How to make friends and influence people? Lancaster Medical Book Club and professional leadership in the early NHS

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ABSTRACT

The early years of the NHS have been characterised as 'provider capture' by opponents, with services organised around professional interests rather than patients. This analysis, whilst flawed, has influenced subsequent attempts by politicians to manage medicine. Such an analysis when applied locally illuminates the diffuse and ethereal influence wielded by doctors in the realisation of services. Drawing on archival and published sources relating to the Lancaster Medical Book Club, this paper contextualises how competing professional, educational and social purposes of medical association influenced local leadership in the early years of the NHS from the 1940s to the 1960s.

INTRODUCTION

The early years of the National Health Service (NHS) have been characterised as one of 'provider capture' by neoliberal opponents, arguing that services were organised around professional interests rather than patients.[1] Indeed, this analysis – whilst flawed – has exerted considerable influence on political attempts to manage medicine since the 1980s.[2] Yet analysis has rarely examined the situation outside of the national politics of Westminster and Whitehall. When applied locally such an analysis illuminates the diffuse and seemingly ethereal influence wielded by doctors in the realisation of services. It was this growing army which helped to turn the negotiated compromise of Bevan into a 'national institution', an 'unshakable pillar of the welfare state' during its initial phase.[3] Just as the mobilisation efforts between the failure of the Franco-Prussian and First World Wars turned parochial peasants into Frenchmen according to Eugen Weber,[4] it was the pragmatic organisation and realisation of patient provision which turned doctors from Condottiere into the Praetorian Guard of the NHS.

Reconstructing the influence of doctors in the local realisation of services is difficult in terms of sources and methods. Local health policy lacks the abundant records of the Ministry of Health, personal papers of key protagonists, and the availability of associational materials found in London. This paucity creates methodological problems which are magnified by the organisation of the NHS during its early 'classic' phase. Here, lay governance was mirrored with a parallel form of medical administration running from individual clinics through hospital management committees and regional boards to the centre. Isolating decisions, or decision-making is difficult given this diffusion of power despite a notional hierarchy and claims of a command-and-control approach.

This paper uses published and archival sources relating to the Lancaster Medical Book Club (LMBC) and the local health economy to understand the influence exerted by the medical profession on service realisation during the early years of the NHS. It spans the period from its foundation in 1948 through its 'classic' phase to the arrival of the postgraduate movement in 1966 with the opening of a centre at the Royal Lancaster Infirmary. The competing professional, educational and social purposes of medical association are explored to understand the role of the LMBC in being a local clinical leader and becoming an NHS doctor in Morecambe Bay.

MEDICAL ASSOCIATION BEFORE THE NHS

Medical associations were crucial in the rise of the profession during the nineteenth century. They were not interchangeable, with different types offering distinct purpose to the professionalisation project. Crucially, these distinctions had largely elided by 1948, with further changes engendered by the elevated position of clinicians within the early NHS

LMBC was founded in 1823 by local doctors to bring proliferating advances in medical knowledge integral to professional identity to one of the furthest flung cities in provincial Britain. The Club's aims and practices were not fixed and changed with developments in medical education and regulation.[5] The 1858 landmark Medical Act delineated clear terms of both professional and club membership.[6] LMBC was an important conduit in disseminating the latest debates beyond the key periodicals, helping to constitute and stabilise a 'medical fraternity'.[7] The establishment of new medical schools outside the cloisters of Oxbridge or the renown of Scotland further transformed medical practice, education and the Club. First in London then the provinces, the growth of new medical schools and their incorporation into universities displaced medical book clubs as the locus of local learning.[8] By 1948 the educational role of the Club was residualised to postgraduate forms given the focus of the 1944 Goodenough Report on standardising practice and the Ministry of Health struggling to manage competing priorities during the formative period of nationalisation.[9]

Professionalisation was primary in the purpose medical societies throughout the eighteenth and mid-nineteenth century but following the 1858 Act the ascendancy and virtual monopoly exercised by the British Medical Association (BMA) centralised these energies. Local societies became branches of the national umbrella, with General Practitioners (GPs) initially constituting the bulk of membership with steady growth amongst both voluntary and local authority practitioners. The influence they exerted in shaping the NHS, especially negotiations around terms of service for GPs, meant that local branches possessed limited clout.[10] This was also the position for the Royal Colleges which intensified the chasm between physicians and surgeons despite conferring both recognition of competency and esteem. They, too, were instrumental in securing favourable remuneration under the NHS and a political commitment to 'universalise the best' from Minister of Health Aneurin Bevan which meant a rapid expansion in their numbers.[11] Accordingly, many local medical societies continued in existence but, like Lancaster, waned in relation to new tendencies.[12]

