Liverpool's Medical Community 1930-1998:
Social, Knowledge and Business Networks

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy by

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Contents

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Abstract

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Felix Goodbody

This thesis provides a social history of Liverpool's medical community between 1930 and 1998. The development of medical societies, local professional organisations, hospitals and general practice is used as a lens to explore how professional networks mediated the reception of national health service reform and professional change.

The working hypothesis of this study was that the mixed economy of pre-NHS medical work required practitioners to maintain frequent interactions across local networks in order to ensure a cohesive and harmonious professional environment. These networks were sustained through professional societies, clubs and organizations. However, the creation of the NHS challenged their traditional role through the introduction of increasingly formalised systems to govern career progression, postgraduate medical education and monitoring of professional standards. These new structures were administered at national level, and undermined the importance of local professional associations.

This thesis enables a new perspective on the history of the NHS by demonstrating how local networks mediated the reception and discussion of changes to the national service. Practitioners from a range of clinical areas, professional and social backgrounds contributed to local medical culture, and accommodated local tradition and national reform during their careers. This thesis demonstrates how medical identity was anchored in local networks, and these links had a fundamental influence on practitioners' engagement with national reform.

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List of Abbreviations

AHA – Area Health Authority (AHA(T) – Area Health Authority (Teaching)

BHA – British Hospitals Association

BMA – British Medical Association

BMI – Birmingham Medical Institute

BMJ – British Medical Journal

BoG – Board of Governors

CHC – Community Health Council

DGH – District General Hospital

DHA – District Health Authority

DHSS – Department of Health and Social Security

FHSA – Family Health Service Authority

FPC – Family Practitioner Committee

GMC – General Medical Council

GP – General Practitioner

GVS – Gynaecological Visiting Society of Great Britain

HLF – Heritage Lottery Fund

HMC – Hospital Management Committee

IMR – Infant Mortality Rate

JCPTGP – Joint Committee on Training for General Practice

JMS – Jewish Medical Society

LEC – Local Executive Committee

LMC – Local Medical Committee

LMI – Liverpool Medical Institution

LMPC – Local Medical and Panel Committee (later Local Medical Committee)

LMRO – Liverpool Medical Research Organisation

LMSS – Liverpool Medical Students Society

LOC – Liverpool Orthopaedic Surgeon

LPC – Liverpool Paediatric Club

LRO – Liverpool Record Office

LSA – Liverpool Society of Anaesthetists

LSHTM – London School of Hygiene and Tropical Medicine

LSTM – Liverpool School of Tropical Medicine

MPU – Medical Practitioners' Union

MWF – Medical Women's Federation

NHI – National Health Insurance

NHS – National Health Service

NPHT – Nuffield Provincial Hospitals Trust

NWCRF – North West Cancer Research Fund

PEC – Postgraduate Education Committee (regional)

PGMC – Postgraduate Medical Centre (/Postgraduate Medical Education Centre)

RAWP – Resource Allocation Working Party

RCGP – Royal College of General Practice

RCOG – Royal College of Obstetricians and Gynaecologists

RCP – Royal College of Physicians (London)

RCS – Royal College of Surgeons (England)

RHA – Regional Health Authority

RHB – Regional Hospital Board

RLUH – Royal Liverpool United Hospital

RSM – Royal Society of Medicine

SCA – University of Liverpool Special Collections and Archives

SMA/ SHA – Socialist Medical Association (later Socialist Health Association)

SMSA – State Medical Service Association

ULH – United Liverpool Hospitals

Introduction

In 1930, Liverpool's medical community comprised 652 practitioners working in private and insurance practice and at more than fifty voluntary and public hospitals, sanatoria and public health facilities across the city.[1] The annual report of the Medical Officer of Health recorded a resident population of 879,657, close to its historic peak, and local practitioners discussed the business of medicine, accessed educational materials, and interacted socially at the city's oldest medical society, the Liverpool Medical Institution (LMI, established in 1837).[2] By 1998, the number of practitioners had risen to over 1,700, while the resident population had nearly halved to 453,000, the National Health Service (NHS) had been established for fifty years, and a newly elected Labour government was embarking on a fresh programme of health service reform.[3] The sprawling hospital estate inherited at the creation of the NHS in 1948 had been rationalised into a handful of independent NHS trusts, and the Liverpool Medical Institution was struggling to encourage its declining membership to attend meetings and events.

This thesis explores how Liverpool's medical community experienced professional change since 1930, and demonstrates how local networks mediated the development of medical education, the

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[1] General Medical Council *The Medical Register for 1930* (London: General Medical Council, 1930).

[2] Arthur Mussen, *Report on the health of the City of Liverpool during the year 1930* (Liverpool: Liverpool Health Department, 1930).

[3] General Medical Council, *The Medical Register for 1998* (London: General Medical Council); Office for National Statistics, "Mid-1991 to 2000 Population Estimates: Selected age groups for local authorities in the United Kingdom," http://www.statistics.gov.uk/hub/population/population-change/population-estimates/index.html [accessed 12 February 2020]; Labour's plans for the NHS were published in the December 1997 White Paper *The New NHS: Modern, Dependable* (London: HMSO, Command no. 3807).

business of medicine, and the implementation of reform to medical services nationally. This thesis addresses three primary research questions. Firstly, it seeks to establish how changes to medical networks affected the efficiency of local medical services, professional practices, and the communication of medical knowledge. Secondly, this thesis explores how Liverpool's medical community has developed since 1930 in terms of overall numbers, specialties, places of employment and backgrounds. Finally, this thesis considers the role of the Liverpool Medical Institution, alongside other independent professional organizations and clubs, in providing educational, training and social resources for the medical community, and how they responded to professional change following the creation of the NHS.

1. Medical professionalisation before 1948

Independent professional networks occupied a prominent place in local medical communities before 1948. Medical societies such as the LMI encouraged notions of shared professional heritage, and sought to facilitate a profitable business environment, support academic development, and connect practitioners from across a range of medical services. The mature professional status of medicine in Britain was recognised in the Medical Act of 1858, which established a public record of all registered practitioners.[4] Medical registration enabled a clear distinction between regular and irregular practitioners, and various areas of practice were progressively brought into the professional medical sphere.[5] The enhanced status of the profession

[4] Irvine Loudon, *Medical Care and the General Practitioner* (Oxford: Oxford University Press, 1986), 299-300; "An Act to regulate the Qualifications of Practitioners in Medicine and Surgery" (the Medical Act 1858) http://www.legislation.gov.uk/ukpga/Vict/21-22/90/enacted [accessed 10 December 2019].

[5] William Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), 176, 191.

after 1858 led to a greater cultural presence, and practitioners boosted their social credentials through positions in the Victorian public health administration, prestigious voluntary hospitals and through lucrative private practices.[6] Medical practitioners in Liverpool inherited a professional identity formed during the city's prosperous nineteenth century; local economic vitality was reflected in ornate voluntary hospitals, a thriving medical school, and vibrant professional organizations such as the LMI alongside a range of smaller medical clubs and specialist societies.

Despite the legal unity of the profession after 1858, medical practitioners remained a diverse group with a range of backgrounds, working methods, and ambitions.[7] By the end of the nineteenth century, the medical profession was characterised by two popular archetypes; the charismatic and eccentric hospital consultant, and the hardworking patient-oriented general practitioner, and these models continued to influence notions of professional identity.[8] The emergence of scientific medicine during the second half of the nineteenth century prompted some practitioners to look back to a (largely invented) notion of the traditional 'country doctor'.[9]

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[6] Donald Light and Sol Levine, "The Changing Character of the Medical Profession: A Theoretical Overview," *The Milbank Quarterly* 66.2 (1988), 12; Christopher Lawrence and Michael Brown, "Quintessentially Modern Heroes: Surgeons, Explorers, and Empire, c.1840–1914," *Journal of Social History* 50.1 (May 1, 2016); Steven Novak, "Professionalism and Bureaucracy: English Doctors and the Victorian Public Health Administration," *Journal of Social History* 6.4 (Summer, 1973), 455.

[7] Christopher Lawrence, "Incommunicable Knowledge: Science, Technology and the Clinical Art in Britain 1850-1914," *Journal of Contemporary History* 20.4 (1985), 503.

[8] Rosemary Stevens, *Medical Practice in Modern England: The Impact of Specialization and State Medicine*. (New Haven: Yale University Press, 1966), 33.

[9] Lawrence, "Incommunicable Knowledge," 503; Christopher Lawrence, "Edward Jenner's Jockey Boots and the Great Tradition of English Medicine 1918-1939," in *Regenerating England: Science, medicine and culture in inter-war Britain,* eds. Christopher Lawrence

Networks of practitioners at hospitals, universities and medical societies played an important role in fostering of a sense of shared professional heritage and culture. Effective intraprofessional relationships were essential in order to maintain an efficient and profitable medical system, and local networks sought to promote a cohesive and mutually-supportive professional environment.

