctors, GP principals are not state employees. Their independent contractor status guarantees them a limited freedom of action in professional matters of which they are fiercely protective, being ever-wary of attempts by politicians and administrators to manipulate or control them for political ends. It was a desire to understand how GPs came to occupy this unique position, why they value this freedom, and maintain such a distrust of politicians and the representatives of the state, that led me to begin the research on which this thesis is based.

At a special meeting in January 2016, called in response to a widely-held belief that British General Practice was in crisis, the Conference of Representatives of Local Medical Committees resolved 'that should negotiations with government for a rescue package for General Practice not be concluded successfully within six months…the General Practitioners Committee should canvass GPs on their willingness to submit undated resignations.'[1] Spokesmen for the British Medical Association (BMA) acknowledged that resignation from NHS contracts was a measure of last resort for GPs, designed to provide publicity for their concerns and to 'up the ante' in negotiations with NHS England. In explaining his motives in an article he wrote for an on-line journal, the proposer of the motion, Dr James Murphy of Buckinghamshire Local Medical Committee, referred to previous occasions on which GPs had successfully used the threat of

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[1] Matthew Limb, 'GPs threaten mass resignation', *BMJ* 6 February 2016, vol. 352; i646.

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mass resignation to persuade government to accede to their demands.[2] The most notable example cited was the 'Family Doctors Charter' negotiations of 1965.[3] However, GPs' attempts to challenge government policy over terms offered for their services have a much longer pedigree. The action proposed by Dr Murphy owes its origins to the political crisis which began in 1911 when the Liberal Chancellor of the Exchequer, Lloyd George, announced the health insurance provisions of his National Insurance Bill and culminated the following year in the submission of 'pledges' by 27,000 doctors to decline to participate in the scheme.[4] This thesis investigates the attitudes and beliefs which led to the action taken by the GPs in 1912 and explains their often difficult relationship with Government in Britain prior to and following the advent of National Health Insurance (NHI). This task involves an explanation of the even more problematic relationships existing between GPs and other institutions offering health insurance for the working classes or facilitating delivery of medical care to them during the same period. The thesis expressly excludes, however, medical care of the indigent under the Poor Law and Local Government Acts, and, while I refer to the growth of local authority clinics offering maternity, child welfare and sexual health services during this period, these are also outside the scope of this study.[5] My study is confined to mainland Britain.[6] However the preponderance of research material relating to English GPs has inevitably resulted in a greater focus on them than on of their counterparts in Wales and Scotland.

This thesis focuses on the evolving relationship between British GPs and the state before and during the interwar period. In so doing it explains how the development of GPs' political

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[2] James Murphy, 'What GPs need to know about submitting undated resignations' *Pulse,* 18 February 2016. http://www.pulsetoday.co.uk/your-practice/what-gps-need-to-know-about-submitting-undated-resignations/20031151.article
[3] See *BMJ,* 2 July 1966, 'Report of Special Representative Meeting; Supplement, pp. 6-8.
[4] Paul Vaughan, *Doctors' Commons: A Short History of the British Medical Association* (London, 1959) pp. 200-203.
[5] Relevant references are made to this in chapter 7, principally pp.271 and 284-285.
[6] Implementation of NHI in Ireland was confounded by the nationalist struggle for independence. See R.W. Harris, *National Health Insurance in Great Britain, 1911-1948* (London, 1946), p.192, 'Why Medical Benefit did not extend to Ireland'. NHI was only extended to Northern Ireland in the 1920s.

consciousness was influenced by an overarching desire for professional self-determination and why the professional representative institutions created under NHI became so enmeshed with the culture of British General Practice that they have survived to the present with remarkably little alteration. In addressing these issues this thesis askes a series of related questions. First, what were the beliefs on which GPs' political activities in the early twentieth century were based and how were these influenced by concerns related to health insurance? Secondly, what prompted GPs to mobilise politically prior to and after 1911 and what were the consequences of their actions in this arena? And, finally, what was the nature of their emerging relationship with the state during and after the First World War and what prompted GPs to abandon a policy of co-operation and to challenge government authority through collective action?

The remainder of this introduction outlines the beliefs which I contend lie behind GPs' political activities and which are explained and developed throughout the thesis. Following this, I describe the historiographical context and the sources and methodology used in my research. I then trace briefly, by way of background to the subsequent analysis in the body of the thesis, the evolution of General Practice in the century preceding NHI, with reference to the GPs' feelings of social and economic insecurity, the development of a recognisable *habitus* (to use the term popularised by Pierre Bourdieu), and the completion of a process of professionalisation concomitant with a striving for 'collective upward social mobility'.[7]

Cultural aspirations and the GPs' 'articles of faith'

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[7] Habitus may be defined as 'a system of dispositions which generate perceptions, appreciations and practices within a field or locus of activity which will determine how the actors in that field will behave.' See Karl Maton,'Habitus' in Michael Grenfell (ed.) *Pierre Bourdieu: Key Concepts*, (2nd edn, Abingdon, 2012) p. 50. 'Collective upward social mobility' is identified as a key factor in the professionalisation of British doctors in Noel and Jose Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London, 1976). This is described further on in this chapter.

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Understanding GPs' belief systems is essential, I suggest, to comprehending their collective political consciousness before and during the era of NHI. Historians are perhaps more reluctant than sociologists to generalise about belief systems and culture, particularly when talking about a group as heterogeneous as British GPs. Moreover, sociologists tend to over-generalise when talking about 'the professions' and even more so when talking about the 'medical profession', ignoring the often significant differences which exist between different classes of medical practitioners in different countries and their social milieux during different time periods. I have nevertheless drawn useful insights from those who have written about the sociology of the medical profession and about points of similarity with other professions.[8] In applying sociological constructs to GPs in this time period it is important to recognise that there are always exceptions and the terms used should be viewed as non-empiric labels intended to aid understanding. As such they are always open to challenge or alternative interpretation. While acknowledging that not all GPs in Britain necessarily subscribed to all of the beliefs I identify, all the time, there were, I argue, three attributes which all GPs in Britain during this period desired and considered necessary to their wellbeing and to enable them to give their best to their patients. These were: gentility (or 'respectability'); economic security; and, professional and occupational autonomy. These aspirations have been, according to sociologists, to a large extent, common to all branches of the medical profession internationally.[9] In the case of British GPs during this period, however, they crystallised into a subset of principles which became collective 'articles of faith' which their representative bodies were sworn to defend at all costs. These included a commitment to independent contractor status, the patient's right to free choice

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[8] These include, inter alia, Elliot Friedson, *The Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York, 1970); Phillip Elliot, *The Sociology of the Professions* (Basingstoke, 1972); Daniel Duman,'The Creation and Diffusion of a Professional Ideology in Nineteenth-Century England' *Sociological Review*, 27 (1979) pp.113-138.

[9] See: Parry and Parry, *The Rise of the Medical Profession* p. 32, p. 79; D. Rueschemeyer, 'Professional Autonomy and the Social Control of Expertise.' in Robert Dingwall and Phillip Lewis, *The Sociology of the Professions: Doctors, Lawyers and Others* (London, 1983) ch.2, p. 41; Friedson, *The Profession of Medicine* pp. 10 and 174;.

of doctor, and professional control over standards of competence and behaviour. Explaining why these principles were so important to GPs and the lengths they went to in order to preserve them is a central objective of this thesis.

When seeking to uphold these articles of faith both before and after the advent of NHI the profession's leaders demonstrated a commitment to democratic self-government. This resulted in a form of corporatism through which GPs sought to expand their status and influence using collective bargaining. It also led to impassioned debates about the merits and disadvantages of medical trade unionism. This was, as will be seen, no idle question for the medical profession as it went to the heart of how doctors saw themselves and their position in society. As will be demonstrated, the National Insurance Act, despite the profession's significant misgivings about it, accorded GPs considerable professional autonomy and a major share in the administration of NHI.[10] This helped mitigate their fears of becoming vassals of the state. GPs were able to secure considerable freedom of action by effective engagement with the apparatus of the state at local level, through the Local Medical and Panel Committees (LMPCs), and at national level through the BMA's Insurance Acts Committee (IAC). This, at times uneasy, partnership involved, I suggest, what Harold Perkin, *pace* Colin Crouch, calls 'bargained corporatism'.[11] Underpinning this strategy was a belief shared by doctors of every political persuasion which Perkin calls the 'professional social ideal', that is an ability to justify professional self-interest 'in terms of the service performed for society…and the principle of social justice.'[12] As will be demonstrated throughout this thesis, the medical profession's ability to conflate their professional interests with the public interest proved to be a defining feature of their relationship with government and their attempts to influence public opinion during this period.

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[10] See Harris, *National Health Insurance in Great Britain,* pp. 133 and 143.

[11] This may be summarised as 'a tacit entente between government officials and putatively representative organisations offering themselves as intermediaries in negotiating with the state outside parliamentary channels and regulating their membership within a wider system of order.' Harold Perkin, *The Rise of Professional Society: England since 1880.* (2nd edn, Abingdon, 2002) pp.286-287. This is explored in chapters 4 ,5, and 6.

[12] *Ibid*, p. 288.

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Historians such as Mary Poovey and Patrick Joyce among others, have argued that the state in late nineteenth and early twentieth century Britain was a pluralist assemblage of interests and institutions – private, public, charitable and voluntary – and not confined to the narrow definition of central government and its appointed office holders.[13] Pat Thane describes this as 'bounded pluralism'.[14] More recently, James Vernon has argued that the state during this period extended its reach to tackle social problems which it considered unrelated to or outside the control of the market economy and that thenceforward, 'those who wished to be left alone by it had to demonstrate…appropriate forms of self-government'.[15] In mediating between GPs and the apparatus of the state, I suggest that the LMPCs and the IAC may be seen as representative of the diffuse networks of power through which both Liberal and Conservative governments of this period sought to exercise authority. Thanks to the limited degree of self-government they were accorded, GPs were therefore effectively among those privileged groups Vernon describes.[16]

However, as local defenders of GPs' professional interests and guarantors of their claimed right to self-determination, LMPCs were, paradoxically, the means through which, during periods of conflict, the profession mobilised resistance to government authority. Thus, the relationship between GPs and the state during the period studied was characterised by alternating periods of harmonious cooperation, in which GPs were willing to work with the government for the public good, and mutual distrust and antagonism, in which the profession, fearing a threat to its interests and those of the public, showed a determination to resist government using all legal means possible.[17] I have chosen to conclude this study in 1939

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[13] Mary Poovey, *Making A Social Body: British Cultural Formation 1830-1864* (Chicago, 1995) p. 14; Patrick Joyce: *The State of Freedom: A Social History of the British State since 1800* (Cambridge, 2013) pp. 31-34.
[14] Pat Thane, *Foundations of the Welfare State*, (2nd edn. London, 1996) p. 291.
[15] James Vernon. *Cambridge History of Britain: 1750 to the Present* (Cambridge, 2017) ch. 4, p. 146.
[16] See Nikolas Rose, 'Government, Authority and Expertise in Advanced Liberalism', *Economy and Society*, (1993) 22 (3) p. 285.
[17] This relationship can be characterised as what Michel Foucault termed an 'agonism', that is a perpetual struggle -see Michel Foucault 'The Subject and Power'. *Critical Inquiry*, 8 (4) (1982) p. 790.

because, I argue, professional views on the merits of state funding for health services, and what these should comprise, had by then reached a point of maturation from which there was thereafter no significant divergence. While the Second World War did not curtail the vigorous debates about the shape of future health services it also did not witness any major changes in the way panel GPs worked or thought about health services. By 1939 most GPs favoured the inclusion of hospital care and additional services in a comprehensive state-funded service, provided that is, the distinction between private practice and publicly-subsidised services remained intact. Only a minority wished to erase that distinction. Critics of professional privilege are accustomed to question the extent of medical altruism.[18] A number of historians have likewise argued that the BMA's blueprints for the reform of health services in this period were suffused with self-interest.[19] In my concluding chapter, therefore, I re-examine the proposals the BMA put forward for the reorganisation of national health services in 1930 and subsequently, and the reception they received at the time, in the context of ongoing discussions throughout the 1920s and 1930s between the BMA and government, and with influential political interest groups with whom the profession was sometimes at odds, such as the approved societies and the Labour movement.[20] The profession, I suggest, was willing to support the establishment of more comprehensive medical services to all who could not afford to pay for healthcare directly at the point of delivery, provided the GPs' 'articles of faith' were respected and their economic security guaranteed. This is something which, I argue, previous historians and sociologists have not sufficiently appreciated or understood.

Historiographical context and review of research

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[18] Friedson states that 'the profession's service orientation is a public imputation it has successfully won in a process by which its leaders have persuaded society to grant and support its autonomy.' *The Profession of Medicine,* p.91.

[19] See for example, Brian Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales* (London, 1964) p. 350.

[20] British Medical Association, *A General Medical Service for the Nation* (London, 1930).

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Given recent developments in the historiography of the modern British state, the role of GPs in the development of state-funded healthcare warrants re-evaluation.[21] The most recent substantive analysis of General Practice in the late nineteenth and early twentieth centuries, Anne Digby's *The Evolution of British General Practice,* published in 1999, is socio-economic in approach, and largely eschews the political dimension.[22] Digby uses what she describes as 'Lamarckian evolutionary theory' to explain the development of General Practice. She determines that GPs' activities were focussed on finding the appropriate 'ecological niche' within a community and that the success of their practices as businesses was dependent on their ability to adapt to the varying needs of patients as clients or customers.[23] She also documents the practical travails of individual practitioners struggling to make a living in a competitive market for healthcare services and the complexities of their professional and social lives. Apart from Digby, most of the important historical research in this area was published over forty years ago, so a fresh approach is timely. Bentley Gilbert's seminal work on National Health Insurance remains essential reading but must now be qualified by more recent studies of the Liberals' social legislation.[24] Norman Eder's detailed and insightful examination of the GPs' interactions with NHI is the closest thing to a standard text but is narrow in focus and now seems very dated in terms of recent historiography.[25] Some of its conclusions need to be reconsidered in the light of the new source material I have uncovered which will be discussed below. The same is true of Frank Honigsbaum's eclectic and discursive study.[26] David B.

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[21] See for example Bernard Harris, *Origins of the British Welfare State* (Basingstoke, 2004); Geoffrey R. Searle. *New Oxford History of England, A New England? Peace and War 1886-1918* (Oxford, 2004); and Martin Daunton, *Wealth and Welfare: An Economic and Social History of Britain, 1851-1951* (Oxford, 2007).

[22] Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999).

[23] *Ibid*, p.12

[24] Bentley B. Gilbert. *The Evolution of National Health Insurance in Great Britain: The Origins of the Welfare State* (London, 1966). More recent historiography of the origins of the Liberals' social legislation is considered in chapter 2 of this thesis.

[25] Norman Eder, *National Health Insurance and the Medical Profession in Britain 1913-1939* (New York, 1982).The contributions of more recent authorities are also considered in chapter 2 of this thesis.

[26] Frank Honigsbaum, *The Division in British Medicine*: *A History of the Separation of General Practice from Hospital Care* (London, 1979).

Green's work on the Friendly Societies' battle with the medical profession contains some useful insights, though his conclusions, which betray his neo-liberal political leanings, deserve to be challenged.[27] His analysis of the friendly societies has been superseded by more recent works by Simon Cordery, Martin Gorsky and Bernard Harris.[28] I also make use of John Marks' MD thesis, written in 1974.[29] This provides a detailed chronology of the LMPCs, their conference and their interaction with the BMA from 1912 to 1968, but is lacking in critical analysis and understanding of historical context. The only recent political study of note is that of Andrew Morrice, whose analysis of the BMA's activities in the decade preceding the National Insurance Act serves as a useful reference point for my own analysis of that period.[30]

This thesis offers both a sociological and an economic context for the development of British GPs' collective political consciousness. An understanding of this context is essential, I maintain, in order to make sense of GPs' relationship with the state before and after the advent of NHI. My thoughts about the processes involved take account of views advanced by Harold Perkin, Patrick Joyce, Pat Thane and James Vernon. They also involve consideration of the broader political context of Britain before and after the First World War as described by, among others, Jose Harris, G.R. Searle, Jay Winter, Kenneth Morgan, and James E. Cronin. [31] My analysis also considers the role and status of GPs within society at large, taking account of

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[27] David B. Green, *Working-Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948* (Aldershot, 1985).

[28] Simon Cordery, *British Friendly Societies 1750-1914* (Basingstoke, 2003). Martin Gorsky, 'Friendly Society Health Insurance in Nineteenth Century England' in Martin Gorsky and Sally Sheard (Eds) *Financing Medicine: The British Experience since 1750* (Abingdon, 2006); Bernard Harris, 'Social Policy by Other means? Mutual Aid and the origins of the Welfare State in Britain during the Nineteenth and Twentieth Centuries.' *Journal of Social Policy,* 30 (2) 2018.

[29] John H. Marks, *The History and Development of Local Medical Committees, their Conference and its Executive.* Edinburgh University MD Thesis 1974.

[30] Andrew Morrice, 'The Edwardian BMA and Contract Practice.' in Martin Gorsky and Sally Sheard (Eds) *Financing Medicine: The British Experience since 1750* (Abingdon, 2006).

[31] Jose Harris, *The Penguin Social History of Britain: Private Lives, Public Spirit: Britain 1870-1914* (London, 1993); Geoffrey R. Searle, *New Oxford History of England, A New England? Peace and War 1886-1918* (Oxford, 2004); Jay Winter, *The Great War and the British People* (2nd edn, Basingstoke, 2003); Kenneth O. Morgan, *Consensus and Disunity: The Lloyd George Coalition Government 1918-1922* (Oxford,1979); James E. Cronin, *The Politics of State Expansion: War, State and Society in Twentieth-Century Britain* (London, 1991).

studies of class interactions during the interwar period by W.D. Rubinstein, Richard Trainor and Ross McKibbin and recent works on the social history of medicine by, among others, Jane Lewis, Christopher Lawrence, Helen Jones, and Joan Lane.[32]

My thesis therefore offers a new dimension to the broader history of Britain in this period in three respects. First, it adds to our understanding of professionalisation by showing how a diverse group that was individualistic in nature came to terms with the need to act collectively to achieve political goals. Second, it contributes to our understanding of the growth of the Liberal welfare state and its complex relationship with experts, by explaining why professionals entrusted with a share of state authority were prone to resist that authority and remained so strongly opposed to the bureaucratization of state-funded medical services. Finally, it illuminates the British class system, by explaining how GPs' activities in the political sphere were driven by a mix of ideological imperatives in which class distinction and the desire for gentility went hand in hand with the need for economic security and just reward for their labours.

Sources and methodology

With its research questions and historiographical objectives in view, this thesis draws on a wide variety of sources. It builds on a new and systematic analysis of the relevant entries in the professional journals written and read by GPs from the 1890s to 1939, principally the *British Medical Journal (BMJ), Lancet,* and *Medical World*, and correlates these findings with previously unresearched records of internal discussions within the BMA which are kept in the

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[32] W.D. Rubinstein, 'Britain's Elites in the Interwar Period 1918-1939' and Richard Trainor 'Neither Metropolitan nor Provincial: The Interwar Middle Class' in Alan Kidd and David Nichols (eds) *The Making of the British Middle Class? Studies of Regional and Cultural Diversity Since the Eighteenth Century* (Stroud, 1998); Ross McKibbin, *The Ideologies of Class: Social Relations in Britain 1880-1950* (Oxford, 1990). Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939* (London,1980); Christopher Lawrence, *Medicine in the Making of Modern Britain 1700-1920* (London, 1993); Helen Jones, *Health and Society in Twentieth Century Britain* (London, 1994); Joan Lane*, A Social History of Medicine: Health, Healing and Disease in England 1750-1950* (London, 2001).

BMA's archive and in the Wellcome Institute in London. It also draws on relevant ministerial records in the National Archive, Kew, along with parliamentary discussions and newspaper articles, extracts from Royal Commission and other reports and surveys as well as critical commentary from other journals, in order to reflect a broader, societal view of the developments under consideration. My research incorporates, in addition, biographies and memoirs of prominent personalities and a surprisingly rich source of material in contemporary fiction offering vivid descriptions, based on first-hand knowledge, of GPs' lives and work in this period. Apart from those of the London Panel Committee located in the BMA archive, the records of LMPCs were assumed to have been lost.[33] In the summer of 2017 I undertook an enquiry via *Survey Monkey* of the Local Medical Committees (LMCs) currently existing in mainland Britain to ascertain the scope for archival research. This revealed that LMPC records dating from 1913 onwards exist in LMC Offices in North Staffordshire, Lancashire, and Kent, along with some isolated examples from the 1920s and 30s in North Yorkshire and elsewhere, and in the Medical Collections in Manchester University's Central Library. Analysis of these records has enabled me to determine how the LMPCs interacted with local Insurance Committees, with other LMPCs, the BMA, the Medical Practitioners Union (MPU), the NHI Commissioners and later the Ministry of Health, and how they sought to ensure the representation of their constituents' views. It convinced me that their role in the local administration of NHI has been underappreciated and that the LMPC/BMA axis is key to an understanding of all political activities affecting or involving GPs during this period.

No understanding of these developments is possible, however, without some knowledge of the evolution of general practice as a distinct part of the medical profession in Britain with its own, distinct professional culture, in the century preceding the advent of National Insurance. The remainder of this introduction is therefore devoted to a brief description of this

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[33] Eder, *National Health Insurance and the Medical Profession* p. 194, note 72.

evolutionary process. It focuses on GPs' rise from poorly educated tradesmen to members of a profession enjoying a measure of public esteem and state recognition and shows how the idealised vision of the cherished family doctor was compromised, at the turn of the twentieth century, by the overcrowding of the profession and the threat posed by the coordinated activities of organisations representing or catering for patients as consumers of healthcare services.

The evolution of professional identity

During the eighteenth century, the medical profession in Britain was effectively divided into three classes: physicians, surgeons, and apothecaries. Each had its own corporation which sought to maintain the professional privileges accorded to its members.[34] The forerunners of General Practitioners (GPs) were a hybrid of all three types of practitioner and noticeably unsure as to their social position. They were described in the *Lancet* in 1839 as 'a new class…different from any hitherto known, formed by a combination of the three already in existence but having no exact resemblance to any of them.' [35] By 1847 GPs comprised 68% of doctors in London and 85% in the provinces.[36] The stratification of social classes which was a defining feature of nineteenth century Britain was something of which GPs as an emerging social group were acutely conscious. They liked to think of themselves as educated gentlemen and situated firmly within the newly emergent middle class, but their claims to higher social status were undermined by a lack of state recognition, the absence of recognised educational standards, and by economic conditions which periodically depressed their income, forcing

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[34] The Royal College of Physicians of London (founded 1518), Edinburgh (1681), and Ireland (1667 and 1692); The Royal College of Surgeons of Edinburgh (1778), London (1800), and England (1843); and the Worshipful Society of Apothecaries, London, founded 1617 and given authority to license medical practitioners under the Apothecaries Act 1815.

[35] M. Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (London, 1978) p.182.

[36] Irvine Loudon, *Medical Care and The General Practitioner 1750- 1850* (Oxford, 1986) p. 225. This estimate is based on an analysis of contemporary medical directories.

many of them to maintain links with the apothecary's trade.[37] They were described by one American observer in 1834 as 'a mongrel kind of doctor, man-midwife, surgeon and druggist, a true jack of all trades and master of none…used by the public yet looked upon by them with a sort of good-natured contempt.'[38]

In a study of GPs in early nineteenth century Sheffield, Ian Inkster described them as 'marginal men' keen 'to legitimise their social and intellectual positions through social action'[39] The development of an increasingly scientific basis for medical practice in the mid-nineteenth century, however, coincided with increased demand for medical care from the new industrial middle classes. The social status of GPs therefore improved as medicine became a valued commodity in what was fast becoming a consumerist society.[40] Women of the new middle class increasingly called in medical practitioners to attend them during childbirth and employing the services of a medical practitioner became an indication of wealth and status.[41] The quest for gentility and social acceptance in the late nineteenth century made the GP in many ways the epitome of the aspirant middle classes whose overwhelming desire was to achieve what contemporaries referred to as 'respectability'.[42] In 1885 the GP-turned-specialist Morrell Mackenzie described this thus:

> In the breast of the ordinary middle-class John Bull, no emotion is stronger than to appear
> "respectable"; in the heart of the medical body corporate this feeling is intensified almost
> into a passion. The truth is that in in this country at least we are just a little doubtful as to
> our position in the social scale, and we are naturally somewhat ticklish about the matter.[43]

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[37] *Ibid,* p.202
[38] *Ibid,* p.203.
[39] Ian Inkster, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850' in John Woodward and David Richards (eds) *Healthcare in Popular Medicine in Nineteenth-Century England: Essays in the Social History of Medicine,* (London,1977) p.129. See also Loudon, *Medical Care and The General Practitioner* p.203.
[40] Loudon, *Medical Care and The General Practitioner* p.129.
[41] Margaret Stacey, *The Sociology of Health and Healing* (London, 1988) p. 87.
[42] Loudon *Medical Care and The General Practitioner* p.274.
[43] Peterson, *The Medical Profession in Mid-Victorian London,* p.251.

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Many historians have described the increasing influence of the professions in nineteenth century Britain coinciding with government reliance on expertise as part of a growing compact between the state and the new professional middle class.[44] This reliance was manifested in public medical officer appointments. Many GPs combined private practice with part time appointments as Poor Law medical officers which made them, in one sense, state appointees.[45] The widening of social legislation also saw GPs being involved in certification of births and deaths, infectious disease notification and public vaccination. The equation of expertise with authority resulted in the 'prodigious growth' in the number of medical officer appointments in the second half of the nineteenth century. [46] These provided an economic mainstay for many GPs.[47] Against a background of increasing state regulation, organisations engaging with, caring for, or employing large numbers of people were committed to employing their own medical officers to advise on medical aspects of their activities. The putative expertise of the medical officer lent a degree of scientific validity to whatever activities they undertook, measured, mediated, or certified.[48] By the early twentieth century the state had begun to call on GPs for 'a myriad of other duties' under Acts relating to factories, children, public health, workmen's compensation and housing'.[49] They were thus becoming valued agents of the state without at any point having to surrender the independent professional status they held so dear.

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[44] Rueschemeyer, 'Political Autonomy and the Social Control of Expertise' pp.41-48 and John Turner, ''Experts' and Interests: David Lloyd George and the Dilemmas of the Expanding State 1906-1919', in Roy MacLeod (ed) *Government and Expertise: Specialists, Administrators and Professionals 1860-1919* (Cambridge, 1988) pp.204-211.

[45] Lawrence, *Medicine and the Making of Modern Britain* p.79. Loudon, *Medical Care and The General Practitioner,* pp.238-239.

[46] Peterson, *The Medical Profession in Mid-Victorian London,* p.110.

[47] Digby, *The Evolution of British General Practice,* pp.78-82.

[48] Poor Law Medical Officers were part-time appointments and occupied almost exclusively by GPs. Following the Medical Act of 1858 these appointments were confined, at the prompting of Sir John Simon, to those possessing dual qualifications in medicine and surgery. Jeanne C. Brand, *Doctors and the State* (Baltimore, 1965) p.88. By the end of the century doctors had become the leading officials in the workhouse infirmaries, and, as whole time medical superintendents, could make demands for resources which lay poor law guardians found hard to refuse. Abel-Smith, *The Hospitals 1800-1948,* p.96.

[49] Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine* (New Haven, 1966) p.35.

The mid-nineteenth century was an era of unprecedented social mobility, fuelled by individual enterprise and invention and facilitated by the industrial revolution and the opportunities offered by an expanding overseas empire. In the absence of anything resembling an education 'system', those who rose through the ranks as businessmen, bankers and factory owners were often self-educated. A best-selling book, *Self-help*, written by the former GP Samuel Smiles, perfectly captured the zeitgeist and inspired a generation to believe that anyone could achieve success in their chosen career through a combination of thrift, hard work, determination and healthy habits.[50] The self-directed and self-funded nature of medical education in the nineteenth century encouraged self-reliance. Succeeding as a GP in a highly competitive and sometimes hostile economic environment, required huge reserves of determination and personal resilience.[51] Despite the restrictions, slights, and humiliations GPs sometimes endured, and the vicissitudes of making a living in such an environment, however, general practice still offered a measure of freedom and self-determination rarely found in other professions.[52] GPs may have been 'marginal men' but they were 'self-made' men (and women).[53] The former GP Sir Arthur Conan Doyle, inventor of the fictional detective Sherlock Holmes, sums this up in his semi-autobiographical novel, *The Stark Munro Letters,* when his hero, musing on the opportunity of starting his own practice says:

> ...if there was the promise of poverty and hardship, there was also that of freedom. I would
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> be my own - my very own. I had youth and strength and energy, and the whole world of
>
> medicine packed in between my two ears.[54]

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[50] Samuel Smiles, *Self-Help*, (London, 1859).

[51] Many GPs from modest beginnings found solace and inspiration in it as they struggled to make their hard-won careers, for example see Francis Brett Young, *Dr Bradley Remembers* (London, 1938) p.222.

[52] Friedson argues that medicine is the only profession that has been truly autonomous. Friedson, *The Profession of Medicine* p.143. The BMA's medical secretary Alfred Cox opined that 'a doctor in practice is, or used to be, as much his own master as anyone can be.' Alfred Cox, *Among the Doctors* (London, c.1949) p.82.

[53] The number of registered women doctors rose from about 200 in the late 1890s to about 600 in 1907. Between 1898 and 1910 nearly one on four female medical graduates from Glasgow University opted for a GP career. Women saw general practice as a career involving 'individuality and initiative.' Digby, *The Evolution of British General Practice,* pp.161-163.

[54] Arthur Conan Doyle, *The Stark Munro Letters* (London, 1898) ch. X, 21 May 1882.

Figure 1. *GPs and self-made men*: Samuel Smiles (left) author of *Self-Help*, and Arthur Conan Doyle (right) the creator of Sherlock Holmes and author of the semi-autobiographical *Stark Munro Letters*.

Although often overburdened with work and financial worry, GPs at the turn of the twentieth century had what philosophers and social scientists like Anthony Giddens and Pierre Bourdieu would recognise as valuable 'cultural capital'.[55] This comprised membership of a generally respected profession with a claim to a higher calling of public service, expertise based on a rigorous vocational education and practical knowledge of the healing arts, and a claim (albeit tenuous) to scientific knowledge. [56] This cultural capital was, moreover, transferable. If the GP failed to make a good living in his or her chosen location, they could always pack up and try their luck elsewhere. Operating in isolation and largely without scrutiny or control served to reinforce GPs' personal attributes of individualism and entrepreneurialism, and their appetite for risk taking. But given that they were individualists, whether naturally, by reason of

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[55] Pierre Bourdieu, 'The Forms of Capital' in H. Lauder, P. Brown, J-A. Dillabough and A. H. Halsey (eds) *Education, Globalisation and Social Change* (Oxford, 2006) p.107.

[56] Harold Perkin states that Bourdieu, Giddens et al 'have familiarised the concepts of human, educational , cultural and intellectual capital by which investment in acquired knowledge and expertise yields a rate of return commensurate with that of all material capital.' Perkin, *The Rise of Professional Society,* p.7.

temperament, or experientially, through operating in a competitive market for their services, how are we to explain the development of a collective identity and, indeed, a movement? Sociologists and historians seem to agree that this sense of collective identity was accomplished by a process of professionalisation.[57]

For GPs in Britain this process, I suggest, involved essentially four elements. The first was *differentiation*. As qualified medical practitioners, GPs made strenuous and largely successful efforts to distinguish themselves from competitors they believed themselves superior to, that is unqualified quacks and other recognised but evolving healthcare professions such as midwives, nurses, health visitors and pharmacists.[58] This differentiation was reinforced by state recognition under the Medical Acts of 1858 and 1886. The second relates to s*tandards of education*. During the second half of the nineteenth century GPs fought and eventually won a battle against the medical corporations to obtain conjoint examinations in medicine, surgery and midwifery.[59] This combination of qualifications was essential to render them educationally fit to meet the medical needs of the broadest range of potential clients.[60] The third element of professionalisation was *public and state recognition of expertise*. The increasing importance of Public Health in British society, reinforced by advances in medical science linked to ideas of social progress, increased the value of medical knowledge.[61] This was testified by the growth in the number of medical officer appointments of which GPs enjoyed a virtual monopoly. The final element involves *self-regulation and common standards of behaviour*. Resisting lay

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[57] The views of Friedson, as in *The Profession of Medicine,* and Terence J. Johnson , *The Professions and Power*, (London, 1972) on professionalization are well summarised in Parry and Parry, *The Rise of the Medical Profession* pp. 26-49.

[58] Parry and Parry describe this form of occupational closure as a consequence of 'upward collective social mobility' *The Rise of the Medical Profession,* p.79.

[59] Ivan Waddington, *The Medical Profession in the Industrial Revolution* (Dublin, 1984) p.126.

[60] A magazine contributor called George Birkbeck had noted in 1834 that the GP was popular with middle-class families because his combined expertise in medicine, surgery and midwifery, made him a cheaper alternative to employing each of those professionals separately. Waddington, *The Medical Profession in the Industrial Revolution* p.25.

[61] W.F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century,* (Cambridge, 1994) p.220. Peterson says that 'the rise of the expert required social acceptance not of the fact of expertise…but of the equation of expertise with authority.' *The Medical Profession in Mid-Victorian London* p.286.

control over their activities was a defining feature of the GPs' collective experience in the nineteenth and early twentieth centuries. Although subject to minimal external scrutiny, the threat posed to GPs' incomes and status by uncontrolled market forces led to the establishment of new intra-professional bodies designed to moderate and advise on professional etiquette and 'ethics'.[62] These bodies, as will be seen in chapter one, played an important part in the development of GPs' representative bodies in the early twentieth century.

Given that GPs were largely solitary, working, as will be shown, excessively long hours, competing vigorously with each other as well as with alternative practitioners, and therefore having limited time for social interaction, how then were they able to communicate with one another, in the interests of pursuing collective objectives? It is clear that GPs did sometimes meet one another in professional societies, including BMA branches, and mixed in similar social circles within their local communities.[63] But it was primarily professional journals like the *Lancet* and *BMJ, General Practitioner* and later, *Medical World,* which, by articulating commonly held beliefs, reinforced the GPs' sense of professional identity. They provided a rallying point for the numerous campaigns which GPs fought, whether for state registration and educational standards, or against 'unfair' competition and lay attempts to control their activities.[64] They also provided a means of advertising to other practitioners the times and locations of local and national meetings which those GPs who were able to could attend, to participate in the formation of collective policy, endorse professional champions, or form new representative organisations.

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[62] Parry and Parry *The Rise of the Medical Profession.* 'Professionalisation is…a strategy for controlling an occupation in which colleagues who are in a formal sense equal, set up a system of self-government.' p.83.

[63] In 1908 there were apparently 177 Medical societies in England. M. West, 'One Hundred Years of an Association of Physicians.' *Quarterly Journal of Medicine*, vol. 100, 3, 1 March 2007, pp.151- 183, paragraph ending with note 18.

[64] Under the editorship of Thomas Wakley, the *Lancet* in particular played a leading part in campaigns to persuade parliament and the public to support GPs in their battles with the medical oligarchy of the colleges. See E.S. Turner *Call the Doctor: a Social History of Medical Men* (London, 1958) pp.155-162.

When talking of group formation, Pierre Bourdieu says that groups often exist in a 'space of relationships' that is as real as geographical space.[65] GPs rarely interacted in geographical space before the events of 1911. Yet they shared a virtual social space in which they imbibed and shared similar ideas based on a similar educational background and common professional experiences which they exchanged through letters to journals and occasional interactions in local medical societies. Digby talks about this in terms of a kind of cultural 'diffusion' or 'replication' 'working vertically, through medical education, and horizontally, through professional imitation.'[66] Their *habitus* was increased by endogamous marriage and shared lifestyles which served to create a 'homogeneity of kind'.[67] One thing all GPs shared was the overarching necessity to make a living from their professional activities. But did competition for patients support or undermine attempts to establish professional unity?

The overcrowded profession

In the second half of the nineteenth century GPs' patients came from a broad socioeconomic spectrum, ranging from domestic servants and labourers to the minor gentry and professional people. It was principally for middle-class families, however, that GPs were able to provide the full range of services and continuity of care associated with the idea of the family doctor.[68] The family doctor combined a clinical and pastoral role and success was less dependent on medical science than on an ability to understand and respond to the social as well as medical needs of a diverse range of patients on a personal level.[69] In stark contrast to the specialist's detached 'clinical gaze', GPs as family doctors practiced what Gordon Horrobin describes as

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[65] Pierre Bourdieu, 'The Social Space and the Genesis of Groups,' *Theory and Society*, 14. (6) (1985) pp.723-744 at 725.
[66] Digby, *The Evolution of General Practice* p.11.
[67] Parry and Parry, *The Rise of the Medical Profession* p.77.
[68] For a full description of the origins of this concept see Irvine Loudon 'The Concept of the Family Doctor' *Bulletin of the Society for the Social History of Medicine* 58 (1984) pp. 347-359.
[69] Loudon, *Medical Care and the General Practitioner* p.277.

Figure 2. *The family doctor idealised*: 'The Doctor' by Sir Samuel Luke Fildes RA. The Tate Gallery, London.

'biographical medicine', relying more on the patient's narrative than on the latest diagnostic aids.[70] The caring family doctor eventually became 'a fictional stereotype'.[71] It was given visual expression in Luke Fildes' reverential portrait 'The Doctor' (see Figure 2) which proved immensely popular when it appeared at the Royal Academy exhibition in 1891 and was subsequently reproduced in thousands of lithographic copies. [72]

However, as Anne Digby has shown, efforts to improve the status of British GPs were undermined in the later decades of the nineteenth century by an explosion in the number of new entrants to the medical profession, which increased by 62.7% between 1881 and 1911.[73]

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[70] Gordon Horrobin, 'Professional Mystery: the Maintenance of Charisma in General Medical Practice' in Robert Dingwall and Phillip Lewis, *The Sociology of the Professions: Doctors, Lawyers and Others* (London, 1983) p.100.

[71] Loudon, *Medical Care and The General Practitioner* p.275

[72] One doctor was quoted as saying to a group of medical students: 'A library of books written in your honour would not do what this picture has done and will do for the medical profession.' He went on to exhort his audience to 'hold before you the ideal figure of Luke Fildes' picture and be at once gentlemen and gentle doctors.' Peterson, *The Medical Profession in Mid-Victorian London* p.131.

[73] Digby *The Evolution of General Practice* p.30.

The picture was similar elsewhere in Europe and the U.S.[74] This contrived to stem the rise in average GP incomes and resulted in the creation of what Digby describes as an 'emerging professional proletariat' who were forced to appeal to the lower end of the market for medical services.[75] According to Digby these so called 'sixpenny doctors' adopted 'an economically rational strategy', maximising numbers by a faster throughput and lower fees and offering only the simplest and most inexpensive remedies to their poorer patients. The GPs' plight was made worse by vigorous competition from unqualified practitioners including bonesetters, herbalists, faith healers and others in what Digby describes as 'a diffuse, fluid and heterogenous medical pluralism'.[76] At the same time in London and the major metropolitan areas many people, including the lower middle classes, preferred to make use when needed of the outpatient departments of the local charitable hospitals or free dispensaries. *Burdett's Hospitals and Charities* estimated that one in four of the population of London obtained free medical relief in this way in 1877, one in 2.5 in 1894 and one in 2.1 in 1904.[77] The increase in competition for patients, practices and medical officer appointments during this period led to a corresponding reduction in income for a sizeable proportion of the profession.

The remaining alternative to paying the doctor directly for treatment was the provident prepayment scheme whereby contributors obtained medical treatment via friendly society, trade union-sponsored or medical practitioner-managed 'sick clubs' (collectively referred to as 'contract practice'). Estimates vary as to how many members the friendly societies had but the most recent and authoritative calculation suggests that there were 3,318,000 members in 1889-1891 rising to 7,884,000 in 1905.[78] All but a small proportion of these were adult males. Many

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[74] *Ibid.* In Germany the number of doctors doubled between 1885 and 1905 - see Ioan G Gibson, *Medical Benefit in Germany and Denmark* (London, 1912) p.231. In the U.S. it increased by 153% between 1870 and 1910 - see Paul Starr, *The Social Transformation of American Medicine* (New York, 1982) p.112.

[75] Digby, *The Evolution of General Practice* p.32.

[76] *Ibid* p.34

[77] Green, *Working-Class Patients and the Medical Establishment*, p.91.

[78] Bernard Harris 'Social Policy by Other Means?' p. 222 (table 3).

GPs consequently ran their own sick clubs for women and children.[79] In Gateshead the Doctors' family clubs subscription was 3d a week and according to local GP Alfred Cox was 'the only way poor people could pay for medical attendance.'[80] Midwifery remained an economic mainstay for GPs and according to another GP, H.W. Pooler, 'No practice could be built up or maintained without it.'[81] Price competition in all these areas inevitably led to a lowering of standards as the 'sixpenny doctors' undercut established doctors in competing both for friendly society and similar contracts and the services of the fee-paying poor. This served to reignite GPs' feelings of insecurity and, as will be seen in chapter one, stimulated a desire to take collective action to combat these 'abuses'.

Given the wide variety of competitors and alternatives to private medical practice, it is not surprising that before the advent of the National Health Insurance Act in 1911 one fifth of GPs were struggling to achieve a viable income.[82] The editor of *The Spectator* writing in December 1911 said 'The profession of medicine in this country is unfortunately one which, as a whole, is distinctly ill paid. Of the general condition of the profession it is scarcely too much to say that it is hard and precarious.'[83] Even critics of the profession agreed that this situation was not in the public interest. George Bernard Shaw commented that the ills of the medical profession arose from 'the doctor's position as a competitive private tradesman, that is out of poverty and dependence' and concluded that 'There is nothing more dangerous than a poor doctor.'[84] In the final decades of the nineteenth century it became clear to many GPs that they were faced with an existential dilemma: to protect their individual livelihoods, preserve their autonomy as

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[79] See Sidney and Beatrice Webb, *The State and the Doctor* (London, 1910) p.138.
[80] Cox, *Among the Doctors*, p.56.
[81] H.W. Pooler, *My Life in General Practice* (London,1948) p.50.
[82] Digby, *The Evolution of General Practice* p.40.
[83] *The Spectator*, 2 December 1911, Editorial. This precariousness is evidenced by the establishment of a number of Medical Benevolent Societies aimed at the financial relief of doctors and their families who had fallen on hard times. H.N. Hardy notes in 1900 that 'the London societies' received 450-500 requests for relief each year and thus could not satisfy every request 'even for doles of £5 or £10 a year.' H.N. Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* (Dublin, 1901), p.25.
[84] George Bernard Shaw, Preface to *The Doctor's Dilemma* (London, 1906) Penguin Edition 1946, p.86.

actors within their field, and defend their hard-won position in a pluralistic medical market, they would have to set aside temporarily their naturally competitive instincts and bind themselves together as a professional group in corporate self-defence. The process by which they came to this conclusion and the organizations which were created or evolved to help GPs fulfil that objective, are described in chapter one of this thesis.

Chapter one also explains how the growth of provident sickness insurance schemes at the turn of the twentieth century fuelled GPs' fears of economic dependency, and a class-inspired conflict with the advocates of a system they disparaged as an organised and collective assault on their interests. This resulted in the creation of a plethora of representative organisations adopting trade-union tactics which many doctors found incompatible with idealised notions of selflessness and public service. Chapter two describes the origins of National Health Insurance and the events surrounding its legislative enactment which brought the profession into conflict with the Liberal government. It analyses the reasons for and progress of that dispute and its consequences, including the government concessions which granted the GPs a share of administration of the scheme. The exercise of this delegated responsibility, via the medium of the Local Medical and Panel Committees, is described, and its significance evaluated, in chapter three. As chapter four makes clear, the GPs' acclimatisation to NHI had barely begun when the First World War altered the demographic of the insured population, leading to demands for increased remuneration in recognition of the GPs' increased workload and responsibility. This was accompanied by a demand for more effective political representation. Chapter five describes the opportunity which the creation of the Ministry of Health provided for the GPs' leaders to exercise bargained corporatism, the failure of which led to the mobilisation of the profession in a high-stakes showdown with the government over remuneration and the renewed threat of approved society influence. Chapter six describes the

efforts of the profession's leaders to work constructively with government to improve NHI and the GPs' experience of it in the 1920s and 30s, and how these efforts were undermined by the worsening economic situation of the country, a hostile press and by ministerial chicanery. The final chapter examines the profession's attitude towards the wholesale reform of NHI and its replacement by a comprehensive National Health Service. It shows how far the GPs' political consciousness had evolved in the interwar period, demonstrating that while GPs' concerns about the role of the state in provision of healthcare had diminished, their ideological commitment to self-determination remained as strong as ever. This commitment was, moreover, calculated to bring them into conflict with government at any moment the state appeared to threaten GPs' autonomy.

Chapter One. Political associations and the quest for professional solidarity.

On 3 May 1900 Dr Edward Jepson, the honorary Secretary of the Durham Medical Union, introduced a debate on 'medical organisation' at a national conference convened by the Manchester Medical Guild with the following words:

> In the year of grace 1900, we find the medical profession without any proper organisation
>
> for ethical or political purposes. It may be likened to a homogeneous mass, having similar
>
> elements, but each element or atom pursues his own way, having no care for the wants of
>
> others. This mass of medical intelligence, built up of atoms, has no solidity, no strength
>
> and no life which can assert itself in matters ethical or political.[1]

The focus of this chapter is on GPs' growing awareness, at the turn of the twentieth century, of the need to act collectively to realise their professional goals, and the development of professional representative structures by which to achieve them. It will thereby explain what Dr Jepson's audience understood him to mean by 'ethical and political purposes' and consider the accuracy of his comments about competitive individualism serving to frustrate the need for solidarity and collective organization.

There is a notable gap in historiography regarding the antecedents to the professional representative structures formed in response to the National Insurance Act. Anne Digby has written extensively about National Health Insurance (NHI) but her otherwise comprehensive analysis of the evolution of general practice from 1850 to 1948 says almost nothing about GPs' political activities prior to 1911.[2] Other than the aforementioned Green and Morrice, references

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[1] *Manchester University Medical Collections,* MMC/7/4/3/4/ Report of Conference on Medical Organisation 1900, p 51.

[2] Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford,1999). This is surprising given the intended congruence between her book and Irvine Loudon's work on GPs up to 1850 (see the Preface to Irvine Loudon, John Horder and Charles Webster (eds), *General Practice Under the NHS 1948-1997* (Oxford,1998) and the fact that Loudon ends his book with a chapter looking specifically at the various GP associations which arose during the first half of the nineteenth century. Irvine Loudon, *Medicine and the General Practitioner 1750-1850* (London, 1986) pp. 280-299.

to the organisations formed to represent GPs' interests in the late nineteenth century are confined to brief comments in the official and unofficial histories of the British Medical Association (BMA).[3]

When the BMA was established in 1832, its objects were 'friendly and scientific.'[4] By the mid-nineteenth century it had established a national reputation as a lobby group promoting the profession's claim to scientific authority in its successful campaigns for public health legislation. It had never seen or portrayed itself as a trade union, however, given its leaders' desire to exalt the profession's noble calling and deprecate any connection between medicine and trade. A myriad of independent local associations therefore emerged to defend the GPs' collective interests, employing tactics which bore a close similarity to those of trade unions but which, as will be explained later in this chapter, those bodies preferred to see as a means of enforcing medical 'ethics'. These bodies enjoyed occasional, but not always effective, support from the BMA until, after 1900, root and branch reforms rendered the Association more willing and able to assume this responsibility. [5] In the first part of this chapter I explain why the growth in membership of the friendly societies and hospital dispensaries posed such a threat to the GPs' collective desire for economic security, improved social status and professional autonomy, detailing efforts made by local GP groups to counter that threat using trade union-like tactics. I then explain how the GPs' concerns became focussed on Medical Aid Institutes and how the refusal of the General Medical Council (GMC) to support their objections to these bodies' actions encouraged a more militant response for which the GPs looked in vain for

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[3] David B. Green, *Working-Class Patients and the Medical Establishment* (Aldershot, 1985) and 'Medical Care in Britain before the Welfare State' *Critical Review* (1993*) 7:4.* Andrew Morrice. 'The Edwardian BMA and Contract Practice.' in Martin Gorsky and Sally Sheard (Eds) *Financing Medicine: The British Experience Since 1750* (Abingdon, 2006). Ernest Muirhead Little, *History of the British Medical Association 1832-1932*, (London, c. 1932); Paul Vaughan, *Doctors' Commons: A Short History of the British Medical Association* (London, 1959); Paul Bartrip, *Themselves Writ Large: The British Medical Association, 1832-1966* (London, 1996).

[4] Little, *History of the British Medical Association 1832-1932*, p.19. It was founded in Worcester in 1832 as the Provincial Medical and Surgical Association and changed its name to the British Medical Association in 1856.

[5] *Ibid,* p167.

national coordination. Finally, I explain how fear of competition from rival organisations led the BMA to reform itself in order to provide that coordination, and to develop a model for professionally-run provident schemes to rival those to which the GPs so objected. It was against that backdrop that free choice of doctor and resistance to lay control over standards of competence and behaviour rose to prominence. As will be shown later in this chapter and in subsequent chapters, these issues became a continuing political animus for GP representative bodies, both locally and nationally.

The need for representation: local 'combinations', and the 'battle of the clubs'.[6]

During the forty years following the passing of the Medical Act in 1858 a number of political representative organisations were established locally and nationally by GPs seeking relief from various 'abuses' which they saw as threatening their vital interests.[7] These can be summarised as: firstly, the abuse of contract or 'club' practice by friendly societies, which in later decades included the activities of Medical Aid Associations and Institutes; secondly, the abuse of the voluntary hospitals through outpatient clinics and provident dispensaries. As explained in the introduction, 'contract practice' was the generic term used to describe the various schemes by which GPs were contracted to provide medical care for individuals, usually working-class men and, less commonly, women, who paid for that care via regular contributions into a sickness

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[6] Morrice's use of the word 'combinations' is borrowed from the book by Samuel Squire Sprigge, (later editor of the *Lancet*) *Medicine and the Public* (London, 1905) p.234. The use of the phrase 'The battle of the clubs' to denote the conflict between the medical profession and the friendly societies in the 1890s owes its origin to the series of articles which appeared under that title in the *Lancet* from 1894 which were written by their 'special correspondent' Adolphe Smith (described later on in this chapter).

[7] Irvine Loudon and M. Jeanne Peterson have each described the attempts by GPs during the early nineteenth century to establish organizations representing their interests alone. Loudon, *Medicine and the General Practitioner 1750-1850* pp. 280-299. M Jeanne Peterson, *The Medical Profession in Mid-Victorian London* (London, 1978) pp. 135, 287. The object of these bodies was to reform the system of education and reduce the restrictive powers of the existing medical corporations by winning parliamentary backing for a separate college of GPs. This idea came tantalisingly close to reality in 1848 but thereafter subsided amid a welter of parliamentary bills aimed at creating a unitary system of registration for qualified medical practitioners. 'Information as to the fate of these bodies is limited, though it is probable that they gradually died of inanition and the indifference of their members.' Little, *History of the British Medical Association 1832-1932*, p. 36.

insurance scheme or 'club'. These were run by friendly societies, trade unions, commercial insurance companies or by the doctors themselves. The most common variety were those run by friendly societies. Some of these were small, local societies comprising a few hundred members or less, while others, like the Hearts of Oak, the Oddfellows or the Foresters, were large and influential national bodies comprising thousands of members organised through a federated network of local branches or 'lodges'.

Doctors were not commonly employed by friendly societies before the 1840s.[8] The societies were at that time chiefly concerned to offer benefits during sickness rather than curative treatment.[9] The role of the GP medical attendant with whom the societies contracted was generally concerned with confirming if sickness and 'lying in' claims were genuine and, after 1858, providing death certificates as a necessary precondition for payment of burial costs.[10] Gradually, however, the friendly societies began to offer treatment from the GPs they had contracted with, recognizing that, if successful, it would offset the cost of sickness benefit.[11] The 'club' doctors were therefore required to attend on and provide medicine to members for an annual fee per member based on the number of members. This was, usually, between 2s to 5s per patient annum, out of which the doctor was expected to provide and pay for medicines needed by the patient.[12] For GPs competing with each other for patients in an overcrowded medical market, clubs offered a guaranteed steady income and the opportunity which being the club doctor offered to introduce themselves to future custom from the wives

[8] Martin Gorsky. 'Friendly Society Health Insurance in Nineteenth Century England' in Martin Gorsky and Sally Sheard (eds) *Financing Medicine: the British Experience since 1750* (Abingdon, 2006) ch.9 pp.150-152.
[9] Bernard Harris, 'Social Policy by Other Means? Mutual Aid and the Origins of the Welfare State in Britain during the Nineteenth and Twentieth Centuries.' *Journal of Policy History*, (2018) 30 (2) p.205.
[10] Gorsky 'Friendly Society Health Insurance in Nineteenth Century England.' p.154.
[11] Medicalisation of friendly society sickness benefits arose for actuarial reasons, that is, properly assessing risk and 'moral hazard' (ie false claims) as the societies became larger and more impersonal. Gorsky, 'Friendly Society Health Insurance in Nineteenth Century England.' p 156.
[12] This is attested by numerous contemporary authorities and confirmed in the BMA Contract Practice Report 'An Investigation into the Economic Conditions of Contract Medical Practice in the United Kingdom', *BMJ,* 22 July 1905, Supplement, pp.1- 96.

and families of club members. The *Lancet* opined that 'in towns the wives of club members are often fruitful vines.'[13]

An appointment as a club or lodge doctor, or surgeon as they were sometimes termed, offered the prospect of a steady if modest income and spared the GP the inconvenience of collecting fees from patients and the risk of bad debts.[14] The principal benefit of club medicine, however, was that it extended working-class acceptance of qualified practitioners rather than quacks, and entrenched scientific medicine within the fields of life and sickness insurance.[15] For David B. Green the friendly societies were the epitome of working-class thrift and self-reliance, and doctors' complaints about them were founded in self-interest and class prejudice.[16] He maintains that fees paid to doctors were entirely down to what the members or subscribers could afford to pay and regards efforts by doctors to join together to demand higher fees as protectionist and anti-consumer.[17] However, more recent studies have shown that fees for doctors rose broadly in line with general wage levels and when those fees were increased society members seldom raised any objections.[18]

The quality of medical care provided to members of friendly societies was often felt to be below the standard offered to fee-paying clients and was widely disparaged. Sidney and Beatrice Webb quoted a 'respectable medical witness' who asserted that 'club practice is most distasteful. No practitioner remains a club doctor any longer than he can possible help.'[19] The *British Medical Journal (BMJ)* confirmed the view that club practice was no more than a stepping stone to something better when its editorial opined in 1895 that 'no one surely will

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[13] *Lancet,* 22 January 1870 p.126,

[14] For an illustration of the problem of bad debts see the *Lancet*, 18 February 1871 p.239.

[15] Gorsky, 'Friendly Society Health Insurance in Nineteenth Century England.' p.155.

[16] Green, *Working-Class Patients and the Medical Establishment*, pp. 117-118.

[17] *Ibid* p.75 and p.28.

[18] J.C. Riley, *Sick not Dead: the Health of British Working Men During the Mortality Decline* (London,1997) p.49.

[19] Sidney and Beatrice Webb, *The State and the Doctor* (London, 1910) pp.140-141.

suggest that the position of dispensing or club doctor is sufficiently attractive as an ultimate goal to make men study medicine as a science.'[20] Against the friendly societies' complaints that their members sometimes received cursory treatment from club doctors, the GPs responded that the large number of patients and the niggardly remuneration offered prevented them from giving their best to the patient in each case. [21] The principal grievances of the profession at that time were less about the fees paid for medical attendance, however, than about the societies' refusal to apply an income limit to membership. This meant that prosperous artisans and others whose income had increased to the level at which the doctors felt they could afford to pay privately for treatment, obtained medical services 'on the cheap'. If unchecked, this kind of behaviour, the doctors felt, would undermine their ability to maintain a gentlemanly income from private practice.[22] Ernest Little, historian of the BMA, notes that the medical profession had always adjusted its fees to the financial status of its patients, but 'the societies professed themselves unable to see why the same advice and medicine given to a rich man should cost more than when given to a poor one.'[23]

Green dismisses such complaints as a disguised hostility to competition.[24] He says the societies did not wish to exclude loyal and active members who had contributed to their social activities just because their circumstances had improved, especially as their more well-to-do status added to the societies' prestige.[25] An example of this can be found in Francis Brett Young's novel, *My Brother Jonathan*, where a local factory owner, Morse, having begun life as a labourer, maintains his lodge membership and continues to use the services of the club

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[20] *BMJ*, 23 March 1895, pp.657-658.
[21] Green, *Working-Class Patients and the Medical Establishment* p.16.
[22] *Lancet* 11 October 1851'Vigilans' p.359. Loudon, *Medicine and the General Practitioner 1750-1850.* p. 258; Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine.* (New Haven, 1966) p. 215.
[23] Little, *History of the British Medical Association 1832-1932.* p.200.
[24] Green *Working-Class Patients and the Medical Establishment.* p.28.
[25] *Ibid* p.21. See also E.S. Turner, *Call the Doctor: A Social History of Medical Men.* (London, 1958) p.50; Bartrip, *Themselves Writ Large.* p.136; and Sidney and Beatrice Webb, *The State and the Doctor*, footnote to p. 231.

doctor long after his social circumstances have improved.[26] The author notes that the hero's partner, Dr Hammond, had served the clubs of the working men of the town faithfully and had been made an honorary member of some them.[27] H.W. Pooler confirms that GPs were often expected to become honorary members of the friendly societies they worked for and pay an annual subscription. He does not appear to have found this a great imposition and wryly notes that he was 'two or three sorts of Oddfellow, the same number of Foresters, a Druid, a Loyal Caledonian Cork, a Royal Antediluvian Buffalo and…a Rechabite.'[28] Harry Roberts was likewise bemused rather than irritated by his induction into the ancient order of Buffaloes with its 'ceremonial knocks; passwords; grips; regalia; drawn swords' and by having to pay court to its chief officer, who was the local dustman! [29] However, many GPs resented being forced to become members of the societies they were contracted to and the requirements of membership, such as being obliged to march in their annual parades (like the one shown in Figure 3). In 1900 a Surrey Doctor informed the *Lancet* that he had been dismissed as medical officer of a small friendly society for challenging the 'customary' deduction of a membership fee from his remuneration.[30]

Many commentators have highlighted the fact that GPs strongly disliked lay control of their activities. Class considerations clearly played a part in this. A *BMJ* article in 1875, stated that a committee 'being wholly composed of working men, is not a pleasant master for an educated man to serve under.'[31] For many doctors, however, the tyranny of club practice was compounded by the behaviour of club members. 'A surgeon' writing in the *BMJ* in 1896

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[26] Francis Brett Young, *My Brother Jonathan*. (London, 1928) pp. 219 and 272-273.
[27] *Ibid,* p.219.
[28] H.W. Pooler, *My Life in General Practice.* (London, 1948) p.484.
[29] Winifred Stamp, *Doctor Himself: An Unorthodox Biography of Harry Roberts MD* (London, 1949) pp. 74-75.
[30] *Lancet*, 3 March 1900, Dr C. Scott-Watson, p.654.
[31] *BMJ* 10 April 1875, p. 484.

Figure 3. *'A hundred boorish taskmasters'*. (Unnamed) Friendly Society procession 1913. Club or lodge medical officers were expected to be members and participate in such processions. Photograph the Historical Association.

opined that 'no patient is as exacting as a club patient'.[32] Another wrote of club practice in 1900, that the doctor's duty 'to the patient was apt to be forgotten in his indignation at being sweated by a hundred boorish taskmasters.'[33] Some GPs were 'perpetually at odds with their flock, who knew only too well that the doctor regarded them as an inferior class of patient.'[34] An attitude which irked the GPs greatly, and which continued under National Health Insurance (NHI), was the idea that they had a 'right' to send for the doctor even for trivial matters because 'they had paid for his services already.'[35] Members of colliery clubs were notorious for expressing this feeling. The GP James Mullin illustrates this in his memoirs:

[32] *Ibid,* 22 February 1896 pp. 489-490.
[33] *BMJ* 32 March 1900, 'Scapula' p.816.
[34] Turner, *Call the Doctor* p.250.
[35] *Ibid*

> If only the little finger of a collier ached or a thimbleful of recalcitrant wind lost its way in
>
> the corridors of his colon, it was "Off to the Doctor immediately; why shouldn't he come
>
> and cure me at once? Are we not his master, do we not keep the roof over him, the clothes
>
> on his back, feed his family and provide him with a horse when he ought to tramp around
>
> like the rest of us?[36]

Disdain was often not one-sided in this relationship. An early commentary on NHI noted that the hoped-for custom of the club members' families could not be relied on 'owing to the prevalent idea that the club doctor is an inferior sort of practitioner, and if attendance on the family is required for which an ordinary fee is to be paid 'a proper doctor' as they say, is often called in.'[37]

The low estimation of club doctors' services is testified by the comment by 'a surgeon' in the *BMJ* in 1896 that 'Working people judge that things that are cheap are invariably nasty.'[38] Another of the GPs' complaints about club practice concerned the issue of certification for sickness benefit purposes. In a dispute in Birmingham in 1867 the doctors complained that this often brought them into conflict with both members and club committees.[39] They were criticised if they were too willing to accept the members' word and issued too many certificates, as this served to diminish the society's funds, but were likely to incur the hostility of influential committee members to whom they failed to issue certificates when requested.[40] Alfred Cox, the future BMA medical secretary, was dismissed from one of his clubs for declining to issue a certificate to the secretary's brother in law.[41] However, doctors sometimes colluded in

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[36] James Mullin, *The Story of a Toiler's Life.* (Dublin, 1921) UCD edn (2000) p.152.
[37] A.S. Comyns Carr, W.H. Stuart-Garnett, and J.H. Taylor, *National Insurance* (London, 1912) p.56. 'As an exercise in snobbery', friendly society members often called an outside doctor to attend their families on the grounds that 'the club doctor was not good enough.' Turner, *Call the Doctor*, p.251.
[38] *BMJ* 22 February 1896. pp. 489-490.
[39] Green, *Working-Class Patients and the Medical Establishment* p.18.
[40] *Ibid*
[41] Douglass W. Orr and Jean Walker Orr, *Health Insurance with Medical Care: the British Experience* (New York, 1938) p. 168. Cox had had no complaints about his service but after offending the secretary's brother in law 'by refusing to certify him for a slight ailment' he was dismissed when a vote to change doctor was taken by a meeting attended by only 30 out of 300 hundred members .

certifying as sick elderly claimants for whom the boundaries between 'sickness', 'unemployment' and 'old age' were increasingly blurred.[42] Another contemporary noted that many men awaiting the outcome of applications under the workmen's compensation act were advised by their lawyers to remain off sick and claim money from clubs on legal and not medical grounds.[43]

Relationships between friendly societies and the doctors with whom they contracted did not seriously deteriorate until the last few decades of the nineteenth century.[44] However, professional objections to friendly society medical clubs began as early as 1837, in Cricklade and Wooton Bassett, and the first boycott by an 'organised medical profession' over what were perceived to be inadequate terms and conditions occurred in Sunderland in 1844.[45] The earliest attempt to sign pledges not to work for a friendly society club occurred in the same year in Pickering in North Yorkshire.[46] The most concerted attempt at 'combination' however, took place in Birmingham in the late 1860s when, with the encouragement of the *BMJ* and support of the *Birmingham Daily Gazette*, doctors sought improvements in workload and fees, and enforcement of an income limit on subscribers. It culminated in 1868 in the signing of a pledge of solidarity by 168 doctors but was only partially successful in obtaining concessions desired.[47]

The continued failure of attempts by GPs to band together to resist unsatisfactory terms was invariably due to undercutting by fellow doctors. This was an inevitable result of the overcrowding of the medical market observed by Digby and its consequential lack of opportunities for advancement for many young doctors.[48] There is ample evidence of the extent

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[42] John MacNicol, *The Politics of Retirement in Britain 1878-1948* (Cambridge, 1998) pp.129-131.
[43] Herbert De Carle Woodcock, *The Doctor and the People* (London, 1912) p.84.
[44] Green, *Working-Class Patients and the Medical Establishment* p.20.
[45] *Ibid,* p.15 .
[46] *Ibid*
[47] *BMJ* 8 Feb 1868. p128.
[48] Digby, *The Evolution of British General Practice*, pp. 96-97.

of competition for club medical doctor appointments. At Worcester in 1871 there were 30 candidates for post paying £170 a year (with a house) and in 1905 the Lincoln Oddfellows had 22 applications for an annual salary of £240.[49] As Green cheerfully acknowledges, attempts by doctors to organise boycotts failed because there was always some doctor desperate enough, or unprincipled enough, to ignore the local profession's call for solidarity.[50] 'A Poor Club Doctor' writing to the *BMJ* in 1867 described the difficulties of persuading colleagues to support an unofficial boycott of a club that had unjustly injured his reputation. Even when his colleagues supported him, outsiders were brought in and when eventually the club offered to meet his terms if he would resume the role a local man still undercut him. [51] Ernest Little concluded that 'The strength of the position of the societies lay in the lack of union among medical men.'[52]

In Francis Brett-Young's novel, *Dr Bradley Remembers,* 'Scottish invaders' threaten Dr Bradley's friendly society contract work by offering to undercut his fees.[53] Echoing the commonly held view of Scottish doctors as interloping 'sixpenny men', Dennison, the hero of Frank Layton's novel, *The Old Doctor*, explains to Dix, a naïve newcomer, that his best club pays him 3s 6d per member but 'McFadd has been at them. Says he'll take them on at three shillings. Naturally they want me to do the same.'[54] Dennison bemoans the insecurity of club work stating that a 'lodge surgeon is liable to be kicked out of his job at the end of any year – because he is too strict in the matter of beer; because he refuses sick notes when he considers them uncalled for; because someone else – say McFadd – will do the work for less.'[55] Alfred Cox observed that club practice in those days was 'a sort of guerrilla warfare between the

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[49] Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England 1750-1950* (London, 2001). p.78.
[50] Green, *Working-Class Patients and the Medical Establishment*, p.16.
[51] *BMJ* 17 August 1867, 'A Poor Club Doctor' pp. 139-140.
[52] Little, *History of the British Medical Association 1832-1932.* p. 200.
[53] Francis Brett Young, *Dr Bradley Remembers.* (London, 1938) p. 547.
[54] Frank G. Layton, *The Old Doctor.* (Birmingham, 1923) p.10.
[55] *Ibid,* p. 17. On the temperance question Green says some doctors saw it as part of their 'humanising mission' to discourage the societies from holding their meetings in public houses. Green, *Working-Class Patients and the Medical Establishment* p.15.

doctors and the promoters of the clubs. The latter very often played off one doctor against the others and appointed the man who accepted the lowest terms.'[56] Controversially perhaps, he states that 'It was no secret that many of these appointments were obtained by bribery and corruption.'[57]

One means of preventing undercutting was for the profession to establish an agreed tariff of fees. The most widely quoted tariff was that created by the Manchester Medical Ethical Society in 1865 which enjoyed wide currency among GPs and was revised and re-circulated several times over the next forty years.[58] It became a point of reference in disputes with friendly societies and Poor Law unions about the market rate for GP services.[59] The 1879 version reflected the commonly held practice of setting fees according to the client's ability to play and was 'fixed at such a rate that even the humblest member of the profession need not hesitate to make it the basis of his charges.'[60] The tariff used house rentals to determine ability to pay and based the fee on the value of the practitioner's time and skill.[61] It may seem strange that something calling itself an ethical committee should be concerned with setting a tariff of fees. In the twentieth century medical ethics came to be understood as principally about doctors' behaviour towards patients and their best interests. In the eighteenth and nineteenth centuries, however, ethics was indistinguishable, in the minds of many doctors, from professional etiquette.[62]

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[56] Alfred Cox, *Among the Doctors* (London, c.1949) p.30.

[57] *Ibid,* p.57. 'If their office holders were offered bribes the societies were fortified in their arrogance as dispensers of patronage.' Turner, *Call the Doctor*, p.251.

[58] Established in 1847, its original objects were 'to maintain the honour, and interests of the profession and to promote good fellowship among its members.' *Manchester University Medical Collections* MMC 7/2/8.

[59] Comyns Carr, *National Insurance* p.75. Noel Parry and Jose Parry, *The Rise of the Medical* Profession *: A Study of Collective Social Mobility* (London, 1976) pp. 149-150.

[60] Parry & Parry, *The Rise of the Medical Profession*. p.149.

[61] *Ibid,* p.150.

[62] The first modern code of ethics in Britain was devised by Thomas Percival in 1794 to prevent his 'quarrelsome colleagues' at the Manchester Royal Infirmary falling out with each other. Subsequent generations felt his use of the word ethics was a misnomer because what he was describing was not ethics but etiquette. *BMJ* 29 August 1936, T.A. Goodfellow, 'Medical Ethics' Supplement. p.146.

In the absence of any agreed codes of behaviour, the fees tariff was simply one means by which to identify those inclined to depart from behavioural norms.[63] An interesting comment on this can be found in Conan Doyle's semi-autobiographical novel, *The Stark Munro letters.* Munro's partner Cullingworth dismisses his plea for fraternal solidarity commenting 'My methods are unprofessional and I break every law of medical etiquette.' When asked to explain his reasoning he responds that, as a doctor's son, he understands the workings of the medical 'machine' and concludes 'All this etiquette is a dodge for keeping the business in the hands of the older men. It's to hold the young men back.'[64]

Discussions about medical ethics also focused on the behaviour of consultants as, from the 1870s onwards, the increasing prestige of hospitals made their outpatient departments a popular alternative to GPs for middle-class city dwellers, and hospitals capitalised on this popularity by setting up provident dispensaries.[65] The dispensaries delivered care when needed to middle-class or prosperous working-class patients in the major cities who were willing to pay a regular subscription and were thus a viable alternative to friendly society clubs. They were praised as a commendable form of self-help which 'maintained the dignity and independence of the subscriber, removing the stigma of charity and pauperism'.[66] Outpatient attendances at the London Hospital in Whitechapel rose from 7,000 a year in 1840 to 52,000 a year in 1870 and 200,000 by 1900 and a similar pattern appears to have occurred in most of voluntary hospitals in London and the provinces.[67] By providing free care to poor patients who might otherwise be members of GPs' own family clubs, or cheaply to those capable of meeting GPs' reasonable fees, these departments were denying income to GPs struggling to make a

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[63] For 'Courts of honour' see Squire Sprigge, *Medicine and the Public* (London, 1905*)*, p.234, also mentioned by H.N. Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* (Dublin, 1901) p.72.
[64] Arthur Conan Doyle, *The Stark Munro Letters.* (London, 1895) ch.V11 The Parade, Bradfield, 9 March 1882.
[65] For a detailed account see Keir Waddington, 'Unsuitable Patients: The Debate over Outpatient Admissions, the Medical Profession, and the late Victorian London Hospitals', *Medical History*, 42 (1998) pp.26-46.
[66] Loudon, *Medical Care and The General Practitioner,* p.252.
[67] *Ibid*, p.222.

living in an overcrowded market and were thus described by the editor of the *Lancet* as 'ruinously unfair'.[68] The GPs were not alone in viewing these developments with alarm. The Charity Organisation Society voiced concern that free care encouraged pauperism and that hospitals wasted charitable resources by treating a mix of patients who could afford to pay for their care.[69] The outpatient departments, run by consultants who extolled the merits of their specialist knowledge above that of the humble GP, gradually became extensions of specialist inpatient units rather than general clinics.[70] In 1872 the *BMJ* identified this factor as the main cause of the stagnation in GPs' income, commenting that: 'the indifference and traditions of successful and eminent practitioners at the head of consulting practice are among the chief causes which combine to stereotype, and therefore relatively to depreciate, the remuneration of practitioners in general.'[71]

Contemporary commentator H.N. Hardy noted that in South London discerning patients would send for the GP or go to them for medicine in bad weather but 'in fine weather they all flock to the hospitals.'[72] He added that London hospitals charged as little as 1s for small operations when the GP charged 1s or even 1s 6d for a visit and medicine.[73] During the 1880s and 1890s GPs regularly wrote complaining letters to the *BMJ* and the *Lancet* about this 'hospital abuse'.[74] In 1883 Dr Robert Rentoul wrote in the *BMJ* that 110 doctors had signed resolutions condemning abuse of hospital outpatients.[75] One of the most egregious examples

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[68] Sprigge, *Medicine and the Public,* p.59.
[69] Waddington, 'Unsuitable Patients', p.28
[70] Stevens, *Medical Practice in Modern England,* p.32.
[71] *BMJ* 10 August 1872 p. 170. The comment was made by the eminent French medical journalist Dr Caffe in relation to the situation in France but was felt by the *Journal* to be equally true of Britain.
[72] Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* p.21.
[73] *Ibid.*
[74] See for example the letter from Dr W. Strange, *BMJ* 3 August 1889 p.286.
[75] Brian Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales* (London, 1964) p.162. Rentoul was the first doctor to advocate the establishment of a Public Medical Service run by doctors. *BMJ,* 9 November 1889, 'Hospital Dispensary and outpatient reform' pp.1067-69. His proposal attracted great interest but the 'Rentoul plan' was rejected by BMA branches after investigation by a specially convened BMA committee. *BMJ* 28 September 1889 pp.742-743.29 June 1889 p.1495 and 28 November 1889 p.1194.

of Provident Dispensary abuse, from the GPs' point of view, involved the Coventry Dispensary, to which by 1900 approximately half that city's population had become subscribers. The Doctors' objections to this featured in a long running correspondence with the BMA aired in the *BMJ* and local and national press. The establishment of a rival scheme run by the doctors themselves failed to diminish its appeal.[76]

By the last three decades of the nineteenth century the emergence of specialist hospitals, in London principally, increased GPs' insecurities about hospital-based competitors.[77] In an article in the *Fortnightly Review* in 1885 Morrell MacKenzie, a former GP who opened the country's first specialist Ear Nose and Throat hospital, wrote that 'the family Doctor…comes to look upon the specialist as a receiver of stolen goods if not the actual thief.'[78] Writing in the *BMJ* a year later Dr Rentoul announced that an organisation calling itself 'The Association of General Practitioners' was to be formed 'with the aim of forcing consultants to confine themselves to consulting practice.'[79] Other Associations were formed with similar intentions. One calling itself 'The General Practitioners' Union' gave evidence to the Parliamentary Select Committee on Metropolitan Hospitals during 1890-1893.[80] Another, 'The Incorporated Medical Practitioners' Association', wrote to the *BMJ* in 1896 complaining 'that it is undesirable for those holding honorary appointments to see patients for a fee at such charitable institutions.'[81] Judging by the reports referring to hospital abuse after this date it does not seem as if the efforts of any of these associations were particularly effective.[82] In other parts of the

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[76] *Lancet,* 4 July 1896, 'History of Coventry Public Medical Service', Letter from Dr Edward Phillips, pp. 56-57.
[77] Peterson, *The Medical Profession in Mid-Victorian London* p.258.
[78] *Ibid,* p.272.
[79] *BMJ* 12 June 1886 p.1114 and 18 December 1886 p.1190. This followed in the footsteps of the Hospital Outpatient Reform Association established by GPs in 1873. Waddington, 'Unsuitable Patients', p.38.
[80] Second report para. 25517 (quoted in Abel Smith, *The Hospitals*, p.166).
[81] *BMJ* 31 October 1896 p.1350.
[82] Keir Waddington says ,'they invariably proved stillborn.' 'Unsuitable Patients' p.38. He opines that after 1913 the National Insurance Act, by reducing admissions and making outpatient departments serve a more consultative role, 'achieved something hospital doctors and general practitioners had not been able to do.' p.46.

country local organisations considered a variety of strategies to tackle these and other abuses. In 1895 the newly formed Manchester Medical Guild published a report on 'Provident Medical Aid'. It stated that the provident principle was in itself 'commendable' but that the methods of carrying it out were such as 'to incur the just opprobrium of the medical profession' for whom they had become 'grinding tyrannies'.[83]

The guild's report is instructive in cataloguing the often overlapping professional grievances.[84] Sick club rates in Manchester at that time were usually 3s per patient per annum but were often as low as 2s 6d. Repeating the now familiar complaint, the report regrets that 'the club doctor does not usually become the family doctor as well', suggesting that many wives and children used the free dispensaries instead. Sick club medical officer posts were thus regarded as 'underpaid offices'. The report concludes that rates offered by friendly society clubs were generally too low and offered recommended fees for treatment, pre-admission medicals, and sick notes. Duties should be standardised, it suggested, and, repeating a familiar complaint, friendly societies 'should relieve the attendance upon those whose pecuniary status renders them improper recipients at the club rate.' [85] The report then details objections to the provident dispensaries established in Manchester and Salford in 1875 which, in addition to those already mentioned, included unethical touting for members by advertising and canvassing and destabilising other clubs such as those run by GPs themselves. The report concludes with a list conditions essential to professional recognition of provident schemes and dispensaries.[86] In other parts of the country, however, provident schemes were beginning to coalesce into something altogether more threatening from the doctors' point of view.

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[83] *Manchester University Medical Collections* MMC/7/4/3/1, 'Provident Medical Aid', Report by the Manchester Medical Guild 1895. p. 2.
[84] *Ibid,* pp. 3-4.
[85] *Ibi,d* p. 4.
[86] Although these recommendations were not immediately taken up locally or elsewhere, they formed the basis of a new Manchester fees tariff which subsequently influenced the funding of National Health Insurance (NHI) in Manchester and Salford and fees charged by GPs for non-NHI patients. Manchester and Salford were the only

Medical Aid Institutes, the GMC, and medical trade unionism

In the 1890s disputes between GPs and friendly societies began to be focussed on Medical Aid Institutes (MAIs). These were institutions formed by federations of friendly societies in a given locality which employed whole time salaried medical officers and ancillary staff to provide medical services for subscribers and, often, their dependents, from a central facility. This facility usually comprised consulting rooms and a dispensary and often rudimentary operating and diagnostic facilities. The Institutes were managed by joint lay committees.[87] At around the same time miners, steelworkers and railwaymen's Medical Aid Associations established similar institutions for themselves and their families. Green describes the creation of MAIs as 'a side effect of the agitation of the 1860s and 1870s'.[88] The first MAI, the Preston Associated Friendly Societies Provident Dispensary opened in January 1870 and was according to Green a response to the demands for better pay and conditions by local doctors through what the local friendly societies called the 'Preston medical trades union'.[89] However, the MAIs were not, he says, merely an attempt to frustrate the doctors but were a considered response to the failings of the lodge system. Firstly, they addressed the issue of doctors not giving their best to club members, because of the competing demands of other clubs and private patients, by employing GPs and ancillary staff on whole time contracts. Secondly, they overcame the increasing tendency of club doctors to prescribe rather than supply medicines, on the grounds that they were too expensive to be met from the members' capitation fees, by purchasing their drugs at wholesale prices and supplying them direct through their own dispensaries. Thirdly, they

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areas of the country which adopted fee-for-service rather than capitation as the basis for NHI panel remuneration (see below chapter 3). Norman Eder devotes a whole chapter of his book to this experiment which was discontinued in 1927. Norman Eder, *National Health Insurance and the Medical Profession in Britain 1913-1939* (New York, 1982) ch. VI.

[87] *BMJ*, Letter from Friendly Society Medical Officer, 7 December 1889 p.1209.

[88] Green, *Working-Class Patients and the Medical Establishment* p.21.

[89] *Ibid.* See also Simon Cordery, *British Friendly Societies 1750-1914* (Basingstoke, 2003) p.155.

overcame the problem of dependants falling outside benefits of society membership by providing for the whole family through a single subscription. [90] In the 1870s most MAIs typically charged 8s per year for the whole family compared with the usual 3s 6d or 4s for the single member. By 1877 MAIs had been founded in Bradford, Derby, Newport, Nottingham, Worcester and York.[91]

For many GPs the MAIs compounded the problems of club practice by further restricting free competition. Some doctors working in them complained of an intolerable workload, one example noted in the *Lancet* being a single GP responsible for over 3,000 patients, sometimes attending well over a hundred patients a day.[92] Posts in MAIs were nevertheless said to appeal to 'the humbler sort' of doctor who could not afford to buy or set up their own practices and would otherwise be condemned to the equally exacting servitude of an assistantship to another GP.[93] One institute medical officer wrote to the *Lancet* claiming that, contrary to what many colleagues were saying, 'I find it a very pleasant and comfortable berth. I am not at all overworked.' He added that the profession would never succeed in preventing doctors from working for MAIs whilst 'the scandal' of GP principals earning £1,000 p.a. but offering their assistants as little as £60-£70 p.a. continued.[94] In a letter to the *Lancet* in 1892 another GP also disputed the claims of 'sweating' by critics of MAIs stating 'We, Sirs, have escaped from the slavery, the hard work and bad pay which were ours as assistants to medical men to comparative freedom, comparative ease and comparative affluence.'[95]

In 1879 the Friendly Societies Medical Alliance (FSMA) was established to promote the development of MAIs. By 1883 there were 32 institutes and by 1898 about 40, with a total of

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[90] Green, *Working-Class Patients and the Medical Establishment* p.22.
[91] *Ibid* p.23.
[92] *Lancet,* 'The Medical Work of Friendly Societies', 7 December 1889 p.1209. In Northampton 3 doctors were required to care for 14,369 patients. Green, *Working-Class Patients and the Medical Establishment* p.39.
[93] James Mullin accounted the two and a half years he spent as an assistant to a GP in the mining district of Blaenavon 'among the hardest in my life.' Mullin, *The Story of a Toiler's Life,* p.154.
[94] *Lancet* 16 April 1887 p.809.
[95] *Ibid,* 22 October 1892, 'Verax' pp. 962-3.

213,000 members and employing 75 medical officers.[96] Green points to the pride which advocates of the MAIs had in them and their goal of providing the best medical care for their members at prices they could afford'.[97] He alleges GPs objected to the inclusion of women and children within the MAIs' coverage and the establishment of 'juvenile clubs', fearing these developments would lead to the demise of private practice.[98] However, against this it should be remembered that many GPs, like Alfred Cox, ran their own clubs for women and children which were often a 'charitable exercise' given the frequency with which patients proved unable to keep up their subscriptions.[99] The altruistic Harry Roberts came up with a solution to overcome his East End patients' fears of incurring excessive bills when they were seriously ill. He allowed them to purchase, for 2s 6d, a weekly card entitling them to unlimited attendances and medicines.[100] As the *BMJ* pointed out in 1895, contract practice had in it 'an element of charity. It does not pay; the doctor cannot live on it alone.'[101] In an obvious dig at MAIs, the Manchester Medical Guild's report on Provident Medical Aid said that sick clubs 'are more truly representative of honest providence than any other scheme of organized provident medical aid met with in practice.'[102]

The GPs' main objection to the Institutes was that, while robbing them of a sizeable proportion of their potential income, they undermined professional autonomy by requiring their salaried doctors to follow the rigid dictates of a lay managing committee. The Manchester Medical Guild's report opined that 'it is neither necessary or desirable…that members of our profession…be permitted to become paid servants of a lay committee…or used as a source of

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[96] Green, *Working-Class Patients and the Medical Establishment,* p.24.
[97] *Ibid,* p. 27.
[98] *Ibid,* p. 28.
[99] Cox, *Among the Doctors*, p.56.
[100] Stamp, *Doctor Himself,* p.72.
[101] *BMJ* 23 March 1895 pp. 657-658.
[102] *Manchester University Medical Collections*. MMC/7/4/3/1 'Provident Medical Aid', Report by the Manchester Medical Guild 1895. p.3.

profit by lay speculators in medical attendance.'[103] Some doctors complained of 'degrading bondage' as when a doctor's assistant offended a member of a miners' institute he had treated by declining to have a drink with him and was told: 'You're nowt but a servant, my b…..servant!'[104] James Mullin was another doctor offended by the way members of the Colliery clubs treated their medical attendants. He wrote: 'I could only shape my feelings into unutterable maledictions, not on the tyrannical colliers, but on that man or body of men who first put the collier's foot on the neck of the doctor by introducing contract practice.'[105] Another doctor wrote to the *Lancet* citing numerous examples of insolence, disrespect and discourtesy by club members and their officers, and a total disregard or advice given, resulting in excessive consumption of medicines provided, stating, 'If objection was raised to an insult, you were immediately reminded that you were paid to do the work.'[106] They continued to complain also about the granting of benefits of club membership to the well to do who could afford private fees. In 1894 the BMA's Oxford branch complained that the Banbury Medical Aid Association solicited membership 'from high and low, rich and poor' for the same subscription and that their membership included 'the Mayor of Banbury and many others of like standing.'[107] They also objected to the fact that the institutes, like the friendly societies generally, did not normally offer the patient a choice of doctor.[108] Some doctors believed the best way to counter the spread of MAIs was to set up similar services run by the doctors themselves but, crucially, offering the patients a free choice of doctor. The first of these, which came to be known as 'Public

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[103] *Ibid,* p.9.
[104] *BMJ,* 2 January 1909 p.68.
[105] Mullin, *The Story of a Toiler's Life*, p.152.
[106] *Lancet,* 30 January 1886, 'Fairplay', p.235.
[107] Bartrip, *Themselves Writ Large* p.136.
[108] Institutes usually employed a single medical officer who was allowed to employ one or more assistants. Some of these were sweated and greatly resented the cut of their remuneration made by the MO. For an illustration of this see A.J. Cronin, *The Citadel*, (London, 1937) Vista edition 1996 p. 142. By the 1900s the larger type of MAIs were offering members a 'limited choice' of doctor. Green, *Working-Class Patients,* p.127.