Medical societies were not all about work, and play, socialisation and leisure were important functions and helped to create a 'medical fraternity' across the whole local milieu.[13] Whilst 'enterprise and self-help' were important in using such societies to advance educational and professional knowledge,[14] and consolidate the limits of increasingly scientific medical knowledge,[15] social activities aimed to build stability and solidarity amongst members deeply divided by the basis of their practice. Antagonisms between elite honorary consultants working in voluntary hospitals, public health doctors seen primarily as administrators, salaried appointments in local government municipal hospitals from 1929, 'club doctors'

and GPs, and the isolated world of asylums ran deep even when practised in the same locale. Such divisions rendered national and specialist more associations more attractive, with local BMA branches often substituting such functions given the uneven spread of historic societies and the national growth of professional representation.[13]

In short, by 1948, the different educational, professional and social functions of clubs had often elided, with each being eclipsed by a growing function of professional representation, state regulation, and specialised societies able to articulate their branch of clinical expertise.

THE CLUB AND COMMUNITY

LMBC did not exist in isolation, and its changing functions reflected shifts in both the NHS policy landscape and the concomitant mobilisation of services. Understanding the factors which influenced the local milieu of the medical community is central to grasping its role on professional leadership in the early NHS.

Firstly, to membership. Table one shows the steady growth in membership of the Club from 1948 to 1964, accounting for gaps in reporting total members through noting the numbers of subscribers at 10 shillings per year. This growth reflects two trends. Firstly, the 1946-48 settlement recognised that access to consultant and specialist hospital services was the keystone of policies to 'universalise the best'. As official historian of the NHS Charles Webster identifies from 1948: 'Consultants were free to colonise the tracts of Britain formerly deprived of their services'.[3] Initial post-war austerity to fund the Korean War meant that expanding the consultant corps was a substitute for capital development, only building momentum following the 1962 Hospital Plan. Morecambe Bay was no exception. The number of consultants at the 95-bed Westmorland County Hospital, part of the Lancaster and Kendal Hospital Management Committee (HMC) Group, increased from nine in 1948 to 24 by 1967, although some were split posts with sessions in Lancaster.[16] Lancaster Moor HMC increased from one in 1948 – the medical superintendent – along with a handful of junior doctors and locums, to three further part-time consultants with clinics stretching from Barrow to Blackpool, assisted by six full-time junior appointments in 1961.[17] This growth mirrored wider trends as the number of consultants across Manchester Regional Hospital Board (RHB), which oversaw Lancaster HMC, rose from 326 to 623 between 1948 and 1965. Manchester was one of 14 RHBs responsible nationally, 15 by 1959, and consultant numbers across England increased from 4851 to 7434 over the same period.[18] Whilst GP numbers grew modestly in Westmorland – especially principals[19] – they declined steadily in North Lancashire, reflecting the regional picture placing Manchester second only to Sheffield for the lowest numbers of GPs and largest average patient lists until the 1970s.[18] Both currents were reflected in LMBC membership where GPs had a strong representation. The decline of public health broadened the reach of membership with Assistant and Deputy Medical Officers of Health (MOsH) from outside the city, including Frank T. Madge in Westmorland, 'a key point of continuity' in medical administration given waning professional fortunes, joining in 1967.[20, 21]

Year	Subscriptions	Membership
1947	75	
1948	75	
1949	92	
1950	87	
1951	87	
1952	86	
1953	89	
1954	92	
1955	90	91
1956	100	
1957	86	
1958	83	85
1959	96	103
1960	98	
1961	96	
1962	97	111
1963	98	115
1964	99	118
1965	104	121

Table 1. Subscriptions and Membership of Lancaster Medical Book Club, 1948-64. Numbers taken from the Minute Book, 1947-64. For details see note 20.