Medical practice before 1948 had an important business dimension: John Stewart described general practitioners (GPs) during the 1930s as 'independent entrepreneurs', with their practices constituting assets that were bought and sold.[10] GPs had achieved a degree of financial security after the creation of National Health Insurance in 1911, however they continued to compete for private patients, hospital posts and a range of public medical appointments.[11] Practitioners engaging in club or insurance practice were considered professionally inferior to those who could afford not to do so, as it was felt that private practice offered greater autonomy.[12] Some practitioners accessed lucrative private practice through honorary appointments at voluntary hospitals, which put them in contact with wealthy families that held roles as hospital governors and subscribers.[13] Hierarchies of status and professional appointments were reflected across medical networks, and a number of smaller

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and Anna-K Mayer (Amsterdam: Rodopi, 2000), 50; George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization*, (Oxford: Oxford University Press, 2006), 26.

[10] John Stewart, '*The Battle for Health': A Political History of the Socialist Medical Association, 1930-1951* (Aldershot: Ashgate, 1999), 55.

[11] Anne Digby and Nick Bosanquet, "Doctors and Patients in an Era of National Health Insurance and Private Practice, 1913-1938," *The Economic History Review* 41.1 (1988), 93.

[12] Anne Digby, *Making a Medical Living: Doctors and Patients in the English Market for Medicine, 1720-1911*. (Cambridge: Cambridge University Press, 1994), 37.

[13] Ibid, 149-150.

groups catered to the local medical elite alongside general interest societies such as the LMI.

The pre-1948 British hospital system was diverse and uncoordinated: voluntary hospitals were funded by philanthropy and patient payments, and publicly-funded municipal hospitals offered free treatment, often in former Poor Law infirmaries taken into local authority ownership following the 1929 Local Government Act. Municipal hospitals varied between regions, depending on local medical officers and the condition and availability of former Poor Law buildings available for appropriation following the 1929 Act.[14] Alysa Levene, Martin Powell and John Stewart described the 1929 Act as 'kick-starting the development of a nationwide public health hospital service' as local authorities assumed greater involvement in local hospital coordination and management.[15]

Provincial voluntary hospitals evolved from purely philanthropic institutions to key sites of professional influence, and the system was fiercely defended during debates over health service reform.[16] Honorary voluntary hospital posts carried prestige among the profession, and the legacy of the hierarchical hospital system continued after 1948, when many leading voluntary hospitals had their special status recognised through designation as teaching hospitals. Historians have challenged simplified notions of voluntary hospitals as examples of paternalistic philanthropy, as patient

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[14] Nick Hayes and Barry Doyle, "Eggs, rags and whist drives: popular munificence and the development of provincial medical voluntarism between the wars," *Historical Research* 86.234 (2013), 712-740; Alysa Levene, Martin Powell, John Stewart, and Becky Taylor, *Cradle to Grave: Municipal Medicine in Inter-War England and Wales* (Oxford: Peter Lang, 2011), 77.

[15] Alysa Levene, Martin Powell, John Stewart, "The Development of Municipal General Hospitals in English County Boroughs in the 1930s," *Medical History* 14.3 (2006), 4.

[16] Steven Cherry, "Accountability, Entitlement, and Control Issues and Voluntary Hospital Funding c. 1860–1939," *Social History of Medicine* 9.2 (1996), 215.

influence grew through the development of contributory schemes, trades unions, and the local press.[17] Practitioners and patients alike developed emotional connections to the local hospital system, and during the interwar years many members of the local community participated in voluntary hospital philanthropy.[18] Important networks were maintained at Liverpool's hospitals, and hospital practitioners were encouraged to identify and maintain specific institutional cultures reflective of their history, patient population, and leading consultants. Several of Liverpool's former voluntary hospital buildings remained in use for decades under the NHS, and their place in the public and professional imagination informed local views over subsequent hospital reform.[19]

2. Medical networks and the National Health Service

The creation of the NHS in 1948, and the numerous reforms implemented during its first fifty years, had major consequences for all British medical practitioners. Nonetheless, the concessions secured by the profession during negotiations over the 1946 NHS Act led to the survival of several fundamental elements of pre-1948 practice. The continued use of Liverpool's Victorian hospital buildings after

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[17] Jonathan Reinarz, "'Investigating the 'deserving' poor: charity and the voluntary hospitals in nineteenth century Birmingham" in *Medicine, Charity and Mutual Aid: The Consumption of Health and Welfare, C. 1550–1950* ed. Peter Shapely, (Aldershot: Ashgate, 2007), 133; Barry Doyle, "Power and accountability in the voluntary hospitals of Middlesbrough 1900-1948," in *Medicine, Charity and Mutual Aid*, ed. Shapely, 207.

[18] Hayes and Doyle, "Eggs, Rags and Whist Drives," 714.

[19] Local practitioners published their own hospital histories, often with elements of memoir, upon retirement or closure of the institution, for example Henry MacWilliam, *Memories of Walton Hospital* (Liverpool: Young, 1965); Arthur Clifford Brewer, *A Brief History of the Liverpool Royal Infirmary, 1887-1978*. (Liverpool: Liverpool Area Health Authority (Teaching), 1980); Michael Cook, *Liverpool's Northern Hospital 1834-1978*. Liverpool: Liverpool Area Health Authority (Teaching), 1981).

1948 prevented any immediate institutional transformation in the local medical community, while the independence enjoyed by GPs under the NHS enabled the survival of various elements of traditional practice. The creation of the NHS was a transitional rather than transformative event for British medical practitioners, as the continuities after 1948 prevented any dramatic rupture with earlier professional norms.[20] Independent professional networks at medical societies, clubs and other groups helped sustain aspects of pre-NHS culture, and provided practitioners with reassuring spaces of continuity and tradition during a period of considerable uncertainty.

This thesis takes Liverpool as a case study to explore the role of local medical networks in the reception of national political and professional developments, and argues that specific local considerations often exerted a fundamental influence on reform. The NHS is widely regarded as the most significant achievement of the post-war welfare state, and its origins, implementation and administration have received substantial academic analysis. Charles Webster, Rudolf Klein and Geoffrey Rivett have provided essential overviews of the service, with a focus on the political, professional and intellectual sources of policy change.[21] Webster followed his official history with a concise outline of his left-wing critique of the NHS, which describes how early aims for the service were hamstrung by the medical profession and political opponents.[22] Klein argued the

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[20] Anne Digby, *The Evolution of British General Practice 1850– 1948* (Oxford: Oxford University Press, 1999), 342; Charles Webster, "Doctors, Public Service and Profit: General Practitioners and the National Health Service," *Transactions and Report of the Royal Historical Society* 40 (1990), 213-214.

[21] Martin Gorsky, "The British National Health Service 1948–2008: A Review of the Historiography," *Social History of Medicine* 21.3 (2008), 438.

[22] The official histories are Charles Webster, *The Health Service Since the War. Problems of Health Care. The National Health Service before 1957* (London: HMSO, 1988); Charles Webster, *The Health Services Since the War, Vol II: Government and Health Care: The*

NHS evolved from a technocratic 'church' model to that of a 'garage', defined by consumerism and patient choice, while Rivett, a former GP and civil servant at the Department of Health and Social Security [DHSS], contributed a detailed study alert to professional responses to policy change.[23] Former policy journalist Nicholas Timmins also produced an exhaustive 'biography of the welfare state', in which political decision-making around the NHS is considered alongside broader government strategy.[24]

The initial structure of the NHS reflected a range of conflicting professional, economic and political concerns, and echoed prior attempts at state coordination of medical services. The introduction of National Health Insurance (NHI) in 1911 established a precedent for state involvement in the provision of primary health care, despite being administered by a separate system of 'approved societies' underwritten by government. Anne Digby claimed NHI forced British general practitioners to acknowledge 'the need to temper Victorian individual commercialism with Edwardian social welfarism' but nonetheless 'rescued the typical GP from economic struggle' as a result of the regularity and certainty of payment.[25] NHI 'panel' practitioners nonetheless remained independent contractors paid through the capitation system (rather than becoming salaried), and continued to be fiercely protective of their professional autonomy.

British National Health Service 1958–1979, (London: HMSO, 1996); Charles Webster, *The National Health Service: A Political History,* (Oxford: Oxford University Press, 1998).

[23] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Harlow: Longman, 1995), 248; Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*. (London: King's Fund, 1998).

[24] Nicholas Timmins, *The Five Giants: A Biography of the Welfare State* (London: HarperCollins, 2001).

[25] Digby, *The Evolution of British General Practice*, 323; idem, *Making a Medical Living,* 169.

The uncoordinated system of local authority and voluntary hospitals were forced into regionally-administered cooperation during WWII through the Emergency Hospital Service (later Emergency Medical Service, EMS), established in 1939. Richard Titmuss described the effect of the wartime service.