Medical Services' (PMS) opened in Coventry in 1893 in response to the threat posed by the Coventry Provident Dispensary and became a model for several others which were to follow.[109]

Many doctors came to believe that those who accepted club or MAI posts with intolerable working conditions were guilty of 'infamous conduct in a professional respect' which deserved to be investigated and proscribed by the General Medical Council (GMC).[110] In 1892, at the prompting of the Medical Defence Union, the GMC investigated a GP from Stourport Worcestershire who was accused of 'covering', that is conniving at provision of medical services by unqualified persons, through the Stourport Amalgamated Friendly Societies and Medical Aid Association. The accused was, however, let off with a caution.[111] The following year a committee set up by the GMC submitted a critical report into MAIs. It recommended that a medical practitioner should be deemed guilty of infamous conduct if a) they held an appointment whose duties 'were so onerous that he cannot do justice to the sick under his care', b) they issued certificates not justified on medical grounds, or c) accepted employment by an association which employed canvassing to attract members.'[112] However, the committee's report was not adopted .[113] GPs suspected that this was because the GMC was largely made up of Consultant physicians and surgeons who had little interest in contract practice. Dr W.H. Rowthorn wrote to the *BMJ* in 1900 complaining of the GMC's 'dog in the manger' attitude stating 'So long as the GMC is composed of professors and consultants the general practitioner

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[109] *Lancet,* 4 July 1896 pp. 56-57. It was not universally successful. The most successful of these, the Leicester PMS, founded in 1912 is described further in chapter 7. The Public Medical Service concept was first proposed by Dr Robert Rentoul, see below n. 75.

[110] *Manchester University Special Medical Collections*, Manchester Medical Guild Annual Report 1904 MMC/7/4/3, p.2.

[111] Little, *History of the British Medical Association 1832-1932,* p.202.

[112] *Ibid*

[113] 'The Council shirked responsibility' Little, *History of the British Medical Association 1832-1932* p.202. GMC member Sir Samuel Wilks explained in the *Medical Magazine* in 1896 that the Council demurred because a decision to condemn doctors constrained to perform an impossible level of work would have led to a similar condemnation of medical assistants in hospitals. Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* p.72. Green regards the report's recommendations, and the GMC 'ban' on advertising, as anti-competitive (ignoring the argument about protecting the public from false or misleading claims and invidious comparisons.) Green, *Working-Class Patients and the Medical Establishment*, p.132.

will have to wait in vain for anything of a really beneficial nature.'[114] The editor of the *Lancet*

agreed, noting that 'it happens that those who have few or no grievances are exactly those who

would have most influence in obtaining redress.'[115]

In 1895 Dr Leslie Phillips, the Secretary of the Medical Defence Union sent a memorial

to the GMC in which he condemned the 'sweating' of medical men by MAIs as 'a serious

danger to the welfare of the public and the profession.'[116] In 1897 a number of individuals and

associations lobbied the GMC to launch a further investigation into the way MAIs operated,

one of which was from 'the medical men of Norwich' requesting the GMC's views on its

dispute with the Norwich Medical Institute.[117] The GPs argued that the conditions of service

were 'detrimental to the public and derogatory to the profession' and therefore considered it

unprofessional for any medical man to be associated with the institute which, the GPs also

argued, constituted a 'trading body' making profits which were invested in real estate.[118] The

GMC again declined to act but appointed a subcommittee which spent two years consulting

with aggrieved GPs and the friendly societies about contract practice. It concluded that the

principal point of contention was remuneration, subdivided into related grievances about the

inclusion, as members, of women and children, and of individuals wealthy enough to pay

directly for their own care.[119] The outcome was a proposal to establish a 'conciliation board

consisting of representatives from both sides 'to discuss and, if possible, determine, the points

at issue.'[120]

Discussion of means to tackle the abuses by which GPs considered themselves to be beset

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[114] See letter from 'Rotherham GP', *BMJ,* 3 March 1900, p.546.
[115] Squire Sprigge, *Medicine and the Public*, p.232.
[116] *Manchester University Special Medical Collections* MMC/7/4/3/1 'Provident Medical Aid', Report by the Manchester Medical Guild 1895. p.7.
[117] Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* p.33.
[118] *Ibid*
[119] *Ibid,* pp 33-34.
[120] *Ibid,* p 34. This never met, however. According to Green this was because 'the BMA kept dragging its feet.' But when the BMA did meet a delegation from the friendly societies in 1909 no agreement could be reached on the sticking point of a wage limit because the societies 'disliked the idea intensely.' Green, *Working-Class Patients and the Medical Establishment* p. 55.

frequently turned to the tactics adopted by trade unions. Thus, in Oldbury in 1868 doctors sought to ostracize newcomers taking up boycotted posts, pledging 'neither to meet them professionally or socially (or)…meet in consultation any physician or surgeon who recognises them.'[121] The BMA was not entirely comfortable with trade union-like behaviour, however, and the same year the *BMJ* stated that it hoped the BMA branch in Birmingham 'would not approve of a strike (sic) which sought 'by intimidation and sudden inconvenience to force a decision.'[122] Trade union tactics were plainly employed, however, in the dispute in Cork in southern Ireland in 1894 where, in response to an organised boycott by a local medical association, the friendly societies brought in 'scab' medical labour to break the 'strike'.[123] The setting up of a defence fund to support those who had been dismissed offered a precedent for later action by the BMA, and in the journals doctors openly referred to those failing to heed the call to solidarity as 'blacklegs' and 'strike breakers'.[124] In a letter to the *BMJ* in 1896 Dr James Dalgleish praised the Lincoln GPs who had stood firm against the efforts of those seeking to subvert the boycott of friendly society posts ending that he hoped 'the men of Lincoln will show no white feather.'[125] Writing in the Manchester Guild Quarterly in 1899 Edward Jepson criticised those 'low types' who 'do not think it wrong to take advantage of a dispute' and take away a fellow GP's post. The Northern Medical Unions had therefore established a new disciplinary system, he reported, whereby 'cases of 'blacklegging…will be tried and investigated' by a 'judicial committee' involving consultants and anyone found guilty 'will be boycotted by the whole profession.'[126]

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[121] *BMJ* 11 July 1868 p.321.
[122] *Ibid*, 15 February 1868. p.152.
[123] Eder, *National Health Insurance and the Medical Profession* p.21 and *Lancet*, 'The Battle of the Clubs', Report by special correspondent, Adolphe Smith, 18 March 1905 p.738. The latter suggests that by so doing they alienated their members who were largely sympathetic to the doctors.
[124] See *BMJ* 18 April 1896 p.999; 16 January 1897 p.168.
[125] *BMJ* 18 April 1896, Dr James Dalgleish, p.999.
[126] *Manchester University Special Medical Collections*, MMC/7/4/6 *Manchester Medical Guild Quarterly*, no. XVII July 1902. p.9.

Although these tactics had been employed at various times and places in Britain and Ireland prior to 1900, militants within the GP community were also inspired by continental examples. In the first of his celebrated series of articles in the *Lancet* under the heading 'The battle of the clubs' Adolphe Smith reported on a strike by doctors in Brussels in 1895 organised by the *Syndicat Médicale* in which would-be strike breakers were deterred by ostracization.[127] The actions of the strikers were, Smith notes, supported by socialists and local trade unionists. In 1900 H.N. Hardy wrote expectantly of the first International Congress of Medical Ethics taking place in Paris that year which would deal with questions of relations between medical men and the state 'or other collectivities such as clubs and dispensaries, on the best trade-union lines.'[128] It was Germany, however, that offered the best illustration of what doctors could achieve when they were prepared to stand together and adopt trade union tactics. The most powerful doctors' trade union, which had started in Leipzig and was therefore known colloquially as the *Leipziger Verband,* had by 1911 a membership of 95% of German medical practitioners and successfully coordinated strikes and boycotts of local sickness insurance societies (*Krankenkassen*) across the country.[129] The union, also known as the *Hartmannbund,* was by then confident of obtaining national acceptance of the principle of the patient's free choice of doctor.[130] The President of the BMA applauded their success in his address to the 1911 representative meeting.[131]

Morrice notes that the success of British trade unions in improving their members wages and working conditions was not lost on the GPs who attended those workers.[132] Alfred Cox

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[127] *Lancet*, 4 August 1895, pp 476-477 and 4 July 1896, pp. 54-56.

[128] Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900,* p.30.

[129] Between 1910 and 1911 there were said to have been 1,022 conflicts between doctors and the sickness insurance societies in Germany of which 921 were allegedly decided in the doctors' favour. Ioan Gwilym Gibson *Medical Benefit in Germany and Denmark* (London, 1912) p.229. The *Leipziger Verband* was also known as the *Hartmannbund* after its founder, Dr Herman Hartmann. It still exists today as a trade union for doctors.

[130] *Ibid,* p.230.

[131] *The Times*, 27 June 1911, p.4.

[132] Andrew Morrice, 'The Edwardian BMA and Contract Practice.' pp.168-9.

explained that when setting up a local GP association in Gateshead 'I had become friendly with some of my patients who were keen trade unionists and I wondered why we should not adopt some of their methods.'[133] The association he founded in 1898 with 15 fellow GPs was active until 'the BMA came alive' in 1902. It managed to raise the minimum fee for midwifery and negotiate a fee of 3s 6d as the minimum friendly society per annum payment in place of the 'Dutch auction' which had previously taken place.[134] Cox was not alone in his efforts to improve GPs' circumstances but his success led him to be invited to assist in other areas. Edward Jepson, who helped found the Durham County Medical Union with the intention of improving the lot of the colliery doctors made Cox an honorary organiser.[135] Together they gradually 'wore down the opposition', forcing the miners, who at that time were enjoying an unprecedented level of prosperity, to increase the doctor's pay to 9d per patient per fortnight.[136] Cox then helped form the Northumberland Medical Union of which he became Honorary Secretary and in that capacity entertained Adolphe Smith, when he toured the country gathering information for his articles.[137]

By 1900 there were a plethora of ethical or political organisations representing GP interests, some national, some local. In addition to the two medical defence societies which had been formed in the 1880s, the Medical Defence Union and the London and Counties Medical Protection Society, there were two national bodies campaigning against hospital 'abuses', and nearly thirty local 'ethical and medical defence associations' and 'guilds'.[138] For Alfred Cox

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[133] *Ibid,* p. 57.

[134] Cox continued his crusade to improve the lot of local GPs when he became honorary Secretary of the BMA's Gateshead division, at which time he received 'some useful tips' for his organisational work from his 'trade union friends'. Cox, *Among the Doctors* p.60.

[135] *Ibid,* p.73.

[136] *Ibid*

[137] *Ibid* His association was hailed as an example to others by Squire Sprigge, in *Medicine and the Public*, p.235

[138] The Hospital Reform Association and the Corporate and Medical Reform Association, and local ethical associations and guilds in Ashton under Lyne, Brighton, Cork, Coventry, Durham, Eastbourne, Eastern Valley, Gateshead, Great Yarmouth, Lincoln, Nottingham, Inverness, Manchester, Middlesbrough, Newcastle, Salford, Small Heath, South Shields, Stockport and Wigan; and in the greater London area the Incorporated Medical Practitioners Association and associations in Battersea and Clapham, Beckenham and Penge, Eastern Suburbs, Surbiton and Southwest London. There was also a national Colliery Surgeons Association, a Police Surgeons

'The multiplicity of organisations was bad' and underlined the need for to concentrate the GPs efforts under one strong body.[139] Cox's preference was for the BMA but when he helped form associations in the north east of England, the BMA seemed reluctant to involve itself in local disputes and completely eschewed any notion of becoming a trade union for doctors. The specialist physician Herbert Woodcock recognised that district associations like that formed by Cox and Jepson were meeting an urgent need not met by the unwieldy BMA branch structure commenting: 'Somehow the BMA cannot get close hold of the districts and these local associations can.'[140] While expressing hopes for what the reform of the BMA's branch structure could achieve, Squire Sprigge observed that 'much of the work of protecting the practitioner from the effect of unfair competition has fallen on local organisations.'[141]

Hardy makes the case for the BMA becoming a trade union but claims the idea was, for the Tory-inclined majority of the BMA's Council, the proverbial 'red rag to a bull.'[142] He was at pains, however, to differentiate that form of trade unionism characterised by 'tyrannical oppression of workmen' by unscrupulous and self-serving officials 'which should be avoided by all honourable men', from the more beneficial kind of combination demonstrated successfully, he opined, in the dispute in Cork.[143] Sprigge reflected the conventional view, however, when stating that what was needed was 'medical combination in an intelligent form, a professional union based on the public needs and not a trade union directed towards the

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Association and a Poor Law Medical Officers Association. Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900*. p.31 To these must be added the seven regional federations established to represent women doctors which subsequently coalesced into the Northern Association of Women Doctors and the Association of Registered Medical Women. Clara Stewart, 'History of the Federation', *Journal of the Medical Women's Federation*, vol.49 (1967) p.70.

[139] *Manchester University Special Medical Collections* MMC/7/3/4, Official Report of the Conference on Medical Organisation 1900. p.56.

[140] Herbert De Carle Woodcock, *The Doctor and the People* (London, 1912) p.94.

[141] Sprigge, *Medicine and the Public* p.235.

[142] Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900*. pp. 29-30.

[143] The implication here seems to be that the doctors' motives were always honourable by virtue of the professional social ideal.

amelioration of a class against the community.'[144] Among the evidence that many GPs were inclined towards trade unionism at this time, are glowing references made by some GPs to the National Union of Teachers (NUT). In his presidential address to the Lancashire and Cheshire Branch of the BMA in 1897 Dr Samuel Woodcock described them as an 'admirable example of what may be accomplished by efficient local organisation.'[145] In the introduction to the report of the Manchester conference of medical organisations in 1900 the NUT is held up as an example of what GPs should aspire to. Formed only in 1870, the NUT had a membership comprising 90% of elementary school teachers paying an annual subscription which was one third that of the BMA. It was 'always consulted by the government on any question of importance bearing on education and had two representatives (sic) in parliament.' In 1900 it had 430 branches with an aggregate membership of 40,000.[146] 'The problem with the medical profession,' the author of the introduction opines, is that 'it does not contain men as business-like and as devoted to the its interests as the teachers have shown themselves to be in theirs.'[147] The key to the NUT's success was said to lay in having 'active branches and a proper system of delegation and accountability with an annual conference as ultimate arbiters of policy.'[148] This was a message not lost on those seeking to reform the BMA.

Guilds and associations, the reformed BMA, and the Report on Contract Medical Practice

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[144] Sprigge, *Medicine and the Public* p.232. Hardy felt inspired by European examples such as the formation of a medical ethical society in France, stating 'The leaders of the BMA will, doubtless, learn some instructive lessons from countries in which the principles of trade unionism have been carried out by medical societies for years.' Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* p.30.

[145] *Manchester University Medical Collections*, MMC/21/1/3/4, 'Presidential address by Samuel Woodcock MD', BMA Lancashire and Cheshire Branch correspondence.

[146] *Manchester University Medical Collections*, MMC/7/4/3/4 'Official Report of the Conference on Medical Organisation 1900' pp.8-9.

[147] *Ibid,* p.8.

[148] *Ibid*

While bemoaning the proliferation of medical bodies representing GPs, there was, Cox notes 'a growing desire among these bodies for some kind of national action.'[149] The cry was taken up by the Manchester Medical Guild, when it convened a conference of like-minded organisations in 1900. The Guild had been established in 1895.[150] Its objectives were not purely to bring about improvements in its members' remuneration and working conditions but also to promote 'cooperation for the common good' and 'guide medical opinion on all matters affecting the profession.'[151] The Guild worked closely with the Manchester Medical Ethical society to produce a joint report containing a medical fees tariff. From this and subsequent annual reports in the early 1900s it appears the Guild was determined to enforce adherence to its recommended minima by what they called the 'club pledge'.[152] Although the idea of practitioners signing written undertakings to support collective bargaining had by this time a long history, the prestige of the Manchester Guild and its ability to self-publicise through its own quarterly journal, may have served to reinforce the idea of pledges in the minds of many within the profession, and thereby influence the thinking of those behind the pledges of non-cooperation with the National Insurance Act collected by the BMA in 1912.

The three day conference took place on 1-3 May 1900 in the Memorial Hall, Albert Square, Manchester.[153] All medical societies and BMA branches in England and Wales were invited to send representatives and thirty five organisations did so including six BMA branches.[154] When

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[149] Cox, *Among the Doctors*, p.74.

[150] *BMJ* 14 October 1899, Letter from Dr Samuel Crawshaw, pp.1043-1044. However, the List of Manchester medical societies in the University Medical Collections compiled in 1901, MMC/7/2/8, says that it was established in 1892.

[151] *BMJ,* 14 October 1899, Crawshaw, pp.1043-1044.

[152] On which, the report notes, no definite action had yet been taken 'except at Middleton where the profession had resolved not to accept less than 4s per member per annum.' *Manchester University Medical Collections,* MMC/7/4/2, Manchester Medical Guild Annual Report 1898. They first use the terms 'club pledge' in their 1903 Annual Report. *Manchester University Medical Collections* MMC/7/4/3, Manchester Medical Guild Annual Report 1903 p.6.

[153] *BMJ* 6 September 1899 pp. 735 and 750.

[154] *Manchester University Medical Collections,* MMC/7/4/3/4 Official Report of the Conference on Medical Organisation 1900. p.1.

it convened, the emergence of a rival body to the BMA 'appeared to be on the cards.'[155] Writing to the *BMJ* in the lead up to the conference, the Manchester Guild's secretary, Samuel Crawshaw, wrote that it would take too long to reform the BMA in the way the GPs wanted. Moreover, as currently constituted, the Association was unrepresentative of the profession as its meetings were dominated by consultants, he said, it was undemocratic in its decision-making, and ineffective in influencing policy.[156] Crawshaw was careful to praise the BMA for its contribution to the development of medicine and to the charge that the BMA was yet capable of becoming an effective medical trade union he wrote that to do so 'would assuredly destroy it for scientific work , for it is evident that the majority of the men who have made it successful as a scientific body , that is the consultants, would at once be excluded.'[157]

The conference began, however, with a report on the Medical Acts and their shortcomings by a consultant member of BMA council who was sympathetic to the GPs' calls for reform, Mr Victor Horsley.[158] Later, Mr R.B. Anderson of the Corporate and Medical Reform Association read a paper on 'medical polity' in which he condemned the Royal Colleges, the BMA and the GMC as 'medical oligarchies' which had failed to serve the interests of the profession. The 'new polity', he said, must 'render the profession self-governing and place the profession in a more proper rank in the state and in better relations with the government.'[159] On the third day of the conference debate on medical organisation began in earnest when Dr Crawshaw proposed that 'no scheme of medical organisation can be considered satisfactory' unless it provided machinery comprising: local district associations formed to discuss medical ethical or medico-political topics to which all practitioners in the locality had the right to belong; an annual conference of delegates of those associations; and a central executive

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[155] Bartrip, *Themselves Writ Large,* p. 142.
[156] *BMJ* 14 October 1899 pp. 1043-4.
[157] *Ibid*
[158] *Manchester University Medical Collections,* MMC/7/4/3/4 Official Report of the Conference on Medical Organisation 1900, p.4.
[159] *Ibid,* pp.18-19.

nominated and elected annually by those local associations.[160] Crawshaw explained that the local associations should cover so small an area that 'every member would find no difficulty in getting to the meetings after his day's work was done.'[161] The present BMA branches he said were too large and unwieldy. For example, the Lancashire and Cheshire branch was 100 miles long and 50 miles wide so attendance involved the loss of a day's work for some practitioners.

The debate reached its climax in the afternoon session when Dr Garrett Horder of Cardiff proposed that the conference appoint a 'provisional committee' to carry out its decisions and that it be instructed to request the BMA to organise a permanent ethical department, failing which it was to encourage the principal organisations committed to more effectively represent the GPs to amalgamate, or form an entirely new representative organisation.[162] During the debate, however, some of the leading lights of the independent associations declared that their energies would be better directed towards 'capturing' the BMA.[163] Alfred Cox was one of these and his intervention proved decisive. Decrying the multiplication of associations, he argued that, although it urgently needed reformation, beginning with its branch structure, the BMA was the 'proper body to undertake the work'. He stated that 'The Association had existed for 60 years and had obtained a position of importance which ought not to be thrown away.'[164] He therefore proposed a new resolution calling on all local medical organisations to convert the BMA Council into 'an energetic body really representative of the majority of members.'[165] The resolution was passed but many GPs were sceptical, Cox noted, including one who had made a name for himself at the conference, James Smith Whitaker, the founder of the Great

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[160] *Ibid,* pp. 51-54.
[161] *Ibid,* p.54.
[162] *Ibid,* 2nd resolution pp. 61-62.
[163] *BMJ* 12 May 1900 p.1169 and Cox, *Among the Doctors,* p.75.
[164] *BMJ* 12 May 1900 p.1169 and *Manchester University Medical Collections,* MMC/7/4/3/4 Official Report of the Conference on Medical Organisation 1900, p.56.
[165] *Ibid*

Yarmouth Practitioners Association and who was not then a BMA member. However, he agreed to serve with Jepson and Cox on the provisional committee which was to negotiate with the BMA.[166]

Although the *BMJ* made no announcements regarding any of these events, it was clear that many in the BMA recognised how close they had come to facing a new and effective rival for their GP membership. An extraordinary general meeting of the Association was consequently held in London on 18 July to consider proposals for an amended constitution and more considered proposals presented for debate at the subsequent Representative Meeting in Ipswich.[167] An invitation was meanwhile extended to the provisional committee established at the Manchester conference to meet with BMA Council during that meeting. Cox notes that 'We had an unexpectedly favourable reception…with the result that a constitutional committee was appointed with full power to make recommendations about the constitution of the Association.'[168] Half of the committee was nominated by the Council but included internal proponents of reform like Horsley, and the other half included external critics like Cox and Whitaker, who soon impressed with his skills as a 'draftsman' (sic) and conciliator'.[169]

Several of the provisions recommended by the committee and adopted at the BMA's annual meeting in Cheltenham in 1901 were 'lifted' from the Guild conference resolution.[170] In particular the primary unit of local organisation would henceforward be 'divisions' of similar size to parliamentary constituencies and whose meetings were likely to be better attended than those of branches, which were thereafter more like a regional committees of divisions.[171] The divisions would send representatives to an annual meeting of the Association, thereafter

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[166] Cox *Among the Doctors*, p.75.
[167] Bartrip, *Themselves Writ Large* p.144.
[168] Cox, *Among the Doctors*, p.76.
[169] *Ibid*
[170] Bartrip, *Themselves Writ Large* p.145.
[171] *Ibid*

renamed the Annual Representative Meeting which would henceforward serve as the parliament of the Association, determine BMA policy, and hold the Council, as the BMA's executive, to account.[172] These proposals were passed with few objections by a meeting attended by over 800 members, the few dissenting voices expressing the familiar fear that the BMA was becoming more like a trade union.[173] The *Lancet* opined that 'disaster was averted', and 'the threat of the guilds' had been 'repulsed'.[174] But this was largely because the BMA had adopted many of their ideas.[175] Another factor was the BMA's decision to neutralise the influence of some of its more effective critics, that is Whitaker and Cox, by making them into 'BMA men'. Whitaker was appointed the BMA's first medical Secretary in 1902 and Cox became his deputy in 1908.[176]

One of Whitaker's main tasks was to take charge of all committees dealing with medical political and organisational affairs.[177] He immediately set about establishing a Central Ethical Committee.[178] This committee made it a priority to establish 'ethical rules' which the new divisions, acting as what Squire Sprigge later described as 'courts of honour', could attempt to regulate professional behaviour and punish 'infamous conduct'.[179] In practice this involved boycotting of designated friendly society and MAI posts and ostracising those who ignored the boycott and applied for them. In 1900 the *BMJ* had begun to publish 'warning notices' against

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[172] *Ibid.* Council members could attend and speak at the ARM but were prevented from voting and the Council were duty bound to comply with any resolution passed by a two thirds majority.

[173] *BMJ* 17 August 1901 p.433.

[174] *Lancet* 8 June 1901, p. 29-30.

[175] Bartrip, *Themselves Writ Large.* p.148.

[176] Cox, *Among the Doctors* pp. 78-79. Less compliant critics like Crawshaw remained on the side-lines and continued to fulminate from time to time about the BMA's shortcomings.

[177] *Ibid,* p.78.

[178] Morrice, 'The Edwardian BMA and Contract Practice.' p.171.

[179] Sprigge, *Medicine and the Public*, p.234. 'A court of medical ethics of some sort is badly needed in the profession.' Hardy, *The State of the Medical Profession in Great Britain and Ireland in 1900* p.72. 'Courts of honour' were an established feature of medical practice in Prussia in the late nineteenth century and were given state sanction by the 'Honour Court law' of 1899. See Claudia Huerkamp, 'The Making of the Modern Medical Profession 1800-1914 ' in Geoffrey Cocks and Konrad H. Jarausch (eds) *German Professions 1800-1950* (Oxford, 1990) p. 78. See also Andreas-Holger Maehle, *Doctors, Honour and the Law: Medical Ethics in Imperial Germany* (Basingstoke, 2009) pp. 6-46.
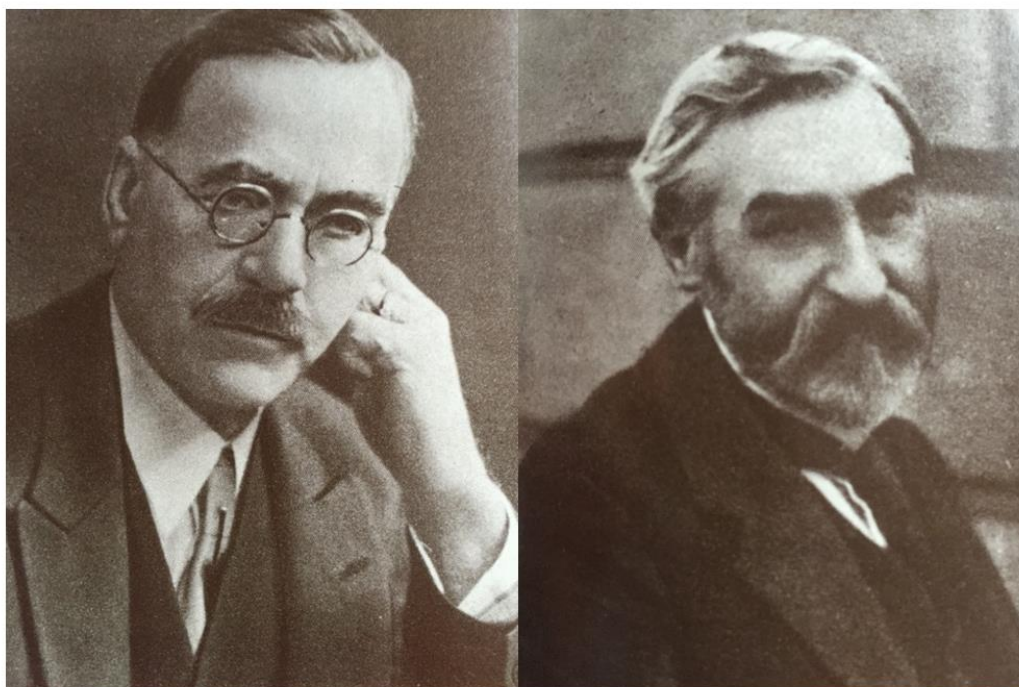
Figure 4. *Architects of BMA reform:* Dr Alfred Cox (left) and Dr James Smith Whitaker (right). Photographs from BMA archive.

taking such appointments.[180] These became more regular after 1905, when the Central Ethical committee's model rules were approved at the representative meeting in Bradford and were thereafter referred to as the 'Bradford Rules'.[181] The list of posts deemed worthy of such condemnation was determined by the newly established Contract Practice Subcommittee and referred to colloquially as the 'blacklist'.[182] The *BMJ* and the *Lancet* continued to print letters from irate GPs, however, about the abuses of club practice and the insidious growth of MAIs.[183] In 1903 therefore the representative meeting asked the Association's Medico-Political Committee to investigate club abuses and in 1904 it issued 12,000 questionnaires as part of an inquiry into contract practice.[184]

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[180] These were successfully applied in Durham, Gateshead, Walsall and Rotherham (*BMJ* 6 June 1903 pp.1339-41, 13 June 1903 pp.1380-81.)

[181] In 1906 these warnings covered 22 such appointments. *BMJ* 14 April 1906 p.876.

[182] Morrice, 'The Edwardian BMA and Contract Practice.' p.171. Blacklisted advertisements were accompanied by the injunction 'Consult the secretary of the local BMA Division before applying' or similar wording.

[183] See editorial in *BMJ* 6 June 1903 noting continuing difficulties with clubs and MAIs in Sheerness and Birmingham, p.1341.

[184] Eder, *National Health Insurance and the Medical Profession.* p.21.

The report of the inquiry was published in the *BMJ* in July 1905.[185] The value of the report's conclusions must be qualified by the limited number of responses on which it is based.[186] The report nevertheless captures the feelings of many GPs and is consistent with the correspondence which had appeared in both professional journals over several years. It reflected both the minority who had positive things to say about club practice and the majority who did not. The report cited many examples of 'sweating' by friendly societies and their Institutes and abuse by patients. For example, a man who made £30,000 on the sale of public house paid his doctor 1d a week. Another doctor wrote 'I pay the railway porter one shilling for bringing up a parcel to the house; he pays his doctor a shilling a month for his family and himself.' A London doctor complained of being driven out of his home by tipsy members of one of his clubs. His neighbour helped 'somewhat roughly' to clear them out but in consequence the doctor was forced to resign his post. However, a South London doctor noted that he had 'never had anything but the most cordial relations with any of my clubs.'[187] The report showed that 24% of clubs paid less than 4s p.a., 53% between 4 and 5s, and 24% over 5s per patient per annum. It revealed that 82% of GPs' own clubs included all family members and 90% included juveniles from birth whereas only 5% of friendly societies admitted families and 69% juveniles between the ages of one and six years old. Interestingly, however, only 53.5% of respondents considered their remuneration from club practice inadequate.[188]

Meanwhile an opportunity for the BMA to flex its newly developed muscles in defence of its GP members arose in the case of a dispute in South Wales with the Miners' Medical Aid Association in Ebbw Vale. Like many of the miners works clubs originally run by mine owners

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[185] *BMJ* 22 July 1905 'An Investigation into the Economic Conditions of Contract Medical Practice in the United Kingdom', Supplement, pp.1- 96.
[186] *Ibid.* Only 13% responded and only 856 of the 1548 respondents were actually engaged in contract practice at that time.
[187] *BMJ,* Contract Medical Practice Report, 22 July 1905 Supplement, pp.1- 96.
[188] Morrice, 'The Edwardian BMA and Contract Practice.' p.175. Green acknowledges that the contract practice report shows some correlation between the amount paid per practitioner and the number of attendances per annum but he admits that the average consultation rates for low payers 'are not low enough to suggest that doctors seriously neglected their patients.' Green, *Working-Class Patients and the Medical Establishment*, p.86.

and managers responsibility for this scheme had recently been devolved to a workmen's committee which in 1905 unilaterally changed their medical officers' contracts from a capitation to a salaried basis. When the doctors subsequently refused an instruction to relinquish their rights to private practice the doctors were dismissed and replaced by 'blacklegs'.[189] The case quickly became an ideological battleground for the BMA over the extent of lay control of medical practice in which the Association sought to mobilise the whole profession.[190] Attempts to resolve the dispute through mediation by the local MP failed. A temporary truce was agreed by which the dismissed doctors were able to resume their posts but the dispute rumbled on, heightened to some extent by the advent of National Health Insurance, until 1915.[191]

Concern at the threat posed by MAIs and Provident Dispensaries prompted the BMA's Medico Political Committee to instruct its Contract Practice Subcommittee to draw up a model Public Medical Services (PMS) scheme. This followed recommendations included in its Contract Practice report in 1905.[192] The model was developed, taking account of examples of district-wide schemes run by GPs themselves such as those operating at that time in Coventry and Hampstead.[193] The objective was to provide for workers and their families below a defined income limit a comprehensive family medical service offering a range of benefits similar to those being offered by the MAIs and Dispensaries. Significantly, however, the professional schemes would be open to all qualified local doctors and would therefore

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[189] See Ray Earwicker, 'Miners' Medical Services before the First World War: the South Wales Coalfield', *Llafur* (The Journal of the Society for the Study of Welsh Labour History), vol 111, No 2, Spring 1981, pp. 39-52.

[190] *BMJ* 27 October 1906 Supplement pp. 232-3.

[191] *BMA Archive*, Minutes of Medico Political Committee, 7 April 1909. The continuation of this dispute is dealt with further in chapter 4 below.

[192] *BMJ,* Contract Medical Practice Report, 22 July 1905, Part V 'Special report on Provident Dispensaries' Supplement, pp. 30-31.

[193] Eder, *National Health Insurance and the Medical Profession,* pp.19.-20. *BMA Archive*, Minutes of meetings of Medico Political Committee on 18 November 1908 and 22 September 1909.

offer the subscriber free choice of doctor.[194] The PMS would be administered by committees of local doctors and made no provision for lay involvement in their management. It was thus an example of medical paternalism in its purest and most unapologetic form. The BMA spent several years refining the model scheme. It hoped that it would eventually be taken up by doctors across the country, thereby replacing, without the need for compulsion, all existing club contractual arrangements, which would inevitably look inadequate by comparison.

The BMA was given a new impetus to develop such a model by the Royal Commission of inquiry into the Poor Law. Established by a Conservative Government in 1905, it delivered the report of its inquiry in 1909.[195] The BMA was equally alarmed by both the majority and the dissenting minority reports.[196] The recommendations of the majority report included an extension of existing friendly society club practice. The minority report's proposal for 'straightening out the tangle' of overlapping and uncoordinated medical services on the other hand was a state controlled, non-contributory scheme administered through local government agencies available to all citizens below an accepted income limit and delivered by salaried doctors.[197] While the majority report's recommendation was unwelcome to the GPs, the minority's proposals would have represented the end of both clubs and the provident or insurance principle and would have severely restricted GPs' private practice. A minority of doctors welcomed the idea of salaried state medical service, but most saw it as a major threat to their cherished goal of professional autonomy.[198] As it continued its efforts to develop its own scheme, the BMA responded to the Commission reports by stating some principles on which they believed any future state-funded service should be based, which it repeated during subsequent negotiations with the Liberal government. These were: that medical services

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[194] *Ibid*
[195] *Report of the Royal Commission on the Poor Laws and Relief of Distress* Cmd. 4499.1909.
[196] *BMJ* Supp, 'Interim Report of Special Poor Law Committee', 5 February 1910, pp. 41-43.
[197] See Beatrice and Sydney Webb, *The State and the Doctor* p. 233.
[198] *BMJ* Supp, 'Interim Report of Special Poor Law Committee', 5 February 1910, pp. 41-43.

rendered on behalf of the state should be paid for by the state; payment should be adequate and in accordance with the professional service required; and there should be adequate medical representation on all committees formed to control state medical provision.[199] As it happened, the proposals which emerged in the National Insurance Bill owed very little to the inquiry reports and took the debate about medical services for the poor in an entirely unexpected direction.[200]

Conclusion

Fearing that their hopes of financial security and gentility were being jeopardised by the 'unethical' behaviour of a (largely impoverished) minority of doctors, an increasing number of GPs at the end of the nineteenth century began to adopt trade union-like tactics in defence of their collective interests. These tactics served to enforce the professional solidarity on which success in collective bargaining depended, and thus secure their professional autonomy and protect their individual freedom to deliver a proper standard of care to patients. For those engaged in contract practice this freedom was threatened by an intolerable workload, inadequate remuneration, and lay supervisory interference, all of which they believed were accentuated by the expanding power of the Medical Aid Associations. The desired alternative was a Public Medical Service (PMS) run in each district by the doctors themselves. The BMA's reluctance to become a trade union owed much to the distaste which the grandees on its Council still had for any association between medicine and trade. Some of their number clung to an idealistic notion of medicine as a selfless, noble and gentlemanly calling, seemingly above party politics, whereas others, embracing a Conservative ideology, viewed the idea of

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[199] *BMJ*, 5 February 1910 p.43 para 20.
[200] 'The Liberals plans were a long way from what Beatrice Webb and her allies had demanded in the minority report.' Chris Renwick, *Bread For All: The Origins of the Welfare State* (2nd edn, London, 2018) p. 58.

organised labour with alarm. Most of the medical elite of the BMA were, however, disinterested in the plight of the humble GP until the threatened emergence of a rival organisation, heralded by the Manchester Conference in 1900, forced them to heed their GP members' complaints.

The reform of the BMA which this threat instigated rendered the Association better able to assert itself in the conflict that was to come over National Insurance. That conflict nevertheless served to underline how much the interests of GPs as a group differed from other parts of the medical profession and thereby kept alive the dream of a separate national body to represent GPs. The BMA was determined to create, through PMS, a means of delivering medical services to the working class which was as good as anything offered by the detested MAIs but, crucially, under the control of the doctors themselves. The BMA's scheme relied on acceptance by the profession of a structure built around local committees of doctors.[201] These committees would, inter alia, represent the 'courts of honour' which Sprigge, Hardy and other commentators, inspired by German and other continental examples, felt were needed to inhibit the untoward effects of 'unethical' behaviour caused by unregulated competition. The Report of the Royal Commission on the Poor Law added emphasis to the need to finalise such a scheme. The arrival of NHI appeared to negate these aspirations. However, it did not, as will be seen in the next chapter, entirely kill them off.

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[201] The BMA accepted that these committees should represent all local doctors not just members of the Association because 'The principle of collective bargaining of the profession must…be maintained at all costs.' *BMA Archive,* Minutes of joint meeting between Special Poor Law Reform Committee and Contract Practice Subcommittee of 26 October 1910, Doc. 35.

Chapter Two. The coming of National Insurance and the mobilisation of professional resistance.

In 1912 the specialist physician Herbert de Carle Woodcock wrote:

> All those who desire the welfare of our profession as a means to its greater usefulness must
> welcome the changed attitude of the doctor upon political questions…medical men are
> ceasing to be Ishmaelites…The political doctor is now born.[1]

The medical profession's battle with government over the introduction of National Health

Insurance (NHI) has been analysed in great detail by historians interested in British Liberal

politics, and in state formation and welfarism in Britain.[2] It has also been studied by historians

interested in the development of health services, and in the history of British General Practice,

and featured in sociological studies of professionalisation.[3] This chapter offers a new

perspective on these events by considering this conflict as the most visible expression of the

GPs' political consciousness which began to take shape during the 'battle of the clubs' at the

end of the nineteenth century, and which increasingly affected the thinking and activities of the

British Medical Association (BMA) and other representative groups during the first decade of

the twentieth century. It therefore offers further evidence of how GPs during this period became

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[1] Herbert De Carle Woodcock, *The Doctor and the People* (London, 1912) p.80.
[2] Derek Fraser, *The Evolution of the Welfare State* (London, 1973) ch. 7; James R. Hay. *The Origins of the Liberal Welfare Reforms 1906-1914* (London, 1986) *passim*; Jose Harris, *Private Lives, Public Spirit: Britain 1870-1914* (London, 1993) ch. 7 and 8; Pat Thane, *Foundations of the Welfare State* 2nd edn. (Harlow, 1996) ch. 3; Bernard Harris, *Origins of the British Welfare State: Society, State and Social Welfare in England and Wales1800-1945* (Basingstoke, 2004) pp. 150-166; Geoffrey R. Searle, *New Oxford History of England, A New England? Peace and War 1886-1918 New Oxford History of England* (Oxford, 2004) pp.361-371; Martin Daunton, *Wealth and Welfare: An Economic and Social History of Britain, 1851-1951* (Oxford, 2007) pp.521-573; James Vernon. *Modern Britain: 1750 to the Present*, *Cambridge History of Britain* (Cambridge, 2017) ch. 4. Chris Renwick, *Bread For All: The Origins of the Welfare State* (2nd edn, London, 2018) ch. 2-5.
[3] Bentley B. Gilbert, *The Evolution of National Insurance in Great Britain: The Origins of the Welfare State* (London, 1966) *passim* but especially ch.6 and 7; Norman Eder, *National Health Insurance and the Medical Profession in Britain 1913-1939* (New York, 1982) *passim*; Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999) ch. 13; Noel Parry and Jose Parry, *The Rise of the Medical Profession* (London, 1976) pp.43-59,83,192-195; Margaret Stacey, *The Sociology of Heath and Healing* (London, 1988) pp.104-121.

politicised and explains how their bruising encounter with government conditioned their future relationship with the state. It begins by considering the origins of NHI, and how far removed the scheme was from the profession's preferred alternatives to contract medical practice. It then considers the extent to which the apparatus of NHI was modified in response to professional lobbying and orchestrated political resistance before determining if the system thereby created was supportive of, or detrimental to, the articles of faith previously described. The chapter concludes with an assessment of the immediate impact of NHI on GPs and their ongoing need for representation.

The development of the conflict over NHI was, I argue, conditioned as much by the hopes and fears of ordinary GPs as by the personal ambitions and prejudices of the profession's leaders. It was characterised by an unprecedented show of professional solidarity and decisive, yet ultimately ineffective, political action, the failure of which plunged the profession into a crisis of self-doubt and recrimination. This conflict may in one sense be seen as a continuation of the trade union-like activities taking place within the profession in the 1890s. However the surprising militancy exhibited by many doctors and the ideological dogmatism of opposing professional factions in 1911-1913 could be seen as symptomatic of a tendency affecting many areas of public life in Britain at that time. Social and political groups as varied as Irish Republicans and Ulster Unionists, Trade Union syndicalists and the more militant advocates of female suffrage, exhibited a form of political extremism which G.R. Searle characterises as a strain of 'moral absolutism', which rejected the 'liberal culture of compromise' and 'government by discussion'.[4] In what was seen by many doctors as an existential struggle for the survival of their profession, GPs could not be expected to be immune from such influences. The analysis which follows offers a new interpretation of this conflict by emphasising the importance of the precedent set by the use of 'pledges' of solidarity in the BMA's campaign

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[4] Searle, *A New England?* pp. 470-471.

and by showing how the Association's apparent defeat fostered the polarisation of political opinion within the profession and set the scene for future conflicts with government.

The working classes, the state and the provident principle

Historians agree that the reasons for the Liberal government's social welfare legislation of 1906-1914 are complex and various. None would now suggest that the legislation should be viewed as a coherent social welfare programme as such, and certainly not part of a 'grand plan' to establish a welfare state. Lloyd George, the architect of many of the reform measures, and many in his party, were influenced by the experience of social insurance in Germany from the 1880s.[5] The slower growth of the British economy relative to its rivals, Germany and the U.S., after 1870 and the economic depression of the 1880s, had a significant impact on the political classes in Britain.[6] Concerned that the decline in Britain's economic output might be inexorable and symptomatic of a more general decline in the strength and capability of its citizens, both Conservative and Liberal politicians looked to emulate Germany where social reform had been used by the state in an explicitly conservative manner – what Marxist historians have described, somewhat contemptuously, as 'social imperialism'.[7] Like their counterparts in Germany, British businessmen, in the Liberal party and outside it, supported social reforms on the grounds that they could contribute to the efficiency of the workforce. Recognising their value as 'human capital', progressive employers were increasingly concerned about the impact of health on the efficiency of their workers.[8] Health Services were seen to aid efficiency by

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[5] Gilbert, *The Evolution of National Insurance,* pp.291-293.
[6] Hay, *The Origins of the Liberal Welfare Reforms,* p.30.
[7] Geoffrey Eley, *Modern Germany* (New York, 1998) vol. 2, 'Social Imperialism', *passim.* See also Bernard Harris, *The Origins of the Welfare State*, pp.19-21.
[8] Hay, *The Origins of the Liberal Welfare Reforms,* p.54 See also Martin Gorsky, 'The Political Economy of Healthcare in the Nineteenth and Twentieth Centuries' in Mark Jacobs (ed) *The Oxford Handbook of the History of Medicine* (Oxford, 2013) p.431.

ensuring the worker returned to the labour force as soon as possible after illness.[9]

Both Conservative and Liberal imperialists recognised it would be impossible to defend the Empire without a healthy working class.[10] These concerns were given emphasis by studies of the physical and social conditions of the working classes by Booth and Rowntree and revelations from the interdepartmental committee report into the fitness of recruits for the Boer war.[11] As the Prime Minister, Asquith, said: 'What is the use of talking about the Empire when here, at its very centre, there is always to be found a mass of people, stunted in education, a prey of intemperance, huddled and congested beyond the possibility of realizing in any true sense either social or domestic life?'[12] It was this thinking which lay behind the Liberal government's attempt to create a less fragmentary and more effective means of providing for the sick, disabled, elderly and unemployed. There is widespread support, however, for the idea that politicians introduced social reform to boost electoral popularity or to prevent workers turning to extreme Labour, socialist or syndicalist solutions (what T.H. Marshall called the 'class abatement' aspects of the reforms).[13] The Liberal Peer Lord Crewe warned Campbell Bannerman in 1905 that 'the Liberal party is on trial as an engine for securing social reforms. It has to resist the ILP claim to be the only friend of the workers.'[14] Social reforms 'mediated the class tensions to which industrialisation gave rise' and could therefore be viewed as 'property's ransom for security.'[15] The proposition that the measures were introduced as a means of containing the socialist threat is evidenced by the fact that Conservatives and Unionists did not directly oppose them. Proof of a consensus on frustrating socialist ambitions

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[9] J.F. Harris, *Unemployment and Politics 1886-1914* (Oxford, 1972) p.218.
[10] Gilbert, *The Evolution of National Insurance*. p.61. Hay, *The Origins of the Liberal Welfare Reforms*. p.18.
[11] Charles Booth, *Life and Labour of the People of London*. (London ,1892) *passim.* Seebohm Rowntree. *Poverty: A Study of Town Life* (London 1901) *passim.* Renwick, *Bread For All*, pp.93-103.
[12] Gilbert, *The Evolution of National Insurance*. p.77.
[13] Quoted in Hay, *The Origins of the Liberal Welfare Reforms*, p.25 'National Insurance was the Liberal Government's response to the threat of socialism.' Bernard Harris, *The Origins of the Welfare State* p.155.
[14] Searle, *A New England?,* p.361.
[15] Gorsky 'The Political Economy of Healthcare in the Nineteenth and Twentieth Centuries'. p.431.

can be found in the comments of A.J. Balfour that: 'Social legislation…is not merely to be distinguished from socialist legislation, but it is its most direct opposite and its most effective antidote.'[16]

The introduction of welfare measures was also influenced by a gradual change in attitudes towards poverty in the last decades of the nineteenth and the first decade of the twentieth centuries. Many enlightened thinkers recognised the link between sickness and poverty which the Webbs and other social scientists identified in their writings and which added weight to the arguments of those calling for a reform of the Poor Law system on humanitarian grounds.[17] The architects of the Liberal reforms were also influenced by the views of intellectuals like the Oxford philosopher, T.H. Green, who postulated an 'organic' view of society, and D.G. Ritchie, who made a case for a more collectivist approach by government towards social problems in what was still regarded essentially as an individualist society.[18] The new 'advanced Liberalism' which came into being was not, in the view of these authorities, an abandonment but a re-interpretation of individualism, as the state was encouraged to take steps to liberate the faculties of the individual, to remove obstacles to self-development and allow individuals to realise their personal potential.'[19] James Vernon sees the Liberal 'revolution' in government as being grounded in the philosophy of laissez-faire and self-help. It was not just about creating a new kind of state, he says, but creating a new type of citizen who could govern themselves.[20] Making markets free demanded that the state develop new capabilities and

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[16] Quoted in Fraser, *The Evolution of the Welfare State.* p.129.

[17] Sidney and Beatrice Webb, *The State and the Doctor*, (London,1910) pp. 78, 81,123.

[18] Jose Harris, *Private Lives, Public Spirit*, pp. 228-229. Renwick, *Bread For All*, pp.64-72.

[19] 'Advocates of state "collectivism" rarely wished government action to take the place of self-help, philanthropy and the duty to work, but rather wished to supplement and reinforce these attributes which were regarded as socially and morally desirable.' Thane, *Foundations of the Welfare State*, p.12. 'Liberals did not discard their traditional belief in individuality but its meaning was extended by a sophisticated exploration of the interdependence of citizens and the society of which they were members.' Searle, *A New England ?* p.394.

[20] Vernon, *Modern Britain: 1750 to the Present* p.114. See also Michael Bentley 'Boundaries in theoretical language about the British State' in S.J.D. Green and R.C.Whiting (eds) *Boundaries of the State in Modern Britain* (Cambridge 1996) pp. 42-43.

responsibilities and the boundaries of the state were extended to new ways of governing and shaping the 'condition of England' and the 'social question'.[21]

    Recognising the practical difficulties and the economic and political cost of extending state power in this direction, the Liberal government sought to involve private, charitable and local government institutions to mediate its proposals for social welfare, devolving authority to administer these to a variety of agencies on the state's behalf.[22] In what Nikolas Rose describes as 'governing at a distance', the government sought to implement its policy objectives by means of a public/private partnership with a variety of non-governmental institutions and was thus able to operate through networks or nexuses of authority (what Michel Foucault calls 'modalities of power').[23] As Mary Poovey and Jose Harris have explained, there was a long tradition of voluntarism and charitable self-help in Victorian Britain which had produced many social institutions interested in and capable of delivering government sponsored welfare programmes.[24] Foremost among these were the friendly societies whose role and functions were considered in the previous chapter. The path towards social welfare legislation was guided by a small number of prominent civil servants like, Sir George Askwith, Sir Hubert Llewellyn Smith and William Beveridge. By quantifying social problems and presenting them in a statistical rather than polemical manner they succeeded in convincing other government officials as well as Ministers that social reform was consistent with ideas of scientific progress.[25] Studies of government papers and memoirs of civil servants point to the growth of a new type of determinism suggesting that extension of the role of government was a product of a bureaucratic process in which experts in the civil service, rather than politicians were the

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[21] Vernon, *Modern Britain: 1750 to the Present,* p.115.

[22] Jose Harris, *Private Lives, Public Spirit* ch.8.

[23] Nikolas Rose, 'Government, Authority and Expertise in Advanced Liberalism', *Economy and Society,* 22, 3, p.292.

[24] Mary Poovey, *Making A Social Body: British Cultural Formation 1830-1864* (Chicago, 1995) p. 14; Jose Harris, *Private Lives, Public Spirit*, pp.220-250.

[25] Hay, *The Origins of the Liberal Welfare Reforms*, p.39. Renwick, *Bread For All*, pp. 110-115 and 178-180.

prime movers in legislation.[26] These men were often motivated, just as, I would argue, the

doctors were, by the 'professional social ideal'.[27] Through them the authority of expertise

became inextricably linked with the formal political apparatus of the state.[28]

Lloyd George's decision to introduce national sickness insurance was not based on an

awareness of the inadequacies of British medicine. His scheme was a social, not medical

measure designed to mitigate the effects of illness on workers and, indirectly, their dependants,

and to help the breadwinner to return to work as soon as possible. While the Fabians argued

that poverty was one of the principal causes of sickness, for Lloyd George poverty was 'the

evil that sickness caused' and it was this that his scheme was designed to mitigate.[29] The choice

of insurance as the method by which the Liberals sought to achieve this was driven by both

ideology and pragmatism. The careful study which Lloyd George commissioned of the German

Social Insurance model convinced him and his associates that it could be effective and

affordable and they reasoned that it would be more acceptable to most of their supporters, and

to the Treasury, to work through existing agencies in the field.[30] The adoption of the insurance

principle was also influenced by Treasury fears that a future government might introduce tariff

reform to pay for social legislation, while the alternative of leaving implementation in the hands

of local government aroused fears of weakened financial discipline and geographical

variation.[31] Concluding that existing systems of relief and rehabilitation were inadequate, the

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[26] Renwick states that these individuals were jokingly referred to as 'the boffinocracy'. *Bread For All*, p.115.

[27] Harold Perkin, *The Rise of Professional Society: England since 1880* (London, 1989) p. 288. Sir Robert Morant was a perfect example. In 1913 he stated: 'We can make work at the Government Department the most marvellous means for true social reform that the world has seen.' B.M. Allen, *Sir Robert Morant, A Great Public Servant* (London, 1934) .

[28] Nikolas Rose, 'Government, authority and expertise in advanced liberalism', p.285. Pat Thane describes experts exercising power on the state's behalf (what she calls 'bounded pluralism'), as an elite which conflated its personal interests with the national good. Thane, *Foundations of the Welfare State* p.291.

[29] Gilbert*, The Evolution of National Insurance*, p.315. John Grigg, *Lloyd George; The People's Champion 1902-1911* (London, 1978). pp. 316-317.

[30] An early and much quoted authority on NHI, W.A. Brend, an extremely critical commentator, contended that Lloyd George ignored or misinterpreted the evidence from the German experience. William A Brend, *Health and the State* (New York, 1917) pp. 213-214.

[31] The failure of local government attempts to solve social problems, evidenced in the response to Chamberlain's circular of 1886 and the Unemployed Workmen Act 1905, coupled with a clearer appreciation of

Royal Commission on the Poor Laws (majority) report of 1909 recommended that medical assistance for persons incapacitated from wage-earning should be provided on a provident basis, whereas the minority report favoured a much more radical approach, involving a non-contributory state scheme run by Local Authorities. These reports emboldened the Liberals to take decisive action in the way of social reform. Despairing of the possibility of delivering the necessary changes through a reformed Poor Law, however, due to the intransigence of the Local Government Board, however, they judged it politically expedient to bypass the problem and leave the Poor Law as it was, to 'wither on the vine', in the hope that, National Insurance would in time replace it with a more efficient and less stigmatizing alternative.[32]

The 1911 Act was, according to John Turner, 'not a collectivist measure pushing out the boundaries of the state, but an umbrella for the extension of private welfare' which was 'at the limits of the state's competence.'[33] The government therefore relied on external interests to bridge the gap in capacity.[34] The easiest way to introduce national health insurance. Lloyd George decided, was to build on the existing system of sickness insurance operated by the friendly societies, making them, together with trade unions and insurance companies, 'approved societies' responsible for administering the scheme on the state's behalf, and ensuring that all qualifying workers paid into the scheme along with the state and their employers. The nature of the structures which emerged to form the administrative apparatus of the scheme was determined less by utility and idealism, however, than by the need to reach a compromise with competing vested interests, including the doctors who were to work under

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the magnitude of social problems, increased the Liberals' desire for central government solutions. Hay, *The Origins of the Liberal Welfare Reforms*, pp. 40-41.

[32] *Ibid,* p.42; Thane, *Foundations of the Welfare State*, p.90.

[33] John Turner, 'Experts and Interests: David Lloyd George and the dilemmas of the expanding state 1906-19.' in Roy McLeod (ed) Government and Expertise*: Specialists, Administrators and Professionals 1860-1919,* (Cambridge, 1988). p.211.

[34] *Ibid*, p.204.

the Act.[35] It was for this reason that the passage of the Bill has been described as 'an almost classic history of lobby activity.'[36]

Fear, indignation and defiance: the medical response to NHI

Lloyd George and his officials had discussed his evolving proposals for health insurance at length with representatives of the friendly societies before the press and other interested parties, including the doctors, got wind of what was proposed. Although many friendly societies' representatives expressed concerns about a loss of independence, the government's reforms offered them a potential lifeline. Many of the societies feared for their long term stability in view of the increasing cost of sickness benefits claimed by a membership living longer than anticipated.[37] The societies financial health was also threatened by increasing competition for younger workers from the commercial insurance industry. The majority of the smaller friendly societies were already insolvent. The MP Sir Leo Chiozza-Money opined that the scheme 'puts them on their feet again by giving them new reserve funds' and 'keeps them solvent by submitting them to an expert supervision'.[38] If the doctors were aware of these developments, however, they had no discernible effect on their views of National Health Insurance. Previously

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[35] Hermann Levy, *National Health Insurance: A Critical Study* (Cambridge, 1944) p.14.

[36] Gilbert, *The Evolution of National Insurance* p. 356.

[37] As regards the societies' actuarial challenges, Riley contended that age-specific morbidity had begun to rise just as mortality rates were declining (J.C. Riley, *Sick Not Dead: the Health of British Working Men During the Mortality Decline* (London,1997) pp. 198, 106-107) and Martin Gorsky opined that friendly society sickness claims were becoming 'long term, seasonal and chronic' and that the societies feared 'an impending demographic crisis'.('Friendly Society Health Insurance in Nineteenth Century England' p.159). However more recent and in-depth studies of friendly society records by Gorsky and others found very little change in age specific morbidity, concluding that the main reason sickness rates increased with age was that when older people became ill they remained off work for longer. Bernard Harris, Martin Gorsky, Aravinda Meera Guntupalli and Andrew Hinde, 'Long-term Changes in Sickness and Health: Further Evidence from the Hampshire Friendly Society.' *Economic History Review* , 65, 2 (2012), p.744.

[38] Sir Leo Chiozza-Money, *Insurance and Poverty* (London, 1912) p.135. David B. Green, typically, takes an optimistic view of their future prospects and thus a negative view of NHI but for a convincing refutation of those arguments see Bernard Harris, 'Social Policy by Other Means? Mutual Aid and the Origins of the Welfare State in Britain during the Nineteenth and Twentieth Centuries.' *Journal of Policy History*, (2018) 30 (2) pp. 207-213.

wary of state intervention, the medical profession had by this time begun to favour more systematic provision of medical services. As one medical observer wrote in 1912: 'National Health Insurance has long been overdue and a State medical church appeals to medical men as readily as to other people.'[39] Indeed, the BMA's proposals for 'The organization of medical attendance on the provident or insurance basis' (its blueprint for a national scheme of Public Medical Services run by doctors themselves), which the Association finally endorsed in March 1911, were more liberal and extensive than the government's limited proposals for NHI.[40] In a memorandum considered at a meeting between the BMA's Special Poor Law Committee and Contract Practice subcommittee in 1910 Dr W. Gosse asked if the state scheme was to be limited to working men, stating that 'Unless women and children are included it is impossible to see how an efficient national scheme can be carried out.'[41]

The government's proposals for NHI caught the profession by surprise. Lloyd George had met with the BMA only briefly before his Bill was published and given little detail of his intentions.[42] The initial response was understandably cautious.[43] Once the profession had learned of the friendly societies' role in it, however, their mood quickly darkened and the BMA urgently sought meetings with the Chancellor to voice their concerns. If Lloyd George was previously unaware of what the doctors thought of the prospect of letting the friendly societies run the national scheme, he was quickly made aware of their feelings. The backbench Liberal MP Dr Christopher Addison was among those invited to advise the chancellor on the doctors' reaction to his scheme. Addison informed him that, as currently formulated, the scheme 'simply

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[39] Woodcock, *The Doctor and the People* p.99.
[40] *BMJ* 4 March 1911,'Report on the Organization of Medical Attendance on the Provident or Insurance Principle', Supplement, pp.82-107.
[41] *BMA Archive*. Minutes of meeting between the Special Poor Law Committee and Contract Practice Subcommittee, 26 October 1910. Memorandum by Dr W Gosse.
[42] Gilbert notes the discrepancy between the three occasions Lloyd George claimed to have met with doctors' representatives and the single occasion noted by the BMA. Gilbert, *The Evolution of National Insurance* footnote to p.363.
[43] *The Times* 'The State Insurance Bill - Action by the Medical Association' 22 May 1911 p. 9.

stank in the nostrils of the whole medical profession'. If he tried to impose it on them, he said, he would 'find them solid to a man against it.'[44] For the GPs who, over several decades, had chafed at the constraints and humiliations imposed on them by the friendly societies, the government's proposals represented the institutionalisation of lay control. Being national and likely to incorporate a sizeable percentage of the working population, moreover, the scheme threatened to alter irrevocably the market for working-class medical care. If constructed in the way the doctors wanted, it might prove a boon to the GPs and their patients but if the friendly societies had their way it would result for the doctors in greater dependency, demoralisation and permanently depressed levels of remuneration. Fortunately for the doctors, there were other powerful interests determined to prevent the friendly societies having a monopoly of control over the scheme. The commercial insurance companies were less keen to be involved in administering the scheme and wanted to restrict the influence it accorded to the friendly societies. They gradually threw their considerable weight therefore behind a proposal devised by Addison whereby the administration would be conducted not by the approved societies but by local 'health committees' answerable to central government commissioners.[45]

To the consternation of officials working on the scheme, such as Braithwaite and Bradbury, Lloyd George was eventually dissuaded from vesting the power to administer the state-sanctioned scheme in the friendly societies' hands and, to appease the medical profession, he began to express sympathy for their concerns about the societies' failings.[46] According to BMA official Alfred Cox, Lloyd George recognised that 'while a medical service is imaginable without Friendly Societies, it cannot be worked without doctors.'[47] The chancellor was even

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[44] Christopher Viscount Addison, *Politics from Within*, vol 1, 1911-1918 (London, 1924). p.20.
[45] Gilbert, *The Evolution of National Insurance* pp.368-382.
[46] Lloyd George wrote to the Cabinet on 30 March 1911 about this after interviewing 'a large number of doctors' about 'the medical side of the scheme.' Sir Henry Bunbury (ed) *Lloyd George's Ambulance Wagon: The Memoirs of WJ Braithwaite* (London, 1949). pp.141-142.
[47] Alfred Cox, *Among the Doctors* (London, circa 1950) p. 86.

persuaded to support the profession's demand for free choice of doctor, though it was anathema to the societies, and contrary to his previously expressed view that the experience of health insurance in Germany had shown that 'free choice of doctor promotes malingering'.[48] Thus he told the House of Commons in 1911 'No man who could afford to do otherwise would have a doctor prescribed for him by any club or society.'[49] His chief civil servant, Braithwaite, was evidently annoyed by this volte face when he noted that 'The doctors had the whole house on the run with this specious cry of 'free choice of doctor''.[50] He tried and failed to ensure the approved societies were able to select the scheme doctors. He wrote 'I did not realize what a pull the doctors had…I staved off the evil day, but only temporarily. We were doomed to have free choice of doctors thrust right upon us after all.'[51] In any case, the principle commended itself to the House, the authors of the first commentary on National Insurance claimed, because to compel the insured to 'have, as his medical attendant, one whom he might distrust, was unreasonable, especially as confidence in a medical adviser is an essential factor in the cure.'[52]

Mindful that the Conservative press was stirring up opposition among the medical portion of its readership, Lloyd George decided to meet the challenge head on by addressing the Special Representative Meeting called by the BMA on 11 June 1911 to debate the National Insurance Bill, an experience he later likened to being like that of 'Daniel in the lion's den'.[53] He had been well briefed about the doctors' concerns by, among others, Addison, who had been acting as an unofficial intermediary between the government and BMA officials at this time.[54] Following his speech, the BMA compiled a list of demands called 'the six cardinal points'.[55]

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[48] Gilbert, *The Evolution of National Insurance* p.364.
[49] *Hansard*. 1 August 1911. col. 318.
[50] Bunbury, *Lloyd George's Ambulance Wagon* p.198.
[51] *Ibid,* p.182.
[52] A.S. Comyns Carr, W.H. Stuart-Garnett, and J.H. Taylor, *National Insurance* (London,1912) p.63.
[53] Quoted in John Grigg, *Lloyd George: The People's Champion*. p. 334.
[54] Jane Morgan and Kenneth Morgan. *Portrait of a Progressive: The Political Career of Christopher, Viscount Addison* (Oxford, 1980) p. 12.
[55] Peter Bartrip *Themselves Writ Large: The British Medical Association 1832-1966* (London, 1996) p.154. As a member of one of the BMA's advisory committees, Addison may have contributed to the drafting of these

These were : an income limit of £2 per week for any participant in the service; free choice of doctor by the patient, subject to the doctor's consent to act; medical and maternity benefits to be administered by local health committees (later named Insurance Committees), rather than the approved societies, and all questions of medical discipline to be settled by local medical committees composed entirely of doctors; the method of payment to the profession in the area of each Insurance Committee to be decided by the preference of a majority of local doctors; payment to the doctors to be 'adequate' (this was later defined as 8s 6d per patient per annum excluding the cost of medicines and other extras); adequate medical representation among the various administrative bodies working the Act and statutory recognition of the local medical committees previously mentioned.

During his interrogation by the audience at the meeting Lloyd George fielded questions on all of these points and gave affirmatory responses to all of them except the first and last of them. The question of remuneration was, he said, a matter to be further negotiated. On the question of an income limit to exclude the well to do from the scheme, he pointed out that the half a million miners currently enrolled in clubs were highly-paid workmen. Were they to be excluded from the national scheme he asked, and if so, how could the legislation obtain parliamentary approval given the considerable number of MPs who depended on their votes?[56] Gilbert states that Lloyd George's great political achievement was to turn opposition to himself to opposition to the friendly societies.[57] The chancellor won rapturous applause at the BMA meeting when he told them he would support a proposal to transfer responsibility for running the scheme from the friendly societies to local health committees.[58] But the BMA remained suspicious, even when the four cardinal points Lloyd George had conceded were incorporated

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points. Morgan and. Morgan, *Portrait of a Progressive,* pp.14-17 The cardinal points clearly owe something to the BMA's response to the Royal Commission on the Poor Law.

[56] Paul Vaughan, *Doctors' Commons* (London,1959) p.200.

[57] Gilbert, *The Evolution of National Insurance* p.367.

[58] Report of Special Representative Meeting of 31 May, I June 1911, *BMJ*. June 3, 1911, Supplement p.354.

by Addison into an amendment to the Bill which was passed with the chancellor's support. Crucially the amendment did not institute an income limit but left it to the local discretion of the Insurance Committees. However, it was later set at a rate of £160 per year for non-manual workers and there was no income limit for manual workers.[59] If he and Lloyd George thought the amendment was enough to appease the Bill's opponents in the profession, however, they were soon disappointed. Conscious of the power their unprecedented show of unity appeared to have accorded them in negotiations with the government, many doctors urged the BMA to press home their advantage and demand the concession of the remaining 'cardinal points'.

The 'Doctors' Revolt': the BMA and professional resistance

Having witnessed his successful appearance at the BMA meeting, Herbert de Carle Woodcock wrote that 'Lloyd George knows the powers of organised trades and crafts but he apparently does not reckon with the just pride and rational independence which animate such a body of men as the doctors.'[60] Taken together, the issue of remuneration and the income limit for the insured which, as previously demonstrated, lay at the heart of the profession's battle with the friendly societies, was for a great many doctors too important a matter to leave unresolved. As the newspapers reported, the income limit outlined in the Bill would, in the opinion of very many doctors, represent the end of private practice and had to be resisted at all costs.[61] The *Birmingham Post* reported one eminent professor saying that it 'would result in an immediate drop in the saleable value of their practices.'[62] A doctor wrote to the *Daily Mail* stating that the week before the Bill was introduced his rural practice could have been sold for £2,000, but

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[59] There is some doubt as to whether Addison personally supported an income limit. He had asked for it to be included during the bill's first reading. Bunbury, *Lloyd George's Ambulance Wagon* p.171. However, Alfred Cox claims that Addison thought the idea of an income limit was 'absurd'. Cox, *Among the Doctors*, p.91.

[60] Woodcock, *The Doctor and the People*, p.80.

[61] *Daily Mail* 'Doctor's Revolt…Income limit in State practice.' 5 June 1911, p.6.

[62] Professor J.T.J. Morrison, quoted in *The Birmingham Post*, 16 June 1911. Morrison was actually a supporter of a salaried medical service and founder member of the State Medical Services Association.

'this week it would not sell at any price.'[63] At the BMA's representative meeting in June 1911 their president voiced the concerns of many when he referred to the need to compensate GPs for the expected loss in value of their practices.[64]

The BMA eventually set out its case for 'adequate remuneration' stating that they wanted a minimum of 8s 6d per patient p.a. exclusive of the cost of drugs. Were the BMA 'to entertain any suggestion of compromise upon this point' its medical secretary, James Smith Whitaker, wrote to Lloyd George, 'its action would undoubtedly be repudiated by the profession.'[65] Lloyd George had reason be sceptical of the notion that the profession would refuse to accept anything less than this amount. During the second reading of the Bill he had come across for the first time the BMA's 1905 Report on Contract Practice and 'was thrilled by it' as it proved that what he was offering was considerably more than what most GPs could expect to earn under existing club contracts.[66] He was recorded as saying 'If any man had got them 5s he would have been a hero; I have arranged 6s and I am a villain.'[67] The BMA's report should, however, be viewed with scepticism given that, as Comyns Carr was later to point out, it may have seriously underestimated the number of attendances on which the average figure was based.[68] Whitaker assured his colleagues on the BMA's Council that, ultimately, the government would have to concede their demands as no government could force the profession to serve under unacceptable conditions. The doctors had merely to refuse to serve en masse, he contended, and victory would be theirs.[69]

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[63] Quoted in E.S. Turner, *Call the Doctor: A Social History of Medical Men* (London, 1958) p.255.
[64] *The Times*, 27 June 1911, p.4.
[65] Peter Bartrip *Themselves Writ Large: The British Medical Association 1832-1966* (London, 1996) p.156.
[66] Bunbury, *Lloyd George's Ambulance Wagon* p.167.
[67] *Ibid,* p.172.
[68] Comyns Carr, *National Insurance* p.56.
[69] Bartrip, *Themselves Writ Large* p.155.

Figure 5. *Allies and antagonists:* Dr Christopher Addison, MP (left). Photograph from *Medical World* 1914. Dr J A Macdonald (right), Chairman of the BMA Council 1910-1920 and the Insurance Acts Committee 1913-1916. Photograph from BMA Archive.

With the backing of the Association's Council, led by the doughty Ulsterman, J.A. MacDonald (see Figure 4), Whitaker set about mobilising the doctors.[70] On 3 June 1911 he circulated a letter to every member of the profession, distributed through the BMA's new branch and division structures and advertised in the *British Medical Journal (BMJ)*, asking them to support BMA policy by joining the Association if not already members, pledging their refusal to enter the service other than when the BMA deemed it appropriate, and contributing to a fighting fund to meet the costs of opposing the Act.[71] A further circular letter of 21 June invited all doctors to sign an undertaking 'not to enter into any agreement for giving medical attendance and

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[70] As the BMA's principal negotiator, MacDonald met the mercurial Welsh Chancellor several times, informing colleagues of his difficulty in suppressing the urge to throttle him! Cox, *Among the Doctors*, p.87. Lloyd George, however, remembered their encounters more affectionately, asking Ewen Maclean in 1928 'How is Old MacDonald? He was against us but I liked him!' MacDonald Obituary, *BMJ* 5 May 1928, p.782.

[71] The fund was to be used 'for the direct pecuniary assistance of medical practitioners threatened with or incurring actual loss of income' by adhering to BMA policy. *BMA Archive*, Medico Political Committee circular 112, 1 May 1911 'Professional Defence Appeal for £5,000'. A proposal to establish a central emergency fund had been considered by the committee in 1910 in response to fears that the government might seek to implement proposals for a state medical sickness scheme based on the minority report on the Poor Law.

treatment to persons insured under the Bill, excepting such as shall be satisfactory to the medical profession and in accordance with the declared policy of the British Medical Association.'[72] The pledge of solidarity which had been wielded sporadically and, usually, ineffectively by GPs as a weapon in their battles with friendly societies in the second half of the nineteenth century was thus for the first time employed on their behalf systematically at a national scale by a highly organised and influential representative body. It was the first showdown between the government and an organised medical profession the country had witnessed and was to set the pattern for conflicts that were to come.

The reaction to the call from the BMA was immediate and powerful. Old antagonisms were set aside as across the country doctors assembled in noisy and angry gatherings to express their fears and pledge support for the BMA in its quest to secure the guarantees set out in the 'six cardinal points.' One such gathering took place in Nottingham on 21 November 1911 at which the meeting resolved 'That the National Insurance Bill as at present drafted does not satisfactorily meet the demands of the profession as defined in the six cardinal points and that the scheme in its present form is unworkable, is detrimental to the medical profession and dangerous to the public health.'[73] Another GP wrote in his memoirs that the Act, 'stirred up the medical profession like never before. Never before had so many GPs become acquainted with each other. Meetings galore, full of sound and fury.'[74] Significantly, a rider to the undertaking the GPs signed spoke of them joining NHI 'only through a Local Medical Committee representative of the district in which I practice'. Many local meetings thus resulted in decisions to establish provisional local medical committees to coordinate resistance to the Act. The national and local press dutifully reported the increasing tally of doctors refusing to accept

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[72] *BMJ* I July 1911,' National Insurance, Action of the British Medical Association, The Undertaking and the Memorial', Supplement p.2.
[73] *Nottinghamshire County RO*, DD/1440/23/1;1911-193 21 November 1911.
[74] Dr M.F. Taylor quoted by F.E. Lodge, 'Reminiscences from a Fenland Practice.' *BMJ* 22 December1984, p.1760.

service under the Act. They published letters from anxious or irate doctors and reported on the doctors' meetings which the *Daily Mail* christened 'The Doctors' Revolt'.[75] Eventually some 27,400 signed undertakings were received by the BMA.[76]

Despite this massive show of professional solidarity Lloyd George was not cowed. He believed the benefits of the Act to the doctors had been poorly understood and doubted the ability of the BMA's leadership to properly represent the views of the many impoverished GPs he believed would benefit from working under it.[77] As early as June 1911, he estimated that the government could recruit a minimum of 7,000 doctors to offer a service as full time salaried medical officers if the profession withheld cooperation.[78] As signed undertakings, letters of support and criticism, and accounts of opinions voiced at local meetings poured in to the BMA's headquarters, the voices of those in the profession who distrusted the Liberals, and Lloyd George in particular, or opposed NHI on principle, began to dominate the debate. Concerned that the BMA was wavering in its resolve, a group of doctors in Manchester formed a body called the National Medical Union (NMU) to oppose all talk of compromise with the government.[79] The Union denied that it was opposed to the Act or to the BMA. Its advisory committee recorded that its aim was 'to resuscitate' the BMA and 'make it a real mouthpiece for its members' and its opposition to the Act was based on the fact that the 6 cardinal points were not conceded or guaranteed.'[80]

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[75] For example, *Daily Mail*, 9 January 1912, p.8; 10 January 1912, pp. 5-6.

[76] Vaughan, *Doctors Commons*, p.202.Though estimates of the composition of the medical profession at that time vary it is assumed that there were only about 22,500 practising GPs so the pledges were signed by a significant number of others including consultants, hospital staff doctors and possibly even medical students.

[77] He declared that 'a Deputation of Doctors is always a Deputation of swell Doctors.' Gilbert, *The Evolution of National Insurance* p.363.

[78] Bartrip, *Themselves Writ Large* p.155

[79] *Manchester University Medical Collections* NMU 1. Minutes of Advisory Committee 28 December 1911 p.3.

[80] *Ibid,* Minutes of Advisory Committee 19 January 1912 p.1. Another organisation calling itself the British Medical Association Reform Committee which pledged to 'end or mend the B.M.A. Council' was formed at the same time in London, though little more was heard of it. Gilbert, *The Evolution of National Insurance* p.405.

Some of the BMA grandees concealed their political party affiliations but others, like the BMA president Sir James Barr did not. A 'tearing demagogue…with an aversion to all Liberals' according to Alfred Cox, he declared that, in removing the need for self-reliance, National Insurance would 'hasten the degeneracy of a spoon-fed race.'[81] While Liberal-supporting newspapers condemned such intransigence, others condemned the BMA's efforts to secure improvements in the government's offer through continued dialogue. Cox commented that the profession had thus become 'the shuttlecock of politics and the victim of press sensationalism.'[82] Once the Bill became law on 6 December 1911, however, many GPs began to doubt the wisdom of antagonising the government and losing public sympathy. In a letter to the secretary of one of the newly formed local medical committees, one Nottinghamshire doctor expressed a fear that the Conservative party would 'use us as a stalking horse to upset the radicals.' He added: 'The Bill is law now and it is our business to get as much money out of it as we can.'[83]

The agitation of the profession was increased by two further developments. Firstly, while Addison's amendment had secured four of their six demands, an amendment sponsored by the recently elected MP for Luton, known as the Harmsworth amendment, secured an unexpected victory for the friendly societies and trade unions by allowing Medical Aid Institutes to continue to operate and be funded under national insurance, though there was to be a moratorium on further such developments.[84] This was a bitter blow to those in the profession

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[81] *The Times* 14 October 1911. Barr later showed his contempt for the Act by becoming one of the vice-presidents of the NMU when it reconstituted itself in 1913 as a 'rallying ground' for non-panel doctors. *Manchester University Medical Collections* NMU 1. Minutes of Executive Committee 20 February 1913.

[82] In the novel *Dr Bradley Remembers* the narrator notes that although doctors were among the least politically minded members of the community 'the colour of the profession as a whole (and particularly the men with big names who controlled the B.M.A.) was markedly Conservative. The opponents of the Bill realized this as well as he did and were doing their best to exploit it.' Francis Brett Young, *Dr Bradley Remembers*. (London, 1938), p.709.

[83] *Nottinghamshire County RO*, DD/1440/23/20-43 LMC correspondence. Letter 17 December 1911 from Dr F. Broadbent of Collingham to Dr Ernest Ringrose, Secretary, Newark Local Medical Committee.

[84] In the Bye-election of 1911 the friendly societies lobbied prospective candidates to press for an amendment to the Insurance Bill to allow the Institutes to administer local benefit. See Simon Cordery, *British Friendly Societies, 1750-1914* (Basingstoke, 2003) p.168. Comyns Carr, *National Insurance*, pp. 61-63.

who had campaigned for their abolition or replacement by professionally-run Public Medical Services. The second development was more of an 'own goal' by the BMA. Having agreed to include representatives of the profession in the administrative machinery of the Act, the government sought to test the resolve of the BMA by inviting their respected medical secretary, James Smith Whitaker, to become Deputy chairman of the new National Insurance Commission. Before responding, Whitaker placed the matter before the Council of the BMA which, after a lengthy debate, approved the appointment.[85] The resulting furore appeared to catch the Association by surprise and their attempts to rationalise the decision failed to placate the growing chorus of those who characterised it, publicly, as 'the great betrayal'.[86] One of the casualties of the backlash was the former chairman of the Representative Body, Sir Victor Horsley, a supporter of welfare reform and Liberal party member, who was heckled by angry doctors at a BMA meeting at the Queens Hall in December 1911 with cries of 'Traitor!' and 'Go to your Lloyd George!'.[87] The departure of moderates like Horsley and the diminishing influence of his successor as chairman of the representative Body, Dr Ewen Mclean, after he narrowly survived a vote of no confidence in him, left the BMA in the hands of uncompromising diehards egged on by Liberal-baiting newspapers like the *Daily Mail*. [88]

In March 1912 the BMA's acting Medical Secretary, Alfred Cox, wrote to Divisions and branches in England, Scotland and Wales repeating his predecessor's instructions to establish provisional local medical committees (LMCs). The BMA knew that it could not act without the support of an overwhelming majority of GPs, a significant number of whom were not BMA members, so the divisions were told not to confine membership of or voting rights for LMCs

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[85] Vaughan, *Doctors Commons*, p.204.

[86] Letter from Dr F. J. Smith, *The Times*, 6 December 1911.

[87] Sir John Conybeare, 'The Crisis of 1911-1913: Lloyd George and the Doctors', *Lancet*, 15 May 1957, p.1033.

[88] For the *Mail*'s account of the meeting see report dated 21 February 1912 p.7. From then on it continued to praise the efforts of the 'no service' party at the expense of the moderates in the BMA. Dr Broadbent of Newark complained to his colleague Ernest Ringrose that the *Mail* was 'inveigling the doctors' to reject the government's terms. *Nottinghamshire County RO*, DD/1440/23/20-43 LMC correspondence, February 1912.

THE DOCTOR.
(With Apologies to Sir Luke Fildes, R.A.)

PATIENT (*General Practitioner*). "THIS TREATMENT WILL BE THE DEATH OF ME.'
DOCTOR BILL. "I DARE SAY YOU KNOW BEST. STILL THERE'S ALWAYS A CHANCE."

Figure 6. *A popular take on the 'Doctors' revolt': cartoon from Punch 1912.*

to BMA members.[89] This was to prove significant in giving the LMCs, and subsequently Local

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[89] *BMA Archive*, Memorandum D46 accompanying letter (D47) from Dr A Cox to BMA Divisional Secretaries 18 March 1912.

Medical and Panel Committees (LMPCs), a democratic legitimacy which the BMA did not itself possess. In July 1912, the BMA's Council reported that 211 of these provisional LMCs had been established.[90] The militant stance which the BMA appeared to be taking in defence of GPs' interests, and the unified leadership it offered an otherwise disparate profession at that critical time boosted its membership (though its subsequent 'failure' was to result in the opposite effect). [91] Cox's letter also asked the provisional LMCs to coordinate collection from GPs of a 'pledge complimentary to the undertaking' (the undertaking not to serve under NHI without the concessions demanded by the BMA). This involved submitting post-dated letters of resignation from all existing forms of contract practice.[92] The supplemental pledges were to be placed at the disposal of the Association's State Sickness Insurance Committee but were deposited with the provisional LMCs who were to coordinate a collective refusal to accept locally inadequate terms of service.[93] This decision was significant in setting the precedent for a course of action which GPs were later to use more decisively in the standoff with government in 1923. Cox also urged the LMCs to persuade their electorate to contribute towards the local and national 'defence trusts', the profession's political fighting funds.[94] Following this suggestion LMCs began to collect local defence contributions, which were to be used to fund the expenses of the LMCs, and the national defence fund, which was administered by the BMA's State Sickness Insurance Committee and used to recompense doctors who suffered loss

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[90] John H. Marks, *The History and Development of Local Medical Committees*, *their Conference and its Executive* Edinburgh University MD Thesis, 1974, p. 28.

[91] Cox, *Among the Doctors* p. 99. The high water mark of BMA membership in 1912 was 26,568. Bartrip, *Themselves Writ Large,* p.162.

[92] The supplemental undertaking was issued in a further letter from Cox, Memorandum D49, dated 29 April 1912.

[93] These totalled 33,000, that is significantly more than the pledges to refuse service under the Act. Marks, *The History and Development of Local Medical Committees,* p. 26.

[94] *Ibid,* 19 February 1912, p.6. The idea of the pledge supplemental to the undertaking and the establishment of a national defence fund came from a motion to the Representative meeting by the BMA's North Middlesex division.

of income as a result of the dispute. [95]

The polarisation of medical opinion and collapse of professional unity

Cracks were already beginning to appear in the façade of professional unity, however, when in July 1912 the profession's case for a minimum remuneration of 8s 6d per patient was undermined by the publication of the Plender Report. Having agreed to meet with the chancellor in June 1912 to press their case one more time, the BMA had agreed to the suggestion that a respected chartered accountant, Sir William Plender, undertake a co-sponsored investigation into GP incomes. The inquiry considered medical incomes in six towns: Cardiff, Darlington, Darwen, Dundee, Norwich and St Albans. However, the Cardiff doctors largely declined to participate so their data had to be excluded. The data from the remaining towns showed that the ordinary GP received an average of 4s 5d per head per annum from all classes of patient out of which drugs had to be paid for, much less therefore than the 6s per head the chancellor was offering for insured patients.[96] The BMA's State Sickness Insurance Committee had major doubts as to the accuracy of Plender's conclusions, doubts which have been partially vindicated by later investigations.[97] However, the report handed the government a major propaganda victory. It allowed the chancellor to represent himself as the soul of generosity, especially when, in a final attempt to win over the profession he succeeded in persuading the cabinet to increase the remuneration offered to 9s inclusive of the cost of drugs, which meant that the panel doctors could expect to receive between 7s and 7s 6d per

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[95] Some 13,472 'guarantors' contributed £134,397 in total. Vaughan, *Doctors' Commons*, p.203. Sir John Conybeare opined that this 'was quite insufficient…for its purpose of financing doctors who lost money by their refusal to accept service under the Bill.' Conybeare, 'The Crisis of 1911-1913' p.1033.

[96] Gilbert, *The Evolution of National Insurance,* p.408.

[97] Peterson states that the five towns were 'clearly atypical'. M. Jeanne Peterson, *The Medical Profession in mid-Victorian London* (London, 1978) p. 218. The doctor/patient ratio was much lower than what later examinations showed to be the national average and the arithmetic mean Plender used gave an average net income which was much higher than calculated later by Guy Routh in *Occupation and Pay in Great Britain 1906-1979* (2nd edn. London, 1980).

patient.[98] Doctors in the poorest areas found their income would be doubled, and large numbers consequently ignored BMA advice and joined the insurance panels.