Secondly, to those omitted from membership. Increases in appointments and LMBC membership represented senior clinicians in each branch of medicine. More transient junior doctors, locums, practice assistants, and subordinate staff were not well represented in growing membership. Moreover, the changing demographic profile of junior appointments, especially for doctors from former colonial territories and Commonwealth countries who increased nationally, but became workhorses of the local health system,[22] constituting 'probably 50%' of junior hospital staff for Lancaster and Kendal HMC according to the local BMA branch in 1967,[23] is largely absent from Club membership contained in the back of the Minute Book.[20] Whilst medicine was primarily a male profession in the nineteenth century, the creation of the London School of Medicine for Women in 1874 and admission of women to provincial universities saw growing feminisation.[24] This change was felt in Lancaster but not the LMBC with one notable exception. A qualified public health doctor, former GP, and latterly consultant anaesthetist to the HMC, Kathleen Edgecombe Thompson (1902-85) served as its first female President in 1961-62.[20, 25]

Thirdly, to scale and specialisation. Another trend exemplified by the career of Kathleen Thompson was that changes in the NHS brought into focus the importance of multiple memberships. Thompson was a University of Liverpool Medical School graduate and a life member of its renown

Liverpool Medical Institution. She was also a member of the Manchester Medical Society, serving as President of its Anaesthetists section from 1963-64. These long-established provincial centres took on a new life under the NHS as the loci for teaching hospitals as part of the framework of hierarchical regionalism.[26] Accordingly, such societies often served a regional as well as local function. This meant that, along with the expansion of their own consultant corps, large urban medical societies became more impersonal and cumbersome, remaining creatures of their regional capitals.[27] Furthermore, new societies seeking to articulate specialist identities within new NHS structures emerged to complicate the place of older associations. For example, Manchester Paediatric Club was created in 1948 to represent the specialism regionally, with tokenistic efforts at regional inclusion extending to periodic meetings at Blackpool and Preston, although Lancaster remained outside the circuit.[28]

Fourth, to size and space. The Club was, by 1948, no longer just for Lancaster. Membership spread across Lancaster, Morecambe and Heysham, including to Milnthorpe in the north and Dolphinholme in the south. After 1948 this territorial footprint grew to match the new boundaries of Lancaster and Kendal HMC, stretching to Kendal, Kirkby Lonsdale and Sedbergh. By the early 1960s this extended to the northernmost limit of the patch at Windermere and even infringed upon Barrow and Furness HMC with a GP from Grange-over-Sands becoming a member.[20] The calendar of clinical talks each year combined with improving transport links meant that even at this early juncture, being and becoming a doctor in Lancaster was inextricable from the wider service geographies of Morecambe Bay.

Fifth, and finally, to socialisation. Given the absence of junior doctors in LMBC, the common ethnic, class and gender attributes of the senior doctors which constituted the core of the medical community reflected the largely elite profile of British medicine at the time. This profile was well-documented in commissioned research by the 1968 Royal Commission on Medical Education by the Association for the Study of Medical Education.[29] The professional status given to athleticism, especially rugby, cricket and golf, was rooted in routes through education which typically included private or boarding school experiences before university. Indeed, such was the status given to sporting achievement as a mark of character that Charles Wilson – Dean of St Mary's Medical School in London, Winston Churchill's personal physician during the Second World War and later, as Lord Moran and President of the Royal College of Physicians (RCP), an influential figure in the creation of the NHS – shaped the entire curriculum around attracting Oxbridge 'Blues', those known for sporting prowess, and winning inter-medical school competitions.[30] Whilst not to the same extent of Wilson's blueprint, the inauguration of the George Cup in 1948 as an annual golf competition hosted by LMBC spoke to recognised patterns of socialisation based on background which dominated the local medical community and shared class values.

To recapitulate, through the early years of the NHS Lancaster's the membership of LMBC grew steadily in line with the expansion of the consultant corps. The concomitant growth in junior doctors, nor their different social profile, was not reflected in membership. The Club existed alongside other existing and new regional medical associations which also transformed in line with changes in the NHS. The virtual alignment of membership with the new Lancaster and Kendal HMC patch testified to the interconnection of the Club with the organisation of health service delivery. Yet the social intercourse which bound members reflected their background and educational routes into medicine, also signifying the collapse of historic distinctions between medical associations which were hallmarks of professionalisation during the nineteenth century.