> A large number of individual, self-sufficient hospitals approached closer to the conception of a hospital service. The pattern—regionally grouped hospitals with specialist centres—was based on a new idea; a division of labour between all the hospital and medical resources of a region.[26]

The wartime hospital services demonstrated the potential for peacetime coordination, despite the resistance of the voluntary hospitals to ceding their independence.[27] The EMS demonstrated the feasibility of a regionally-administered service, however Martin Gorsky, Karen Lock and Sue Hogarth claimed Aneurin Bevan (1897-1960), the health minister appointed following Labour's election victory in 1945, held the view that 'devolved power did not lead to virtuous localism but rather to spatial unevenness, with inadequate performance in poorly resourced areas' and remained committed to a national health service.[28]

The British Medical Association (BMA) responded with hostility to the 1946 NHS Act a result of concerns over professional independence. John Stewart attributed opposition to Bevan's plans for salaried payment and local authority control to fears that such measures would 'reduce doctors to the equivalent of civil servants

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[26] Richard Titmuss, *History of the Second World War: problems of social policy* (London: HMSO, 1950), 473.
[27] Charles Webster, "Conflict and Consensus: Explaining the British Health Service." *Twentieth Century British History* 1.2 (1990), 127.
[28] Martin Gorsky, Karen Lock, Sue Hogarth, "Public health and English local government: historical perspectives on the impact of 'returning home,'" *Journal of Public Health*, 36.4 (December 2014) 549.

and so destroy the sanctity of the doctor-patient relationship.'[29] Not all practitioners shared this view: GPs in poorer areas were generally more supportive of the NHS, and left-wing practitioners' groups such as the Socialist Medical Association (SMA) hoped that Bevan's initial proposals for salaried service (subsequently withdrawn) would constitute a welcome improvement on the existing system of payment by capitation.[30]

The medical profession was able to secure major concessions from government, and practitioners retained considerable autonomy after 1948.[31] American political scientist Harry Eckstein described the 1946 NHS Act as a 'doctor's measure' in which the profession played a more significant role than left-wing politicians.[32] Charles Webster claimed the 'general medical service under the NHS retained the characteristics of the old panel system. Essentially the spirit of panel practice extended over the whole population.'[33] The NHS formalised the tripartite division of British medicine through the administrative separation of hospital medicine, general practice and local authority services.[34] Webster's verdict was that the benefits of state investment were 'eroded in the interests of pacifying the medical profession, the

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[29] John Stewart, "Ideology and Process in the Creation of the British National Health Service," *Journal of Policy History* 14.2 (2002), 124.
[30] Virginia Berridge, *Health and Society in Britain since 1939* (Cambridge: Cambridge University Press, 1999), 14; Stewart, *'The Battle for Health,'* 70.
[31] Harry Eckstein, "The Politics of the British Medical Association," *The Political Quarterly* 26.4 (1955), 358; Webster, "Conflict and Consensus," 151; Stewart, "Ideology and Process in the Creation of the British National Health Service," 124.
[32] Harry Eckstein, *The English Health Service: Its Origins, Structure, and Achievements* (Cambridge, MA: Harvard University Press, 1958), 3-5.
[33] Webster, "Doctors , Public Service and Profit," 213.
[34] Frank Honigsbaum, *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care, 1911-1968*. (London: London School of Economics and Political Science, 1979), 301.

voluntary lobby, the drug companies, or other forces reflecting the values of advanced capitalism' and that 'the NHS was therefore diverted into an arena offering major gains for professional and corporate interests.'[35]

In spite of the continuities preserved in the founding structure of the NHS, the creation of a comprehensive state service entailed a significant change to professional self-image, as the majority of practitioners were employed either directly or indirectly by the state. The LMI continued to be led by senior figures from the local professional community who had trained and practiced before 1948 during the early years of the NHS, however a new generation of practitioners were entering the profession 'native' to the NHS (despite often being taught, influenced, and working for older consultants with backgrounds in the earlier system). Analysis of medical networks provides new insights into the local negotiation of professional identity during the early years of the NHS. This thesis considers how medical societies, clubs and other groups fought for relevance after 1948, and sought to modify their function to support practitioners working for the state service.

3. Approaches to the history of medicine in Britain

A range of approaches have been utilized by academic historians, sociologists, biographers and others to consider the medical profession in Britain. The process of securing professional status by practitioners during the nineteenth century has been the focus of a number of influential sociological studies; Jeffrey Berlant, Noél and Jose Parry, and Eliot Freidson focused on the claims of intellectual legitimacy made by practitioners in order to insulate themselves from excessive scrutiny or external interference.[36]

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[35] Webster, "Conflict and Consensus," 151.

[36] Jeffrey Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Berkeley, CA: University of California Press, 1975); Noél Parry and José Parry, *The Rise of the Medical Profession: A Study of Collective Social Mobility* (London:

Freidson described practitioners' claims to 'unique adequacy', and knowledge and skills 'so esoteric or complex that non-members of the profession cannot perform the work safely or satisfactorily and cannot even evaluate the work properly.'[37] Focused historical studies of medical culture during this period discuss the construction of a clear professional identity. Michael Brown and Christopher Lawrence noted how practitioners during the nineteenth century were concerned with the 'performance' of both intellectual and social status, in order to encourage both internal standards of behaviour and external recognition.[38]

Social studies of medicine after 1948 highlight the continued importance of professional identity in negotiating structural changes to the health services.[39] The qualitative surveys conducted by Isobel Allen into practitioners' experiences under the NHS demonstrates the important insights to be drawn from direct interaction with practitioners.[40] These studies employ important theoretical approaches towards emerging medical professionalism, and offer an important basis for considering medical culture under the NHS. This thesis builds on these studies by demonstrating how practitioners during the early years of the NHS anchored their sense of professional identity using a clear geographical focus. Analysis of local medical networks provides important new insights into the negotiation of national professional development after 1948.

Croom Helm, 1976); Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (Chicago: University of Chicago Press, 1988).

[37] Freidson, *Profession of Medicine*, 45.

[38] Michael Brown, *Performing Medicine: Medical Culture and Identity in Provincial England, c. 1760-1850* (Manchester: Manchester University Press, 2011); Lawrence, "Incommunicable Knowledge".

[39] Mike Dent, "Professionalism, Educated Labour and the State: Hospital Medicine and the New Managerialism," *Sociological Review* 41.2 (1993), 244-273.

[40] Isobel Allen, *Doctors and Their Careers: A new generation* (London: Policy Studies Institute, 1994).

The growth of medical specialization emerged as a key source of intraprofessional tension during the nineteenth century, and academic analysis has focused on attempts by practitioners to offset the disintegration of professional unity while continuing to encourage innovation.[41] The creation of the NHS enabled the further development of medical specialization, and formalized a clear distinction between hospital consultants, who became salaried employees and represented the elite of the profession, and general practitioners, who continued to work as independent contractors.[42] This separation of hospital medicine and general practice, described by Frank Honigsbaum as an acrimonious 'division' of British medicine, led to a reassessment of general practice, and the 'renaissance' of this branch of the profession has attracted considerable academic analysis.

Seminal contributions on the history of general practice by Irvine Loudon and Anne Digby outlined its development from the diverse medical marketplace of the nineteenth century, introduction of National Health Insurance (and a degree of income security) in 1911, and the creation of the NHS.[43] Studies of general practice after 1948 focus on the 'renaissance' of the specialty by often politically-minded and ambitious practitioners who pursued innovative ways of working, integration with other services, and a new identity for the GP.[44] This thesis tests the notion of a fundamental 'division' between hospital consultants and general practitioners through analysis of shared professional networks oscillating around shared resources and aims.

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[41] Stephen Casper and Rick Welsh, "British Romantic Generalism in the Age of Specialism, 1870-1990," *Social History of Medicine* 29.1 (2016), 154-174; Weisz, *Divide and Conquer*.
[42] Stevens, *Medical Practice in Modern England*; Honigsbaum, *The Division in British Medicine*.
[43] Loudon, *Medical Care and the General Practitioner*; Digby, *The Evolution of British General Practice*.
[44] Irvine Loudon, John Horder and Charles Webster (eds.) *General Practice under the National Health Service 1948-1997* (Oxford: Oxford University Press, 1998); Marshall Marinker, "The NHS in the 1960s and 70s: The invention of general practice," in *Radicalism and Reality* ed. Karen Bloor (York: University of York, 1998).

GP referrals to local hospitals, shared spaces at medical societies and clubs, and common status as alumni of the local medical school all contributed to a sense of local professional identity regardless of area of practice. This thesis instead demonstrates how local networks sought to sustain professional unity during the continuing growth of hospital specialism and agitation for general practice reform.