Seeing that the BMA remained obdurate, Lloyd George also let it be known that he was quite prepared to withdraw concessions already made and let the friendly societies resume the role he had originally intended for them and, in areas where insufficient numbers volunteered to serve on the panels, he proposed to recruit a cadre of salaried doctors to serve the insured. [99]

Conscious of the benefits which the Act would deliver to them and for their patients, GPs eager to work under the Act began to form their own pressure groups. In November 1912 a Liberal MP who was a also a GP of 25 years' standing, Dr John Esmonde, circulated an open letter to the profession urging GPs to serve under the improved conditions now offered and to communicate their names to him, stating 'I am confident the work can be well done in both town and country and that a large majority of GPs wish to give the Act a trial.'[100] In early December, following a split vote in the BMA's Birmingham division, 26 GPs in the city issued a manifesto declaring their willingness to defy their leadership and work under the Act.[101] It was becoming clear to many GPs that many of those who were most vehement in urging the profession to stand firm and ignore the concessions won already from the government were consultants and specialists. These 'swell doctors' as Lloyd George had disparagingly called them, who were not likely to need to work under the Act, were guilty, according to Gilbert, of leaving behind 'the lowly, voiceless general practitioner for whom national insurance promised a larger and steadier income than he had ever known.' [102] A prominent BMA Council member, Dr Lauriston Shaw, criticised those of his colleagues who put their own 'narrow and selfish

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[98] Gilbert, *The Evolution of National Insurance* pp. 411-412.

[99] He made the threat explicit in a published magazine interview: *Nation*, 3 August 1912,'Medical Supplement' pp. i-ii. He later explained to the Insurance Advisory Committee the three options which were open to Insurance Committees to deal with insufficient panels, namely 1. Allow the panel GPs to maintain high lists by employing a sufficient number of assistants. 2. Invite outside GPs to form panel practices de novo. 3. Allow Insurance Committees to employ salaried GPs. *Daily Chronicle*, 3 January 1913 p.5.

[100] *Daily Chronicle*, 22 November 1912, p.5

[101] *Ibid ,* 'Doctors coming round' 12 December 1912, p.4.

[102] Gilbert, *The Evolution of National Insurance* p.407.

interests' above 'the wider interests of the community'.[103] He was one of 300-400 Doctors who formed the National Insurance Practitioners' Association in December 1912 to represent the doctors who were willing to work under the Act.[104] The secretary of the NMU, Dr J. Webster, engaged in a heated exchange of letters with Shaw in the *Manchester Guardian* in late 1912 when the latter suggested that GPs agree to join the panels as 'conditions had now changed'.[105]

Shaw and another prominent supporter of the government scheme, Dr Herbert H. Mills of Kensington, were subject to vitriolic attacks by BMA loyalists as was the unfortunate James Smith Whitaker, especially when he ignored the BMA Council's demand that doctors resign forthwith from any government employment.[106] Those who declared themselves willing to work the under the Act were ostracised by the 'no service' party, labelled 'blacklegs' and found themselves subject to various sorts of pressure. The *Daily Mail* characterised them as 'the dregs of a great profession' and claimed that 'of the small minority who would apply for positions as insurance doctors, the wastrels will form a not inconsiderable portion.'[107] Consultants were urged to limit hospital house staff appointments, and GPs assistant and locum tenens posts, to those who adhered to the BMA's undertaking.[108] In *Dr Bradley Remembers* the eponymous hero resigns from the BMA and refuses to be cowed by comments that 'the position of a medical man who hasn't stood by his colleagues can be rather unpleasant'. The author subsequently notes that 'The strength of the intimidation that had been used could be judged by the fact that even old Wills, a friend of twenty years' standing, refused to return his salute when they met in the high street.'[109]

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[103] Bartrip, *Themselves Writ Large* p.160; *Daily Chronicle* 6 December 1912, p.4.
[104] Vaughan, *Doctors' Commons* p.209. The fact that Shaw was himself a Harley Street Consultant was not lost on some of those attending a meeting of what the *Daily Mail* disparaged as the 'Work the Act League' where 'it was urged that there had been too much Harley Street domination.' *Daily Mail* 14 December 1912, p.8.
[105] *Manchester University Medical Collections,* Extract from *Manchester Guardian* 21 December 1912 GB 133 MMC/7/1/3 and 7/18/1.
[106] Addison acknowledged their bravery in his memoirs *Politics from Within*. vol.1 p.23.
[107] *Daily Mail*, 16 December 1912, p.9.
[108] Conybeare, 'The Crisis of 1911-1913', p.1034.
[109] Young, *Dr Bradley Remembers*, pp. 709-713.

As divisions within the profession began to widen, the response from the press reflected their political allegiances. Government supporting newspapers like the *Daily Chronicle* expressed dismay and incredulity at the BMA's apparent refusal to acknowledge that they had been granted substantially all they had asked for.[110] Despite the BMA's efforts to enforce solidarity, many of the provisional LMCs were pragmatically taking steps to prepare for the eventuality that GPs would work under the Act. They were conscious of the fact that the Act gave the Insurance Committees discretion over several aspects of the scheme and sought to negotiate the best terms they could while that discretion remained in place. In the County of Nottinghamshire for example the provisional Insurance Committee met a 'deputation of doctors' in December 1912, recording that a Dr Jacobs expressed a willingness to advise local GPs to serve on the panel 'if the committee would use its influence to obtain relief for the practitioners of regulations they deemed grievances.'[111]

The BMA's Council published its assessment of what was seen as Lloyd George's final offer, concluding that it still fell far short of what they wanted. The anti-Liberal press lost no time in advising the profession to reject it yet again. Under the heading 'The Doctors' best courses' the *Daily Mail* prophesied that 'the doctor is to be mercilessly sweated in order to avert the financial collapse of the most unpopular Act of Parliament ever passed.'[112] The BMA called another plebiscite in December 2012. The result was 2,408 votes in favour of accepting the government's terms and 11,219 against. The *Daily Mail* carried the headline 'The Doctors say 'No!'', reporting that the vote was 7 to 1 against.[113] Significantly, however, nearly half the doctors who had signed the pledge had abstained from voting, a fact not lost on many in the

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[110] *Daily Chronicle*, 'The BMA and the Doctors' 23 December 1912, p.4.
[111] These included 'the exclusion from medical benefit of illness arising from misconduct, miscarriage or abortions.' *Nottinghamshire County RO*, SO NHI /1-3, Report of the Medical Benefit Subcommittee 29 December 1912.
[112] *Daily Mail*, 2 November 1912 p. 4.
[113] *Ibid*, 23 December 1912, p.5.

profession or in the Liberal-supporting press.[114] The *Daily Chronicle* reported that 6 prominent members of BMA Council, including Lauriston Shaw, Ewan Maclean and Victor Horsley, had resigned in protest at their colleagues' refusal to countenance a change in policy.[115] As the *Chronicle* confidently predicted the 'Inevitable collapse of BMA revolt', Whitaker's successor as medical secretary, Alfred Cox, drafted a report for the BMA's Council which emphasised all the concessions that had been won in a vain attempt to secure a more conciliatory approach.[116] Reports were already reaching Cox and his colleagues, via despairing telegrams and letters from BMA branch secretaries, that the panels were beginning to fill up in many areas.[117] In Bradford, where the GPs stood firm and refused to join the panel, the Insurance Committee advertised for salaried GPs to fill the vacancies. When they announced that they had three times as many applicants as required, many of whom were well qualified doctors working as assistants to established GPs without means of advancement, the established doctors relented and agreed to join the panels en masse.[118] The same thing happened in Lancaster when Lord Ashton announced that he would personally ensure the appointment of a sufficient number of imported medical practitioners to fill salaried posts 'whatever it cost.'[119] Addison was pleasantly surprised to find a large meeting of doctors he had been asked to address in Birmingham entirely sympathetic to working under the Act.[120] A Birmingham delegate to the BMA's meeting in December acknowledged that he came a 'from an infected area' surrounded by districts in which GPs were joining the panels in great numbers.[121] Members of the BMA's Ealing division unsuccessfully picketed a meeting convened by the

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[114] *Daily Chronicle,* 'The BMA and the Insurance Act' 21 December 1912, p.5.
[115] *Ibid,* 'Severe criticism of Association's policy' 24 December 1912, p 1.
[116] *Ibid,* 25 December, p 1. Cox, *Among the Doctors*, p.96.
[117] Cox, *Among the Doctors,* p.97.
[118] E.S. Turner, *Call the Doctor,* p.259. Gilbert, *The Evolution of National Insurance* p.415.
[119] Marks, *The History and Development of Local Medical Committees,* p.31.
[120] Addison, *Politics from Within,* vol.1 p.24.
[121] Bartrip, *Themselves Writ Large* p.161.

Middlesex Insurance Committee at Caxton Hall where 55 doctors agreed to accept service under the Act and the picture was similar in Enfield, Stepney and Camberwell.[122]

The *Daily Chronicle* noted that there were full panels in every part of Scotland.[123] Wales and the north of England had also 'rallied to Lloyd George', although doctors in many parts of the Midlands, the South and much of the capital remained loyal to their pledges.[124] The *Daily Mail* kept up a steady stream of pro-doctor and anti-government rhetoric, maintaining that the number of 'backsliders' was insufficient to rescue Lloyd George's scheme and then denouncing the government's press briefings about the number of panels that had been formed as 'Press Bureau fictions' and the 'Failure of a big bluff'.[125] The growing desperation felt by the BMA's Council is evidenced by the fact that in late December 1912 it actually proposed that the provisional LMCs seek to bypass the Insurance Committees and negotiate terms for providing medical service to the insured directly with approved societies.[126] Addison was quick to point out that this represented a repudiation of one of the cardinal points.[127] Horsley concurred and included this among reasons cited in a statement he issued to the profession titled 'Why you should join the panels.'[128] Any thoughts of pursuing this proposal, however, were quickly dispelled when a meeting of 40 friendly societies unanimously rejected the idea.[129]

On 2 January 1913 Lloyd George announced that 10,000 doctors had now joined the panels, a number sufficient to cover three quarters of the insured population.[130] Seeing the increasing numbers of doctors joining the panels in many areas, government-supporting

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[122] *Daily Mail* 26 December 1912, p.5.
[123] *Daily Chronicle* 27 December, p.1.
[124] E.S. Turner, *Call the Doctor,* p.259.
[125] *Daily Mail* 27 December 1912, p.3; 30 December 1912, p.5.
[126] *Daily Chronicle* 27 December, p 1.
[127] *Ibid*
[128] *Daily Chronicle* 28 December, p.5.
[129] *Ibid*
[130] *Daily Mail* 3 January 1913, p.5; *Daily Chronicle* 3 January 1913 p. 1.

newspapers like the *Daily Chronicle* were now carrying headlines such as 'Stampede of the Doctors' and a sense of panic began to set in among the GPs.[131] Not one doctor in the New Forest had been prepared to join the panel, the GP Philip Gosse records, until a report reached them of 'an omnibus with drawn blinds' arriving at Lymington containing, it was believed, 'several scotch doctors sent there by Lloyd George to break the doctors' strike.' The result was 'an instant undignified scramble to get our names on the panel before it closed.'[132] A similar situation occurred in Sheffield.[133] In Liverpool the insurance committee determined to overcome the boycott by appointing salaried doctors and was reported to have '200 men ready to import into the city.'[134] In Cardiff, the *Daily Telegraph* noted 'there was a remarkable rush of doctors to join the panels.'[135] The diehards resorted to more desperate forms of persuasion and intimidation. A member of the National Insurance Practitioners Association, Dr Atteridge of Ladbroke Grove, London, awoke to find his house covered with posters warning the public that their 'so called choice of free doctor' would be limited to a small minority of 'men who have broken their pledge'.[136] A Willesden doctor told the *Daily Chronicle* that, 'knowing he was a poor man' his GP colleagues had offered to pay him from their own pockets rather than 'see him go down' by not joining the panel.[137] A 'professional man' concerned at the tactics to which extremists had resorted to intimidate those joining the panels wrote to the *Daily Telegraph* claiming that 'the revolting doctors have gone to the length of employing sandwichmen to parade the streets in which the doctors live.'[138]

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[131] *Daily Chronicle* 8 January 1913, p 1.
[132] Philip Gosse, *An Apple a Day,* (London, 1948) pp. 8-9.
[133] E.S. Turner, *Call the Doctor* p.259.
[134] *Daily Mail* 7 January 1913, p.4
[135] *Daily Telegraph* 7 January 1913, p. 9.
[136] *Daily Chronicle* 'Scandalous outrage at Doctor's house' 8 January 1913 , p.1.
[137] *Ibid,* 'Curious story from Willesden' 9 January p.7.
[138] *Daily Telegraph* 16 January 1913, p.11.

On 11 January the *BMJ* acknowledged that the government would be able to launch the scheme on the appointed day.[139] The BMA believed it had another means, however, with which to frustrate the government's intentions. It pinned its hopes on a legal loophole in Section 15 of the Act which it felt would allow non-panel GPs to offer an alternative service to patients exercising their right to 'contract out' of the state scheme.[140] However, the Government dashed that hope when Lloyd George made it clear in a speech to the Insurance Advisory Committee that the provision in question was intended to meet exceptional circumstances and stated, 'We will not allow it to be used to break down the Act in any area.'[141] In answering a question in parliament C.G. Masterman confirmed that Insurance Committees would simply not approve such arrangements.[142] Undeterred, the self-appointed London Local Medical Committee was particularly keen to use this means to circumvent what they saw as the unwelcome control of the largely lay insurance committees. They persuaded a number of London GPs who had signed up to the panels to resign in anticipation of the large number of patients who would be entitled to choose them as their (non-panel) doctor.[143] They even circulated forms for GPs to give to patients for that purpose. [144] Doctors in Middlesex who had attempted to resign were dismayed, however, at being told that their contracts were binding. Their names were 'starred' on the published panel list as having withdrawn from the list but 'not released by the committee.'[145] Although attempts to invoke this provision were subsequently made elsewhere during 1913, most notably in Kent, 'complex bureaucratic procedures' were used to discourage patients from

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[139] *BMJ* Editorial 11 January 1913 p. 83.
[140] 'The Regulations… allow any other persons, in lieu of receiving medical benefit under such arrangements as aforesaid, to make their own arrangements…and in such cases the Committee shall, subject to the Regulations, contribute from the funds…towards the cost of medical attendance and treatment…for such persons.' *National Insurance Act 1911* Section 15, subsection 3.
[141] *Daily Chronicle* 3 January 1913, p 1.
[142] *Daily Mail* 7 January 1913, p.4.
[143] *Ibid,* 9 January 1913, p.5.
[144] *Daily Telegraph* 20 January 1913, p.8. *The Times* 10 January 1913, p.8, reported that 1.5 million of these had been issued by the London Local Medical Committee from its office inside BMA House.
[145] *Ibid,* 13 January 1913, issue 5232 p.5. See also *Daily Chronicle* 8 January 1913 p.1.

contracting out and hopes of using the loophole were dashed.[146] Provisional LMCs continued

in some areas, however, to exploit opportunities to negotiate with Insurance Committees. The

Daily Mail noted that rather than accept the government's terms as they stood, doctors in

Salford 'had come to a temporary arrangement with the Insurance Committee under which the

whole of the funds available for medical treatment…will be handed over to a representative

committee of doctors who will distribute it among the practitioners attending insured persons

in accordance with a scale of fees to be drawn up by the doctors themselves.'[147]

On 8 January the *Daily Telegraph* reported that it was 'a safe estimate that more than

14,000 doctors have now come on the medical panels.'[148] The *Daily Mail* hinted at government

manipulation of the figures signing up by pointing out that a large percentage of doctors were

members of more than one list. They observed that some in London had registered on up to ten

insurance panel district lists simultaneously, describing one such GP as 'ubiquitous'.[149] The

fact remained, however, that, excepting a few lacunae where no GPs had signed up, the

government now had more than enough doctors to service the Act. On 17 January therefore a

gloomy yet still defiant BMA Special Representative Meeting resignedly passed the resolution:

'That this meeting, recognizing the force of present circumstances and consulting the best

interests of the profession now releases all practitioners from their pledges.'[150] Declining to

comment on the inaccuracy of their predictions of the outcome of the dispute, the *Daily Mail*

noted that 'the minority against release from the pledge was composed almost entirely of

London doctors and the London Medical Committee will continue its campaign against

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[146] Eder, *National Health Insurance and the Medical Profession*, pp.52-53.
[147] *Daily Mail* 6 January 1913, p.9. This was to result in the adoption in Salford and Manchester of the method of payment by attendance rather than capitation. This is dealt with further in chapter 3 below. An attempt to introduce this in the neighbouring county of Lancashire failed to materialise. *BMJ* 11 January 1913, Editorial p.83.
[148] *Daily Telegraph* , 'More Panels Formed' 8 January 1913, p.9.
[149] *Daily Mail* 'The Insurance muddle-farcical position of the panels' 15 January 1913, p.3.
[150] *BMJ* 25 January 1913, Supplement p.97.

working under the Act.'[151]

The revolt of the doctors had effectively ended. Many saw it as an ignominious defeat for the BMA and its membership suffered an immediate decline from which it took years to recover. As one Nottinghamshire GP put it, as a fighting machine for the profession the efforts of the BMA 'had been simply futile'.[152] Alfred Cox was in no doubt as to where the fault for this lay. Referring to the grandees on the Council he stated: 'It was a long time before I could forgive those who had led the Association into a humiliating debacle, when we might have claimed a substantial victory- and all, at the end, for the sake of sixpence.'[153] Cox later informed an American audience that the turning point in the battle was when the profession lost the support of public opinion by allowing the government to portray the doctors as out to frustrate the will of parliament.[154] The doctors could hardly have expected to succeed where the House of Lords had failed.

Several historians have accepted Cox's argument that 'the Harley Street leadership' of the BMA were to blame in being out of touch with their GP membership.[155] This is disputed by Peter Bartrip.[156] Analysis of debates and letters to journals during the period of the dispute supports his conclusion by confirming that the 'diehards' were not exclusively consultants and that the BMA was led astray not so much by Harley Street 'swells' than by its elected representatives, most of whom were GPs elected by a mostly GP membership. But Cox's frustration is understandable. For the negotiations had in fact yielded significant benefits for the profession, prompting a National Insurance Commissioner to state in 1912: 'We are

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[151] *Daily Mail* 20 January 1913, p.7.
[152] *Nottinghamshire County RO* Letter from Dr W.B. Hallowes of Newark to Dr Ernest Ringrose, DD/1440/23//20-43, LMC correspondence.
[153] Cox, *Among the Doctors*, pp. 98-99.
[154] Alfred Cox, 'Seven Years of National Health Insurance in England', *Journal of the American Medical Association*, LXXVI, 7 May 1921, p.1310.
[155] See Gilbert *The Evolution of National Insurance*, pp. 407 and 409. Eder, *National Health Insurance and the Medical Profession*, p.45. Morgan and Morgan, *Portrait of a Progressive,* p.12.
[156] Bartrip, *Themselves Writ Large*, pp 163-164.

engaged in ramming down the doctors' throats the refreshing fruits of their own victory.'[157]

The *Westminster Gazette* had observed a few months before the BMA's 'U-turn' that '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.'[158] Cox was in no doubt as to the accuracy of this statement, concluding in his memoirs that 'We had in fact 'won on points'.[159] So, what exactly were the benefits British GPs enjoyed as the fruits of their disguised victory?

Material gain and reputational loss: the immediate impact of NHI on GPs

For many GPs, opposition to NHI had been about more than just remuneration, but remuneration had been the principal bone of contention and the subject of the two cardinal points Lloyd George had been unable to concede. Experience of working under NHI soon demonstrated to the GPs, however, that much of the opprobrium heaped on the chancellor by the profession in this regard was unjustified. Lloyd George proved to be correct in contending that the amount offered to the doctors would substantially increase their average income and provide them with much needed economic stability. It would be an exaggeration to say as Hermann Levy does that 'The National Insurance Act was drafted with the explicit aim of improving the social and professional conditions of the doctor in order to improve the services rendered by him to the patient', but that it did have that effect is undeniable.[160] Sir Leo Chiozza-Money summed it up well when he wrote in 1912 that ' The effect of the Act from the doctor's point of view is to raise the status and pay of Society doctoring and to enlarge and make definite the medical income derived from working-class practice.'[161] The income limit remained a

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[157] B.M. Allen, *Sir Robert Morant, A Great Public Servant* (London, 1934) p.282.
[158] Quoted by Vaughan, *Doctors' Commons*, p.209 (no citation).
[159] Cox, *Among the Doctors* p.99.
[160] Levy, *National Health Insurance* p.122.
[161] Chiozza-Money, *Insurance and Poverty*, p.97.

concern but, recognising that it was in the power of Local Insurance Committees to adjust the limit if they saw fit after consultation with representatives of the profession, a number of LMCs made it their mission to try to secure the necessary adjustments, however unlikely that seemed to be.

In the weeks immediately following the launch of the new system many doctors complained about the extra work and bureaucracy involved in accommodating an increased volume of patients anxious to test out the new system. An inquest in London into the death of a patient suffering from a perforated appendix heard that the deceased' overworked panel doctor from Battersea 'was having a perfectly dreadful time' and the jury added to the verdict of the patient's death by natural causes that the doctor had 'a scandalous amount of work to do.'[162] A Camberwell doctor reported that he had enlisted his wife and daughter to help him deal with the backlog of notes and medical cards.[163] Another 'overtired' panel GP complained of being 'deluged with day books, schedules, printed forms and literature of every description', describing it as a 'national scandal'.[164] However panel GPs were pleased to find at the end of the first quarter after the 'appointed day' that their incomes had risen by an average of 40-60%.[165] In industrial areas of London like Bermondsey and Poplar GP incomes increased by 100%.[166] Having become a salaried doctor, H.W. Pooler returned to being an independent contractor after noting that the Act had boosted his medical neighbours' income to 3-4 times what he was earning.[167] Doctors straight out of training who could previously have expected to earn no more than £300 a year could now expect to earn twice as much from a working-class panel practice which had become 'a worthy investment for the purchase of which a young

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[162] *Daily Mail* 22 January 1913, p.7.
[163] *Ibid* ,25 January 1913, p.3.
[164] *Ibid,* 10 February 1913, p.4.
[165] Eder, *National Health Insurance and the Medical Profession* p.56 .
[166] *Ibid*
[167] H.W. Pooler, *My Life in General Practice.* (London, 1948) p.57.

doctor could now borrow money.'[168] Those 'unsaleable practices' turned out to be saleable after all and some fetched far bigger sums than they would have done before the advent of the panel.[169] NHI did not make GPs rich, but over the course of the next three decades after 1912 it helped a great many of them achieve what they had always craved, that is a comfortable middle-class existence. The panel doctors' reaction to their change of fortunes is perhaps best summed up by one of Pooler's colleagues who commented: 'When I see the queue at my surgery door and when I see the heap of papers on my consulting room table, all of which must be signed, I say 'Oh, damn Lloyd George', but when, at the end of the quarter, I handle the Insurance cheque, it is 'Well, here's to Lloyd George, the Doctors' friend !'[170]

Remuneration aside, the concessions which the BMA had wrung from the Liberal Government had gone a long way towards securing some of the profession's most cherished ambitions. By negating the necessity for panel GPs to be full time NHI ensured that panel GPs would be independent contractors not employees. GPs valued independent contractor status because it meant that they were effectively free agents, able to accept or refuse a variety of part-time work, including, if they had the time, capacity and intention, other medical appointments and hospital work. The income limit on eligibility for the scheme ensured the viability of private practice for those excluded from its benefits. By ensuring all GPs could join the panel, it ended the friendly societies' control over entry to contract practice for the working classes by guaranteeing subscribers free choice of doctor and allowed GPs to compete on a more equal basis than before under what was, in many other respects, a continuation of the club system. Equally important, NHI offered GPs' a means to protect their interests at local level by ensuring that professional representatives sat as members of the Insurance Committees. These

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[168] Gilbert, *The Evolution of National Insurance,* p.44.
[169] *Ibid*, p.440, quoting survey by the *National Insurance Gazette* 13 December 1913. See also E.S. Turner, *Call the Doctor*, p.264.
[170] Pooler, *My Life in General Practice*, p.57.

committees acted as a buffer between the GPs and the approved societies and were, from the GPs' point of view a more objective arbiter of patients' complaints and of whether the terms and conditions of service were being fulfilled than the approved societies on their own would have been. At national level the GPs would be represented in due course in advisory committees and were able, through the BMA's Insurance Acts Committee, to articulate their wishes to the NHI Commissioners, while at local level they were to enjoy, through Local Medical and Panel Committees, a share of the administration of the system in which they worked.

Conclusion

In the novel *The Old Doctor* the GP hero, Dennison, ruefully contemplates the outcome of the agitation preceding the commencement of National Health Insurance (NHI).

> Our leading men have put up a really Number One sized show. They've got for the G.P.'s of this land terms which are going to make General Practice very nearly worthwhile. And the men who are still grousing don't know what they are talking about…The new arrangements will absolutely put the lid on the foul old cheap club system.[171]

Despite this positive prognosis, a significant minority of doctors were determined to remain outside NHI and a large number had joined the panels with the utmost reluctance and had yet to be convinced that it would work to their benefit. The humiliation of their apparent defeat was to live long in the GPs' collective memory. While the GPs' opposition to NHI may be seen as, at best misguided, and at worst driven by selfish and irrational fears and prejudices, it was to create a mythology of noble sacrifice which affected the way GPs saw themselves in subsequent conflicts and determined the nature of political engagement with the governments of Britain for decades to come.

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[171] Frank C. Layton, *The Old Doctor*, (Birmingham,1923) pp.140-141.

As Woodcock had accurately observed, doctors were 'not by nature rebels.'[172] But when the flames of their professional indignation had been fanned by the Conservative press they proved as willing to resort to extreme measures in pursuit of their political objectives as other politically marginalised groups had been. In the GPs' conflict with the government over NHI, their opposition to friendly society control was a continuing political animus, and free choice of doctor, as an article of faith for the profession, had become a powerful propaganda weapon, which Lloyd George neatly sidestepped when he supported Addison's amendment. In this conflict, professional solidarity was tested to destruction and professional pride was severely dented by the spectacle of a humiliating public climbdown. In subsequent political battles the spectrum of political opinion within the profession was just as wide, and the 'moral absolutism' of opposing wings was just as strong, as in 1911-13. This should not, however, obscure the fact that many in the profession were supportive of a greater measure of state intervention in health services and desired a more systematic and less uneven system of healthcare for the poor, always provided that their professional autonomy and the rewards of private practice were vouchsafed. The 'professional social ideal' was never far from the minds of the GPs' leadership.

Whether the struggle the GPs found themselves engaged in in 1912-1913 was really as 'life or death' as many believed it to be, it was one from which GPs emerged, from a material perspective, much stronger and more prosperous, and less socially insecure than they had ever been before, and from the political perspective more divided than ever, but with the means to exert a significant degree of influence over an increasingly important area of Government policy. The more politically astute members of the profession recognised that the GPs' resistance had unwittingly obtained for them an opportunity to exercise a measure of power and self-government through the administrative apparatus of NHI. The challenge was how to

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[172] Woodcock, *The Doctor and the People,* p.100.

make the new system work to their, as well as to the patients' advantage. In the next chapter I

consider how some GPs grasped the opportunities this presented.

Chapter Three. The role of Local Medical and Panel Committees under National Health Insurance

Referring in 1917 to the GPs who had accepted service under National Health Insurance (NHI), Beatrice Webb stated that the Insurance Act 1911 had 'set up a supplementary constitution for the profession' in which 'the medical men have been granted a measure of self-government.' Central to this, she observed, were the Local Medical Committees and Panel Committees (LMPCs), whose decisions, she noted, the local Insurance Committees administering the scheme were obliged to accept.[1] In this chapter I consider how the LMPCs were formed and functioned, and the contribution they made to the day to day operation of NHI. I consider the extent to which LMPCs could be viewed as agents of the government, by virtue of the delegated authority they enjoyed in mediating between GPs and the state apparatus, and how far they fulfilled the profession's cherished aim of self-government in the exercise of professional discipline. I begin with a brief assessment of their historiographical context, followed by a description of the events and ideas which lay behind their establishment and the various functions they exercised under NHI.

Echoing Beatrice Webb's conclusions, the report of the Royal Commission on National Insurance in 1926 acknowledged that LMPCs were 'a valuable element in the medical side of the Insurance scheme', and the civil servant R.W. Harris claimed the major share of administration which these committees afforded the profession was unique in comparison with their continental counterparts.[2] Despite these endorsements, LMPCs, and their role in the administration of NHI, have been almost completely ignored by historians. Important works

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[1] Beatrice Webb, 'Special Supplement on Professional Associations.' *The New Statesman*, 21 April 1917, vol. IX, issue 211, p.9.

[2] *Report of the Royal Commission on National Health Insurance*,1926, HMSO, cmd. 2596 p.61. R.W. Harris, *National Health Insurance in Great Britain 1911-1946* (2nd edn, London, 1946) p. 143.

by Anne Digby and Peter Bartrip make no mention of LMPCs, while they are relegated to a footnote by Frank Honigsbaum.[3] Norman Eder is more generous, making use of the unpublished MD Thesis on the history of Local Medical Committees by former BMA chairman, John Marks, though he regretted that the records of LMPCs had 'not been located.'[4] In this chapter, I aim to redress this deficiency and accord to LMPCs some recognition of their importance as co-authors of the regime under which the insurance doctors operated, using hitherto unresearched archival material.

According to John Turner, Liberal governments relied on professional expertise to bridge the gap in their administrative capacity and professions became in certain cases government 'constituencies', due partly to their expertise and partly to the political power they exercised through their influence over their members.[5] In mediating between GPs and the state apparatus, I suggest that LMPCs may be seen as one of these favoured institutions, and demonstrate this with regard to their role in the policing of prescribing and certification, in determining the scope of what insurance GPs were meant to provide under their contracts, and in the adjudication of complaints by patients, and about GPs by other GPs. LMPCs made it their business to relieve GPs of as much of the bureaucratic burden of insurance practice as possible while at the same time ironing out the rough edges of the scheme and seeking improvements which, in accordance with 'the professional social ideal', they believed to be in the public's interest as much as their own.[6] However, as local defenders of GPs' professional interests and guarantors

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[3] Anne Digby *The Evolution of British General Practice 1850-1948* (Oxford, 1999); Peter Bartrip, *Themselves Writ Large: The British Medical Association 1832-1966* (London, 1996); Frank Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care 1911-1968* (London, 1979), p.60, footnote.

[4] Norman Eder, *National Health Insurance and the Medical Profession in Britain 1913-1939* (New York, 1982), p. 194, note 72. John Marks' 1974 Edinburgh University MD Thesis *The History and Development of Local Medical Committees, their Conference and its Executive.*

[5] John Turner, 'Experts' and Interests: David Lloyd George and the Dilemmas of the Expanding State 1906-1919', in Roy MacLeod, (ed.) *Government and Expertise: Specialists, Administrators and Professionals 1860-1919* (Cambridge, 1988) 204. See also Nikolas Rose, 'Government, authority and expertise in advanced liberalism', *Economy and Society*, (1993) 22 (3) p.285.

[6] *Ibid,* p.288.

of their deep-seated desire for self-determination, LMPCs were, paradoxically, the means through which the profession could mobilise resistance to the government whenever those interests were deemed under threat. Consequently, their relations with the instruments of government authority at both local and national level involved alternating periods of cooperation and conflict.

If this dichotomy seems surprising it is nonetheless consistent with recent research by Peter Collin and others, into what has been called 'regulated self-regulation', in which mutually beneficial cooperation between the state and professional bodies is deemed to be founded in a 'tense relationship' in which state and society 'wrestle with each other.[7] It also echoes the ideas of Michel Foucault, who characterised the relationship between a sovereign power and those to whom it decides to delegate power as 'a perpetual struggle', which he termed an 'agonism'.[8] In criticising LMPCs, in 1919 the BMA loyalist Rowland Fothergill denounced any suggestion that they be viewed as 'fighting units', stating that, as statutory bodies 'they could hardly be expected to maintain martial attitudes to the government.'[9] As will become clear, however, the LMPCs' status as key stakeholders in a government-sponsored scheme did not preclude them from challenging governmental orthodoxy and acting at times in a manner indistinguishable from that of trade union branches.

State agency, representation, and professional self-government

The collapse of the medical profession's opposition to the introduction of NHI in 1912-1913 was seen by many as an ignominious defeat. But as the BMA's medical secretary Alfred Cox

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[7] 'Regulated self-regulation from a legal historical perspective': https://www.rg.mpg.de/1921124/regulated-self-regulation-from-a-legal-historians-perspective?c=2019245   Last accessed November 2020. Project completed 2020.

[8] Michel Foucault 'The Subject and Power'. *Critical Inquiry*, 8 (4) (1982) p.790.

[9] *Medical World* , 30 May 1919 'The National Insurance Defence Fund' pp.454-455.

observed, the outcome was really a disguised victory for the doctors.[10] Under Section 62 of the National Insurance Act 1911, the doctors were granted seats on the Insurance Committees which acted as a buffer between them and the approved societies, thereby inhibiting lay interference in the GPs' work. Just as important, Insurance Committees were obliged to consult 'local medical committees representative of practitioners operating in the area of insurance committees on all matters affecting the administration of medical benefit under the Act.' 'Addison's amendment', as it was called, thereby established for the first time a universal network of recognised representative bodies, through which the medical profession, locally, was to play a part in the administration of state-sponsored social policy. Addison reasoned that the best way of getting the profession to fully embrace NHI was to allow them to play a central part in its administration and envisioned local doctors' committees working alongside Insurance Committees and supporting them in their work.[11] Being aware of the debates which continued to take place in medical circles about intraprofessional etiquette and the need for 'courts of honour', he also saw them as a means by which a responsible profession could police itself and raise standards of practice through authoritative leadership and peer review. Believing that self-government was more compatible with the Liberal traditions of laissez-faire than bureaucratic control, he helped persuade Lloyd George that statutory recognition of local medical committees would meet many of the profession's immediate concerns while enabling them to fulfil a variety of functions on the state's behalf.[12]

The reason this suggestion appealed to Liberal politicians and civil servants is not difficult to fathom. Committees were an essential part of central government apparatus and, as a means of harnessing necessary expertise from a wider community of interests, were a tried and tested

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[10] Alfred Cox, *Among the Doctors*, (London, c.1949) pp.98-99.
[11] Jane Morgan and Kenneth O Morgan. *Portrait of a Progressive: The Political Career of Christopher, Viscount Addison* (Oxford, 1980) p.14.
[12] *Ibid*

means of extending and validating government authority.[13] They were also an essential and familiar part of how the medical profession conducted its professional business.[14] Before NHI there was, as we have seen, no national network of GP representative committees. Medical guilds and local practitioner associations were scattered and diverse in nature and attempts to organise a national structure based on them had failed.[15] The conference on medical organisation in 1900 had identified the need for 'Local district associations formed to discuss medical ethical or medico political topics *to which all practitioners in the locality have the right to belong.'* (my italics).[16] The BMA's attempts to reform itself after 1902 had created new local representative structures, the divisions, which facilitated a greater amount of engagement with and between its membership but, in keeping with its claim to represent a unified profession, the divisions comprised doctors from every rank and craft and were not solely concerned with the interests of GPs.[17] Moreover, the divisions comprised BMA members only and the BMA's membership comprised nowhere near a majority of GPs. They were even less representative after 1913 when so many doctors resigned in protest at what they saw as the failure of the BMA's leadership in the dispute with government over NHI.[18] By insisting that the medical committees recognised under the Act were representative of all local practitioners *in the area of the insurance committees* 'Addison's amendment' ensured the new representative structures were based on and tied to the administrative boundaries of NHI. They were therefore, crucially, independent of the BMA with whose local 'divisions' they were not

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[13] John Turner, ''Experts' and Interests' pp. 204 and 211.

[14] The BMA and the Royal Colleges were structured around committees, and when training and working in the voluntary hospitals, GPs would have been familiar with the medical committees which helped administer the hospitals while representing the views of hospital doctors. Brian Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales* (London, 1964) p. 33.

[15] Honigsbaum, *The Division in British Medicine,* p. 13. See chapter 1 above regarding the decisions of the Manchester Conference on Medical Organisation in 1900.

[16] *Manchester University Medical Collections,* Official Report of the Conference on Medical Organisation 1900, MMC/7/4/3/4, p 51.

[17] Bartrip, *Themselves Writ Large*, pp.145-146.

[18] Cox, *Among the Doctors*, p.99.

co-terminous, and, being elected by and accountable to all local GPs, they enjoyed a democratic

legitimacy to which the BMA itself could not lay claim.

When some Local Medical Committees (LMCs), most notably in London, declined to seek

recognition under the Act, the Government authorised Insurance Committees to appoint, where

necessary, separate 'Panel Committees' comprised of doctors serving on the NHI panels, and

to give them the authority to recognise these as LMCs.[19] This provision, contained in Section

32 of the Amendment Act 1913, was urgently needed in London, where medical opinion

remained polarised and where there were at one time three separate committees contesting the

right to speak for local GPs.[20] The confusion was not abated however as, while it was open to

local GPs to make the Panel committee and their LMC one body, the statutory responsibilities

of each remained distinct and there were certain functions reserved to LMCs which the

government neglected to transfer to the new Panel committees.[21] As proof of its desire to

establish a business-like relationship with the NHI Commissioners, in March 1914 the BMA

jointly agreed a model scheme for LMPCs offering two main options: Scheme A provided for

areas where all GPs had joined the Panel so the membership of the LMC and Panel Committee

was identical, while Scheme B provided for the LMC to consist of a locally determined mix of

Panel and non-Panel doctors, which would operate separately from but in parallel with the local

Panel Committee.[22]

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[19] *National Insurance Act 1913*, 3 & 4 Geo V. Ch. 37, s. 32.

[20] Marks, *The History and Development of Local Medical Committees*, p.32

[21] That is the intra-professional disciplinary functions and 'scope of service' functions described later in this chapter.

[22] *BMA Archive*, Insurance Acts Committee, minutes of meeting on 19 March 1914. Correspondence between Alfred Cox, BMA and S.P. Vivian, National Insurance Commissioners. This symbiosis was recognised in March 1914 when the first of what was to become an annual conference of representatives of 'Local Medical *and* Panel Committees' took place in London. *BMA Archive*, Minutes of the Conference of Representatives of Local Medical and Panel Committees March 1914. A conference of Local Medical Committees had taken place the previous summer in Brighton on 24 July 1913. The origins of the Conference are discussed in the next chapter.

The model scheme set out arrangements for elections which were invariably conducted via electoral 'districts' usually coterminous with Insurance Committee administrative districts, but the GP committees exercised a degree of latitude in determining their size and composition, often co-opting non-panel GPs, consultants, and public health doctors who could bring valuable experience or insights to their deliberations. The previously mentioned Dr Lauriston Shaw, a Harley Street Consultant, was co-opted on to the London Panel Committee and served it faithfully as its treasurer for nearly a decade. The Bermondsey GP Alfred Salter was a scathing critic of the committee, however, stating that in elections to the committee 'in too many cases the wrong man has been returned.'[23] His attacks seem strange considering that the London Panel Committee was packed with supporters of the Panel Medico-Political Union which he helped found. It is not clear also whether he included among 'the wrong men' either of the two women GPs on the 67 strong committee, Elizabeth Baker and Ethel Bentham. Dr Bentham played a prominent part in the committee, representing them at successive Annual Conferences of LMPCs from 1918 (see Figure 8).[24]

In October 1914 the BMA's newly established Insurance Acts Committee (IAC) surveyed LMC and Panel Committees and reported that 110 out of 136 that replied said their LMC and Panel Committee membership was 'practically identical'.[25] From that point they were generally referred to as Local Medical and Panel Committees (LMPCs). Where membership was not identical, the profession and Insurance Committees were obliged to acknowledge their separate identity and functions. Despite the existence of a number of 'non-panel associations' in London, the body eventually recognised as its LMC was not dominated by doctors antagonistic to NHI. The Panel Committee actually worked closely with the LMC

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[23] *Medical World* 'The surcharge problem – who is responsible?', 8 July 1915, p.52.
[24] Like Alfred Salter, Bentham was a Christian pacifist socialist (a Quaker) and was eventually elected to parliament in 1929 as one of the Labour party's first female MPs. C.V.J. Griffiths (September 2004). "Bentham, Ethel (1861–1931)". *Oxford Dictionary of National Biography*. Oxford University Press .
[25] *BMA Archive*, Minutes of IAC meeting of 19 October 1914.

and as early as May 1914 recommended that membership of both bodies be identical.[26] They

proceeded to meet jointly for the first time in July 1916. The Insurance Committee then

reminded them that the two committees still had separate functions and thenceforward they

continued to meet separately and maintain separate minutes.[27] In Staffordshire the fact that the

two committees ran in harness was illustrated in the agenda for the first meeting on 21 April

1914 which showed the LMC meeting at 2.30pm and 'the Panel Committee subsequently about

3.15.'[28] In Kent the Insurance Committee questioned the membership of the Panel Committee

as only two thirds of it were Panel Doctors and in July 1914 it was agreed that the LMC and

Panel Committee remain separate.[29]

While requiring Insurance Committees to consult medical committees on a range of issues,

Addison's amendment had ensured that up to 5 members of each Insurance Committee were

to be drawn from the medical profession. Of these, two were to be 'medical members resident

in the area, elected in a manner provided by regulations by an association of qualified medical

practitioners within the locality', plus up to two medical members appointed by the local

council, and one by the insurance commissioners.[30] In practice the LMPCs served as the 'local

association' in this context. Complaints were made occasionally by LMPCs that more doctors

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[26] *BMA Archive*, minutes of London Panel Committee meeting on 26 May 1914, min 6. The LMC was not recognised by the London Insurance Committee until July of that year. Minutes of meeting of 7 July 1914, min 4. In September the panel committee resolved to co-opt three members of the LMC to ensure their membership was near identical. The LMC concurred that membership should be the same 'in the interests of the profession, and in view of the fact that the committee have no statutory income.' Minutes of meeting of 24 September 1914, min 7.

[27] *BMA Archive*, minutes of London Panel Committee meeting of 18 July 1916.

[28] *North Staffordshire LMC Archive*, agenda for LMPC meeting of 21 April 1914. The Staffordshire LMPC's members' frustration with the requirement for separate elections is evident in their demand in May 1914 that the tenure of the existing membership of the committees be extended for another year 'In view of the fact that three times already in the past 15 months the practitioners of the county area have elected them, substantially the same persons, and have employed machinery …which is…in all essentials that set forth in the model scheme.' Staffordshire LMPC minutes of meeting of 5 May 1914.

[29] *Kent LMC Archive*, KCMC minutes of meetings on 9 October 1913, and 14 July 1914. They eventually merged in 1921 (see note 49 below).

[30] *NI Amendment Act 1913* Section 59 (3) a) to e). In Kent the County Council invited the LMC to nominate their appointee (*Kent LMC Archive*, minutes of KCMC meeting on 5 June 1912). Initially they declined but subsequently provided a nomination (minutes of KCMC meeting on 24 July 1913).

were needed on Insurance Committees to counterbalance the influence of the approved societies.[31] However, the reduction in the number of members of Insurance Committees brought by regulatory changes in 1921 meant that the influence of medical representatives increased proportionately. The Royal Commission in 1926 noted that the average attendance at insurance Committee meetings was as low as 15 - 20 persons.[32] This is reflected in the minutes of the Nottinghamshire County Insurance Committee. Whereas in 1913 there were 5 doctors out of a total membership of 54, by the mid-1920s only 16-20 members attended regularly of whom 3 were GPs.[33] Despite these changes LMPCs still felt underrepresented.'[34]

The interchange of bureaucratic instruction and 'expert' advice between Insurance Committees and LMPCs formed the basis of a relationship on which the local operation of the NHI scheme functioned effectively for thirty-five years. Much of this took place in the standing subcommittees through which most of the Insurance Committees' business was conducted. These comprised: the Medical Benefits subcommittee, which dealt with issues around the scope of service, allocation of patients, certification and record keeping; the Medical Service subcommittee which dealt with disciplinary matters arising from complaints about alleged breaches of contract; and the Pharmaceutical Services subcommittee which scrutinised prescribing, determined whether specific drugs could be provided under the scheme or not, and oversaw creation of local drug formularies.[35] The medical members of these groups were almost always LMPC nominees but Insurance Committees also consulted with LMPCs directly on the matters they discussed. Reflecting the importance accorded to these interactions, the

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[31] Levy maintained that in both the insurance committees and the insurance commissioners, the doctors had expected to get a larger share of representation. Hermann Levy, *National Health Insurance: A Critical Study* (Cambridge, 1944) p.19.

[32] *Report of Royal Commission on National Health Insurance*, (1926) Cmd. 2596, p.167, para 379.

[33] *Nottinghamshire County Archives*, SO NHI/ 1-3; NHI Committee minutes 1913-48, Vol.1.

[34] In 1929 the Lancashire LMPC recorded: 'the opinion being generally expressed that (on insurance committees) the profession was inadequately represented in Lancashire.' *Lancashire and Cumbria LMCs Archive*, minutes of LMPC meeting of 11 September 1929.

[35] Eder, *National Health Insurance and the Medical Profession*, p.270.

LMPCs set up their own sub-committees to coordinate the advice given, which in practice was seldom ignored. The London Panel Committee appointed seven subcommittees, each comprising up to 20 members, listed as 'finance, general purposes, administration, organisation, pharmaceutical, ethical and parliamentary.'[36] Following the introduction of mileage allowances in 1914, Insurance Committees also set up mileage subcommittees which were later allowed to use a proportion of their funds to meet 'special claims' from practitioners such as expenses associated with postgraduate education courses.[37] LMPC representatives played a major part in the work of these subcommittees.[38] In Kent in 1920 the Insurance Committee established an allocations subcommittee to which the LMPC were invited to nominate three representatives.[39] Other subcommittees on which the Kent LMPC was represented included the finance and rural dispensing subcommittees.[40]

How LMPCs functioned was influenced by how they were funded. When the provisional LMCs were established during the 'doctors' revolt' in 1912, the BMA set the precedent of inviting GPs to support the committees' running costs and contribute to a central 'National Insurance Defence Fund' to coordinate the national campaign of resistance, via a voluntary 'levy' of their remuneration.[41] The amount practitioners were invited to contribute to the latter was set nationally. Once recognised by the Insurance Committee, the LMPC were entitled to request from them an amount needed to support local activities, derived from the GPs' remuneration, within a statutory limit of 1d per patient per annum. LMCs, where separate,

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[36] *BMA Archive*, minutes of London Panel Committee meeting on 17 February 1914.

[37] In 1936 the North Riding of Yorkshire LMPC noted approval of expense claims totalling £2,202 from the 'special reserve portion' of the mileage fund in respect of claims for, inter alia, postgraduate study, holidays, and telephone and motor car expenses .*YORLMC Archive,* Appendix to minutes of a meeting of North Riding of Yorkshire LMPC on 19 March 1936.

[38] *Ibid*, minutes of meeting of 1 December 1932, min 7.

[39] This was 'more in the nature of a general purposes subcommittee' and 'would consider various other matters which called for attention besides the allocations.' *Kent LMC Archive*, minutes of LMPC meeting on 26 May 1920.

[40] *Ibid,* minutes of meeting on 7 December 1921.

[41] Marks, *The History and Development of Local Medical Committees*, p.26.

enjoyed no such right.[42] In March 1914 the Lancashire LMPC asked the Insurance Committee to allot ⅜ d per patient of which the Local Pharmaceutical Committee were to receive ⅛ d.[43] In May 1914 the London Panel Committee noted receipt of £500 for administrative expenses but later that year complained that the total received was £700 less than they had asked for.[44] Being statutory, deductions from GPs' remuneration to cover the LMPC's administration costs were compulsory, whereas the additional or alternative contributions recommended by the LMPCs to meet their costs and contribute to the BMA's central defence fund, were not. Voluntary contributions would only be taken from the practitioners' remuneration by the Insurance Committee on submission of a written form of consent. An example of this can be found within the records of the Lancashire County Panel Committee in which a Dr W. Clegg-Newton agreed on 18 June 1914 to contribute ⅛ per patient per quarter (see Figure 7).[45] Not all practitioners were compliant, however, and much time and effort was expended by LMPCs in trying to cajole constituents into paying. In June 1913 the Kent Panel Committee viewed with regret 'the feeble response to the appeal for subscriptions towards the expenses of the Committee.' Only 250 had agreed out of 800 doctors.[46] In August 1914 the Staffordshire LMPC obtained a list of 160 GP 'defaulters' and in 1921 enjoined each member of the committee to 'induce' non-payers to sign the necessary forms.[47] Occasionally objections to levies were ventilated publicly. In an article in the journal *Medical World* in 1915 Alfred Salter openly questioned what the London Panel Committee did with the voluntary levy payments it received. A panel committee member, Dr C.W. Hogarth, responded defensively citing the

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[42] A motion to the LMPCs' conference in 1921 calling for the Ministry of Health to meet LMC members' travel expenses was rejected at the request of the Insurance Acts Committee which 'had always believed these should be financed by the profession .' *BMA Archive*, Minutes of IAC meeting on 27 January 1921 'Expenses of LMCs', min. 36.

[43] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting on 18 March 1914.

[44] *BMA Archive*, minutes of London Panel Committee meeting on 15 December 1914.

[45] *Lancashire & Cumbria LMCs Archive*, levy consent form enclosed with LMPC minutes 1914.

[46] *Kent LMC Archive*, minutes of KCMC meeting on 12 June 1913. In July 1914 the Lancashire LMPC 'deprecated' the decision of GPs in one of its constituent electoral districts ('area 22') not to pay the amount requested. *Lancashire & Cumbria LMCs Archive*, minutes of LMPC meeting on 8 July 1914.

[47] *North Staffordshire LMC Archive*, minutes of LMPC meeting on 29 August 1914.
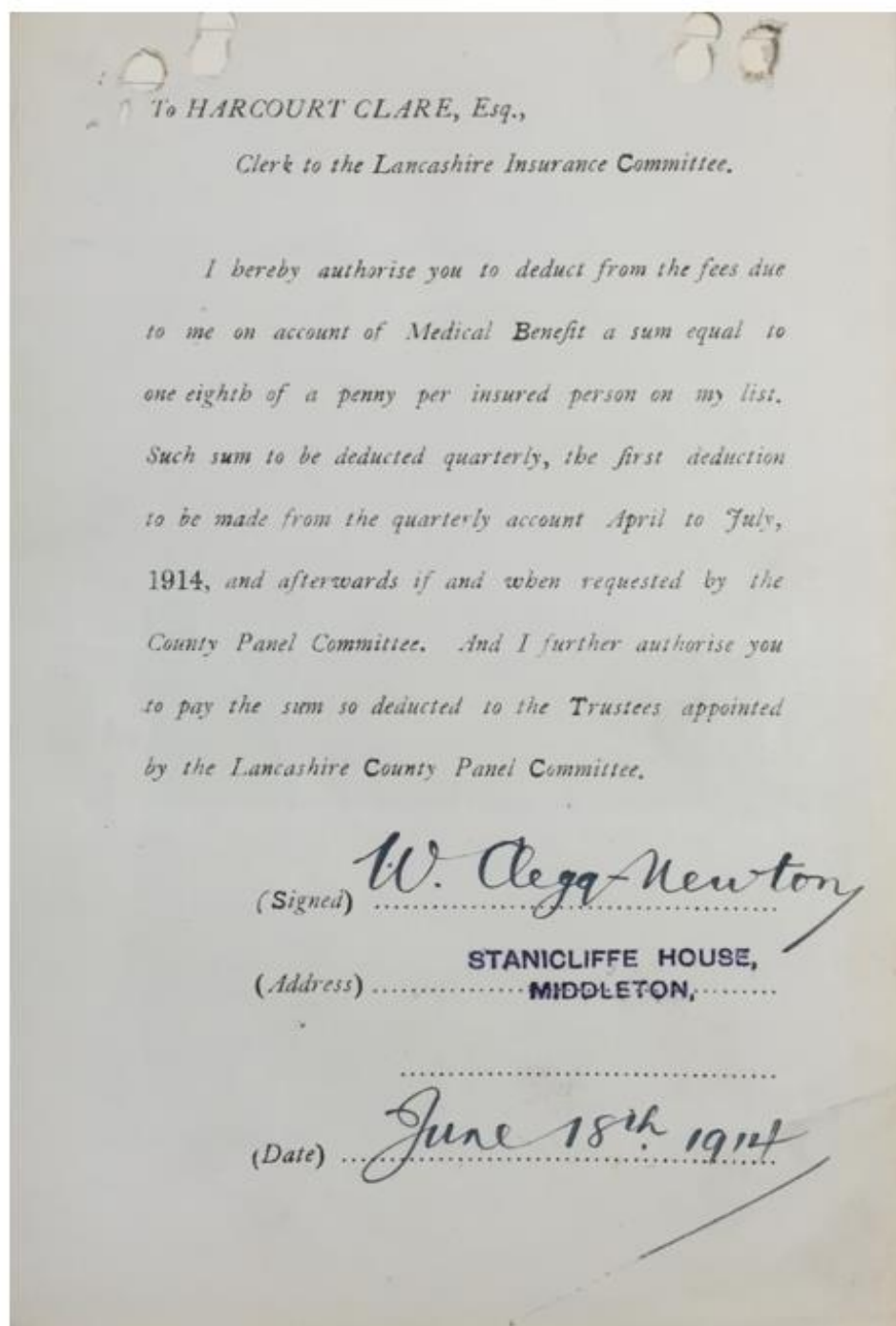
Figure 7. *The price of professional independence*: Signed consent to collection of voluntary levy by Dr W Clegg-Newton, June 1914. (Lancashire and Cumbria LMCs Archive.)

'countless hours spent on committee work' and listing specific projects which had occupied

his and other panel committee members' time.[48] Having no obvious source of income, LMCs

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[48] *Medical World,* Alfred Salter, 'The Panel Practitioner and his interests', 11 March 1915, pp. 298-304; and response by C.W. Hogarth, 18 March 1915. pp. 333-334.

relied on the goodwill of their membership and cross subsidisation of costs by Panel Committees. In Kent in October 1921 the Panel Committee voted to grant the LMC £20 to cover its expenses but this was vetoed by the Insurance Committee. This prompted the Panel Committee to propose that it be officially recognised as the LMC for the county and the Ministry of Health acceded to their request.[49]

What did the expenses received by LMPCs cover? A Statement of Accounts for the Staffordshire LMPC for the year ended June 1921 shows expenses for meeting room hire (the Swan Hotel), printing costs, members travelling expenses, payments for scrutinizing prescriptions, and expenses paid to the chairman, Dr Ridley Bailey.[50] In 1933 the expenses of the North Riding of Yorkshire LMPC included inter alia the 'half cost' of surgery inspections, scrutiny of mileage claims, and donations to medical charities.[51] Some LMPCs paid members for attending meetings. In 1920 Kent LMPC increased its fee for attending meetings from half a guinea to one guinea.[52] It increased it to 2 guineas per day in to 1924.[53] The Lancashire LMPC offered locum costs to its representatives attending the annual conference of LMPCs.[54] Committees were not always generous when it came to expenses as is evident in Staffordshire where they only agreed to reimburse third class travel costs for members' attendances.[55]

The Staffordshire LMPC evidently made do without a paid Secretary at this time whereas for a great many LMPCs this was a major and necessary expense. In the autumn of 1914, an IAC survey revealed emoluments ranging from £10.10s per annum in Nottingham to £250 per annum in London, the same amount being offered in Lancashire, and in Essex where the

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[49] *Kent LMC Archive*, minutes of LMPC meeting on 18 October 1921.
[50] *North Staffordshire LMC Archive*, Statement of Committee accounts enclosed with minutes of LMPC meeting on 29 September 1921.
[51] *YORLMC archive*, minutes of North Riding of Yorkshire LMPC meeting on 13 July 1933, min 4.
[52] *Kent LMC Archive*, minutes of LMPC meeting on 21 October 1920.
[53] *Ibid,* minutes of meeting on 7 February 1924.
[54] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting on 27 May 1913.
[55] *North Staffordshire LMC Archive*, minutes of LMPC meeting on 14 January 1915. The Staffordshire accounts show total committee expenditure to be only £300. 1s. 8d and separate receipts for 'the medical defence trust' totalling £405.11s.7d.

Secretary was a medical practitioner.[56] Being self-employed, GPs were acutely conscious of the value of their time spent on representative activities. In January 1921 the secretary of Kent LMPC, Dr Salisbury, resigned from the Insurance Committee when the latter decided not to pay for his time while he received an honorarium from the LMPC.[57] Disputes with the Insurance Committee about expenses continued in the following year when another Kent LMPC member, Dr Gordon Ward, sought to resign from various subcommittees after the Insurance Committee's auditor 'refused to pass any fees paid to medical members other than those of the panel committee or its subcommittees.'[58] In 1925 the Kent LMPC set up a subcommittee to investigate its secretarial and administrative expenses taking evidence from other committees such as Manchester. Concluding that the costs were 'extravagant' it resolved to terminate existing arrangements, following which its Secretary, Dr Salisbury, promptly resigned.[59]

In general, it appears relations between LMPCs and Insurance Committees were courteous and business-like. This may seem surprising, given the major part the provisional LMCs played in the BMA-led opposition to the Act, but, as one GP put it in 1913: 'We are getting on well with the Insurance Committee…We believe we shall, by tactful and diplomatic dealing, obtain more than by adopting an antagonistic attitude.'[60] However, any lack of trust quickly escalated into conflict. In Bristol in 1915 for example, the LMPC was angered by the decision to withhold payment of 'unallotted funds' from 1913 pending a dispute over the costs of excessive prescribing.[61] The matter was only resolved in 1916 following the intervention of local MPs

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[56] *BMA Archive*, minutes of IAC meeting on 9 October 1914.

[57] *Kent LMC Archive,* minutes of LMPC meeting on 13 January 1921.

[58] *Ibid,* minutes of meeting on 11 May 1922. The same doctor was chastened when in 1923,'on auditor's advice' the LMPC itself rejected his claim for expenses for attending a Medical Practitioners Union meeting. Minutes of LMPC meeting on 21 March 1923.

[59] *Ibid*, minutes of LMPC meeting on 28 April 1925.

[60] Dr A.E. Larking, *BMJ* 12 April 1913, Supplement, p. 325.

[61] *Medical World*, 21 January 1916, pp.81-82.

Sir Philip Magnus and Charles Roberts.[62] In Kent in 1915 the LMPC was likewise enraged by the Insurance Committee's decision to ban the dispensing of 'rep mist' or repeat prescriptions issued more than a month after the original. The LMPC chose the extreme response of encouraging GPs to submit undated resignations from the panel. One hundred were received but 'held over' by the LMPC pending resolution of the dispute.[63]

Norman Eder talks of the professional understanding which the LMPCs had with the Insurance Committee clerks as being based on a 'shared sense of goodwill' and describes the Insurance Committees management of the scheme as 'operating like an informal affair among gentlemen.'[64] Flexibility was the key to this relationship. The Insurance Committees had wide powers but were expected to exercise them with reasonability and tact. Where they failed to do so the LMPCs could be relied upon to resist. In London in 1915 a proposal by the Insurance Committee to institute a wholesale reduction in the capitation fee to reflect the enlistment of large numbers of insured persons in the armed forces led to a 'strong protest' at a mass meeting in which GPs bemoaned 'the chaos at Chancery Lane', the Committee's 'incompetent staff', their 'disgraceful lack of courtesy' and attempted 'breach of contract'.[65] The chairman of the Insurance Committee, Mr F. Coysh, was forced to resign after the Panel Committee felt unable to support its actions.[66] Another rare example of a breakdown in working relationships occurred in Dorset in 1927 when the GPs' unhappiness with the attitude and behaviour of the Insurance Committee clerk, Mr Henry Moore, resulted in an outright refusal to cooperate with the local administration. The dispute was only resolved following Ministry of Health intervention.[67] In striking contrast to this, the mutual respect between the clerks and LMPCs in other areas is

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[62] *Ibid,* 4 February 1916, p.148.
[63] *Kent LMC Archive*, minutes of LMPC meeting on 17 November 1915.
[64] Eder*, National Health Insurance and the Medical Profession* p. 166.
[65] *Medical World* 22 April 1915, p.500 and 'Great Protest Meeting in London', 29 April 1915 p.530.
[66] *Ibid*, p.533.
[67] *BMA Archive*, Minutes of the IAC meeting of 20 January 1928, 'Report of Inquiry into Dorset Case', Doc. 16. See also Eder*, National Health Insurance and the Medical Profession,* pp. 163-166.

evidenced by the fact that in 1925 the Kent LMPC sought to appoint the Insurance Committee clerk, Mr Lloyd, as their secretary, and Staffordshire LMPC appointed his counterpart, Mr Hodgens, as their secretary in 1933.[68] The idea that there could be a conflict of interest seems never to have occurred to them! The generally cordial relationship between the LMPCs and Insurance Committees in the 1930s is further illustrated by the inclusion in the North Riding of Yorkshire LMPC's accounts of the cost of 'entertaining the Insurance Committee to luncheon.'[69]

The assertion of professional expertise and autonomy

LMPCs were quick to assert their rights to be consulted about all aspects of medical benefits under the Act. Remuneration had proved to be the chief sticking point in the profession's dispute with government in 1911-1913 and the method of payment was the first matter to be decided. All LMPCs supported the adoption of capitation fees except Manchester and Salford, which experimented with a system based entirely on fees for attendance and items of service.[70] The LMPCs were also asked to advise on how the total capitation fees for patients who had not registered with a GP were to be distributed among the panel doctors at the year end. Insurance Committees and LMPCs were in regular correspondence about the distribution of these 'unallotted funds' in 1914, particularly in London, where GPs in the inner city areas with small lists but high workload objected to dividing the surplus strictly according to panel list size. The matter was eventually resolved by a compromise whereby the number of patients for which the

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[68] *Kent LMC Archive,* minutes of LMPC meeting on 28 April 1925. *North Staffordshire LMC Archive*, minutes of LMPC meeting on 5 April 1933.

[69] *YORLMC Archive*, North Riding of Yorkshire LMPC accounts enclosed with minutes of meeting on 13 July 1933.

[70] *Manchester University Medical Collection,* MMC 11/2/1/1, Manchester LMPC 'Information to every member of the Medical Profession in Manchester 1913'. This was eventually abandoned in 1928 after the Insurance Commissioners concluded it was unsustainable. Eder, *National Health Insurance and the Medical Profession*, pp. 316-351. Lancashire and Kent had also briefly considered attendance rather than capitation payments.

sum was apportioned was capped at 2,000 per GP.[71] The Lancashire LMPC, by contrast, wrote to its members in February 1914 that 'the division of the surplus at the end of the first year would be pro rata to the number of county members on the list of each Doctor on the county panel, excluding those associated with 'approved institutions'.[72] These examples demonstrate that the advice given by LMPCs was guided by individualistic and sometimes idiosyncratic notions of what was in the profession's, and sometimes the public's, best interests.

Another of the more important matters falling within the remit of LMPCs was the investigation of 'excessive' prescribing. Discussion centred around the cost of individual items and whether they were necessary and effective. There was, theoretically, no financial limit on what panel GPs could prescribe for patients. The only limit on the practitioner, as the chairman of the IAC explained in 1930, was that of satisfying 'not the officers of the Ministry, but his own colleagues, that what he has ordered was reasonably necessary for the treatment of his patients.'[73] The cost of what the GPs prescribed impacted on the amount of profit the pharmacists made in dispensing items and the amount the Insurance Committee spent on drugs, but also, in terms of items dispensed by GPs themselves, on the amount left in the GPs' (pooled) drugs fund.[74] Practitioners found guilty of 'excessive' or 'extravagant' prescribing could be surcharged, that is made to replace the 'excess'. In June 1920 the Lancashire LMPC conducted one such investigation, finding that the practitioner 'had been careless in prescribing and caused an excessive charge on the drug fund.' It recommended that he be surcharged the sum

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[71] Eder, *National Health Insurance and the Medical Profession,* pp. 69-70.

[72] *Lancashire & Cumbria LMCs Archive*, Letter from Dr Thomas Campbell, Hon Secretary, dated 4 February 1914. 'Approved institutions' refers to Medical Aid Institutes and demonstrates the GPs' continuing antipathy towards them.

[73] Quoted in Harris, *National Health Insurance in Great Britain,* p.159.

[74] Initially this comprised 2s per patient but this included a 'floating sixpence' for contingencies, the residue of which was available to be distributed to local GPs (and until 1916, pharmacists) on a per capita basis if there were unspent funds remaining at the financial year end (see p.232 below). The 'floating sixpence' was abolished in 1920, becoming part of the local drugs fund. Eder, *National Health Insurance and the Medical Profession*, pp. 42, and 129. *The National Archive/Public Record Office Kew* MH 62/119, Memorandum by J S Whitaker, 20 September 1919.

of £5.[75] In Kent an investigation into an allegation of excessive prescribing in December 1921 found that 'Dr L was in the habit of ordering tinctures where infusions would do equally well and ordering acqua chloroform as a vehicle.' The GP promised to comply with the LMPC's advice and no further action was deemed necessary.[76] LMPCs were also required to advise on 'whether a substance prescribed was a drug within the meaning of the pharmaceutical regulations.' Thus, in 1928 the Manchester Panel Committee opined that 'Roboleine' should be classed as a food and could not therefore be prescribed as a drug.[77] In 1936 the North Riding of Yorkshire Panel Committee agreed that Myocrisin be added to the drug formulary, recognising its use in the 'modern treatment' of Rheumatoid Arthritis, TB and Lupus. [78]

One area in which LMPCs were strenuous in asserting their expertise was in determining whether a particular service rendered by a panel doctor fell within the scope of insurance practice. If outside it, the practitioner might be able to claim (on form GP11) an item of service fee or be permitted to charge the patient as a private service. The 1913 Regulations spoke of 'service of a kind which can, consistently with the best interests of the patient, be properly undertaken by a general practitioner of ordinary professional competence and skill.'[79] LMPCs considered this to be a matter which they alone could decide.[80] In May 1915 the Kent committee ruled that treatment of a 'smashed finger joint' was within the scope of medical benefits, but in 1916 ruled syringing of ears and operative treatment of haemorrhoids 'out of scope.'[81] When considering questions involving the scope of practice, LMPCs were often wary

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[75] *Kent LMC Archive*, minutes of Kent Panel Committee meeting on 16 June 1920.

[76] *Ibid,* minutes of Kent LMPC meeting on 7 December 1921.

[77] *Manchester University Medical Collections* MMC/11/2/2/3. Manchester Panel Committee circular to panel practitioners dated 7 March 1928.

[78] *YORLMC Archive,* ,minutes of meetings of North Riding of Yorkshire LMPC on 14 June 1934, min. 2, and 19 March 1936, min. 7.

[79] *NHI (Administration of Medical Benefit) Regulations 1913*; Part V, Reg. 50 and First schedule, part 1 (Conditions of service for practitioners) 2 (i).

[80] This was, technically, one of the functions reserved to LMCs and exercised by them on referral by Panel Committees other than where the LMC and Panel Committees were combined.

[81] *Kent LMC Archive*, minutes of Kent Panel Committee meetings on 11 May 1915, 3 February 1916 and 3 May 1916.

of setting any kind of precedent. In November 1920 for example, the Staffordshire LMPC's executive subcommittee supported a practitioner's claim for an item of service fee with the caveat that 'no general definitions are possible or expedient and each case must be decided on its merits.'[82] However, not all LMPCs supported this lack of definition. Many committees, including that of Lancashire in July 1913, lobbied the Insurance Acts Committee (IAC) to specify the procedures lying within the scope of the practitioner's responsibilities under the Act to prevent GPs being overloaded with additional duties.[83] Some who favoured definition did so in the belief that it would support the profession's claim for increased remuneration. It was for this reason that in 1919 the IAC Chairman, Henry Brackenbury, advocated inclusion, within the scope of services, of the administration of Salvarsan, a drug used in treatment of venereal disease.[84] This suggestion was highly contentious. In May 1914 the Lancashire LMPC advised that Salvarsan should not be included in the drug tariff 'because of its cost and questionable value and because administration has serious results…sometimes fatal, and the technique of its administration is complicated and can only be acquired by considerable practice.'[85] The LMPCs Conference rejected the IAC's proposal, concluding that most GPs preferred to leave the administration of such a dangerous drug to specialists employed in local authority clinics.[86]

Where Insurance Committees disagreed with LMPCs, they sought advice from advisory committees set up, after 1919, by the Ministry of Health. Such enquiries most frequently concerned anaesthetics, vaccination, venereal disease, contraceptive advice and minor surgery.[87] Eder lists thirteen examples of what were declared within the scope of medical benefit including things that would be considered quite hazardous to perform today outside

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[82] *North Staffordshire LMC Archive*, minutes of LMPC meeting on 9 November 1920.
[83] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting on 3 July 1913.
[84] Honigsbaum, *The Division in British Medicine*, p. 131.
[85] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting on 20 May 1914.
[86] Honigsbaum, *The Division in British Medicine,* p. 131.
[87] Eder, *National Health Insurance and the Medical Profession* p.168.

hospitals, such as curetting of the uterus and chest drains.[88] Among fifteen items declared to be outside the scope of medical benefit was 'removal of varicose veins' but this proved very controversial. In January 1929 the Ministry appointed referees to consider a case involving a Manchester practitioner who considered that he possessed the necessary skill to undertake the treatment of varicose veins via 'injection of a sclerosing solution' and considered similar cases which had occurred in Sussex and Leicester.[89] Kent LMPC subsequently wrote to the Ministry objecting that such injections should not be carried out by GPs 'as they were still in an experimental stage and no uniformity has yet been arrived at as to the best type of injection to be used.' [90] The Ministry appointed a committee of inquiry which in August 1931 ruled that although the treatment was novel it was now widespread, with very few cases of complications, and was not therefore beyond the skill of GPs.[91] When the IAC questioned LMPCs about remuneration and workload the following year several, including the London Panel Committee, complained that workload had increased due to 'the popularity of sclerosing methods of tackling varicose veins.'[92] While exercising the rights accorded to them to determine the scope of service, the judgment of LMPCs was almost always conservative: they sought to discourage GPs from undertaking innovative treatments until such times as they had become commonplace and relatively free of risk. Consequently, the nature of GPs' practice changed very little during this period, in contrast to the significant advancements of treatment in hospitals.[93] However, the Ministry of Health's rulings prove that they did not always succeed in frustrating attempts

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[88] *Ibid*, pp. 168-69.

[89] *BMA Archive*, Minutes of IAC meeting of 2 July 1931, Memorandum by E Rowland Fothergill, Doc. 58 in which Fothergill decried the referees' decision as 'an illegal attempt to lay down a general rule. ' (p. 4, point 30) and correspondence with LMPCs in Sussex, Caernarvonshire and Kent, Doc.64.

[90] Kent Local Medical Committee, *The History of Kent Local Medical Committee 1912-2012* (2nd edn. Harrietsham, Kent, 2012) p. 21.

[91] *BMJ* 8 August 1931, Supplement pp.126-127. A critic of the London Panel Committee and its LMC was clear where he stood on the matter when, after a lengthy explanation of the controversy, he states 'Every right-minded practitioner will agree with the decision of the referees.' 'AGP', *This Panel Business* (London, 1933) p.219. He later qualifies this statement by stating '…can one expect such doctors as those who serve on Panel Committees to add new treatments for panel patients to their already overworked practices?' *Ibid*, p.270.

[92] *BMA Archive*, Minutes of IAC meeting of 12 May 1932 , Doc 54. Min. 35.

[93] Digby*, The Evolution of British General Practice,* pp. 220-223.

to broaden the scope of service. There were, moreover, other matters affecting panel practice in which the GPs' determination to 'have the final say' did not go unchallenged.

The rules covering certification of sickness benefits were a constant source of dispute between medical practitioners, LMPCs, and the approved societies, in which the Insurance Committees were often reluctant arbitrators. The doctors resisted the societies' efforts to make it compulsory to state the nature of patient's illness on the certificate on the grounds that it would breach doctor/patient confidentiality and felt that the doctor's professional opinion that the patient was unfit for work should be sufficient. At its first meeting in May 1913 the Lancashire Panel Committee objected to the wording of a proposed standard certificate stating its opinion that 'it would be seriously detrimental to the interests of the public to place upon certificates the nature of the disease.'[94] Insurance Committees often looked to the Insurance Commissioners, and later the Ministry of Health, and the IAC, to help resolve these disputes. In July 1914 the insurance commissioners invited chairs and secretaries of Panel Committees to a conference to 'discuss difficulties…experienced by approved societies in dealing with sickness benefit and…giving of medical certificates for that purpose.'[95] It failed to resolve the issue and subsequent discussions proved equally fruitless. In December 1914 the London Insurance Committee dismissed as 'frivolous' complaints by two approved society secretaries that panel doctors had failed to state the nature of the disease 'on a form of certificate not modelled on that issued by the Commissioners.[96] Insurance Committees were sometimes content, moreover, to let LMPCs deal with breaches of certification rules, as in Lancashire in July 1915 when the LMPC summoned three practitioners to explain why they had, contrary to the rules, ante-dated and post-dated certificates. The Committee concluded the GPs had not

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[94] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting on 27 May 1913. At a subsequent meeting with the Insurance Committee, the LMPC stated that what they wanted was a form stating simply 'I certify that the patient from (start date) to (end date) is unable to perform his or her duties', minutes of meeting of 23 June 1913.

[95] *BMA Archive*, minutes of meeting London Panel Committee on 7 April 1914, min 4.

[96] *Medical World* 'Complaints against Panel Practitioners', 3 December 1914, p.638.

breached the rules 'wilfully', that is to save themselves work, but 'through ignorance' and, perhaps because the no harm was suffered by the patients, the trio were let off with a warning.[97]

Beginning in 1920 the Ministry of Health appointed Regional Medical Officers (RMOs) to support panel GPs with second opinions, rule on disputed cases of malingering and inappropriate certification and carry out inspections of medical records.[98] The profession itself had long campaigned for the appointment of what they described as 'medical referees' to prevent the inevitable clashes between GPs and approved societies over certification but LMPCs not infrequently took issue with RMOs' decisions.[99] However, as explained in chapter 6, the profession's leaders eventually found it expedient to cooperate with the approved societies and the Ministry on ways to tackle perceived abuses. Thus, in October 1932 Staffordshire LMPC wrote to GPs recommending that they should 'furnish information in confidence as to the nature and duration of illness when requested to do so by Approved Societies in cases of difficulty.' The LMPC suggested GPs carry out the recommendations 'as far as possible' but added that 'it is not compulsory for you to do so.'[100] LMPCs were thus prepared to advise constituents to act in ways that to them seemed reasonable while always acknowledging GPs' rights, as independent contractors, to determine their own course of action.

The range of matters relating to the administration of medical benefit on which the LMPCs were invited to advise the Insurance Committees was increasingly broad. In 1920 the Kent Insurance Committee asked the Panel Committee's opinion of 'irregularities' in one GP's

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[97] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting of July 1915.

[98] Eder, *National Health Insurance and the Medical Profession,* p.177. See chapter 6 below.

[99] Among other duties the RMOs were also meant to collect statistical information about disease prevalence by random examination of GPs records. This was abandoned in 1926 due to the lack of uniformity and general illegibility of the records ! Eder, *National Health Insurance and the Medical Profession* p.178.

[100] *North Staffordshire LMC Archive*, Letter to Panel Doctors from Dr AV Campbell, Hon. Secretary dated 1 October 1932.

accounts.[101] The claiming of anaesthetic fees also proved the subject of a long running correspondence between the Kent LMPC, its Insurance Committee and the Ministry of Health in the early 1920s. Initially the LMPC decided to allow claims for anaesthetics for operations considered within the scope of the Act even if carried out in hospital.[102] However they later ruled that no fee should be paid to 'a man who administers and anaesthetic himself for an operation which he also performed.'[103] A claim disallowed on these grounds led to an appeal to the Ministry by the practitioner concerned, Dr J.H. Bennett, on which the Ministry ruled that the LMPC had erroneously interpreted earlier advice and a number of disallowed claims had to be reconsidered.[104]

Fees for emergency treatment of other practitioners' patients were another area of the LMPCs' responsibility. When allowing a claim in 1923 for treatment of a scalp wound following a bicycle accident, the Kent LMPC opined that such fees should be paid from ' the practitioners' fund' and not, as the regulations required, deducted from the remuneration of the patient's usual doctor.[105] In September 1928 the Manchester LMPC circulated an admonitory letter stating that 'the business of the panel committee is being increasingly devoted to consideration of (emergency treatment) claims, and in a large number of cases, the patient is on the list of a neighbour of the doctor who makes the claim.' It went on (in underlined capital letters to add emphasis): 'Your committee feels very strongly that most of these claims should not be made but that neighbours should more often act for one another in a friendly

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[101] *Kent LMC Archive*, minutes of Kent Panel Committee meeting on 21 July 1920. The committee informed the Insurance Committee that the accounts submitted by a Dr Swindale 'show evidence of grave irregularity and warrant the further action applicable in such cases.'
[102] *Ibid*, minutes of meeting on 8 September 1920.
[103] *Ibid*, minutes of meeting on 21 October 1920.
[104] *Ibid*, minutes of LMPC meeting on 19 January 1922. The Committee was still free to determine what was within the scope of benefit, however, as when it disallowed claims for anaesthetics accompanying extraction of teeth, removal of tonsils and adenoids, curetting of uterus and intravenous injection of Salvarsan. Minutes of meeting on 13 July 1922. Claims approved included removal or drainage of cysts, abscesses, carbuncles, whitlows and cellulitis and 'stretching of anal sphincter', minutes of meeting on 18 January 1923.
[105] *Ibid*, minutes of meeting on 21 March 1923.

way.' It continued 'In future the panel committee will be inclined to CONSIDER ADVERSELY claims for emergency treatment where both doctors concerned practice in the same district.'[106] Mileage grants constituted a substantial addition to the income of rural practitioners.[107] In the North Riding of Yorkshire, a total of £7,539 was paid out to panel doctors in 1934.[108] The 1913 Benefit regulations also allowed practitioners to make claims for sundry items from the 'reserve portion' of the central mileage funds subject to approval by Insurance Committee subcommittees containing LMPC nominees.[109] In Lancashire in December 1914 the LMPC approved payment from this source for 'tolls over the ship canal.'[110] Claims could also be made for emergency dressings.[111] From 1928 claims for postgraduate courses were included in what the reserve portion could be spent on.[112] In 1933 85 GPs in the North Riding of Yorkshire received between them a total of £165 for attending such courses.[113] At a meeting of the LMPC in that year, the RMO, Dr A.E. Huxtable, explained why one claim had been rejected. He said that payment from the special expenses part of the central mileage fund was meant to provide locum cover for GPs in isolated rural areas who could not otherwise afford to attend courses without assistance. The applicant in this case was in the habit of attending courses at his own expense and his intention to attend was not dependent on being given the grant. Moreover, he had declined to divulge his net professional income.[114] A report

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[106] *Manchester University medical collections* MMC/11/2/2/7 Letter from Manchester Panel Committee 28 September 1928.

[107] Levy, *National Health Insurance* p.123.

[108] YORLMC Archive, minutes of North Riding of Yorkshire LMPC meeting of 14 June 1934, min 4. These were categorised as 'Walking cases' (£2,249);'Narrow bye-lanes' (£1,345); and 'Exceptionally hilly, dangerous moorland and no surfaced road' ('grade 1' -£1,557, and 'grade 2'- £2,388).

[109] *Kent LMC Archive*, minutes of Kent Panel Committee meeting of 2 March 1921.

[110] *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting of 23 December 1914.

[111] *YORLMC Archive*, minutes of North Riding of Yorkshire LMPC meeting of 14 June 1934, appendix to schedule 2 of report on mileage fund. Claims for emergency dressings for the years 1930-1933 showing these to have been £333, £222, £113 and £122 respectively.

[112] Eder notes that in that first year nationally only 86 GPs took advantage of that provision. Eder, *National Health Insurance and the Medical Profession,* p. 194, note 59. However, the Ministry reported that in 1938 it had received 2,500 separate applications. *BMA Archive*, Minutes of IAC Remuneration Subcommittee meeting of 4 April 1938 para.19.

[113] *YORLMC Archive*, minutes of North Riding of Yorkshire LMPC meeting of 13 June 1933.

[114] *Ibid,* minute 2.The LMPC voted on whether to seek to amend the wording of the guidance on applications but decided to leave it unchanged.

to the North Riding of Yorkshire LMPC in 1936 categorised claims totalling £2,202 made from the reserved portion under schedule 2.[115]

Another of the LMPCs' duties involved assisting the Insurance Committees with inspections of GPs' premises to ensure they were in a fit and proper condition. In 1921 Surrey LMPC objected when its Insurance Committee sought to make approval of a GP taking on 'a substantial number of new patients' conditional on his having 'satisfactory' premises.[116] However in Kent in 1923 the LMPC chairman visited the premises of a Dr Edmanston of Greenhithe, reporting that he found the accommodation to be 'grossly inadequate' and the LMPC consequently supported a decision that permission for the doctor to appoint an assistant be withheld pending improvement in the accommodation.[117] In Staffordshire in 1925 the Insurance Committee wrote to the LMPC that a practitioner who had been requested to improve the conditions of his waiting room had so far taken no action. The LMPC secretary subsequently wrote to the practitioner pointing out that 'the matter must be remedied forthwith.'[118] In the 1930s in the North Riding of Yorkshire general inspections of GPs' surgeries took place every 5 years conducted by teams involving LMPC-nominated GPs and the LMPC shared the cost on a 50/50 basis.[119] However, the approach was less systematic in Staffordshire, where the LMPC participated in a general survey of waiting room accommodation in 1936 'on the same lines as that carried out in 1924' and subject to the LMPC warning practitioners that it was taking place.[120] In 1931 *Medical World* commended one Insurance Committee and its LMPC for sidestepping the contentious issue of whether every GP's consulting room should contain an examination couch by stating that it was 'more a

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[115] *Ibid,* minutes of meeting of 19 March 1936. These were categorised as: 'postgraduate study; holiday grant; call house grant (sic), telephone grant, sickness grant, special grant, motor car grant and subsidy grant'.

[116] *BMA Archive,* minutes of IAC meeting on 17 November 1921.

[117] *Kent LMC Archive*, minutes of LMPC meeting on 20 December 1923.

[118] *Staffordshire LMC Archive*, minutes of LMPC meeting of 8 October 1925.

[119] *YORLMC Archive*, accounts attached to minutes of North Riding of Yorkshire LMPC meeting of 13 July 1933.

[120] *North Staffordshire LMC Archive*, minutes of LMPC meeting of 19 September 1936.

matter of equipment than 'accommodation'.'[121] Other functions fell to the LMPCs by default. Some Insurance Committees felt it necessary to set local limits on the number of patients GPs could have on their lists and were obliged to seek the LMPCs' approval.[122] But some LMPCs took a more active role in policing their constituents' behaviour. In 1925 the Kent LMPC recommended that the Insurance Committee impose a limit on the patient list of a Dr Jefferis following the upholding of a complaint about failure to visit a patient, and in 1934 the North Riding of Yorkshire LMPC objected to a GP living too far from his patients and in a separate case to the 'illegal retention' of an excess of patients following the departure of his assistant.[123]

Mediation and self-government: the management of complaints and discipline

A responsibility the LMPCs took very seriously was the adjudication of patient complaints. The LMPCs were allowed to nominate three of the seven members of the medical service subcommittees which oversaw this function. The very first hearing of the Nottinghamshire Insurance Committee's medical service subcommittee took place in June 1913 when they heard a complaint from a Mrs Burton about the treatment she had received from a Dr Park. The accusation of a poor standard of treatment was found to be 'unsubstantiated' but the committee concluded that 'the words and manner of Dr Park were wanting in sympathy and showed an unjustifiable loss of temper.'[124] This echoes a case cited by R.W. Harris in the appendix to his book on National Insurance in which the London Medical Service Subcommittee 'deprecated very strongly' the conduct of a practitioner who thought it 'a confounded impertinence to ring

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[121] *Medical World* 18 September 1931,'National Health Insurance', p.61.

[122] Anne Digby 'The Economic and Medical Significance of the British National Insurance Act 1911' in Martin Gorsky and Sally Sheard (eds) *Financing Medicine: the British Experience since 1750* (Abingdon, 2006) ch.11, p.186.

[123] *Kent LMC Archive,* minutes of meeting of Kent LMPC of 29 October 1925. *YORLMC Archive*, minutes of North Riding of Yorkshire LMPC meetings on 5 April 1934 and 10 November 1934.