THE CLUB AND PROFESSIONAL LEADERSHIP

To what extent did the LMBC act as a forum for articulating medical interests as part of the constitution and realisation of the NHS during its early years? Did it represent a form of 'provider capture'? Did the LMBC give primacy to place over loyalty to medical branches? What role did LMBC play in being a local clinical leader and becoming an NHS doctor in Morecambe Bay? Here, these questions are posed and explored despite limitations imposed by sources and methodology.

First, to the articulation of medical interests. This picture is complicated both nationally and locally. At the national level the role of the BMA and Royal Colleges in the creation and consolidation of the NHS is well documented, with their influence through the medical advisory machinery and mandatory consultation as part of policy changes widely recognised.[31, 32] However, within these formal systems were informal ones, where elite medical associations and dining clubs acted as ways of overcoming obstacles and talking through decisions. Most famously, the 42 Club – comprising politicians, leading doctors, and professional representatives – was the hidden negotiating table which brokered the deal founding the NHS.[33] At the local level a comparable dynamic is not easy to discern as the formal records of the LMBC offer few details. Membership included leading doctors across all three branchers of the tripartite NHS – hospitals, public health, and general practice – along with the superintendents of Lancaster Moor, first Joseph Silverston until 1957 then his successor Stanley Smith representing mental health.[20, 34, 35] Yet at a formal level with local, regional and national policy architecture and inquiries, medical interests for Lancaster and Kendal were articulated through the BMA Branch or specialist associations.[22] The LMBC was not, therefore, a local 42 Club able to constitute a shared set of medical interests for the city.

Second, whether the LMBC and medical interests constituted 'provider capture'. In its early years, the realisation of the NHS rested upon the mobilisation of its medical workforce, especially in a context of capital restrictions. With 'the increasing predominance of lay administration, medical advisory committees at the unit level exercised an important influence' in the view of Charles Webster.[3] Hospital and HMC Medical Advisory Committees (MAC) also constituted a useful counterbalance to regions flexing their muscles, able to articulate their case for appointments and investment against decisions which usually favoured provincial capitals of RHBs such as Manchester which oversaw Lancaster. However, such arrangements favoured consultants – who expected and demanded membership on influential MACs – with mandated GP representation either resented or opposed.[36] Although professionalisation had been a core aim throughout the nineteenth century, divisions between branches ran deep, and intensified during the twentieth century under the NHS which accorded primacy to secondary and tertiary over primary care.[37]

Third, over whether the LMBC created a cohesive medical community or one divided by place and specialisation. Ultimately, when national, regional, or local decision-making required any changes, specialisation and place exerted powerful influences against common or singular medical interests. For instance, in nearby Barrow where geographical isolation, a close medical community and shallow social barriers fostered the 'essential ingredients of effective coordination',[38] the appointment of consultants in place of GP specialists with beds in hospitals – notably gynaecologists given the creeping hospitalisation of maternity services – proved deeply divisive within the MAC.[39] Such appointments were crucial in the expansion of the consultant corps and the deepening divisions of medical labour required by specialisation.[40] For Lancaster and Kendal HMC the most controversial decision facing clinicians was how a District General Hospital (DGH) model demanded by the 1962 Hospital Plan could be applied given two centres. Although undocumented in the LMBC records, such an issue must have loomed large. A revealing meeting in 1967 between Westmorland Public Health Committee and Executive Council – responsible for administering GP contracts and payments – exposes tensions over specialisation and place. Firstly, in terms of place, the meeting had been called 'to co-ordinate matters and get everybody into line' given the volume of 'really emotional and ill-considered' views being expressed by different professional groups. Secondly, regarding specialisation, during the same meeting, a GP commented that services in Kendal were 'run down' not through malice by the HMC or RHB, but through piecemeal improvement at Lancaster resulting in most 'residents go[ing] somewhere else' through choice. He highlighted the unwillingness of recently appointed consultants to undertake 'bad cases' owing to a lack of equipment, trained nursing staff, and linked specialties, and that to keep services in Kendal it was 'necessary to try and stop the vicious circle'.[16] With LMBC membership reflecting the organisational patch of the HMC, place and specialisation inveighed against a monolithic medical milieu.