Medical practitioners shared a range of institutional affiliations, beginning at medical school and teaching hospitals and including medical societies, clubs and other sites of social interaction. The importance of medical education to the development of professional identity and community has been demonstrated in work by Samuel Bloom, Thomas Neville Bonner, Laura Kelly and Keir Waddington, and these contributions underscore the importance of medical schools to practitioners' subsequent professional lives.[45] Medical schools were important spaces for both the development of medical knowledge and experience, and also exposure to professional behavior, and the processes, personalities and institutions of the local medical community. Elsbeth Heaman, Keir Waddington and Mark Weatherall discuss the intellectual, social and professional education received at St Bartholomew's Hospital, St Mary's Hospital and Cambridge University which continued to influence graduates during their professional life.[46] This thesis explores the common status of the

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[45] Samuel Bloom, "Structure and Ideology in Medical Education: An Analysis of Resistance to Change," *Journal of Health and Social Behaviour* 29.4 (2017), 294-306; Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (New York: Oxford University Press, 1995); Laura Kelly, *Irish Medical Education and Student Culture, C. 1850-1950* (Liverpool: Liverpool University Press, 2018); Keir Waddington, "Mayhem and medical students: image, conduct, and control in the Victorian and Edwardian London teaching hospital," *Social History of Medicine* 15.1 (2002), 45-64.

[46] Keir Waddington, *Medical Education at St. Bartholomew's Hospital, 1123-1995* (Boydell & Brewer, 2003); Elsbeth Heaman, *St Mary's: The History of a London Teaching Hospital* (Montreal: McGill-Queen's University Press, 2003); Mark Weatherall, *Gentlemen, Scientists, and Doctors: Medicine at Cambridge 1800-1940* (Woodbridge: Boydell Press, 2000).

majority of local practitioners' as alumni of the Liverpool Medical School during the early years of the NHS, and the impact of their experiences on subsequent professional development.

All medical practitioners during the research period were obliged to attend clinical teaching at local hospitals as part of their medical studies, and these institutions loomed large in the local medical community. John Pickstone and Geoffrey Rivett have provided critical academic studies of the hospital systems in Manchester and London, demonstrating the interconnected social, political and economic dimensions of hospital development.[47] These works contrast with the plethora of uncritical, often celebrative hospital histories published by medical practitioners, which nonetheless demonstrate the emotional and cultural affiliation to local hospitals felt by some members of local medical communities.[48] This thesis considers how a range of medical institutions and sites contributed to local professional culture, and their relationship with medical identity, intraprofessional relationships and other networks.

Medical practitioners also maintained links with a number of professional organizations, which worked variously to support the broad interests of the profession or further the aims of individual specialisms or political viewpoints. Peter Bartrip's history of the *British Medical Journal* outlines the importance of the journal of the British Medical Association in establishing professional unity and a forum for discussion.[49] By contrast, John Stewart's history of the

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[47] John Pickstone, *Medicine and Industrial Society: A History of Hospital Development in Manchester and Its Region, 1752-1946* (Manchester: Manchester University Press, 1985);
Geoffrey Rivett, *The Development of the London Hospital System 1823-1982* (London: King's Fund, 1986).

[48] The Liverpool Area Health Authority published two such celebrative internalist histories; Arthur Clifford Brewer, *A Brief History of the Liverpool Royal Infirmary, 1887-1978*. (Liverpool: Liverpool Area Health Authority (Teaching), 1980); Michael Cook, *Liverpool's Northern Hospital 1834-1978* (Liverpool: Liverpool Area Health Authority (Teaching), 1981).

[49] Peter Bartrip, *Mirror of Medicine. A History of the BMJ* (Oxford: Oxford University Press, 1990).

Socialist Medical Association outlines the development of a professional organization that sought to use political connections to influence health policy, often in the face of majority professional groups such as the BMA.[50] This thesis acknowledges the importance of national organizations in informing practitioners' views, and considers how national debates were received and discussed at local level. The analysis of local medical networks provided by this thesis indicates that local forms of association were just as important, and often provided more immediate and responsive forms of professional debate than national bodies.

4. Local histories of medicine

This study of local networks presents a new view of the history of the NHS by showing how local professional culture influenced the development of medical practice and services. Keir Waddington noted how 'an awareness of region helps challenge metropolitan whiggism and ideas of core and periphery to give a more prominent place to hinterlands, market towns and rural environments.'[51] Liverpool provides an example of a medical community removed from the London-based professional elite, however medical services in the city were already highly developed at the start of the research period. John Pickstone described how government planners visiting Manchester and Liverpool during WWII were 'impressed by the opportunity for radical change' presented in the two cities, and that 'the potential of medical schools within an organised hospital system could be seen more clearly in Lancashire than in most of the country.'[52]

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[50] John Stewart, *'The Battle for Health': A Political History of the Socialist Medical Association, 1930-1951* (Aldershot: Ashgate, 1999).
[51] Keir Waddington, "Thinking Regionally: Narrative, the Medical Humanities and Region," *Medical Humanities* 41.1 (2015), 51.
[52] Pickstone, *Medicine and industrial society,* 319, 322.

The political and professional histories by Webster, Klein, Timmins and Rivett focus on the debates that influenced medical reform during the twentieth century, however detailed consideration of the impact of these changes on local medical communities remains an underdeveloped area of academic analysis.[53] This thesis explores how practitioners in Liverpool accommodated national professional changes with the specific demands of the local medical system. Raphael Samuel claimed that local history 'demands a different kind of knowledge than one which is focused on high-level national developments, and gives the researcher a much more immediate sense of the past'.[54] Important studies of local medical systems during the nineteenth century, and NHS hospital systems, have been provided by Geoffrey Rivett (London), John Pickstone, Emma Jones and Pickstone, and Helen Valier and Pickstone (Manchester), Hilary Marland (Wakefield and Huddersfield) and Steve Sturdy (Sheffield), however there is a dearth of social histories of local medical communities under the NHS.[55]

Medical practitioners in Liverpool felt a distinctly local sense of professional identity, inculcated at the medical school, the city's

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[53] Waddington, "Thinking Regionally," 51.

[54] Raphael Samuel, "Local history and oral history," *History Workshop* 1 (Spring 1976), 192.

[55] Geoffrey Rivett, *The Development of the London Hospital System 1823-1982* (London: King's Fund, 1986); Pickstone, *Medicine and Industrial Society*; Emma Jones and John Pickstone, *The Quest for Public Health in Manchester: The Industrial City, the NHS, and the Recent History* (Manchester: Centre for the History of Science, Technology and Medicine, 2008); John Pickstone and Helen K. Valier, Community, Professions and Business. A history of the Central Manchester teaching hospitals and the National Health Service (Manchester: CHSTM series, Carnegie Press, 2008); Hilary Marland, *Medicine and Society in Wakefield and Huddersfield 1780-1870* (Cambridge: Cambridge University Press, 1987); Steve Sturdy, "The Political Economy of Scientific Medicine: Science, Education and the Transformation of Medical Practice in Sheffield, 1890-1922," *Medical History* 36. 2 (1992), 125–59.

historic hospitals, and local networks such as the Liverpool Medical Institution, specialist clubs and societies. Histories of hospitals and medical schools often note the significance of local connections between individuals, institutions and professional culture. However these discussions tend to be tangential to the specific history of institutions.[56] This thesis develops an understanding of the medical community more broadly by considering a wide range of local professional groups. This involves integrating the perspectives of practitioners committed to traditional forms of working, such as single-handed 'parlour' general practice and the rigid hierarchies of hospital firms, with more progressive practitioners engaged in general practice reform, hospital specialism, and greater cooperation with public health and community medicine.

A body of historical and sociological scholarship has engaged with the emergence and development of medical specialties, a phenomenon that appears to contradict professional groups' tendency to oppose internal differentiation.[57] Academic and internalist histories of specific specialties often describe their transition from fringe 'special interests' to fully-fledged areas of medical expertise complete with national and international societies, journals and symposia.[58] William Leeming suggested 'conceptual and technological innovations' encouraged practitioners to 'concentrate their clinical

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[56] Heaman, *St Mary's: The History of a London Teaching Hospital*; Waddington, *Medical Education at St. Bartholomew's Hospital*; Jonathan Reinarz, "Towards a History of Medical Education in Provincial England," *History* 43.3 (2001), 33–53; Kelly, *Irish Medical Education and Student Culture*.

[57] Marian Döhler, "Comparing National Patterns of Medical Specialization: A Contribution to the Theory of Professions." *Social Science Information* 32.2 (1993), 186.

[58] Stephen Casper, *The Neurologists: A History of a Medical Specialty in Modern Britain, c. 1789–2000* (Manchester: Manchester University Press, 2015); Klaus Doerner, *Madmen and the Bourgeoisie: a social history of insanity and psychiatry* (Oxford: Basil Blackwell, 1981); Michael O'Dowd and Elliot Philipp, *The history of obstetrics and gynaecology* (London: CRC press, 2000).

activities on increasingly narrow fields of endeavour' resulting in intraprofessional competition and the growth of specialisation.[59] Rosemary Stevens noted the rise of medical specialties during the interwar period that led to tensions between the Royal Colleges, which 'wanted to retain medicine as a unified whole' and the emerging groups which wanted to 'raise standards in their own special fields and to advance their own status.'[60] This thesis considers emerging medical specialism within the wider medical community, and demonstrates how local societies and specialist clubs provided essential platforms for subsequent growth at regional and national level.