[124] *Nottinghamshire RO Archives*, SO NHI/ 1-3; NHI Committee minutes 1913-48, Vol.1, meeting in June 1913.

up a doctor at 8.30am about a panel call.'[125] In such cases the practitioner was invariably advised 'to adhere more closely in future to the terms of his agreement with the Insurance Committee.' Sanctions were only employed where there was evidence of a breach of the terms of contract or a failure to perform one or more of the required services, such as a failure to visit or examine a patient or inappropriate charging, in which case the practitioner might suffer a 'withholding' (of part of their contractual remuneration). In rare cases a practitioner might be removed from the panel. In December 1916, Nottinghamshire GPs Coughlan, Hine, Hawson and Simpson were all subjected to withholding for failure to properly complete patient record cards.[126] The necessity to keep medical records was resented by many GPs as the records were, initially at least, simply an aid to the administration of medical benefit rather than any useful source of clinical information. When, following changes in 1921, they became more comprehensive, Kent LMPC drew up a memorandum listing criticisms of the new regulations which it sent to the Ministry of Health and the IAC.[127] This was little comfort to their constituent who refused to keep *any* records and in 1922 was accordingly fined £25 and told that repetition would result in his removal from the panel.[128]

Anne Digby contends that complaints to service subcommittees of poor treatment or negligence were usually rejected but less serious complaints upheld.[129] Eder says charges of negligence were uncommon but not as rare as accusations of incompetence.[130] Further examples given by Harris based on his experience as a Medical Service Subcommittee chair in London give a flavour of what the subcommittees considered. These included: a failure to visit or facilitate the admission to hospital of a patient who was severely burned – the GP was

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[125] Harris, *National Health Insurance in Great Britain*, Appendix 7, Case A, 206.
[126] *Ibid,* minutes of December 1916 and March 1917.
[127] *Kent LMC Archive*, minutes of LMPC meeting on 19 May 1921.
[128] *Ibid,* minutes of meeting on 13 July 1922.
[129] Digby, *The Evolution of British General Practice,* ch.12, p. 311.
[130] Eder*, National Health Insurance and the Medical Profession*, p.174.

censured and subjected to a withholding of £20; a case in which a GP had provided backdated

sickness certificates to a patient whose absence from work turned out to be due to him being in

prison – the practitioner received a warning and a withholding of £10; a blatant case of

inappropriate charging in which two GPs charged patients wanting speedier access a shilling

to be admitted to their consulting rooms via a separate waiting room – the GPs were 'severely

censured' and subjected to a withholding of £150. In the final case described by Harris an

exasperated GP recommended that a patient suffering from a psychosomatic illness attend his

surgery rather than expect him to visit as he had done unnecessarily several times previously.

The patient called in another GP and sent the first GP his bill. The subcommittee's sympathies

are obvious from its laconic finding that 'There was no failure on the part of the (accused)

practitioner to comply with the terms of service.'[131]

An interesting reflection on the insurance complaints procedures can be found in the

novel *The Old Doctor* by the panel GP, Frank Layton, published in 1923.[132] Layton is scathing

about fellow doctors who are neglectful of their professional responsibilities. His hero, the 'old

doctor', Luke Dennison, is pleased that the new insurance panel system provides a means to

hold such doctors to account and subject their conduct to peer review and sanction. To

Dennison's obvious delight, one of the characters typifying these attitudes, McFadd, quickly

finds himself subject to a complaint which, the author says, was 'thoroughly well-founded'.

He was charged with 'refusing to visit a patient who had sent for him one evening; with writing

for the patient, whom he had not seen, a prescription for a disorder which he had not

investigated.'[133] At the hearing McFadd is forced to admit to his negligent practice under

interrogation by the medical members. For Layton, peer review is what made a difference-

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[131] Harris, *National Health Insurance in Great Britain*, Appendix 7, pp. 206-211.
[132] Frank G Layton, *The Old Doctor* (Birmingham, 1923) pp.165-166.
[133] *Ibid,* p.162.

> McFadd seemed uncomfortable. He was rather afraid of the Doctor members of committee. He had no delusions as to how he stood with his professional brethren. They knew all about him and his ways. He knew that he might bluff the lay people, but he could never bluff the doctors.

The result was clear cut: McFadd 'was severely admonished and heavily fined.'[134]

Layton's view of service subcommittees may, however, represent wishful thinking. Critics suspected that the medical members were inclined to be lenient towards accused doctors and, as the lay members did not know what constituted ordinary competence and skill they generally bowed to their expertise.[135] Anne Digby illustrates this with the case of Retford GP, Dr H.R. Chibber-Want who was censured numerous times for failure to visit, irregular prescriptions and certification, and wrongly charging patients for private treatment. His deficiencies prompted the Ministry of Health to question in 1923 if his continuance of the Panel would be 'injurious to the service'. He remained on the panel list, according to Digby, because local doctors on the Medical Services Subcommittee excused his failings, ascribing them to his youth and inexperience.[136] One of those members was the secretary of the Nottingham County LMPC, Dr Ernest H. Houfton (see Figure 8). Having been appointed to the medical service subcommittee in 1913 he was, until his death in 1926, the most assiduous attender of complaint hearings. The fact that he had obtained an undergraduate prize in forensic medicine may explain why he was considered especially skilled in cross-examining witnesses.[137]

Contributors to *Medical World* took an altogether different view of the service committee process. An article in July 1915 claimed the fact that of 100 cases investigated between July 1914 and June 1915, 42 were unsubstantiated, was an indictment of the system. It criticised the

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[134] *Ibid,* p.166.
[135] Eder, *National Health Insurance and the Medical Profession,* p.170.
[136] Digby, 'The Economic and Medical Significance of the National Health Insurance Act 1911', p. 185.
[137] Paul R. Swift, *From Sawbones to Keyholes-Presidents of the Nottingham Medico-Chirurgical Society from 1828-2002* (Grantham, 2003) p. 142.
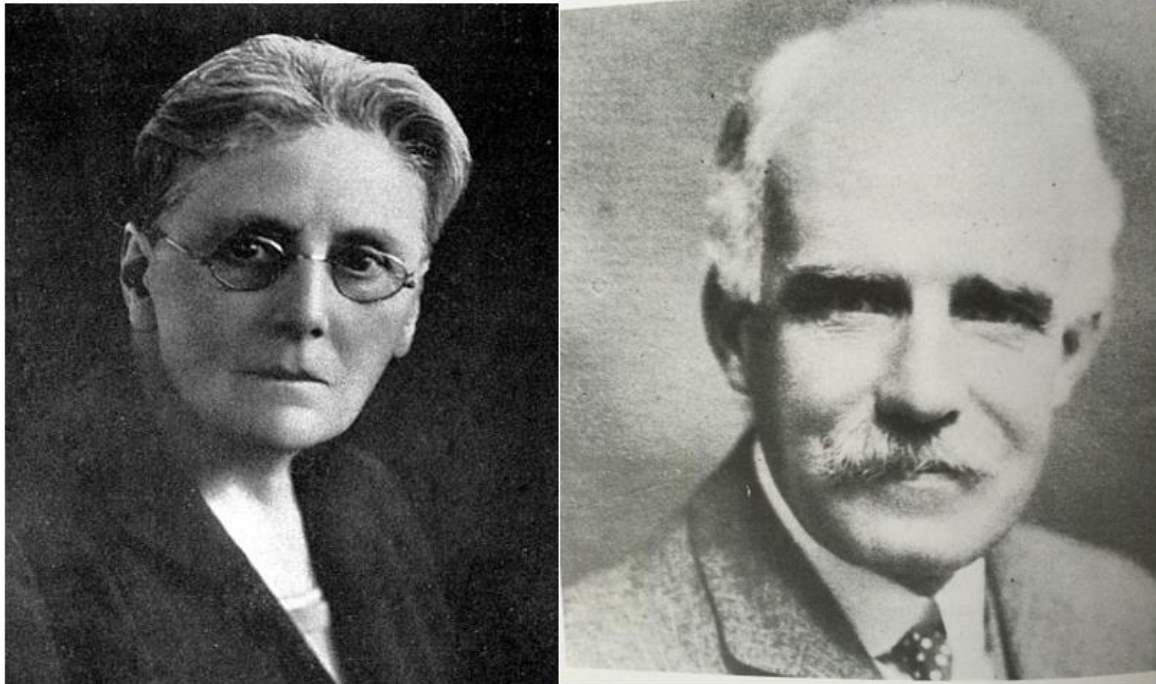
Figure 8. *LMPC Stalwarts*. Dr Ethel Bentham (left), a member of the London Panel Committee from 1914, represented them at the Annual LMPC Conferences from 1918. (Photograph Wikipedia). Dr Ernest Henry Houfton (right) was secretary of the Nottingham County LMPC from 1913 to 1926. (Photograph from Nottingham Medico-Chirurgical Society collection, Nottingham University).

conduct of the medical members of the committee, stating provocatively that 'it is often to the laymen on the subcommittee that the doctor has to look for fair play.'[138] It is perhaps ironic that *Medical World's* bete noire, the BMA's secretary Alfred Cox, appears to have agreed with them on this point. In his memoirs he states that 'Many a man who has been hauled over the coals for extravagance or neglect has told me that he would have got off more easily had he been dealt with by a body of laymen.'[139] *Medical World* did not view this as a good thing. In a comment on the case of 'a Croydon practitioner' who in 1922 won his case against the Insurance Committee on appeal, its editor stated 'We repeat that we protest against a system which compels medical men to prosecute and fine a brother practitioner in cases of which they

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[138] *Medical World* 'Complaints Against Practitioners - the Medical Service Subcommittees', 24 July 1015.
[139] Cox, *Among the Doctors,* p.124

can have only imperfect knowledge.'[140] Cox on the other hand commented later: 'I do not hesitate to say that it was this increased reliance on the doctors to 'police' their own service that made it the smoothly running service it was eventually to become.'[141]

While its nominees served on the medical service subcommittees, LMPCs often expressed concern about the sanctions imposed by Insurance Committees and sought modifications to their rules. In February 1919 the London Panel Committee suggested that a time limit of three months after the event giving rise to the complaint be established. However, the Insurance Committee rejected the idea.[142] In Kent in 1922 the LMPC compiled a comprehensive list of issues justifying changes to the service committee procedure.[143] The Insurance Committee set up a special subcommittee to consider these criticisms and, after acknowledging their validity, drew up new rules of procedure which were circulated to Panel Committees across the country.[144] They were welcomed by LMPCs in Stockport, Nottingham and Birmingham but rejected by the West Riding of Yorkshire LMPC and by Staffordshire LMPC with the pointed reply that 'so far as this area is concerned there is no need of any alteration.'[145] LMPCs sometimes considered the punishment meted out for contractual failings disproportionate, as in a celebrated case in Lancashire in which two GPs accused of inappropriate charging were subjected to a fine of £1,000.[146] However, they sometimes took the opposite view. GPs removed from the panel could appeal to be readmitted, as appears to

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[140] *Medical World*, Comment on 'Letter from Croydon practitioner',13 January 1922.

[141] Cox, *Among the Doctors*, p.124.

[142] *BMA Archive*, minutes of London Panel Committee meeting on 25 February 1919, min 6.

[143] These were: members having no legal training; inclusion within complaints of prejudicial statements; admission of hearsay evidence; failure to formulate definite charges and cite regulations breached; inclusion of supplementary charges for which the accused was unprepared; leading questions; self-incrimination; awarding of costs to the unsuccessful party if the complainant but not the defendant; increasing of penalties by the Ministry; no right of appeal to the courts; and the waste of public money investigating trivial complaints. *Kent LMC Archive*, minutes of LMPC meeting on 20 December 1922.

[144] *Ibid,* minutes of LMPC meeting on 18 January 1923.

[145] *Ibid,* minutes of meeting on 10 May 1923; *North Staffordshire LMC Archive*, minutes of LMPC meeting on 6 April 1923.

[146] *BMJ* 22 December 1923, Supplement, pp. 277-278. It was subsequently reduced to £600.

be the case in Lancashire in 1928 when, on learning that a Dr Godfrey had been reinstated following an appeal to the Minister, the LMPC expressed its disapprobation by informing the Insurance Committee that it 'would accept no responsibility for Medical Services as far as Dr Godfrey is concerned.'[147]

Despite the concerns of some LMPCs about procedures, very few complaints resulted in a fine or withholding. This is not surprising given the relatively low number of patient complaints. The highest number recorded, 520, in 1922, represented a ratio of one to every 24,000 patients.[148] In 1924 only four of 404 complaints resulted in a practitioner being removed from the panel. The same year, the Court of Inquiry into GPs' remuneration heard that there had been only 324 withholdings in the previous four years.[149] However, some authorities questioned the weight that should be attached to such statistics. In evidence to the Royal Commission on National Insurance in 1925, an approved society representative, Mr E.E. England, alleged that for every complaint brought before the Insurance Committees there were ninety-nine that were not, 'merely because the insured person is either afraid of the doctor or is loth to lodge a complaint , or is too lazy to do it.'[150] Although the friendly societies frequently criticised panel doctors in the press it was mostly about lax certification. Patient dissatisfaction with the standard of care given by panel doctors was rarely reflected in the press and then only in terms of reporting of Medical Service Committee decisions.[151] When, in a rare example, the *Daily Sketch* voiced a concern about 'collusion' during a Medical Service Committee hearing, in London , it was forced to issue a retraction and an apology to the medical members.[152]

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[147] *Lancashire & Cumbria LMCs Archive,* minutes of Lancashire LMPC meeting on 19 September 1928.
[148] Honigsbaum, *The Division in British Medicine*, p.208.
[149] Marks, *The History and Development of Local Medical Committees*, p. 118.
[150] Quoted by Levy, *National Health Insurance* p. 116.
[151] For example: *Daily Mail* 'Panel Doctors fined', June 29, 1923 and 'Panel Doctor and a patient.' 9 October 1929.
[152] *Daily Sketch*, 10 March 1923 reprinted in *Medical World* 16 March 1923, p.47.

Practitioners subject to hearings were entitled to be accompanied by a medical colleague who, though not permitted to act as an advocate and address the subcommittee, could offer the individual advice on how to respond.[153] Concerns about conflict of interest were compounded when the individual entrusted with accompanying the accused was the Secretary or Chairman of the LMC or Panel committee. An unnamed LMPC explained in *Medical World* in February 1922 that the Panel Committee chairman was accepted by the Insurance Committee as the defendant's representative and 'is always present at hearings.'[154] Kent LMPC noted in July 1922 that the Insurance Committee had confirmed its agreement that one of the panel committee members should accompany an accused practitioner to medical service subcommittee hearings.[155] LMPC representatives also accompanied practitioners at interviews with RMOs investigating inappropriate certification, a practice recognised and endorsed by the Ministry in a communication to Panel Committees (ICL 808) noted by the North Riding of Yorkshire LMPC in June 1933.[156]

LMCs (and, where recognised as LMCs, Panel Committees) were also given responsibility to investigate and decide on complaints by GPs about other GPs.[157] This was an essential part of self-government and reflected the profession's long-cherished desire for 'courts of honour'.[158] It is also consistent with what recent European researchers have referred to as 'regulated self-regulation.'[159] Allegations of 'serious professional misconduct' were the

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[153] The Staffordshire LMPC explained the necessity for this: 'The panel committee, recognizing the danger in which a medical practitioner is placed, who has a complaint made against him by a patient on the panel, and also the fact that he is liable to prejudice his case in his reply to the accusations made against him, recommend any practitioner who may have a charge against him to obtain expert medical advice before making any reply to the charge.' *North Staffordshire LMC Archive*, minutes of meeting of LMPC Executive Subcommittee on 29 September 1914.

[154] *Medical World,* 3 February 1922 pp.534-535.

[155] *Kent LMC Archive*, minutes of LMPC meeting of 13 July 1922.

[156] *YORLMC Archive*, minutes of North Riding of Yorkshire LMPC meeting of 15 June 1933..

[157] *The National Insurance (Provision of Medical Benefit)Regulations* 1912, Reg. 49 and *National Insurance Amendment Act Regulations* 1913, Reg. 53.

[158] See chapter 1, p.62..

[159] See for example Peter Collin, Sabine Rudischhauser, and Pascale Gonod (eds), "Autorégulation régulée. Analyses historiques de structures de régulation hybrides = Regulierte Selbstregulierung. Historische Analysen

preserve of the General Medical Council (GMC) which had statutory authority to strike off doctors' names from the medical register. But canvassing patients, the most common cause of friction between GPs, although considered unethical, was seldom deemed serious enough to warrant GMC involvement and became the concern of LMCs and LMPCs.[160] In January 1913 for example, Kent LMC were asked to investigate an allegation that a Dr Morris had registered patients 'touted' for him by a Prudential insurance agent.[161] Comyns Carr et al state that on the subject of malingering and GPs wrongly issuing certificates to gain patients 'it will be to the personal interest of other members of the panel and to the Local Medical Committee to keep a sharp watch on any practitioner who is seen to be attracting an unusual number of patients.'[162] Thus in January 1929 the Lancashire LMPC noted an alleged incident in which, on investigation, 200 patient registrations were found to have been completed the same day, mostly in the same handwriting. Summoned before the LMPC in April 1929, the two accused GPs admitted they had filled in registration forms 'for patients' convenience' seeing that they expected to receive a large number registration requests after being appointed the colliery medical institute doctors. The Committee initially decided to refer the matter to the Medical Services Subcommittee as a 'flagrant breach of insurance practice procedures' but subsequently made do with a letter of admonishment.[163]

In 1921 the London LMPC conducted a lengthy hearing of a case under article 36 of the Medical Benefit regulations in which both parties were legally represented, the committee

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hybrider Regelungsstrukturen", in *Trivium. Revue franco-allemande de sciences humaines et sociales*, (2016), Vol. 21.

[160] Other than where, as in Manchester, there was an established medical ethical committee. See David B. Green, *Working -Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948*. (Aldershot, 1985) p. 132. In October 1928 the Lancashire LMPC referred to it a case of alleged canvassing after the accused doctor could not be found to explain himself. *Lancashire & Cumbria LMCs Archive*, minutes of Lancashire LMPC meeting on 2 October 1928.

[161] *Kent LMC Archive*, minutes of KCMC meeting on 29 January 1913.

[162] A.S. Comyns Carr, W.H. Stuart-Garnett, and J.H. Taylor, *National Insurance* (London,1912) p.71.

[163] *Lancashire & Cumbria LMCs Archive,* minutes of Lancashire LMPC meetings on 3 April and 15 May 1929.

being assisted by its own 'legal assessor' and evidence was taken from seventeen witnesses.[164] There were several problems, however, with this exercise in professional self-government. Firstly, having no funds to draw on, LMCs found it difficult to recoup costs incurred in conducting investigations.[165] Secondly, statutory recognition notwithstanding, LMCs had no legal protection if those they investigated or sanctioned claimed they had been unjustly injured by the Committee's actions. In 1926 the IAC established an 'Emergency subcommittee' to draw up guidance for LMCs and LMPCs on how to avoid accusations of bias. They asserted that 'until tested in court it cannot be assumed that any privilege attaches to any of the proceedings of the LMC or its officers.' They suggested that the LMC could only warn or advise the practitioner found in default, their only real sanction being, in extreme cases, to advise the Minister to remove the defaulting GP from the panel list on the grounds that their continuation would be 'detrimental to the good of the service.'[166] The issue of touting continued to trouble LMPCs. In June 1934 the Manchester LMPC felt it necessary to issue a circular letter to its constituents stating that touting and other 'illegitimate means of acquiring patients' were 'on the increase in Manchester' particularly in some of the new housing estates.' The letter stated that 'several districts are being carefully watched' with a view to obtaining evidence and that 'the committee will not hesitate to take appropriate action.'[167]

What do this, and other interventions described in this chapter, tell us about how LMPCs viewed themselves and their role? Clearly, they believed that admonishment by locally elected peers was an effective check on poor practice or questionable behaviour and that LMPCs were

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[164]*Medical World,* Report of meeting of London Panel Committee, LMC section, 6 January 1922, p.443.
[165] Salford LMPC had requested reimbursement of funds but found that these costs were 'taxed' and they were left with a shortfall. *BMA Archive*, minutes of the IAC meeting on 19 November 1925, Doc 17.
[166] *BMA Archive,* minutes of IAC Emergency Subcommittee on 28 January 1928, Doc.38, 1-4. Eventually amendments were made in 1928 permitting investigations under Regulation 39 by panel committees, in recognition of the LMCs' absence of funds. *BMA Archive,* minutes of IAC meeting of 25 June 1928, Report of LMPCs' Conference, p.6.
[167] *Manchester University Medical Collections*, MMC/11/2/2/14, Letter from Manchester Medical and Panel Committee 26 June 1934.

the most appropriate judges of such matters. Comyns Carr et al appear to have agreed, stating that the LMCs intervention 'may prove to be of the greatest value in what will always be a most difficult and odious business.'[168] LMPCs acknowledged the existence of minimum standards but, fearing lay attempts to enforce them, were as anxious to preserve local discretion over conduct and discipline as they were over determining the extent and quality of treatment offered to patients. Were LMPCs in any other ways proactive in how they led and policed the profession? Critics of panel practice like W.A. Brend lamented the fact that the 'public health' role of insurance practitioners in prevention of ill health, which Addison and others had hoped to see, had not materialised.[169] Hermann Levy noted that 'Doctors have other more pressing duties to perform than to elaborate schemes of health improvement'.[170] In the 1920s and 1930s, however, some LMPCs assisted Insurance Committees' 'Health Propaganda Committees', nominating GPs willing to give public lectures on hygiene and ill-health prevention.[171] Many LMPCs were likewise involved in drawing up local drug formularies, which they had printed and distributed at their own expense.[172] Others took the time to draft useful guidance for their constituents which served to benefit both practitioners and their patients. An example can be found in Manchester where in 1931 the LMPC produced at their own expense a 'Handbook of hospital and general information' listing specialists' locations, clinics and appointment times. In 1933 this was expanded to include contacts for district nursing institutions, ophthalmic practitioners and lists of notifiable diseases, and in 1934 they added details of vaccines, child welfare services and pre-maternity centres.[173] This serves to qualify slightly Levy's statement that the LMPCs 'offered little or no encouragement to the dynamic and progressive

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[168] Comyns Carr et al, *National Insurance*, p.71.
[169] William A. Brend, *Health and the State* (London, 1917) pp.222-223.
[170] Levy, *National Health Insurance,* 271.
[171] *North Staffordshire LMC Archive*, Minutes of LMPC meeting on 17 February 1927.
[172] 'Many Panel Committees have compiled and issued at their own cost local drug formularies for the convenience of the doctors and their patients.' 'Report of Court of Inquiry into GPs' Remuneration', Para 25, *BMJ* 5 January 1924 , Supplement, p.8.
[173] *Manchester University Medical Collections*, MMC/11/2/2 'Practitioner handbooks'.

improvement of the medical services rendered under national health insurance.'[174] That they were also proactive in seeking to address their constituents' personal needs was demonstrated by the West Riding of Yorkshire LMPC which devised a superannuation scheme for practitioners which was adopted as the model for a national scheme endorsed by the Conference of LMPCs in October 1932.[175]

Conclusion

Referring to the LMPCs, the Royal Commission on National Insurance 1926 (majority report) stated that 'to secure the full cooperation of the Medical Profession so necessary to the scheme of medical benefit, the independent position given by the two statutory and purely professional committees was essential.' According to Eder, GPs generally had very little direct contact with Insurance Committees - 'Quarterly checks (sic), occasional information circulars, and the filling up of sickness and prescription forms were usually the only reminders of panel service.'[176] In evidence to the Royal Commission the chairman of the Middlesex Insurance Committee, Sir William Glyn-Jones stated: 'the average practitioner – I say it with great respect…does not worry himself very much about the machinery (of insurance committees) provided the terms and conditions are alright for him personally.'[177] As this chapter has demonstrated, this laissez-faire approach may be explained by the fact that LMPCs were involved in regular communication with the Insurance Committees on GPs' behalf on a wide range of issues and mediated between them on matters requiring a collective response. They were also able to articulate local GPs' concerns and present them when necessary to the Insurance Committees, the NHI Commissioners, the Ministry of Health, and the IAC, and, as

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[174] Levy, *National Health Insurance*, p.271.
[175] *BMA Archive,* minutes of IAC Pensions Subcommittee meeting on 30 November 1932.
[176] Eder, *National Health Insurance and the Medical Profession.* p. 176.
[177] Quoted in Levy, *National Health Insurance* p.271.

we shall see in the next chapter, give vent to concerns at the Annual LMPCs' Conference.

LMPCs were not without their critics. In its weekly journal, *Medical World*, the Panel Medico-Political Union (PMPU) frequently attacked the representative credentials of individual LMPCs in its desire to demonstrate the need for a proper trade union to represent panel practitioners.[178] While stating the LMPCs were a 'useless expense and have not justified their existence' it went on to urge panel doctors to take 'a more lively interest in the personnel of these committees.'[179] However, the Union did, unwittingly, identify the LMPCs' chief virtue, their mediatory role, when its editorial opined that they were 'in an equivocal position', and 'have confused in some measure the position of public and medical representative' conceding that 'the task of an intermediary is never an easy one.'[180] A more sardonic commentary in the same journal in June 1915 describes LMPC members as 'men who are willing to devote their time and money to a thankless task', and comments: 'Should however any financial crisis arise, or should there be any addition to the clerical work, the profession momentarily awakes, curses its representatives on the Panel Committee and goes to sleep again.'[181] By 1926, however, the *Medical World* columnist, 'Hereward', acknowledged that 'the newer Panel Committees represent more and mote the rallying point of the best brains and the most important business in each district.'[182]

Whatever their critics within the profession may have sometimes felt about them, the LMPCs were clearly a functional necessity for NHI, offering the authorities a pool of expertise

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[178] Surprisingly, given that its officers were leading PMPU members, the London Panel Committee was the subject of its fiercest attacks. Alfred Salter opined that 'panel committees, unfortunately, can do comparatively little good for panel doctors but they can do a deal of mischief.' *Medical World,* 'The surcharge problem -who is responsible?' 8 July 1915 p.52

[179] *Medical World*, Editorial, 15 April 1915.

[180] *Ibid* ,'The Panel Committees and their relation to the PMPU' 25 March 1915, p.370.

[181] *Ibid,* 'Apathy - The Curse of the Profession.' 24 June 1915, p.786.

[182] *Ibid,* 'On financing the Panel Profession' (Hereward), 22 October 1926, p.126. A more severe critic of the LMPCs, or at least the London Panel Committee over its failure to weed out incompetent GPs, stated 'Panel Committees have again and again shown themselves to be incompetent' but admitted that, because insurance doctors 'do not exhibit much enthusiasm to serve on panel committees…a certain amount of credit is due to those who undertake to give their time to this work.' 'AGP', *This Panel Business*, pp. 269-270.

and advice, a professional 'temperature gauge' offering early warning of problems, and a means of managing professional discipline more acceptable than the alternative of bureaucratic diktat. In that sense they were effectively part of the state apparatus and essential to the smooth running of NHI. However, it is unlikely that the members of any LMPC would have seen themselves as agents of the state. Despite the criticisms of the PMPU and its successor organisations, many members of LMPCs saw their role as fighting the profession's corner and preserving at all costs their independent contractor status and right to professional self-determination. They were therefore perfectly well prepared, as will be seen in the next chapter, to abandon their partnership with the state when it failed to accommodate their needs or acted against what they saw as their professional interests or the professional social ideal.

Chapter Three

Chapter Four. Panel GPs, the War, and the struggle for representative authority.

The First World War had a profound impact on every area of British society and significantly affected the development of the newly-established National Health Insurance (NHI) scheme and the lives of the GPs working under it. However the advent of war did not curtail the arguments about the panel doctors' pay and service requirements, about who could best represent their interests, or about the future development of NHI and its relationship with other medical services. Indeed the arguments became louder and more acute as the war went on. The GPs sacrificed much during the war years and counted themselves among its victims. However, the British Medical Association (BMA) was an unexpected beneficiary of the conflict. As this chapter will show, the patriotic impetus of the call to arms allowed the BMA to demonstrate the merits of professional self-government, and their willingness to work in partnership with the state was in stark contrast with the self-interested recalcitrance of the profession's trade union lobby. While consolidating its representative credentials, however, the BMA's Insurance Acts Committee (IAC) did not, I argue, find it easy to rid itself of the threat of rival organisations. Contrary to what Norman Eder believes, the IAC's right to represent the panel GPs was subjected to repeated challenges between both during and after the war.[1] But neither were left-leaning elements within the profession quite so influential during this period as is contended by Frank Honigsbaum.[2]

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[1] Referring to the Panel Conference of 1915 he states: 'Never again would its (the BMA's) standing as the political mouthpiece on insurance matters for the whole profession be effectively challenged.' Norman Eder, *National Insurance and the Medical Profession in Great Britain, 1913-1939* (New York, 1982) p.101. But, see below references to the Federation of LMPCs and the Association of Panel Committees among many others.
[2] He claims for instance that the LMPCs Conference won the right to nominate members of the IAC 'largely as a result of pressure exerted by the MPU' Frank Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care , 1911-1968* (London, 1979) p.60. The evidence to support this claim is circumstantial at best.

Chapter Four

   In November 1913 the magazine *Medical World* stated, 'The sorry figure cut by the Association at the end of last year did not tend to increase the respect in which it is held by the profession or the general public…The only way for the panel doctors to secure their interests and rights is to form a new association ad hoc.'[3] In this chapter I consider how the BMA managed to turn this situation around and, during the course of the war years, lay the foundations of bargained corporatism. They did this, I suggest, by means of two parallel developments. Firstly, they established, through a not always obvious or deliberate process of alliance-building, a mutually beneficial relationship with the Conference of Local Medical and Panel Committees (LMPCs). This gave them the necessary mandate with which to negotiate on the panel GPs' behalf. Secondly, they succeeded in establishing a positive working relationship with the officials responsible for NHI which was focussed on improving both patients' and doctors' experience of the scheme. This process was accompanied, however, by continued attempts by rival professional interest groups to challenge the BMA's authority. Thus, while battles raged in Flanders, the annual conferences of LMPCs taking place during this period proved the backdrop for an ideological conflict of a similarly unforgiving kind. Crucial decisions were taken during this period which affected the future character and status of British general practice, its relationship with government, and the nature of its representative structures. These, I suggest, previous historians have either not sufficiently understood or failed to accord appropriate significance.[4]

   For the majority of panel GPs during the early years of NHI, the benefits and the deficiencies of the scheme became self-evident. The concentration of national resources and infrastructure under government control during the war years persuaded many of them that

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[3] *Medical World* , 'The Future of the Panel Doctor' 27 November 1913. p 663.
[4] As stated in chapter 3 the only historian to have appreciated the significance of the LMPCs and their conference is Norman Eder, following John Marks, but his assessment of the BMA's relationship with government is perhaps overly positive, as will be demonstrated in this and the subsequent chapter,.

extending NHI to include specialist and ancillary healthcare services was achievable and desirable. Thus, while many GPs remained suspicious of politicians and fearful of increasing state control, most were, by the end of the war, strongly in favour of bringing the diversity of existing medical services together within the unified management of a Ministry of Health. Nevertheless, demographic, economic and social changes brought by the war left the panel GPs with a list of grievances and demands which were not easily satisfied and soon put the BMA's new-found accord with government under strain.

Before the war: negotiating machinery and the mandate of the Conference of LMPCs

In 1913 the BMA found itself being pulled in opposite directions. Pragmatists within its ranks recognised the need to accept that NHI was a reality and to make it work for the public and the insurance doctors. However, the 'diehards' were not completely vanquished and, recognising that a still significant minority of GPs remained unreconciled to the Act, encouraged the Association to establish a 'non-panel doctors committee' to represent their interests.[5] The position of the extremists at opposite ends of the debate over NHI had begun to harden. On the left, an organisation calling itself the State Medical Services Association (SMSA) was already talking of NHI as the first step towards a more comprehensive state medical service centred on salaried doctors.[6] At the other extreme, the National Medical Union (NMU) had confirmed its implacable opposition to any state-sponsored scheme and in December 1913 committed itself to becoming an association of non-panel doctors.[7] Between these positions there were many insurance doctors who, though weary of the conflict which had blighted their reputation with

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[5] *BMJ* Supplement 6 December 1913, p 513. Its first meeting took place on 19 November 1913. *BMA Archive,* minutes of the Non Panel Doctors Committee 1913-14.

[6] The constitution and membership of the SMSA are described in *Medical World* 21 August 1913, p.118. It numbered among its executive notable figures such as Addison, the Fabians Sidney Webb and George Bernard Shaw, and Labour activists like Dr Alfred Salter and Ramsay MacDonald.

[7] *Medical World* 4 December 1913 p.693.

government and the public, wanted stronger representation than the BMA appeared to give them. The BMA's defeat reignited the arguments put forward at the Manchester Guild conference in 1900. It helped resurrect the idea that the interests of GPs would be best served by an organisation representing their interests alone and an increasing number of GPs believed that to be effective such an organisation had to be a registered trade union. A Public Medical Service (PMS) had been established in Leicester in December 1912 when the local doctors had seized the opportunity to take over the local provident dispensary. The organisation set up to run it called itself the Union of Medical Practitioners and was duly registered under the Trade Union Act. When writing to the *British Medical Journal (BMJ)* about this initiative in January 1913 its chairman, R. Wallace Henry, clearly hoped that it might serve as the basis of a national organisation.[8] His announcement elicited little enthusiasm but proved the catalyst for a long running debate in the letter pages of the *BMJ* over the summer of 1913 about the merits of a medical trade union and a new organisation to champion the interests of insurance doctors. In March 1913 under the heading 'Trade unionism and medicine', Dr A. George Bateman, the Secretary of the Medical Defence Union, reiterated the familiar argument that trade unionism was incompatible with medicine.[9] His comments were dismissed by Dr Henry Cardale, future chairman of the London Panel Committee, who contended that it was perfectly possible to establish a medical trade union that acted ethically and in a manner consistent with the honour and interests of the profession.[10] In April 1913 Dr Gordon Ward, a member of the Kent County Medical Committee set out the case for a trade union to work alongside the BMA but in a further letter to the *BMJ* in April he described himself as 'an enthusiastic advocate of the National Medical Guild'.[11] The Guild was established as a trade union sometime in early 1913.

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[8] *BMJ* 25 January 1913 Letter from Dr R. Wallace Henry, 'Union of Medical Practitioners', p 194.

[9] *Ibid,* 15 March 1913 Letter from Dr A. George Bateman, 'Trades Unionism and Medicine', p.581.

[10] *Ibid,* 29 March 1913 Letter from Dr Henry J. Cardale, p.687.

[11] *Ibid* ,19 April 1913 Letter from Dr Gordon Ward, p.852. For more on the subject of doctors as MPs see Roger Cooter, 'The Rise and Decline of the Medical Member: Doctors and Parliament in Interwar Britain', *Bulletin of the Society for the Social History of Medicine* (2004) 78. (1) pp. 59-107.

Writing to the *BMJ* in May 1913 Dr E.H. Worth explained that the Guild 'was really the old London Medical Committee which…helped the London men stick to their pledge.'[12] Acknowledging the distaste which many in the profession had for trade unions, he added 'I freely grant that the name of trade unionism is an unpleasant one but when we have to deal with men like Mr. Lloyd George…a trade union is about the only society that can hold its own.' Though praised by prominent non-panel GPs like Dr Charles Buttar, the Guild was explicitly supportive of panel doctors and was buoyed by the views of GPs like Dr R.W. Innes Smith who informed *Medical World* in January 1914 that a postal vote of practitioners in Sheffield showed them to be 20-1 in favour of a trade union.[13]

In the *BMJ* in December 1913 Dr Russell Combe proposed that a new defence fund be set up and registered under the trade union act.[14] The idea seems to have taken root as a report on it was included in the annual report of BMA Council in May 1914.[15] The report proposed that the fund be established as a trust rather than a trade union, citing once again the example of the National Union of Teachers which, it pointed out, was an unincorporated body which had deliberately refrained from seeking legal incorporation either as a company or a trade union. In the ensuing debate in the *BMJ* under the heading 'The Special Fund: Trade Union or trust? R. Wallace Henry argued strongly in favour of a trade union.[16] He found himself subject to a withering rebuke by fellow BMA Council member E. Rowland Fothergill and tit for tat responses rumbled on over the summer of 1914 concluding with Wallace Henry decrying

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[12] *BMJ* 3 May 1913 Letter from Dr E.H. Worth, p.406.
[13] *Medical World* 15 January 1914, Letter from Dr R.W. Innes Smith, p.18. Buttar congratulated the Guild for its efforts in mounting a legal challenge to the NHI commissioners' ruling that non-panel doctors' certificates could not be recognised for insurance benefit purposes. See his letter to *Medical World* of 10 May 1913 p.1030.
[14] *BMJ* 27 December 1913 Letter from Dr Russell Combe, p.1644. He suggested that this be independent of the BMA but managed by trustees appointed by the Association and organised by officers of BMA divisions.
[15] *BMJ* 2 May 1914, Annual Report of BMA Council, Supplement, Appendix X, p. 319.
[16] *BMJ* 9 May 1914 Letter from Dr R. Wallace Henry, 'The Special Fund: Trade Union or Trust?' p.1045. He informed *BMJ* readers that his Union of Medical Practitioners now comprised 98% of practitioners in Leicester, Leicestershire and Rutland.

Fothergill's imagined 'nightmare of medical syndicalism'.[17] The correspondence was punctuated by a contribution from London GP Dr Percy Raiment, the General Secretary of the National Medical Guild, who pointed out the legal jeopardy faced by an organisation not registered as a trade union, particularly if subjected to a charge of malice, a judgment which, as will be seen, was to prove remarkably prescient as far as the BMA was concerned.[18]

In his memoirs, the BMA Secretary Alfred Cox recorded that 'If the controllers of the National Health Insurance Commission had been small minded people they would have treated the Association as a defeated and discredited body and would have encouraged attempts…to side-track it in dealing with insurance affairs.'[19] The GPs were fortunate, however, that the civil servant Lloyd George had entrusted to implement the scheme, the highly capable Sir Robert Morant, was broadly pro-doctor and keen to enlist the BMA's support in making NHI a success both for the insured and the panel GPs.[20] He was supported by the commission's deputy chairman James Smith Whitaker who, despite the rancour shown towards him by many of his erstwhile colleagues in the profession, was anxious to foster harmony between the commissioners and the Association. The new leadership of the BMA was equally keen to establish a constructive working relationship.[21] When in April 1913 the government announced its intention of introducing clarifying amendments to the Act, the BMA's State Sickness Insurance Committee set to work compiling a list of what they considered sensible and reasonable amendments. Almost all of these were overlooked in the amending Act published in July 1913 apart from the reaffirmation of the £160 income limit for non-manual workers.

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[17] *Ibid,* 27 June 1914 p.1451.

[18] *Ibid* , 23 May 1914 Letter from Dr Percy C. Raiment, pp.1155-1156.

[19] Alfred Cox, *Among the Doctors* (London, c. 1949) p. 101.

[20] Eder, *National Health Insurance and the Medical Profession*, p.118.

[21] In May 1914 the annual report of the BMA's Council noted that 'It is obvious that with the large numbers of practitioners who are now giving service under the Insurance Act…it is to the interest of the profession that the Association acting on behalf of the profession generally, should be on good terms with the commissioners.'
BMJ 2 May 1914 Supplement, p.285, para 125. Norman Eder states 'Exhausted by its three year adversary relationship with the government, the BMA quickly tried to move to a new position of partnership with the Health Insurance administration.' Eder, *National Health Insurance and the Medical Profession,* p.67-68.

However, the Act made provision for regulations to be drawn up by the Joint Insurance Commission which quickly found itself in the position of having to adjudicate on competing suggestions from the profession and from representatives of the approved societies, who still harboured a desire to exercise greater control over the scheme.[22]

At the BMA's annual meeting in Brighton in July 1913 the representative body reflected on the Association's recent failings. A proposal that the Association become a trade union was heavily defeated but the meeting approved the recommendation from its Council which stated that 'no system of reorganisation of the Association can be effective which does not take into consideration the position of Local Medical Committees and devise some means of coordinating their work with that of the Association.'[23] This message set the tone for discussions which took place immediately after the annual meeting at a conference of Local Medical Committees (LMCs) instigated not by the BMA Council, which had declined, on grounds of cost, a request to host the conference, but by the local BMA division and its secretary, E. Rowland Fothergill. [24] The conference was a modest affair attended by less than a full complement of LMC representatives. It was most notable for the fact that a motion calling for 'fusion' between the BMA and the LMCs was rejected but a resolution was passed that 'as far as possible there should be cooperation between the LMCs and the BMA'.[25] The BMA's representative meeting had decided to replace the State Sickness Insurance Committee with a new Insurance Acts Committee (IAC) as a standing committee of the Association. The IAC's remit was 'to deal with all matters arising under the National Insurance Act that are dealt with

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[22] *Ibid,* p.63. The approved societies' efforts were spearheaded in parliament by the MP Godfrey Locker-Lampson.

[23] *BMJ* 26 July 1913 Report of the Annual Representative Meeting on 18 July 1913, Supplement p.124.

[24] *Ibid,* 5 July 1913 , Supplementary Report of Council, Supplement, p.9 para 232. Fothergill was to play a major part in relations between the BMA, LMPCs and other bodies, although he frequently exasperated BMA colleagues and their opponents. Cox describes him as a 'pronounced individualist' and 'devoted worker for cooperation amongst doctors' who unfortunately made a 'hobby' out of points of order. Cox, *Among the Doctors*, p. 100.

[25] *BMJ* 2 August 1913, Supplement p.168

by the National Insurance commissioners, insurance committees and local medical committees.'[26] Members were to be elected by council and the representative body on a territorial basis, with reserved seats for representatives of women doctors, public health doctors, and Poor Law Medical Officers. All were required to be BMA members, though at least one fifth were to be panel doctors.[27] An amendment requiring that four seats on the committee be reserved for LMC officers was rejected.[28] The chairman, appointed at its first meeting later that month, was the respected chairman of the BMA council, J.A. Macdonald. Much of its first meeting was taken up with a discussion about the need to establish a special defence fund for the organisation of the profession, but at its second meeting in September 1913 the committee appointed a LMC subcommittee comprising the chairman and four members of the committee and five others 'co-opted to represent other interested parties'. It thereby allowed for input into the committee's business from doctors involved in LMCs (and subsequently, Panel Committees).[29]

The National Insurance Amendment Act 1913 included the provision to establish separate Panel Committees.[30] The IAC therefore began discussions with the commissioners about the model scheme for LMCs and Panel Committees mentioned in chapter three and persuaded the BMA to convene, in March the following year, a conference in London of 'Local Medical *and* Panel Committees.' By then the benefits and the deficiencies of the NHI scheme from the doctors' viewpoint had become obvious and the steps which the BMA had taken to raise concerns with the NHI commissioners were the subject of agitated debate and argument. While

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[26] *Ibid,* 26 July 1913, Report of the Annual representative Meeting on 18 July 1913, Supplement p.127.
[27] The surgeon Mabel Ramsay was appointed to the IAC 'in her own right' but was duly appointed the Medical Women's Federation representative when it came into being in 1917. Joyce Cockram, 'The Federation and the British Medical Association' *Journal of the Medical Women's Federation*, vol. 49 (1967) p.76. She remained their IAC representative until the late 1930s.
[28] *BMA Archive* 26 July 1913, Report of the Annual Representative Meeting on 18 July 1913, Supplement p.127.
[29] *BMJ* 30 September 1913, report of meeting of IAC on 11 September 1913, Supplement p.250.
[30] *National Insurance (Amendment) Act 1913*, (enacted 15 August 1913) Section 32.

most of the representatives present recognized the need for good working relationships with government there were many who felt the Association's response was too conciliatory and believed an entirely new organisation would be more effective. The Conference therefore debated a proposal to establish an Association of LMPCs. This was opposed by those who felt it would prove a rival to the BMA.[31] Some among the trade union lobby wanted to remain separate from the BMA but others supported a proposal from the Isle of Wight Panel Committee that the Conference and the BMA be associated with the National Medical Guild 'since it was a trade union'.[32] The Conference ultimately resolved to establish a *Federation* of LMPCs which would be associated with the BMA and to establish a voluntary levy of panel practitioners' remuneration to support its operation. A provisional committee was appointed to devise an appropriate constitution for this new body which was also instructed to consider its potential relationship with the National Medical Guild.[33] The provisional committee wrote to all LMPCs about the Federation and found the majority to be in favour of its proposed links with the BMA.[34] In May 1914 the IAC met with the provisional committee and proposed to the BMA Council that the Federation be able to appoint seven additional members of the IAC, and that accommodation, facilities and staff be provided for it at the BMA's headquarters and space given in the *BMJ* Supplement to report on its activities.[35]

The advocates of trade unionism in the medical profession were largely but not exclusively supporters of independent contractor status. Most GPs at this time believed that salaried service was antithetic to their desire for autonomy, and many still feared that NHI would prove the first step towards the development of a state medical service in which doctors would become government employees. In a lecture in early 1914, one of the leading lights of the SMSA, Sir

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[31] *BMJ* 21 March 1914, 'Conference of Local Medical and Panel Committees on 13 March 1914', Supplement p.163.
[32] *Ibid*, p.164.
[33] *Ibid*, p.165-166.
[34] *BMJ* 23 May 1914 Supplement p.383.
[35] *Ibid*, 27 June 1914, Supplementary Report of Council, Supplement p.478, recommendation J.

John Collie, set out their case for a full-time salaried service as the logical extension of the panel scheme.[36] At the same time a similar proposal was advocated in the *BMJ* by Dr R. Milson Rhodes.[37] His comments aroused an impassioned response from defenders of independent contractor status and free choice of doctor. One commentator, Dr J. Charles, stated that such proposals would 'break with a system of practice which has long and adequately served its purpose' and, as an illustration of the extent to which both the insurance doctors and their patients had become acclimatised to the new system, he added 'and departs from a system which had already found widespread favour with the public and general acceptance by the medical profession.'[38] Even some left-leaning doctors wanting a more comprehensive service for the population balked at the idea of doctors becoming civil servants, or worse, subordinates of Local Authority Medical Officers. Writing to *Medical World*, Lauriston Shaw urged his colleagues to allow the existing panel service to develop and evolve rather than initiate radical changes to which doctors would be even more vehemently opposed. This was to be preferred, he said, as 'the British way of doing things.'[39] The maverick East-end GP Harry Roberts echoed Shaw's comments, suggesting that the panel system was working well and that all it needed to offer a complete service to patients was access to specialist treatment.[40]

A number of doctors involved in setting up of the London Panel Committee, including its Chairman, Henry Cardale, and Secretary, Alfred Welply, were enthusiastic supporters of the panel system and questioned the BMA's right, based on its record, to champion the interests of

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[36] *Medical World* 'The Medical Man and National Health Insurance' Lecture by Sir John Collie, and 'Defects in the Act and their Remedy' 15 January 1914 pp. 94-99.

[37] *BMJ* 24 January 1914. Other SMSA stalwarts supportive of the salaried service idea, Professor Benjamin Moore and Dr Charles Parker, set out their views in the *Lancet*. See Bernard Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales 1800-1945* (Basingstoke, 2004) p.225.

[38] *BMJ* Supplement 14 February 1914, p.82.

[39] *Medical World* 25 December 1913 p.821.Shaw was a Liberal but clearly favoured the Fabian approach to social reform which rejected Marx's contention that class war was a necessary precondition for the emergence of socialism, a philosophy which put them at odds with the British Social Democratic Federation and the majority of European socialist movements which were syndicalist in nature.

[40] *Ibid,* 1 January 1914 p.18.

the panel GPs. Unimpressed by other medical organisations, they decided to establish their own trade union to represent panel doctors. The inaugural meeting in July 1914 of what they named the Panel Medico Political Union (PMPU) was chaired by Christopher Addison and founding members included a number of socialist doctors such as Alfred Salter.[41] Henry Brackenbury, the chairman of the Middlesex LMPC was among a minority of doctors attending the meeting who opposed the establishment of a new representative body.[42] The IAC was clearly fearful of the influence of the anti-BMA lobby and when surveying LMPCs in November 1914 about their constitution, membership and funding, asked each committee if they were in favour of 'entering into a close and steady relationship' with the BMA.[43] It was not until March 1915 when, in a letter to all insurance practitioners headed 'What the Association has done for panel practitioners' Alfred Cox reported that the response from LMPCs to this question was 'very favourable', citing 162 out of 192 supporting the close relationship described.[44] By this time the PMPU had openly condemned the Federation of LMPCs, which the London Panel Committee pointedly refused to join when denied what it regarded as a proportionate number of seats on its executive.[45] The extent to which opinion was divided on this matter is illustrated by the debate reported in *Medical World* in December 1914 in which London Panel Committee member H.G Cowie commented sarcastically that 'the close and steady relationship' between the BMA and LMPCs implied that 429 Strand (the BMA's headquarters) 'should be recognised as the Mecca for all panel pilgrims and especially for secretaries of panel committees.'[46] His Panel Committee colleague Dr Angus further objected to 'the temerity of the BMA in claiming

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[41] *Medical World* 16 July 1914, pp. 88-95.

[42] *Ibid,* p.91. His suggestion that it was unnecessary to establish a new organisation as the BMA was now pro-panel was met with derisive cries of 'Oh!' and 'Bosh!'

[43] *BMA Archive*, Minutes of the Insurance Acts Committee 12 November 1914, Doc M2.

[44] *Ibid,* Minutes of the Insurance Acts Committee's LMPCs subcommittee 6 May 1915.

[45] *Medical World* 29 October 1914 'The Panel Doctor and his interests' pp. 511-513.

[46] *Ibid,* 17 December 1914, Report on London Panel Committee p.688.

representative authority when not one of 8,000 GPs who were not BMA members were eligible to serve on the IAC.'[47]

In July 1915 *Medical World* became the official organ of the PMPU and from then on its editorials and commissioned articles became increasingly strident in their criticism of the BMA which it felt was not up to the task of defending the panel GPs against existential threats. In an article in February 1915 these were summarised as being : 'disease and injury, the menace of the approved societies wishing to hold us as 'bondslaves', and politicians, commissioners and civil servants wanting to reduce the GP's pay.'[48] By then, however, the profession, like the rest of the British public, was preoccupied with matters of a less parochial nature.

The profession and the war: self-government, self-sacrifice, and a system under strain

On the eve of the BMA's annual representative meeting in Aberdeen in July 1914, Dr Mark Taylor of the National Medical Guild wrote to the *BMJ* arguing that the BMA be affiliated to the Guild, which, with the Association's support and sponsorship, could, he said, take on the task of defending medical interests. Referring to the recently reported success of the *Leipziger Verband* in its battle with the German insurance funds, he said that for evidence to support the virtues of medical trade unionism one need only look to Germany.[49] At the close of the representative meeting all eyes were indeed fixed on Germany, but for entirely different reasons. Alfred Cox noted that during the meeting 'we noticed that the national and territorial medical officers silently disappeared' and on the Monday following the BMA officials' return to London their suspicions were realized when war was officially declared with Germany and

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[47] *Ibid,* p. 689.
[48] *Ibid,* 11 February 1915. 'What we have to fight'. p.298-304
[49] *BMJ* 4 July 1914 Letter from Dr Mark Taylor, pp 44-45 . See also the editorial 'The organization of the profession in Germany' *BMJ* 28 March 1914 p.726 which offers an accurate account of the status and activity of the *Verband.*

its allies.[50] Due to the popular belief that it would be over by Christmas there was no immediate concern about the impact of the war on civilian medical services even though within the first few months some 10% of the country's medical practitioners had either volunteered or been called up as reservists.[51]

The patriotic response of the medical profession reflected that of the professional and managerial classes generally, which showed a far greater willingness to serve than the general population.[52] An article in August 1914 in *Medical World* noted the recent decision by the London Panel Committee to treat gratuitously families of enlisted men who had volunteered for service in the forces. This, it said 'exemplifies the self-sacrificing tradition of the medical profession and will doubtless be followed by other medical committees.'[53] LMPCs were equally concerned, however, to protect the interests of the GPs who had volunteered to serve their country. Thus, Lancashire LMPC's Honorary Secretary wrote to its constituents in September 1914 urging them to 'loyally safeguard the interests of those of their colleagues who are called to leave their practices in the service of their country and to undertake any medical duties entailed for the sole benefit of the absentees.' He reported that they had requested the local insurance committee to rule that no transfer take place of the patients of any doctor absent on military service for the duration of the war.[54] It quickly became apparent, however, that unless recruitment from the ranks of the medical profession was organised in some way large and potentially destabilising gaps could appear within the fabric of civilian medical services.

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[50] Cox, *Among the Doctors*, p.109.
[51] Jay Winter, *The Great War and the British People* (2nd edn, Basingstoke, 2003) p.155-159.
[52] The percentage of the 'the professions' volunteering during 1914-1916 (41.7%) was the joint highest of occupational groups. Winter, *The Great War,* p.34 Table 2.3.
[53] *Medical World*, 13 August 1914 'The Medical Profession and the War' p.259
[54] *Lancashire and Cumbria LMCs archive*, Letter from Dr Thomas Campbell, Hon. Sec of Lancashire LMPC, 10 September 1914.

The BMA had already resolved to support the war effort by 'placing the whole resources and machinery of the Association at the disposal of the government.'[55] In the month following the outbreak of war the BMA's Scottish Committee had voted at a meeting in Edinburgh to establish a Scottish Medical Service Emergency Committee which quickly set about organizing a network of local medical war committees, linked to BMA divisions, to supervise substitution arrangements for doctors who had enlisted and arrange provision of free medical attendance for soldiers' families.[56] This offered a model for the rest of the country to follow and in January 1915 the Association set up a Central Medical War Committee (CMWC) which the Annual Representative Meeting endorsed in July.[57] The establishment of the CMWC was broadly welcomed by the government and seen as 'part of the general tendency towards planning for a protracted war.'[58] Sir Alfred Keogh, director general of the army medical service subsequently agreed to devolve to the CMWC the whole responsibility for recruiting doctors. He did this, according to Cox, 'because he believed it was the only way to avoid the risk of depleting the profession in those areas in which essential munitions work was being done.'[59] Though the doctors were unaware of it, the government's reliance on the BMA and its CMWC was consistent with the way in which it harnessed the expertise of industrialists and trade unionists in the service of the war effort and was a form of corporatism which government officials proved only too willing to embrace.[60] Cox was the central figure behind the CMWC's work.[61] He benefited from a constructive relationship with Morant.[62] One the committee's first tasks was to establish an accurate register of where practitioners were based. A survey showed

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[55] Cox, *Among the Doctors*, p.110.
[56] *Ibid.* Winter, *The Great War*, p.156. See also J.R. Currie, *The Mustering of Medical Service in Scotland 1914-1919*, (Edinburgh,1922) pp. 5-6.
[57] *Ibid*
[58] Winter, *The Great War,* p.157.
[59] Cox, *Among the Doctors*, p.112.
[60] James E. Cronin, *The Politics of State Expansion: War, State and Society in Twentieth-Century Britain* (London, 1991) p.67.
[61] Winter, *The Great War*, p.157.
[62] Cox, *Among the Doctors*, p 111. Morant lent them a number of civil servants to supplement the large staff ('mainly girls') supporting the work of the committee.

that by July 1915, 25 % of the profession had joined up and it was apparent that 'certain areas are already depleted and cannot spare more men.' [63] The committee's main task, therefore, was 'to find the men who could be spared and make it easier for them and others who might wish to join by arranging for voluntary substitution by older men.'[64] Divisional secretaries were instructed to help set up local medical war committees to supply information about the local medical workforce and in consultation with the LMPCs provide early warning of any problems with civilian services.

The CMWC recognised that unrestricted recruitment would compound pre-existing problems caused by the maldistribution of panel GPs. An editorial in *Medical World* at the start of the war stated: 'The profession at the moment is seriously undermanned' adding 'We require at least 8,000 more doctors to cope with the normal amount of sickness and ill health that may be expected each year.'[65] In fact, as the CMWC were to find out, some areas were actually comparatively over-provided with doctors whereas others had barely enough to service the insured population. Ensuring that there were a sufficient number of doctors to serve the needs of the Army and the civilian population was made more difficult by the fact that the pattern of civilian need in wartime was different to that preceding the war due to the concentration of large parts of the economy on war work. This saw a huge expansion of industries related to munitions concentrated in certain areas, and the replacement of much of the existing industrial workforce by women and boys.[66] At the start of the war it was expected that the shortage of

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[63] *BMA Archive*, minutes of Central Medical War Committee meeting 30 July 1915.

[64] Winter, *The Great War*, p.157. Women were denied opportunities to serve at the front though many undertook supplementary roles as civilian medical practitioners and eventually as members of the Women's Army Auxiliary Corps , the Women's Royal Naval Service and Women's Royal Air Force. Letitia Fairfield, 'Women Doctors in the British Forces 1914-1918', *Journal of the Medical Women's Federation* (MWF*)*, vol. 20 (1967) pp.99-100. The suggestion that vacant positions in Local Authority medical services could be met by women made by Jane Walker, President of the MWF, was ignored but eventually the demand for women as GP locums exceeded supply. Winter, *The Great War*, p.171. Racial prejudice meant that suggestions that better use could be made of non-white doctors, failed to be acted upon until late in the war. See *BMJ*, letters from C. Muthu 21 August 1915 p.312 and Dr H. Khoras 28 August 1915 p.348. By 1918 Indian, Chinese, Portuguese and Egyptian doctors were performing locums in various British cities. Winter, *The Great War*, p.170.

[65] *Medical World* , 'The Medical Profession and the War' 13 August 1914, p.259.

[66] Winter, *The Great War*, p.159.

medical manpower within the civilian population would be offset by the demands of the armed forces for new recruits. Indeed, the insured population initially fell by 12.5% but this was counterbalanced by the entry into insured employment of hundreds of thousands of mainly female munitions workers.[67] In addition to catering for their needs, the panel GPs were expected to provide the often extensive medical care needed by discharged soldiers previously eligible for NHI who had been invalided out of the forces as casualties of war. Thus, the proportion of persons who were considered 'poor insurance risks' within the insured population rose and with it the workload of the panel doctors, who felt constrained by their patriotic duty and recognition of the ultimate sacrifice made by others from complaining too loudly about their situation.[68] By the end of 1915 over 70 doctors per week were being recruited into the Royal Army Medical Corps (RAMC).[69] The continued demand for doctors by the war office meant that cuts in the civilian medical workforce were beginning to bite. The Secretary of the Leicester medical war committee reported that 'local men are working to their utmost capacity, as 68 out of 247 in practice in 1914 have joined up' and 'There was now a serious risk of men breaking down under the strain if more work is put on them.'[70] The attitude among those left to cover their colleagues began to change the longer the strain of substitution arrangements continued. In August 1915 in an article in *Medical World* a Dr W.F. Copley-Woodhead wrote that 'There are certain medical men in Blackpool with large panels eligible to join his majesty's forces. Why should I, with a small panel, attend their panel patients for nothing?'[71]

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[67] Eder, *National Health Insurance and the Medical Profession*, p. 91. By October 1916 1.2 million men, 200,000 boys and 400,000 women were engaged in munitions work. Winter, *The Great War*, p.207.

[68] The existence of previously undiagnosed and untreated illness among insured women may explain the disproportionately high use made by female patients of the panel doctors' services acknowledged by the commissioners. Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939* (London, 1980) pp. 44-47.; Helen Jones, *Health and Society in Twentieth Century Britain* (London, 1994) pp.62-63. See, however ,letter from 'Anxious' in *BMJ* 9 December 1916 as an example of complaints of malingering by 'munitions girls'.

[69] Winter, *The Great War*, p.158.

[70] *Ibid,* p.160.

[71] *Medical World*,19 August 1915 p. 249.

In November 1915 Morant circulated a memorandum to the war cabinet in which he declared that the point of dangerous depletion of medical manpower may already have been reached in certain areas.[72] At a joint CMWC/NHI Commission meeting later that month the CMWC accepted his proposal that exemption from recruitment of medical personnel be accorded to those in rural areas where the population to GP ratio was over 1,500:1, in 'semi-rural' areas 3,000:1, and in urban areas 5,000:1.[73] At the same meeting the CMWC submitted proposals for the order in which different categories of doctors should be called up, taking account in particular of their marital status. At the head of the list of those liable to be called up were 'all newly qualified men without practices', followed in descending order by 'junior medical men employed by local authorities, hospital registrars and assistants, and partners in general practice'. At the bottom, single-handed GPs in private practice were considered more worthy of exemption that single-handed GPs in panel practices.[74] An indignant Morant objected that this ranking proved that the committee had been thinking entirely about medical interests and not those of the public.[75] The CMWC was forced to give ground and thereafter effectively had to negotiate with the commissioners over every panel doctor considered for enlistment.[76] The GPs' absence caused escalating problems. In Salisbury the local war committee reported that 'it was absolutely impossible to lose another doctor.'[77] Many working-class areas of London were also struggling and the impact on remaining doctors was considerable. In parts of Scotland GPs were working 15-16 hours a day.[78] A correspondent to the *BMJ* complained that GPs

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[72] Winter, *The Great War,* p.160.

[73] *BMA Archive*, minutes of CMWC meeting on 19 November 1915.

[74] *Ibid*

[75] *Ibid,* 6 December 1915.

[76] One example brought to the attention of CMWC was the town of Connor's Quay in Flintshire which had a population of 5,000 served by 2 GPs. When one GP offered to enlist the insurance committee, using Morant's criteria, objected and his call up was rescinded *BMA Archive*, minutes of CMWC 23 December 1915.

[77] *Ibid*, 31 December 1915.

[78] Currie, *The Mustering of Medical Service in Scotland,* p. 23.

across the country were overworked and 'threatened with physical breakdown'.[79] 'The strain on older doctors was terrific' Cox noted, 'and some of them died under it.'[80]

Up until this point the authority of the CMWC and its Scottish equivalent was unchallenged. They had somehow managed to deliver all the doctors the war office demanded. The government was therefore happy to recognise them as statutory professional organisations with powers to act as appeal tribunals for doctors claiming exemption.[81] However, some within the profession were not happy with the way these powers were wielded. They objected to the fact that the age limits for medical service were higher than that of the civilian population. Under the Military Conscription Act they were set at 45 for overseas duty and 55 for home duty.[82] In January 1916 the CMWC instituted an enrolment scheme whereby GPs willing to serve in the RAMC allowed their names to be entered on to a list of those eligible to be called up when required.[83] The same month *Medical World* quoted 'a recent article in *The Times*' which referred to 'mutterings…against the authority of the central war committee' which it considered to be 'the outcome of the bitterness…experienced during the passage of the National Insurance Act.' [84] In February 1916 an unattributed article in *Medical World* entitled 'More work and less pay for panel doctors' complained that 'The panel doctor, unlike some businessmen, has not gained but lost by the war. He has had to face the increased cost of living and receives no war bonuses and has done a vast amount of gratuitous work for the dependants of those fighting for the empire.' [85] In a rather unsentimental commentary on the actuarial basis of the panel system it continues 'It has taken from us the healthy lives who gave us no trouble and left us with the unhealthy ones.' This view was echoed in the minutes of the London Panel

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[79] *BMJ* 30 September 1916 Letter from J. Cuthbertson-Walker, pp 476-477. See also *BMJ* 17 February 1917, letter from 'Scarified' p.245.
[80] Cox, Among the Doctors, p 112.
[81] Winter, *The Great War*, p.165.
[82] *Ibid*
[83] Currie, *The Mustering of Medical Service in Scotland*, p.52.
[84] *Medical World* 7 January 1916' Doctors on war service' p.20.
[85] *Ibid,* 4 February 1916 p.149.

Committee which in September 1916 noted that the work performed by panel doctors now exceeded that of before the war and 'The men who have been removed from the panel lists were among the best lives (sic) and were unlikely to be any serious charge on the services of practitioners for many years' and that 'many of these men are now returning permanently damaged in health.'[86]

Civilian GPs' contribution to the war effort were not confined to tending the sick. The military relied on them rather than RAMC officers to medically examine the thousands of volunteers and conscripts for the forces but their recommendations were often ignored or overridden.[87] Contemporary comments suggest that the exercise was often perfunctory. 'Another examiner of recruits' complained in the *BMJ* he was obliged to examine up to 120 recruits an hour.[88] By the end of the war, the author of *The Old Doctor* notes, 'the examination of recruits was increasingly left to local doctors who performed the work practically every day of the week when not attending to their patients.'[89] As further testament to the inequity of the recruitment process, GPs were outraged to discover that they were only paid in respect of recruits they passed as fit for service and received no payment for those they rejected.[90] The additional responsibilities heaped on civilian GPs did not end there. Frank M. Smith states in his memoirs that 'civilian doctors had their work cut out in writing, or refusing to write, bad medical histories for men called up against their will.' There were 'troublesome interviews' he says, 'with men who had some abnormality of possible exemption value such as round shoulders, bowlegs or a bunion.'[91] Soldiers on leave posed problems of another kind. The

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[86] *BMA Archive*, minutes of the London Panel Committee, 28 September 1916, min 6.
[87] 'A civilian examiner of recruits' complained that the RAMC had discharged a man with a mild case of flat feet…even though he was a professional footballer! *BMJ* 1 January 1916 p. 33.
[88] *BMJ* 28 April 1917 p. 565.
[89] Frank G. Layton, *The Old Doctor*, (Birmingham, 1923) p. 158.
[90] *Medical World,* 'Medical Examinations of recruits' 21 January 1916 , p. 81.
[91] Frank M. Smith, *A G.P.'s Progress to the Black Country* (Hythe, 1984) p. 91.

Figure 9. *The medical profession and the war*: doctors examining recruits, 1916. Photograph *Daily Telegraph* archive.

nearest he ever came to being assaulted, he said, was when he refused to certify that a soldier's mother was so ill that he should be excused from re-joining his unit at the appointed time.[92]

In August 1916 in order to reach the latest recruitment quota, the CMWC felt obliged to alter the exemption limit, increasing the ratio of patients to doctor in rural areas to 3,000 and in semi-urban to 4,000.[93] However, doctors were now more reluctant to come forward, recognising that RAMC officers' skills were not being utilised efficiently and were left with little to do in between offensives except administrative duties.[94] The CMWC was well aware

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[92] *Ibid*

[93] Winter, *The Great War,* p.165.

[94] In *Dr Bradley Remembers*, the elderly John Bradley is left with one other colleague to manage all the patients of panel colleagues who have been called up and notes begrudgingly that while he was working all hours 'they led the only intermittently strenuous life of medical officers in military hospitals far removed from danger,

of this situation and felt obliged to complain about it to the military. [95] However, Keogh adamantly refused to respond to the CMWC's complaints which he seemed to regard as a personal insult.[96] By 1917 mounting casualties increased the military need for doctors but the Germans' decision to torpedo hospital ships meant that more had to be treated in field hospitals in France. The government therefore decided to include the medical profession within the General Mobilisation order and on 21 April 1917 enlistment notices were sent to every civilian medical practitioner in the country.[97] Morant had warned the war office that mass conscription of doctors would endanger civilian health if there were no means to compel redistribution of medical manpower. The CMWC concurred with Morant and his officials that the 'tipping point' had now been reached and threatened to take no further part in medical recruitment. The message struck home and the mobilisation order was rescinded a few days later.[98] Despairing of how to solve the problem, Keogh escalated the problem to Sir Auckland Geddes, the minister of National Service. Although a doctor himself, Geddes was equally unsympathetic to the CMWC's complaints. His irritable comment to them that 'A great many medical men in the army get the complaints put up for them by outside bodies, statutory committees or something like that' suggests that LMPCs were involved in articulating the complaints of GPs both at home and in the armed services.[99]

The burden of gratuitous work relating to ex-servicemen and their families was beginning to become irksome to many GPs. Thus, when the Staffordshire LMPC considered a request for GPs to complete a form for the benefit of disabled servicemen without charge the committee

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where their duties allowed them to play golf nearly every day of the week.' Francis Brett Young, *Dr Bradley Remembers* (London, 1938) p. 718.
[95] The letters pages of the *BMJ* cited numerous examples. See 'GP' 17 July 1915 p.117, A. Macbeth Elliot 16 October 1915 p. 588 but allegations of poor organisation were disputed by 'official observer' J. Lynn Thomas, 26 February 1916, p.325.
[96] Winter, *The Great War,* p.165.
[97] Currie, *The Mustering of Medical Service in Scotland,* pp. 111-112.
[98] Winter, *The Great War,* p.166.
[99] *Ibid,* p. 168.

referred the matter to the BMA 'in order to secure uniformity of action throughout the country.'[100] By 1917 Kent LMPC's discontent about the conscription of GPs was evident from their resolution that 'The attention of the Kent Insurance committee be called to the waste of medical men in the district on military duties'.[101] Patients and approved societies were evidently not always happy either with the substitution arrangements in place to cover the absent GPs, as is evident from the complaint referred to the Lancashire LMPC from the Independent Order of Rechabites in February 1915. They stated that patients of a Dr Carrell believed the service they received during his absence, from Dr Monks of Wigan and Dr Fletcher of Ince, was inadequate. They complained that Dr Monks' surgery was open only once a day whereas Dr Carrell's had been open three times a day. The committee authorised its Secretary to identify some more satisfactory arrangements for the patients.[102]

Determined to resist the war office's latest demand for medical recruits, Morant wrote to Geddes in December 1917 warning him that meeting the quota 'would occasion a row in parliament.'[103] Services were at breaking point and the CMWC concurred with Morant in stating that 'should an epidemic occur the consequences for the civilian population would be grave.'[104] Morant backed up his campaign with statistics showing that the army now had proportionally 6 to 8 times the number of doctors available to civilians.[105] Throughout the war the CMWC had considered a variety of forms of collective substitution arrangements. Many successful schemes were developed as local initiatives.[106] By 1918 the CMWC were

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[100] *North Staffordshire LMC archive*, Minutes of extraordinary meeting of the Staffordshire LMPC, 10 January 1917.

[101] *Kent LMC archive*, Minutes of the Kent LMPC, 2 May 1917.

[102] *Lancashire and Cumbria LMCs archive*, Minutes of the Lancashire LMPC, 10 February 1915.

[103] Winter, *The Great War,* p. 169.

[104] *BMA Archive,* minutes of CMWC meeting on 29 December 1917.

[105] *National Archives,* MH 79/7. 'The question of further withdrawals of doctors from civilian practice for recruitment of the army medical services,' memorandum by Sir Robert Morant 5 March 1918.

[106] The Manchester medical war committee developed one in 1916 involving a rota to cover depleted practices and pooling of fees so as to provide doctors in uniform with half the sum they had earned in the last full year prior to their enlistment. In 1916 the Glasgow Committee proposed the creation of district centres to concentrate panel work and by 1918 similar arrangements had been set up by Nottingham, Leicester, Birmingham and Oxford. Winter*, The Great War*, p.171.

considering an altogether more radical idea suggested by Morant, namely a compulsory system of medical transfer whereby doctors from 'overstocked' areas like Bournemouth could be directed to go and work as panel doctors in 'understocked' areas like Shoreditch in London. Cox expressed doubts as to whether this could be implemented. However, by the summer of 1918 a Treasury guarantee and a standard contract for substitution had been agreed whereby each doctor would be paid £525 p.a. plus a share of the earnings of the practitioner they were covering for above that level.[107] The fact that this did not take place was due to a change in the Allies' fortunes following the U.S. entry into the war and a commitment by the Ministry of National Service to make more efficient use of the existing RAMC establishment and rely on medical school graduates to replace those killed or discharged from duty.[108]

By the time of the armistice in November 1918 some 14,700 doctors, approximately half the profession, were in uniform and 574 had been killed or died on active service.[109] The medical profession prided itself that it had 'done its bit' and gone the extra mile in its service to the country. It was due to the hard work and sacrifice of the mainly older doctors left at home that medical services for the civilian population had not broken down. Research into the health of the civilian population suggests that for a good proportion of the civilian population general health and life expectancy actually improved during the war.[110] This was due to the rise in family incomes resulting from the availability of well-paid war work and near full employment, the increase in wages relative to prices, the imposition of rent controls and improved nutrition despite shortages of certain foodstuffs. Restriction of alcohol consumption under war time licensing laws also brought health benefits as did workplace canteens available to over one million workers.[111] But, Jay Winter states, 'It would be a mistake to suggest the medical

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[107] *BMA Archive,* minutes of CMWC meeting on 18 June 1918.
[108] Winter, *The Great War,* pp.171-172.
[109] Cox, *Among the Doctors*, p. 109.
[110] *Ibid,* pp. 105-115.
[111] *Ibid,* pp. 209-216.

profession played no part in the successful defence of public health' during 1914 to 1918, adding 'The achievement of the medical community in Britain was basically to prevent worse things happening.'[112] The workload of GPs did not immediately improve following the cessation of hostilities, however, as the presence of displaced soldiers increased the spread of Spanish flu across Europe. This added to the strain on the returning doctors struggling to rebuild their practices after the war.[113]

After the war: the demand for recompense and debates about improvement and expansion

Alfred Cox wrote that 'The war did much to re-establish my faith in the integrity and good sense of my profession, a faith that had been somewhat shaken by the manifestations of the 'mob' complex during the insurance struggle… In the war one saw the profession at its best.'[114] Indeed, the government and the nation had reason to be grateful for the doctors' many sacrifices and the remarkable way in which the BMA managed to organise medical manpower and balance the competing demands of the military and civilian populations. The BMA could also congratulate itself on having ensured, through support for substitution arrangements, that, barring a few exceptions, the panel doctors who had gone away to war still had viable practices to come home to. This was not always the case for those in private practice. But it would be wrong to suppose that GPs generally, both those returning and those who stayed behind, were happy with their lot. The level of prosperity enjoyed by many owners of businesses supporting the war effort and by the workers whose earnings for exceeded pre-war levels, did not escape

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[112] *Ibid,* pp. 154-155.
[113] For an account of what GPs faced in dealing with this epidemic see Smith, *A G.P.'s Progress to the Black Country*, pp. 111-116. Smith caught the flu himself and was critically ill for six days before recovering. See also the account of Harry Roberts' experience in Winifred Stamp, *Doctor Himself: An Unorthodox Biography of Harry Roberts MD*, (London, 1949) pp.77-78.
[114] Cox, *Among the Doctors*, p 120.

the notice of GPs whose workload increased while their income remained largely static.[115] In August 1916 Dr E.H.M. Mulligan wrote to the *BMJ* complaining that 'Our capitation fee of 7s is now only worth about 4s 2d due to the increased cost of living'.[116] The parlous situation faced by the country had not prohibited a number of successful strikes by organised trade unions who saw it as a perfect opportunity to press their case for improved working conditions and wages.[117] The GPs, however, had been constrained by middle-class mores and their sense of patriotism from taking extreme action in support of their case for better pay and conditions. Now that the war was over they looked for signs that their selflessness was to be rewarded.

Despite the pressures facing the practitioners during the war, panel GPs still found time to register concerns and complaints about the way NHI was administered and to press their representatives at local and national level to obtain improvements in the scheme and their remuneration.[118] Surprisingly, the minutes of LMPCs and the IAC during this period contain only passing references to the war. They are almost entirely taken up with the same matters which concerned them before the war began, and although their membership was depleted by the call to arms, Insurance Committees and LMPCs continued to meet and conduct routine business, as did BMA divisions and committees, including the IAC. Nor did the war curtail political infighting between supporters and opponents of the BMA, the latter now adding dissatisfaction with the CMWC to their list of complaints about the Association. While the PMPU used this to support their claim to supplant the IAC as the authentic voice of the panel

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[115] See *Medical World*, 4 February 1916 (editorial) 'More work and less pay for Panel Doctors' p.149, and 11 February 1916 J. Nelson 'The effect of the war on civil practice' p.167.

[116] *BMJ* 26 August 1916, Letter from E.H.M. Mulligan p.309.

[117] Miners and dockworkers principally, but engineers, typographers and even teachers threatened strikes and were rewarded with pay rises, though a few trade unionists were arrested and prosecuted under the Munitions at War Act. See Hugh A. Clegg, *A History of British Trade Unionism since 1889*, vol ii, 1911-1933 (Oxford,1985) pp. 119-160 and 168-170.

[118] Dr J.A. Bell, Chair of the Gloucestershire LMPC, complained that the IAC had failed to seize an opportunity to address the multiple grievances of panel doctors.' *BMJ* 1 September 1917. p.305. He subsequently recorded receiving dozens of postcards from 'scores of panel committee officers' sympathising with his views, *BMJ* 15 September 1917 p 374.

doctors, even those sympathetic to the BMA believed they had much to prove before they could hope to secure the unqualified support of anything like a majority of panel doctors and/or LMPCs. Following the outbreak of war, the idea of a Federation of LMPCs to work with or under the BMA seems to have fallen into abeyance, as did the National Medical Guild of whom little more is heard.[119] But while the PMPU sought to promote itself as a more effective alternative to the BMA, individual LMPCs in York, Cheshire and Kent tried unsuccessfully to register local representative bodies as trade unions.[120] The PMPU membership was at that time almost exclusively London-based but after it had acquired the ownership of *Medical World*, the union succeeded in gaining new members in areas as far apart as Glasgow and Bournemouth and began to target LMPCs where it found individuals sympathetic to its cause.[121] After his efforts to establish an independent medical trade union in Kent had come to nothing, Dr Gordon Ward became a zealous convert to the PMPU and one of its most vociferous and effective spokesmen.[122]

Although the PMPU's combative Secretary, Alfred Welply, openly disparaged LMPCs, his London Panel Committee colleagues recognised that to have any hope of supplanting the BMA they would need to attend and seize control of the annual LMPCs conference. At the annual conference in June 1915 therefore they sought to eliminate the BMA from panel politics by moving an amendment to a motion on future panel contract negotiations that 'No action of the

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[119] They were still in existence in 1917 as shown by correspondence with Kent LMPC about the unsuccessful attempt to register the Kent Medical Guild as a trade union. *Kent LMC archive*, minutes of the Kent County LMPC meeting on 21 May 1917.

[120] See letter from Dr Denis Sheahan *BMJ* 30 September 1916 p. 476. In Kent, Gordon Ward's attempts to register the Kent Medical Guild as a trade union were stymied when the GMC 'did not see its way clear to giving consent to Kent Panel Doctors to form a trade union.' *Kent LMC archive*, minutes of the Kent County LMPC meeting on 1 November 1916. See also his letter to the *BMJ* 21 October 1916 p.572.

[121] In 1915 18 of its 30 council members were from London and a further 7 were from south east England. *Medical World* 29 July 1915 p. 210. Glasgow panel GPs formed a Scottish branch of the MPU in 1915. *Medical World* 22 April 1915, p.490. A Bournemouth branch was established in 1919. *Medical World* 2 May 1919.

[122] After lengthy discussion of legal advice on challenging the GMC decision involving correspondence with the National Medical Guild, and a decision to join the Association of Panel Committees, the Kent LMPC eventually decided to form themselves into a branch of the MPU. *Kent LMC archive,* minutes of Kent County LMPC meeting on 14 November 1917. Ward then began writing a regular column in *Medical World* using the nom de plume *Hereward.*

British Medical Association shall be deemed to interfere with the right of panel committees to make representations to the commissioners on their own initiative.'[123] The amendment was overwhelmingly lost and a resolution passed whereby the Conference urged LMPCs to view the BMA as their 'voice' in central contract negotiations.[124] They sought to further strengthen their links with the IAC by resolving that six representatives be nominated to serve alongside BMA nominees on that committee.[125] While dismissing the need for any other representative body, the Conference invited the IAC to come up with a scheme for collective bargaining for consideration at the following year's Conference. Eder views this Conference as marking the point at which the IAC's authority became unassailable.[126] But this conclusion is untenable. The obvious frustration shown occasionally by even the most ardent BMA supporters at the IAC's failure to ameliorate the panel doctors' concerns meant the IAC could never completely rely on the support of the Conference with any certainty, and the spectre of a rival organisation emerging to take its place was never entirely laid to rest.

The endorsement which the IAC received from the Conference in 1915 was strengthened by the adoption the following year of its scheme for collective bargaining which involved defeating an alternative proposal devised by Kent LMPC by which responsibility for industrial action could be devolved to LMPCs.[127] This was sufficient to convince the NHI commissioners that it was the IAC alone with whom they should consult on insurance matters. In a Commission memorandum undated and unsigned but most likely written by James Smith Whitaker sometime in 1916 entitled 'Is the Insurance Acts Committee representative?' the commissioners were advised of the status of LMCs and panel committees and the Conference

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[123] *BMJ* 26 June 1915 Supplement p.329.
[124] *Ibid*
[125] *BMJ* 6 May 1916, Supplement p.97. s.120. The Conference nominees subsequently elected included Henry Brackenbury, the chairman of the Middlesex LMPC and Ridley Bailey, the chairman of Staffordshire LMPC.
[126] See p.147 above, note 1.
[127] *BMJ* 4 November 1916, Report of Conference of Local Medical and Panel Committees 19 October 1916, pp. 128-129.

of LMPCs which 'has come to adopt the IAC as virtually an executive committee.'[128] The IAC, it concludes, 'may thus fairly be regarded as representative of the Local Medical and Panel committees throughout Great Britain; and is so accepted by them, and therefore also by the insurance practitioners and the medical profession generally.'[129] The form of corporatism which the BMA had exercised when recognised as the government's industrial partner in managing the supply of doctors for the war effort was now extended, by association, to the IAC in the resolution of the panel GPs' grievances, once the NHI commissioners were satisfied as to their representative credentials.

The annual report of BMA Council in May 1916 noted that 'The representative body will be glad to know relations between the Association and the large majority of Local Medical and Panel Committees…continue to be close and mutually beneficial.' It continued that 'Head office is being used as a clearing house for passing on to local committees the expertise gained and forwarded by other committees' and that 'The addition to the IAC of representatives of Local Medical and Panel Committees has greatly strengthened that body.'[130] Despite this, the IAC's enemies still had plenty of ammunition with which to castigate them. The controversial inclusion within the Administration of Medical Benefit (Amendment) Regulations 1915 of a provision permitting Insurance Committees to abolish 'rep mist' prescriptions and another requiring prescriptions be personally signed by panel doctors provided one example.[131] The IAC was embarrassed to report that they had not been consulted about either of these measures but compounded the fault in the eyes of many GPs when in circular M7 they 'urged that the new regulations might well be accepted' by LMPCs.[132] The reaction to this in Kent can be

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[128] *National Archives* MH 62/116. Undated, unsigned memorandum, p.1 point 3.

[129] Showing his understanding of the political manoeuvrings within the profession at that time, the author notes 'dissentient voices' in some recent conferences 'as to the representative character of the IAC coming from three or four committees, namely Chester, Kent and York.' *National Archives* MH 62/116 p.2, point 5.

[130] *BMJ* 6 May 1916 Supplement , p.98 s.125.

[131] *Ibid,* p.99 s.134.

[132] *Ibid*

gauged by the fact that, as we have noted, the LMPC went so far as to collect undated resignations prevent the abolition of 'rep mist' being enacted, and in London, Cardale, the chair of the Panel committee, criticised it as adding to the burden of urban practitioners with large numbers of patients.[133] The BMA was accused of even greater dereliction of duty when, for reasons not altogether clear, it agreed to a reduction in the notification fee for measles from 2s 6d to 1s following an epidemic in 1916, a decision which earned them the opprobrium of not just the PMPU but also the NMU, and even the Medical Protection Society.[134]

Medical World reserved its most excoriating diatribes for the Association's Medical Secretary, Alfred Cox and the GP chosen to replace McDonald as chairman of the IAC in July 1916, Henry Brackenbury. Both these men firmly believed in reasoned argument rather than table-banging threats as the best means to secure improvements in the panel doctors' remuneration and regulations governing the scheme. They hoped to win the trust and sympathy of the commissioners by proving themselves to be reasonable, responsible and ethical intermediaries, anxious to bring about improvements in the service to the insured and if possible extend the benefits of the scheme.[135] The longer the war went on, however, the more discontented and angry the overworked and unappreciated panel doctors became. In September 1916 Dr Dennis Sheehan decried the 'chronic medico-political inertia with which the profession was gripped' alleging that it was 'seething with discontent'.[136] He stated that 'sporadically as in Kent and Cheshire men are prepared to take matters into their own hands' and were 'prepared for resignation from the panel.' Brackenbury found himself on the back

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[133] *Medical World* 23 June 1916, H.J. Cardale 'The present position of Insurance Practice- its difficulties and possible development' pp. 785-786. Earlier a Dr A. Gordon Ede was outraged that his LMPC (Surrey) supported the IAC which he felt did a disservice to GPs in urban areas- *Medical World* 17 March 1916 pp. 341-343.

[134] *Medical World* 19 May 1916 p.627; 22 May 1916 p.66. See also *BMJ* 15 April 1916 letter from E. Surridge , Supplement p. 67.

[135] A summary of the points discussed with the commissioners was published in the *BMJ,* 14 October 1916, 'Medical Remuneration under the Insurance Act', Supplement pp.102-107.