Fourth, and last, the role that LMBC played in being a local clinical leader and becoming an NHS doctor in Morecambe Bay. Notwithstanding the above regarding how elite clubs function elsewhere in the NHS, the shortcomings of 'provider capture', and the limits to which LMBC could forge a medical community against interests of place and specialism, the Club undoubtedly played an important role in the transition from Condottiere to Praetorian Guard by doctors in the NHS. As Teddy Chester noted for ancillary staff in the early NHS, 'the really important place for the distribution of information was the executive committee of the social club' rather than the Joint Consultative Committee.[41] Given the interdependencies between medical professions, the services of the 'classic' tripartite NHS, and hierarchical links between Hospitals, HMCs, RHBs and the Ministry of Health, the LMBC remained an important forum for doctors to learn of, and reach out into, the sweeping changes shaping the wider NHS. This can be seen in the subjects of postgraduate study from invited speakers and domestic members of LMBC in meetings, but also through a small core of members – around one third – which regularly attended events.[20] By the 1970s it was clear that the purpose of all medical associations was largely 'convivio-medical' as Donald Ractliffe suggests, for newcomers and old timers to meet and learn about one another in a local health economy reliant on relationships for referrals. Moreover, such 'meetings, laced with food and drink can bring people together, increase mutual understanding and reduce personality clashes more effectively than any earnest meeting'.[42] Accordingly, becoming a doctor in Morecambe Bay did not require membership of the Club, but becoming an effective NHS doctor did given the largely professional isolation of GPs and consultants alike in smaller institutions at the time.[39] Becoming a clinical leader was predicated on membership and the ability to trade information, and learn of the wider health system, and make decisions cognisant of their relation to the local medical milieu.

CONCLUSION

Teddy Chester wrote with pinpoint precision in his preface to Gordon Forsyth's study of the early NHS that 'doctors in fact, seem to be remarkably unselfconscious about the social forces surrounding their work, and their role within a social and political complex'.[36] The NHS has never been one organisation but many, conditioned by separate service histories, cultures, and their places.[43] The realisation of patient provision in Morecambe Bay in the early years of the NHS rested heavily on doctors turning a national blueprint aiming to 'universalise the best' into a local reality when resources remained few. Whilst many see this as 'provider capture', there is a world of difference between the well-documented professional influence of doctors felt in Westminster and Whitehall through associations and elite clubs, and pragmatic organisation in place. However hard to grasp owing to a paucity of sources, such experiences turned doctors from Condottiere – mercenaries renowned for turning sides having their mouths 'stuffed with gold' – into the Praetorian Guard of the NHS as a 'national institution'.

The role of the Lancaster Medical Book Club is uncertain but influential. By the time of the NHS the professional, educational and social functions of local medical associations had elided to see them largely as 'convivio-medical' bodies. Each of the functional aspects had been centralised into the state apparatus, including postgraduate medical education by 1966 with the opening of the centre at the Royal Lancaster Infirmary. Yet the LMBC was a significant forum and network for the local medical milieu. Composed mainly as a group of senior doctors with a narrow social and educational profile, it failed to overcome divisions of specialisation and place, remaining heterogenous from a professional position. Once contextualised in the emerging health system and the transformations of the NHS through a growth in the hospital consultant corps in place of capital, GPs and public health, the influence of LMBC can be detected beyond its uncertainty. Many became doctors during the early years of the NHS with abundant opportunities, but to become an NHS doctor and a custodian of change meant membership of the Club. Likewise, although not a 42 Club for Lancaster, nor a cabal of medical mandarins, LMBC membership was a necessary component of clinical leadership through informal contact with changes in other facets of the NHS. Revisiting local health policy history through the lens of social and professional networks engendered through Club membership reveals the extent and limits of focus on 'provider capture' and the place of provincial medical associational life.

Whilst medical curricula are required to keep pace with technological developments, biomedical advances, and clinical practice, the complex contexts which shape and surround them noted in Chester's day have become even more interwoven, yet they typically continue to remain absent. Moreover, the

forces which shape their work and role in a social and political complex are not static, but inseparable from the layers of 'sedimented governance' which have accrued over time.[44] These forms of institutional memory are learned through written and oral sources, including established clinicians able to impart these cumulative experiences and tensions to younger members. Although the contours of place and specialisation have changed from the early years of the NHS, the LMBC continues to provide a forum where such a transmission can occur, mindful of the more diverse professional, social, and educational identities of those being and becoming doctors in Morecambe Bay.

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