Local practitioners' engagement with the Liverpool Medical Institution can be interpreted as a barometer of the changing values of the local professional community. The decline of the LMI during the 1980s and 1990s echoed the falling importance of intraprofessional deference, patronage and local relationships in securing medical appointments. A small number of academic studies on medical societies during the nineteenth century have highlighted their potential as a means of accessing local professional culture, with the social and personal relationships formed in such groups of equal importance to their professional significance.[61] Nonetheless, the

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[59] William Leeming, "Professionalization Theory, Medical Specialists and the Concept of 'national Patterns of Specialization.'" *Social Science Information* 40.3 (2001), 455–85.

[60] Stevens, *Medical Practice in Modern England,* 38.

[61] Jacqueline Jenkinson, "The Role of Medical Societies in the Rise of the Scottish Medical Profession 1730-1939," *Social History of Medicine* 4.2 (1991), 253–75; Brown, *Performing Medicine,* 25. Accounts of learned societies have been published by their members, including the overview by surgeon and medical historian D'Arcy Power (1855-1941), *British Medical Societies* (London: Bailliere, Tyndall 1939); physician and medical historian Anthony Batty Shaw (1922-2015), "The Oldest Medical Societies in Great Britain," *Medical History* 12.3 (1968), 232–44; Jamieson Hurry, *A History of the Reading Pathological Society*: Bale & Danielsson, 1909); John Wynn Jones, "Peripatetic Medical Societies," *Royal College of*

provincial medical society remains an under-explored area of the history of medicine in Britain during the twentieth century, and provides an excellent point of entry to consider how practitioners experienced professional and structural change.

This thesis provides a detailed analysis of Liverpool's medical community since 1930 that offers insights into how practitioners negotiated the expectations of their peers, the professional model of teachers and mentors, and the local professional establishment. This addresses the previously neglected question of how local professional networks reconciled traditional professional practices with the demands of the NHS. The specific social and economic challenges facing Liverpool after 1930, alongside the existence of an historic and well-established medical society at the LMI, make it an ideal site for this analysis. The experience of national medical reform at local level remains an underdeveloped area of historical analysis, and insights drawn from local developments challenge and add nuance to claims made about the service as a whole.

General Practitioners 71 (1995), 39; Penelope Hunting, "The Medical Society of London," *Postgraduate Medical Journal* 80.944 (June 1, 2004), 350-354 and "The Royal Society of Medicine," *Postgraduate Medical Journal* 81.951 (January 1, 2005), 45-48; Thomas Allibone, "The Club of the Royal College of Physicians , the Smeatonian Society of Civil Engineers and Their Relationship to the Royal Society Club," *Notes and Records of the Royal Society of London* 22.1 (2017), 186-92.

Chapter 1
Methodology

This study uses a mixed methods approach to explore the range of professional networks operating within Liverpool's medical community. Written archival materials are complemented by oral history interviews in order to address three primary research areas; the impact of changes to medical networks on medical services in Liverpool; the changing composition of the local medical community; and the role of Liverpool's foremost medical society, the Liverpool Medical Institution (LMI) in providing social, educational and business support to local practitioners. The working hypothesis of this study was that the mixed economy of pre-NHS medical work required practitioners to maintain frequent interactions across local networks in order to ensure a cohesive and harmonious professional environment. There was therefore an important economic rationale to maintaining a mutually supportive professional community. Local medical networks were sustained through professional societies, clubs and organizations, however the creation of the National Health Service (NHS) in 1948 challenged their traditional role through the introduction of increasingly formalised systems to govern career progression, postgraduate medical education and monitoring of professional standards.

The periodisation of this study enables an introduction to Liverpool's medical community before the creation of the NHS (Part 1: 1930-1948), an assessment of its development during the first years of the service and first major reorganisation in 1974, and the opening of a major new teaching hospital in Liverpool in 1978 (Part 2: 1948-1978), and the impact of the management and internal market reforms of the 1980s and 1990s (Part 3: 1978-1998). The end point of this study in 1998 corresponds with the start of the new Labour government's NHS reforms, and the formal reopening of the Liverpool Medical Institution following a major refurbishment. This

thesis demonstrates the continued significance of local professional networks during the first decades of the NHS, as hospital rationalisation, professional organisations, and general practice reform developed in response to specific local concerns. NHS reforms, notably the creation of independent hospital trusts, GP fundholders and the internal market, undermined the cooperative philosophy of the local medical community, while the formalisation of postgraduate medical education undermined the educational significance of local professional networks.

This study develops a prosopography of Liverpool's medical community, a methodology defined by Lawrence Stone as the 'investigation of the common background characteristics of a group of actors in history by means of a collective study of their lives'.[62] Prosopography has been used for uncritical internalist histories of 'great men', or, in the case of the medical profession, hagiographic tributes to famous predecessors, however such studies have often ignored rank and file members of professional communities.[63] Critical prosopography, as advocated by historians Lewis Namier (1888-1960) and Robert K Merton (1910-2003), considers the intellectual and professional development of historic groups through a consideration of their cultural and social origins.[64] Steven Shapin and Arnold Thackray suggested prosopography is a particularly useful tool to consider the British scientific community during the eighteenth and nineteenth centuries, as the 'cultural insulation' of scientists and

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[62] Lawrence Stone, "Prosopography," *Daedalus*, 100.1 (Winter 1971), 46.

[63] Samuel Shortt, "Physicians, science, and status: issues in the professionalization of Anglo-American medicine in the nineteenth century," *Medical History* 27.1 (1983), 51.

[64] Lewis Pyenson, "'Who the guys were": Prosopography in the history of science," *History of Science* 15.3 (1977), 165-166.

emerging boundaries of professional groups rendered them a distinct analytical subject.[65]

Prosopography is suited to the study of local medical networks, and a consideration of how they affected the social, intellectual and business dimensions of the professional community. Precedents for this methodological approach include Arnold Thackray's 1974 study of the Manchester Literary and Philosophical Society (inaugurated in 1781), which included a significant number of medical members.[66] Over sixty per cent of the Manchester Literary and Philosophical Society were medically qualified, and both founding presidents held leading roles in the Manchester Royal Infirmary, the city's leading voluntary hospital.[67] Thackray outlined the social functions of the society, and its function as a source of mutual support among peers. Medical members harnessed the prestige of the local scientific community to further their own professional aspirations, and engage with wider society.[68]

1.1. Written materials

The periodisation of this study enabled the inclusion of personal testimony from members of the local medical community through oral history interviews, which were conducted alongside traditional archival research to develop a mixed-methods source base. The mixed methods approach allowed interviewees to offer personal reflections on archival sources relating to the changing professional,

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[65] Steven Shapin and Arnold Thackray, "Prosopography as a research tool in history of science: The British scientific community 1700–1900," *History of science* 12.1 (1974), 4.
[66] Arnold Thackray, "Natural Knowledge in Cultural Context: The Manchester Mode," *The American Historical Review* 79.3 (1974), 672-709.
[67] Thackray, "Natural knowledge in cultural context," 684.
[68] Shortt, "Physicians, Science, and Status," 61-2.

organizational and institutional landscape of medicine in Liverpool.[69] Three three-month placements (and repeated archive visits) to the Liverpool Medical Institution (LMI) helped develop an understanding of the educational, training and social resources it provided to the local medical community. Archival material held at the LMI, alongside other sources held at local repositories, was cross-referenced with national records such as the *Medical Register,* the medical press and records of the medical colleges. The mixed methods approach arguably privileges certain forms of evidence. In this study archival records were used to provide context and quantitative background for detailed oral history interviews with local practitioners.[70]

Written sources for the history of medicine are plentiful and readily accessible, reflective of the mature professional status of medicine in twentieth century Britain. The national medical press, notably the *British Medical Journal* and *Lancet,* provide insights into profession opinion across the research period, and local practitioners regularly contributed research articles, opinion pieces and letters to these publications. The annual List of Registered Medical Practitioners (the 'Medical Register') published by the General Medical Council offers a historic database of all practitioners, with appendices including the 'local list' of practitioners by area, information on medical societies, specialist organizations, and postgraduate medical centres. William Bishop (1903-1961) and his successor as librarian at the Wellcome Library in London Noël

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[69] Julia Brannen, "Mixing Methods: The Entry of Qualitative and Quantitative Approaches into the Research Process," *International Journal of Social Research Methodology* 8.3 (2005), 182.

[70] Janice Morse, "The implications of interview type and structure in mixed-methods designs," in *The SAGE Handbook of Interview Research: the complexity of the craft,* eds. Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney (Sage Publications (Online), 2012) 193; Jennifer Mason, "Linking qualitative and quantitative data analysis," in *Analyzing qualitative data*, eds. Alan Bryman and Robert Burgess (Abingdon: Routledge, 1994), 107.