[136] *Ibid,* Letter from Denis Sheahan 30 September 1916 p.476.
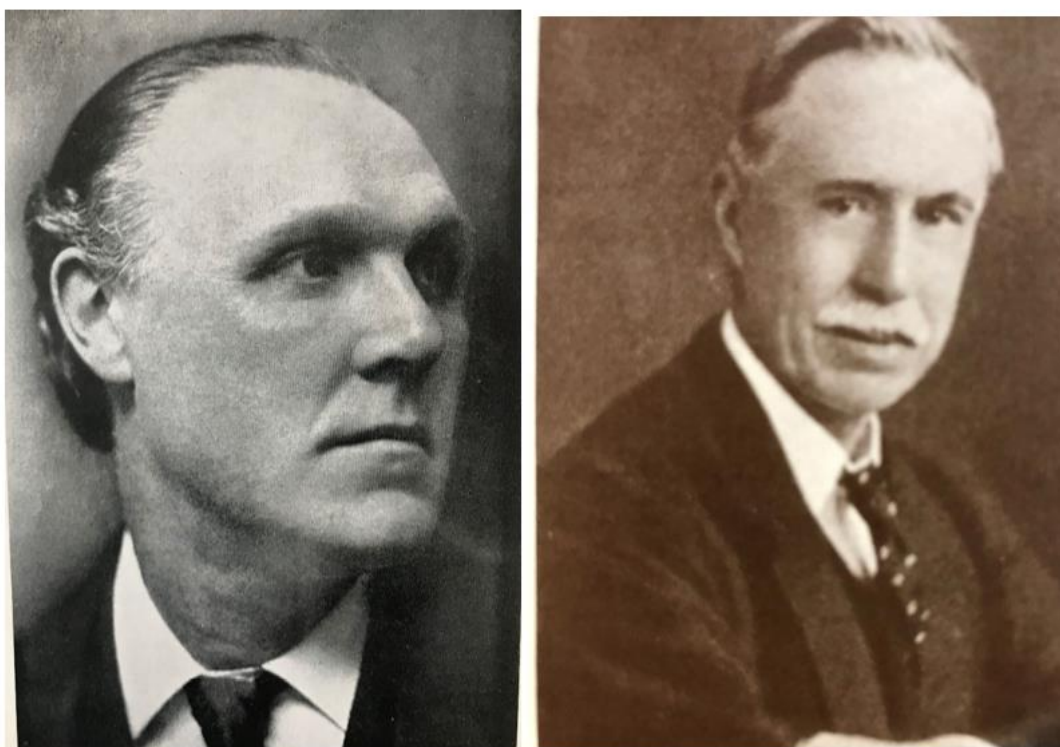
Figure 10. Convivial adversaries. Sir Robert Morant (left), Permanent Secretary, Ministry of Health. Photograph from B M Allen's biography. Dr (later Sir) Henry B Brackenbury (right), Chairman of the BMA's Insurance Acts Committee 1916-1924, Chairman of Council 1927-1932. Photograph from BMA archive.

foot in defending the IAC's decision to accept an arrangement to compensate GPs for the extra of work of attending to discharged servicemen through an attendance payment rather than a general increase in capitation. His critics alleged that the money for these attendance fees would, like temporary residents fees, be taken from the existing insurance fund 'pool' and was not therefore 'new money'.[137] Brackenbury denied this and justified the IAC's agreement on the basis that the arrangement was temporary and would allow the profession time to gather more compelling data to support a claim for a general increase in remuneration.[138] The aforementioned Dr Sheehan castigated the IAC's 'meek acceptance' of this arrangement as

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[137] *Ibid,* Letter from Brackenbury 19 September 1916 p.437 and replies from J A Bell et al 22 September 1916 p.403.
[138] *Ibid,* 22 September 1916, Supplement p.61.

'the very negative of virile leadership.'[139] In May 1917 dissatisfaction with the IAC led the London Panel Committee to write to LMPCs about the desirability of establishing a new organisation directly representative of their interests.[140] With the support of Kent LMPC they organised a conference in London in July at which representatives agreed to establish a new organisation calling itself the Association of Panel Committees.[141]

The BMA and collective bargaining: South Wales, Coventry and the GPs' war bonus

In answering those who questioned its effectiveness in representing doctors' interests, the BMA could point to its success in using, when required, trade union-like tactics. In an article in the *BMJ* in 1919 Alfred Cox described how the Association had bested the miners' Medical Aid Institutes (MAIs) in South Wales following a dispute which in his memoirs he admitted 'occupied much of my time and attention when I was Medical Secretary.'[142] The dispute noted in chapter one as having begun in 1905, escalated in 1912-1913 when GPs were locked out of some of the South Wales Institutes after refusing to accept the unilateral decision to introduce fixed salaries for medical officers in place of 'poundage'.[143] The BMA had responded by 'blacklisting' those appointments. Cox observed that the disputes in South Wales which continued during 1914 and 1915 were in the nature of a class conflict. The miners took the unjustified view, he said, that the doctors were generally 'masters men' and the miners 'wanted to be sure that they would be *their* men and could be dismissed if not found satisfactory.'[144]

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[139] *Ibid,* 14 October 1916 p.342.

[140] *Kent LMC archive*, minutes of the Kent LMPC meeting on 2 May 1917.

[141] *Ibid,* minutes of 25 July 1917. *BMA Archive, m*inutes of the London Panel Committee 25 September 1917 min.11.

[142] *BMJ* 22 March 1919 'Why should the medical profession be organised and how should it be done?' Supplement, pp. 39-40; Cox, *Among the Doctors,* p. 172.

[143] For a first-hand account of the bitterness caused by this dispute see Francis Maylett Smith, *The Surgery at Aberffrwd: Some Encounters of a Colliery Doctor Seventy Years Ago* (Hythe, Kent, 1981) ch.19 'The doctors' halfpenny strike.'

[144] Cox, *Among the Doctors,* p.173.

The miners' MAIs were strongly opposed by local doctors, 'many of whom were as a result brought almost to the point of ruin' he noted. Cox states that he 'enjoyed addressing the miners in the disturbed areas and they enjoyed heckling me.'[145] As a trade unionist himself in all but name, a sometime socialist and friend of Keir Hardie, Cox felt sure of his ground and was later tickled by the description of him by a Welsh colleague as 'the A.J. Cook of the medical profession.'[146] As a result of the BMA's efforts, the Institutes struggled to find suitable candidates for their medical officer posts and in early 1915 responded to a suggestion of a meeting with representatives of the BMA's medico political committee which, in a BMA Council report had set out a series of conditions for withdrawing their boycott.[147]

The meeting took place at the BMA's headquarters on 18 July 1915 and was attended by members of the medico political committee's contract practice subcommittee, the Friendly Societies Medical Alliance and the South Wales and Monmouthshire Alliance of Friendly Societies.[148] In a tense meeting the BMA succeeded in playing off the Welsh and English delegations against one another. Surprisingly it was the former who were most willing to compromise in the hope of ending the dispute. The BMA Council recommendation that 'the strongest opposition be offered to any extension of similar institutions all schemes…under section 15 (3) of the Act' was directed at the South Wales situation but the Institutes offered a compromise, stating that if the BMA agreed to recognise the existing schemes they would be willing to participate in a joint deputation to the Welsh NHI Commissioners to ask that the body approve no further MAI schemes.[149] Agreement on these points was sufficient to bring a

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[145] *Ibid,* p.174.
[146] *Ibid,* p.176 . A.J. Cook was a leader of the Miners' Union in the mid-1920s noted for his intransigence. See Peter Clarke, *Hope and Glory: Britain 1900-2000* (2nd edn, London, 2004) p.139.
[147] *BMJ* 8 May 1915, Annual Report of BMA Council, Report of Medico Political Committee 28 April 1915, Supplement p.188, recommendations L and M.
[148] *Wellcome Collection* (BMA archive) SA/BMA/C.102 Box 54, 'Friendly Societies and Medical Aid Institutes 1910-1948', Minutes of Conference between representatives of Medico Political Committee Contract Practice Subcommittee and representatives of the Friendly Societies Medical Alliance and the South Wales and Monmouthshire Alliance of Friendly Societies, 18 July 1915.
[149] *Ibid,* p.6.

temporary halt to the conflict.[150] In 1917, however, the BMA's freedom to employ its by now familiar tactics in disputes of this kind was seriously challenged in what became known as the 'Coventry case.'

The success of the Coventry Dispensary Friendly Society to which 50% of the working population of that city belonged, had long been a source of consternation to the BMA. While its rival Public Medical Service, established in 1907, failed to attract the same following, the local BMA division determined to use every means at its disposal to make life uncomfortable for the medical officers the Dispensary employed.[151] Not only did they ostracize these doctors, they also pressurised consultants in hospitals in Coventry and Birmingham to cut all ties with them and, even more shockingly, to decline to see patients they referred. Even local dentists and members of the nursing profession were pressurised into withholding treatment from the dispensary's patients.[152] In 1914, having taken legal advice, four dispensary doctors instituted legal proceedings against the BMA division and its officers alleging that they were victims of libel, slander and conspiracy and the Association itself was joined as co-defendant. The hearing of the case was delayed by the war but in a lengthy judgment published in the *BMJ* in October 1918 the judge, Mr Justice McCardie, subjected what he described as the 'menacing possibilities' of the *Bradford rules* to forensic examination.[153] He noted that the 'humiliation and bitterness of the campaign fell not only on the dispensary doctors but on their wives and families to whom other GPs and consultants were enjoined not to offer medical treatment.'[154] In one particularly egregious instance, one of the defendants, Dr Kenderdine, declined to attend to a dying patient whom the dispensary GP, Dr Burke, being ill himself, could not attend, until the patient's husband signed a resignation letter renouncing Dr Burke as their medical

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[150] *BMJ* 31 July 1915, Report of BMA Annual Representative Meeting 23-24 July 1915, Supplement pp. 61-62.
[151] *BMJ* 26 October 1918, 'The Coventry Case' Supplement pp .53-60, p.55.
[152] *Ibid,* p.55-56.
[153] *Ibid*, p.54.
[154] *Ibid,* p.55.

attendant. After noting that Kenderdine inspected the letter as the patient lay unconscious, the judge commented laconically 'she expired the next day and the boycott ceased to affect her.'[155]

The judge was clearly troubled by the fact that the boycott was employed against non-members of the Association and concluded that 'the uncontested power to bring ruin in on any medical men was… void of any statutory sanction.'[156] He deduced that the 'infamous conduct' of which the dispensary doctors were accused was financial rather than moral in character and said that the question of ethics, as the word was popularly understood, had nothing to do with the matter.[157] He thus found the defendants, both the BMA division officers and the Association itself, guilty of restraint of trade and actual malice, declared that the wording used in the blacklist was defamatory and awarded significant damages. This damning verdict was a catastrophic blow to the BMA which immediately set up a committee to consider its implications and necessary changes to its policies and procedures.[158] It marked a turning point in determining how far the BMA, and any group of medical professionals, could or should go in the legitimate pursuit of professional interests. The effects of the case were not lost on the advocates of trade-union status, however, and reignited the debate about whether the political fighting fund to support action in support of collective bargaining could be wielded by any organisation that was not a registered trade union.[159]

When the annual conference of LMPCs met in October 1917 Brackenbury, the IAC chairman, was once again forced to defend his committee's negotiating record. To the

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[155] *Ibid,* p.56.
[156] *Ibid,* p.58.
[157] *Ibid,* p.59.
[158] *BMA Archive*, minutes of Special Committee on Position Arising out of the Coventry case. The Committee met twice, on 4 December 1918 and 14 March 1919. On legal advice, they issued new guidance to Divisions which, inter alia, discouraged unilateral action. The wording of 'warning notices' in the *BMJ* was also altered significantly.
[159] In a memorandum considered by the committee and attached to the minutes of its first meeting (see previous note) Alfred Cox complains (p.4 para 6) of being cross examined continuously by 'those who believe trade unionism offers a short cut out of our legal difficulties.' The Coventry judgment he said, 'will accentuate this belief'.

accusation of Dr Genge of Croydon that the IAC were 'ever anxious to find favour with the commissioners' Brackenbury said that it was true that they did not go seeking a fight but to present a case 'which would bear investigation on its merits.'[160] He was aware that earlier that month the London Panel Committee had endorsed the establishment of a new Association of Panel Committees (APC), under the chairmanship of the York GP Peter Macdonald.[161] It came as no surprise therefore when the London representative Dr Cowie proposed an amendment stating that 'the time has now arrived when negotiations affecting the panel service should be carried on with direct representatives of the panel committees.'[162] The London amendment was lost and a motion of confidence in the IAC passed by a substantial majority. Brackenbury then moved a new proposal for collective bargaining which included for the first time an explicit provision for mass resignation from insurance contracts should negotiations with the commissioners break down irretrievably.[163] Once again the conference endorsed the recommendations of its executive, increasing the range of sanctions available to it to wield on their behalf.

In June 1916 the Faculty of Insurance, a lobby group representing the friendly societies and the insurance companies, published a report which advocated the extension of NHI in a way which would give the approved societies more responsibility.[164] The IAC responded by

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[160] *BMJ* 28 October 1917 Report of Annual Conference of Local Medical and Panel Committees, Supplement p.77. Henry J. Cardale proposed that the regulations recently agreed be withdrawn because conference had never authorised payment by attendance for discharged servicemen and claimed that the IAC's actions 'infringed the statutory privileges of the panel committees.' Cardale's motion was lost by 133 votes to 20. p.80.

[161] *BMA Archive*, Minutes of the London Panel Committee meeting of 9 October 1917, min 3.

[162] *BMJ* 28 October 1917 Report of Annual Conference of Local Medical and Panel Committees, Supplement p.81. He was supported by PMPU members Stanscombe of Southampton and Coke of Kent who said that in his area 'they distrusted the IAC which had given the birthright of panel practitioners away.' Major Todd of Durham, the GP who had previously been elected to chair the short-lived Federation of Panel Committees pointed to the anomalous position the IAC found itself in as a BMA Committee but Brackenbury responded that the IAC was 'a more or less independent committee of the BMA' whose remit gave it powers to deal independently with all matters relating to the interests of insurance practitioners.'

[163] *Ibid,* p.85. His proposal was opposed by MPU spokesmen on the grounds that IAC was not an appropriate body to direct such action but also by the moderate Lauriston Shaw who described it as 'a declaration of war on the commissioners without any accompanying plan as to what the profession was to do after the war.'

[164] Eder, *National Health Insurance and the Medical Profession*, p. 102

attempting to draw up its own list of improvements. In January 1917 it wrote to BMA divisions and LMPCs about the future nature of insurance practice enclosing a questionnaire (D9) in which doctors were invited to evaluate the clinical, social and political aspects of the scheme.[165] These were brought together in a report which was presented to the LMPCs' Conference later that year.[166] An example of one LMPC's reply can be found in the minutes of the Staffordshire LMPC executive committee meeting on 20 February 1917. While stating that the feeling of the medical profession in their area towards NHI was 'Generally satisfied' they reported that they did not consider the remuneration to be fair and that they required 'a 30% increase on the present rate.'[167]

   The report subsequently published notes that 'Many politicians, the press and public may hold that the service is inadequate in extent and in quality and that it carries with it the taint of cheapness and semi-charity which should have no place in a system…for which the state is responsible.'[168] It concludes that 'The profession entirely agrees that medical benefit is inadequate in extent and all are agreed that the present system is imperfect and requires modification.' The report found that GPs wanted:

- inclusion within NHI of consultant and specialist services, institutional facilities, diagnostic and laboratory services, dental, mental, physiotherapeutic and nursing services.

- exclusion of certain services, to be paid for separately, e.g. anaesthetics, or provided separately by specialists, e.g. venereal disease treatment.

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[165] *BMJ* 27 January 1917, 'The Future Policy of the British Medical Association as regards National Health Insurance', Supplement pp.13-14.
[166] *BMJ* 23 June 1917 Supplement pp.143-147.
[167] *North Staffordshire LMC archive*, minutes of the Staffordshire LMPC meeting on 20 February 1917.
[168] *BMJ* 23 June 1917 Supplement p.144

• relief from the burden of clerical work and a ban on approved societies demanding clinical details as a condition for payment of benefit.

• an independent national medical referee service to adjudicate on medical questions within the scheme.

• a Ministry of Health to oversee the working of the Act and coordinate state-sponsored health services under the National Insurance, Poor Law, and Education Acts.

• an increased capitation fee to reflect the increased usage of the scheme and wartime inflation.[169]

The report agreed that an attempt should be made to include all classes of workers and their dependants in the scheme and an income limit not exceeding £160 per annum applied to all workers, both manual and non-manual.[170]

In the summer of 1917, however, discussions with the commissioners focussed on the more immediate issue of a war bonus for panel GPs and in February 1918 the IAC's conditions of service subcommittee met with the commission chairman, Sir Edwin Cornwall MP. Cornwall was dismissive of their entreaties and his 'insults' attracted great opprobrium in the medical journals and at the subsequent LMPC conference.[171] Having failed to win over one influential member of the government, the IAC then sought and obtained a meeting with the chancellor

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[169] *Ibid,* p146.

[170] *Ibid,* p.143. The authors of the report noted that in respect of replies received 'the degree of unanimity…is remarkable.' What is also remarkable is the correlation between the profession's thoughts and those of the NHI Commission's medical advisory committee. An undated memorandum from around this time prepared at the direction of the chairman of the NHI joint commission contains a list of proposed improvements which is almost identical to that featured in the BMA's report. *National Archives* MH 62/116, Memorandum, undated and unsigned, prepared for Joint Insurance Commission –'Developments Necessary for the Provision of a Complete Medical Service for Insured Persons.'

[171] In *Medical World* 19 April 1918 E.H. Stanscombe claimed the IAC's ineffectiveness resulted in a reply (from Cornwall) 'that would not have been given to a bricklayer's union.' p. 246. See also comments of Dr Modlin of Sunderland at the Conference of LMPCs in October 1918, *BMJ* 2 November 1918 Supplement p.65.

of the exchequer, Andrew Bonar Law.[172] He eventually agreed to consider the idea of a war bonus and urged the IAC to collect evidence to support their claim for an increased capitation fee. The committee responded by drawing up a questionnaire to send to LMPCs (M36 1917-18). In correspondence with Cox about a draft of this document in early 1918 the civil servant R.W. Harris advised that it would suffice as 'preliminary information' but would lack validity unless supported with confirmatory information such as practice receipts.[173] In August Cox sent the commissioners the tabulated results of the rather limited response from LMPCs comprising six urban, six semi-urban and ten rural districts.[174] The commissioners responded that there was insufficient detail, and that further supportive information was required.[175] Seeing that the civil service bonuses had now been extended to those earning below £1,000 a year, however, a Commission memorandum noted that an extension to the panel GPs of the allowance for increased costs of living 'cannot now be resisted.'[176] To the GPs' consternation, however, the Treasury did succeed in restricting the amount of the bonus awarded.[177]

In April 1918 a special conference of LMPCs was held to consider the outcome of the IAC's latest negotiations. The mood was sombre and quickly turned to a debate about mass refusal to sign contracts from 1919.[178] In a surprising move, given their previous stance on this issue, the London Panel Committee then proposed a motion that, 'while in no way relinquishing the

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[172] The chancellor received them courteously but respectfully explained that war bonuses had been given to 'those whose income was so low that the increased cost of living was intolerable.' With regard to civil service bonuses these had been confined to those earning less than £500 a year and it wasn't the case, he said, ' that those of middling income were to be brought up to the level of income they had enjoyed pre-war.' *National Archive* MH 62/125, Verbatim report of meeting between Andrew Bonar Law and IAC deputation 15 March 1918 p.11

[173] *Ibid,.* Undated memorandum to National Health Insurance Commissioners .

[174] *Ibid,* Letter from Cox dated 6 August 1918.

[175] *Ibid,* Letter from NHI Commission Secretary dated 23 August 1918.

[176] *Ibid,* Undated and unsigned memorandum I.C 151/617, p.2

[177] It was limited to 12.5% for practitioners earning below £500 a year and 10% for those earning between £500 to £1,000 per year, subject in each case to a maximum increase of £60 per GP per year. *National Archive* MH 62/125, Unsigned letter from HM Treasury to NHI Commissioners dated 5 December 1918.

[178] *BMJ* 20 April 1918, Report of Special Conference of Local Medical and Panel Committees 11 April 1918, Supplement p.41. Brackenbury explained that the IAC had written to individual LMPCs about this but a number had misunderstood what was asked, stating that they could not contemplate a strike during wartime, which he said was not what was being proposed. p.43.

justice of the profession's demand for improved remuneration…it was right to postpone action given the perilous situation of the country at the present time.'[179] The call to panel doctors to follow their patriotic duty was opposed by representatives from Lancashire and Southampton but was carried by a large majority.

At the annual conference of LMPCs later that year Brackenbury described further meetings which had taken place with the commissioners.[180] The conference was generally supportive of the IAC's efforts but was fearful that the profession was being played with. When Cardale moved a motion that the requirement for conference's nominees to the IAC to be BMA members be withdrawn, it may have surprised him to find the motion 'heartily supported' by Brackenbury himself.[181] In explaining this action, the IAC chairman stated that his LMPC 'wanted to have partnership between the panel committees and the British Medical Association as wholehearted and unsuspicious as possible.' Brackenbury had clearly prepared the way for this momentous change to the constitution of one of the BMA's most important committees by consulting BMA Council members beforehand.[182] However, it was insufficient to quell the feelings of distrust among his opponents who complained that 'panel practitioners were the only body of people in the country who had withheld their hand from fear of embarrassing the government.'[183] A heated debate followed in which Brackenbury urged the conference not to support a motion requiring the IAC to reject the government's offered bonus and 'break faith with the commissioners' lest the government seek to suspend the NHI scheme altogether.[184]

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[179] *Ibid,* p.42. Cardale then once again called on the IAC to promote the formation of an organisation 'directly representative of various sections of the profession', meaning no doubt the APC (p.43). Brackenbury reminded conference that in the previous October it had strongly deprecated the formation of other representative bodies and the motion was defeated overwhelmingly.

[180] *BMJ* 2 November 1918, 'Report of Conference of Local Medical and Panel Committees 24 October 1918', Supplement, pp. 62-63.

[181] *Ibid*, p.65

[182] At the BMA's Annual Representative Meeting in 1919 he reminded the Representative Body of their agreement the previous year that 'those things which were matters of interest to Insurance practitioners only should be dealt with by the Conference (of LMPCs).' *BMJ* 2 August 1919, Supplement p.45.

[183] The comments were by Dr Modlin of Sunderland who had earlier condemned BMA officials 'who had laid down to insults from Sir Edwin Cornwall and Mr. Bonar Law.'

[184] *Ibid,* p.66. His remarks were described by Cardale as 'an admission of impotence.'

The motion was lost but significantly by only 53 votes to 29. The conference ended with a discussion of proposals to establish a new defence fund, which prompted MPU council member Dr Stanscombe, with reference to the Coventry case, to ask what would happen if the use of the fund were ruled to be in restraint of trade.[185] This was a question which the MPU and its supporters would continue to ask and which bedevilled for years to come the IAC's attempts to establish a uniform support structure for its political activity on behalf of panel doctors.

Conclusion

Before the war began GPs, like their patients, were just beginning to appreciate the benefits of NHI. However, the bitterness surrounding the BMA's 'defeat' in 1913 continued to colour the way GPs in opposing camps, and the plethora of interests groups vying for GPs' attention, viewed the situation of panel doctors and ideas about how it could be improved. The BMA leadership had learned a hard lesson in 1912-1913 and was quick to adapt to the new reality. The First World War gave the Association an unprecedented degree of autonomy in the organisation of medical services but its achievements, though impressive, were not always appreciated by the rank and file. By 1918 the Annual Conference of LMPCs was recognised by the profession and government officials as the fount of the panel GPs' political authority. This provided the foundation for the IAC's use of bargained corporatism but the somewhat fragile accommodation between the Conference and its 'executive', was to prove for the latter to be at once both its main source of strength and yet an effective constraint on its ability to consider and support radical ideas.

The war temporarily negated any chances of expanding the service to include specialist treatment or dependants of the insured. Debates about these matters and about the need to

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[185] *Ibid,* p.67.

integrate NHI with other organised health services continued, however, throughout the conflict which saw the capacity of a diminished GP workforce stretched to breaking point as medical services were subsumed within an economy dedicated to the promulgation of 'total war'. During the war, the GPs' workload was greatly affected by the increased incidence of chronic ill health experienced by disabled servicemen and by women workers whose health problems had previously often gone undiagnosed and untreated. Many panel doctors continued to look at this, like the approved societies, from an insurance point of view in terms of the balance between healthy and unhealthy lives and complained that the 'bargain' they had entered into with the government was based on assumptions which no longer held true. In the coming decades, as will be seen in the next chapter, panel GPs continued to be obsessed about the level of their remuneration, although a significant number of them had begun to look beyond the limitations of what NHI offered in response to evolving professional and societal expectations of what medicine and the state should provide.

Chapter Four

Chapter five. The Insurance Acts Committee and the qualified success of bargained corporatism

In October 1921 an editorial in *Medical World* stated:

> There have been sad stories of late of the passing of the family doctor. We are told that
> the one time friend of the household has gone for ever…The root cause is financial
> exiguity. The middle class, at one time the doctor's mainstay, is now the new poor.[1]

This statement neatly encapsulates some important points explored in this chapter: firstly, that while two-thirds of GPs in the early 1920s maintained panel lists and devoted a considerable proportion of their time to the care of working-class patients, their aspirations to be family doctors still relied on the custom of the fee-paying middle class; secondly, that the middle class, of whom the GPs counted themselves members, believed themselves to be suffering at that time a significant decline in living standards; and lastly, that the post-war squeeze on middle-class incomes made the GPs more anxious than ever to receive an adequate financial return from their exacting panel work, which they pressed their political leaders to obtain for them. In this chapter I evaluate the success of the Insurance Acts Committee (IAC) in negotiating improvements in the panel GPs' pay and lobbying for an extension and expansion of National Health Insurance (NHI). I suggest that the creation of a Ministry of Health provided the conditions necessary for the profession's leaders to cultivate a working relationship with civil servants and to practice collective bargaining. Their limited success in that regard exposed them, however, to trenchant criticism from the trade union lobby. I then explain how the IAC's negotiating strategy was jeopardised by changes of government and in civil service personnel

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[1] *Medical World* 21 October 1921, p.1921. Newspapers like the *Daily Mail* popularised the description of the middle class as 'the new poor', see Andrew McDonald, 'The Geddes Committee and the Formulation of Public Expenditure Policy, 1921-1922', *The Historical Journal,* 32 (1989) p.645.

and how, in the early 1920s, when retrenchment left NHI facing an existential crisis, the need to square up to their old adversaries, the approved societies, brought the insurance doctors together as never before in one brief but effective attempt to challenge government authority. When their leaders' negotiating prowess fell short of expectations, militant action was, I suggest, an inevitable default for the panel GPs. This action was fuelled not only by a justified set of grievances on the panel GPs' part, but also by a fear, common to the professional middle class during this period, that their status and economic power were being eroded relative to their working-class clientele, and that their hard-won autonomy might be wrested from them by a newly-assertive approved society lobby.

It is important, I suggest, to situate this analysis within the political and social history of Britain in the interwar period, as comprehensively described by historians such as Kenneth Morgan, Ross McKibbin, James Cronin and Peter Clarke.[2] A common belief among these historians is that the economic recession which followed the end of the First World War enabled opponents of state expansion to force the coalition government and its successors to return to budgetary orthodoxy and cut back on commitments to widen the scope of welfare provision. This punctured hopes of expanding NHI. It also, as will be seen, made it difficult for the doctors' leaders to reconcile their desire to expand and develop the scheme with the need to meet their constituents' overarching need for remuneration sufficient to maintain their social status as middle-class professionals. It therefore led, inexorably, to a questioning of the benefits of partnership between GPs and the state and a further political showdown between the government and the profession.

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[2] Kenneth O. Morgan, *Consensus and Disunity: The Lloyd George Coalition Government 1918-1922* (Oxford,1979) *passim*; Ross McKibbin, *The Ideologies of Class: Social Relations in Britain 1880-1950* (Oxford, 1990) pp.28-30 and 269-299; James E. Cronin, *The Politics of State Expansion: War, State and Society in Twentieth-Century Britain* (London, 1991) ch.5-7. Peter Clarke, *Hope and Glory : Britain 1900-2000* (2nd edn, London, 2004) ch. 4-5.

The Ministry of Health, the Insurance Acts Committee, and the trade union question.

As the survey conducted by the Insurance Acts Committee (IAC) in 1917 had demonstrated, the medical profession was broadly supportive of the idea of a Ministry of Health.[3] The process by which the Ministry came into being was tortuous and punctuated by attempts to reconcile the very different objectives of reformers within central government, the profession and the Local Government Board.[4] The fusion of the NHI Commission and the Board was precipitated by Addison's appointment as the Board's president in 1918. For the profession at this time a satisfactory conclusion to the negotiations over their remuneration was paramount.[5] Addison's eyes were firmly fixed, however, on a different objective, that is realising his ambitions for an integrated model of health and social services, extending coverage to include, at one end, preventative public health measures, and at the other a range of secondary care services not confined to hospital settings.[6] He was also preoccupied with the task of building hundreds of thousands of new houses, something added to his ministerial brief as a consequence of Lloyd George's pledge to create 'homes fit for heroes.'[7] Addison was in no hurry to forgive the personal attacks on him by diehards within the BMA even if its GP leaders' views of NHI were now more closely aligned with his. However, the BMA were anxious that in his zeal for consolidating health services Addison did not sacrifice what the profession had gained in the

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[3] *BMJ* 23 June 1917 Supplement p.146.
[4] The Local Government Board had 'provided a steady, depressing resistance to change, especially to the proposed formation of the new Ministry of health.' Morgan, *Consensus and Disunity* p.81
[5] Dr H.J. Oldham said at the LMPCs Conference that GPs' work deserved recognition as marked as that given to other workers ' but they were not going to be paid the wages of scavengers for doing it.' *BMJ* 2 November 1918, 'Report of Conference of LMPCs 24 October 1918', Supplement, p.66.
[6] He had set out proposals to achieve this in a memorandum written in 1914 to Lord Rhondda with the help of Morant and Sir George Newman. Kenneth O Morgan and Jane Morgan, *Portrait of a Progressive: The Political Career of Christopher, Viscount Addison* (Oxford, 1980) p.75.
[7] Morgan, *Consensus and Disunity,* pp. 92-94.

way of autonomy by making GPs salaried and subordinating them to Local Authority control.[8]

When a BMA delegation met with Addison and the chairman of the NHI Joint Commission Waldorf Astor in April 1919 Addison deflected discussions of their concerns by suggesting they would be addressed in the recommendations of the new medical consultative council he had established which he had tasked with drawing up plans for the development of NHI and its integration with other health services.[9] The Council, chaired by the respected physician, Sir Bertrand Dawson, comprised a number of medical luminaries though initially only one GP.[10] The membership of the Council proved to be the subject of debate and argument in the medical journals. An article in *Medical World* in October 1919 alleged it was full of BMA 'bigwigs' and 'controlled by a body of middle-class nobodies inexperienced in affairs.'[11] Always keen to impugn its rivals, the MPU alleged that Morant and the NHI Commissioners were involved with the BMA in a conspiracy to keep their nominees out of the inner circles of power.[12] The truth, however, was more mundane. Addison was clearly irritated by the political infighting among the medical representative bodies and soon made it clear that while they could put forward names he alone would decide who was to be on the Council and what its remit was. He informed those appointed that, 'they did not sit upon the council in a representative capacity and he hoped that he might rely upon receiving from the of the best advice they could furnish

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[8] Frank Honigsbaum, *The Division in British Medicine : A History of the Separation of General Practice from Hospital care 1911-1968* (London, 1979) p.83 and pp. 86-87.

[9] *National Archive* MH 62/117 Memorandum on meeting between Addison, Astor and IAC deputation 15 April 1919.

[10] *Ibid,* p.3 Dr Adam Fulton of Nottingham, who was described as being 'a GP of special experience.'

[11] *Medical World* 10 October 1919 'Oestrus' comments on the consultative council, p.351.
Some of the BMA's own nominations, including Brackenbury, had also been ignored, though the Council did now include additional IAC members such as H. Guy Dain and J.A. MacDonald. Peter Bartrip, *Themselves Writ Large: The British Medical Association 1832-1966* (London, 1996) p.211. The work of the council and its report are considered further in chapter seven.

[12] *Medical World* 10 October 1919, p.351 'Oestrus' says that Morant had 'cunningly' invited the PMPU to nominate two individuals but 'the dear old lady', its preferred epithet for the BMA, 'would have nothing to do with such a prickly pair so, to prove his devotion to her interests, Sir Robert again with his tongue firmly in his cheek decided to do without their assistance.'

as independent individuals.'[13]

Addison had supported the establishment of the Panel Medico Political Union (PMPU) in 1914 when it seemed like a logical extension of State Medical Services Association but he was now beginning to find his erstwhile friends a handful. The PMPU had changed its name to the Medico-Political Union (MPU) in 1918. In April 1919 its secretary, Alfred Welply, circulated MPU members about its stance on remuneration and insurance practitioners' terms and conditions stating that the Union 'has interviewed Dr Addison and the commissioners' (sic), and 'the promise of amendment has been made'. In June an irritated Morant wrote to Astor that if a substantially increased war bonus was to be given to the doctors it should be given without delay lest it seem 'due to pressure from the PMPU *which is not the case.*' (my italics).[14] In reference to the upcoming discussions with the IAC, an undated civil service memorandum from around the same time refers to 'a certain small but noisy section of insurance doctors who have been increasingly cantankerous and difficult throughout the five years and have been combined in a rival organisation' which had been 'carping' at the IAC for being 'inexcusably supine'.[15] The Ministry was clearly unwilling to entertain the arguments of this cantankerous minority. A commission document entitled 'Memorandum of agreement for medical services under the Insurance Act' described the LMPCs as the principal means by which the profession was consulted and concludes with a statement that the IAC is 'the executive body of the successive conferences of the Local Medical and Panel Committees of Great Britain.'[16]

The strident demands of the MPU with regard to the level of GPs' capitation fee had the effect of making the IAC's proposals seem reasonable by comparison. The civil servant R.W. Harris wrote in a memorandum of September 1919 that 'It is difficult to know what figure is

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[13] Honigsbaum, *The Division in British Medicine*, p.61
[14] *National Archive* MH 62/124 Letter from Morant to Astor 19 June 1919.
[15] *Ibid,* Unsigned undated memorandum, p.2.
[16] *National Archive* MH 62/124, NHI Commissioners, Memorandum on 'Agreement for medical services under the Insurance Act.' p.5.

intended…The wild men are talking about £1 or even more; in other areas opinion is hardening in favour of 15s while it appears likely that the moderate elements in the profession would concentrate on some figure between 12s and 13s.'[17] The IAC finally settled on a capitation fee of 13s 6d per annum but the Ministry were only prepared to offer 10s. However, the treasury's unwillingness to support an award of this size concerned James Smith Whitaker who opined that the resultant average GP income 'can hardly be maintained to be high.'[18] He repeated his concern that if remuneration was 'not sufficiently high to attract the best men in the profession to insurance work (we) should at least aim at retaining the best men who are present on the panel.' In a further memorandum to Morant and Newman he spoke about collateral damage to the efficiency of the service of a failure to meet the GPs' reasonable demands and its negative impact on the chances of obtaining improvements and extension of benefits to include specialist treatment. In the run up to negotiations with the IAC, civil servants were, however, preparing arguments to counter the IAC's claim for compensation for the additional work incurred in caring for discharged servicemen.[19] A supplementary note on the doctors' remuneration by Whitaker refers to two tests set out by his colleague Harris in support the rate of 10s. per annum. These were: '1) whether the rate was sufficient to secure the best work; 2) whether it was merely sufficient to avoid a strike.' Whittaker said, 'a strike, that is a general withdrawal from service, is not much to be feared' but he suggested there should be a third test: 'whether it will secure a service of the quality that any reasonable insured person would expect to be delivered if he were paying for it as a private patient.'[20]

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[17] *National Archive* MH 62/119, Memorandum to Commissioners from R.W. Harris 19 September 1919.
[18] *Ibid,* Undated Memorandum by J.S Whitaker regarding treasury response. In a separate memo to Morant copied to Sir George Newman dated 25 October 19191 he claimed a rebuttal of the IAC's claim might ' be regarded by the profession as a breach of the implied understanding with Mr. Bonar Law…in 1918.'
[19] *National Archive* MH 62/119, Unsigned and undated Memorandum headed 'Medical remuneration'. It notes how the IAC's methodology could be undermined with reference to variables like the average time taken in consultations, average list sizes, urban vs. rural practices, seasonal variations etc.
[20] *Ibid,* Undated memorandum by Whitaker.

Although his officials were happy to accept that the BMA had authority to represent the profession in negotiations with the Ministry, Addison briefly pinned hopes on an alternative means of developing professional consensus. This was an independent body established in 1918 to support the campaign for the Ministry of Health called the Medical Parliamentary Committee.[21] It was originally chaired by Sir Henry Morris and was given strong support by the *Lancet.*[22] In February 1919 a meeting of GPs was held at Wigmore Hall, London to discuss the need for more effective representation. At the meeting Brackenbury wearily pointed to the futility of trying to reach a medico-political consensus. Citing the diametrically opposed views of the National Medical Union and the MPU respectively he said that 'they always would have in medical politics…views that would never meet' and which were 'were absolutely antagonistic.'[23] The editor of the *Lancet*, Sir Samuel Squire Sprigge therefore moved that, as an ostensibly non-partisan body, the Medical Parliamentary Committee be empowered to speak for the profession but, crucially, he failed to win sufficient support.[24] The meeting ended inconclusively and the Medical Parliamentary Committee subsequently ceased to have any influence in debates about the profession's future.[25]

Concerned that the constant anti-BMA refrain voiced by *Medical World* and a minority of representatives at the annual LMPCs Conference undermined the IAC's authority and threatened to impede its negotiating prowess, Alfred Cox responded with an article in the *BMJ* in March 1919 explaining why it was unnecessary for the BMA to become a trade union.

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[21] *Lancet*, 23 November 1918, p.712, 7 December 1918, p.786 and 1 February 1919 p.90.
[22] *Ibid*, Editorial 'Medicine and the State' p.185.
[23] *Medical World* 7 February 1919 p.90.
[24] *Ibid*
[25] In May 1919 at Addison's suggestion, it changed its name to the British Federation of Medical and Allied Services. Honigsbaum, *The Division in British Medicine*, p.60 note c. See also Roger Cooter, 'The Rise and Decline of the Medical Member: Doctors in Parliament in Edwardian and Interwar Britain', *Bulletin for the Society for the Social History of Medicine* (2004) 78. 1 pp. 81-82. Cooter notes that membership excluded the BMA. However, Sprigge regretted that 'the BMA saw no reason to revise its opinion that the Federation has no reason for its existence. ' *Lancet* editorial 2 August 1919, p.207.The Medical Women's Federation remained affiliated but given its close working relationship with the BMA 'found this gradually becoming a source of embarrassment.' Joyce Cockram, 'The Federation and the BMA', *Journal of the Medical Women's Federation*, vol.49 (1967) p.78.

Taking account of the Association's conclusions about the Coventry case, the article cited advice from the foremost experts on trade union law, F. Gore Brown K.C. and H.H. Slesser, 'author of the most recent book on the legal position of trade unions and standing council of the Labour party.' These experts had said that the benefits of being a trade union were doubtful in the BMA's situation, as a loophole in the Trades Disputes Act could still leave the Association vulnerable.[26] Cox took great pleasure in describing the successes the BMA had enjoyed in supporting doctors engaged in industrial disputes, citing opponents' begrudging acknowledgment of their power and influence. These included an MP who in 1916 described them as 'the most powerful syndicalist trade union in the kingdom', miners' leaders praising the Association's robust defence of its members' interests, and a *Daily Express* editorial in 1918 which described them as 'the strongest trade union in the world.'(!) [27]

Cox's article also served to advertise the introduction of the new National Insurance Defence Trust which was formally established by the BMA in March 1919. Its objects were: i) to help meet expenses incurred in organising or taking any action to protect the profession in connection with NHI; ii) to provide financial support for medical practitioners disadvantaged by participating in such action. The trust was to be entirely separate from the BMA but the IAC would constitute the trustees.[28] The memorandum establishing the trust recommended the LMPCs ask their constituents to contribute ½ d per patient p.a. but it was a voluntary contribution separate from any statutory levy supporting LMPCs. [29] At a meeting in September

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[26] *BMJ* 22 March 1919, 'Why should the medical profession be organised and how should it be done?' Supplement pp 39-40. The article prompted a letter to *Medical World* from a J.C. Lyth who described advice given to the MPU by one of the same experts stating that in respect of the Coventry case the MPU as a Trade Union would be protected from accusations of restraint of trade whereas the BMA would not. *Medical World,* 28 March p.238.

[27] He might have added the admiration of Beatrice Webb who described the BMA as ' one of the most highly developed and most efficient of all British Professional Organisations' which had 'adopted some of the most efficient methods of warfare of the manual-working Trade Unions.' *New Statesman*, 21 April 1917, vol. IX, issue 211, 'Special supplement on professional associations' pp. 9-10.

[28] *Wellcome Collection,* BMA Archive , National Insurance Defence Trust File, memorandum dated 20 March 1919.

[29] *Ibid.* It noted that as the IAC included non BMA members, the defence fund could be supported by non BMA members and even by non-panel doctors.

1919 Cox was appointed Secretary of the trust and Brackenbury chair of the trustees. The meeting noted that 86 LMPCs had agreed to support the trust, 34 had declined and 107 had yet to reply.[30] The issue of whether individual LMPCs would support the trust was complicated by the attacks which the MPU levelled against the BMA, the IAC and its motives during increasingly rancorous exchanges throughout 1919 and the advice given to LMPCs by the Union to decline the BMA's request and pay instead into the MPU's political objects fund.[31] The London Panel Committee resolved to 'act in conformity with the advice of the Association of Panel Committees (APC) with regard to defence levies but in October 1919 noted that the latter had decided to leave this decision to individual LMPCs' discretion.[32] One MPU supporter reported in *Medical World* that Middlesex LMPC, which was chaired by Brackenbury, had voted 11 to 3 in favour of supporting the BMA fund but advised his colleagues to ignore this and pay it to the MPU, claiming that he would 'rather feed a live dog than a dead lion.'[33] In June 1919 the Kent County Panel Committee pointedly rejected the BMA's request and decided to pay £100 from voluntary contributions to the MPU and the following month wrote to its constituents seeking permission to donate to the Union the accumulated fund of £2,000.[34]

Why was it that certain LMPCs at this time were so critical of the IAC and anxious to promote the MPU in its place? A careful reading of their minutes suggests opinions regarding support for the IAC and for the MPU respectively fluctuated depending on the presence or absence of key personalities, and on internal politics. The London Panel Committee had been firmly supportive of the PMPU/MPU and the latter was, as has been seen, largely London-centric. The combative MPU Secretary Alfred Welply was absent from the committee between

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[30] *Wellcome Collection,* BMA Archive, National Insurance Defence Trust File, extract from minutes dated 11 September 1919.

[31] *Medical World* 27 June 1919, A Welply, 'The snare of M.21' p.539.

[32] *BMA Archive*, minutes of the London Panel Committee meeting of 25 March 1919, min. 7 and 28 October 1919 min. 7.

[33] *Medical World* 13 June 1919, Letter from JF Holloway p.502.

[34] *Kent LMC archive*, minutes of Kent County LMPC meetings of 5 June 1919 and 15 July 1919.

July 1918, when he was called up for military service, and September 1920, and during that period, in which Brackenbury attended committee meetings in one capacity or another, a significant change of attitude is detectable. In June 1919 for example two London Panel Committee representatives, B.A. Richmond and H.G. Cowie, withdrew from a conference called by the Union after refusing to condemn the BMA's report of its negotiations over amendments to terms and conditions.[35] In July, moreover, the committee instructed its representatives to the LMPCs' Conference to support the afore-mentioned report (M25) and recognize the IAC as the Conference's executive, mandated to negotiate on their behalf.[36] The same month, after learning that the Association of Panel Committees (APC) had not come to a decision about which defence fund to support, it decided to support the BMA defence trust and in September, when invited to send to representatives to the MPU's annual conference, resolved that 'no action be taken on the matter'.[37] Following Welply's return, however, the London Committee resumed its previously hostile stance.

Many within the profession were dismayed by the spectacle of the MPU and BMA trading insults and calls were repeatedly made in letters to the respective journals for the two organisations to set aside their differences. One of the peacemakers was E. Rowland Fothergill who chaired the BMA's Ministry of Health subcommittee which at its first meeting in February 1919 sought to co-opt members of the MPU ' if they will act' and committed itself to organizing a conference involving the MPU, and other organisations to 'define obstacles to cordial relations'.[38] Fothergill was subsequently persuaded to withdraw his suggestion of co-opting

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[35] *Medical World* 4 July 1919 Report of Conference p.13. and letter from Richmond and Cowie p. 24.

[36] BMA archive, Minutes of the London Panel Committee meeting of 17 July 1919, though the committee proposed an amendment that IAC be 'instructed' rather than 'requested' to 'keep in close touch with LMPCs throughout the negotiations'.

[37] *Ibid,* 23 September 1919. This wording was identical to that used by the Staffordshire LMPC with regard to the same request. Staffordshire, which had always been loyal to the BMA, had resolved to ask all its practitioners to contribute to the BMA defence trust. *North Staffordshire LMC archive*, minutes of the Staffordshire LMPC meetings of 10 July 1919 and 4 September 1919.

[38] *BMA archive*, minutes of the Ministry of Health Committee 11 February 1919, min .34. The committee comprised representatives of the BMA, British Dental Association, Poor Law MOs Association, Medical

MPU representatives on to his committee but the joint conference he campaigned for went ahead in May 1919. It was attended by representatives of the APC, the MPU, the Medical Parliamentary Committee, the Medical Women's Federation and the BMA. The National Medical Union and State Medical Services Association were invited but failed to field any representatives. The meeting quickly ran into difficulties when E.H. Stanscombe called unsuccessfully on BMA representatives to recognise the MPU as the only body capable of conducting collective bargaining in negotiations with government.[39] The conference established a liaison committee, however, which met ten days later. At this meeting the APC chairman Peter MacDonald pointed out that if the IAC consisted solely of insurance practitioners a 'modus vivendi' could be established between the BMA and MPU and then 'his association would be quite satisfied and would probably cease to exist.'[40] As a compromise, Brackenbury proposed that MPU representatives to be invited to 'accompany IAC representatives in meetings with the NHI commissioners and officials of the new Ministry.' However, at a second meeting Welply dismissed this proposal and the APC's suggestion of a permanent liaison committee, and further dialogue was abruptly curtailed.[41]

The extent of the animosity between the IAC and MPU over the issue of defence funds can be gauged from an unpublished draft circular to insurance practitioners and LMPCs considered by the IAC in July 1919 which the committee decided not to approve, fearing its intemperate

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Women's Federation and State Medical Services Association. Its purpose seems to have been to coordinate advice for Addison's consultative council and consider how to implement its recommendations.

[39] *BMA archive*, minutes of 'Conference of representatives of various medical bodies' 6 May 1919.

[40] *Ibid,* minutes of Committee established by Conference of representatives of various medical bodies 16 May 1919.

[41] *Ibid*, 16 July 1919. At the BMA's ARM in July 1919 Fothergill criticised the Medical Parliamentary Committee (now British Federation of Medical and Allied Services) as an attempt to weaken the authority of the BMA, *BMJ* 2 August 1919 , Supplement pp. 52-53, and initiated a lengthy correspondence in the *BMJ* under the heading 'The Cult of Individualism' *BMJ* 13 September 1919 pp. 358-359. At the MPU's annual general meeting in June 1920 the chairman, Coode Adams, gave a report of these meetings, concluding 'I regret to record failure in an attempt to bring about a working arrangement.' *Medical World* 25 June 1920, p.581.

language would only inflame the situation.[42] The document states that the MPU's recent circulars were 'grossly mendacious in character and…vulgarly offensive in language' and that insurance practitioners deserve to know the facts of the matters referred to.[43] The document describes the MPU's circular on the IAC's memorandum of changes to conditions of service, M25, as 'one colossal lie', rejecting among other claims their allegations that the insurance commissioners wrote it as well as agreeing to pay for its distribution.[44] The document claimed these attacks showed how 'hopelessly ignorant' the council of the MPU were about matters of administration, ridiculing their instruction to panel doctors to leave representation of GPs' interests in their hands.[45] The circular reveals why attempts to establish a professional consensus at this time were doomed to failure.

Arbitration, retrenchment and the renewed threat of the approved societies.

The ongoing conflict with the MPU was in any case an unwelcome distraction for the BMA from the difficult business of securing improvements in the panel GPs' pay. In September 1919 the IAC reported a wide range of responses to its survey of LMPCs about the appropriate amount by which the capitation fee should be increased. These ranged from 10s to £1, 3s 6d.[46] At the annual LMPCs Conference in November the York representative, Peter MacDonald, congratulated the IAC on 'the strong fighting lead which had been given' but proposed a rider

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[42] *BMA archive,* minutes of IAC meeting of 4 July 1919, Draft circular to Insurance practitioners and LMPCs. It seems likely to have been written by Cox who, despite his experience, was more thin-skinned and less statesmanlike than Brackenbury.

[43] *Ibid,* point 1. It describes the MPU's statement that GPs were being asked to agree to a deduction of 1s 2d per patient from their quarterly panel cheque as 'a lie' as the true figure was 1s 2d *per year* (point 3). It notes that the MPU's objections to the proposal agreed by the BMA to increase the income limit for the insured from £160 to £250 per year failed to mention that the rise in average wages during previous years meant that one million workers 'among whom were the best lives' (sic) would otherwise drop out of the insurance fund (point 4).

[44] *Ibid,* point 5. The author also rejected the suggestion that consultants and midwives were to be paid out of the pool used by the GPs, thus diminishing their income (point 7).

[45] *Ibid,* point 9.

[46] *BMA Archive*, Minutes of the IAC meeting of 11 September 1919 (Doc IAC 4).

to a debated motion calling on the IAC to refuse to accept anything less than 13s 6d.[47] Brackenbury opposed this on the grounds that it would tie the hands of the negotiators and the amendment was lost, prompting E.H. Stanscombe to wonder if the LMPCs 'had sent up men or rabbits'.[48] However, the LMPCs accepted the non-financial provisions of the proposed amendment regulations contingent on there being a sufficient increase in remuneration. Morant clearly sympathised with the doctors, opining that 'the moderates in the profession had succeeded in keeping the extremists at bay and 13s 6d was not an unreasonable figure.'[49] Due to pressure from the Treasury, however, Addison had little room for manoeuvre and was unmoved even by the IAC's agreement to broaden the range of services to the insured, something which Brackenbury had only with difficulty persuaded conference to accept.[50]

In January 1920 Addison informed the IAC that he was prepared to offer them 11s in spite of Treasury opposition.[51] Despite having won the vote at Conference, Brackenbury insisted that the LMPCs would not permit the IAC to accept anything less than 13s 6d and proposed the matter be settled by arbitration. After further correspondence Addison reluctantly agreed and the IAC accepted 11s as an interim award.[52] A board of arbitration was hastily convened and considered the evidence presented to it, including the IAC's data which Ministry officials had previously deemed insufficient and unconvincing. It was perhaps not surprising therefore when the board confirmed the 11s offered by the government as a fair and reasonable settlement.[53] The IAC was left to shamefacedly report its failure to the profession. In an article in the *Lancet* in March 1920, Brackenbury said that, given the pressure on the Ministry, 'the

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[47] *BMJ* 6 December 1919, Report of annual Conference of LMPCs 27 November 1919, Supplement p.138.
[48] *Medical World* 12 December 1919 p.604.
[49] *National Archive* MH 78/96, Memorandum from Morant dated 13 December 1919.
[50] *BMJ* 26 July 1919, Report of Special Conference of LMPCs on 17/18 July 1919, Supplement p. 29 (Range of Services).
[51] Eder, *National Health Insurance and the Medical Profession*, pp. 118-119.
[52] *BMJ* 24 January 1920, Insurance Remuneration, Supplement p.19.
[53] The Arbitration Board noted that 'there was unfortunately a surprising absence of evidence from the doctors' side.' *BMJ* 13 March 1920, 'Arbitration on rate of medical remuneration', Supplement p. 74.

extraction of the offer of 11s…appears something of an achievement'.[54] He admitted, however, that the absence of data was 'our chief weakness before the arbitrators.' This was not he said the fault of the IAC 'who have appealed over and over again to the profession to produce such statistics.'[55] Reinforcing his confidence in the process he added that 'The machinery of negotiation was not at fault' and in an indirect reference to the lack of unity, and arguments over the defence fund, he said that negotiations could not succeed 'without the entire support, both moral and financial, of the whole profession.' The LMPCs seem to have appreciated Brackenbury's candour, and during the course of 1920 a large number wrote expressing their gratitude for the IAC's efforts.[56] *Medical World*, however, condemned his 'apologia' as 'a whitewash'.[57]

Following the arbitration award, the IAC committed itself to gathering the most persuasive data it could find to support its case for an increase in the capitation fee. In March 1920, however, Morant died unexpectedly and his place as permanent Secretary was taken by the altogether less sympathetic Sir Arthur Robinson and, by the following year Addison too was gone, shortly to be cast into the political wilderness as a matter of expediency by his once great friend Lloyd George.[58] In September 1920, the London Panel Committee, following Welply's return to it, once again expressed its opinion that the interests of panel GPs could only be served by an independent body devoted to them alone. It politely declined to nominate candidates for seats on the IAC and invited other LMPCs to support the APC instead.[59] The IAC once again

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[54] *Lancet,* 13 March 1920, H.B. Brackenbury, 'Some thoughts on the arbitration', p.621. A *BMJ* editorial had previously praised Brackenbury's performance in the negotiations which it said were 'wisely handled' by the IAC. *BMJ* 6 December 1919, 'The Court's Award', p.206.
[55] *Ibid*
[56] *BMA Archive*, minutes of IAC meetings of 22 July 1920 and 27 November 1920.
[57] *Medical World* 26 March 1920, ' Brackenbury's apologia' pp. 257-259.
[58] Morgan*, Consensus and Disunity*, p. 81.
[59] *BMA Archive*, minutes of IAC meeting of 23 September 1920, min. 53.

found itself having to face down militants questioning its right to represent the insurance GPs, although over the ensuing months most LMPCs responded with expressions of support.[60]

In September 1921 Robinson wrote to Cox on behalf of the new minister, Sir Alfred Mond, conveying the devasting news that the government proposed to reduce the panel GPs' capitation fee to 9s 6d.[61] Cox replied that the IAC 'were at a loss to understand why the minister has decided to set aside the decision of the arbitrators.'[62] A subsequent meeting with the minister took place on the eve of the annual LMPCs conference. Mond explained that he was responding to the Geddes committee's call for the complete abolition of the government's supplemental payments into the national insurance fund, amounting at that time to £1.7 million annually.[63] A dismayed and angry conference of LMPCs debated whether to accept the proposed reduction or to continue to press for a higher fee than that awarded by arbitration, and what to do in the event of a continued refusal of their reasonable claim.[64] The Conference decided to nominate its own delegation to join the IAC negotiators in the reconvened meeting with the minister and his officials on the evening of the first day of the Conference. One of those chosen was Henry Cardale, chair of the London Panel Committee who had earlier withdrawn a motion critical of the IAC and urged conference to rally behind them. The meeting showed how determined Mond was and revealed his implied threat if that GPs did not accede to his proposed reduction 'on grounds of citizenship' the government might abandon NHI

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[60] *BMA Archive*, minutes of IAC meetings on 18 November 1920, min. 119, 15 September 1921 min. 39, and 27 November 1921 min 135. The IAC did not take the London Panel Committee's opposition lying down. In March 1921 its executive subcommittee noted a resolution from the 'propaganda subcommittee of the Association' that 'the attention of the metropolitan counties branch council and all divisions in the county of London be drawn to the necessity of taking timely action in respect of pending the London Panel Committee elections'. Minutes of IAC Executive subcommittee 3 March 1921, min 12.
[61] BMA Archive, minutes of the IAC meeting of 11 October 1921, letter dated 27 September 1921.
[62] *Ibid,* letter from Cox dated 29 September 1921.
[63] *BMJ* 15 October 1921, Supplement pp.147-150. Appointed in August 1921, the Committee on National Expenditure was chaired by the businessman Eric Geddes. It was seen as a response to the Anti Waste campaign and was very much attuned to the views of Treasury hawks. Cronin, *The Politics of State Expansion*, pp.89-91. Chris Renwick, *Bread For All: The Origins of the Welfare State* (2nd edn, London 2018) pp.146-147.
[64] *BMJ,* 29 October 1921, Supplement pp.100-167.

altogether.[65] Brackenbury proposed a face-saving compromise by describing the reduction as a temporary 'rebate' but Mond dismissed this as 'mere camouflaging'.[66] When the deputation reported back the following day, the representatives were in a sombre mood when debating what to do next. A crestfallen Cardale said that he got the impression that the insurance system was 'in a bad state' and that the government thought they were being generous in offering 9s 6d.[67] In the debates which followed, several LMPC representatives confessed that their constituents had no stomach for a fight. A Scottish representative said that GPs in Scotland would accept the offer and E.A. Gregg had to admit that even in London 'men would not refuse service for 9s 6d.'[68]

The IAC subsequently informed Mond that the profession reluctantly accepted his proposals while maintaining that 'they did not accept that anything less than 11s was sufficient to maintain an adequate service for the public.'[69] The IAC also made it clear to Mond that to maintain the panel GPs' remuneration at the level recommended in the 1920 arbitration award if not to increase it, the approved societies should be compelled to meet the shortfall from their accumulated reserves.[70] The societies were clear, however, that if they were required to contribute more they would expect to be a party to the negotiations over the GPs' remuneration and enjoy a greater share in the administration of medical benefit.[71] The MPU and the London Panel Committee were greatly alarmed at this prospect, but Cox and Brackenbury were less

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[65] *Ibid,* p.168. Mond said that 'There is a question on a paper in the House of Commons tomorrow asking whether , in view of general dissatisfaction, I should not be well advised to scrap the whole thing.' This rather cavalier approach to the destruction of a key part of the Prime Minister's legacy is rather surprising. Even his Conservative successors were more circumspect in their language.

[66] *Ibid*

[67] *Ibid,* p.170.

[68] *Ibid,* p.171.The conference ended with an unprecedented show of unity and promises from erstwhile dissenters to contribute to the defence fund. This elicited the comment from Brackenbury that 'A procession of repentant sinners is always a delightful spectacle.'

[69] *Ibid*

[70] In 1922 these amounted to about £42 million. *National Insurance Gazette*, H.A. Parker 'National Health Insurance' 28 January 1933 p. 46.

[71] *National Insurance Gazette,* 'Doctors and Approved Societies ' I July 1922 p.307.
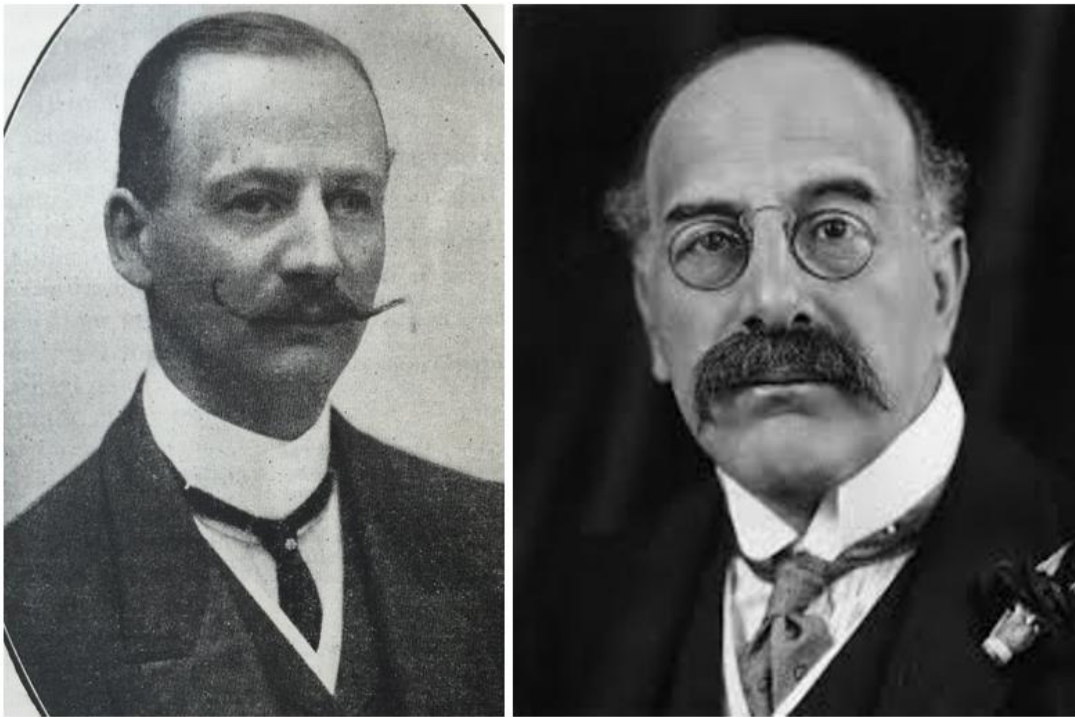
Figure 11. *Inveterate opponents.* Dr Henry J Cardale (left) , Chairman of the London Panel Committee. Photograph from Medical World, 1914. Sir Alfred Mond MP (right), Coalition government Minister of Health 1921. Photograph from Wikipedia.

fearful.[72] Robinson had assured him, Cox informed the IAC, that the Ministry had no intention of giving the societies any more say in the administration of NHI but could not say so publicly. Robinson was 'certainly playing the game with us' Cox added but it was his considered opinion that the new regulations would offer no cause for concern. Cox admitted to fuelling the London Panel Committee's fears by telling them that 'there may shortly be a time when it is necessary for London doctors to join a national fight.'[73] Welply echoed this when urging Union members to prepare for 'the biggest fight the profession has ever had to wage.'[74] In order to disprove the MPU's accusations of inertia on their part, the IAC published a timetable of its discussions

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[72] In a confidential memorandum in March 1922 Cox reported that he and Brackenbury had been 'recipients of a good many confidences' from the Ministry 'which they cannot put on paper.' *BMA archive,* Minutes of IAC, Confidential letter from Cox to IAC members dated 29 March 1922.

[73] *Ibid*

[74] *BMA archive,* Minutes of IAC meeting of 30 March 1922, Appendix A. To support this concern, Welply enclosed an article from *The Star* newspaper of 8 March 1922 by Mr P. Rockliffe of the New Tabernacle friendly society, one of the approved societies' most uncompromising and unrepentant critics of the panel GPs. The IAC Appendix also includes a testy exchange of letters between Cox and Rockliffe.

with the Ministry, exchanges of letters and memoranda, and press briefings.[75] They further demonstrated their resolve when in March 1922 they informed Robinson that 'under no circumstances would they tolerate interference by the approved societies in negotiations with the profession as to the regulations or the capitation fee.'[76] Fear of the societies' resurgence was sufficient to compel the MPU towards rapprochement with the IAC and in April 1922 they set aside their differences, stating that they would 'be pleased to afford every possible assistance to the Insurance Acts Committee to prevent Approved Society control.'[77] Before considering the profession's preparation for this new conflict it is important to understand the root causes of the panel GPs' discontents at this time.

The 'ideologies of class' and renewed attempts at professional consensus

In their discussions with both government and the approved societies in the early 1920s the IAC vented their constituents' growing sense of anger at what they saw as a refusal to accord a proper value to their services. This reflected a common feeling among the professional and managerial classes that they had lost out during the war and its aftermath to the working class which had grown in relative prosperity and influence. The wages of unskilled workers doubled between 1917 and 1924 whereas the cost of living rose by only 70%.[78] As Kenneth O. Morgan states 'the middle class…felt themselves to be, in major respects, a casualty of the war and suffering a real cut in its living standards.'[79] This view is shared by Ross McKibbin.[80] The Middle Classes Union founded in 1919 and the Anti-Waste League founded in 1921 were

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[75] *Ibid*
[76] *BMJ* 8 April 1922 Supplement p.97.
[77] *BMA Archive,* minutes of IAC meeting of 12 May 1922. Letter from MPU secretary Alfred Welply dated 13 April 1922.
[78] Morgan, *Consensus and Disunity*, p.295.
[79] *Ibid,* p.299
[80] McKibbin, *Ideologies of Class*, p.298 He states that for the middle classes 'the real problems which many of them faced were seen as directly proportional to the gains made (as they supposed) by the working classes.'

manifestations of this feeling.[81] Other 'bourgeois demons' as McKibbin describes them, included 'profiteers, the Lloyd George government, and capital.'[82] For the militant columnists of *Medical World,* the latter two were personified in the new minister of health, Sir Alfred Mond, whom Gordon Ward, under his nom de plume 'Hereward', pointedly described as 'a Hebrew financier.'[83] Although the GPs' leaders did not describe their sense of injustice in ideological terms, their comments can be viewed as reflecting the 'functional theory of social justice' and the principles of 'economic reciprocity' which enjoyed wide currency among socialist progressives at that time. As individuals who made a productive contribution to the community they came to believe that, in the words of Ben Jackson, 'as a matter of right the community owed them a fair share of the social product.'[84] This view, combined with notions of the professional social ideal, added to the GPs' sense of injustice, highlighting the government's failure to properly value or reward their services.

The gains won by the working classes during the war were of course undermined by increasing unemployment, the effects of which GPs attending to working-class families could see at first hand as the economy headed towards recession. While the majority of GPs recognised the value of the Insurance Act to their own economic wellbeing, there were varying degrees of sympathy for their working-class clientele. The views of the author of *This Panel Business* are clear from his statement that, 'The insurance patient is usually of a lower type'.[85] However, the Walsall GP novelist Frank Layton saw the feckless, workshy and rudely assertive as exceptions to the rule and in general marvelled at the stoicism with which most working-

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[81] On the Union, later the Income Tax Payers Society, see Cronin, *The Politics of State Expansion*, pp.74 and 79, and McKibbin, *Ideologies of Class*, p.299. On the Anti-Waste league see Cronin p.89, Clarke, *Hope and Glory*, p.108, and Renwick, *Bread For All*, pp. 144-146.

[82] McKibbin, *Ideologies of Class,* p.299.

[83] *Medical World* 21 April 1922, Hereward 'The Great Betrayal.'

[84] Ben Jackson, *Equality and the British Left: a Study in Progressive Political Thought 1900-1964* (Manchester, 2007) pp. 41-43.

[85] He complained that they attended collarless or coatless and that he had to put a notice in the waiting room asking patients, in the interests of public health, to refrain from spitting on the floor. 'AGP', *This Panel Business,* p.127.

class people confronted their daily struggles, especially the women.[86] Others resented the panel

patients' tendency to ignore advice given and were impatient when confronted with a wide

range of mental health-related symptoms which they were largely ill equipped to treat.[87] Many

would have happily abandoned insurance practice altogether if they could gather together

enough fee-paying clients to maintain a decent income.[88] In contrast, a small number of

committed altruists like Alfred Salter subordinated their own and their families' needs, and

health, to the interests of their patients.[89] Salter was a Christian socialist but shared with his

Conservative rivals a contempt for state bureaucracy, declaring on one occasion that 'I am a

doctor not a clerk.' [90] He manifested his own version of the professional social ideal. His

biographer notes Salter was in this respect something of guild socialist.[91] By the 1920s guild

socialism had become, in Morgan's words, 'an idea of the past'. It was being supplanted by a

socialist pluralist movement which was dedicated to 'associational independence' and

emphasised the capacity of groups to protect the individual from the growing influence of the

central state.[92] Salter, and those of his MPU colleagues who saw the Union as the modern

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[86] Frank G. Layton, *The Old Doctor* (Birmingham , 1923) e.g. p.49. See also 'A Panel Practitioner', *On the Panel: General Practice as a Career* (London, 1926) p. 63-64 and ch.4 'The Working-Class Mother'.

[87] See Anonymous, *On the Panel* (London, 1926) pp. 9-12. In the 1930s one in six working-class female patients admitted not following advice given. Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999) p.240. The GP turned MP Henry Morris-Jones described the problems of neurotic patients attending with 'le malade au petit papier' in *Doctor in the Whipps' Room* (London, 1955) p.56

[88] 'If it were at all possible I would have nothing to do with contract work but it is so interwoven and connected with the private work in a mixed district that it is impossible to give up one without the other suffering as a result.' 'AGP', *This Panel Business*, p. 126.

[89] Salter opted to live among his patients, entertained them at his home, and sent his daughter to the local primary school where, tragically, after contracting a malignant form of scarlet fever, she died. His biographer notes 'The young doctor knew that Joyce had died because she lived in Bermondsey.' A. Fenner Brockway, *Bermondsey Story: The Life of Alfred J. Salter* (London, 1949) pp. 43-44.

[90] *Ibid*, p.63.

[91] *Ibid,* p.149. Although the 'guild idea' had been described in the New Statesman in 1917 as 'an attractive fallacy' it enjoyed a brief resurgence of interest following the war when attempts were made to establish local building guilds in Manchester and other cities as a suggested means of overcoming obstacles to Addison's social housing building programme. *New Statesman*, 3 March 1919 'The Guild Idea' vol. VIII. No 204 p.523; Morgan, *Consensus and Disunity*, p.93.

[92] Marc Stears, *Progressives, Pluralists and the Problems of the State: Ideologies of Reform in the United States and Britain 1909-1926* (Oxford, 2002) pp.101-106. Modifying and indeed rejecting some of the guild socialist ideas of F.N. Figgis, the leaders of the movement, G.D.H. Cole, Harold Laski and R.H. Tawney believed that 'democratic mechanisms were essential to any and every form of association.' Ironically the MPU did not recognise that LMPCs, despite their proximity to the state apparatus, could legitimately claim to be to a large extent a reification of the socialist pluralists' ideas.

inheritor of the medical guild traditions which had become resurgent in the 1890s, encouraged the panel GPs' fear of state interference in their 'craft' and, in common with many LMPC members and their IAC representatives, came to view independent contractor status as central to their understanding of what a GP was and aspired to be.[93]

This view was shared by others including, surprisingly, many approved society representatives. When the societies met with the IAC in January 1923, Sir Thomas Neal, chair of the Executive Committee of the National Association of Approved Societies acknowledged the benefits of GPs working in private practice and hospitals saying that 'he did not want an insurance practitioner who was *only* an insurance practitioner.'[94] In contrast with the small minority of socialist doctors who formed the State Medical Services Association (SMSA), the MPU's leaders were not, at this stage, wedded to the idea of becoming state employees and became increasingly sectionalist, protectionist, and suspicious of attempts either by the BMA or the government to alter the nature of GPs' professional responsibilities.[95] Though not without progressive ideas of their own, the MPU became increasingly fixated on the material wellbeing of their GP members at the expense of all other considerations.[96] While Brackenbury and his successors sought to promote a more expansive vision of the family doctor service, the MPU pursued a defensive policy focused on maintenance of the status quo and the submission of unrealistic demands for increased remuneration while refusing to accept any corresponding

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[93] See *Medical World* 1 October 1926, 'Pharos' 'Improving the Medical Service' p.37.

[94] *BMJ* 10 February 1923 'Conference of parties interested in Insurance Act', Supplement p.35.

[95] See *Medical World* 30 June 1916, Editorial on 'State Medical Service', p.825. Salter was an advocate of professional self-government. Gordon Ward by contrast had advocated salaried service in 1917 and continued to believe that better working conditions, sick pay and pensions were a price worth paying for loss of autonomy. *BMJ* 20 January 1917, 'The Future of Medical Service' pp. 86-88. Despite contradictory comments by its members about salaried service, Honigsbaum argues that by the late 1930s the MPU Council were broadly in favour of it. *The Division in British Medicine*, pp. 182-184.

[96] Their commentary on the IAC's report of its negotiations with government in 1919 stated that 'The amount of remuneration is the most important matter affecting medical men' and that it is 'not the business of a defensive medical association' to help towards securing a really satisfactory service for insured persons.' This prompted Cox to ask: 'Could the objects of the Union be put on a lower plane? *BMA Archive*, Minutes of IAC meeting of 4 July 1919, Confidential memorandum by Cox on MPU's response to M25, point 5.

increase in public scrutiny or accountability.[97] Their focus was therefore directed more on the pragmatic concerns of panel GPs struggling to maintain their economic and social status than on lofty ideals of public service.

In May 1922, following the unsatisfactory outcome of the latest meeting with Robinson, a special conference of LMPCs was convened.[98] The conference passed a resolution insisting on the continuance of the existing system of direct negotiations between the profession and government without the interference of any third party. But, in an attempt to make the GPs appear reasonable to public opinion Brackenbury secured the addition of the rider 'but will continue to welcome cooperation of all those interested in the best possible medical service for insured persons.'[99] Believing a fight with government over the capitation fee and increased powers for the approved societies to be ever more likely, the IAC instructed its general purposes subcommittee to consider 'steps to be taken to organise the profession including the provision of a Public Medical Service (PMS), in case of suspension of medical benefit.'[100]

In the resulting document, called 'Organisation of insurance practitioners in the event of a struggle with government', the subcommittee outlined various scenarios including the government abandoning the scheme and handing subscriptions to the insured themselves to spend on schemes of their choosing, or handing complete control to the approved societies.[101] The subcommittee admitted to a reluctance to develop PMS proposals fearing that organising

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[97] Somerville Hastings, the founder of the SMSA found the MPU's obsession with economic issues like panel list sizes and the right to sell panel practices as 'morally repugnant'. John Stewart, *The Battle for Health: A Political History of the Socialist Medical Association 1930-1951* (Abingdon, 1999) p.71.

[98] *Medical World* 26 May 1922 'Report of Special Conference of Local Medical and Panel Committees', Following the MPU's rapprochement with the BMA, *Medical World* reported without comment Brackenbury's address to the conference in which he said that 'a lot of silly things had been said by officers of the approved societies about panel practitioners but after all they were not so silly and severe as the things said about the Insurance Acts Committee by an organised body of the profession.' p.297

[99] *Ibid* p.301. In the debates which followed about the use of the defence fund to support political action, a number of LMPCs representatives attacked the London Panel Committee for not contributing, prompting E A Gregg to respond that 'a big whacking fund was needed and such a fund could not be left unprotected.'

[100] *BMA Archive* Minutes of IAC's General Purposes Subcommittee meeting on 22 June 1922, min. 36.

[101] *Ibid,* Doc 83.

contract medical practice as a substitute for the panel system 'would be bad policy.' But in light of the recommendation from the IAC's rural practices subcommittee that 'it is desirable to encourage the formation in rural areas of organisations on the broad general lines of the Association's Public Medical Services scheme', a newly revised version of the original scheme was put together and presented to the annual conference of LMPCs in October. This stated that 'in some circumstances it will be necessary for Public Medical Services to be worked not by a division of the Association but by the personnel of the Local Medical and Panel Committee.'[102] This was a significant acknowledgement by the BMA of the central importance of LMPCs.

Meanwhile attempts to establish a professional consensus continued. Following a meeting in June 1922 chaired by Guy Dain between representatives of the IAC and the MPU, the IAC considered a proposal that MPU representatives be co-opted on to the IAC.[103] The IAC accordingly invited the MPU to nominate two representatives to attend IAC meetings 'for the purpose of assisting in its deliberations during the remainder of the present session' and established a special subcommittee to look at cooperation between the two bodies.[104] When the annual Conference of LMPCs convened in October 1922 the representatives were fully expecting a fight with government and Brackenbury, knowing ministerial observers were present to gauge the mood of the profession, made no attempt to dissuade them. A paper on the organisation of the profession in the event of the dispute with government explicitly referring to mass resignation, and another containing the model PMS scheme, were approved

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[102] *Report of Insurance Acts Committee 1921-22 to Annual Conference of Local Medical and Panel Committees*, 20 October 1922, item 23(c).

[103] *BMA Archive,* minutes of IAC meeting on 6 July 1922 , Doc 94, Report of meeting with MPU on 20 June 1922. In September the IAC considered a paper by Brackenbury in which he underlined the threat of always having the MPU on the side-lines, noting that a small number of LMPCs had declined invitations to attend the annual conferences, preferring to attend MPU conferences instead. These were infrequent and not very important, he said, but if a significant number were to repudiate the conference 'its representative character and consequently its authority would be seriously undermined.' Minutes of IAC 5 October 1922, Memorandum by H.B. Brackenbury, item 7.

[104] *BMA Archive,* minutes of IAC's Special Subcommittee meeting on 16 November 1922. The subcommittee invited the MPU to respond to a series of questions about their attitude to collaborating with the IAC. The responses showed the MPU to be as conciliatory as they could be without at any time conceding their time-honoured principle that only a trade union could properly represent the panel GPs.

for circulation to all panel doctors to view and comment on, the IAC being anxious to ensure panel GPs knew what was in store before any call for mass resignation was made. [105]

Efforts to cement better relations between the MPU of the IAC continued with the MPU eventually offering in December 1922 to allow the merging of the two defence funds on the condition that three seats were reserved for them on the IAC.[106] Unfortunately, this proved too much for BMA loyalists. The afore-mentioned special subcommittee concluded that the MPU was not as great a threat to the BMA as many believed and advised the IAC at its meeting in November that direct representation of the MPU on the committee would 'be widely objected to and so would be impracticable to obtain.'[107] The IAC consequently declined to endorse the MPU's latest proposal. A document describing the attempts at reconciliation circulated to the profession by them in December 1922 explained that to reserve seats for the MPU on the IAC 'would provoke a division in the ranks of the profession' and would risk 'losing the support of many LMPCs who up to the present day have been absolutely loyal.'[108] *Medical World* denounced the decision which it said should be up to the LMPC Conference rather than the IAC to decide, stating that this was 'a good example of an executive committee which is responsible to two different bodies, the British Medical Association and the panel conference.'[109] It subsequently branded Brackenbury 'a last ditcher' opposed to a closer bond

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[105] *BMA Archive*, Document M 10 1922/23 circulated in January 1923.
[106] *Ibid,* 22 December 1922 p.387.
[107] *BMA Archive,* minutes of IAC's Special Subcommittee meeting on 16 November 1922. To undermine the MPU's support among LMPCs and increase links between the conference and its executive, it suggested that the number of LMPC-nominated members of the IAC be increased. They were influenced by a paper by BMA Council member, Dr Robert Bolam, which noted that of an estimated 12,000 panel doctors 8,000 were BMA members and 3,000 MPU members. However, by the MPU's own admission 75% of their members were also BMA members which meant that there were only 750 GPs who were MPU members only, and 3,250 panel doctors not belonging to either organisation. Minutes of IAC meeting on 5 October 1922.
[108] *BMA Archive,* minutes of IAC 30 November (Doc M31).
[109] *Medical World* 12 January 1923 pp. 441-442. The MPU had unwittingly provided its opponents with the means to counter such arguments however when, at some point in 1922, in an effort to broaden its membership to explicitly include consultants and non-panel GPs, it restructured itself and consigned the representation of panel GPs to its 'National Health Insurance' section. The latter, its opponents gleefully pointed out, was exactly equivalent to the status of the IAC within the BMA. *Medical World* 2 February 1923 p.47.

between the two organisations and claimed: ' We are now condemned as heretics and if not yet consigned to the stake we are already excommunicated.'[110]

Believing that the government would seek to exploit the animosity between the panel GPs and the approved societies, the LMPCs Conference supported a proposal in October 1922 that the IAC meet with representatives of the societies in a public forum.[111] A conference between the two sides and representatives of the Insurance Committees took place in London in January 1923.[112] The discussions began respectfully though in Eder's words 'pleasant words could not hide the implacable hostility of the societies towards the continued independence of the panel medical service.'[113] The meeting nevertheless gave rise to a series of recommendations aimed at reducing the causes of tension between panel GPs and the societies, which subsequently featured in discussions between the IAC and the Ministry, and both sides agreed to continue to meet periodically.[114] While separate negotiations took place over remuneration, the IAC continued to discuss necessary changes to the benefit regulations including clarification of the scope of service. Their suggestions for reducing the burden of paperwork on GPs were rejected by the Ministry which also decided to reduce the maximum list size from 3,000 to 2,500 patients.[115] Brackenbury and his colleagues eventually secured at least one thing from these negotiations: persuading the Ministry not to allow the approved societies to initiate complaints to Insurance Committees on their members' behalf.[116] The continuation of these negotiations

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[110] *Medical World* 10 August 1923 p.595.

[111] *Lancet* 28 October 1922 p.921

[112] *BMJ* 10 February 1923, 'Conference of Interested parties on Insurance Medical Service on 30-31 January 1923' Supplement pp. 31-38.

[113] Eder, *National Health Insurance and the Medical Profession* p.209.

[114] These included certification arrangements, the work of RMOs, delays in payments of benefits to the insured, and possible extensions of the scope of service.

[115] *BMJ 16 June 1923,* Supplement pp.245-261. The IAC countered with a request for panel GPs to be able to employ more assistants but this was dismissed with the argument that it would restrict the insured patients' opportunities' to see their registered GP and therefore ran counter to the principle of 'free choice of doctor'.

[116] *BMA Archive,* minutes of IAC meeting of 22 September 1923. This was something which the Societies were keen to do, arguing, as they maintained in evidence to the Royal Commission three years later, that their subscribers lacked the means to properly promulgate complaints themselves or feared antagonising their GPs by doing so. *Royal Commission on National Health Insurance* , Cmd. 2596, 1926 p.188, para 440.

demonstrated the IAC's persistent confidence in the value of negotiations and the power of reasoned argument. But on what was this confidence based ?

The remuneration crisis and political brinkmanship

By campaigning for a Ministry of Health the profession's leaders helped create the conditions necessary for them to exercise bargained corporatism.[117] Paraphrasing Harold Perkin and others, this may be described as a tacit entente between government officials and putatively representative organisations offering themselves as intermediaries in negotiating with the state outside parliamentary channels and regulating their membership within a wider system of order. The public school-educated civil servants who ran the Ministry recognised the doctors' representatives as fellow technocrats with whom, though not quite their social equals, they shared a common set of values and cultural assumptions, and a common commitment to the ideals of public service.[118] Confirming Nikolas Rose's contention that 'Liberal government is inherently bound to the authority of expertise', these officials were thus content to countenance the doctors' leaders' suggestions when it served the broader interests of the state.[119] The IAC did not always succeed in convincing ministers or officials of the rightness of their arguments but were reassured that at least their representations would be received with equanimity rather than the hostility they might have expected from the approved societies. Brackenbury was convinced that, as educated and honourable men, Ministry officials were open to reasoned argument. Cox subscribed to the same view, stating in a *BMJ* article in April 1923 'Our Civil Service is incorruptible. It does not take sides. I would rather see the Government standing

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[117] Perkin credits this phrase to the social scientist Colin Crouch. Harold Perkin, *The Rise of Professional Society; England since 1888* (2nd edn. Abingdon, 2002) pp. 287.
[118] *Ibid*, pp.286-288.
[119] Nikolas Rose ,'Government, Authority and Expertise in Advanced Liberalism', *Economy and Society,* 22 (3) (1993) p.285.

between the insured person and the medical profession than the approved societies.'[120] Eschewing the aggressive chest-beating of the MPU, Brackenbury explained to a meeting of GPs in Liverpool and Cheshire in April 1923 that 'It is no use going into negotiations with an ultimatum…in a bullying spirit.' [121] Contents of ministerial memoranda show him to have been broadly correct in his assumptions. Those officials had little time for or sympathy with the MPU 'wild men' whose bellicose attitude Cox dismissed when stating that 'to be potentially pointing a pistol which will not go off or goes off at the wrong end is not the way to impress any one worth impressing.'[122]

As we have seen, Morant's successors were not as well disposed to the doctors as he was, but Whitaker and Newman generally served to mitigate any antimedical bias, and in general the civil servants appreciated the IAC's restraint. Harry Eckstein describes the relationship which developed between the BMA and the Ministry of Health under the National Health Service after 1948 as a 'non-statutory partnership' whose origins he traced to the interwar period.[123] Reflecting on the relationship across the twentieth century, he concluded that the BMA had actually lost all the crucial public disputes over medical policy but conceded that 'behind the record of public failures is a much more impressive record of not so public successes, greatest of all on minor matters, points of detail, but impressive enough also in the case of principles.'[124] In 1922 Brackenbury struggled to get this message across to those he represented. The 'minor matters' on which at that time the IAC could claim to have succeeded included securing a temporary reprieve for GPs from the burdens of completing medical records during wartime, negotiating the introduction of rural mileage allowances, and

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[120] *BMJ* 7 April 1923 Supplement p.106.
[121] *Ibid,* 28 April 1923, Supplement p.161.
[122] *Ibid,* 22 March 1919, Supplement p.40.
[123] Harry Eckstein, *Pressure Group Politics : The Case of the British Medical Association* (London, 1960) p.84.
[124] *Ibid,* p.93 and p.96.

successfully campaigning for the establishment of a Regional Medical Referee service.[125]

These successes failed to impress the IAC's critics, especially the MPU. Nevertheless, the IAC had succeeded in persuading government officials that they could be trusted to represent the true intentions of the majority, whatever their rivals or antagonists might say. In so doing they achieved what Eckstein calls a 'clientele relationship' which gave them a privileged position.[126] The fact that the showdown which occurred in 1923 and subsequent periodic contretemps were quickly followed by a return to 'business as usual' proves how mutually beneficial this relationship was.