Poynter (1908-1979) published informative guides on historic and active medical societies, and directories of local medical societies were featured in the *Medical Directory*.[71] Following the National Health Insurance Act of 1911, local insurance committees published directories of insurance practitioners, and similar directories were produced after 1948 of practitioners registered with NHS Family Practitioner Committees.[72]

Municipal and voluntary hospitals produced a range of institutional records with information on finance, staffing and administration before 1948. Much of this material is available at local archives and online databases. The Voluntary Hospitals Database, developed by John Mohan and Martin Powell between 1996 and 1999 (digitised by the London School of Hygiene and Tropical Medicine), gathers information from *Burdett's Hospitals and Charities: The Year Book of Philanthropy and Hospital Annual,* published between 1892 and 1930, and its successor, *The Hospitals Yearbook*.[73] The digitised Wellcome Trust/ National Archives 'Hospital Records' project also provides historic information on hospitals across all forms of ownership in Britain.[74]

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[71] William Bishop, "Medical Book Societies in England in the Eighteenth and Nineteenth Centuries," *Bulletin of the Medical Library Association* 45.3 (1957), 337; Frederick Noël Lawrence Poynter, "British Medical Societies 1868-1968," *The Practitioner* 201 (1968), 238–45.

[72] National Health Insurance: Liverpool Insurance Committee, "List of insurance medical practitioners, chemists, etc." (1946) [LRO: 610.58 LIV]; National Health Service. Liverpool Executive Council, "List of medical practitioners who have undertaken to provide service in the Liverpool area." [LRO: 610.58 NAT].

[73] London School of Hygiene and Tropical Medicine, Voluntary Hospitals Database, http://www.hospitalsdatabase.lshtm.ac.uk/the-voluntary-hospitals-database-project.php [accessed 12 November 2018]; Financier and philanthropist Henry Burdett (1847-1920) founded the British Hospitals Association in 1884).

[74] The National Archives/Wellcome Trust, The Hospital Records Database http://www.nationalarchives.gov.uk/hospitalrecords/ [accessed 19 February 2020].

Senior members of the local medical community were elected to fellowship of the medical colleges in England, Scotland and Ireland. The Royal College of Physicians and the Royal College of Surgeons of England both maintain databases (now digitised) of obituaries of elected fellows, *Munk's Roll* and *Plarr's Lives of the Fellows*.[75] Equivalent bodies in Scotland and Ireland, alongside other professional organizations such as the British Medical Association, specialist colleges and College of General Practitioners (established in 1952) also published obituaries of members. The obituary collections of the national medical colleges and other organizations tend to be limited to the professional elite, and local obituaries were published in the annual *Transactions* of the Liverpool Medical Institution.[76] Obituaries provided by the LMI often offer a more intimate and personal perspective on the life of their subject, with particular focus on local contributions and relationships.

The reports of the Medical Officer of Health for Liverpool (produced annually from 1848-9 until the termination of the role in 1974) provide important statistics pertaining to public health, population and public medical services. These records are complemented by official government statistical returns, which provide information on national expenditure, manpower and administration of the health services.[77] NHS administrators routinely produced reports and analyses of the Liverpool area in the course of restructuring and reorganization: the area surveys commissioned prior to the NHS reorganization in 1974 provide essential supporting information for policy decisions around the local medical system, and

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[75] *Munk's Roll* and *Plarr's Lives of the Fellows* accessed online at https://history.rcplondon.ac.uk/inspiring-physicians and https://livesonline.rcseng.ac.uk/client/en_GB/lives.

[76] Printed and bound copies of the *Transactions and Report* are held at the Liverpool Medical Institution.

[77] Figures were published by local boards of health until the establishment of the Ministry of Health in 1919, followed by the Department of Health and Social Security (after 1968), and Department of Health (after 1988).

responses to these publications from the medical community revealed tensions between administrators and the profession.[78]

The challenges facing Liverpool's medical system during the 1960s and 1970s led to in-depth inquiries by government and academic investigators. Liverpool's high usage of hospital resources during the 1960s prompted a detailed investigation by a team at the London School of Hygiene and Tropical Medicine led by Professor Robert Logan, published in 1972 as *Dynamics of medical care. The Liverpool study into use of hospital resources*.[79] In 1978, amid delays, overspending and industrial disputes at the new teaching hospital, a committee of inquiry into the Liverpool Area Health Authority led by Professor Roger Dyson submitted a detailed report on the local medical system.[80] These studies provided valuable perspectives and data on the development of medical services in Liverpool, and the findings could be discussed in greater detail with oral history interviewees.

Archival records relating to general practitioners were less readily available than for hospital medicine, reflecting their underrepresentation in the broader historical record, and oral history interviews therefore provided essential insights. The incomplete records of the Local Medical Committee (LMC, formerly the Local Medical and Panel Committee established with the introduction of National Health Insurance in 1911), held at a local GP surgery,

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[78] Liverpool Area Health Authority (Teaching), "Central and Southern District In-Patient and Out-Patient Services" (March 1975) [LRO: HQ362.061.LIV].

[79] Robert Logan, John Ashley, Rudolf Klein and David Robson, *Dynamics of Medical Care. The Liverpool Study into Use of Hospital Resources* (Kent: Dawson & Sons, 1972).

[80] Mersey Regional Health Authority, "Report of a committee of inquiry to examine the management and development of health service resources and the conduct of industrial relations in Liverpool Area Health Authority (Teaching.)" (1978) [LRO:362.061 MER].

provided some access to discussions between local GPs.[81] The personal papers of Liverpool GP and former Socialist Health Association president Cyril Taylor (1921-2000), deposited at the Liverpool Record Office, also provided important insights into radical general practice in the city.[82]

The Liverpool Medical Institution both collected and published a range of material related to the local medical community. William LeFanu (1904-1995), medical bibliographer and librarian at the Royal College of Surgeons in London, compiled a list of the huge number of general, special interest and regional medical journals in 1937 (in which he noted their 'high infant mortality rate').[83] The decision to definitively cease publication of the *Liverpool Medico-Chirurgical Journal* (which had existed in various forms since 1823, and paused publication in 1948) was taken in 1954.[84] The Liverpool Medical Institution continued to publish news in the *British Medical Journal*, and also published an annual *Transactions* alongside its annual report, with details of research papers given at the society, professional and social activities, visiting speakers, finance reports and appeals for funds. The *Transactions* provide information on leadership appointments and funding of the institution, and give intermittent quantitative information on membership numbers and function attendance. The Liverpool Medical History Society was founded 1984, and its journal *Medical Historian,* continues to publish

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[81] Incomplete surviving records of the LMC were located at Greenbank Road surgery, Liverpool.

[82] Archival collection of materials relating to Dr Cyril Taylor. [LRO: 613 TAY].

[83] William LeFanu, *British Periodicals of Medicine: A Chronological List* (Baltimore: Johns Hopkins, 1938), 1.

[84] Thomas Bickerton, *The Liverpool Medico-Chirurgical Journal: Its past, present, and future* (reprinted from *Liverpool Medico-Chirurgical Journal* (1906). Wellcome Collection https://wellcomecollection.org/works/wd95pdse [accessed 12 February 2020].

articles of relevance to local medical history, often authored by or with the contribution of local practitioners.[85]

The archive and library collections of the city's oldest members club, the Athenaeum (established 1797), hold material on its medically qualified members. Records from smaller groups, such as the consultants' dining clubs, the Liverpool branch of the Medical Women's Federation, and other specialist clubs and societies, have been gathered in the archive at the Liverpool Medical Institution.[86] The University of Liverpool Special Collections and Archives holds administrative and staffing records from the medical school, the personal papers of staff members, the Liverpool Medical Students' Society, founded in 1874, and the University Lodge of Liverpool, a masonic lodge (no. 4274) consecrated in 1921 with a significant medical membership.[87]

The wealth of written sources provided wide-ranging insights into the development of hospitals, medical education, and key professional networks in Liverpool across the research period. Working with archival material also offered a foundation for informed and targeted oral history interviewing of members of the local medical community, and familiarity with the institutions, events and personalities discussed during interviews.

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[85] *Medical Historian* is undergoing digitization at the Liverpool Medical Institution, [https://www.lmi.org.uk/limhs-medical-historian] (accessed 6 February 2020).

[86] "Innominate Club (papers of)" [LMI: ICP]; "Liverpool Medical and Literary Society" [LMI: MLS]; "Liverpool Medical Research Organisation" [LMI: HV 15]; "Liverpool Orthopaedic Circle" [LMI: LOC]; "Liverpool Paediatric Club" [LMI: HV 6]; "Liverpool Society of Anaesthetists" [LMI: HV 9]; "North of England Obstetric and Gynaecological Society" [LMI: OGS]; "Twenty Club Minutes (XX Club)" [LMI: TCM].

[87] "University Calendars - 1882-2009" [SCA: PUB/1/1]; "*Sphincter*: Magazine of Liverpool Medical Students' Society: Bound Vols - 1937-2008" [SCA: PUB/3/8]; "Copy of "University Lodge of Liverpool No 4274 1921-1971" [SCA: D109].

1.2. Oral history

Oral history interviews conducted for this project complement written sources, and interviewees were invited to challenge or add nuance to the archival record. Documentary sources often raise further questions and are open to a number of interpretations, and benefit from dynamic engagement with interviewees around their provenance and impact. Oral history has grown in popularity since the 1970s: the British Institute of Recorded Sound (now the British Library Sound Archives), launched the journal *Oral History* in 1971 and founded the Oral History Society in 1973, and the first International Conference on Oral History was held at the University of Essex in 1979.[88] Interviewing introduces technical and epistemological challenges to the research process, and Jennifer Platt described interview research as 'an area of richly diverse practice about which few convincing generalizations can be made'.[89] Interviews provided an essential point of access to underrepresented historical actors, and offer an important corrective to interpretations limited to discussion of social and professional elites.[90]

Oral history remains an under-utilized methodology among histories of professional groups: early studies tended towards 'history from below' and Rob Perks, Lead Curator of Oral History at the British Library, noted the lack of studies that diverge from the 'well-

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[88] Donald Ritchie, "Introduction: The Evolution of Oral History,: in *The Oxford Handbook of Oral History* ed. Donald Ritchie (Oxford: Oxford University Press, 2011), 9.

[89] Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney, "Introduction: the complexity of the craft." in *The SAGE Handbook of Interview Research: the complexity of the craft,* eds. Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney (Sage Publications (Online), 2012), 3-5; Jennifer Platt, "The history of the interview," in *The SAGE Handbook of Interview Research: the complexity of the craft,* eds. Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney (Sage Publications (Online), 2012), 24.

[90] Ritchie, "Introduction: The Evolution of Oral History," 5.

worn focus on working-class experience, the marginalized and the voiceless'.[91] The availability of written materials related to the development of medical services provides several starting points for productive oral history interviewing, and medical practitioners are often articulate and confident interviewees. Anne Digby and Graham Smith have demonstrated the potential of oral history to include rank and file medical practitioners in historical discussion, accessing the lives of those who fail to appear in hospital histories or hagiographic tributes to professional pioneers.[92] Oral history has been used to address the comparative lack of channels for accessing the history of general practice: Graham Smith conducted interviews with general practitioners in Scotland to provide insights into this traditionally under-researched branch of medicine, and scrutinised the changing professional identity of practitioners based on age, gender and social background, alongside their participation in the wider professional community.[93] Michael Bevan worked with a sample of 41 interviews with GPs that qualified between 1923 and 1955 to explore the role of social and family background on their career choices.[94]

Mary Kay Quinlan noted that 'at its core, the oral history interview has changed little since the earliest days of wire recording devices. It remains an intensely interpersonal exchange between a

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[91] Rob Perks, "The roots of oral history: exploring contrasting attitudes to elite, corporate, and business oral history in Britain and the US," *The Oral History Review* 37.2 (2010), 215.
[92] Digby, *The Evolution of British General Practice*, 260; Graham Smith and Malcolm Nicolson, "Re-Expressing the Division of British Medicine under the NHS: The Importance of Locality in General Practitioners' Oral Histories," *Social Science and Medicine* 64.4 (2007), 938; Graham Smith, Malcolm Nicolson and Graham Watt, "An oral history of everyday general practice: speaking for a change," *British Journal of General Practice*, June 2002, 517.
[93] Smith, "An oral history of everyday general practice," 868.
[94] Michael Bevan, "Family and vocation: career choice and the life histories of general practitioners," in *Oral History, Health and Welfare* eds. Joanna Bornat, Robert Perks and Jan Walmsley (Abingdon: Routledge, 2005), 21.

prepared interviewer and a willing narrator.'[95] Quinlan also signalled the importance of an informed interviewer in order to 'establish rapport with a narrator', and for this reason interviews were conducted during the second year of the project, in order to develop sufficient understanding of the research area.[96] Prior to commencing interviews, the plan for this study was passed by a university ethics committee to ensure correct procedures were followed to gain informed consent from participants.[97] The process of securing ethics approval from the university ethics committee involved the submission of consent forms, project information, and questionnaires (included as appendices). Participants were provided with an information sheet and consent form during the interview, and could request anonymity in any final publications (five participants chose to remain anonymous).[98]

Individual Interviews

In order to recruit participants for this study an email invitation was sent to all members of the Liverpool Medical Institution (included as an appendix). Printed invitations were also circulated at LMI events and displayed in the institution building. Participants who responded to this initial circulation were then asked to suggest further interviewees, this strategy, known as 'snowballing', led to contact with participants with little or no engagement with the LMI, and helped correct the issue of only interviewing practitioners

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[95] Mary Kay Quinlan, "The Dynamics of Interviewing" in *The Oxford Handbook of Oral History* ed. Donald Ritchie (Oxford: Oxford University Press, 2011), 24.
[96] Quinlan, "The Dynamics of Interviewing," 30.
[97] Jinjun Wang and Ying Yan, "The interview question," in *The SAGE Handbook of Interview Research: the complexity of the craft,* eds. Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney (Sage Publications (Online), 2012), 241.
[98] Ritchie, "Introduction: The Evolution of Oral History," 15.

linked to the institution.[99] The LMI offered a valuable starting point for engagement with the local medical community, and affiliation with a recognised membership organization potentially induced some interviewees to participate. A combination of the circulated call for participation through the LMI, direct contact with practitioners, and referrals from participants resulted in a final sample size of 35 individual interviews.

Individual interview testimony is to a certain extent representative of unique personal experience, and it is impossible to find participants who are truly 'representative' of the wider medical community. The public circulation of the call for participants predictably did not result in sample of interviewees evenly distributed across different ages, genders, backgrounds and professional areas. Similarly, the 'snowballing' method of recruiting further participants often led to meeting with interviewees' professional colleagues (either from the same hospital, practice or professional area). It was therefore necessary to target underrepresented groups in the sample, and specifically request interviewees suggest participants from among groups that had not been previously consulted.

The total sample of 35 interviewees included 25 hospital practitioners (representing a range of institutional affiliations and medical specialties), 7 general practitioners, 2 medically qualified public health professionals and one former chair of a statutory patients' organisation. The sample included 8 women and 19 Liverpool graduates, the earliest graduate was renal physician John Goldsmith (London, 1947), and the most recent graduate was general practice academic Christopher Dowrick (Liverpool, 1987).

Hospital practitioners made up the majority of participants (25/35), this was partly a result of the 'snowballing' form of participant recruitment (hospital practitioners tended to suggest colleagues from their own specialist area or hospital), however it was

[99] Alan Bryman, *Social Research Methods* (Oxford university press, 2015), 202.

also essential to interview practitioners from across as many of Liverpool's hospitals as possible. Several hospital practitioners interviewed were also engaged in medical teaching, and were involved to a substantial degree in institutional networks at hospitals and the university. Fewer general practitioners responded to the initial call for participants. It was nonetheless possible to secure interviews with GPs with a wide range of experience, including Katy Gardner (who worked alongside socialist colleagues at the Princes Park Health Centre), Nuala Gallagher (who inherited a traditional 'parlour practice' from her father), and Rob Barnett, long-serving chair of the Local Medical Committee. Interviews with public health practitioners John Ashton and Alex Scott Samuel provided an additional perspective on the development of local medical services. Further insights were provided in an interview with Sylvia Hikins, Chair of the Liverpool Central and Southern Community Health Council between 1981-1990, a statutory patients' representation organisation created with the NHS reorganisation in 1974.

Figure 1.1. Individual interviews conducted for this project (n =35)

Name	Qualified	Specialty	Date	Venue
Anonymous Interviewee 1	1950, Ireland	Hospital Medicine	6/6/2018	Home
Armour, Roger	1956, Lahore	Vascular Surgery	25/9/2018	Telephone
Ashton, John	1970, Newcastle	Public Health	27/6/2018	LMI
Barnett, Rob	1983, Liverpool	General Practice	6/7/2018	Surgery
Brace, Christine	1968, Liverpool	General Practice	27/3/2018	LMI
Anonymous Interviewee 2	1964, Ireland	Hospital Medicine	24/5/2018	Home
Coakley, John	1980, Liverpool	Intensive Care	31/5/2018	LMI
Cranney, Mike	1979, Liverpool	General Practice	25/5/2018	Surgery
Dangerfield, Peter	1969, St Andrews	Clinical Anatomy	16/7/2018	LMI
Dowrick, Christopher	1987, Liverpool	General Practice	25/5/2018	University of Liverpool
Anonymous Interviewee 3	1983, London	Hospital Medicine	23/7/2018	Place of Work
Evans, Chris	1964, Liverpool	Chest Medicine	6/3/2018	Home
Evans, Susan	1964, Liverpool	Dermatology	20/3/2018	Home
Fazackerley, Janice	1979, Liverpool	Anaesthesia	9/5/2018	LMI
Gallagher, Nuala	1953, Liverpool	General Practice	30/4/2018	Home
Anonymous Interviewee 4	1979, Liverpool	Hospital Medicine	6/11/2018	LMI
Gardner, Katy	1974, Cambridge and London	General Practice	5/4/2018	Home
Gilbertson, Anthony	Liverpool	Anaesthesia	20/8/2018	Home
Gilmore, Ian	1971, Cambridge and London	Hepatology	24/7/2018	Telephone
Goldsmith, John	1947, London	Renal Medicine	28/2/2018 and 21/8/ 2018	Home and LMI
Hikins, Sylvia	-	Patients' Organisation	9/7/2018	Home
Howard, Clare	1976, Liverpool	Anaesthesia	22/10/201 8	LMI
Hunter, Jennifer	1971, St Andrews	Anaesthesia	4/10/2018	Royal Liverpool
Nye, Fred	1966, London	Infectious Diseases	25/9/2018	Home
Parsons, Keith	1970, Liverpool	Urology	4/6/2018	Rodney Street practice
Ridyard, John	1968, Liverpool	Respiratory Medicine	31/5/2018	LMI