In the early part of 1923, many LMPCs still hoped for a rapprochement between the IAC and the MPU.[127] The IAC was in no mood to be distracted, however, from its primary goal of preparing the profession for a major showdown with government over remuneration. This was rendered even more likely when the coalition government was succeeded, following the 1923 general election, by a Conservative administration, led by Stanley Baldwin, which was committed to a policy of even greater retrenchment, in compliance with the Rothermere and Northcliffe press's 'anti waste' campaign.[128] The new minister of health, William Joynson-Hicks, quickly signalled his intention to seek an even greater reduction in the capitation fee than his liberal predecessor. The minister was advised to offer to fix the capitation fee for five years, as a means to negate the efforts of the IAC whom, in a memorandum written in August 1923, Robinson described condescendingly as 'incorrigible hagglers.'[129]

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[125] *BMJ* 10 February 1917, Supplement p.23; *BMA Archive*, minutes of IAC meeting of 21 October 1919, Doc 24; *BMJ* 30 October 1920, Supplement p.116.

[126] Eckstein, *Pressure Group Politics,* p.38. This could also be viewed as a manifestation of what Pierre Bourdieu refers to as 'the mystery of the Ministry' whereby the spokesman or agent becomes the embodiment of the group it represents and the agent's views are seen as normatively valid and authentic. Pierre Bourdieu, 'The Social Space and the Genesis of Groups', *Theory and Society* 14 (1985) pp. 739-741.

[127] *BMA Archive* Minutes of IAC meeting 15 March 1923, doc. 64. Some, like Sunderland, blamed the IAC for the breakdown in negotiations and henceforth refused to pay into the defence trust.

[128] The campaign found a willing supporter in the 'People's Union for Economy' founded by the Conservative MP Godfrey Locker-Lampson. Honigsbaum, *The Division in British Medicine* , p.76.

[129] *National Archive* MH 62/128, Memorandum from Robinson to Joynson-Hicks dated 1 August 1923..

At Robinson's suggestion, Joynson-Hicks decided to meet with representatives of the approved societies. His intention was to gather ammunition for his contest with the doctors but also to test the strength of the societies' opposition to underwriting the cost of any increase in medical benefit from their reserves.[130] Despite their polite discussions with the IAC, the societies' representatives immediately sought to discredit the doctors' claims for increased remuneration, stating that the 7s 3d they had been awarded before the war, was more than adequate.[131] Joynson-Hicks pointed out that the average number of patient attendances was now 3.25 per annum compared with the 1.25 which the Plender report had found to be the norm in 1912. The doctors complained, the minister said, 'that every working man earned more than he did before the war so why should doctors be treated any differently?'[132] In response Alban Gordon, a Fabian society member who was later to become a firm advocate of a state medical service, opined that Lloyd George had been overly generous and that the pre-war figure now represented fair reward.[133] The minister made it clear that as regards the future funding of NHI 'there was not the slightest chance of getting any more money out of the government' and that extra funding for the doctors would have to come from the societies' funds. Gordon advised the minister not to be intimidated by threats of industrial action by the doctors stating that 'Our friends, the black coated Bolshevists of 429 Strand, are past masters in the art of bluff.'[134]

The IAC were still hopeful that militant action would not be necessary. They believed in the strength of their case for increased remuneration and backed it with reasoned argument and

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[130] He began by stating that while some of their number represented trade unions they should be aware that 'on the other side are the doctors who- perhaps they would forgive me for saying so -are a pretty firm trade-union themselves.' (The response was 'hear, hear'). *National Archive* MH 62/128, Verbatim report of meeting between Minister of Health and Approved Societies 27 September 1923, p.1.

[131] *Ibid,* p. 2.

[132] *Ibid,* p.3.

[133] *Ibid.* A member of the medical consultative council who was present, the economist Professor Alexander Gray, objected at this point that the figure of 7s 3d awarded by Lloyd George 'was not, as Mr Gordon intimated, entirely imaginary' and that in fixing the new figure they needed to be thinking of the current figure of 9s 6d and not its pre-war level.

[134] *Ibid*

statistics. The memorandum that formed the basis of their written submission in August 1923 acknowledged the need for economy in public services but stressed the importance of the remuneration being sufficient to attract the next generation of doctors.[135] It argued that remuneration of insurance practice must compare favourably with that of private practice and other branches of medical work. It supported this with statistical arguments about the cost of living, drawn from an attached memorandum on changes to the cost of living between 1914, 1920 and 1923 by the BMA's statistician, Professor A.L. Bowley, concluding that the lowest fee the profession could accept was between 10s 4d and 10s 9d per head per annum.[136] In the Minister's meeting with the IAC, Brackenbury said that they were not concerned about remuneration per se but that a decision to reduce their income would curtail further development and lead 'to the service remaining at or sinking below a level we should not like.'[137] What GPs wanted he said was a service that would not only retain the best GPs but was capable of attracting in the one third currently outside the service, thereby addressing the current shortage of GPs in some areas which led to unacceptably high patient lists and reduced choice of doctor.[138] The meeting ended without agreement but when the minister spoke of the societies' contention that many of their members were dissatisfied with the quality of panel service Brackenbury strongly disputed this and the extent to which the societies understood or accurately represented their members views, stating 'in no sense whatsoever did they really

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[135] *BMA Archive,* minutes of IAC meeting of 7 August 1923, Memorandum on Remuneration.
[136] *Ibid,* Bowley's memorandum dated 21 July 1923.
[137] *National Archive* MH 62/128, Undated verbatim Report of meeting between Minister of Health and IAC, p.6.
[138] *Ibid,* pp. 8-9. In what may have been an attempt to rile the IAC delegation, the Minister said that, being entirely unfamiliar with the panel system himself, he sought to ascertain at random the views of two subscribers-female typists working at his old office- on the subject of panel doctors. 'One said ' Do not touch them. They are dreadful people'' he reported, 'while the other said 'It is the best thing I've ever known. One is better treated than by a private doctor.' The IAC representatives failed to rise to this provocation and in the discussion which followed pointed to the increase in average attendances. When the minister said in reply that the approved societies had made the point that a great number of these attendances were merely for the purpose of signing a certificate, Brackenbury replied 'Well! One is absolutely astonished at that coming from the approved societies as they attach far more importance to the proper signing of certificates than anything else. (laughter)'

represent the insured person.'[139] The Minister seems to have accepted this point.[140] He was

conscious, however, of the influence wielded by the approved societies in parliament.[141] As

negotiating tactics, Robinson suggested offering the IAC the choice of 8s 6d per patient for

three years or 8s for five years.[142] Whitaker felt the GPs would not accept 8s because they had

been 'exasperated by the venomous attacks made upon them by the approved societies' which

reinforced the risk of large scale resignations, he said, especially by those doctors with small

lists who, financially, had little to gain from remaining on the panel.[143]

   In conveying the Minister's offer in October 1923, Robinson argued that the 1920 arbitration

'took place at a period of optimism and inflation when increases of remuneration were being

considered liberally on all hands' adding 'On economic grounds…medical incomes must be

expected to fall' and the Ministry could not justify a higher rate unless the rewards of insurance

medical practice were to be set higher than those of private practice.[144] The IAC declared the

response 'very unsatisfactory', repeating the contention that any shortfall in funding could be

met from the National Insurance Fund 'owing to windfalls of various sorts.'[145] The letter hinted

that the IAC might accept the reduction if their case was referred to arbitration.[146] Robinson

replied that the minister did not propose to discuss it any further and would not go to arbitration

since the results of the previous arbitration were fully taken into account in his decision.[147]

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[139] *Ibid,* pp. 19-20. Brackenbury repeated this point in his speech to Conference reported in *The Times* 19 October 1923 p. 9.

[140] As he admitted in a subsequent meeting on 3 October with his key officials, Robinson, Whitaker, Sir George Newman and Sir Walter Kinnear. *National Archive* MH 62/128, Memorandum of meeting on 3 October 1923.

[141] *Ibid,* pp. 1-2. Robinson pointed out that the doctors had their allies in parliament too. He concluded that 8s 6d was the proper rate and would eventually be accepted by the GPs 'though not of course without alarums and excursions.'

[142] *Ibid,* pp. 2-3.

[143] *Ibid* p.5.

[144] *National Archive* MH 62/128, Letter from Robinson of 3 October 1923. p.3 item 6 and p.15 item 9.

[145] *Ibid*, Letter from Cox of 8 October 1923, p.1 item 1 and p.7 item 17.

[146] *Ibid,* p.8 item 18.

[147] *Ibid,* Letter from Robinson 15 October 1923. As if to underline how far the moderate stance taken by the IAC was from that of the militants of the MPU, Alfred Welply wrote to the minister submitting a memorandum in support of a claim for 10s 6d. *National Archive* MH 62/128 letter dated 8 October 1923.

When the annual conference of LMPCs met in October 1923 they unanimously rejected the minister's offer.[148] However, at a special meeting of the LMPC in Kent the same month members acknowledged that most of their constituents would accept 8s 6d if it were 'stabilised' or guaranteed for an adequate period.[149] The day following the conference Cox wrote to LMPCs and insurance practitioners advising them to prepare for resignations to become effective as from 1 January 1924.[150] He reminded them of the model scheme for PMS which the profession was now advised to adopt as an alternative to NHI, the significance of which was not lost on the press.[151] His missive included a letter for practitioners to use in giving notice to Insurance Committees (see Figure 12).[152] Fortunately for the panel GPs, support for their arguments came from an unexpected source. As reported in *The Times,* the Trades Union Congress (TUC) and Labour Party national executive had published a pamphlet setting out their views on NHI.[153] It stated that a Labour government would be willing to guarantee a capitation fee of 9s 6d for five years on the grounds that 'we have satisfied ourselves that the National Insurance Fund in the aggregate contains sufficient money to meet the costs without

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[148] *BMJ* 27 October 1923 Report of Annual Conference of LMPCs 18 October 1923 supplement p.194.

[149] *Kent LMC Archive*, Special LMPC meeting 12 October 1923.

[150] *BMA Archive,* Letter from Cox to LMPCs dated 18 October 1923 (M29) enclosing letter to insurance practitioners (M30) and notice of resignation to Insurance Committees (M 31).

[151] *The Star*, 18 October 1923, p. 11.

[152] *BMA Archive,* minutes of IAC meetings of 26 October 1923 and 7 November 1923. The letter referred to the work of the propaganda committee which had been established to win public and parliamentary support for the GPs' cause. The Committee included the Walsall GP Frank Layton. The defence Fund contributed £100 towards the publication of his novel *The Old Doctor* and, believing it to be a way of winning support for the GPs, encouraged LMPCs to purchase copies and send them to their MPs and other interested parties. *BMA Archive* Minutes of the London Panel Committee meeting 23 October 1923, Finance & General Purposes subcommittee min. 6. Kent LMPC had canvassed local MPs' support and prepared a leaflet of what the dispute was about which pulled no punches in its attacks on the approved societies. *Kent LMC Archive*, minutes of Kent County LMPC meetings of 9 October and special meeting of 12 October 1923 detail the considerable attempts made by this LMPC to win public and parliamentary support for the GPs' cause and counter the approved societies' arguments. The IAC drafted a similarly leaflet which was considered at a special conference on 24 November. The leaflet was headed : 'Insured Persons- it is important you should know…'. The IAC resolved to take no immediate action re the leaflet. *BMA Archive* Minutes of IAC meeting of 29 November 192, min. 198.

[153] *The Times* 17 October 1923 'Panel Fees-Doctors to decide tomorrow-Labour basis proposed.' p.14, col 2. It included things which needed addressing which the IAC itself had no real problem agreeing with, that is a cap on list sizes, new rules on use of assistants and more effective means of securing removal of unsatisfactory doctors.

Figure 12. *Symbol of resistance*: Panel GPs' resignation proforma, M.31, 1923. From BMA archive .

lowering or endangering the revision of other benefits.' The pamphlet added that they considered it justifiable to lay claim to some of the societies' 'hidden reserves.'[154]

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[154] Although Robinson dismissed the document, Joynson-Hicks asked if he should invite to Labour leader Arthur Henderson to see him to ask if his party were supportive of giving more money to the doctors even if trade-union approved societies might not agree. *National Archive* MH 62/128, Undated note of meeting between

The minister vented his concern that his policy of playing the doctors off against the approved societies might backfire when he said 'he would not be made a cockshy by both the approved societies and the doctors.'[155] As a last resort he admitted he could ask the Commons to pass a suspensory Bill continuing the 9s 6d for two years and set up a Royal Commission to inquire into the operation of the scheme. Robinson still felt the GPs would accept his offer and encouraged the minister to call their bluff but that, as a contingency, the government might consider arbitration 'objectionable as that might be.'[156] The minister was clearly getting twitchy as reports of meetings of doctors around the country expressing support for the IAC and its call for mass resignations were sympathetically reported in *The Times*.[157] He dismissed talk of the approved societies' large surpluses saying that if the case was to go to arbitration, representations must be tripartite. His irritation was clear from his concluding remarks to the IAC that 'I am not enamoured of the panel system and if the doctors would prefer…a full enquiry into the best method of dealing with medical benefit…I am willing to submit a proposal for an early Royal Commission on the whole subject.'[158] To this Cox responded bullishly, commenting that the profession hated 'this periodic dragging of its affairs before the public' and concluding that 'the profession is prepared for a full inquiry, either departmental committee or Royal Commission, at any point you like, provided it is a full inquiry.'[159] A final meeting took place shortly after between the minister, his officials and the IAC. Joynson-Hicks repeated that the government actuary had confirmed that they could not afford to pay more than 8s 6d

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Joynson-Hicks, Robinson, Whitaker, Kinnear, Brock and Leishman p.2. In what seems like an overt breach of the civil service code of impartiality Robinson replied that 'it would be sound tactics to spread confusion in the Labour ranks when the bill was introduced.'

[155] *Ibid,* p.3 He was reported in as describing himself as 'a buffer state' between the doctors and the approved societies. 'Minister's position' *The Manchester Guardian* 24 October 1923 p.5.

[156] *National Archive* MH 62/128, Undated note of meeting between Joynson-Hicks, Robinson, Whitaker, Kinnear, Brock and Leishman p. 4

[157] See *The Times* articles of 13 October 1923, p. 12 col 2 and 15 October 1923 p.12, col 6.

[158] *National Archive* MH 62/128, Letter to Cox from Joynson-Hicks dated 26 October 1923.

[159] *Ibid,* Letter from Cox to the Minister dated 27 October 1923. Not all GPs were convinced , however, that arbitration would bring a satisfactory outcome. A meeting of Yorkshire and Middlesbrough LMPC representatives recorded that 'Some considered that arbitration was in a measure giving the position away'. *YORLMC Archive,* minutes of meeting of 'Group C' regional Committee of LMPCs 10 October 1923.

and that the chancellor of the exchequer had ruled out any rise in taxes.[160] Brackenbury repeated that an adequate service could not be provided for that amount and said the fact that practically 95% of resignations had been sent showed how united and determined the profession was.[161] Joynson-Hicks adjourned the meeting, stating testily that 'they had better send in their resignations because if no settlement could be reached there would be no alternative but to scrap the existing panel system.'[162]

At a reconvened meeting on 31 October, the beleaguered minister offered a Royal Commission and 8s 6d for five years, plus an additional £250,000 to the rural mileage fund.[163] The IAC rejected the offer and with 95% of panel doctors expected to resign (the figure was 100% in 59 areas) the government found itself looking down the barrel of what Eder calls the 'gun with a single bullet' which the profession was now united in wanting to fire.[164] In a last ditch attempt to prevent this happening, the Ministry amended its offer to 8s 6d guaranteed for 5 years pending the outcome of a commission of inquiry into GPs' remuneration, plus a Royal Commission to investigate and report on all aspects of the scheme.[165] In light of this, a special LMPCs Conference was called in November 1923 at which Brackenbury declared the IAC finally willing to recommend that resignations be withdrawn.[166] The Conference recognised that the IAC's measured but determined approach had won significant concessions from a seemingly implacable opponent. More importantly, they were confident that the rightness of

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[160] *National Archive* MH 62/128, Undated note of meeting between Joynson-Hicks, Robinson, Percy, Newman, Smith Whitaker and IAC deputation p.2.

[161] He added that and that 'the desire to secure a worthwhile service and…the freedom of the doctors from approved society control' were the real issues on which the bulk of the profession were fighting. He continued that the IAC would welcome a full inquiry but as the process was likely to take some time wanted the existing capitation rate to continue pending its outcome. *Ibid,* p. 3.

[162] *Ibid,* p.4.

[163] *Ibid*, note of meeting between Minister of Health, officials and IAC deputation 31 October 1923.

[164] Eder, *National Health Insurance and the Medical Profession* p.211. With reference to this, IAC member Mabel Ramsay informed her Medical Women's Federation colleagues that 'the response was magnificent'. Joyce Cockram 'The Federation and the British Medical Association', *Journal of the Medical Women's Federation,* vol. 49 (1967) p.77.

[165] *BMJ* 3 November 1923, Supplement p.209.

[166] *Ibid* ,24 November 1923, Report of Special Conference of LMPCs, 14 November 1923, Supplement pp.238-239 and 243;)

their cause would be self-evident to the independent inquiry and so, after a modicum of debate, the conference voted to accept the minister's offer by 141 votes to 29.[167] The minister made it clear when setting up the inquiry that it was not to be a prolonged affair and indeed it was not, concluding its business and reporting its recommendations in less than a month. But it was to a different government that the court of inquiry submitted its final report in March 1924 as in January the Labour party embraced for the first time the challenge of forming an administration following the inconclusive results of the general election in December 1923.[168]

When the court of inquiry met for the first time on 4 January 1924 the IAC put its case for the continuation of 9s 6d in a detailed memorandum supported by comparative data on incomes, expenses and cost of living by their retained expert, A.L. Bowley.[169] The government presented its by now familiar case for 8s 6d and the approved societies argued that the doctors remuneration be reduced to the pre-war figure of 7s 3d.[170] On 23 January the arbitrators announced their 'Solomon-like' decision, awarding the doctors 9s guaranteed until the end of 1927.[171] The IAC had no choice but to accept the result, which was undoubtedly a victory of sorts but, to appease the many GPs who felt less than thrilled at the prospect of the modest reduction proposed, responded that it was still unshaken in its opinion that 9s per capita per annum 'was not an adequate fee for services under the Act.' [172] The new Labour government honoured the inquiry's recommendations and in March 1924 introduced a bill to enable it to be paid out of the insurance fund without the necessity to increase either employers' or employees' contributions, relying on 'previously unacknowledged funds from the sale of insurance stamps and interest since 1913.'[173] The Labour party proved that the statement it had made in its joint

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[167] *Ibid,* p.243.
[168] Clarke, *Hope and Glory*, pp. 124-126.
[169] *BMJ* 12 January 1924, 'Report of proceedings of Court of Inquiry and statements of evidence by interested parties', Supplement pp. 30-53.
[170] *Ibid*
[171] *BMJ* 2 February 1924, Supplement, p.205
[172] *BMA Archive,* minutes of IAC meeting of 20 March 1924, min 264.
[173] Eder, *National Health Insurance and the Medical Profession*, p.231.

leaflet with the TUC was correct and that Robinson and the previous government actuary had not given an entirely accurate assessment of the situation. This must have dismayed the approved societies who saw a large part of their surpluses disappear while their opponents, the panel doctors, exulted in the (partial) vindication of their claims.

Conclusion

The panel GPs' 'victory' in 1924 may seem a fairly hollow one, in reducing, though only by 6d per patient per annum, the amount which the panel doctors were up until then being paid. If Brackenbury and others were to be believed, moreover, it had left the service still unable to attract or retain the best doctors. But it was a victory nonetheless, the importance of which cannot be overstated. It represented a high watermark for unified professional action by GPs in support of political objectives. Proving that professional solidarity could be achieved and used effectively in the right circumstances, it set a precedent for future action because, as Eder puts it, 'the government and the approved societies recognised that the threat of a boycott of the panel system was no longer a fantasy.'[174]

The reasons for the IAC's success in 1923 were twofold. Firstly, it had succeeded in obtaining the backing of an overwhelming majority of insurance practitioners. The figure of 94.6% of eligible doctors being ready to resign represented a degree of professional unity that was never equalled before or since. This was due at least in part to the fact that the IAC had acted reasonably and honourably in their pursuit of economic reciprocity and service improvements over a considerable time period and called for resignations only as a last resort once other avenues had been exhausted. The profession was thus able to enjoy a good deal of support from the public, if not from all sections of the press, and to take the moral high ground

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[174] *Ibid,* p.230.

due to its leaders having emphasized continually that the dispute was not purely about money but about the desire to provide a proper and sustainable medical service of which the profession could be proud and with which the public could be satisfied.[175] The GPs' leaders' confidence was boosted by comments such as those made by *The Times* medical correspondent, McNair Wilson, who observed that the arbitrators' decision 'disposed at once of the idea that…the doctors were exhibiting a greedy spirit. On the contrary, they were entering a protest against the scale of payment which rendered efficient service difficult or impossible. *That action was their clear duty to the public as well as themselves*.'(my italics)[176]

The second factor influencing the outcome was the fact that, if the government had not backed down, the panel doctors were confident that they had a viable alternative. The panel service was still relatively new and underdeveloped and covered only part of the population. GPs provided medical care for dependants of the insured and the middle classes excluded from the scheme through fully private, or alternative insurance or provident-based, schemes which could, with some effort, have been extended to include panel patients if the NHI scheme was wound up. Historians seem to have ignored or underestimated the potential viability of PMS as professionally-run alternatives to approved societies' schemes in the event that the National Insurance Acts were rescinded. The IAC, at the prompting of conference, had updated its model PMS scheme and now had, in the LMPCs, democratically enfranchised bodies through which to implement such schemes across the country using the knowledge they had gained from a decade of involvement in the administration of NHI. While it would no doubt have proved difficult, particularly in rural areas, it was entirely feasible for LMPCs to set up their own services with financial help from the defence funds, as indeed a number were to do during the

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[175] As an example of this consider Brackenbury's speech to the LMPCs conference in 1921 when he said ,'The profession has a right … on public grounds, to say that the government must not go beyond the point at which the profession considered it possible to carry on a service satisfactory to the public.' *BMJ* 29 October 1921, Supplement p.164.

[176] *The Times* 25 November 1924, 'Panel Doctors' Fees' p.11, col 4.

1920s and 1930s. This became necessary, as will be explained in the next chapter, when the government's need for greater economy seemed to have ended hopes that NHI could be extended to include the dependants of the insured population. This left the profession agonising once again over the necessity to challenge government authority.

Chapter Five

Chapter Six. The consolidation of National Health Insurance and the realisation of the professional social ideal.

In his book on National Health Insurance (NHI), the former Ministry of Health Official R.W. Harris wrote:

> I believe the share accorded to the medical profession in the administration (of NHI) is unique. Comparing the English system with all the Continental systems the difference in this respect is very marked and that is doubtless the reason why the doctors here are comparatively satisfied and, in the opinion of many qualified to judge, give a better service.[1]

In this chapter I examine several questions relating to the perceptions and experience of panel GPs in the late 1920s and 30s. First, the extent to which their central role in administration of NHI, and influence with government, was affected by retrenchment and bureaucratization. Second, the extent to which they achieved during this period the financial security and middle-class status they had always craved. Lastly, as insurance panel practice came to be regarded as one of the supporting pillars on which the vast majority of independent medical practices in Britain were balanced during this period, the extent to which the bulk of panel GPs embraced or rejected the professional social ideal. I begin this chapter by considering the evolving nature of the GPs' role in policing and regulating the administration of medical benefits under NHI during the interwar period. This involves a study of the profession's engagement with the Ministry of Health over the key system pressure points of alleged overprescribing and lax certification. I then consider two important influences on the GPs' relationship with the state: the government-imposed cuts in the panel GPs' remuneration in response to the economic depression of the early 1930s, and the expanding remit of the Regional Medical Service. The

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[1] R.W. Harris, *National Health Insurance in Great Britain, 1911-1946* (London, 1946) p.143.

panel GPs' negative views of both those developments resulted, I contend, in a questioning of the BMA's use of bargained corporatism and a concern that the state was impinging on the GPs' autonomy by interfering in their professional affairs and suffocating them in 'red tape'. I then ask if, individually and collectively, GPs experienced any discernible improvement in their economic and social status in the late 1920s and 1930s, and whether the rewards of panel practice were adequate and equitably distributed. Consideration of these questions will help determine if the panel GPs were as satisfied with their lot as Harris suggests. I conclude that the rewards of panel practice varied enormously as did GPs' and their patients' experience of it during this period. I suggest, however that increasing numbers of GPs viewed the panel as a major if not the principal component of their medical practice businesses and strove to maintain a high standard of practice consistent with a continuing attachment to the professional social ideal. My analysis leads me to challenge the conclusions of some historians who, I believe, have been too willing to take contemporary criticisms of the panel GPs and the service they offered at face value.[2] Such questions are, I suggest, more complex than they appear at first sight and deserve an altogether more nuanced interpretation.

System pressure points: overprescribing and lax certification.

 According to Eder 'Overprescribing and lax certification drew more attention than any other issues associated with the National Insurance panel service.'[3] But the Insurance Acts Committee (IAC) was not, it seems, prepared to admit to the existence of these problems until after the report of the Royal Commission in 1926 when they no longer feared the influence of the approved societies. It was only then that the GPs' leaders were prepared to

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[2] These include, for example, Anne Digby who condemns the quality of care given by panel GPs as 'generally mediocre', *The Evolution of British General Practice, 1950-1948* (Oxford, 1999) p.321.
[3] Norman Eder, *National Health Insurance and the Medical Profession in Britain, 1913-1939* (New York, 1982) p. 304.

address these issues as a matter of self-regulation in the wider interests of the service and the reputation of the profession. Concerns about 'excessive prescribing' began soon after the panel service began. The GP's capitation fee included a nominal 2s per patient to cover the costs of medicines GPs dispensed themselves as 'stock mixtures'. Of this 6d per patient was retained in a shared fund by the Insurance Committee to cover any excess in the costs of medicines prescribed by GPs and dispensed by pharmacists above the amount in the Committee's drugs budget. The residue of this 'floating sixpence' could be distributed to local GPs on a per capita basis if there were unspent funds remaining at the financial year end.[4] It thus served as an incentive for GPs to keep prescribing costs under control. However, although LMPCs were assiduous in their efforts to police 'excessive' prescribing they were unable to prevent increasing overspends.

 In 1914 an extensive investigation into the causes of prescribing overspends in London proved inconclusive.[5] The average cost of prescriptions continued to rise during the war, however, as demand for medical care from women workers and those invalided out of the services increased and GPs were more inclined to prescribe named drugs rather than dole out stock mixtures of questionable efficacy.[6] It was a difficult problem to tackle, recognising that overprescribing was 'less a matter of fact and more one of opinion' about the needs of the individual patient and the doctor's management of them.[7] The 'floating sixpence' was abolished in 1920, and the amount assimilated into the local drugs fund. A Ministry of Health memorandum noted that one reason for abolishing it was a concern that it afforded 'an inducement to unscrupulous doctors to economise unduly in the ordering of drugs.' [8]

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[4] Eder, *National Health Insurance and the Medical Profession*, p. 42.

[5] It cost £2400 yet resulted in a net saving for the drugs fund of only £500. *BMA Archive*, minutes of the London Panel Committee meeting of 28 April 1914.

[6] *Ibid,* minutes of meeting of 27 March 1917.

[7] Eder, *National Health Insurance and the Medical Profession* p.268.

[8] *The National Archive/Public Record Office Kew* MH 62/119, Memorandum by J S Whitaker, 20 September 1919.

However, the same officials subsequently realised that LMPCs now lacked an incentive to properly investigate allegations of excessive prescribing.[9] The Ministry therefore created pricing bureaux to collect comparative data on individual GPs' prescribing habits and asked Regional Medical Officers (RMOs) to target for investigation areas with exceptionally high costs.[10] Insurance Committees likewise appointed drug advisory committees and drew up local formularies to try to iron out variations in prescribing habits.[11] From 1927 chemists were instructed to institute generic substitution of named drugs in accordance with local formularies and from 1929 a national formulary was drawn up in agreement with the IAC.[12]

Rising drug expenditure from the mid-1920s onwards was attributed to a variety of causes. These included patients exceeding the recommended dosage or becoming addicted to medicines, patients demanding that medicines be flavoured to make them palatable and thereby more expensive, and doctors prescribing large quantities of Cod liver oil and other food substitutes to compensate for the effects of malnourishment.[13] Harry Roberts became something of a national celebrity when he and his partners were fined £100 for prescribing 'excessive' quantities of Cod liver oil and malt. The press took up the case with the headline 'Doctors fined for idealism.'[14] A comparative study of prescribing costs in Leeds and Bradford revealed inexplicable differences and prompted the Ministry to establish a more effective disciplinary process.[15] Individuals whose prescribing costs were abnormally high were visited by a RMO and if no explanation was offered or the explanation was inadequate the RMO could

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[9] *National Archive*, MH 62/118, Memorandum from J.S. Whitaker to Morant dated 24 July 1919, MH 62/107, memorandum by Whitaker dated 19 June 1922.

[10] *National Archive*, MH 62/107, Undated 'Extract from the Instructions Issued to the Medical Staff, Investigation of Prescribing'.

[11] Eder, *National Health Insurance and the Medical Profession* p.270.

[12] *BMA Archive*, minutes of IAC meeting on 23 June 1927, Doc 68.

[13] Hermann Levy, *National Health Insurance: A Critical Study* (Cambridge, 1944) pp.188-195.

[14] Winifred Stamp, *Doctor Himself: an Unorthodox Biography of Harry Roberts MD* (London, 1949) pp.82-85. Francis Maylett-Smith, was another GP criticised by the Panel Committee for overprescribing Cod liver oil, see his *A GP's Progress to the Black Country* (Hythe, 1984) pp.140-142.

[15] *National Archive*, MH 62/109, Unsigned memorandum dated 8 February 1926.

request a formal hearing of the case by the panel committee. The IAC were by this time happy to participate in a propaganda campaign to advise panel GPs to be more careful about prescribing.[16] The number of GPs investigated for this problem rose from 1369 in 1929 to 1885 in 1930 but the number subject to a punitive deduction from remuneration, which in 1928 was 45, dropped to only 13 in 1930 and thereafter never exceeded 10 a year.[17] Prescription expenditure remained stable in the early 1930s but rose steadily between 1933 and 1937 when Health Minister Sir Kingsley Wood complained that it was out of all proportion to the increase in the insured population.[18] Critics noted that the cost in England was significantly higher than in Scotland prompting the Minister's Chief Medical Adviser, Sir George Newman, to describe the English as 'a nation of medicine drinkers'.[19]

Allegations of lax certification lay at the centre of the political antagonism between the approved societies and the medical profession. In 1913 the London Insurance Committee appointed six medical referees to investigate the problem and of 471 cases of alleged malingering 208 were declared capable of work.[20] The referees' report did not, however, support the approved societies' view that doctors were complicit. The problem was felt to be one of definition. Often the patient was not fit to return to their usual work but not incapable of *any* work and attempts by Ministry officials to clarify this matter only served to confuse the panel GPs further.[21] The government actuary, Sir Alfred Watson, reported that sickness claims by males rose by 51% between 1921 and 1927 and disablement claims by 85%. For unmarried women the figure was 60% and 98% and for married women 106% and 159% respectively.[22] When the Ministry gave its RMOs the primary responsibility to investigate malingering and

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[16] *BMA Archive,* minutes of IAC meeting on 30 November 1927, Doc 23.
[17] Eder, *National Health Insurance and the Medical Profession*, pp.275-276.
[18] *BMJ* 30 October 1937, Supplement, p.275.
[19] Quoted by Eder, *National Health Insurance and the Medical Profession,* p.277.
[20] *The New Statesman* 6 December 1913 p.263 and the *Lancet* 3 January 1914 p.77.
[21] *National Archive* MH 62/45, Letter (undated) from L.G. Brock to Cox.
[22] Eder, *National Health Insurance and the Medical Profession,* p.282

lax certification in 1920 the profession accepted this as preferable to approved society involvement.[23] RMOs were eventually swamped with referrals, however, the number rising from 69,544 in 1921 to 372,324 in 1928.[24] The *National Insurance Gazette* complained in 1928 that 'False certificates given by doctors to persons who are not ill are in fact robbing persons who are ill of services they need.'[25] The IAC strenuously denied that GPs knowingly issued certificates to those who were not ill but acknowledged their reluctance to police the benefits system, as was made clear by the chairman of York LMPC, Dr J.C. Lyth, who said in 1928 that 'Medical practitioners as a profession are not trained to regard the issuing of medical certificates as the main object of life, nor even an important part of it.'[26] As the economic situation worsened the Treasury became increasingly suspicious that the sickness benefit fund was being denuded by kind-hearted doctors certifying the unemployed as ill or disabled. Levels of sick certification certainly rose significantly during strikes, especially in coal mining areas.[27] However, when workers were laid off they had time to go to see their GP about medical conditions that had often been unattended to and which may have warranted treatment and certification.

The approved societies continued to regard malingering as a national scandal, viewing GPs as the primary contributors and were supported by their allies in parliament and the press.[28] The Ministry, however, confined its efforts during the mid-1920s to issuing advice rather than

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[23] *YORLMC Archive*, minutes of meeting of Group C Regional Committee of LMPCs 9 October 1929.

[24] *Ibid*, p.286.

[25] *National Insurance Gazette* 4 August 1928 p.367.

[26] *BMJ* 12 May 1928 Supplement, p.206.

[27] *Ibid,* 15 November 1927 Supplement, pp. 44-46. Anne Digby 'The Economic and Medical Significance of the British National Health Insurance Act 1911', in Gorsky, Martin, and Sheard, Sally (eds) *Financing Medicine: the British Experience since 1750* (Abingdon, 2006), p.184.

[28] *Daily Mail* ,'Health Insurance Inquiry Needed', by special correspondent 7 April 1930 p. 9. *The Times*, 'Claims for Sick Benefit', 7 April 1930, p.11. Some MPs' complaints, such as those raised by Sir H. Cautley, were admitted to be hearsay and easily shown to be based on ignorance or out of date information. 'AGP' *This Panel Business* (London, 1933) pp.111-115.

Figure 13. *GPs' sympathies tested:* striking workers in the 1930s. Photograph Historic-UK.com

taking punitive action.[29] The majority of referrals to RMOs resulted in suspension of benefit but there were often legitimate excuses. Many patients had either already returned to work, were waiting for the certificate to run out or were too intimidated to turn up for the RMO's examination.[30] GPs were also severely criticised for issuing sick certificates to pregnant women. By 1930, women made up a third of NHI contributors, half of claimants and two thirds of cases referred to RMOs.[31] While it was accepted that pregnancy was not an illness, medical problems associated with pregnancy made it difficult for GPs to determine what was the exact cause of patients being unable to work in the later stages of pregnancy and this undoubtedly

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[29] 'bureaucratic pressure…was the preferred official strategy for reducing panel doctors' lax gatekeeping. So that only a small number…were singled out for deterrent financial penalties.' Digby, *Evolution of British General Practice,* p. 253.

[30] *BMJ* 20 June 1931, pp.1079. *BMA Archive* Minutes of the IAC meeting of 23 September 1932, Doc 1. This explanation is corroborated by 'A Panel Doctor', the anonymous author of *On the Panel: General Practice as a Career* (London, c.1924) pp.144-145.

[31] Noel Whiteside, 'Central Control and the Approved Societies: Access to Social Support under the Interwar Health Insurance Scheme' *Bulletin of the Society for the Social History of Medicine*, 32 (1983) p.16. Claims reflected an inability to claim extended unemployment benefits and 'illness directly attributable to pregnancy.'

added to the number of supposedly questionable sick certificates.[32] But, to counter the arguments of critics who alleged that GPs issued certificates to patients whom they feared would otherwise seek to change doctor, the IAC persuaded the Conference in 1927 to agree to a change in the regulations introducing a time delay in registration.[33] A further change was made in March 1931 whereby patients could change doctor only once during each quarter after a month's notice was given.[34]

In 1928 the IAC began a series of regular conferences with the Ministry regarding the causes of the rising sickness benefit rate.[35] The IAC representatives offered a series of reasons as to why the cost of benefits had increased. In addition to the increasing the number of elderly insured and the increasing tendency of women to seek sick benefits before and after pregnancy, they suggested it was due to:

> • 'the undermining of individual self-reliance, ie an awakening by the public to their sense of their rights and a grasping of such rights'.
>
> • 'the inclusion of additional NHI benefits which encouraged an increase in claims because 'the more there was to get, the greater the desire to get it'.
>
> • 'the success of the profession's health propaganda which meant that patients were no longer ignoring trivial matters which would get worse and were seeking preventative treatment' (which the IAC acknowledged 'was possibly bad for the insurance funds').[36]

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[32] See debate at Annual LMPCs Conference 1930, *BMJ* 11 November 1930, Supplement, pp. 189-190. However in 1927 one GP reported that a large manufacturing firm was actively advising its pregnant employees 'to go on the funds', *Medical World* 27 January 1927,'Over certification- a cause?' p.468. Another GP, writing in 1933, declared 'The pregnant woman is a great nuisance in pestering for certificates.' 'AGP', *This Panel Business,* p.146.

[33] *BMA Archive*, minutes of IAC meeting of 20 November 1930, Doc. 9, reference to Medical Benefit (Amendment) Regulations 1930.

[34] Eder, *National Health Insurance and the Medical Profession*, p.300.

[35] *BMA Archive*, minutes of IAC meeting on 19 January 1928, Doc 39.

[36] *Ibid,* pp.2-4. According to one GP, the rising costs of drugs and benefits and patients' determination to get their maximum entitlement to both was proof that NHI 'was a failure' and had led to a 'lowered morale', that is to a lack of scruples, among both patients and doctors. 'AGP' *This Panel Business,* pp.36-7,43-49,71-72.

While never accepting that GPs were at fault, the IAC agreed a change to the Medical Benefit Regulations in 1930 requiring LMPCs to investigate cases where there was 'a prima facie case for considering that the doctor had failed to exercise reasonable care in the issue of certificates.'[37] The IAC insisted that under no circumstances were the approved societies to be involved in any investigation, and therefore accepted that disciplinary action under the new procedure, usually involving a withholding from remuneration, was reserved to the Ministry itself. [38] The approved societies did not take their exclusion from this process lying down. Sir Arthur Robinson had to fend off an attack by the societies via the National Association of Insurance Committees but failed to persuade his colleagues at the Scottish Health department, which dug its heels in and insisted that its Insurance Committees continued to be involved.[39] In 1931 the panel committees were grouped together into larger districts for the purposes of enquiring into lax certification so as to remove the embarrassment of their members having to investigate close colleagues.[40] Despite all these efforts to address the problem, by August 1932, 'the Ministry had come to appreciate that all attempts at defining and reducing lax certification had proved to be cosmetic at best' and the problem remained unresolved.[41]

With pardonable exaggeration Eder says that the joint efforts by the Ministry and the IAC to address the problems of overprescribing and lax certification strengthened their relationship to the point that 'the IAC became almost an arm of the Ministry of Health.[42] However, this conclusion has to be challenged on two fronts. Firstly, the IAC's efforts to work constructively with the Ministry were, as will be shown, dealt a severe blow when the panel GPs' pay was unilaterally cut in 1931 and the Ministry declined repeated requests to restore the shortfall until

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[37] *BMA Archive,* minutes of IAC meeting of 20 November 1930, memorandum on Medical Benefit Amendment Regulations 1930, Doc.9, point 1.
[38] *Ibid,* minutes of IAC meeting on 6 March 1930, Doc 27.
[39] Eder, *National Health Insurance and the Medical Profession*, pp.296-297.
[40] *BMA Archive,* minutes of IAC meeting on 24 September 1931, Doc IA 5 referring to ICL 751 MoH.
[41] Eder, *National Health Insurance and the Medical Profession*, p.300.
[42] *Ibid,* p. 305. He says that 'The doctors, observing the close working relationship between their leaders and the Ministry could feel fairly certain that profession's views were receiving a fair and usually friendly hearing.'

four years later. This created tension between the IAC and the Ministry and made it hard for many GPs to accept that the government was sympathetically disposed towards them. Secondly, the increasing number and complexity of new regulations and the zeal with which some RMOs exercised their inquisitorial functions on behalf of the Ministry convinced many ordinary GPs that the state was increasingly intruding into areas touching their judgment and responsibility, thereby diminishing what many doctors held most dear, that is their professional autonomy. These two matters deserve to be considered in more detail.

The 'national emergency' and the widening remit of the Regional Medical Service

Remuneration became once again the principal point of contention between panel GPs and the government in 1931 when the Economy Committee chaired by Sir George May recommended total cuts in public spending of £96 million. These were to be met in part by cuts in benefits and a significant reduction in the remuneration of public servants, including the panel GPs.[43] In September 1931 the Ministry informed the IAC that as part of their contribution to national recovery, panel GPs would be expected to face a cut of 1s in the annual capitation fee (almost 11%).[44] Compared with the 15-20% cuts which teachers, the police and members of the armed forces were expected to suffer, the doctors felt they had come off lightly and a motion that panel GPs accept 'the decision of HM government', as their share of the burden falling on the community, was carried by the IAC with only one dissentient.[45] Sir Arthur Robinson responded expressing warm appreciation of the IAC's decision by the minister, Neville Chamberlain.[46] Their mutual respect quickly dissipated, however, when, in the aftermath of the Inver Gordon

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[43] *Report of Committee on National Expenditure* chaired by Sir George May, Cmd. 3920, 1931. See James E. Cronin, *The Politics of State Expansion: War, State and Society in Twentieth-Century Britain* (London,1991). p.100 and Peter Clarke, *Hope and Glory: Britain 1900- 2000* (3rd edn. London, 2004) p.186.

[44] *BMA Archive*, minutes of IAC meeting on 8 September 1931, min. 5, point 6 (letter from Robinson dated 5 September 1931).

[45] *Ibid.* The dissentient was the London GP E A Gregg.

[46] *Ibid,* minutes of IAC meeting on 24 September 1931 min 18 (letter from Robinson dated 10 September 1931).
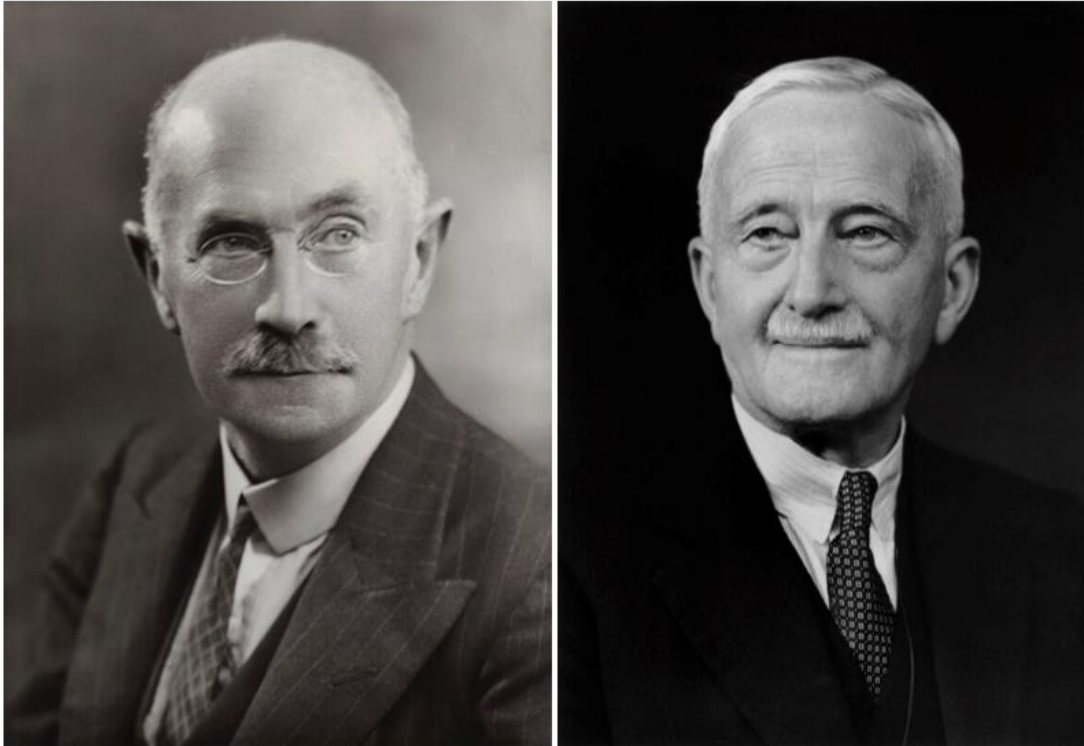
Figure 14. *Distrustful collaborators.* Sir Arthur Robinson (left), Permanent Secretary, Ministry of Health 1920-1935. Photograph National Portrait Gallery. Dr (later Sir) Harry Guy Dain (right) , Chairman of Birmingham LMPC, Chairman of the IAC 1924-1936, Chairman of BMA Council 1943-1949. Photograph National Portrait Gallery.

mutiny and a well-publicised campaign of opposition by the teaching profession, the cabinet revised its proposals for variable cuts to public sector salaries and opted instead for a 10% cut across the board.[47] Dain, the IAC chairman, claimed this was unfair and seriously compromised the IAC's position as negotiators.[48] His reasoning seems at first glance a little obtuse as the cut was slightly smaller than that previously proposed. However, the fact that the cut was from the gross remuneration of the panel doctors whereas for public sector employees it was their net remuneration, meant that GPs were hit harder than other public servants because of the effect of practice expenses equating to between 25 to 35% of their income.[49] The MPU was indignant

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[47] *Ibid.* See also Clarke, *Hope and Glory* p.159.

[48] *BMA Archive*, minutes of IAC meeting on 8 September 1931min. 19.

[49] Anne Digby and Nick Bosanquet, 'Doctors and Patients in an Era of National Health Insurance and Private Practice 1913-1938', *Economic History Review*, vol. 41, no.1 (1988) p.84. The MPU estimated the cut to be the equivalent of 16% and Dain admitted that it was around 15% rather than, as some were alleging, 20%.

that GPs were once again being called on to make sacrifices in the national interest.[50] *Medical World* printed letters from angry GPs including one who advocated 'passive resistance' by refusing to complete certificates and forms and one from a GPs' wife showing, by means of a detailed breakdown of practice costs, how close to penury the cut would bring them.[51] Given the parlous state of the national economy, the IAC felt helpless to resist the government's entreaty and were supported by the LMPCs Conference.[52] They decided however to set up a remuneration subcommittee, once again drafting in the statistician A.L. Bowley, to help prepare the case for increased remuneration when circumstances were propitious.[53] The MPU, however, expressed a view felt by many GPs that the inquiry process seemed rigged in favour of the government and that the IAC negotiators were no match for wily government officials.[54]

In 1933 the IAC's subcommittee listed a number of factors in support of their claim. These included an increase in the time and cost of medical education, and increases in the number of items rendered to, and in the average amount of time spent with, panel patients. They were forced to accept that the cost of living had decreased but were able to demonstrate an increase

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Medical World 2 October 1931 'Insurance notes' p.110 and 30 October 1931,'The cut and the conference' p.199. The minister's refusal to make changes in this respect might have been influenced by the knowledge that the GPs' expenses could be offset against income tax.

[50] They objected that those criticising the IAC's 'ill-advised actions' were called 'carping and unpatriotic', and questioned why 'we have to help the bogged nation out of the morass', stating 'has not the profession done its bit already?*' Medical World* 25 September 1931, 'National Health Insurance', p.85.

[51] *Medical World*, 25 September 1931, letter from Henry H. Haward, p.94, and 9 October 1931 letter from 'Wife' p.138. 'Many medical men whose sole earnings are from an average-sized panel are just about managing to keep themselves from starvation.' 'AGP', *This Panel Business*, p.91.

[52] An amendment by London to a motion supporting the IAC's actions protested 'against the inequality of the sacrifice as compared with other sections of the community' but was overwhelmingly lost. *BMJ* 31 October 1931 'Report of Annual Panel Conference ', Supplement p.246. In an article titled 'The mystery of the Conference' a *Medical World* columnist commented caustically that the IAC would probably rank their actions 'with some former events that in the vocabulary of the British Medical Association are termed 'victories'.' *Medical World* 6 November 1931, p.221

[53] *BMA Archive*, minutes of IAC Remuneration Subcommittee meeting on 9 February 1933.

[54] The MPU condemned the IAC's failure to challenge the May Committee's contention that the panel GP's fee was too high or to secure a definite date for the cut to be reviewed and for not calling a special LMPCs Conference before agreeing to it. *Medical World* 2 October 1931, p.109. They seemed to be inclining towards salaried service when in relation to GPs' pay they opined   'no insurance scheme of medical benefit can be run entirely on the lines of private practice'. *Medical World* 27 November 1931, p.289.The following year Dr Manson of Warrington expressed his LMPC's fears that the cut might be permanent stating 'Many practitioners had a lurking fear lest the clever officers of the Ministry, by their powers of persuasion, should prevail over the Insurance Acts Committee.' *BMJ* 29 October 1932 'Report of Annual Panel Conference' Supplement, p.222.

in practice expenses.[55] Being a veteran of previous battles with the Ministry, Brackenbury counselled the IAC against reliance on the increased number of attendances which he knew the Ministry would attempt to explain away. He advocated instead a greater reliance on the increased responsibilities of panel GPs following recent regulatory amendments.[56] Fortunately for the country, the departure from the gold standard in September 1931 led to a gradual improvement in the economic situation over the next few years such that the annual conference of LMPCs resolved in November 1933 that 'the time has arrived when the 10% reduction…voluntarily accepted in the national emergency of 1931 is not now justified and should cease.'[57] The author of *This Panel Business* stated bluntly 'There seems no doubt that panel practitioners as a body have had to pay more than their fair share of the national burden.'[58] Initially their remonstrations fell on deaf ears but in July 1934 the government agreed to restore half of the reduction, still leaving the panel GPs 5% short of what they had earned in 1930 and the fee was not restored to its full amount until July 1935, some time after other public sector workers' pay cuts had been restored.[59] After further pressure from the BMA and its allies in Parliament, the Ministry eventually conceded another Court of Inquiry into panel GPs' remuneration. The Court, chaired by Lord Amulree, met in 1937 but the IAC were dismayed when the Ministry sought to undermine the profession's case by attacking the general quality of the panel service.[60] The GPs were particularly incensed by the evidence of two RMOs who opined that the majority of panel GPs' work was concerned with the alleviation of catarrhal or rheumatic conditions and that they referred anything more complicated to the hospitals, an

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[55] *BMA Archive,* minutes of IAC meeting on 2 May 1933, Doc.80.
[56] *Ibid,* Doc.91. These included the keeping of statistics and compiling of many more medical reports for official purposes.
[57] *BMA Archive*, minutes of IAC meeting on 16 November 1933, minutes of Annual Conference of LMPCs 19 October 1933, min. 25.
[58] 'AGP', *This Panel Business*, p.204.
[59] *BMJ* 24 August 1935, Supplement, p.109.
[60] *Ibid,* 29 May 1937, Supplement p.330.

account which the IAC described as 'as astonishing as it was grotesque.'[61] For once the approved societies' representatives were less critical of the panel GPs, their representative, Mr Stanley Duff, stating that there was 'no general dissatisfaction with the service' on their part and that 'the service deserved more commendation than was occasionally awarded to it in ill-informed quarters.'[62]

Refuting with detailed economic arguments the IAC's claim for a capitation fee of 12s 6d, the Ministry argued that only 8s would be appropriate. The IAC put forward what they felt was a strong case but once again their evidence failed to impress, largely because of faults in its methodology such as the obvious fact that its sample practices were self-selected. The Court consequently awarded them 9s per patient.[63] Predictably, the profession's initial response was one of anger and disappointment but there was this time also a sense of resignation and a greater determination to ensure the evidence presented in future was truly incontrovertible. The IAC negotiators noted that the Court had cited the statistician Bradford Hill when impugning the validity of their evidence. The IAC therefore enlisted Bradford Hill's assistance in improving the quality of their data.[64] This resulted in the institution of an entirely new and more robust form of evidence-gathering and in 1938 the IAC was pleased to report that the evidence collected using these now impeccable methods, from 500 randomly selected practices, 'had placed beyond doubt the fact that the figures placed before the Court…were substantially accurate'.[65] The IAC was insistent that their case be reconsidered, but the outbreak of war in

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[61] *BMA Archive*, minutes of IAC Remuneration Subcommittee meeting on 3 November 1938 , Doc 10. p.4, point 5.
[62] *BMJ* 5 June 1937, Supplement p.356.
[63] *Ibid,* 12 June 1937, Supplement, p.369.
[64] *BMA Archive*, minutes of IAC meeting on 20 January 1938 , Doc. 29.
[65] *Ibid,* minutes of IAC Remuneration Subcommittee meeting on 3 November 1938, Doc. 10, pp.3-4

1939 brought a temporary halt to such considerations and it was not until 1946 that the Spens report offered some vindication of their claims.[66]

The panel GPs' relationship with the state was further complicated by the growth in power and responsibility of the Regional Medical Service. Initially, it will be remembered, the panel GPs welcomed the establishment of a medical referee service to offer advice and second opinions on disputed certification cases and to work with panel committees in the problematic area of overprescribing. The GPs did not initially object when RMOs were also given powers to inspect medical records but opinions changed when the limitations of these records, and the GPs' lukewarm commitment to record-keeping in general which these investigations exposed, led to punitive withholdings.[67] When GPs began to be fined also for overprescribing and lax certification, RMO inspection visits came to be resented and eventually feared, such that GPs asked for and were granted the right to have a panel representative present during such visits.[68] From working constructively with RMOs many panel committees were now jealous and resentful of the latter's widening remit, especially when it was made clear that the RMOs would not be accountable to Insurance Committees but directly to Ministry officials. A letter to the *BMJ* in 1923 attacked these 'government limpets' and the needless bureaucracy that 'keeps him in power with his salary.'[69] An editorial in *Medical World* in 1926 complained that RMOs were 'almost a service per se, a department within a department, an *imperium in imperio*.'[70] Many GPs objected to what they saw as arbitrary judgements based on putative norms.[71] In the

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[66] *Report of the Interdepartmental Committee on the Remuneration of General Practitioners 1945-46* Cmd. 6810, HMSO London.

[67] For an example of the lackadaisical approach to these records and preparation for the RMO's visit by some GPs see Geoffrey Barber, *Country Doctor* (2nd edn. Woodbridge, 1975) p.46.

[68] *North Staffordshire LMPC Archive*, minutes of the LMPC meeting on 5 April 1934.

[69] *BMJ* 10 March 1923, G.B. Sleigh ' Administrative Expenses' , Supplement p.82

[70] *Medical World* 17 December 1926, 'Health Insurance in 1925', p.317. This was in keeping with public fears voiced by the Anti-Waste league and others about the growth of bureaucracy, which was seen as one of 'the most pernicious evils of the modern world.' Andrew McDonald, 'The Geddes Committee and the Formulation of Public Expenditure Policy 1921-1922', *Historical Journal,* 32 (1989) p.647.

[71] 'The exigencies of medical practice and the daily life of the industrial nation are of necessity unknown to the civil servant who sits in an office and studies disease by returns, forms and written evidence', *Medical World* 24 December 1926 ,G. Rome Hall 'Civil Service Control', pp.348-349.

Walsall GP Frank Layton's novel, *The Little Doctor*, his hero Steel says 'The panel doctor is in danger of being tripped up at any moment. If he gives too much Cod liver oil he's fined for extravagance; if he gives too little he's fined for neglect.'[72] Steel vents his spleen at RMOs whom he disparages as 'ex GPs who have got sick of practice and hanker after a pension' and who 'have the nerve to pose as superior to us who have stuck to the firing line.'[73]

For the columnists of *Medical World,* who showed their displeasure at the disciplinary procedures used against panel GPs by describing them, habitually, as 'courts martial', the absence of judicial appeal against ministerial sanctions added insult to injury.[74] They also railed against and the stereotypical 'regulation-monger of officialdom' whose actions threatened to 'ruin' NHI.[75] This view is echoed by, Dennison, another of Layton's characters, who complains that NHI 'has been ruined since the Ministry was established. When once a Ministry is given power to issue what it calls Regulations it becomes capable of spoiling anything and sometimes does.'[76] However, the Ministry's efforts to enforce regulations were not always successful.[77] In a number of cases in which they sought to make an example of GPs alleged to be 'in breach' of their contractual obligations the profession quickly closed ranks, objecting that the Ministry's actions impinged upon the principle of professional autonomy.[78] 'Red tape' was something to which most GPs at this time professed an aversion, and *Medical World*

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[72] Frank G. Layton *The Little Doctor* (Edinburgh, 1933) p.109. This view was based on Layton's personal experience. In a letter to the *BMJ* he described how his opinion in one case was overruled by an RMO who admitted he had been out of practice since 1914! *BMJ* 8 April 1933 'Incapable' Supplement, p.131.For a further account of a RMO visit in the same part of the country in 1928 see Maylett-Smith, *A GP's Progress to the Black Country* pp.140-142. See also Barber, *Country Doctor* p. 46.

[73] Layton, *The Little Doctor* p.191

[74] See for example *Medical World* 21 October 1927, 'As we see it' which decries ' a tendency to subordinate professional opinion to the views of officials.' pp.121-122 and 18 December 1931, 'Court martial procedure' p.35.

[75] *Medical World*, 1 October 1926,'Pharos','Improving the Medical Service' p.36.

[76] Layton, *The Little Doctor,* pp.110-111.

[77] *The Times*, 'Health Ministry Challenged', 5 April 1928, p.17.

[78] Examples included a homeopathic GP, Dr Harvey, who in 1925 was accused of negligence after the death of a patient and was strongly defended by the MPU (Frank Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care 1911-1968* (London, 1979) pp.165-167) and a Welsh GP, Dr McQuillian, fined for lax certification in 1934, who was absolved of blame after independent investigation (Eder, *National Health Insurance and the Medical Profession*, pp. 301-304).

complained that it greatly added to GPs' workload.[79] However the IAC saw regulations as a necessary trade-off for the preservation of professional freedom, as the chairman of the IAC, Guy Dain, explained in the Foreword to the 1929 edition of the panel doctors' handbook, *Insurance Medical Practice:*

> It must to many have seemed amazing that so everyday a matter as the doctoring of a person (sic) could have produced or required such a mass of regulations and terms of service…but…the need for so complicated a system is brought about…when the service rendered by the doctor to the patient is paid for by a third party…and by the insistence of the medical profession on the right of every registered medical practitioner to go on to the panel if he wish, and on the right to free choice of doctor by both doctor and patient.[80]

But were the rewards of panel practice really sufficient to compensate GPs for such annoyances?

GPs' economic and social status and the quality of panel practice during the interwar period

Reflecting on GPs' economic and social situation in the 1930s, Rosemary Stevens states that while most GPs were not 'well to do', they were 'comfortably situated' with an average net income in 1936-1938 of about £1,000 a year.[81] Supporting Stevens' view, Anne Digby and Nick Bosanquet maintain that during the interwar period the medical profession enjoyed a substantial improvement in both absolute and relative incomes.[82] The perception of improved financial status led, they state, to an increase in public esteem.[83] Thus, it was stated in the *BMJ*

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[79] In *Medical World* 28 April 1933 an editorial complains of 'the numerous reports called for by Regional M.Os at short notice, entailing special consultations or visits' which 'demand further time and labour.' p.177.

[80] R.W. Harris and L.S. Sack, *Medical Insurance Practice*, (3rd edn. London , 1929). Foreword by H.G. Dain.

[81] Rosemary Stevens , *Medical Practice in Modern England: the Impact of Specialization and State Medicine* (New Haven, 1966) p. 57.

[82] Anne Digby and Nick Bosanquet, 'Doctors and Patients in an Era of National Health Insurance and Private Practice 1913-1938', *Economic History Review*, vol. 41 1 (1988) p.77.

[83] Stevens, *Medical Practice in Modern England,* p.57. She states that accordingly GPs and consultants grew closer in social position during this period.

in 1937 that 'Medicine gives to those who follow it an honourable position…the well-educated doctor stands high among his neighbours.'[84] Parry and Parry assumed it was the greater security and improved incomes from NHI that led to a contemporary feeling that 'a better class of men was attracted to general practice.'[85] Some medical Deans were apparently concerned that many new entrants were motivated by the prospect of an assured income rather than a 'call' to become a doctor [86] These new entrants were said to be 'staunchly middle class' with 70% in 1938-39 being self-financing.[87] All of this might suggest that by the late 1930s popular acceptance of the profession's demands for adequate reward had at last been achieved. But such views should be treated with caution. Charles Webster says 'the burgeoning of medical incomes should not be exaggerated', pointing out that 42% of net incomes were below £1,000 p.a. which in itself represented, in the words of Ross McKibbin, 'a good but not outstanding professional income' and the figure for urban GPs was 55%.[88] The relative lack of prosperity experienced by a significant proportion of GPs helps explain the remarks of the BMA president Colin Lindsay who said in 1938 'There is a tendency for this branch of the profession to sink lower and lower in the estimation of the public and of the student body from which the profession itself is recruited.'[89]. Whereas Digby and Bosanquet maintain that GPs in the 1930s enjoyed 'a handsome income' and an ample measure of respectability the GPs' leaders continued to argue that the panel GPs' financial rewards and public respect were insufficient. How can these viewpoints be reconciled?

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[84] *BMJ* ,'The Profession of Medicine', 4 September 1937, p 445.

[85] Noel and Jose Parry, *The Rise of the Medical Profession* (London, 1976) p.198.

[86] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance' p.80.

[87] Stevens, *Medical Practice in Modern England,* p.57. However as early as 1914 Alfred Salter complained that the profession 'had been recruited almost entirely from the upper middle classes' which he attributed to the cost of medical education. Brockway, *Bermondsey Story* p.51.

[88] Charles Webster, 'Doctors, Public Service and Profit' *Transactions of the Royal Historical Society*, vol. 40 (1990) p.200 Ross McKibbin, 'Politics and the Medical Hero: AJ Cronin's 'The Citadel', *English Historical Review*, 123 (502) (2008) p.663.

[89] *BMJ* 23 July 1938. 'The Profession and the Public.' p.163-4. He argued that an increasing role in the management of common mental conditions might serve to arrest this decline.

As proof that GPs incomes had improved, Digby and Bosanquet cite the shortage of applicants for public health posts where salaries rarely exceeded £600 a year, an argument used by the Court of Inquiry into panel GPs' remuneration in 1937.[90] But these salaries were clearly below what the profession estimated them to be worth judging by the fact that the Society of Medical Officers of Health joined with the BMA in urging that no doctor applying for such posts, other than in training, accept a salary below this amount.[91] The report by Political and Economic Planning (PEP) in 1937 noted that British doctors were comparatively well-paid compared with doctors in other countries.[92] But this includes consultants who on average earned double what GPs earned.[93] It is also useful in this context to look at Guy Routh's analysis of how GPs' income compared with the profession doctors might reasonably compare themselves with, that is the Law. In general GPs earned less than members of the legal profession throughout the interwar period, though the differential narrowed somewhat in 1935-37 when GPs' average professional earnings per annum (£1094) momentarily exceeded those of barristers (£1090) but were still much less than solicitors (£1238).[94]

The number of panel patients rose from 13.7 million in 1913 to 19.2 million in 1936. However, the number of panel GPs also rose, from 13,700 in 1920 to 19,060 in 1938.[95] This was not surprising as during this period, in the words of one contemporary, 'the Medical Schools were pouring out young doctors far in excess of available jobs' [96] The vast majority of GPs were involved in panel practice at this time.[97] The average panel list therefore dropped

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[90] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance', p. 86.
[91] Political and Economic Planning, *Report on the British Health Services* (London, 1937) p. 157.
[92] *Ibid,* pp.9-10.
[93] Digby, *The Evolution of British General Practice, 1850-1948* (Oxford, 1999) p.192.
[94] Guy Routh, *Occupation and Pay in Great Britain 1906-1979* (2nd edn. London, 1980) p. 63
[95] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance' pp.74-75
[96] Mabel Rew, 'Looking Back', *Journal of the Medical Women's Federation*, vol.49 (1967) p. 85.
[97] Rosemary Stevens claims it was around 90%. Stevens, *Medical Practice in Modern England* p.53. However Bernard Harris offers a much more cautious estimate of between 2/3 to ¾ of registered GPs. Bernard Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales,1800-1945* (Basingstoke, 2004) p.223. The PEP report on the British Health Services (1937) noted 19,000 panel GPs out of total workforce of 29,000 registered doctors. Allowing for at least 5,000 non-GPs, this suggests more than 75% were 'on the panel'.

from 1,000 in 1920 to 930 in 1930.[98] The percentage of GPs' total income from panel practice consequently declined, from 60% in 1913 to 50% in 1922 and to as little as 33% in 1936-1938.[99] The increase in their average earnings was entirely due to their earnings from private practice.[100] In the interwar period GPs' total average net earnings increased by about a third, boosted by a 79% increase in earnings from private practice.[101] However, the situation may not be as clear cut as these figures or analyses suggest and may disguise a significant disparity between the net incomes of the average and lowest-earning panel doctors. Digby and Bosanquet state that there were substantially two groups of 'losers': rural GPs, and those practicing in industrial and mining districts which were worst hit by the depression.[102] Some 40% of GPs were rural and their expenses, largely due to travelling costs, were higher than for other doctors.[103] Urban doctors, however, suffered higher levels of bad debts owed by poor families, which could be as high as 20% compared with the professional average of 5%.[104] But Digby and Bosanquet fail to mention the real 'losers', namely the GPs' salaried assistants, very few of whom, even when whole time, earned more than £500 per year. It is unclear exactly how many practices during this period employed salaried assistants which was a means by which GP principals were allowed to increase list sizes from 2500 to 4000 patients.[105] In Bradford Hill's sample the figure was 18% of those studied though the PEP report noted that the figure in London was just over 7% .[106] The BMA acknowledged the fact that a number of

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[98] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance' p.75

[99] *Ibid,* p.79 .

[100] This conclusion is supported by a contemporary observer. In answer to the question 'How can one account for the large numbers of apparently prosperous panel doctors?' 'AGP' replies 'The solution lies in private practice.' AGP, *This Panel Business* (London, 1933) p.286

[101] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance' p.79

[102] *Ibid,* p.85.

[103] For a detailed explanation of the increased costs of rural compared with urban panel practice, see *BMJ* 21 April 1923 ,'The Plight of the Country Practitioner' by Dr J.P. Williams-Freeman, Chairman of Hants LMPC, Supplement pp.117-119.

[104] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance' p.85.

[105] A. Bradford Hill, 'The Doctor's Day and Pay', *Journal of Royal Statistical Society*, Series A (Gen) vol.114, 1 (1951) p.23.

[106] Bradford Hill, 'The Doctor's Day and Pay', p.23, Table 14. PEP, *The British Health Services* p.143.

GP principals exploited or 'sweated' their assistants. In 1924 the IAC's propaganda subcommittee under the heading 'Question of giving more help to assistants' noted a stinging rebuke from an exploited assistant who had resigned from the BMA stating, 'The Association spends all its energies on those medical men who have passed the troublesome stage of getting a practice…As regards an assistant who in perhaps 50% of cases does as much work if not more than the principal, very little is done.'[107] In 1925 the BMA's representative meeting passed a resolution supporting actions recommended by the Medico Political Committee aimed at preventing exploitation of assistants by specifying minimum salaries. These ranged from as little as £120 to £400 a year. The resolution was prefaced, however, by the substantial caveat that this 'opinion' was issued as 'advice' only and could not be enforced as policy.[108] Attempts to discourage the *BMJ* from advertising assistantships offering less than the recommended salary levels therefore quickly foundered.[109] The Medico Political Committee also found it impossible to prevent female doctors who worked as assistants or locums being paid at lower rates than their male counterparts. Even though the BMA had adopted a policy of equal pay as early as 1907, letters to the *BMJ* in 1924 suggested that female doctors received only ⅓ of the BMA's recommended rates.[110] The Medico Political Committee undertook an investigation into locum emoluments in June 1934 at the prompting of the Medical Women's Federation. Correspondence with the principal locum bureaux established that in only 19% of cases did women doctors earn close to the average rates paid to men (about £8, 8s a week). The bureaux insisted that they always sought to get the highest possible rates for all their clients but that ultimately it was 'a matter between buyer and seller' and women doctors often accepted

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[107] *Wellcome Collection* BMA Archive, SA/BMA/C 522. Box 139. Minutes of Propaganda Committee 11 March 1924. He said he would therefore consider re-joining if and when he became a principal himself.

[108] *Ibid,* Extract from minutes of BMA's ARM 1925 , min 125 point f).

[109] *Ibid,* Extract from minutes of Medico-Political Committee meeting of 16 March 1927.

[110] *BMJ* 18 October 1924 p.743. For a comprehensive analysis of the challenges facing women GPs in this period see Digby, *The Evolution of British General Practice*, ch. 7.

whatever remuneration they were offered.[111] The Spens Report in 1946 found that all but a very small percentage of women GPs earned well below the putative average of £1,000 p.a. gross.[112]

An altogether more important factor not taken account of by Digby and Bosanquet is the high level of debt which many GPs found themselves in. The returns mentioned earlier show income net of allowable expenses but these did not include repayments of loans used to pay for education (amounting to £1,500 on average according to PEP) or the cost of buying a practice (which was equivalent to 1½ years income, that is £2,500 to £3,000).[113] They may also not have taken into account the fact that many young GPs at this time were effectively sharing their practice income with third parties, either retired GPs from whom they were in the process of purchasing the practice in instalments, or others who had seen an opportunity to make a financial killing by buying a practice and employing an impecunious GP to work it for them on the promise of a later opportunity to purchase it outright. There is conflicting evidence about the extent of this problem. Honigsbaum seems in no doubt that it was widespread, stating that in the 1930s around a third of panel practices were in the hands of 'insurance companies or moneylenders.'[114] This is consistent with evidence from Lancashire. In November 1934 IAC member S.A. Winstanley, chairman of the Lancashire LMPC, submitted a memorandum to the IAC regarding the mortgaging of practices, stating that there were 102 cases in Lancashire in which the panel fees had been assigned to a third party.[115] One practice he knew of had changed hands four times in seven years, the fees being assigned to the same third party on each occasion. Doctors who were heavily mortgaged and in financial distress were, however, often

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[111] *Wellcome Collection* BMA Archive, SA/BMA/C 522. Box 139. Extract from Minutes of Medico-Political Committee meeting of 3 January 1934, memorandum on 'Emoluments of Women Practitioners'.

[112] *Report of the Inter-Departmental Committee on the Remuneration of General Practitioners 1945-1946,* Cmd. 6810 (the Spens Report) 1946 reproduced in *BMJ* 18 May 1946, Supplement pp.149-150, tables 8 and 9.

[113] PEP, *The British Health Services*, p.9.

[114] Honigsbaum, *The Division in British Medicine* p. 275.

[115] *BMA Archive,* agenda of IAC meeting on 13 November 1934, Doc. 6. p. 1.

reticent or too embarrassed to disclose details, but the Lancashire Insurance Committee was sufficiently concerned to wonder if a change should be made in the regulations to prevent this happening.[116] Initially the IAC contended that a change in regulations was not called for 'in as much as the abuse complained of arises upon very rare occasions.'[117] However, the Annual Conference of LMPCs in 1935 disagreed, stating that the conference 'viewed with alarm the rapid increase…in the traffic of insurance practices by bodies of lay persons.'[118] They consequently instructed the IAC to devise a scheme by which practitioners 'with limited means' could obtain loans with which to acquire practices 'on reasonable terms.'[119] The IAC's chairman, Guy Dain, certainly recognized the problem, stating, when interviewed by American observers, that speculative buying and selling of practices had resulted in young doctors being exploited by 'commercially minded men', and resulted in what he described as 'share cropping'.[120] *Medical World* believed GPs were being exploited more by financial institutions and money-lenders than fellow GPs and although there is little hard evidence to back this claim it is consistent with Digby's contention that entrepreneurialism was not widespread among GPs.[121]

Another factor which is often overlooked when looking at the comparative affluence of GPs in the 1930s is the maldistribution of panel practitioners which, as Martin Powell demonstrates, was often a reflection of local levels of general prosperity.[122] There were generally fewer panel doctors serving the impoverished areas of London and other major cities

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[116] *Ibid,* p.2.
[117] *BMA Archive,* minutes of IAC meeting on 13 November 1934, min. 85.
[118] *Ibid,* Report of the Annual Conference of Representatives of LMPCs 1935, min. 19.
[119] *Ibid,* minutes of IAC meeting on 23 April 1936, Appointment of Subcommittee on Mortgages of Medical Practices. The work of this subcommittee led eventually to the establishment of the General Practice Finance Corporation (GPFC). When the NHS brought an end to the purchasing of practices, the GPFC was one of the main sources of finance for the building of GP-owned surgery premises.
[120] Douglass W. Orr and Jean Walker Orr, *Health Insurance with Medical Care: the British Experience* (New York, 1938) p. 147. It was otherwise referred to as 'farming out'. 'AGP', *This Panel Business*, p.191.
[121] Digby, *The Evolution of British General practice*- viz: ' little organised interest in business methods was evinced by the profession.' p.125. 'GPs continued to operate in a cottage industry environment.' p.153.
[122] Martin Powell, 'Coasts and Coalfields: The Geographical Distribution of Doctors in England and Wales in the 1930s'. *Social History of Medicine*, 18 (2) 2005 pp. 245-263.

than in wealthier suburbs and there were also fewer doctors serving coalfield communities than spas and seaside resorts favoured by middleclass retirees.[123] Charles Webster notes that 'In seaside towns , where GPs were found in the greatest density, two-thirds of the patients would commonly be private.'[124] Historians who have studied the fortunes of the middle classes in this period such as W.D. Rubinstein and Richard Trainor have nevertheless shown that the provincial middle class was no longer as wealthy, numerous or as influential as they were before the First World War and that London and the home counties sustained a much greater proportion of white collar workers who would have been obliged to pay for medical treatment then could be found elsewhere in the country.[125] While it is too simplistic to talk of a 'north-south divide', the decline of the country's industrial base led to greater levels of unemployment during this period among both the labouring classes and white collar workers outside the southeast of England, as was noted by contemporary commentators such as J.B. Priestley.[126] This meant that for provincial GPs the opportunity to garner fees from middle-class patients was accordingly diminished.[127] Thus, from evidence given to the Spens inquiry, Charles Webster notes 'Dr Pierce in the mining valleys of South Wales could not anticipate any income from private practice.'[128]

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[123] *Ibid,* pp.255-256. Powell notes a six-fold variation between highest and lowest numbers of doctors in County Boroughs but as much as a 24 fold variation between wealthiest and poorest areas of London.

[124] Charles Webster, 'General Practice under the Panel: the Last Phase', *Bulletin of the Social History of Medicine,* 32 (1983) p.21.

[125] W.D. Rubinstein, 'Britain's Elites in the Interwar Period 1918-1939' and Richard Trainor 'Neither Metropolitan nor Provincial: The Interwar Middle Class' *passim* in Alan Kidd and David Nichols (eds) *The Making of the British Middle Class? Studies of Regional and Cultural Diversity Since the Eighteenth Century* (Stroud, 1998).

[126] Trainor 'Neither Metropolitan nor Provincial.' pp. 206-207. J.B. Priestly *English Journey: being a rambling but truthful account of what one man saw and heard and felt during a journey through England during the autumn of the year 1933* (London, 1934) *passim.* The picture is however nuanced. Trainor sees a breaking down of barriers between London and other parts of the country leading to the formation of a more 'national' middle class. 'Neither Metropolitan nor Provincial.' p.204

[127] 'The situation of the lower middle class remained perilous…in the interwar years ordinary doctors' bills threatened family solvency' Richard Trainor, 'The Middle Class' in Martin Daunton (ed) *Cambridge Urban History of Britain vol. 3 1840-1950* (Cambridge, 2001) p.687.

[128] Webster, 'General Practice under the Panel', p.21.

For GPs dependent more on panel practice than on private fees who may have been having to share their income with others, the government's attempts to reduce panel fees in the late 1920s and again in the 1930s must have seemed injurious and unfair but even more so when considering just how hard they worked. As the IAC had said in 1923, the work of the panel practitioner was 'strenuous and unremitting.'[129] Webster agrees, asserting that 'NHI income was hard-earned.'[130] Twelve to fourteen hour working days were taken as normal according to one Welsh GP who reportedly undertook up to 50 domiciliary visits a day in winter months.[131] While income from panel work declined, the demand for GP services from panel patients continued to rise. In 1912 the Plender Report had estimated the average number of patient attendances per annum at 1.25. In 1924 it was 3.5 according to Ministry estimates and 3.8 according to the BMA. In 1931 the Ministry's estimate was 3.68 but the BMA's much higher estimate of 5.13 was closer to Bradford Hill's later and more authoritative estimate of 5.02.[132] Thus, while in the late 1930s panel practice made up only 30-40 % of GPs' income on average it actually took up more than 60% of the GP's time.[133] But, unlike solicitors, the professional group which GPs might reasonably expect to compare themselves to, GPs did not enjoy the luxury of a nine to five existence and lived in perpetual fear of 'the night bell'.[134] It was not uncommon for a GP to spend a whole night attending a difficult labour and then be obliged to attend a full surgery of panel patients the following morning without the benefit of sleep.[135] Being on call 24 hours a day 365 days a year meant that general practice, as Digby acknowledges, 'was not for the fainthearted or lazy'.[136] Mortality figures among GPs were

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[129] *BMA Archive,* minutes of IAC meeting on 7 August 1923 ,'Memorandum on Remuneration'
[130] Webster, 'Doctors, Public Service and Profit' p.201.
[131] Webster, 'General Practice under the Panel', p.22.
[132] Digby and Bosanquet, 'Doctors and Patients in an Era of National Health Insurance' pp. 86-87.
[133] *Ibid,* p.79; *Report of the Interdepartmental Committee 1945-46* (The Spens Report) p. 11.
[134] In Brackenbury's summing up of the IAC's arguments to the Court of Inquiry into GPs' remuneration he said, 'one only said things when the telephone rang but one was listening for the telephone bell all the time.' This he felt justified the description of the panel GPs' obligations as 'oppressive' if not 'menacing'. *BMJ*, 12 January 1924,'Insurance: the Court of Inquiry', Supplement, p.49.
[135] For an illustration of this occurrence see Layton, *The Old Doctor* pp.18-21.
[136] Digby, *The Evolution of British General Practice*, p.149 based on the Spens report .

correspondingly much higher than in other professional groups.[137] For the kind of doctor Layton portrayed in his novels it was hard to discern any of the improvement in the doctors' wellbeing which Digby and Bosanquet imply and even those whose income meant they could afford the trappings of a comfortable middle-class existence seldom had the leisure time necessary to enjoy it.[138] In 1933 in a memorandum on the increased workload of panel GPs, the London Panel Committee stated 'Amongst insured persons, social and cultural improvement has been accompanied by reduction in hours of work, improved conditions of life and a substantial rise in the economic value of wages. There has on the other hand been little improvement in the conditions or standard of life for the insurance practitioner.'[139] In this light the efforts made by the profession's representatives to challenge the government's persistent refusal to increase panel fees do not seem unreasonable.

Some of those contemporaries most apt to criticise the motives of the GPs' leadership appear to have been influenced by a belief that GPs offered a better service to their fee-paying clientele and that panel patients therefore got a raw deal. This was a view regularly vented in certain sections of the press but the evidence for this is scanty at best.[140] The Royal Commission took copious evidence from individuals supportive of and hostile to the GPs' cause including Ministry officials before concluding that there was no evidence to support two-tierism in the quality of care.[141] Compelling evidence to counter the claims of two-tierism can be found in

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[137] A footnote to the Spens Report notes that 'In 1931 the mortality among doctors between the ages of 20 and 65 was 54% above that of higher civil servants and 26% above that of professional engineers.' *BMJ* 18 May 1946,'The Spens Report' Supplement p.143.

[138] 'A Scottish survey revealed that few doctors took more than half-day breaks and many had virtually no leisure.' Webster, 'General Practice under the Panel', p. 22. It is only when he is recovering from a serious illness that Layton's hero, Steele, feels justified in taking his first holiday in 10 years. *The Little Doctor* p.301.

[139] *BMA Archive*, Minutes of a meeting of the IAC's Remuneration Subcommittee on 9 February 1933. 'Memorandum by London Panel Committee's specially appointed section' Doc. 55 p.3 point d.

[140] See the comments of government Minister Sir Kingsley Wood in *The Times* 21 March 1923 'Insurance Panel System-Conference needed' p.11. The principal authority Digby and Bosanquet quote in their article is the highly partisan Sir Arthur Robinson. 'Doctors and Patients in an Era of National Health Insurance' p.90.

[141] *Report of Royal Commission on National Health Insurance*, (1926) Cmd. 2596 p.12, para 20. The BMA estimated average visits to private patients numbered 3.96 p.a. compared to 3.77 for those on the panel. However, it should be remembered that at this time most women and children were classified as private patients, and this could legitimately account for the proportionately larger share of attendances.

the contemporary investigation by the American Douglass Orr and his wife Jean, who conducted interviews not just of doctors but of patients, both in person and by postal questionnaires to which they had around 150 responses.[142] They quote Liverpool GP Dr Gray 'who certainly does not distinguish between private and panel patients.' 'How could he ?' he asked, 'when the wives or parents of one's panel patients come as private patients?'[143] Based on their research, the Orrs conclude that accusations of two-tierism 'were largely hearsay based on others' experience' and those interviewed 'found no difference in care'.[144] They found that, generally, panel patients were appreciative of the quality of care they received, particularly those with chronic illnesses for whom care would otherwise have been unaffordable. However, many felt the doctors were unduly restricted in the services they could give and many desired a fuller medical service.[145] Tellingly, over 50% of those responding to their questionnaire were members of a hospital contributory scheme.[146] It is possible that in their positive portrayal of NHI the Orrs were motivated in part by a desire to influence the debates taking place in the U.S. at that time, where the Roosevelt administration was actively contemplating an insurance-base health service, despite fierce opposition from a variety of vested interests, including the American Medical Association.[147] However, it is difficult to fault the meticulousness with which the Orrs gathered evidence to support their conclusions, from a wide variety of sources and viewpoints.

Alfred Salter informed the Orrs that 'the quality of medical practice is distinctly better now the doctors had the security that comes from a regular and a fairly adequate income.'[148] However, a number of interviewees admitted that there was a minority of doctors who were

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[142] Orr and Orr, *Health Insurance with Medical Care,* pp. 40-44.
[143] *Ibid,* p.28
[144] *Ibid,* pp. 39-40.
[145] *Ibid,* p.42.
[146] *Ibid,* p.48.
[147] See Paul Starr, *The Social Transformation of American Medicine: the Rise of a Sovereign Profession and the Making of a Vast Industry* (New York,1982) pp.266-279.
[148] Orr and Orr, *Health Insurance with Medical Care,* p.174.

not up to the job and probably responsible for the bad press they sometimes received. Harry

Roberts said that 'out of 18,000 panel doctors there might be 500 slackers but it is they who

make 'news' not the vast majority who give good service.'[149] Likewise, a 'Liverpool consultant

of conservative views', Mr T.P. McMurray, stated that 'Out of 1,000 doctors anywhere there

will be 50 slackers but most of the doctors under the panel system were doing a good job.'[150]

But while excessive prescribing, inappropriate charging of fees, or failure to offer treatment

required might be punished, medical service committees found it difficult to agree on matters

of competence or negligence. As the hero of *The Little Doctor* says to one of his colleagues:

'When have you heard of anyone being called up for gross incompetence? It isn't done. You

know that all right. And you know who are the incompetent, the slackers in this district as well

as I do.'[151] LMCs found it difficult, however, to censure doctors of whom other constituents

complained for fear of being sued and, being without funds, they were never fully able, in the

absence of state indemnity, to realise their potential as professional 'courts of honour.'[152] Many

of the doctors complained about by their peers were actually liked by their patients but, having

worked so long in professional isolation, were now hopelessly out of touch with developments

in modern medicine. In his 1937 novel *The Citadel,* A.J. Cronin's hero, Manson, describes one

such GP, Urquhart, as a 'good old type' of family doctor ' – shrewd, painstaking, experienced,

a doctor sentimentalised by his patients and the public at large, who had not opened a medical

book in over twenty years and was almost dangerously out of date.'[153] Some of the doctors not

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[149] *Ibid,* p.176.

[150] *Ibid,* pp.198-199. These views echo those expressed a generation earlier by Bernard Shaw: 'The medical profession, like the other professions, consists of a small percentage of highly gifted persons at one end, and a small percentage of altogether disastrous duffers at the other.' George Bernard Shaw, Preface to *The Doctor's Dilemma* (London, 1906) Penguin edn, 1946, p.74.

[151] Layton, *The Little Doctor,* p.111.

[152] *BMA Archive* Minutes of the IAC meeting of 21 June 1934, min 234, discussion of new model rules drafted by BMA's solicitor, W.E. Hempson, to help LMPCs avoid risk of legal action when applying powers under Reg 39 of the Medical Benefit Regulations. 'AGP' claimed that efforts by the London Insurance Committee to improve services were nullified by the Panel Committee 'that is the doctors themselves, who are prepared to back up their faulty and incompetent colleagues to an unjustified extent.' *This Panel Business*, p.258.

[153] A.J. Cronin, *The Citadel*, (London, 1937) part 2, ch.8.

'up to the mark' and suspected of not giving good service, however, were elderly or infirm GPs who were obliged to continue working due to a lack of alternative means of supporting themselves or their families.[154] Page, the GP for whom Cronin's hero, Manson, goes to work as an assistant in South Wales was one such doctor.[155] Recognizing this problem, Kent LMPC encouraged the adoption of a scheme launched in Dartford in 1920 whereby a payment equivalent to one year's income was paid to panel GPs forced to retire through age or infirmity, or to their dependants in the event of death in service.[156] Attempts to obtain the endorsement of conference for a wider application of the scheme failed but in 1931 a debate took place at the LMPCs conference about the merits of a proper pension scheme for panel GPs.[157] The IAC agreed to set up a subcommittee to consider the matter, taking account of the successful local practitioners' superannuation scheme instituted by the West Riding of Yorkshire LMPC. [158] In considering the need for such a scheme the pension subcommittee noted the risk of the panel service being brought into disrepute as a consequence of aged and infirm practitioners continuing to work and were anxious to prevent their compulsory retirement where complaints were made against them.[159] A scheme was accordingly established in 1932 in conjunction with Legal and General, the Medical Sickness Society and Yorkshire Insurance Company and was approved by Conference in October that year and arrangements made with the Ministry to permit deduction of contributions from GPs' remuneration by Insurance Committees.[160] An

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[154] Webster, 'General Practice under the Panel' p.22. In 1946 some 1200 practising GPs were over 71 years old.
[155] Cronin, *The Citadel,* part 1, ch. 1 and 2.
[156] *Kent LMC Archive*, minutes of Kent County LMPC meetings on 8 September 1920 and 21 October 1920.The London Panel Committee considered a similar scheme in October 1919 to be enacted through the medium of 'A Society of Insurance Practitioners' offering pensions, financial hardship payments and loans for purchase of practices , houses etc. They recommended it to for consideration by the IAC. *BMA Archive* , minutes of a meeting of the London Panel Committee, 28 October 1919, min.4 (6).
[157] *BMA Archive*, minutes of IAC meeting on 19 November 1931. Report of Annual LMPCs Conference M24.
[158] *Ibid,* Doc 19.The IAC Pensions subcommittee noted that the scheme had also been adopted by LMPCs in Doncaster, Rotherham and Wakefield.
[159] *Wellcome Collection,* BMA archive, SA/BMA/ H. 10 Box 258.Extract from minutes of Pensions subcommittee meeting of 3 March 1932 referring to the provisions of Regulation 4 (4) of part 1, schedule 1of the Medical Benefit Regulations 1930.
[160] *BMA Archive,* minutes of IAC Pensions Subcommittee 30 November 1932 noted adoption by LMPCs Annual Conference on 20 October 1932 and correspondence between BMA Medical Secretary George Anderson and Ministry, Doc. 30.

appeal was also made to the Defence Trust to support existing practitioners needing to retire in the interests of avoiding damage to the reputation of the service. The first case referred to it , in March 1933, concerned an 81 year old practitioner from Leeds with dependants. It was initially denied because there had been no complaints about this doctor but eventually awarded when it was ruled that, given his situation, complaints about him 'were likely to arise.'[161]

Frank Honigsbaum contends that as GPs were gradually excluded from hospital work many failed to keep up to date with advances in medical science and that panel practice thereby stagnated.[162] This negative view of general practice was confirmed in the post-war study by Collings.[163] When it began, NHI was hailed as one of the most ambitious forms of state-coordinated medical care in Europe. But, with the failure to extend the scope of coverage and medical benefits in the 1920s it was soon eclipsed by more progressive European schemes.[164] Fears of increasing bureaucratization notwithstanding, British GPs consoled themselves with the belief that the machinery of NHI gave them more influence over administration and freedom from lay interference than their European counterparts. This belief was bolstered by published reports of meetings of the *Association Professionelle Internationale des Médecins* in which insurance doctors from across Europe complained of concerted attempts to diminish their pay and status.[165] A contemporary American investigation into health insurance found 'the Germans are the most loud in their complaints and the British are apparently the most satisfied.'[166] The accord brokered in 1914 between the German medical profession and the

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[161] *Wellcome Collection* BMA archive, SA/BMA/ H. 10 Box 258.Extract from minutes of Pensions subcommittee meeting of 16 March 1933.

[162] Honigsbaum, *The Division in British Medicine* pp.137-150 and 175-179. This general conclusion is disputed by John Eversley who points out that the number of GPs holding part-time hospital appointments increased under the NHS and reached 40% by 1977. John Eversley, *Continuity in a Changing World: 100 years of GP Representative Bodies* (BMA Report, published 2012) p.10.

[163] J. S. Collings 'General Practice in England Today: a Reconnaissance', *Lancet* , 25 March 1950 *passim*.

[164] The Scandinavian countries for instance 'set an example to the world in efficiency and amplitude of provision.' Sir Arthur Newsholme, *Medicine and the State* (London, 1932) p. 76.

[165] 'AGP' *This Panel Business*, ch. III, p.51.

[166] *Ibid,*, ch. VI, p.99, quote attributed to D.M. Simon and Nathan Sinai in a book called *The Way of Health Insurance* (provenance unknown).

government had broken down as a consequence of the post-war depression and in 1923 insurance doctors undertook a three month strike. However, measures taken by the German government in 1931 actively favoured the profession at the insurance funds' expense and placed the mechanism for resolving their disputes 'totally in the physicians' hands.'[167] Once they had purged the profession of Jewish doctors, moreover, the Nazis strengthened the role of the profession, due in part to their ideological obsession with health and fitness. In France meanwhile, the profession secured a major victory when an Act of 1928 accorded state recognition to the principles of the doctors' 'Medical Charter', guaranteeing free choice of doctor, freedom to prescribe, and direct payment of doctor by patient according to an agreed tariff.[168] This prompted *Medical World* to state categorically that French doctors 'enjoy a superior social and legal status to ours.'[169] Elsewhere in Europe, however, the situation of doctors was said to be less favourable and in many countries specialists were beginning to outnumber GPs.[170] British GPs noted with alarm the declining numbers of GPs in Europe and the U.S. where hospitals and clinics were becoming the predominant providers of healthcare and where the detrimental effects of over-hospitalization were beginning to be felt.[171] To that extent they would have agreed with R.W. Harris's comments noted earlier and this increased their leaders' determination to defend the British system and, as we shall see in the next chapter, to extol the, as yet unappreciated, benefits of the continuity of care which the British family doctor provided.

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[167] Jan Blanpain, *National Health Insurance and Health Resources: The European Experience* (Harvard, 1978) p.29.

[168] *Ibid*, p.101.

[169] *Medical World*, 27 November 1931,'National Health Insurance' p.289.

[170] 'AGP' *This Panel Business* p.57 in which Alfred Cox is quoted as saying 'Too strong an emphasis cannot be placed on the gravity of the position of the profession in many countries.'

[171] Newsholme, *Medicine and the State*, pp. 81-86. See also comments of H.G. Dain in discussions with Ministry. *BMA Archive*, minutes of IAC meeting on 8 January 1931, Doc 18, Report of Deputation to Ministry of Health on 27 November 1930.

Chapter Six

Conclusion

GPs were given an important role in administering medical benefits under NHI. However, in the late 1920s and 1930s, the rising costs of the scheme forced the Ministry of Health to look critically and in more depth at how individual doctors exercised their responsibilities. In 1930 the Ministry found it necessary to introduce new regulations boosting the role of RMOs, bypassing to some degree the LMPCs, whose judgments were felt to be suspect when it came to punishing those deemed guilty of failing to comply with professional norms. While not questioning the panel GPs' ability to do their best for their patients, the Ministry sought but ultimately failed to find a solution to the rising costs of medical benefit even when the IAC was at its most compliant and supportive of their efforts. The IAC could hardly have been expected to do more in any case when the panel GPs' pay was cut and the government pointedly ignored their request for restitution. Bargained corporatism had its limits and many rank and file GPs, particularly those who relied on panel work as their main source of income, were resentful of their leaders' willingness to accept changes which seemed to bring them little benefit.[172]

By the late 1930s many established GPs were economically secure and had achieved the prosperous middle-class status they had collectively aspired to as a profession since the turn of the century. A significant proportion of GPs were less fortunate, however, finding themselves struggling with debt, beholden financially to other GPs, financial institutions, or money lenders, and completely overburdened with work. The situation of this exploited underclass of GPs was not far removed from that of the 'medical proletariat' Digby had identified in the

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[172] '…the profession was never satisfied that the level for the capitation fee had been fixed correctly or upwardly adjusted sufficiently.' Webster, 'General Practice under the Panel' p.20. The MPU claimed that replies to questionnaires it sent to panel GPs in 1931 suggested that, due to its handling of the cut in remuneration, the IAC had lost the confidence of two thirds of panel GPs. *Medical World* 30 October 1931,'The cut and the Conference' p.197. Dissatisfaction with the IAC's quiescence may have contributed to the MPU's increased membership which reached a peak of 5,857 in 1938 before declining thereafter. Honigsbaum, *The Division in British Medicine* p.169.

1890s.[173] In the 1930s it is safe to say that the majority of GPs remained firmly wedded to independent contractor status, although the MPU was now openly questioning its supposed benefits.[174] However, the symbiotic relationship between private and panel practice on which this 'article of faith' relied had unintended consequences. One effect of the free market in GP services was the obvious maldistribution of GPs which the Ministry and professional leaders were aware of but made no attempt to address in the interwar period. This compounded problems of inequality and resulted in limited choice of doctor in 'under-doctored' areas, a lower quality of service for those most needing it and a lower standard of living for those delivering it.[175] It also provided ammunition for critics of the system. There is little evidence to suggest that panel GPs cared less for their panel patients than for their fee-paying patients but there was no shortage of critics ready to disparage the quality of the service they offered. Often their strongest critics were from the middle class who, while having to pay higher fees for private treatment themselves, were incensed by newspaper allegations that GPs were certificating malingerers who enjoyed benefits partially paid for by tax revenues. The Ministry itself was not above criticising the quality of the panel service when it served a political purpose, as they demonstrated in 1937. Yet, as impartial observers like the Orrs found, the panel service was, in general, widely appreciated by insured patients who only wished their doctors were in a position to deliver more of the same. The doctors they interviewed acknowledged that there was a minority of panel GPs who were underperforming ('slackers') and damaging to the collective reputation. Alfred Cox's successor George Anderson may be guilty of a degree of hyperbole when in 1936 he stated, in response to 'an ill-informed article' by a critic of NHI in the *Chicago Tribune,* that 'The standard of insurance practice is as high

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[173] Digby, *The Evolution of British General practice*, p. 32.

[174] 'The Profession cherished its system of remuneration allowing payment of substantial prizes to the few , if necessary at the cost of penury for a substantial residuum.' Webster, 'General Practice under the Panel' p.23.

[175] This effect continued into the subsequent NHS and formed the basis of what Dr Julian Tudor Hart christened 'The Inverse Care Law'. Julian Tudor Hart, ' The Inverse Care Law' *Lancet*, 27 February 1971, pp.405-412.

as the highest in the profession.'[176] It is probably more accurate to state that, in general, panel doctors gave their patients as good as service as their limited time, resources and skills, and the state of their own health, allowed them to. As will be seen in the next chapter, those who recognised the need for improvements in health services understood that their effectiveness was not wholly dependent on the efforts of the panel GPs, and could not be made in isolation, or sustained, without major changes in national organisation and funding.

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[176] *Chicago Tribune*, Letter from Dr George Anderson 3 November 1936 in reply to article by John S Steele, Quoted in Orr and Orr *Health Insurance with Medical Care,* p.163.

Chapter Seven. GPs and interwar debates about the future of health services in Britain

In 1939, when commenting on the future nature of health services in Britain, the distinguished physician Lord Horder wrote: 'the doctor must remember that he is a citizen as well as a "health man", and potentially the most valuable citizen yet evolved. It behoves him to be public minded, and by this I do not mean politically minded.'[1]

In this chapter I consider the attitude of GPs towards the development of National Health Insurance (NHI) and the extent to which they influenced, even if they did not control, its evolution during the interwar period. This analysis involves a detailed consideration of the various plans put before the profession and the public to improve and eventually replace NHI, during the 1920s and 1930s, that is, principally, the Dawson Report, the Royal Commission on NHI, the BMA's manifesto, *A General Medical Service for the Nation*, and Political and Economic Planning's *Report on the British Health Services*. I consider these sequentially in the context of contemporary debates about health, medical services and their organisation, and the role and aspirations of the country's medical practitioners. In doing this I seek to demonstrate the GPs' continued willingness to embrace the development of NHI medical services, while acknowledging the extent to which their enthusiasm for reform was tempered by fears of state control and the need to maintain their social status and financial security. The principal objective of this chapter, however, is to consider the extent to which the profession's leaders were prepared, as Horder suggested, to lead debates about the shape of publicly subsidised health services, even if it meant subordinating their professional interests to the public good. The GPs' determination to bring about improvements in the NHI, led them, I contend, to acknowledge the need to incorporate the scheme within a more comprehensive and

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[1] Lord Horder, Foreword to S. Mervyn Herbert, *Britain's Health* (Harmondsworth, 1939) p. xiii.

integrated healthcare system catering for all sections of society. It also led them to accept the increasing separation of general practice from specialist care and to embrace a vision of a family doctor service whose chief virtue was continuity of care for the patient. This analysis leads me to question the assertions of historians whom, I argue, have been unjustly critical of the profession's motives and sceptical of the GPs' commitment to the professional social ideal.[2] In endeavouring to explain the moral dilemmas with which the GPs were faced, I emphasise the symbiotic relationship between public and private medicine and the dangers of determinism when looking at how health services were configured or were likely to evolve during this period. I conclude that by the end of the 1930s many panel patients were as likely as private patients to view their panel GP as their family doctor and that this convinced the GPs' leaders and other influential authorities that the family doctor should lie at the heart of any future national health service, however it was organised and funded.

The Dawson Report: the organisation of health services and a collectivist vision of general practice

Discussions about improvements in health services and their organisation had begun as soon as NHI was established, with Addison informing a dinner organised by his supporters in 1914 of his hopes of adding to it a domiciliary nursing service. He also stated that 'It might be of great value…for medical men to work in groups where for certain purposes they could combine at a common centre for mutual help and have access to better means for confirming diagnosis.' This would, be said, 'help to keep men up to date.'[3] In May the same year the newly established London Panel Committee noted proposals made in Lloyd George's budget for 'the establishment of centres for the cooperation of practitioners on the panel.' Fearing that local

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[2] Such as Anne Digby and Brian Abel-Smith. See further discussion below pp. 282-283.
[3] *Medical World* 12 February 1914, 'Complimentary dinner to Dr C Addison' p. 254.

authorities would be put in charge, the committee resolved that panel committees should decide the scope of what these centres would provide, concluding that they should be accessible to all panel doctors, and provide consulting rooms for up to five GPs and accommodation for a trained nurse, X ray operator, clerk, and dispensing chemist, under the joint control of the local insurance and panel committees.[4] The outbreak of the First World War nullified any prospect of implementing such proposals but during the war arguments about future provision of state funded medical services continued, influenced by the progress of efforts by the Local Government Board to establish municipal health clinics offering maternity and child welfare services, and separately, community based clinics for venereal disease sufferers.[5] Many GPs were alarmed at the thought of losing a large part of the maternity work which had been a mainstay of their practice throughout the nineteenth century, although others acknowledged the benefits of dedicated antenatal and postpartum care and were not so hostile to the idea of collaborating with the new breed of qualified midwives.[6] Few GPs opposed the creation of venereal disease clinics, as they made clear at the Conference of LMPCs in 1919, when demonstrating their reluctance to assume responsibility for administering Salvarsan.[7] The profession's representatives fought hard, however, to ensure that as many as possible of the salaried medical officer posts in the new municipal clinics were part-time and therefore open to panel GPs, in order to prevent the growth of a whole-time salaried service.[8]

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[4] *BMA Archive*, minutes of the London Panel Committee meeting on 26 May 1914, Report of the Panel Service Subcommittee (meetings of 5 & 12 May 1914) min. 3.

[5] Frank Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care 1911-1968* (London, 1979) pp. 34-35,46, 120. Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939* (London, 1980) p.97; Helen Jones, *Health and Society in Twentieth Century Britain* (London, 1994) pp. 37 and 76.

[6] Honigsbaum, *The Division in British Medicine* p. 35. The medical profession as a whole was in any case committed during the interwar period to the promotion of hospital-based births, which increased from 15% in 1927 to 35% in 1937. Bernard Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales, 1800-1945* (Basingstoke, 2004) p.232.

[7] Honigsbaum, *The Division in British Medicine,* p.131.

[8] *Ibid*, p.38. Dr Christine Pillman Williams, a member of the BMA's Ministry of Health Committee, reported on efforts to ensure the Maternity Centres remained 'advisory and preventative and not for treatment' and 'to work the clinics with part-time medical officers selected from the GPs of the district.' Joyce Cockram, 'The

Chapter Seven

As Minister of Health in 1919, Addison looked forward to realizing his dream of creating a comprehensive, integrated medical service from the myriad of separate and often overlapping services for which he was now responsible, about which he hoped to build consensus through his Consultative Council. Addison rejected the idea of the Council being directly elected by their colleagues and showed a determination to harness the best ideas from those he considered the brightest and most respected members of the profession. He may have hoped the advice they provided would be objective but he could not expect it to be untainted by professional interest, and in choosing Sir Bertrand (later Lord) Dawson as chairman he must have been aware that he was relying of an individual who had made no secret of his belief in the supremacy of medical over lay advice and the desirability of medical leadership of organised health services. Dawson strongly supported doctors' autonomy and freedom from bureaucratic influence, as he demonstrated in his Cavendish lecture in 1918 in which he stated that 'the practice of putting the skilled under the control of the unskilled must cease.'[9] Places where doctors worked should be controlled by doctors, Dawson had maintained, and, when established, the Ministry of Health should be peopled by a mix of medical and lay officials while strictly medical matters should be subject to the advice of a central medical board.[10]

For Frank Honigsbaum, the origins of the *Interim Report of the Consultative Council on the Future of Medical and Allied Services*, to give Dawson's report its full title, and its reception by the profession, were intricately bound up with concerns about a salaried medical service. This assertion is central to his explanation of the separation of general practice from hospital care which took place while NHI was in force.[11] However, Dawson was motivated by much

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Federation and the British Medical Association', *Journal of the Medical Women's Federation*, vol.49 (1967) pp. 77-78.
[9] *BMJ* 13 July 1918 , Sir Bertrand Dawson, 'The Future of the Medical Profession'(The Cavendish Lecture) p.25.
[10] *Ibid*
[11] His argument is almost certainly overstated. Neither the Minister nor Morant were especially wedded to the idea, and their key medical advisers, Whitaker and Newman, had each put forward arguments as to why it was not desirable. *National Archive* MH 62/116, Undated memorandum assumed to be by Whitaker 'Developments

more lofty ideals. His experience as a Major General in the Royal Army Medical Corps had convinced him of the benefits of doctors and ancillary professions working together in teams under an organised structure and, as a leading specialist, he was aware of the difference which new diagnostic and therapeutic equipment and technology could make, if only doctors generally had access to them. The proposals set out in the interim report were principally concerned therefore with organisation and involved what later health planners would have referred to as a 'hub and spoke' model involving primary, secondary and tertiary medical centres whose number and location would be determined by geography and the extent to which existing estate could be modified and utilised for the purpose.[12] The scheme was to be available for all classes of society but not 'free to all'. Although the Council stated that their remit did not extend to the question of how the new system should be funded, they made it clear that they expected preventive, public health and 'communal' services to be provided free to users at public expense, but that 'curative' services would be means-tested as under NHI.[13] This meant that, as with NHI, the majority of the population would access services under some kind or provident or insurance arrangement and individuals earning more than a specified amount would be expected to pay for their treatment and the usual privileges which that guaranteed.[14]

At the heart of Dawson's proposals was the health centre, 'an institution wherein are brought together various medical services, preventive and curative, so as to form one organisation.'[15] The primary health centre (PHC) would vary in size and scope but would form the basis of

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necessary for provision of a complete medical service for insured persons'; and *BMJ* 23 October 1920, Sir George Newman 'Preventive medicine and the Ministry of Health' p.635. Honigsbaum admits that Addison had ruled out the idea by January 1919 but repeatedly claims that the prime minister, Lloyd George, favoured a salaried service, even though he was dissuaded from that view in 1913.

[12] *Interim Report of the Consultative Council on the Future Provision of Medical Services,* Cmd. 693, London 1920, paras 10, 17 and 46. The report cites as an existing example of this model the scheme established by Gloucestershire County Council under the leadership of its Medical Officer of Health, Dr J. Middleton Martin, see para 16.

[13] *Ibid,* paras 7, 71-72.

[14] *Ibid*, paras 69-72.

[15] *Ibid*, para 9.

'domiciliary services' provided by GPs, nurses and others. While the GP would continue to attend patients at their homes or at the surgery and carry out such treatment as fell within the GP's competence, the PHC would provide a base from which GPs could obtain for patients when needed a range of facilities such as a minor operating suite, radiography and laboratory facilities. The PHCs would also house a dispensary, hydrotherapy baths, therapeutic massage and physiotherapy, together with clinical records storage and a common room in which doctors could meet and share in postgraduate instruction.[16] The centre would include maternity beds for more complex labour cases and other services already available in local authority clinics such as antenatal, child welfare, school medical inspections, and medical examination of infectious diseases and occupational disease.[17] GPs would be paid to provide these services under separate contracts, the report suggested, and PHCs might also provide a place for dental clinics and ambulance services. The Council hoped the establishment of PHCs might encourage GPs to work in large groups just as Addison had hoped but they did not want to be coercive. They stated that 'the custom whereby every GP has his own consulting rooms in his own house should continue but where it is impossible for a Doctor to provide adequate accommodation at his own expense…it should be possible for the health authority (which is described later in the report) to provide such accommodation at the Primary Health Centre or elsewhere on such terms as are reasonable'.[18] They continued that where medical opinion favoured the plan, 'collective surgeries might with advantage be tried, either attached to the Primary Health Centre or set up elsewhere.'

Under the plan the more numerous PHCs would feed into a smaller number of Secondary Health Centres at which consultants and specialists would deal with more complex cases. These 'would of necessity be based in towns' and would be linked to a small number of

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[16] *Ibid,* paras 19 and 37.
[17] *Ibid*, paras 19 and 39.
[18] *Ibid*, para 21.

teaching hospitals in cities with attached medical schools. They would provide the 'highest skill available' for patients and facilitate postgraduate instruction.[19] Consultants would also attend patients' homes in cases of emergency or 'special summons' by the GP.[20] The PHC would be the 'home' of the health organisation and of 'the intellectual life of the unit'. It would bring to an end the professional isolation experienced by most GPs who would thereby commune with specialists and consultants and develop 'an intellectual traffic and camaraderie to the great advantage of the service.'[21] While the question of salaried service was incidental to their proposals, the Council was clear that they saw no benefit in GPs working in PHCs being whole-time salaried employees because choice of doctor was necessary, the report says, 'to win the confidence so vital to the treatment of illness'.[22] Securing the efficient working of the new system would require a new type of health authority, the report said, but the council were divided as to its form or location.[23] They were clear, however, that one of the conditions of efficient service was that the medical profession 'should come into organic relation with the health administration' as success was dependent on their 'cooperation and enthusiasm.'[24]

Dawson was careful to anticipate and acknowledge the profession's fears and possible objections to the Council's proposals.[25] The report's conclusions were carefully qualified but its critics were reluctant to accept its provisos at face value. The cautiously favourable response in the *BMJ*'s editorial and the endorsement of the much-venerated Sir James MacKenzie, who acknowledged similarities between the PHC and the successful clinic he had established in St Andrews, were quickly superseded by a succession of admonitory diatribes in the medical

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[19] *Ibid*, paras 12 and 13.
[20] *Ibid* para 47.
[21] *Ibid,* para 50, These proposals would provide the advantage of better organisation while ensuring 'the preservation of liberty of thought and action.' (para 51).
[22] *Ibid,* para 52. The report adds that the 'voluntary character of the association between patient and doctor' stimulates the latter 'to excel in skill and helpfulness', whereas whole-time service would tend 'to discourage initiative, to diminish the sense of responsibility and to encourage mediocrity.'
[23] *Ibid*, paras 93-94.
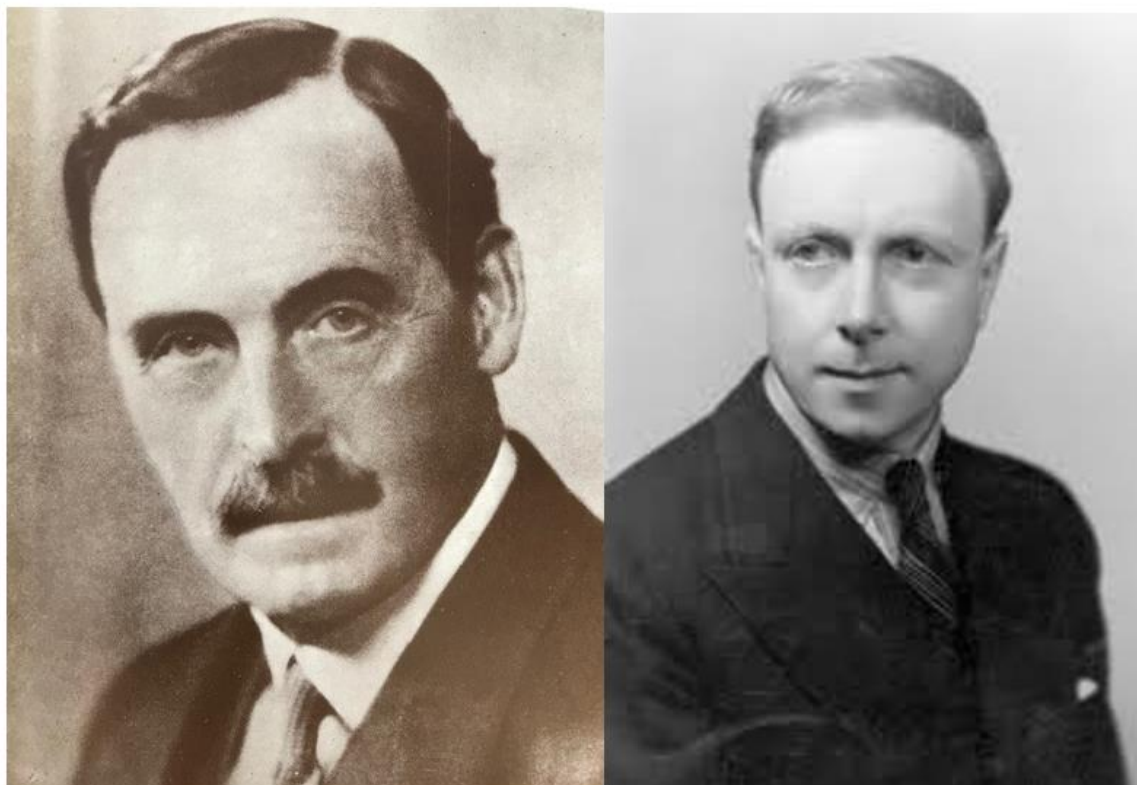[24] *Ibid,* para 96.
[25] *Ibid*, para 17.

Figure 15. *The visionary and the agnostic*: Sir Bertrand, later Lord Dawson of Penn (left), Chairman of the Ministry of Health Consultative Council 1919-1920. Photograph from BMA archive. Dr A.J. Cronin (right), GP author of the best-selling novel, *The Citadel*. While this became the touchstone of growing public support for a National Health Service in the late 1930s, Cronin remained suspicious of state control and was personally agnostic about what a reformed health service should look like. Photograph from Britannia.com.

press.[26] Ignoring the report's carefully rehearsed arguments, Dr Blackhall Morrison thought the report provided ammunition for the supporters of salaried service while Dr W. Gordon feared that GPs would become 'mere first aiders' under Dawson's scheme.[27] Others had more principled objections. Dr Michael Dewar questioned the need for its recommendations , stating that 80 to 95% of illness 'was amply and carefully attended to by GPs already' while Dr J.L. Halstead considered the whole thing 'extravagant' and unnecessary.[28] Others rose to defend the report. Dr J.W. Marshall offered another example of a successful PHC already in existence

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[26] *BMJ* 29 May 1920, Editorial, 'The Future Provision of Medical Services' pp. 756-7; *BMJ* 5 June 1920, Sir James McKenzie, p.783..
[27] *BMJ* 12 June 1920 p.812.
[28] *Ibid,* 19 June 1920, p.850; 26 June, p.882.

in Scotland showing how cottage hospitals could be transformed in the way the report envisaged.[29] When in July 1920 the BMA invited Dawson to speak to its representative meeting he was evidently frustrated by the debate in which many speakers voiced concerns based on a misreading or misunderstanding of the report's intentions. Typical of these was Dr John Stevens of Edinburgh who thought it meant healthcare was to be 'free to all.'[30] Reflecting the unrestrained comments of the anti-government lobby, Sir James Barr stated that the proposals were completely unaffordable and, repeating his objections to NHI voiced in 1913, said, provocatively, that it was not the duty of the state to look after sick people.[31] Although there was little likelihood of such reactionary views being supported, Dawson urged the meeting not to follow Barr's 'evil path' and was no doubt grateful when Brackenbury pointed out that the proposed PHCs corresponded in many respects to 'a cottage hospital with improvements'.[32] He was supported by another of the report's authors, his fellow IAC member, H. Guy Dain, who said that it would be the GPs' own fault if, by not embracing the health centre concept, the growth of local authority clinics staffed by whole time salaried doctors was thereby allowed to continue unchecked.[33] Ignoring the critics, the Representative Body confirmed support for the principles behind the report and instructed its Ministry of Health Committee to consider it further. The committee was to present its conclusions to a special representative meeting convened for the purpose, but this did not take place.

The fact that Dawson's proposals were not taken forward, and no final report was ever published, was down to a combination of institutional inertia and the hostility of anti-

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[29] *Ibid,* 17 July 1920 pp. 93-94. A report to Kent LMPC welcomed Dawson's proposals as 'a sane and practical statement of the lines along which the reconstruction of public health administration may best proceed'. *Kent LMC Archive,* minutes of Kent County LMPC 13 January 1921.

[30] *BMJ* 3 July 1920, 'Report of Annual Representative Meeting', Supplement p.19

[31] *Ibid,* p.19.

[32] *Ibid* p.19, and p.21.

[33] *Ibid* p.21. The extent of local government involvement in 'personal health services' increased during and after the first world war as a result of legislation touching maternal and infant welfare, and the treatment of venereal disease and TB. See Becky Taylor, Martin Powell and John Stewart, 'Central and Local Government and the Provision of Municipal Medicine 1919-1939', *English Historical Review* 122 (2007) p.399.

government forces led by the press, for whom the report was very epitome of the coalition government's overweening ambition and extravagance.[34] The ambitious scope of the programme raised fears of significantly increased public expenditure at a time when the economy was struggling to cope with the effects of post-war debt and dislocation and was heading inexorably into depression. The 'anti-waste' campaign championed by the Northcliffe and Rothermere press combined with ideological opponents of state intervention to denounce the Council's proposals.[35] The death of Morant, moreover, signalled a change on the part of the officials dealing with the report. Robinson was of a more prosaic mind than his predecessor and had none of his passion to effect social change, and when Addison was replaced by Sir Alfred Mond, a minister more interested in reducing rather than enhancing the state's role in health, the plan itself was quickly buried and GPs' attention turned once more to their familiar grievances. Sir George Godber, the NHS Chief Medical Officer, noted with regard to the plan that 'The British did not really believe in the capacity of government at any level to run such human health services in 1920'.[36] However, the ideals Dawson articulated and his vision of a truly integrated and comprehensive health service remained a cherished, if elusive, objective for many within the profession and outside it and continued to exercise considerable influence in debates about the extension or expansion of NHI and about what might replace it.

Honigsbaum cites evidence that Dawson was primarily interested in extending the range of services to the public, rather than extending existing NHI coverage to dependants of the insured and argues that this put him at odds with Brackenbury.[37] But there is nothing in the report to

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[34] Typical of press criticisms is *The Times* 15 December 1920,'The Health Bill Rejected' p.13 which denounces Dawson's scheme as 'fantastically costly'.

[35] See James E. Cronin, *The Politics of State Expansion: War, State and Society in Twentieth-Century Britain* (London, 1991) pp.87-90, Kenneth O. Morgan, *Consensus and Disunity: The Lloyd George Coalition Government 1918-1922* (Oxford, 1979) p.290. and Peter Clarke, *Hope and Glory: Britain 190-2000* (2nd edn, London 2004) pp.108-109.

[36] Sir George Godber, 'The Domesday Book of British Hospitals', *Bulletin of the Society for the Social History of Medicine*, 32 (1983) p.4.

[37] Honigsbaum, *The Division in British Medicine,* p.74 and pp. 122-125.

suggest the exclusion of women and children from its proposals. It offers no view on the issue of coverage and how services should be funded, only that they should be available, though not free, to the entire population.[38] Honigsbaum also suggests that the BMA's leaders, Cox and Brackenbury, were at odds at this time in that Cox favoured the inclusion of specialist work by GPs over the care of dependants whereas Brackenbury strongly favoured the latter.[39] Certainly, Brackenbury wanted the GP to provide a complete family medical service to the insured and their dependants and felt that they could not do this effectively while becoming part time specialists, but he was not averse to GPs continuing to undertake minor surgery in cottage hospitals, maintaining interest in maternity care, or administering any form of treatment that was within their competence to perform outside hospitals. The only real point of departure between Dawson and the BMA's leadership was over the importance of GPs working in groups, an idea for which, despite its obvious merits, the individualistic nature of general practice at that time guaranteed a lukewarm response.[40] With Dawson's utopian vision side-lined, the profession subsequently pinned its hopes for beneficial changes to health services on the Royal Commission which had been conceded by a reluctant government as a condition of the settlement of the GP's grievances in 1924.

The Royal Commission on NHI: conflicting expectations of future development

When it came to improvements to medical benefits under NHI, the regular discussions between the approved societies and the IAC which had begun in September 1920 at the Ministry's instigation showed that there was actually much common ground between them. Both sides

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[38] *Interim Report* paragraphs 7, 71-72. Honigsbaum suggests that the expansion in the scope of services which Brackenbury vainly attempted to persuade the LMPCs conference to accept in 1919 was somehow 'in opposition to the Dawson report' but this conclusion does not seem tenable.

[39] Honigsbaum, *The Division in British Medicine,* pp. 126-128.

[40] *Ibid,* ch.10.

wanted a better service for the insured and for dependants to be covered by it. Although they differed about how much the doctors should be paid to deliver a more adequate service, both recognised that this would require a great deal more money which, in the worsening economic climate, would be increasingly difficult to come by. The antagonism between the profession and the approved societies was based on the issue of who should control the evolving system. The societies' desire for more control was frustrated by the doctors' newfound confidence and influence with government officials. The inevitable showdown between the two sides took place within the context of the Royal Commission into National Health Insurance in 1926 but was preceded by a series of publicised skirmishes and orchestrated attacks on panel practice in the national press.[41] In a series of articles in the *National Insurance Gazette* in December 1923 Dr H.S. Beadles, the chair of the West Ham insurance committee (also, surprisingly, the chairman of the LMPC) set out a case for a comprehensive new NHI system but questioned the value of letting the approved societies be involved.[42] The *Gazette* then published a series of articles entitled 'The Future of National Insurance' by one of the profession's staunchest critics among the approved societies' representatives, Alban Gordon, the author of a book on social insurance published by the Fabian Society.[43] Surprisingly, these articles also questioned the appropriateness of approved society involvement, prompting the editor to state that Gordon's thoughts 'reach conclusions which many of us will find ourselves unable to accept.'[44] Gordon did not want a State Medical Service as such but wanted an extended range of benefits available to every citizen.[45] The solution he suggested was to 'regroup' approved societies on a territorial

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[41] The draft report to the LMPCs conference considered by the IAC in September 1923 included an item (58) entitled 'Unfair criticism of Insurance Practitioners' referring to orchestrated press attacks by opponents of NHI. *BMA Archive*, minutes of IAC meeting on 11 September 1923.

[42] *National Insurance Gazette* 'A Review of the National Health Insurance System in England' 15 and 22 December 1923. To support this, Beadles referred cryptically to recent examples of 'financial irregularities' in certain societies' dealings with the scheme.

[43] *Ibid,* 'The Future of National Insurance' 16 and 23 February and 1 and 8 March 1924.

[44] *Ibid,* 16 February 1924, Editorial p.79.

[45] *Ibid,* p.87. NHI had been a success he said but 'was beginning to prove a failure…as its drawbacks increasingly outweigh its advantages.'

basis with a smaller number of 'insurance authorities' elected on local government franchise to manage medical and unemployment benefits, pensions and poor law provision.[46]

When the Royal Commission met, it was against a background of orchestrated and politically-inspired criticism of the panel system in the popular press. Typical of these was the *Daily Express* article entitled 'A fraud on the patients.'[47] Having taken copious evidence from all parties, however, the Commission concluded that it had received 'very little evidence directed against the scheme as a whole, nor have we any reason to think there now exists any considerable body of opinion adverse to the principle of National Health Insurance.'[48] With regard to the critics of NHI, the Commission agreed with the Ministry which stated in its evidence that 'with few exceptions, those persons who speak to the detriment of the Insurance Medical Service have never been under treatment of the panel practitioner.'[49] Indeed, the fiercest critics of the scheme were the National Medical Union.[50] Alban Gordon was among a small number of witnesses who accused GPs of providing a better service to their private patients than to their panel patients, echoing views previously given credence by the MP Sir Kingsley Wood.[51] However, the Commission stated 'we are glad to say that, except from some rather contradictory evidence given by witnesses from the national conference of friendly societies…we have found no support for this allegation. On the contrary there has been a great body of evidence not only from interested parties – the doctors and chemists – but from the societies and representative bodies, showing that no such distinction is made.' The Commission

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[46] Gordon was a Labour party member and failed parliamentary candidate. His personal views are quoted extensively in the Royal Commission majority report (paras 131, 372 and 395).

[47] *Daily Express*, 4 September 1924. Angered by the *Express* campaign against NHI, the IAC was incensed by comments in it attributed to a member of the BMA's Non-Panel Doctors Committee, Dr Blackhall-Morrison. *BMA Archive*, Minutes of Non-Panel Doctors' Committee 25 September 1924, min 10.

[48] *Report of Royal Commission on National Health Insurance*, (1926) Cmd. 2596 p.12, para 20.

[49] *Ibid*, p.34 para 68.

[50] Although the aforementioned *Daily Express* article spoke of the National Medical Union (NMU) as representing the 16,000 doctors not on the panel (of which of course a significant proportion were specialists) the NMU were forced to admit to the Commission that their membership numbered only 247!

[51] Wood had stated in 1923 'there are too many cases today where a panel patient is treated differently from a private patient…' *The Times* 21 March 1923 'Insurance Panel System-Conference needed' p.11.

noted moreover 'a growing tendency among practitioners to be more scrupulous to avoid giving offence in the case of insured patients than in the case of private patients, since the former are, in a sense, protected by the machinery under the Act for the investigation of complaints.'[52]

The Commission saw its main task as being to decide how the present system could be improved. They decided the first priority should be to expand the scope of services to include access to (essentially outpatient) specialist advice but not, it must be emphasized, to allow inclusion of hospital treatment. Then, in descending order of priority, they recommended extension of the insurance system to dependants, improved maternity services provision, and improved dental service provision.[53] They decided that the inclusion of hospital inpatient treatment was unaffordable and were concerned that it would leave non-insured persons 'of moderate means' at a great disadvantage.[54] They were clearly thinking of the Dawson report when they sought to justify their outpatient proposal saying that the panel GP 'suffered great disadvantages in the maintenance of his professional efficiency' due to his professional isolation. Regretting that GPs had few opportunities of coming into contact with those at the leading edge of developments in medicine and surgery, they argued that 'a more systematised referral process would aid GP diagnosis and learning' and that specialist feedback would 'act as a valuable form of postgraduate instruction that would probably be welcomed by the isolated general practitioners.'[55] The Commission was careful to avoid expressing any opinion on what GPs should be paid. It was with the administration of NHI that it was principally concerned.

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[52] *Report of Royal Commission* pp. 36-37, para 72.The modern day champion of the friendly societies, David B. Green, also acknowledges that such complaints were largely unfounded. David B. Green, *Working-Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948*' (Aldershot, 1985) pp. 88 and 150. Despite this Anne Digby implies that the additional courtesies enjoyed by private patients resulted in a better quality of care, *The Evolution of British General Practice, 1850-1948* (Oxford, 1999) p.318 and, accepting this argument, Bernard Harris states 'practitioners failed to give their insurance patients…the same priority they accorded to their private patients.' *The Origins of the Welfare State : Social Welfare in England and Wales ,1800-1945* (Basingstoke, 2004) p.223.

[53] *Report of Royal Commission*, Recommendations, ch. XIV p.280, para 42.

[54] *Ibid*, p.124, para 263 and p.126, para 126.

[55] *Ibid*, pp.130-131 para 280.

They were therefore highly critical of the approved societies whose involvement had been 'justified by the necessity of retaining, under a system imposed by the state, a system of insurance that had 'been evolved by the people themselves.' The Insurance Act was thus 'an experiment in democracy, no less than in the domain of social betterment' but in some of the larger societies associated with industrial insurance companies 'there was no effective means whereby the members could exercise control over the societies' affairs.'[56] Despite these shortcomings the majority report did not propose that the approved societies be stripped of their role. It proposed instead that Insurance Committees be abolished and that their work 'pending any radical remodelling and unification of Health Services' should be handed over to committees of 'the appropriate local authorities'.[57] It was not that the Insurance Committees had been inefficient, they argued, but that their role was currently so narrow that it did not justify their existence as independent administrative authorities.[58] Alban Gordon had argued that 'the continued existence of Insurance Committees within their present limitations is, except for one single function, pure farce.' The exception he referred to was the Medical Services Subcommittee which, he acknowledged, 'performs useful work.'[59] The commission spent some time looking at the NHI complaints machinery and it was to this that the Medical Practitioners Union (MPU) directed most of its evidence. It completely failed to impress the commission, however, who commented that 'the privileged position which the MPU argues should be granted to practitioners under the complaints procedure is one that we do not think could be conceded or any grounds public policy.'[60] The BMA fared little better when they

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[56] *Ibid,* p.93, para 199 and p. 92, para 197. The Report adds that the democratic deficit in management of the societies was not surprising, as 'most of us are content not to be too keenly involved even in matters that might directly affect us.' p.107, para 231.

[57] *Ibid*, p.173, para 396.

[58] *Ibid*, p.60, para 125 and pp.166-7 paras 375 and 379.

[59] *Ibid,* pp.171-172, para 395. (This contrasts with views expressed by Gordon during a conference between the approved societies and the IAC in January 1923 when he said that as secretary of a society he would have nothing to do with medical service committees as 'these had become iron tribunals.' *BMJ* 10 February 1923, 'Conference of Parties interested in National Health Insurance', Supplement p.37.)

[60] *Ibid,* p.187, para 437.

argued that complaints about behaviour rather than the quality of treatment should not be disciplinary matters. To the argument that the patients' remedy was already to hand in the ability to change doctor, the commission responded that it was not a remedy in areas where the shortage of panel doctors left patients with no choice of alternative GP and dismissed the idea that the LMPCs be left to adjudicate on such matters as 'highly undesirable.'[61]

The approved societies' reputation was thus more tarnished by the Commission's report than the doctors'. The minority report even went so far as to call for local authorities to take over insurance funds from the societies on the grounds that their lack of accountability 'negated parliament's original intentions in involving them in the administration of NHI' and that they were 'a hindrance to further development.'[62] Eder states that 'The doctors were given good but only scant reviews but found it hard to conceal their delight at the societies' bad notices.'[63] The doctors were particularly pleased to see the Commission accept their opinion, supported by Ministry officials, of Medical Aid Institutes, confirmed by the statement that 'the treatment given to members of these institutions is generally of inferior quality to that provided under the normal panel arrangements.'[64] The fall of the Labour government and the changing political and economic situation of the country, however, meant that the Commission's recommendations, like those of the Consultative Council, remained unimplemented. While they continued to consider improvements to and expansion of the service, the Ministry focussed its attention instead on trying to reduce the cost of medical benefits by tightening up the rules on certification. The IAC therefore decided to take the initiative and offer its own views on what the ideal national medical service should comprise.

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[61] *Ibid*, p.188, paras 430 and 440 and p.189 paras 442-443.
[62] *Ibid,* Minority report, p.304, para. 26 and p.310, par 54.
[63] Norman Eder, *National Health Insurance and the Medical Profession in Britain 1913-1939* (London, 1982) p.234.
[64] *Report of Royal Commission* p.261, paragraph 642. The Commission concluded that MAIs were an anomalous feature of the scheme and recommended amendments to the Act to prevent any more of them being established.

The BMA's vision and the expedient alternative of Public Medical Services

Finding themselves unsatisfied with the slow progress of discussions about reform of NHI, the IAC decided in early 1929 to set out their own proposals for the future of health services, and established a committee for that purpose, the General Medical Services Committee, under the chairmanship of Guy Dain. It listed among its reference documents the Dawson report, the Royal Commission report and extracts from recent *Lancet* articles on modern hospitals in Sweden and Denmark.[65] The Committee's remit, explained in a memorandum from Cox, was to address the following questions: 1. What kind of medical service should be at the disposal of every member of the community? 2. Under what conditions should the service be placed? 3. What were the financial and administrative details of such a scheme? Cox noted that there would be no need for the committee to consult with the profession before drafting a scheme addressing these questions 'since there will be nothing very new to the medical profession in the plan, it being an attempt to synthesise those separate policies which have already received the approval of the Representative Body.'[66] What was unique about the report, published in 1930 under the title *A General Medical Service for the Nation*, was the emphasis it gave to the importance of the family doctor.

Prior to the mid-1920s the terms 'insurance practitioner' and 'family doctor' were not synonymous. Most panel doctors provided care for dependants of the workers for whom they were responsible under NHI but such provision was often ad-hoc, precariously funded and by no means equivalent to the ideals of family medical practice which the profession's leaders espoused. In the early days of the scheme panel doctors were not universally esteemed by either

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[65] *BMA Archive,* General Medical Services Committee 1929-1930, minutes of meeting on 29 October 1929.
[66] *Ibid*

the public or their peers.[67] By 1926 however, as the Royal Commission noted, NHI was an established and appreciated part of the social fabric of the nation and those of the panel patients' families who could afford to were generally happy to make use of panel doctors' services and regarded them as their family doctors. The BMA therefore felt able to state much more strongly than Dawson had done that 'the family doctor is the foundation of any complete and efficient medical service' and insisted on provision for every individual, regardless of status or ability to pay, of 'a personal practitioner or family doctor.'[68] The report extolled the virtues of the GP not just as a medical attendant but as 'guardian of the health interests of the family' and 'home doctor' who was uniquely conversant with the patient's personal environment.[69] It equated the GP's role in helping patients access the services of specialists when needed to that the solicitors helping clients choose a barrister. Consequently, the specialist was always to be a consultant brought in by and acting in concert with the GP as family doctor and consultant service and all ancillary forms of diagnosis and treatment should be available to the patient only through the medium of the GP.[70] The relationship between the patient and doctor was sacrosanct, the report argued, and consequently while the service envisaged might be a state-coordinated or state-subsidized service, the interposition of any third party between doctor and patient 'should be as limited as possible.'[71] 'The patient needs to think of the doctor as *his* doctor' the report stated, not a representative of the state which might be the case in other European countries where there was interference 'for political reasons' and which is 'alien to

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[67] 'The position of the panel doctor has not any great prestige attached to it, and his faults have been more widely advertised than his merits' 'A Panel GP', *On the Panel: General Practice as a Career* (London, 1926) p.49.

[68] BMA, *A General Medical Service for the Nation* (1930) para 8.

[69] *Ibid,* para 9. It contrasted this with the situation in the U.S. where the supply of specialists far exceeded that of generalists and family medicine was now fast disappearing (para 10). For a detailed explanation of the causes of the changing complexion of medical practice in the U.S. in the early Twentieth Century see Paul Starr, *The Social Transformation of American Medicine*: *The Rise of a Sovereign Profession and a Vast Industry* (New York, 1982) pp.165-167, 210-213, and 224.

[70] BMA, *A General Medical Service for the Nation*, paras 8 and 13.

[71] *Ibid*, para 25.

the British experience'.[72]

The Report put forward a modified version of Dawson's health centre idea in the form of the 'home hospital'. Where domiciliary care and treatment was needed and the patient's home was not best suited to such care, and the patient could not afford 'good nursing home care', patients could be safely and efficiently catered for in beds in a home hospital, or home hospital ward, located at or adjacent to existing hospitals, either voluntary or municipal.[73] They would be cared for there by nurses, or midwives in maternity cases, under the overall supervision of their GP, with consultants brought in only where needed. Utilising existing buildings meant that the costs of these new establishments could be minimised.[74] Such proposals, the report stated, would help GPs maintain an interest in institutional care and ensure that the convalescing patient benefited from continuity of care from the doctor who knew them best. Dawson's primary health centre was not completely abandoned, however. 'Local Medical Centres' with consulting rooms, nursing services, diagnostic equipment and laboratory facilities 'would be very useful' the report noted, stating that many forms of treatment could be carried out at such centres by the family doctor more satisfactorily then at the patient's home or the doctor's surgery.[75] In some cases, home hospitals and local medical centres could be combined, and here too, it adds, the doctor would be given the opportunity of cooperation with professional colleagues and the help of nursing and all ancillary facilities.[76] Echoing Dawson's views about team working and education, the report opines that these facilities would widen the GPs'

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[72] *Ibid*, para 26-27. This is one of a number of references by GPs leaders at this time to citizens' choice of doctor being more restricted in other countries, though they fail to cite any definite evidence.

[73] The terms 'Home Hospital' had first been employed by Sir Henry Burdett in 1877 to describe a hospital run by GPs, see Brian Abel-Smith, *The Hospitals 1800-1948: A Study in Social Administration in England and Wales* (London, 1964) , p.350.

[74] BMA, *A General Medical Service for the Nation*, para 50-55. The report noted that as the Poor Law infirmaries had recently come under the control of local authorities as a result of the Local Government Act of 1929 it was a propitious time to make such suggestions. (para 53). While not explicit about the role Local Authorities might play in future health service provision it may be inferred from the report that the BMA saw the municipal hospitals being subsumed at some point within a more unified hospital service supported by compulsory hospital contributory schemes like the one described in the Report's appendix..

[75] *Ibid*, para 44.

[76] *Ibid,* para 51.

experience and knowledge and bring them into closer contact with their colleagues. They would learn from each other and 'be stimulated by the sense of fellowship and common purpose.'[77] The report reiterates the conclusions of the BMA's maternity services scheme issued in 1929 which suggested that GPs resume control of antenatal and postnatal care while working in collaboration with midwives and suggested that while local authority child health clinics should continue 'their admirable work of instruction in mothercraft' they should, under these proposals, be free to refer children needing treatment to GPs, safe in the knowledge that parents would not be discouraged by inability to pay.[78] This was because dependants of the insured, under the BMA's proposals, would be included under NHI, which would be enhanced by the addition of nursing, midwifery, diagnostic, laboratory, and possibly dental, services in community settings.[79] This would of course benefit GPs indirectly. While the inclusion of dependants might initially increase demand, GPs would be more likely to offer treatment before illness became acute and thereby prevent the need for longer term care. They would also be spared the necessity of chasing patients for payment of bills they could not afford. Those who could afford to pay for the services directly, however, would continue to do so, and Local Authorities would pay into NHI to ensure provision for indigent (formerly Poor Law) patients.[80] Recognising the prohibitive costs involved, hospitals or specialist services would be available to all via a separate contributory scheme for which, in an appendix, the report helpfully provided a model.[81] The report strongly favoured the contributory system which 'helps preserve self-reliance and independence and promote thrift.' It also helped preserve 'the most valuable features of private practice' including free choice of doctor and 'reasonable competition'.[82]

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[77] *Ibid,* para 54.
[78] *Ibid*, paras 65-66.
[79] *Ibid,* Appendix A, A. (1) (i)- (iv) and B, (1) (i)- (iii) .
[80] *Ibid*, Appendix A, B, (1) (iii).
[81] *Ibid*, Appendix B.
[82] *Ibid*, para 31 (a) and (c).

It is easy to see in the BMA scheme, as some historians have done, a self-interested attempt to justify the continuance of a mixed practice system. Thus, Anne Digby dismisses the BMA's report as 'more a self-interested response to concern in a wider society than the setting of a radical agenda' and claims that the BMA 'missed an opportunity to work towards a social health service' and that they 'privileged doctors' remuneration over other concerns.'[83] There is likewise more than a hint of disparagement in Brian Abel Smith's comment that 'the scheme gave full payment to doctors for all services but preserved their position as independent entrepreneurs who were responsible only to their professional code of honour.'[84] These comments reflect an inability to understand the workings of the medical mind at that time and in particular the 'professional social ideal', overlooking the fact that GPs, both the rank and file and the IAC leadership, sincerely believed that what they were proposing would be of equal benefit to themselves, their patients and the wider society at a time when the idea of an entirely tax-funded system was dismissed by all but a minority of idealist progressives. They also underestimate the indirect benefits which private practice brought to panel patients. The fees earned from middle-class patients could be seen as subsidising the care of the poorer sections of the community by helping GPs maintain their income at a reasonable level.[85] But private practice was at the same time a place in which GPs were free to experiment with innovative techniques, procedures and drugs not available or permitted under NHI.[86] It was in this less accountable arena that enterprising GPs had the freedom to pursue interests in fringe medicine or specialist areas like psychotherapy and acquaint themselves with new drugs, therapeutics

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[83] Anne Digby, *The Evolution of British General Practice 1850-1948* (Oxford, 1999) p.326.

[84] Abel-Smith, *The Hospitals*, p.350.

[85] Dain was reported to have described this as 'the method of climbing over the backs of the poor into the pockets of the rich'. Charles Webster, 'General Practice under the Panel: the Last Phase', *Bulletin of the Social History of Medicine,* 32 (1983) p.26 (no citation).

[86] Digby notes that mixed practices began to invest in equipment like x ray machines, ophthalmoscopes and blood-pressure monitors and experimented with new drugs like Sulphonamides, and vaccines which private patients were willing to pay for relating to influenza, typhoid, catarrh, rheumatism, scarlatina, cholera and whooping cough. pp.213-214.

and diagnostic devices which only private patients could afford, and in time share the benefits of this experience with their panel patients.[87]

In 1930, under Dain's leadership, the IAC was clear that the inclusion of dependants within NHI was of far greater importance than any other development of it, and the LMPCs conference agreed, resolving that 'the time is now ripe for the medical profession to ask for the inclusion for the purposes of medical benefit…of the dependants of insured persons.'[88] Their pragmatic proviso - 'provided that such an extended scheme includes adequate safeguards respecting remuneration and conditions of service' - does not detract from their idealism. Due to past experiences, panel GPs were in no mood to allow their altruistic intentions to be exploited. When a delegation led by Dain met with the Ministry in November 1930, he acknowledged that 'from a financial point of view a more inconvenient moment possibly could not have been chosen for bringing the matter forward.'[89] The delegation persevered, however, stating that the alternative was the continued expansion of local authority maintained clinics catering for women and children which would fatally undermine general practice.[90] His comments illustrate the continuing fear among many GPs that Local Authorities might extend to others the range of free personal health services they offered at this time to women and children. This fear was heightened when the Local Government Act of 1929 gave Local Authorities direct responsibility for the Poor Law Infirmaries, a number of which were thereafter developed as

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[87] Rhodri Hayward, *The Transformation of the Psyche in British Primary Care 1870-1970* (London, 2014) details the development of a special interest in psychological medicine and psychotherapy among many GPs. He notes 'Psychology and General Practice enjoyed a symbiotic relationship. Each derived a new significance from its association with the other' and that 'Health Insurance encouraged psychological approaches' particularly as regards functional illness, p.35. He states, 'As even Consultant Psychiatrists recognised, by the late 1930s the family doctor played a key role in the achievement of mental health.' p.57. Digby effectively acknowledges the indirect benefits private practice brought to panel patients and that two-tierism was not universal but cannot disguise her disapproval. See *The Evolution of British General Practice* pp.211-212.

[88] *BMA Archive*, minutes of the IAC meeting on 20 November 1930, Doc M23; Minutes of the Annual Conference of Representatives of LMPCs, min 40.

[89] *BMA Archive*, minutes of IAC meeting on 8 January 1931, Doc 18, Report of Deputation to Ministry of Health on 27 November 1930.

[90] *Ibid*

generously equipped municipal hospitals with an increasing complement of salaried staff .[91]

The GPs' leaders feared that the expanding scope of municipal medicine would reduce demand for their services, leaving impecunious GPs susceptible to accepting the security of local authority employment as subordinates of the hated Medical Officers of Health.[92] 'If the public did not wake up' Dain complained 'the time was coming when the general practitioner…would cease to exist', as was the case, he was given to understand, in some parts of the U.S.[93] For the Ministry, Robinson appeared to agree with the thrust of Dain's argument and said that while 'the time had not yet come' for the inclusion of dependants, he would bring the Conference's resolution to the Minister's attention.[94] When the IAC debated this apparent impasse, Rowland Fothergill submitted a memorandum in which he questioned the wisdom of letting the matter rest.[95] He suggested pre-empting future changes by offering under NHI a GP domiciliary service providing medical benefits to children under five and their mothers. However the Dependants Subcommittee which the IAC established to consider this and similar suggestions concluded in 1932 that the financial situation of the country meant any extension of medical benefit to dependants of insured persons under NHI 'had been placed at the time being outside the bounds of practical politics.'[96] It therefore proposed that 'other means be made available

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[91] Some pioneering Local Authorities and Medical Officers of Health prioritised funding for personal health services, aided by the new Treasury block grants, but politically-inspired opposition and Ministry of Health disapproval often served as effective obstacles to such developments. See Becky Taylor, Martin Powell and John Stewart, 'Central and Local Government and the Provision of Municipal Medicine 1919-1939', *English Historical Review* 122 (2007) pp.397-426 and Martin Gorsky, 'Local Government Health Services in Interwar England: Problems of Quantification and Interpretation.', *Bulletin of History of Medicine*, 85, 3 (2011) pp.384-412.

[92] To GPs, according to Charles Webster, 'the MoH was an officious and bullying bureaucrat, presiding over an empire of clinics and institutions run along inhumane lines and delivering services of proportionately small benefit considering the cost involved.' John Welshman, 'The Medical Officer of Health in England and Wales 1900-1974: Watchdog or Lapdog?' *Journal of Public Health Medicine*, vol 19, 4, p.443, note 4.

[93] As in Germany, there was increasingly little distinction in the U.S. between GPs and specialists. By 1928 ⅔ of American physicians held hospital appointments but patients could access specialists without the need for GP referral. 'In the long run, this failure to gain a mediatory role contributed to the breakdown of general practice.' Paul Starr, *The Social Transformation of American Medicine,* pp.166-167 and 224.

[94] *BMA Archive*, minutes of IAC meeting on 8 January 1931, Doc 18, Report of Deputation to Ministry of Health on 27 November 1930.

[95] *Ibid*, minutes of IAC meeting on 8 January 1931, Doc 20.

[96] *Ibid*, minutes of the IAC Dependants Subcommittee meeting on 5 May 1932, p.9, item (10).

for all classes under consideration to obtain domiciliary medical attendance from private practitioners through arrangements incorporating the choice system.' The subcommittee thereby made explicit its preference for dependants being treated through Public Medical Services (PMS) and recommended that the BMA's model scheme be updated accordingly.[97]

The Conference of LMPCs consequently resolved that the National Insurance Defence Trust be required to collaborate with the BMA 'in assisting the effective development of Public Medical Services.'[98] This meant permitting the Trust to provide loans for groups of GPs, often led by their LMPCs, to set up new PMS schemes. There was already a precedent for this. In January 1924 the Essex PMS set up by IAC member C.H. Panting had requested a temporary loan which the IAC thought deserving of consideration by the Trust.[99] In November 1932 practitioners proposing a scheme for Midlothian requested a loan of £150 but that decision was deferred pending approval of its rules by the Medico-Political Committee.[100] Shortly after this a request for £300 was made to extend the scheme existing in London and later in 1933 the Defence Trust agreed to award this scheme £1,000 subject to its endorsement by the BMA's Council.[101] The extent to which PMS schemes were beginning to take off can be gauged from the survey which the IAC's Remuneration Subcommittee conducted as a data-gathering exercise in 1933. In addition to cities like Birmingham, Reading, Nottingham, Coventry, Swansea, Norwich and Newcastle, there were schemes covering rural areas such as

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[97] *Ibid,* item (11). They noted that as this was now a matter falling outside the scope of NHI, it was the Association's Medico Political Committee rather than the IAC, that should take it forward. Despite Fothergill being a member of the subcommittee, they also concluded that 'his method of piecemeal penetration of age groups is so hedged around with practical, economic, administrative and other difficulties that they were unable to recommend further consideration of it.' Item (12).

[98] *BMA Archive*, minutes of Annual Conference of Representatives of LMPCs, 20 October 1932, minute 51.

[99] *Ibid,* minutes of the IAC meeting on 17 January 1924, min 242. The *National Insurance Gazette* noted, in March 1924, p.93 that the Essex PMS 'had already made a promising start.' A Dr Eldred informed the Defence Trust that it comprised 170 doctors including some non-panel GPs and in Colchester it ensured 'all club arrangements had been wiped out of existence.' *Wellcome Collection* (BMA archive), SA BMA/H.10 Box 258, extract from report of conference of LMPCs October 1924.

[100] *Wellcome Collection,* BMA archive, SA BMA/H.10 Box 258, minutes of defence trust meeting of 12 January 1933,

[101] *Ibid,* supplementary agenda.

Lincolnshire and Hampshire. Demonstrating the autonomous nature of such schemes the survey of 26 schemes revealed wide variations in policies and criteria for membership. Some involved a flat rate per family while others charged separately for uninsured males, females, and juveniles and many charged for children on a sliding scale.[102]

Despite their support for PMS, the IAC maintained its commitment to seeking extension of NHI to dependants and in its report to the LMPCs conference in June 1933 stated that it had responded to a request from the Conference of Friendly Societies to cooperate with them in preparing the way for such an extension.[103] In 1934 the IAC reappointed its General Medical Services Subcommittee asking it to determine if there was any reason to revise its previous proposals in the light of changes to legislation relating to Public Assistance and NHI.[104] No substantial changes were recommended though the subcommittee took careful note of a memorandum from the chair of the BMA's hospitals committee, Peter MacDonald, who made a plea for GP to be given access to beds in which to treat their own cases in hospitals. In light of recent changes such as the increased use of nursing homes by the middle classes and the need for more expensive equipment it would be 'disastrous' for all concerned, he said, were increased use made of hospitals 'to further separate the patient from the family doctor.'[105] Frank Honigsbaum provides a detailed account of the process by which GPs were excluded from hospital work which he concludes was more or less accomplished by the mid-1930s. However, as he acknowledges more than once, many GPs maintained an interest in surgery and other specialist work at this time due to their pre-eminent position in the running of cottage

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[102] *BMA Archive*, minutes of the IAC Remuneration Subcommittee meeting on 1 June 1933, Doc 92. By comparison, a separate memorandum containing results of a similar survey of contract medical attendance in the colliery areas noted that while in South Wales 106 of the 130 areas were subject to 'poundage' at the rate of 2d in the Pound, others charged widely varying rates, some as little as 3d per week compared with 6d per week in parts of Yorkshire. *Ibid*, Doc 93.

[103] *Ibid*, minutes of the IAC meeting on 2 May 1933, Draft report to LMPCs conference, p.17.

[104] *Ibid*, agenda for the General Medical Services Committee meeting on 23 May 1934.

[105] *Ibid,* Memorandum (undated) from Dr Peter MacDonald, p.2.

hospitals.[106] Between 1900 and 1936 the number of cottage hospitals in Britain doubled from around 300 to around 600 by which time they accounted for around 10,000 beds.[107] While the quality of accommodation and the care provided was variable, many cottage hospitals had the kind of facilities advocated by Dawson for primary health centres, like X-ray machines, electrotherapy, hydrotherapy and massage, and a smaller number had laboratory facilities and ambulance services.[108] In 1938-1939, according to a later study by Bradford Hill, some 2.5 million surgical operations were performed by GPs in cottage hospitals, an average of three per doctor per week.[109]

Some observers were critical of the quality of care in these institutions, claiming it represented medical practice at its worst. In the *Lancet* in May 1930 E.W. Hay-Groves, professor of surgery at the University of Bristol, commented that there was 'a great deal of bad surgical work in smaller hospitals but this is really no reflection upon the professional attainments of the staff. They are being asked to carry out an impossible task, that of being general practitioners and also specialists at the same time.'[110] It seems likely that many cottage hospitals and nursing homes were associated with PMS schemes. The very first PMS scheme, the Leicester PMS which in 1911 had 90,000 subscribers, was built around a hospital provident dispensary and created a network of branch dispensaries.[111] It seems likely that others would also have wanted to maintain a central facility for their members' use. The Leicester scheme was run by the self-styled Union of Medical Practitioners but the membership of its Leicester

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[106] Honigsbaum, *The Division in British Medicine*, pp. 144-5 and 147-8.

[107] *BMJ* 19 September 1936, C.E.S. Flemming, 'Cottage Hospitals' Supplement, p.162.

[108] Meyrick Emrys-Roberts, *The Cottage Hospitals 1859-1990: Arrival, Survival and Revival* (Motcombe, 1991) pp.161-167.Accordingly, a great number of these institutions were absorbed into the NHS when it was established in 1948. *Ibid,* pp.185-189.

[109] A Bradford Hill, 'The Doctor's Day and Pay', *Bulletin of the Royal Statistical Society*. Series A (General) vol.114, no.1, (1951) p.17.

[110] Quoted in Sir Arthur Newsholme, *Medicine and the State* (London, 1932) p. 93 (Unfortunately his citation on p.88 is incorrect!)

[111] *University of Leicester, David Wilson Library medical archive*, E1/1/3, 1960 , F.A. Alexander 'Leicester Royal Infirmary Maternity Hospital'.

subdivision was identical to the local Panel Committee and LMC which consequently held their meetings sequentially.[112] LMPCs were clearly the driving force behind PMS in other areas such as Kent, where the first draft scheme was considered in October 1924 and an East Kent branch was launched in Bromley in September 1925 to 'face down a threat from a public dispensary with imported full-time salaried doctors.'[113] The Kent LMPC agreed to provide the scheme with £100 from its voluntary levy to pay for 'the necessary stamps and cards'. In April 1926 the LMPC resolved that the committee 'transform itself' into the governing body of the Kent County PMS and recorded in September 1926 that governing body meetings would now routinely follow meetings of the LMPC.[114] The same was true of the London PMS.[115]

Some of the most interesting contemporary comments on PMS can be found in the study of NHI conducted in 1938 by the American physician Douglass Orr and his wife Jean. They found that GPs considered PMS 'a most valuable adjunct to NHI' and 'the most satisfactory form of contract practice'.[116] The London scheme had made a slow start they noted, having enrolled only 50,000 families.[117] The more established Birmingham scheme was highly regarded even by the local Medical Officer of Health, Dr H.P. Newsholme.[118] Starting in 1923 it initially had 250 doctors and 250,000 subscribers. Commenting on its success, the *Birmingham Medical Review* opined in 1936 that the popularity of PMS around the country was demonstrated by the numbers represented at the recent Conference of PMS schemes and that they might soon need their own national representative body equivalent to the IAC.[119] A Dr A, whose practice was in the West End of London, described the benefits of PMS to GPs more prosaically, stating that without it 'the wife is likely to run off to a hospital or a clinic where she and the children might

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[112] *Ibid*
[113] *Kent LMC Archive,* minutes of Kent County LMPC meeting on 25 September 1924, 24 September 1925.
[114] *Ibid,* 24 June 1926, 23 September 1926. Plans to extend the service were considered in June 1936.
[115] *Medical World* 4 February 1927 ,'London Panel Committee' p.494.
[116] Orr and Orr, *Health Insurance with Medical Care*, p.48.
[117] *Ibid*
[118] *Ibid*, p.136.
[119] *Ibid*, p.159.

get less intelligent care than can be given by a family doctor.'[120] To those who viewed PMS as being purely a matter of economic survival, Orr notes that doctors in PMS scheme 'cooperated to maintain standards' and 'were arranging refresher courses in paediatrics, infant feeding and the like in order to be able to compete with the public clinics.'[121] On speaking to Alfred Cox, who on his retirement as BMA Secretary became, in September 1933 the Secretary of the London PMS, he learned that the BMA had brokered an arrangement whereby consultants would see PMS patients for one third of their normal fee.[122] Cox states in his memoirs that he was anxious to develop the 'professional side of PMS work', thus emphasising that 'it was not a mere collecting agency.'[123] Assisted by Dr Frank Gray, a practitioner from Wandsworth, he laid great stress on the PMS family doctor being an adviser in health as well as sickness and encouraged its doctors to take more interest in maternal and child welfare. The London scheme proved unusual in seeking to offer its services to middle-class households at an increased premium.[124]

The Orrs observed another possible motive behind the GPs' enthusiasm for PMS. After declaring that PMS was 'definitely a good thing' a Dr Wilson of Oxford said that the BMA was assuming that the government would eventually extend NHI to include the dependants of wage earners and so 'for this reason they are promoting PMS both as a temporary stopgap and as a means of getting in on the ground floor when the government extends medical benefits to include the worker's family group.'[125] As was the case with the Leicester scheme from its inception, the friendly societies were often happy to contract with PMS schemes, thereby

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[120] *Ibid*, p.160.

[121] *Ibid*

[122] *Ibid* p.158.

[123] Alfred Cox, *Among the Doctors* (London c.1949) p.200.

[124] Political and Economic Planning, *Report on the British Health Services* (London ,1937) p.154.This may have become necessary because, as one London GP disdainfully noted, many subscribers to the PMS lied about their income. 'AGP', *This Panel Business* (London, 1933) p.49. He declared acerbically that 'the London Public Medical Service has been a failure.' p.275.

[125] Orr and Orr, *Health Insurance with Medical Care*, p. 159.

surrendering the control they once had over the doctors as far as the families of insured workers were concerned.[126] The number of subscribers to PMS continued to grow therefore throughout the 1930s. In a survey conducted by the BMA in 1943, returns from 70 out of 80 known PMS schemes allowed them to postulate a minimum estimate of 650,000 subscribers from which Green deduces that they could have been catering for as many as 1.2 million individuals.[127]

It is clear from the preceding comments that GPs favoured the extension of insurance based services to workers' dependants, expecting that at some point they would be so included under a state-sponsored scheme. They wanted and expected the middle classes to continue paying directly for private consultations. They also wanted ready access to hospital services for all sections of the community and, recognising that charity was insufficient to sustain the demands of modern medicine and that the costs of intensive treatment were beyond what even middle-class families could afford, that hospital contributory schemes should be universally available. Only a minority of socialist doctors considered a non-contributory, tax-funded system to be a realistic option. Alfred Welply was one of these. 'Why devise an elaborate and expensive administrative machinery to exclude the twenty per cent who could afford to pay?' he asked. As was the case with schools, he told the Orrs, 'the rich would always make their own arrangements.'[128] Welply's MPU colleague Alfred Salter shared this view, opining that the BMA proposals for a complete medical service were 'quite incomplete' and that such a service would have to await a Labour majority in parliament.[129] His view was not necessarily shared by all sections of the Labour movement. Space does not allow for consideration of the remarkable accord between the BMA and the Trades Union Congress on the shape of future

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[126] David B. Green, 'Medical Care in Britain Before the Welfare State', *Critical Review*, 7:4. (1993) p.490.

[127] *University of Leicester, David Wilson Library medical archive,* E1/2/13 BMA Report, 'Analysis of Reports from Public Medical Services 1943.' Green, 'Medical Care in Britain Before the Welfare State', p. 490.

[128] Orr and Orr, *Health Insurance with Medical Care*, p.181

[129] *Ibid,* p.180.

health services which arose from their Joint Committee on Medical Questions.[130] It is perhaps

sufficient to note Honigsbaum's comment that in the late 1930s 'both organisations found their

interests converging as a result of difficulties encountered with the approved society system.'[131]

The Labour Party was of course obliged to give due regard to views on reform of health services

put forward by its professional supporters in the Socialist Medical Association (SMA).

Although suspicious of the BMA, the SMA had by this time distanced themselves from the

MPU, whose continued obsession with economic issues dismayed the SMA's founder, Charles

Brook.[132] However, historians agree that in the late 1930s all shades of political opinion were

more greatly influenced by a report from another source, namely the non-partisan lobby group,

PEP.[133]

The PEP Report and contemporary experiments in primary healthcare provision

The independent think-tank Political and Economic Planning (PEP) published their hugely

influential *Report on The British Health Services* in 1937.[134] It is generally considered to be

the most thorough and authoritative assessment of medical services in Britain at that time. Its

dispassionate analysis of the existing system is based on a clear understanding of its problems

to which it acknowledges the contributions of the individual and wider society. Like the Webbs

in 1910 and the Royal Commission in 1926, the report describes the inefficiency of

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[130] This was established following the successful joint arbitration of the Llanelli Miners Institute dispute in 1937. See Ray Earwicker 'A Study of the BMA/TUC Joint Committee on Medical Questions 1935 – 1939', *The Journal of Social Policy,* 8 (3) (1979) pp. 335 – 356.

[131] Frank Honigsbaum, 'The BMA/TUC Alliance and the Beveridge Report' *Bulletin of the Society for the Social History of Medicine,* 32 (1983) p.19.

[132] Brook opined that the MPU at this time was 'definitely more reactionary than the BMA' John Stewart *The Battle for Health: A Political History of the Socialist Medical Association 1930-1951* (Abingdon, 1999) p.73.

[133] Virginia Berridge, Mark Harrison and Paul Weindling, 'The Impact of War and Depression 1918-1948', in Charles Webster (ed) *Caring for Health: History and Diversity* (3rd edn, Buckingham, 2001) p.141.

[134] Political and Economic Planning (PEP), *Report on The British Health Services* (London, 1937). Its influence with the public increased due to the fact that the summary of it, *Britain's Health*, by S M Herbert was published in paperback by Penguin in 1939 with a foreword by Lord Horder.

uncoordinated and overlapping services.[135] It confirms many of the conclusions of the Royal Commission but is also at one in many respects with the BMA's proposals in *A General Medical Service for the Nation*, particularly in its appreciation of the role of the GP who, 'with his essential knowledge of the patient's background should be recognised as the specialist in diagnosis'. They also acknowledged the GP's gatekeeper role, stating that their function included seeing that 'best use is made of specialist services by the patient under his care.'[136] The authors deprecate excessive use of specialist services which 'is bad for those services and for the public, lowering standards, increasing congestion and often wasting time and money', and state that 'We consider that the making universal of general practitioner services is one of the most urgent conditions of an adequate National Health policy and that the most practical way of securing this object is by a reform or extension of National Health Insurance.'[137] The report argues for extension of NHI to dependants, juvenile workers and low-earning self-employed, and the addition to it of both a comprehensive maternity service and hospital services. It suggests that these can all be provided via increased insurance contributions into a centrally administered compulsory National Insurance scheme in which the approved societies and the voluntary organisations managing hospitals would no longer play any part.[138] However, PEP do not go so far as to say that the system should be open to all regardless of income and they reject the idea of it being fully tax-funded.

The report's conclusions are therefore remarkably similar to the BMA's which, as we have noted, some historians have been perhaps unfairly critical. Indeed, the PEP report, while acknowledging the deficiencies of the GP service, is remarkably sympathetic to the panel doctor's problems. 'The present status of the general practitioner is unsatisfactory' it states,

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[135] *Ibid*, p.25.
[136] *Ibid,* p.10.
[137] *Ibid,* p.10 and p.15.
[138] *Ibid,* p.16.

'because he is too overburdened with routine work to exercise judgment and to act as an effective health adviser.' PEP's proposed 'reorientation' of the service would involve increased efforts to reduce the GPs' workload to manageable proportions. Echoing the Royal Commission's views that NHI had provided much needed treatment to many in society who would otherwise not have received it, it says that 'the original service is much improved in quality.'[139] Rejecting those authorities who felt that GP services were stagnating, they quoted the Ministry's chief medical officer who stated that: 'The vast majority of insurance practitioners interpret the terms of their contract in no niggardly spirit, and undoubtedly the standard of service they give is not only high but is yearly rising as fresh advances in medical science add to the general practitioner's armamentarium in diagnosis and treatment.'[140] However, the service, they admit, is not as good as it could be, especially in working-class areas of large towns where the GP has neither the facilities or the equipment necessary to provide an adequate service and as a result passes on more patients to hospital and 'tends to become little more than an agent for signing certificates.' These tendencies are strengthened where, 'owing to the low remuneration he receives and the circumstances of the area in which he lives, the practitioner is forced to undertake more work than he can conscientiously perform.'[141] The solution, the report concludes, is to do what Dawson and the Royal Commission recommended, that is facilitate opportunities for local groups of doctors to operate from well-equipped centres or 'central dispensaries', offering the latest diagnostic and therapeutic equipment, a small operating theatre, a pathology laboratory, etc and housing ancillary health professionals under the same roof.[142]

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[139] *Ibid,* p.162.
[140] *Ibid,* p.146.
[141] *Ibid*, p.162.
[142] *Ibid,* p.164.Given the influence this document undoubtedly had on subsequent governments' health policies, it is not surprising that the idea of the health centre, while not at this time popular with the generality of GPs, found its way into the Labour government's National Health Service Act in 1946. Ironically perhaps, given the profession's views of MAIs, PEP believed that those run by the GWR Medical Fund Society in Swindon and the Llanelly and District Medical Service offered the most obvious model for such centres. pp. 151-152.

The BMA was clearly conscious of the influence of the PEP report when compiling the revised version of *A General Medical Service for the Nation* in 1938. According to Honigsbaum the only major change between this and its original was that while home hospitals still featured prominently, all mention of Health Centres had been dropped.[143] There is no doubt that the majority of panel GPs were at best ambivalent and at worst openly hostile towards Dawson's 'big idea'. The hostility was due to fears that local authorities would inevitably seize control of these centres and that this would lead inexorably to the demise of GP independent contractor status.[144] Dawson hoped that the sharing by GPs of facilities in such centres would crystallise into some form of group practice. Unfortunately, the spirit of individualism was too great for GPs at this time to really trust each other enough to want to work side by side, other than when compelled to do so, as in wartime. That is not to say that they were blind to the benefits of having access to improved facilities or the support of other professionals in their day to day tasks. In the 1920s the East End GP Harry Roberts had become something of a celebrity and visiting dignitaries were invited to inspect the 'state of the art' premises he had established in Stepney.[145] He had paid for these premises himself, making no secret of the fact that this was possible due to his having the largest panel list in the capital, if not the country, a situation which had earned him some notoriety. Roberts employed a dentist, and a medical masseur qualified in electrotherapy and soon had four partners, one of whom was female. He expanded his premises by acquiring the property adjacent to his original house in Harford Street and then the three adjoining ones.[146] He had thereby created a local health centre of sorts but it was not open to other practitioners.

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[143] Honigsbaum, *The Division in British Medicine*, p.148

[144] According to one observer 'whereas the medical profession would regard themselves, if under the control of the Approved Societies, as being chastised by whips, they would look upon the control of the local authorities, as they at present exist, as chastisement by scorpions.' (!) R.W. Harris, *National Health Insurance* pp.174-175.

[145] Winifred Stamp, *Doctor Himself: An Unorthodox Biography of Harry Roberts MD* (London, 1949) p. 76.

[146] *Ibid*, p.87.

Roberts' experience was similar in many ways to that of the Bermondsey GP Alfred Salter, who formed a partnership with other GPs sharing his socialist convictions and desire to alleviate the suffering of his impoverished patients.[147] Being intricately bound up with local politics, he found his proposals for a health centre in Bermondsey blocked by the Tory-dominated London County Council in 1929 but the proposal was given the go ahead following a Ministerial inquiry and the centre eventually opened its doors in 1936.[148] No discussion of Health Centres can fail to mention the Pioneer Health Centre in Peckham which opened in 1926 and in purpose-built premises in 1935. But while this centre, the brainchild of the pathologist, Scott Williamson, and his GP wife, Innes Pearse, offered many of the benefits which Dawson had envisaged, it was effectively a healthy living centre and consequently did not house or facilitate GP treatment.[149] However worthy its intentions therefore, and however great its influence on future health centre design, it cannot be said to represent a realisation of Dawson's vision. Nor could that be said of the of the other ground-breaking health centre of the period, the Finsbury Health Centre designed by the Russian architect Berthold Lubetkin which was opened by the local authority in 1937. For many, this iconic building offered an inspiring example of modernity- it featured in posters in the 1940s offering war-weary Britons a vision of the kind of health services and public buildings they could expect to see once victory had been achieved. Its futuristic façade was a world away from the wholesomely suburban and backward-looking designs for primary health centres featured in the Dawson report (see Figure 16). But the vision it offered proved to be just as illusory. It housed all the facilities Dawson

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[147] A. Fenner Brockway, *Bermondsey Story: The Life of Alfred Salter* (London, 1949) p.25. Salter was one of the leading lights of the Socialist Medical Association founded in 1930, but he favoured the idea of a 'health guild' of doctors, dentists, midwives and nurses to replace both the panel and voluntary system. p.149.

[148] *Ibid,* pp.168-169. See also Esyllt Jones, 'Local Labour and London's Interwar Health Centre Movement' *Social History of Medicine*, vol. 25 (2011) no.1, pp.87-90.

[149]Jane Lewis and Barbara Brookes, 'A Reassessment of the Work of the Peckham Health Centre 1926-1951', *Health and Society* (1983) Vol. 61, no 2. pp 307-350. It was essentially an experiment in improving the health of its local population by educating families about ill health prevention and encouraging the adoption of more healthy lifestyles. Its emphasis was thus holistic and preventative rather than curative.

Figure 16. *The envisioned locus of GP group practice*: Dawson Report Primary Health Centre 1920 (top) and the Finsbury Health Centre designed by Berthold Lubetkin 1937 (bottom). Photograph, The 20th Century Society.

envisaged other than what he considered the most essential, the GPs, who remained steadfastly opposed to any thought of becoming local authority tenants.[150]

It is true to state that GPs at this time remained largely isolated from one another and from developments in medicine and surgery. The upside of this for them was that they remained

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[150] A.B. Stewart, 'Health Centres of Today', *Lancet* 16 March 1946, pp.392-393. By 1946 the centre was already needing to be expanded and the MOH, Dr Stewart, clearly hoped the GPs could be persuaded to set aside their hostility to local authority involvement and play a part in it, stating 'If in future a medical gregariousness of this character can be attained, the general practitioner can lose his present partial isolation and regain some of the atmosphere of his hospital days'.

subject to minimal supervision and regulation. By the end of the 1930s, however, the number

of partnerships was beginning to rise and the number of practices employing staff or working

in some way with other professionals was increasing. At the beginning of the twentieth century

about 20% of practices were partnerships. This figure had risen to 25% by 1929 but it did not

reach 50% until 1950.[151] Thus, the spirit of individualism continued to dominate GPs' thinking

and outlook. As an illustration of this it may be useful at this point to look at the novel which

many commentators considered to be as influential as the PEP report in changing the tide of

public opinion in favour of a National Health Service. This was *The Citadel*, by the GP novelist

A.J. Cronin published in 1937.[152] In his illuminating study of Cronin's portrayal of the 'medical

hero', Ross McKibbin notes that while it proved an enormous hit with the public, being the

best-selling hardback of the decade and, according to a survey by Gallup, 'impressing more

people than the Bible', the medical profession's reaction to *The Citadel* was largely hostile.[153]

This is not surprising, since it paints an equally unflattering portrait of panel practice for the

poor, private practice for the rich, Medical Aid Institutes and District Medical Officers, and

the medical establishment in the form of the Ministry of Health, the Medical Research Council

and the General Medical Council! Much of its appeal as a 'truly modern novel' rests on the

fact that its hero, Dr Manson, is a fully drawn individual whose character defects are as visible

as his virtues. The reader witnesses his transformation from an idealistic young doctor,

challenging medical and social conventions while witnessing the poverty and hardship of a

panel practice in South Wales, to the owner of a successful London practice, sacrificing his

ideals, and his marriage, for material gain. He experiences an epiphany brought on by the tragic

consequences of another doctor's incompetence and his wife's death. This leads him to seek a

more fulfilling life in a provincial town where he will offer patients a new type of practice, a

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[151] Digby, *Evolution of General Practice*, p.131.
[152] A.J. Cronin, *The Citadel* (London, 1937).
[153] Ross McKibbin, 'Politics and the Medical Hero: A.J. Cronin's 'The Citadel'', *English Historical Review*, 123 (502) (2008) pp. 651 -678.

group practice composed of himself and his colleagues Denny, a surgeon, and Hope, a pathologist.

The Citadel is not, however, as McKibbin points out, a direct plea for a National Health Service. The hero, Manson, fears the bureaucracy of state control would be stifling and Cronin appears ambivalent about any service which, like the MAI at which he had worked in Tredegar, allows patients carte blanche to call for medical attention day or night.[154] Though *The Citadel* is often viewed as the touchstone of growing public support for the idea of a National Health Service in the late 1930s, Cronin himself can perhaps best be described as agnostic about the benefits of a government-managed National Health Service.[155] What the novel does do most effectively, however, is expose the ramshackle nature of medical organisation at that time and the adverse consequences for patients and doctors and the urgent need for root and branch reform. McKibbin states that Cronin's 'account of general practice as far as it goes is largely correct.'[156] Certainly, there is nothing in Manson's experience as a doctor of which one could not find evidence somewhere in Britain at that time, but it would be as incorrect to regard this description as typical as to say that Cronin, with his varied career in and out of medical practice, was a typical GP. Manson in no way resembles the family doctor lauded by Brackenbury and exemplified by Roberts, Salter or by the Yorkshireman Will Pickles, a pioneer of epidemiological research, the sort of GP of whom the authors of *A General Medical Service for the Nation* were thinking when setting out their vision of a service offering the best available care to all sections of the community.[157] The vision which these men espoused is in many respects one which later generations of medics would willingly endorse. Brackenbury in particular, in his book *Patient and Doctor*, published in 1935, came as close as any of his

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[154] *Ibid*, p.676.

[155] *Ibid*, p.675. McKibbin concludes 'it is difficult to know what Cronin thought about the National Health Service.'

[156] *Ibid*, p.663.

[157] Pickles was described in the *Lancet* as 'The grand old man of General Practice'. See John Pemberton, *Will Pickles of Wensleydale (*London, 1970) passim, and Digby, *Evolution of General Practice,* pp.218-220.

contemporaries to describing a philosophy of practice which was to influence generations of doctors and is still recognized in the teaching of general practice today.[158]

Honigsbaum describes this somewhat dismissively as the GP's 'social work' role.[159] More recent commentators would characterise this as a holistic, person-centred approach in which the GP combines the role of generalist medical attendant with that of health adviser, advocate and gatekeeper to other services, providing continuity of care based on the widest possible knowledge of the patient's circumstances. Doctors like Brackenbury, who had been in panel practice for over 20 years, treating generations of the same families, could justly claim to have acquired insights into the progress of common diseases and the impact on these of the home and work environment. Like McKenzie and Pickles, such doctors were already starting to share knowledge through research, based on painstaking analysis of their patient encounters. Brackenbury's philosophy can perhaps best be summed up by his statement that 'The opportunities he (the GP) has of seeing his patients for minor ailments as well as for serious illness, his acquaintance with their family history, habits of life, and social circumstances, and many other personal details learned only after a long and confidential intercourse, give the general practitioner just that knowledge which enables him to treat the patient and not merely the disease.'[160] Brackenbury was also forward-thinking in appreciating the impact of the patient's mental state on their physical health. As a later generation of GPs were to do under the guidance of Michael Balint, he thought it beneficial for GPs to acquire the skills of a psychotherapist.[161] As doctors are taught in medical schools today, he also believed that recovery from illness was often dependent on the success of a partnership between the patient

[158] Sir Henry B. Brackenbury, *Patient and Doctor* (London, 1935).
[159] Honigsbaum, *The Division in British Medicine*, p.122
[160] Brackenbury, *Patient and Doctor*, p.133
[161] *Ibid,* pp. 61-63, 254 and 272-273. See Michael Balint, *The Doctor, his Patient and the Illness* (London, 1956), *passim*, and Hayward, *Transformation of the Psyche*, ch. 4, in particular pp.112-115.

and doctor, one which, he said, 'involves mutual loyalty, and the possession of such qualities by each partner as to make such loyalty possible.'[162]

Conclusion

By 1939, some 21 million workers in Britain were covered by National Health Insurance and about 19,000 GPs participated in the scheme.[163] In *Patient and Doctor*, Brackenbury described the period in which he practiced as one of 'transition', that is from the experiment of NHI covering part of the population to one in which doctors looked forward to a more comprehensive, state sponsored national health service covering all sections of society.[164] This chapter has attempted to analyse the extent to which NHI was transformed during this period and the medical profession's involvement in anticipating and planning for what should follow it. There was little disagreement during this period about the need for NHI to be improved, both in scope and quality, but the worsening economic situation in Britain following the First World War forced the government, professional leaders, and other interested parties to list possible improvements in order of priority, according to cost and ease of implementation. To later sensibilities, Dawson's bold vision may have seen both logical, and deliverable, given sufficient political will. It was meant to begin the debate about the future of health and allied services but changing economic and political circumstances, and the reactionary nature of the response to it in certain quarters of the profession, closed down discussion of it prematurely. The report was, however, to exert a powerful influence on future health service planning up to and including the early days of the NHS. For a variety of reasons the ideal of group practices and primary healthcare teams set out by Dawson failed to appeal to the generality of GPs, who

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162 Brackenbury, *Patient and Doctor,* p.76.
163 Bernard Harris, *The Origins of the British Welfare State: Social Welfare in England and Wales,1800-1945* (Basingstoke, 2004) p.234; PEP, *Report on the British Health Services* (London, 1937) p.142.
164 Brackenbury, *Patient and Doctor,* p.162.

saw the growth of local authority clinics during the 1920s and 1930s as a threat to their economic status, even though they struggled to meet the demand for their services, both from patients insured under NHI and the considerable number, including dependants, who remained outside it. The benefits of group practice could not for most GPs outweigh the loss of personal freedom of action that it appeared to entail.

Honigsbaum is correct to identify two distinct and occasionally competing objectives for development of NHI: extension, to include dependants, or expansion in the range of services, to include specialist care.[165] For the reasons documented in his book, GPs found themselves gradually excluded from specialist hospital work in this period even though, as this chapter has shown, their involvement in cottage hospitals and nursing homes was significant and requires greater acknowledgement. While some GP leaders hoped to prevent or mitigate what Honigsbaum calls 'the division in British medicine' others, including Brackenbury, viewed it more philosophically, believing that the future of general practice lay in the realisation of the old nineteenth century ideal of the family doctor.[166] Healthcare, they realized, was not just about prescribing bottles of medicine or removing diseased organs, it was about prevention of ill health and promotion of healthy lifestyles through a long association with patients and their families and a thorough understanding of the complex interaction between their environment, work and lifestyle. Extending the benefits of NHI to dependants was thus of paramount importance to men like Brackenbury and it was only when the economic crisis of 1931 rendered that 'beyond the bounds of practical politics' that the profession's leaders actively promulgated PMS schemes as the most acceptable alternative.

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[165] Honigsbaum, *The Division in British Medicine*, pp.122-129.
[166] Compare Irvine Loudon, 'The Concept of the Family Doctor', *Bulletin of the Society for History of Medicine*, 58 (3) 1984, pp.347-352

Historians seem to have failed to appreciate the significance of PMS and how it might have evolved, had not political circumstances eventually favoured a more radical approach in the development of a tax-funded National Health Service. It is easy from a late twentieth and early twenty-first century viewpoint to criticise the GPs' determination to hold on to private practice. But, prior to 1945, none but a minority of socialist doctors thought a non-contributory, fully tax-funded scheme feasible or desirable and, however selfish it might seem, the panel GPs' attachment to the mixed practice model was one which they found easy to justify. In general practice at this time there was a symbiotic relationship between private and state-funded healthcare. The fees GPs charged to middle-class patients who could afford them helped maintain the level of income GPs needed to continue to undertake panel practice and compensated for the government's refusal to increase their remuneration from it. But we should not forget that many so-called private patients were actually dependants of insured workers for whom charges for medical cover had to be set at affordable levels.

In the late 1930s GPs were on the whole more economically secure than they had been a generation earlier but there were wide disparities in status and income, and workload was for many an intolerable burden. Partnerships were becoming more common but, as it was largely unregulated, general practice remained individualistic in character. The downside of this was that GPs remained professionally isolated and were seen by many leading members of the profession as irredeemably backward.[167] The continuity of care the family doctor offered had not yet come to be fully appreciated. Nor is it possible even now to try to quantify the other intangible benefits which the panel GPs offered their patients. Although always subject to time pressures and occasionally exasperated by what they deemed unreasonable demands, the panel

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[167] This belief was one professed by many leading specialists as later evidenced by Lord Moran's famous comment about GPs falling off the consultants' career ladder. *Royal Commission on Doctors' and Dentists' Remuneration 1958*, Minutes of evidence, Days 3-4, Q1023. HMSO 1958. However, it was given substantial support by the critical findings of J.S. Collings' study 'General Practice in England Today: a Reconnaissance', the *Lancet*, 25 March 1950. These criticisms were only partially offset by the subsequent less critical study by Stephen J. Hadfield, 'A Field Study of General Practice 1951-1952', *BMJ* 26 September 1953, pp.683-706.

GPs doled out sympathy and reassurance to their patients in equal measures, and the faith which patients put in their family doctor was often as important as any medicine they prescribed in facilitating recovery from illness.[168] Their value to society as a whole during the interwar period was arguably much greater, therefore, than they have generally been given credit for.

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[168] There is a plethora of research on the effect of placebos and the patient's faith in the doctor. A good starting point for those interested would be Michael Dixon and Keiran Sweeney, *The Human Effect in Medicine: Theory, Research and Practice,* (London, 2000).

Conclusion

Oh, who'd not be a medical man

On Lloyd George's great Insurance Plan

Which such a glorious time began

For the State Insurance Doctor?
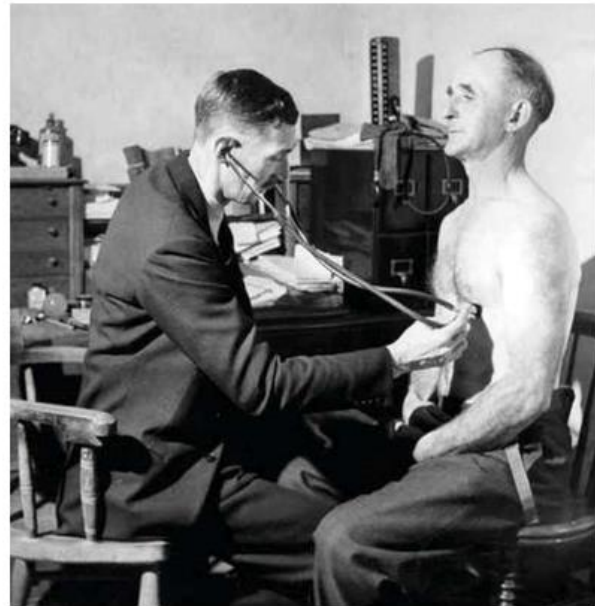
'The State Insurance Doctor', *Dr John Johnson, BMJ* 23 December 1911 'Literary Notes' p.1164

Figure 17. *'The State Insurance Doctor'.* Panel GP and patient, 1930s. Photograph Historyextra.com

In writing this thesis my primary objective was to investigate and explain the culture, professional aspirations, and collective ideology of British general practitioners before the National Health Service (NHS) came into being. My particular focus was on GPs' growing awareness of the effect of politics on their desire for self-determination and on the development of organised healthcare services in early twentieth-century Britain. My analysis led me to explain how new representative structures came into being in the interwar period that reflected and embodied GPs' political culture and professional aspirations. These structures also proved an effective lobby to protect GPs' interests. My analysis has challenged some common misconceptions about GPs' conflicts with governments during the period studied. These include the idea that GPs were consistently opposed to state coordination of healthcare services, and that there was no higher purpose to their leaders' actions than their own material benefit. My thesis has therefore encouraged, perhaps, a greater appreciation of their collective sacrifices

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and contributions to the nation's wellbeing. It has also made clear why collective opinions formed during this period continued to exercise an influence on the thinking of the GPs of subsequent generations, extending even to the present. The following sections elaborate on the major themes explored and demonstrated in this thesis.

Individualism, contractor status and professional autonomy

Throughout the period studied, general practice remained very much an individual undertaking. Sir George Newman believed that individualism was a determining characteristic of the medical profession and central to the doctor's success as a clinician, stating:

> His competence is not only his learning and knowledge, but his practical capacity, his clinical skills and experience and above all his resourcefulness, adaptability, common sense and imagination…These are individual virtues and the medical practitioner is individualistic in upbringing and in purpose.[1]

Partnerships between GPs thus often proved difficult to sustain given the inevitable personality clashes which occurred when strong minded individuals disagreed. As the GP MP Morris-Jones observed in relationship to the dissolution of his own partnership, 'Partnership in medicine is more difficult than in any other profession…There are abundant opportunities for disagreement, discord and dissension. Temperamental variation and dissimilarities are emphasised and accentuated.'[2] Single-handed practice therefore remained the norm during this period.[3] The GP's practice was essentially a personal enterprise in which individual doctors invested much of their waking lives.[4] The advent of National Health Insurance (NHI) did not

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[1] Quoted by Henry Brackenbury in *Patient and Doctor* (London, 1935) p.134.

[2] Sir Henry Morris-Jones, *Doctor in the Whipps' Room* (London, 1955) p.80.

[3] Elliot Friedson quotes a fellow sociologist, Karl Evang, who stated that as regards medicine 'solo practice is a sacred cow in more than one country.' Elliot Friedson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York, 1970) p.91.

[4] Charles Webster says that 'like shopkeepers they looked for little beyond their list.' Charles Webster, 'General Practice Under the Panel: the Last Phase', *Bulletin of the Society for the Social History of Medicine*, 32 (1983)

put an end to commercial rivalry and competition between practitioners. Even without the divisions which occurred as a result of the bitter intra-professional disputes which accompanied NHI, many doctors found it hard to cooperate with their local competitors, even though they were occasionally compelled to seek assistance from other doctors, whether for a second opinion, the administration of an anaesthetic during an operation, or treatment for themselves or their families when sick. A layman, Mr. Atherton Moore, writing in *Medical World* in 1914, offered the following astute observation:

> Accustomed throughout their professional lives to act alone, to come to decisions in a moment, guided by the needs of the moment, without opportunity for consultation with others, they develop a moral temper which unfits them to act with others. The very quality of being self-contained, adequate to the task of the moment which is so invaluable a part of the mental equipment of a country Doctor, this quality itself makes it difficult for him to sink his individuality and cooperate with other men.[5]

For most GPs, independent contractor status, as the embodiment of their individualistic spirit, became an article of faith which Local Medical and Panel Committees (LMPCs) and their national executive, the Insurance Acts Committee (IAC), had pledged to defend at all costs. Steve Watkins observes that independent contractor status has 'a deep emotional appeal' to GPs and that the Medical Practitioners Union (MPU) ' suffered very heavily when it declared its support for a salaried service.'[6] As noted in the introduction to this thesis, the desire for autonomy is common to all branches of the medical profession internationally. It was their ability as independent contractors to undertake their clinical work unsupervised, and without being monitored by those to whom they were contractually responsible, which made British GPs feel superior to salaried doctors, or any of their continental counterparts, who may have

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p.23. Anne Digby notes that 'General Practice was frequently referred to as a cottage industry' *The Evolution of British General Practice 1850-1948'*(Oxford, 1999) p.136.
[5] *Medical World,* 8 January 1914 'Doctor's Disunion' p.57-58.
[6] Steve Watkins, *Medicine and Labour : The Politics of a Profession* (London, 1987) p. 96.

been less free to determine who to accept as a patient, when and where to deliver treatment, or determine how many patients they could safely be responsible for. These freedoms exercised a powerful attraction for which the fringe benefits of a salaried service, such as nominally fixed hours and employer-sponsored pensions, never succeeded in outweighing.

Watkins believes, however, that the freedom of action which doctors believed independent contractor status accorded them is largely illusory in that doctors have always had an overwhelming tendency to conform to accepted norms of practice and behaviour.[7] But whenever individual GPs were singled out for criticism by the Ministry of Health in the 1930s, the doctors' representative bodies usually rose to defend to the utmost their constituents' right to exercise their clinical and professional freedom without lay interference, even where their behaviour exceeded the bounds of what they believed to be good practice.[8] The preservation of independent contractor status gave rise to what Watkins describes as the 'laager mentality' which resulted from the profession's sense of 'being embattled, being powerless, pushed around by hostile and powerful forces against which it must maintain relentless hostility in order to have some slight influence on events.'[9] The GPs' original antagonists – non-qualified quacks, interloping professional rivals, self-enlarging local authorities and the friendly societies – were soon supplanted in the GPs' imagination by manipulative politicians hell-bent on reducing the doctors' power to determine their own future and by a hostile press reflecting the political preferences and prejudices of the political elite. This feeling was accelerated by the events of the 1920s and 1930s when the panel GPs' patience and reserves of goodwill and public-spiritedness were tested by the persistent undermining of the profession's claim for just reward by ministers, civil servants and those in the press who were dismissive of their claim to be acting in the public interest. Out of this process emerged a collective feeling, which survived

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[7] *Ibid,* pp.21-24
[8] See ch. 6 above, the defence of the anti-vaccinationist Harvey for example.
[9] Watkins, *Medicine and Labour* pp.22 and 18.

into the era of the NHS, which Watkins describes as 'a fierce libertarianism, radical in an unfocused almost unrealistic way, impatiently dismissive yet at the same time fearful of administrators, politicians, unions, other health workers or any group of patients who claimed to be more than passive recipients of the profession's devoted service.'[10]

Free choice of doctor, private practice and the professional social ideal

Hand in hand with independent contractor status was the principle which became in itself a separate article of faith for the profession, that is, free choice of doctor. This was something which was calculated to appeal to the man in the street as much as it did to Lloyd George but it was not, as W.J. Braithwaite maintained, a specious claim.[11] GPs genuinely believed in the patient's right to choose their medical attendant because the effectiveness of the confidential relationship between doctor and patient was based on trust, even if, judging by many contemporary accounts, there was often a good deal of suspicion on both sides. David B. Green's argument that the friendly societies were the unheralded champions of consumer choice falls down when he accuses the GPs of being anti-competitive.[12] Their adherence to the principle of free choice of doctor proved that GPs were in favour of competition, provided it was 'fair' competition, that is competition based on quality of service or the doctor's reputation rather than price, and this is effectively what they got under NHI. Their collective experience of the excesses of the free market had led them to believe that undercutting by impoverished and unscrupulous doctors would, by lowering the market rate for their services, result in an

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[10] *Ibid* p.22.

[11] See above ch.3. Sir Henry Bunbury (ed) *Lloyd George's Ambulance Wagon: the Memoirs of W.J. Braithwaite* (London, 1957) p. 198.

[12] David B .Green, *Working-Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948* (Aldershot, 1985) p. 132.

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increasingly lower of quality of service being delivered by an increasingly inferior brand of doctor.

NHI brought a halt to that process but when the actions of successive governments led not just to a failure to increase their remuneration from panel practice but to actually reduce it, it was not surprising that GPs, fearing a resultant and unwelcome lowering of standards, sought to maximise their income from private practice. In many cases this exceeded their income from panel practice as GPs sought to maintain the standard of living they believed they deserved and which guaranteed their proper place in society. They believed very strongly, as we have seen, that an adequate lifestyle was necessary for them to maintain proper standards of practice and to do their best for patients. As contemporary commentators noted, patients' respect for their doctors and the advice they gave was often influenced by the outward appearance of 'respectability'. Thus, James Smith Whitaker asked, when commenting on the GPs' pay claim in 1919 if the amount the doctors were asking for (10s per patient) was no more than sufficient 'to remunerate a doctor working at the maximum of his single-handed capacity *taking into account the social position it is desirable that he should occupy?*' (my italics).[13] In the BMA's evidence to the Court of Inquiry into GPs' pay in 1923 Professor Bowley echoed this feeling when he said that the doctors' 'professional success, from the financial point of view, is to some extent dependent on their maintaining a social position in proper relationship to those among whom they work.'[14] Even socialist doctors like Alfred Salter believed that GPs should be adequately paid. Accompanying this view is the belief that to be effective in all aspects of their work, GPs needed to be cultured individuals, a view endorsed by the League of Nations' report quoted by Brackenbury in his book, *Patient and Doctor*, which said that 'The Doctor should, in the best sense of the words, belong to the elite. His professional knowledge should

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[13] *National Archives* MH 62/118, Memorandum from Whitaker to Morant dated 24 July 1919, part 4, point 10.
[14] *BMJ* 5 January 1924 'Court of Inquiry into the Insurance Capitation fee' Appendix D Memorandum by Professor Bowley dated 21 December 1923 , Supplement p.11.

be enhanced by his general culture.'[15] Rightly or wrongly, GPs believed that they could not achieve that level of 'culture' without an adequate standard of living.[16]

Independent contractor status was the foundation of the mixed public and private practice model and essential to their autonomy. It allowed GPs to maintain a list of panel patients as large as they felt able to manage while still allowing them time to treat dependants of the insured and fee-paying middle-class patients and undertake other remunerative medical work. It was acknowledged by the GPs themselves that fee-paying patients generally enjoyed greater courtesies and convenience than panel patients but GPs devoted no less attention to the latter's medical needs. As we have seen, GPs, other than the minority who favoured a salaried service, wanted a comprehensive national medical service available, though not free, to all, and expected those able to afford to pay for a GP's services privately to continue to do so. From the perspective of historians writing in the late twentieth-century, this attitude seemed reactionary and inconsistent with the altruistic outlook which doctors professed, and the public had come to expect of them, under the NHS. There is more than a hint of determinism in this, influenced by the views of an earlier generation of historians and social scientists whose reverence for the NHS inclined them to see the welfare state as the inevitable culmination of a century of social reform and state expansion.[17] Now that such views no longer go unchallenged the motives of the profession's leaders warrant a more open re-examination. If those who accuse the doctors of these times of being interested only in their own wellbeing are correct then the public pronouncements of their leaders were a cynical façade, of which one would expect to find evidence in their confidential documents and communications. The absence of any such evidence supports my contention that they were sincere in their adherence to the ideals

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[15] Brackenbury, *Patient and Doctor*, p.261.

[16] 'For much of the nineteenth and twentieth century, culture was understood to be a significant - if not indispensable – part of what it meant to be middle class.' Simon Gunn, 'Translating Bourdieu: Cultural Capital and the English Middle Class in Historical Perspective', *British Journal of Sociology*, vol.56 (2005) p 54.

[17] For a comprehensive analysis of this issue see Martin Gorsky, 'The British National Health Service, 1948-2008: A Review of the Historiography.' *Social History of Medicine*, (2008) Vol.21, no. 3 pp.437-460.

of public service, albeit in their own terms, and that they genuinely wanted to establish the best possible health service the country could afford, based on a mix of private and public funding. It should be remembered that many panel GPs had almost no private patients other than the families of the insured, whom they endeavoured to cater for through Public Medical Service schemes in the expectation that they would eventually be included in any future state-organised health service. The level of bad debts incurred by many 'slum doctors' is, moreover, consistent with the continued element of charity which they were forced to adopt towards their poorest patients.[18] As we have seen, private practice remained an area in which GPs had greater freedom to experiment with new treatments, pursue special interests and acquire new skills which could prove to be of benefit to their panel patients. For those GPs able to grasp its opportunities, private practice offered the prospect of greater financial rewards. It also offered freedom from the increasing effects of 'red tape' and officialdom which the panel GPs found irksome. It was therefore viewed as a potential bolt-hole into which GPs could retreat if their experience as reluctant agents of the state proved unpalatable or unsustainable. This was an essential weapon in their conflicts with the government and proved to be one of the sticking points on which their subsequent opposition to Aneurin Bevan's proposals for the NHS was based. What they also feared those proposals might threaten was their freedom to self-regulate.

Self-regulation and bounded pluralism vs bureaucratisation and state control

For doctors, autonomy demanded professional control over the setting of standards for competence and behaviour. This control was not at any time surrendered by the profession during the period studied. The General Medical Council, as the ultimate arbiter of professional

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[18] '..receipts from the Clubs, for looking after their families (who gave twice as much trouble) scarcely covered the cost of drugs and dressings.' Frank Maylett Smith, *A G.P.'s Progress to the Black Country* (Hythe,1984) p.86.

conduct and standards and of who could be and remain a qualified medical practitioner, continued to be dominated by clinicians and its power and decision-making was seldom questioned by government. When it came to NHI, the state had every right to expect a role in determining if those it contracted with to deliver medical services were complying with their contracts but accepted the need to defer to the profession's expertise in clinical matters. The doctors generally exercised the decisive voice in medical service subcommittee investigations. Politicians were also content, as we have seen, to grant the profession the responsibility to police disputes between practitioners and share ground-rules for professional etiquette through the Local Medical and Panel Committees (LMPCs). The deference shown towards the profession by Lloyd George, Addison, Morant, and his key officials in the early days of NHI did not sit well with the approved societies or their allies in the press but was consistent with Liberal party views of how the expanding state should operate, that is by means of 'bounded pluralism'.[19] The relationship between the state and professional bodies, statutory or otherwise, may also be viewed in terms of what a number of European researchers are now referring to as 'regulated self-regulation'.[20] For the BMA and their critics in the MPU, 'there were no severer critics of delinquent doctors than a body of their own colleagues invested with the control of purely professional affairs.'[21] But while excessive prescribing, inappropriate charging of fees, or failure to offer treatment required might be punished, service committees found it difficult to agree on matters of competence or negligence. The Local Medical Committees also found it difficult to censure doctors of whom other constituents complained for fear of being sued and, being without funds, they were never fully able, in the absence of state indemnity, to realise their potential as professional 'courts of honour.'

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[19] As noted in ch. 3, the phrase coined by Pat Thane, *Foundations of the Welfare State* (2nd edn. London 1996) p.291

[20] See for example Peter Collin, Sabine Rudischhauser, and Pascale Gonod "Autorégulation régulée. Analyses historiques de structures de régulation hybrides = Regulierte Selbstregulierung. Historische Analysen hybrider Regelungsstrukturen", in *Trivium. Revue franco-allemande de sciences humaines et sociales*, (2016), Vol. 21.

[21] BMA, *A General Medical Service for the Nation* (London, 1930) para.30.

Conclusion

The advent of the Regional Medical Officer (RMO) Service signified the beginning of a change in the dynamics of the relationship between panel GPs and the state. Relations between the GPs, LMPCs, and Insurance Committees remained cordial but, being directly accountable to the Ministry, the plenipotentiary RMOs soon merited, in many panel doctors' eyes, the same degree of opprobrium they accorded to the local authorities' Medical Officers of Health. While rigorously exercising their inquisitorial functions in inspecting GPs' records and prescribing, and questioning their judgment in issuing certificates, the RMOs came to represent for some panel GPs an unwelcome, intrusive and in some cases feared emissary of the state. In 1923 the Walsall GP Frank Layton had welcomed the changes wrought by the advent of NHI in his novel *The Old Doctor* whose publication the BMA had helped sponsor as an act of propaganda. Layton had dedicated his novel to Morant. Ten years later in his novel *The Little Doctor*, Layton complains that the Ministry has 'ruined' the scheme of which GPs like him had such high hopes. He concludes his fulminations with regret at Morant's passing: 'Why did the big man die…? His death was a catastrophe…He would never have consented to panel doctors being treated as untrustworthy clerks.'[22] For Layton it would seem that the relationship between panel GPs and the state was scarcely one of partnership. Moreover, the behaviour of ministers and officials like Robinson hardly merited the degree of confidence and trust which Cox had expressed in his paean to the 'incorruptible' civil service.[23] Though it would be considered distinctly 'light touch' by modern standards, the degree of monitoring of contractual noncompliance by Insurance Committees and RMOs was seen by many GP as a constraint on their professional freedom and unwelcome evidence of increasing state control, fuelling concerns about the possibility of a future state medical service.[24] It was to their representative

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[22] Frank G. Layton, *The Little Doctor* (Edinburgh, 1933) p.200.
[23] *BMJ* 7 April 1923 Supplement p.106.
[24] '..the panel doctor is being brought more and more under the stultifying influence of authority.' *Medical World* 1 October 1926, G. Rome Hall 'Improving the Medical Service.' p.37.

bodies that the GPs looked to counter this and other existential threats.

Representative authority, bargained corporatism and political extremism

Unity, Watkins observes, was the profession's main weapon in its battle against a hostile world.[25] But unity was, as we have seen, elusive. While it was the desire for an effective political response which led the profession back to the IAC leadership in moments of crisis, the BMA's inability to speak forcefully and monolithically for a united profession was a constant constraint on its effectiveness. The dilemma facing those who sought to organize the profession for political objectives was how to bring these individuals together in a common cause. Doctors, as Woodcock had observed, were not by nature rebels, so it took a lot to move them to the point where they felt compelled to collaborate in mutual self-defence.[26] The 'battle of the clubs' was really a succession of local skirmishes with an enemy which an astute minority of doctors recognised as representing a serious and long term threat to their wellbeing. The effect of the agitation following the Manchester conference in 1900 was to force the BMA to recognise its political role and, though it hotly denied it, to become, for the benefit of its largely GP membership at that time, a trade union in all but name. Its structures, the divisions and new central committees, were not fully developed when the first great opportunity came for the BMA to flex its political muscles as it galvanised the profession in opposition to the Insurance Act. However, their collective judgement of what this legislation offered the profession was off-target, as was readily admitted by later generations of its leaders. Their inexperience was their undoing. As Lloyd George, in forgiving mood, informed a dinner organised in his honour

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[25] Watkins, *Medicine and Labour* p.19.
[26] Herbert de Carle Woodcock *The Doctor and the People* (London, 1912) p.100.

by veterans of the conflict in 1933 'It was the first time the profession as a body had come into politics, and politics is a very heady wine if you are not used to it, and they were not.' [27]

As we have seen, the conflict over NHI divided the profession and the very wide spectrum of political opinions it encompassed included extreme wings which those who aspired to lead the profession at times found difficult to ignore. Yet, while every GP had an opinion, the number who were sufficiently motivated or had the time and energy to become actively involved in professional politics remained small. In 1912 Woodcock opined that the local branches of the BMA 'were too much in the hands of correct and starchy men, dry, longwinded, anti-social', confessing to being one such man himself.[28] He observed, however, that 'the political doctor' was 'now born' and there were among those who emerged as local and national leaders of the GPs after 1912 a group of capable individuals who fully understood that politics was 'the art of the possible' and built on painstaking efforts to build relationships with those at the centre of power in the state. While many medical luminaries found it hard to disguise their distaste for the squabbling over financial reward which much of their political activity necessarily involved, the reaction of a good proportion of the profession, other than at times of greatest agitation, was one of resignation and apathy. Even when great political questions affecting the work and future of panel practices were at issue, few GPs could rouse themselves to attend meetings. Writing to the *British Medical Journal* in 1916 a Dr J. MacBeth Elliot reported that when enquiring as to why BMA division meetings were poorly attended one colleague had informed him that 'These medico political matters do not interest me in the least.'[29] When collecting evidence to present to the Royal Commission in 1926 one regional committee of LMPCs noted that 198 meetings had taken place across the country at which not

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[27] Alfred Cox, *Among the Doctors* (London, c. 1949) p.197.
[28] Woodcock, *The Doctor and the People*, p.94.
[29] *BMJ* 30 September 1916 p.477.

more than 21% of panel GPs had attended.[30] Eckstein shrewdly observes 'There is power which rests on sympathy and power which rests on apathy; that of the BMA's leaders rests on apathy. It is therefore easily turned into weakness under circumstances requiring strong corporate cohesion.'[31]

The local structures on which the profession's power rested remained peopled by representatives nominally elected by their peers but who were in reality largely self-selected, as the number of uncontested elections and vacant seats on LMPCs during this period attest. The political allegiances of these institutions were sometimes determined by the personalities of their local leaders and battles for control are evident in the minutes of LMPCs and the debates at their annual Conference. In Kent the LMPC's adherence to the MPU effectively came to an end in a showdown in the late 1920s between its local spokesman, Gordon Ward, and the LMPC officers, and by 1938 the accommodation between the London Panel Committee and the IAC was complete when E.A. Gregg became chairman of both, as well as chairman of the London Insurance Committee and the London Public Medical Service ![32] The LMPC representatives were meant to reflect the views of their constituents which was why elections were conducted on the basis of geographical districts, but in the face of widely diverging views among their constituents it was the representatives' own views which usually emerged more strongly. They might have justified their actions by quoting one of Edmund Burke's sayings of which Harry Roberts was fond: 'Your representative owes you not his industry only but his judgement; and he betrays, instead of serving you, if he sacrifices it to your opinion.'[33]

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[30] *YORLMC Archive,* minutes of meeting of Group C Regional committee of LMPCs on 10 March 1925.

[31] Harry Eckstein, *Pressure Group Politics: The Case of the British Medical Association* (London, 1960) p.72.

[32] *Kent LMC Archive*, minutes of Kent LMPC meetings on 9 October and 6 November 1924 and 22 December 1927; John H. Marks, *The History and Development of Local Medical Committees, their Conference and its Executive* (Edinburgh MD Thesis 1974) pp.139-140. Douglass W. Orr and Jean Walker Orr, *Health Insurance with Medical Care: the British Experience* (New York, 1938) p. 175.

[33] Winifred Stamp, *Doctor Himself: an Unorthodox Biography of Harry Roberts MD* (London, 1949) p.110. Believed to have been said during one of Burke's Speeches on arrival at Bristol (1774), *Oxford Concise Dictionary of* Quotations (4th edn, Oxford, 2001) p.74, 17.

Conclusion

Views are divided about the success of the BMA's attempts at bargained corporatism. Eckstein argues that the BMA and the Ministry worked constructively together most of the time and that while GP leaders did not succeed in major confrontations they made up for this with less well publicized successes in more minor matters.[34] Digby questions Eckstein's assessment of this 'meso-corporatist' approach stating that 'During the interwar years the BMA was ineffectual in its attempts to raise state payments to panel doctors.'[35] She accords this failure to the difficulty of bringing the profession together in a united effort. As we have seen, the profession's leaders in the 1920s and 1930s generally sought to give ministers and officials the benefit of the doubt as to their motives for wanting to reduce expenditure and increase regulation. However, the effects of government actions were to depress panel GPs' income and morale, which fomented dissatisfaction both with government and with GPs' professional leaders, whom many GPs, like the MPU, deemed too conciliatory. A frequent critic of the IAC, Dr Genge, a representative of Croydon LMPC, typified this view when he said in 1931 that the IAC contained too many 'perfect little gentlemen' and that the GPs should instead be represented 'by someone who was not quite a gentleman.'[36] In any event, the government's deference to professional expertise was tempered by its ability to put forward its own medical experts, namely the Ministry's senior medical advisers and the network of RMOs, who came to be despised by many rank and file GPs as the proverbial 'poachers turned gamekeepers'.

Yet, as this thesis has shown, the principal bulwark against government control and chief weapon in their battle for self-determination was the collective might of the professional institutions to which NHI had given birth, the LMPCs. Although their individual effectiveness and influence over Insurance Committees was often dependent on the personalities of the

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[34] Eckstein, *Pressure Group Politics*, p.96.
[35] Anne Digby 'Medicine and the English State 1901-1948' in S. J. Green and R.C. Whiting (eds.) *Boundaries of the State in Modern Britain 1851-1951* (Cambridge, 1996) p. 217.
[36] *BMJ* 31 October 1931, 'Report of Annual panel Conference' Supplement, p.248.

committees' membership, collectively they represented a powerful lobby group bolstered by a nominally democratic mandate, able to articulate (what they believed were) the opinions of grassroots GPs and certainly capable of mobilising their constituents in support of political objectives. Over time the local relationships between the LMPCs and the Insurance Committees became close to the point of being almost incestuous, especially when, as in a few cases, the LMPC chairman became the chairman of the Insurance Committee or their secretary was the Insurance Committee Clerk ![37] To remain free of government control it was essential that LMPCs remained self-funding but this represented a fundamental weakness. The amount of statutory levy payments they could collect to support their activities was circumscribed by regulations and the amount of voluntary contributions constrained by their constituents' ability, or willingness, to pay. Without the resources necessary to pay for much beyond the honorarium of a secretary and members' travelling expenses, the LMPCs could not fulfil the active leadership role which Addison and others had hoped they would and the policing of professional behaviour was, as we have seen, fraught with legal difficulties. Those LMPCs who produced formularies and professional guidance for their constituents did so at their own expense and on their own initiative but such actions show how much more effective they could have been had they been funded adequately.

From a political perspective, the importance of the LMPCs' Conference as a policy-making body has been overlooked by historians who in general have tended to see it as less important than the BMA's Annual Representative Meeting. This was certainly true when it came to the negotiations about the NHS the 1940s, but during the interwar period the IAC and its leaders were in no doubt that their power, though bolstered by the resources of the BMA, rested squarely on the democratic mandate which the Conference of LMPCs had bestowed on them.

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[37] In 1926 a *Medical World* editorial lamented the fact that only about 6 out of 126 Insurance Committees in England were chaired by Panel GPs, dismissing newspaper claims that this was a new development. *Medical World* 26 November 1926, p.224.

Conclusion

The increasing proportion of IAC members elected by the GPs themselves, regardless of whether or not they were BMA members, is, moreover, testament to the overriding political necessity of keeping the LMPCs Conference loyal and 'on side'. Failure to do so, the IAC's leaders believed, would result in attempts to establish a rival organisation. As we have seen, this was no idle threat, but it was one which the IAC and its supporters just about managed to suppress. The fortunes of the MPU waxed and waned depending on general levels of dissatisfaction within the profession. They never looked like supplanting the IAC and their activities sometimes seemed only to increase the latter's bargaining power, not by forcing them to take a more extreme stand, but by providing the Ministry with a less palatable alternative if an accommodation with the IAC proved unattainable.

What is not disputed is the fact that dissatisfaction with their lot encouraged successive generations of GPs to continue to create lobby groups and new organisations threatening the BMA's political hegemony. For those on the extreme wings of political opinion, the BMA's business-like relationship with the Ministry smacked of collusion and the LMPCs' equally cordial relationship with Insurance Committees was just as reprehensible.[38] Political extremists are always difficult to accommodate and often made use of the political platform offered them by the conference of LMPCs. As a *BMJ* editorial in 1919 stated: 'In every body of ardent reformers there have always been doctrinaires who will make more noise and thus exerted more influence than their numbers or the weight of the arguments warranted.'[39] In many cases the strategy adopted by those playing to the gallery at the LMPCs conference involved advocating extreme forms of action to which the word 'strike', whether justified or not, was widely applied. The fact that the IAC backed away from such extreme measures was characterised as weakness but the profession's leaders' reluctance was due to an abiding wish to avoid harm to patients,

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[38] *Medical World* 8 October 1926, 'Grettir' opines, in relation to IAC members giving advice to the Ministry on the scope of service that 'The tar of officialdom will stick to the feet of those who consort with officials.' p.80.
[39] *BMJ* Editorial 22 March 1919 p.349.

and the loss of the profession's moral superiority which that would have involved. It was also due to the recognition that even a temporary reduction in panel income could prove fatal to many doctors' businesses. The BMA had flexed its muscles successfully in disputes over Medical Aid Institutes, even if it had got its knuckles rapped during the Coventry case, but implementing industrial action on a national scale was fraught with risk to doctors' livelihoods and reputations and its reluctance was therefore understandable.

The paradox of how to equate the ostensibly selfish need for material reward with the selfless calling of a noble profession continued to perplex doctors throughout this period, as their opponents recognised only too well. As John Marks, the GP chairman of BMA Council in the 1990s and sometime historian of LMCs, stated in his autobiography:

> While studying the origins of Local Medical Committees I became increasingly aware that ever since Lloyd George introduced the National Insurance bill in 1912 the state had ruthlessly exploited doctors' vocational spirit. Civil servants and politicians appreciated medico political history and knew that doctors were unwilling to take any action that would jeopardise their patients and that, under pressure, they would blame the BMA for their troubles and form splinter groups.[40]

As this thesis has shown, this somewhat jaundiced view contains more than a grain of truth. But what, finally, does this thesis reveal about British GPs' relationship with the state and where does it sit within the broader context of historical scholarship?

Panel GPs and the state: the significance of this study

The relationship between panel GPs and the state was, as we have seen, complex. In one sense it was feudatory, with the doctors acting as agents of the state in helping to manage an essential

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[40] John Marks, *The NHS: Beginning, Middle and End? The Autobiography of John Marks* (Oxford, 2008) p. 101.

area of government activity and being given in return wide latitude to self-govern. In another, it was one of purchaser and supplier, subject always to uneasy negotiations about the value of the supplier's product. But, to the more suspicious and pessimistic among the profession, the relationship was one which the state was always keen to transform into one of master and servant by introducing regulations which reduced the doctors' professional autonomy and paved the way for the substitution of independent contractors by a full-blown salaried service. While such fears existed, normally cordial and business-like relationships between professional representatives and instruments of government at national and local level could, with the appropriate stimulus, descend into conflict and become a power struggle. Rowland Fothergill may have deprecated the IAC's tendency to act independently of the BMA and dismissed the idea of LMPCs being 'fighting units', but it was these bodies rather than the BMA itself and its divisions which mobilised and led the GPs politically during the interwar period.[41] When writing of power dynamics Michel Foucault claims at every moment a relationship of power may involve resistance by the subject. At the heart of the relationship between ruler and ruled is a kind of tension which he describes as an 'agonism' involving 'reciprocal incitation and struggle' which is 'less of a face to face confrontation which paralyzes both sides than a permanent provocation.'[42] This, I would suggest, is an apt description of the relationship between the panel GPs' representatives and the state during this period and one that has not featured in any previous historical analysis.

There is a substantial body of historical scholarship devoted to the medical, social and economic aspects of General Practice under NHI. Studies of GPs' political activities during the era of NHI, however, are rare and, as was noted in the introduction, over forty years old in most cases. Although worthy, they are deficient in many ways. This thesis has sought to fill the gaps

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[41] *Medical World* 30 May 1919 pp.454-455.
[42] Michel Foucault , 'The Subject and Power', *Critical Inquiry*, 8 (4) (1982) p. 790.

in previous analyses, focusing on a better understanding of the sociological impulses behind GPs' behaviour in resisting lay and ultimately government control of their activities, and documenting the evolution of their collective political ideology. The profound impact GPs have had on British society was determined, I have argued, by the way in which contract practice evolved before NHI and how panel practice evolved under it and engaged with the state apparatus through the representative institutions formed during that period. By shining a light on neglected aspects of those processes I have sought to establish a new paradigm for understanding GPs' relationship with the state in Britain in the interwar period.

From a broader historical perspective, this study has also added to our knowledge of the rise of the professions and their place within British society during this period. It has offered a new perspective on the nature of the Liberal welfare state and the complexities of bounded pluralism by examining governments' relationships with GPs as expert intermediaries. It has also shown how GPs enjoyed state patronage in the exercise of self-government but were nonetheless determined to resist any extension of its authority over their professional activities. This tension is illustrative of a larger theme on which this thesis sheds light: the nature of the British class system during the interwar period, and in particular the insecurities of the middle class, of whom the GPs themselves were to some degree emblematic. By casting a spotlight on the changing roles, politics and self-perception of GPs, this thesis has shown how middle-class insecurities were manifested politically and otherwise during a period of massive social and economic upheaval which saw the sweeping away of the old Liberal order. These concerns were not, however, unique to the interwar period. Considering the events of 2016 described in the introduction, this thesis has explained how the political ideology of GPs during the period studied and their articles of faith became engrained in their collective culture to the extent that they are clearly recognisable in the speeches and actions of their present day representatives. It has shown how the GPs' limited ability to self-regulate encouraged a desire to resist

governmental interference, fostered a distrust of politicians, and engendered a fierce, unfocussed libertarianism which formed the basis of a professional narrative which today's doctors find no less compelling.

Bibliography

Primary Sources

Archives

British Medical Association

Medico Political Committee Minutes, 1908 – 1938

State Sickness Insurance Committee Minutes, 1910 – 13

Insurance Acts Committee Minutes, 1913 – 1939

Insurance Acts Committee archives and manuscripts 1918 – 1939

Central Medical War Committee Minutes 1915 – 1918

General Medical Services Committee Minutes, 1929 – 1930

General Medical Services Committee Minutes, 1933 – 1934

General Practice Committee Minutes, 1938 – 1939

Miscellaneous: Conference of Medical Organisations 1919

Non-Panel Committee Minutes 1913 – 1914, 1917, 192 – 1924

Special Committee on 'Position arising out of the Coventry case' 1918 – 1919

Special Medical Services Scheme Minutes, 1938 – 1939

County of London Panel Committee Minutes, 1914 – 1939

Joint BMA & TUC Committee on Medical Questions, 1938 – 1939.

Wellcome Institute Library

Complaints 1917-1950 SA/BMA/D.237 Box 180

Friendly Societies and Medical Aid Institutes 1910 – 1947, SA/BMA/C.102 Box 54

Medical Women's Federation, 1917 – 1939, SA/MWF/C.78 Box 24

Medico-Political Union, 1918 – 1939 SA/BMA/A.48 Box 13

National Insurance Defence Trust Minutes 1919 – 1933 , SA/BMA/H.10 Box 258

Partnerships and Assistants SA/BMA/C.522 Box 139.

University of Manchester, Central University Library

Manchester Medical Associations, Newspaper Cuttings, GB133MMC7/1/3, History of Associations, GB133MMC7/2/8; Manchester Ethical Association, Tariff of Medical Fees, GB133MMC7/2/4.

Manchester Medical Guild, Rules of Members Medical Pamphlets AI.13605; Rule Books, GB133MMC7/4/1; Annual Reports, B133MMC/7/4/2; 'Reports', GB133MMC/7/4/3; Provident Dispensary Report, GB133MMC/7/4/3/1; AGM, GB133MMC/7/4/3/2; Agenda for Conference,

GB133MMC/7/4/3/3; Official Report, GB133MMC/7/4/3/4; Correspondence with BMA, GB133MMC/7/3/5.

Medical Guild Quarterly, GB133MMC/7/4/6.

NMU, Press Cuttings, GB133MMC/7/18/1; NMU Minutes 1911-1913 .

BMA Lancashire & Cheshire Branch GB133MMC/7/21.

Manchester Medico Ethical Society, Guide to Fees for Insurance Committees, GB133MMC/11/1/2.

Manchester Insurance Committee, Medical Benefits Sub-Committee, GB127.M40, 1912 – 1948.

Report on the Manchester Medical Service, GB133MMC/11/1/2/1; Circular re Cut in

Remuneration, GB133MMC/11/1/3/4, 1934; Circular re Amended Terms of Service, GB133MMC/11/1/3/5, 1934; Discontinuation of Deductions, GB133MMC/11/1/3/7, 1935.

Manchester LMPC, Formation of Committee and Scope, GB133MMC/11/2/1, 1913+.

Circular to GPs re Panel Committee, GB133MMC/11/2/1/1, 1913+; Annual Accounts of Insurance

Doctors, GB133MMC/11/2/1/2, 1913+; LMPC Accounts, GB133MMC/11/2/1/3, 1913+; LMPC

Circulars, GB133MMC/11/2/2/2, 1925 – 1936; Memorandum on Methods of Payment,

GB133MMC/11/2/2/2/1,1925; Circular on Touting for Patients, GB133MMC/11/2/2/2/14, 1920s; Circular on Joint Committee of BMA and LMPC re District Medical Services, GB133MMC/11/2/2/2/17, 1936; Handbooks for Practitioners (1,2 and 3), GB133MMC/11/2/2/3, 1930s; Newspaper Cuttings, Opposition to the Act, GB133MMC/11/3/2, 1912+; District Service, GB133MMC/11/3/3, 1935.

Medical Guild Quarterly, 1898 – 1907.

Manchester Medical Review, 1908 – 1909.

University of Leicester, David Wilson Library

Leicester Royal Infirmary Maternity Hospital: Essay by F A Alexander, E1/1/3 – 5, 1960; Constitution of Leicester Public Medical Service, Objects of PMS, E1/1/6, 1912+;

Union of Medical Practitioners, Working Rules, E1/1/10, Rules including Reference to Registration as Trade Union, E1/1/30, 1912, GP Membership Form, E1/1/20, 1920s; Letters From A Cramp, Oddfellows to S B Couper, Secretary, Leicester PMS, Leicester District Juvenile Society, E1/2/2, 1937; Collectors Agreement, E1/2/10, 1930s; Leicester Sub-Division Committee Report, Scheme for Collective Locum Tenancies, E1/1/11, 1948; Leicester Sub-Division Report, Discussion of Winding Up, E1/1/19, 1950; Letters from Accountants, Compensating Loss of Employment, E1/2/12, 1946; BMA Minutes of Conference of Representatives of PMS, GP12 1941/42, E1/2/13,1942; BMJ Supplement re Trade Union Law, E1/1/20, 1948.

National Archives, Public Records Office, Kew

Ministry of Health (NHI) Records:

Registered files series 1, 1912 – 1968

MH 81/26, 1929 – 30, Development of NHI/Medical certification.

MH 81/28, 1929 – 30, Panel Conference resolutions.

Registered files series 2, 1912 – 1965.

MH62/44, 1921 – 22, Amendment of Regulations, Terms of service.

MH 62/107, 1919 – 1962 , Excessive prescribing.

MH 62/109, 1926 – 27, Investigation arrangements.

MH 62/116, 1918, Doctors' Terms of Service, conferences with IAC.

MH 62/117, 1919   "   "

MH 62/118, 1919 – 1920 Revisions to Medical Benefit Regulations.

MH 62/119, 1919, Terms and conditions of medical service.

MH 62/ 124, 1919 Discussion papers.

MH 62/125, 1917 – 19, Special grant to Panel Practitioners.

MH 62/128, 1923 – 24, Summary of negotiations.

MH 62/ 175, 1931 – 1935 National economy, reductions in remuneration.

MH 78/96, 1919 – 20, Appointment of medical referees.

MH 79/7, 1918, War Office demand for Medical Practitioners.

Kent LMC, Maidstone

Kent County Medical Committee Minutes, 1912 – 1913.

Kent Panel Committee and LMPC Minutes 1914– 1939 and related documents.

Lancashire and Cumbria, LMCs Preston

Lancashire LMPC Minutes, 1914 – 1925.

Lancashire LMPC Minutes, 1928 – 1931 and related documents.

North Staffordshire LMC, Stoke-on-Trent

Staffordshire LMPC Minutes, 1914 – 1939 and related documents.

YOR LMC (North Yorkshire), Harrogate

Group D Standing Joint Committee of LMCs and Panel Committees Minutes 1921 – 1923.

Group C Standing Joint Committee of LMCs, Minutes 1923 – 1939.

Local Medical & Panel Committee for County of Yorkshire (North Riding) Minutes 1932 – 1936.

Nottinghamshire County Public Records Office, Nottingham

Notts County Insurance Committee Minutes, 1912 – 1939, SO.NHI.1-3.

Notts County Insurance Committee Medical Benefits Sub-Committee Minutes, 1913 – 1926, SO.NHI/10.

Notts LMPC Correspondence 1912+, D/1440/23/20-43.

Newark LMC Minute Book, 1911 – 1913 DD/1440/23/1,

Government Reports

Report of the Royal Commission into the Poor Laws and Relief of Distress 1905-1909. Cmd. 4499, 1909.

Report of Sir William Plender in Respect of Medical Attendance and Remuneration in Certain Towns 1912-1913. Cmd. 6305, (the Plender Report) 1913.

Interim Report to the Minister of Health by the Consultative Council on the Future Provision of Medical and Allied Services . Cmd. 693 (the Dawson Report) 1920.

Report of the Royal Commission on Health Insurance. Cmd. 2596, 1926.

Report of the Inter-Departmental Committee on National Expenditure. Cmd. 3920 (the May Report) 1931.

Report on Social Insurance and Allied Services. Cmd. 6404 (the Beveridge Report) 1942.

Report of the Inter-Departmental Committee on the Remuneration of General Practitioners 1945-1946, Cmd. 6810 (the Spens Report) 1946.

Other Reports

Report of an Investigation into the Economic Conditions of Contract Medical Practice, British Medical Association Medico-Political Committee (BMA Contract Practice Report) 1905.

Report into the Organisation of Medical Attendance on the Provident or Insurance Basis, British Medical Association Medico-Political Committee (BMA Public Medical Services Scheme Report) 1913.

A General Medical Service for the Nation, British Medical Association Report 1930.

A General Medical Service for the Nation, British Medical Association Report (amended) 1938.

Report on the British Health Services, Political and Economic Planning (the PEP Report) 1937.

Contemporary newspapers and periodicals 1890-1939 (*selective use*)

British Medical Journal

Daily Chronicle

Daily Express

Daily Mail

328

Daily Mirror

Daily Sketch

Daily Telegraph

Fortnightly Review

Lancet

Manchester Guardian

Manchester Medical Guild Quarterly

Medical World

Nation

National Insurance Gazette

National Medical Journal

New Statesman

The Practitioner

The Star

The Times

Westminster Gazette

Biography and Memoirs

Addison, Christopher, Viscount, *Politics from Within*, vol. 1, 1911-1918 (London,1924).

Allen, Bernard M. , *Sir Robert Morant. A Great Public Servant* (London,1934).

Barber, Gerald, *Country Doctor* (Woodbridge, Suffolk, 1974).

Brockway, Archibald Fenner, *Bermondsey Story: The Life of Alfred J. Salter* (London, 1949).

Bunbury, Henry, (ed), *Lloyd George's Ambulance Wagon: The Memoirs of W. J. Braithwaite* (London, 1957).

Cox, Alfred, *Among the Doctors* (London, c. 1949).

Gosse, Phillip, *An Apple a Day* (Bristol, 1948).

Marks, John *The NHS: Beginning, Middle and End? The Autobiography of John Marks* (Oxford, 2008).

Morris-Jones, Sir Henry, *Doctor in the Whipps' Room* (London, 1955).

Mullin, James, *The Story of a Toiler's Life* (London, 1921, UCD edn 2000).

Pemberton, John, *Will Pickles of Wensleydale* (London, 1970).

Pooler, H.W., *My Life in General Practice* (London, 1948).

Smith, Francis Maylett, *The Surgery at Aberffrwd: Some Encounters of a Colliery Doctor Seventy Years Ago* (Hythe, Kent, 1981) and *A G.P.'s Progress to the Black Country* (Hythe, Kent, 1984).

Stamp, Winifred, *Doctor Himself: An Unorthodox Biography of Harry Roberts 1871-1946* (London, 1949).

Watson, Francis, *Dawson of Penn: A Biography* (London, 1951).

Wilson, McNair, *The Beloved Physician: Sir James Mackenzie* (London, 1926).

Fiction

Brett-Young, Francis, *My Brother Jonathan* (London, 1928) and *Doctor Bradley Remembers* (London, 1938).

Conan-Doyle, Arthur, *The Stark Munro Letters* (London, 1898).

Cronin, A.J*., The Citadel* (London, 1937).

Layton, Frank G., *The Old Doctor* (Birmingham, 1923) and *The Little Doctor* (Edinburgh, 1933).

McLaren, Ian, *A Doctor of the Old School* (London, 1898)

Shaw, George Bernard, *The Doctor's Dilemma* (London, 1906- Penguin ed. 1946).

Other Primary Sources

Anon ('A Panel Doctor'), *On the Panel: General Practice as a Career* (London, 1926).

Anon ('AGP'), *This Panel Business* (London, 1933).

Ashe, Isaac, *Medical Education and Medical Interests* (Dublin, 1868)

Brackenbury, Henry Britten, *Patient and Doctor* (London, 1935).

Brend, William A., *Health and the State* (London, 1917).

Briggs, I .G., *How to start in General Practice* (London, 1928).

Booth, Charles, *Life and Labour of the People of London* (London, 1892).

Chiozza-Money, Sir Leo, *Insurance and Poverty* (London, 1912).

Comyns-Carr, A. S., Stuart-Garnett W.H, and Taylor, J.H., *National Insurance* (London, 1912).

Currie, J.R. , *The Mustering of Medical Service in Scotland 1914-1919* (Edinburgh, 1922),

Gibbon, Ioan Gwilym, *Medical Benefit: A Study of the Experience of Germany and Denmark* (London, 1912)

Hardy, Horatio Nelson, *The State of the Medical Profession in Great Britain and Ireland in 1900 (Carmichael Prize Essay)* (Dublin, 1900).

Harris R.W., and Sack, L. S., *Medical Insurance Practice* (London, 1924).

Harris, R.W., *National Health Insurance 1911 – 1946* (2nd edn., London, 1946).

Herbert, S. Mervyn, *Britain's Health* (London,1939).

Newsholme, Sir Arthur, *Medicine and the State* (London, 1932).

Orr, Douglass W. and Orr, Jean Walker, *Health Insurance with Medical Care in Great Britain* (New York, 1938).

Rowntree, Seebohm, *Poverty: A Study of Town Life* (London, 1901).

Smiles, Samuel, *Self- Help* (London,1859 -OUP edn. 2002).

Sprigge, Samuel Squire, *Medicine and the Public* (London, 1905).

Webb, Beatrice, and Webb, Sydney, *The State and the Doctor* (London, 1910).

Webb, Beatrice, 'Special Supplement on Professional Associations' Part II, *The New Statesman*, IX (211) 21 April 1917: pp. 1-24.

Woodcock, Herbert De Carle, *The Doctor and the People* (London, 1912).

Secondary sources

Abel-Smith, Brian, *The Hospitals 1800 - 1948: A Study in Social Administration in England and Wales* (London, 1964) .

Alborn, Timothy, 'Senses of Belonging: the Politics of Working-Class Insurance in Britain 1880-1914', *Journal of Modern History* (2001) 73: 561-602

Armstrong, Barbara N., *The Health Insurance Doctor: His Role in Great Britain, Denmark and France* (Princeton, NJ, 1939).

Armstrong, David, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge, 1983)

Bartrip, Paul, *Themselves Writ Large: The British Medical Association 1832-1966* (London, 1996).

Bentley, Michael, 'Boundaries in Theoretical Language About the British State.' in Green S J, and Whiting, R.C., (eds) *The Boundaries of the State in Modern Britain* (Cambridge, 1996).

Berridge, Virginia, 'Health and Medicine', in Thompson, F.N.L. (ed) *Cambridge Social History of Medicine: Britain 1750-1940* (Cambridge, 190) pp.171-242.

Berridge, Virginia, Harrison, Mark and Weindling, Paul 'The Impact of War and Depression 1918-1948' in Charles Webster (ed) *Caring for Health: History and Diversity* (3rd edn, Buckingham, 2001) p.141.

Berlant, Jeffrey, *Profession and Monopoly* (Berkley, CA, 1975).

Blanpain, Jan, *National Health Insurance and Health Resources: The European Experience* (Harvard, MA, 1978).

Bourdieu, Pierre, *Distinction: A Social Critique of the Judgment of Taste* (London, 1984)

Bourdieu, Pierre, 'The Social Space and the Genesis of Groups' *Theory and Society*, 14. (6) (1985) pp.723-744.

Bourdieu, Pierre 'The Forms of Capital' in H. Lauder, P. Brown, J-A. Dillabough and A. H. Halsey (eds) *Education, Globalisation and Social Change* (Oxford, 2006).

Bradford Hill, A., 'The Doctor's Day and Pay' *Journal of the Royal Statistical Society* (1951) Series A (General) vol.114, no1, pp. 1-34.

Brand, Jeanne C., *Doctors and the State: the British Medical Profession and Government Action in Public Health 1870-1912* (Baltimore, MD, 1965).

Briggs, Asa, 'The Welfare State in Historical Perspective', *Archives Européene de Sociologie*, 2 (1961) 22.

Bynum, William F., *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge, 1994).

Carpenter, Niles H., The Literature of Guild Socialism', *The Quarterly Journal of Economics,* 34. No (4) (1920) pp. 763 – 776.

Clarke, Peter, *Hope and Glory: Britain 1900 – 2000* (2nd edn, London, 2004).

Clegg, Hugh A., *A History of British Trade Unionism since 1889*, vol.2 1911 – 1933, and vol. 3 1933 – 1939 (Oxford, 1994)

Coburn, D., 'Medical Dominance Then and Now: Critical Reflections', *Health Sociology Review*, 15:5: (2006) pp. 432-443.

Cockram, Joyce, 'The Federation and the British Medical Association', *Journal of the Medical Women's Federation,* vol.49 (1967) pp.76-78.

Collin, Peter, Rudischhauser, Sabine, and Gonod, Pascale, 'Autorégulation régulée. Analyses historiques de structures de régulation hybrides = Regulierte Selbstregulierung. Historische Analysen hybrider Regelungsstrukture', *Trivium. Revue franco-allemande de sciences humaines et sociales*, vol. 21. (2016).

Conybeare, Sir John, 'The Crisis of 1911-1913: Lloyd George and the Doctors', *Lancet*, 15 May 1957 pp.1032-1035.

Cook, Chris, *The Age of Alignment: Electoral Politics in Britain 1922-1929* (London, 1975).

Cooter, Roger, 'The Rise and Decline of the Medical Member: Doctors and Parliament in Edwardian and Interwar Britain', *The Bulletin of the Society for the Social History of Medicine* 78. (1) (2004) pp. 59 – 107.

Cordery, Simon, *British Friendly Societies 1750 – 1914* (Basingstoke, Hants 2003).

Corfield, Penelope, *Power and the Professions in Britain 1700 – 1850* (London, 1995).

Cronin, James E, *The Politics of State Expansion: War, State and Society in Twentieth Century Britain* (London, 1991) .

Cox C. and Mead A. (eds) *A Sociology of Medical Practice* (London, 1975).

Daunton, Martin, 'Payment and Participation: Welfare and State Formation in Britain 1900 – 1951', *Past & Present* No 150 (1996) pp. 169– 216.

Daunton, Martin, *Wealth and Welfare: An Economic and Social History of Britain 1851 – 1951*, (Oxford, 2007).

Digby, Anne, 'Medicine and the English State 1901-1948' in Green, S J, and Whiting, R C (eds), *The Boundaries of the State in Modern Britain* (Cambridge, 1996).

Digby, Anne, 'The Economic and Medical Significance of the British National Health Insurance Act 1911', in Gorsky, Martin, and Sheard, Sally (eds) *Financing Medicine: the British Experience since 1750* (Abingdon, Oxon, 2006), Chapter 11.

Digby, Anne, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911* (Cambridge, 1994).

Digby, Anne, *The Evolution of British General Practice 1850-1948* (Oxford, 1999).

Digby, Anne, and Bosanquet, Nick, 'Doctors and Patients in an Era of National Health Insurance and Private Practice 1913 – 1938', *The Economic History Review* 41 (1) (1988) pp. 74 –94.

Dixon, Michael, and Sweeney, Keiran, *The Human Effect in Medicine: Theory, Research and Practice,* (London, 2000).

Duman, Daniel, 'The Creation and Diffusion of a Professional Ideology in Nineteenth-Century England', *Sociological Review*, 27 (1979) pp. 113-138.

Earwicker, Ray, 'A Study of the BMA/TUC Joint Committee on Medical Questions 1935 – 1939', *The Journal of Social Policy,* 8 (3) (1979) pp. 335 – 356.

Earwicker, Ray, 'Miners' Medical Services before the First World War; the South Wales Coalfield' *Llafur* (the Journal of the Society for the study of Welsh Labour History) vol. III, No.2 (1981) pp.39-52.

Eckstein, Harry, *Pressure Group Politics: The Case of the British Medical Association* (London, 1960).

Eckstein, Harry, *The English Health Service: its Origins, Structures and Achievements* (Cambridge MA, 1964)

Eder, Norman R. , *National Health Insurance and the Medical Profession in Britain 1913-1939* (New York, 1982)

Edgerton, David, *Warfare State: Britain, 1920-1970* (Cambridge, 2006)

Eley, Geoffrey, *Modern Germany vol. 2, 'Social Imperialism'* (New York, 1988).

Elliot, Phillip, *The Sociology of the Professions* (Basingstoke, Hants,1972).

Emrys-Roberts, Meyrick, *The Cottage Hospitals* (Motcombe, Dorset, 1991).

Eversley, John, *Continuity in a Changing World: One Hundred Years of Representative Bodies* (London, 2012).

Fairfield, Letitia, 'Women Doctors in the British Forces 1914-1918' *Journal of the Medical Women's Federation,* vol.49 (1967) pp. 99-102.

Foucault, Michel, *The Birth of the Clinic: An Archaeology of Medical Perception*, (trans A.M Sheridan Smith, New York, 1975).

Foucault, Michel, 'The Subject and Power', *Critical Inquiry*, 8 (4) (1982).

Foucault, Michel, *The Foucault Effect* (Chicago, 1991).

Fox, Daniel M. , *Health Policies, Health Politics: the British and American Experience 1911-1965* (Princeton NJ, 1986).

Fraser, Derek, *The Evolution of the Welfare State* (London, 1973).

Friedson, Elliot, 'Client Control and Medical Practice', *American Journal of Sociology* 65 (1960), pp. 374-382.

Friedson, Elliot, *The Profession of Medicine: a Study of the Sociology of Applied Knowledge* (1st edn. New York, 1970)).

Giddens, Anthony, *The Consequences of Modernity* (Cambridge, 1990).

Gilbert, Bentley B., *The Evolution of National Insurance in Great Britain: The Origins of the Welfare State* (London, 1966).

Gilbert, Bentley B., *British Social Policy 1914-1939* (London, 1970).

Godber, Sir Charles, 'The Domesday Book of British Hospitals', *Bulletin of the Society for the Social History of Medicine* , 32 (1983) pp. 4-12.

Gorsky, Martin, 'Friendly Society Health Insurance in Nineteenth Century England', in Gorsky Martin, and Sheard, Sally (eds) *Financing Medicine: the British Experience since 1750* (Abingdon, Oxon 2006) Chapter 9.

Gorsky, Martin. 'The Political Economy of Health Care in the Nineteenth and Twentieth Centuries' in Jackson, Mark (ed) *The Oxford Handbook of the History of Medicine* (Oxford, 2011).

Gorsky, Martin, 'The British National Health Service 1948-2018: A Review of the Historiography', *Social History of Medicine,* vol.21, no. 3 (2008) pp.437-460.

Gorsky, Martin, 'Local Government Health Services in Interwar England: Problems of Quantification and Interpretation.' *Bulletin of History of Medicine*, 85 (2011) pp.384-412.

Green, David B., *Working-Class Patients and the Medical Establishment: Self-help in Britain from the Mid-Nineteenth Century to 1948* (Aldershot, Hants,1985).

Green, David B., 'Medical Care in Britain Before the Welfare State', *Critical Review*, 7:4. (1993) pp. 479- 495.

Grenfell, Michael (ed), *Pierre Bourdieu: Key Concepts* (2nd edn. Abingdon, Oxon, 2012).

Grey-Turner, Elston, *History of the British Medical Association 1932–1972* (London, 1982).

Grigg, John, *Lloyd George: The People's Champion 1902-1911* (London, 1978).

Grigg, John, *Lloyd George: From Peace to War 1912-1916* (London, 1985).

Gunn, Simon, 'Translating Bourdieu: Cultural Capital and the English Middle Class in Historical Perspective', *British Journal of Sociology*, vol.56 (2005) pp.49-64.

Halevy, Elie, *History of the English People in the 19th Century. Vol.5, 'Imperialism and the Rise of Labour'* (London, 1961).

Harris, Bernard, *Origins of the Welfare State* (Basingstoke, Hants, 2004).

Harris, Bernard, 'Social Policy by Other Means? Mutual Aid and the Origins of the Welfare State in Britain during the Nineteenth and Twentieth Centuries.' *Journal of Policy History*, 30 (2) (2018).

Harris, Bernard, Gorsky, Martin, Guntupalli, Aravinda Meera, and Hinde, Andrew, 'Long-term Changes in Sickness and Health: Further Evidence from the Hampshire Friendly Society.' *Economic History Review*, 65, 2 (2012) pp.719-745.

Harris, J.F., *Unemployment and Politics 1886-1914* (Oxford, 1972).

Harris, Jose, 'Political Thought and the Welfare State 1870 - 1940: An Intellectual Framework for British Social Policy', *Past & Present*, No 135 (1992) pp. 116 – 141.

Harris, Jose, *Private Lives, Public Spirit: Britain 1870-1914* (2nd edn, London, 1994).

Hart, Julian Tudor, 'The Inverse Care Law', *Lancet*, 27 February 1971, pp.405-412.

Hay, James R., *The Origins of the Liberal Government Reforms 1906 – 1914* (London, 1983) .

Hayward, Rhodri, *The Transformation of the Psyche in British Primary Care* 1870 – 1970 (London, 2014).

Hennock, E.P., 'Poverty and Social Theory in England: The Experience of the Eighteen Eighties', *Social History* 1 (1) (1976) pp 67 – 91.

Himmelfarb, Gertrude, *Poverty and Compassion: The Moral Imagination of the Late Victorians* (New York, 1992).

Holloway, W.F., 'Medical Education in England 1830-1858: a Sociological Analysis', *History,* vol. 49.167. (1964).

Honigsbaum, Frank, *The Division in British Medicine: a History of the Separation of General Practice from Hospital Care 1911-1968* (London, 1979).

Honigsbaum, Frank, 'The BMA/TUC Alliance and the Beveridge Report' *Bulletin of the Society for the Social History of Medicine,* 32 (1983) pp.18-19.

Honigsbaum, Frank, 'Christopher Addison: a Realist in Pursuit of Dreams' in Porter, Dorothy and Roy (eds) *Doctors, Politics and Society: Historical Essays* (Amsterdam, 1993).

Horrobin, Gordon, 'Professional Mystery: The Maintenance of Charisma in General Medical Practice', in Dingwall, Robert and Lewis, Paul (eds) *The Sociology of the Professions*, (London, 1983) .

Huerkamp, Claudia, 'The Making of the Modern Medical Profession 1800-1914: Prussian Doctors in the Nineteenth Century' in Cocks, Geoffrey and Jarausch, Konrad H. (eds) *German Professions 1800-1950* (Oxford, 1990).

Inkster, Ian, 'Marginal Men: Aspects of the Social Role of the Medical Community in Sheffield 1790-1850 ' in Woodward J. and Richards D. (eds) *Healthcare in Popular Medicine in Nineteenth century England: Essays in the Social History of Medicine*. (London, 1977).

Jackson, Ben, *Equality and the British Left: A Study in Progressive Political Thought 1900-1964* (Manchester, 2007).

Jenkinson, Jacqueline, 'More 'Marginal Men': A Prosopography of Scottish Shop-keeping Doctors in the Late Nineteenth and Early Twentieth Centuries', *Social History of Medicine*, 29 (1) (2016) pp. 89 – 111.

Jenkinson, Jacqueline, 'A 'Crutch to Assist in Gaining an Honest Living': Dispensary Shop-keeping by Scottish General Practitioners and the Responses of the Medical Elite 1852 – 1911', *The Bulletin of the Society for the Social History of Medicine* 86 (1) (2012) pp. 1 – 36.

Jewson, Nicholas, 'Medical Knowledge and the Patronage System in Eighteenth-Century England' *Sociology* 8 (1974) pp. 369-385.

Johnson, Terence J., *The Professions and Power*, (London, 1972).

Jones, Esyllt, 'Local Labour and London's Interwar Health Centre Movement', *Social History of Medicine,* vol.25 (2011), no.1, pp.84-102.

Jones, Helen, *Health and Society in Twentieth-Century Britain* (London, 1994).

Joyce, Patrick, *The State of Freedom: A Social History of the British State since 1800* (Cambridge, 2013).

Kent Local Medical Committee, *The History of Kent Local Medical Committee 1912 – 2012* (2nd edn Harrietsham, Kent, 2012).

Ketelaar, Eric, 'Tacit Narratives: The Meaning of Archives', *Archival Science*, 1 (2001) 131 – 141.

Kidd, Alan J, 'Historians or Polemicists? How the Webbs Wrote Their History of the English Poor Laws', *Economic History Review*, 40 (3) (1987) pp. 400– 417.

Kidd, Alan J., *State, Society and the Poor in Nineteenth Century England* (Basingstoke, Hants,1999).

Kidd, Alan J., The 'Liberal State': Civil Society and Social Welfare in Nineteenth Century England', *The Journal of Historical Sociology*, 15 (1) (2002).

Koven, Seth, and Michel, Sonya, 'Womanly duties: Maternalist Policies and the Origins of the Welfare State in France, Germany, Great Britain and the United States, 1880-1920', *American Historical Review,* 95 (4) (1990) pp. 1076-1108.

Lane, Joan, *A Social History of Medicine* (London, 2001).

Larkin, G., *Occupational Monopoly and Modern Medicine* (London, 1983).

Lawrence, Christopher, *Medicine and the Making of Modern Britain 1700 – 1920* (London, 1994).

Levy, Hermann, *National Health Insurance: A Critical Study* (Cambridge, 1944)

Lewis, Jane, 'Providers, Consumers, the State and the Delivery of Healthcare Services in Twentieth Century Britain' in Wear, A. (ed) *Medicine and Society: Historical Essays* (Cambridge, 1993).

Lewis, Jane, *The Politics of Motherhood: Child and Maternal Welfare in England 1900-1939* (London, 1980)

Lewis, Jane, and Brookes, Barbara, 'The Peckham Health Centre, 'PEP', and the concept of General Practice during the 1930s and 1940s', *Medical History*, 27 (1983); 'A Reassessment of the Work of the Peckham Health Centre 1926-1951', *Health and Society*, vol. 61, no.2 (1983), pp.307-350.

Little, Ernest Muirhead, *History of the British Medical Association 1832-1932* (London, c. 1933).

Loudon, Irvine, *'The Concept of the Family Doctor', Bulletin of the History of Medicine,* 58 (3) (1984) p.347-352.

Loudon, Irvine, *Medical Care and the General Practitioner to 1850* (Oxford, 1986).

Loudon, Irvine, Horder, John, and Webster, Charles (eds), *General Practice Under the NHS 1948 – 1997* (Oxford,1998).

Macleod, Roy, 'The Frustration of State Medicine', 1880 – 1899, *Medical History*, 11 (1) (1967) pp. 15-40.

MacLeod, Roy, 'Law, Medicine and Public Opinion: the Resistance to Compulsory Health Legislation, 1870-1907', *Public Law*, (1967) p. 211.

MacNicol, John, *Politics of Retirement in Britain 1878 – 1948* (Cambridge, 1998)

Maehle, Andreas-Holger, 'Beyond Professional Self-interest: Medical Ethics and the Disciplinary Function of the General Medical Council of the United Kingdom 1858-1914', *Social History of Medicine*, vol.33 no. 1 (2020) pp.41-56

Mann, Michael, *The Sources of Social Power (vol 2):. The Rise of Classes and Nation States 1790-1914* (2nd edn. Cambridge, 2012).

Marshall, T.H., 'The Recent History of Professionalism and Social Policy', *Canadian Journal of Economics and Political Science,* 5 (3) (1939) reprinted in Marshall T.H. *Sociology at the Crossroads* (1963), pp. 150-170.

Maton, Karl, 'Habitus' in Michael Grenfell (ed.) *Pierre Bourdieu: Key Concepts*, (2nd edn Abingdon, Oxon, 2012), pp.48-64.

McDonald, Andrew, 'The Geddes Committee and the Formulation of Public Expenditure Policy, 1921-1922', *The Historical Journal,* 32 (1989) pp. 643-674.

McKibbin, Ross, *The Ideologies of Class: Social Relations in Britain 1880-1950* (Oxford, 1990).

McKibbin, Ross, 'Politics and the Medical Hero: AJ Cronin's 'The Citadel'', *English Historical Review*, 123 (502) (2008) pp. 651 – 678.

McLarren-Caldwell, Janis, *Literature and Medicine in Nineteenth Century Britain* (Cambridge, 2004).

Morgan, Jane and Kenneth, *Portrait of a Progressive: The Political career of Christopher Viscount Addison* (Oxford, 1980).

Morgan, Kenneth O., *Consensus and Disunity: the Lloyd George Coalition Government 1918-1922* (Oxford, 1978)

Morrice, Andrew, ''Strong Combination': The Edwardian BMA and Contract Practice', in Gorsky, Martin, and Sheard, Sally, (eds) *Financing Medicine*: *the British Experience since 1750* (Abingdon, Oxon, 2006).

Morris, A.D. , 'Two Colliery Doctors; the Brothers Armstrong of Treorchy' in Cule, John (ed) *Wales and Medicine: an Historical Survey* (Llandysul, Ceredigion, 1975)

O'Hara, Glenn, and Gosling, G.C., 'Healthcare as Nation-building in the 20th Century: the case of the British National Health Service' in Weindling, Paul, (ed) *Healthcare in Private and Public from the Early Modern Period to 2000* (Oxford, 2015).

Parry, Noel and Jose, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London, 1976).

Pearson, Robert, and Williams, Geraint, *Political Thought and Public Policy in the Nineteenth Century: an Introduction* (London, 1984).

Pelling, H.M., *Population, Politics and Society in Late Victorian Britain* (London, 1969).

Perkin, Harold, *The Rise of Professional Society: England since 1880* (2nd edn, Abingdon, 2002).

Peterson, M. Jeanne, *The Medical Profession in Mid-Victorian London* (London, 1978).

Peterson, M. Jeanne, 'Gentlemen and Medical Men: the Problem of Professional Recruitment', *Bulletin of the Society for the Social History of Medicine*, vol.58, no.4 (1984) pp.457-473.

Pierson, Christopher, *Beyond the Welfare State? The New Political Economy of Welfare* (Cambridge, 1991).

Poynter , F.N.L. (ed*) Medicine and Science in the 1860s* (London, 1968).

Poovey, Mary, *Making a Social Body: British Cultural Formation 1830 – 1864* (Chicago, 1995).

Porter, Dorothy and Porter, Roy, 'The Politics of Prevention: Anti-vaccinationism and Public Health in Nineteenth Century England', *Medical History*, 32 (1988) p.231.

Porter, Roy, 'Lay Medical Knowledge in the Eighteenth Century: The Evidence of the Gentleman's Magazine', *Medical History*, 29 (1985) pp. 138-168.

Powell, Martin, 'Coasts and Coalfields: The Geographical Distribution of Doctors in England and Wales in the 1930s', *Social History of Medicine*, 18 (2) 2005 pp. 245 – 263.

Renwick, Chris, *Bread For All: The Origins of The Welfare State* (2nd edn, London, 2018).

Rew, Mabel, 'Looking Back', *Journal of the Medical Women's Federation,* vol.49 (1967) pp.84-86.

Riley, J.C. , *Sick not Dead: the Health of British Working Men during the Mortality Decline* (London, 1997).

Rimlinger, G.V., 'Welfare Policy and Economic Development: A Comparative Historical Perspective', *Journal of Economic History*, 26 (1966) p. 566.

Rivett, Geoffrey, *From Cradle to Grave: Fifty Years of the NHS* (London, 1997).

Robinson, Paul (ed), *The Foucault Reader; an Introduction to Foucault's Thought* (London, 1984).

Rose, Nikolas, 'Government, Authority and Expertise in Advanced Liberalism', *Economy and Society*, 22 (3) (1993) p. 292.

Rose, Nikolas, and Miller, Peter, 'Power Beyond the State: Problematics of Government', *The British Journal of Sociology*, 43 (2) (1992) pp. 173 – 205.

Routh, Guy, *Occupation and Pay in Great Britain* 1906 – 1979 (2nd edn. London, 1980).

Rubinstein, W.D., 'Britain's Elites in the Interwar Period 1918 – 1939' in Kidd, Alan, and Nichols, David (eds) *The Making of the British Middle Class? Studies of Regional and Cultural Diversity since the Eighteenth Century* (Stroud, Glos,1998)

Rueschemeyer, D., 'Political Autonomy and the Social Control of Expertise' in Dingwall, Robert and Lewis, Paul (eds) *The Sociology of the Professions* (London, 1983)**.**

Searle, Geoffrey R., *The Quest for National Efficiency: A Study in British Politics and National Thought 1899-1914* (Oxford, 1971).

Searle, Geoffrey R., *A New England? Peace and War 1886-1918* (Oxford, 2004).

Stacey, Margaret, *The Sociology of Health and Healing* (London, 1988).

Starr, Paul, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and a Vast Industry* (New York, 1982)

Stears, Marc, *Progressives, Pluralists and the Problems of the State: Ideologies of Reform in the United States and Britain 1909-1926* (Oxford, 2002)

Stears, Marc, 'Guild Socialism', in Bevir, Mark (Ed*) Modern Pluralism: Anglo-American Debates Since 1880*, (Cambridge, 2012).

Stevens, Rosemary, *Medical Practice in Modern England: the Impact of Specialization and State Medicine* (New Haven, Ct, 1935).

Stewart A.B., 'Health Centres of Today', *Lancet*, 16 March 1946, pp.392-393.

Stewart, Clara, 'History of the Federation', *Journal of the Medical Women's Federation*, vol.49 (1967) p.70.

Stewart, John, "For a Healthy London': The Socialist Medical Association and the London County Council in the 1930s.' *Medical History*, 42 (1997).

Stewart, John, *The Battle for Health: A Political History of the Socialist Medical Association 1930-1951* (Abingdon, Oxon,1999)

Swift, Paul, *Presidents of the Nottingham Medico Chirugical Society* (Grantham, Lincs, 2001).

Taylor, Arthur J., *Laissez-faire and State Intervention in 19th Century Britain* (London, 1972).

Taylor, Becky, Powell, Martin and Stewart, John, 'Central and Local Government and the Provision of Municipal Medicine, 1919-1939', *English Historical Review*, 122 (2007) pp.397-426.

Thane, Pat, *Foundations of the Welfare State* (London, 1982).

Titmuss, Richard M., *Essays on the Welfare State* (Boston, Mass, 1969).

Trainor , Richard, 'Neither Metropolitan nor Provincial : the Interwar Middle Class' in Kidd, Alan, and Nichols, David (eds) *The Making of the British Middle Class? Studies of Regional and Cultural Diversity since the Eighteenth Century* (Stroud, Glos, 1998).

Turner, E.S., *Call the Doctor: A Social History of Medical Men* (London, 1958).

Turner, John, 'Experts' and Interests: David Lloyd George and the Dilemmas of the Expanding State 1906-1919, in MacLeod, Roy (ed) *Government and Expertise: Specialists, Administrators and Professionals 1860-1919* (Cambridge, 1988).

Vaughan, Paul, *Doctors' Commons: A Short History of the British Medical Association* (London, 1959).

Vernon, James, *Modern Britain*: *1750 to the Present* (Cambridge, 2017).

Waddington, Keir, 'Unsuitable Patients: the Debate Over Outpatient Admissions, the Medical Profession and the Late Victorian Hospitals.' *Medical History*, 42 (1998) pp.26-46.

Waddington, Ivan, 'General Practitioners and Consultants in Early Nineteenth Century England' in Woodward J.. and Richards D (eds) *Healthcare in Popular Medicine in Nineteenth century England: Essays in the Social History of Medicine*. (London, 1977).

Waddington, Ivan, *The Medical Profession in the Industrial Revolution* (Dublin, 1984).

Waddington, Ivan, 'The Movement Towards the Professionalisation of Medicine', *British Medical Journal* 301 (6754) (1990) pp. 688 – 690.

Watkins, Steve, *Medicine and Labour: The Politics of a Profession* (London, 1987).

Webster, Charles, 'Healthy or Hungry Thirties?' *History Workshop Journal* (1982) 13, pp.110-129.

Webster, Charles, 'General Practice under the Panel: The Last Phase', *Bulletin of the Society for the Social History of Medicine*, 32 (1983) pp.20-23.

Webster, Charles, 'Doctors, Public Service and Profit: General Practitioners and the National Health Service', *Transactions of the Royal Historical Society*, 40 (1990) pp. 197 – 216.

Webster, Charles, 'The Metamorphosis of Dawson of Penn' in Porter, Dorothy and Roy (eds) *Doctors, Politics and Society: Historical essays* (Amsterdam, 1993).

Webster, Charles, 'The Politics of General Practice', in Loudon, Irvine, Horder, John, and Webster, Charles (eds) *General Practice and the National Health Service 1948-1997* (Oxford, 1998).

Webster, Charles, *The National Health Service: A Political History* (2nd edn., Oxford, 2002).

Welshman, John, 'The Medical Officer of Health: Watchdog or Lapdog?' *Journal of Public Health Medicine,* 19 (1997) pp.443-450.

West, M., 'One Hundred Years of an Association of Physicians' *Quarterly Journal of Medicine* vol.100 (2007) pp.151-183.

Whiteside, Noel 'Central Control and the Approved Societies: Access to Social Support under the Interwar Health Insurance Scheme.' *Bulletin of the Society for the Social History of Medicine* , 32 (1983) pp.16-19.

Whiteside, Noel 'Counting the Cost: Sickness and Disability among Working People in an Era of Industrial Recession 1920-1939', *The Economic History Review*, vol.40 (1987) pp.228-246.

Whiteside, Noelle, 'Private Agencies for Public Purposes' *Journal of Social History* vol.12 (2) (1983) pp. 165-193.

Winter, Jay M., *The Great War and the British People* (2nd edn, Basingstoke, Hants, 2003).

Young, Linda, *Middle-Class Culture in the Nineteenth Century: America, Australia and Britain* (Basingstoke, Hants, 2003).

Youngson, A.J., 'Medical Education in the later Nineteenth Century: the Science Take-over', *Medical Education*, 23 (1989) pp. 480- 491).

Unpublished documents

John H. Marks, *The History and Development of Local Medical Committees, their Conference and its Executive.* (Edinburgh University MD Thesis 1974).

Websites

www.hansard.parliament.uk
www.nhs.history.net
www.pulsetoday.co.uk