Saltissi, Stephen	London	Cardiology	26/2/2019	Home
Scott Samuel, Alex	1971, Liverpool	Public Health	1/5/2018	Home
Seaton, Anthony	1962, Cambridge	Chest Medicine	22/8/2018	Home
Anonymous Interviewee 5	1972, Cambridge and London	Hospital Medicine	3/4/2019	LMI
Taylor, Bill	1969, Liverpool	Pathology	14/3/2018	LMI
Turner, John	1966, London	Geriatrics	21/8/2018	LMI
Verbov, Julian	1959, Liverpool	Paediatric Dermatology	28/8/2018	Home
Wong, David	1977, Liverpool	Ophthalmology	3/8/2018	Home
Yorke, Reginald	1954, Liverpool	General Practice	8/2/2018	Formby

Interview location can exert a significant influence over participant responses, and helps define the content, atmosphere and productivity of the interview.[100] Out of the total of 35 individual interviews conducted for this project 11 were held at the Liverpool Medical Institution, 15 at interviewees' homes, 6 at interviewees' place of work, 2 via telephone, and one interview (with an elderly participant) in a restaurant near their supported living accommodation. Interviews conducted at the Liverpool Medical Institution did not appear to noticeably alter discussion (interviewees were questioned on their perspective on the LMI regardless of interview location), and were reminded that despite developing with the cooperation of the institution, the research did not aim to either flatter or criticise it.

Quinlan noted interview location 'may evoke important memories for the narrators and contribute to the depth of their recollections and responses', and some participants' shared photographs, memorabilia and other material during interviews at their home.[101] Interviews conducted at participants' place of work arguably encouraged discussion of their immediate working environment, and these locations included the Royal Liverpool University Hospital, the University of Liverpool Medical School, a private consulting room on Rodney Street (the traditional medical precinct in the city) and several GP practices.

Alongside new interviews, this study makes use of interviews conducted by the Anaesthesia Heritage Centre, the Medical Sciences Video Archive (a resource developed by the Royal College of Physicians and Oxford Brookes university), the Royal College of Physicians 'Voices of Medicine' oral history project, and the Wellcome Trust/ Queen Mary, University of London project 'The

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[100] Hanna Herzog, "Interview location and its social meaning," in *The SAGE Handbook of Interview Research: the complexity of the craft,* eds. Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney (Sage Publications (Online), 2012), 215.
[101] Quinlan, "The Dynamics of Interviewing," 28.

History of Modern Biomedicine' (see Figure 1.2).[102] Several of these projects can be described as 'public history', described by Graham Smith as a 'political activity, whether practiced in the name of the people, or in the service of charities, religious organizations, governments, or capitalist corporations'.[103] These resources are treated critically in this study, and their occasionally celebratory or hagiographic perspectives are acknowledged.[104] Oral histories of medicine have tended to privilege the professional elite, and the interviews conducted in the course of this study aim to gather the experiences of the professional rank and file that remain underrepresented in the public history collections of national organizations.

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[102] Association of Anaesthetists Heritage Centre, 'Oral Histories' https://anaesthesiaheritagecentre.wordpress.com/oral-histories/ [accessed 5 February 2020]; Oxford Brookes Medical Sciences Video Archive https://radar.brookes.ac.uk/radar [accessed 17 January 2019]; Royal College of Physicians, 'Voices of Medicine' https://history.rcplondon.ac.uk/blog/voices-medicine-changes-doctor-patient-communication [accessed 5th February 2020]; Wellcome Trust/ Queen Mary University of London 'History of Modern Biomedicine' https://qmro.qmul.ac.uk/xmlui/handle/123456789/12359 [accessed 6 February 2020].

[103] Graham Smith, "Toward a Public Oral History," in *The Oxford Handbook of Oral History* ed. Donald Ritchie (Oxford: Oxford University Press, 2011), 429.

[104] Smith, "Toward a Public Oral History," 442.

Figure 1.2. Existing interviews consulted (n=11)

Name	**Qualified**	**Specialty**	**Date**	**Interviewing Body**
Beeching, Nicholas	1976, Oxford	Tropical Medicine	25/4/2016	Royal College of Physicians
Bennett, John	1957, Liverpool	Gastroenterology	7/5/2015	Royal College of Physicians
Clarke, Cyril (1907-2000)	1932, Cambridge and London	Genetics	15/5/1986	Oxford Brookes
Gill, Geoff	1972, Newcastle	Tropical Medicine	4/9/2015	Royal College of Physicians
Gilmore, Ian	1971, Cambridge and London	Hepatology	24/9/2015	Royal College of Physicians
Goldsmith, John	1947, London	Renal Medicine	11/5/2015	Royal College of Physicians
Gray, Thomas Cecil (1913-2008)	1937, Liverpool	Anaesthesia	28/8 and 25/11/1996	Oxford Brookes
Hillson, Rowan	1974, Birmingham	Endocrinology	15/6/2016	Royal College of Physicians
Hunter, Jennifer	1971, St Andrews	Anaesthesia	9/8/2016	Anaesthesia Heritage Centre
Jackson-Rees, Gordon (1918—2001)	1942, Liverpool	Anaesthesia	28/8 and 25/11/1996	Oxford Brookes
Seaton, Anthony	1962, Cambridge	Chest Medicine	16/8/2016	Queen Mary, University of London

Group Interviews

Two group interviews were convened for this study; a discussion of hospital medicine in Liverpool before the opening of the new teaching hospital in 1978, and a discussion of medical teaching in Liverpool (see Figure 1.3). Several practitioners who had completed individual interviews were approached to participate in these group interviews, and they followed a general schedule rather than specific set of questions (invitations to group interviews are provided as an appendix). The group interview on hospitals before 1978 benefitted from participants with experience of both the pre-1978 hospital system and the process of amalgamating staffs at a new site. The group interview on medical teaching included six practitioners who graduated from the University of Liverpool Medical School between 1964 and 1980, half were women, and all had pursued professional careers in different medical specialities.

Anna Green claimed it is 'only through active discourse with others within the same social or cultural groups…that the inchoate dreamlike impressions of individual recollection' become 'meaningful, durable memories.'[105] With this in mind, the group interviews were convened to give participants the opportunity to share, discuss and defend their ideas about two central aspects of the local medical community: hospital medicine and medical teaching. Group interviews of this nature expose the co-production of 'truths' approximately representative of the collective experience.[106] Disagreement and discussion in the group setting provided the chance to further observe and question participants as they responded to their professional peers. There was a performative element to the group

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[105] Anna Green, "Can Memory be Collective?" in *The Oxford Handbook of Oral History* ed. Donald Ritchie (Oxford: Oxford University Press, 2011), 99.

[106] David Morgan, "Focus groups and social interaction," in *The SAGE Handbook of Interview Research: the complexity of the craft,* eds. Jaber Gubrium, James Holstein, Amir Marvasti, and Karyn McKinney (Sage Publications (Online), 2012), 163.

interviews, and participants traded stories about memorable characters, places and experiences (during the second group interview the participants even sang the medical school song).

During the two group interviews participants were given minor prompts and encouraged to discuss ideas and experiences with each other. The majority of participants in the group interviews were known to each other, however some participants were gently encouraged to contribute to avoid domination by older or professionally senior participants. Both group interviews were held at the University of Liverpool, in a space that had formerly been part of the medical school. This location encouraged some participants to share their memories linked to the site, and offered a practical, comfortable and accessible venue.

Various forms of group testimony have been used for research purposes by historians and social scientists, a popular method in the history of medicine has been the convening of witness seminars. Tilli Tansey, lead researcher at The Wellcome Trust's History of Modern Biomedicine Research Group, defined witness seminars.

> Taking a large scale social, scientific or technological change, an important development or a discovery as a starting point, witness seminars pull together the people involved in making it happen – from clinicians, scientists and patients to policymakers and journalists.[107]

The History of Modern Biomedicine project began convening witness seminars in 1993, and has published the transcripts of seminars on topics ranging from medical ethics, breastfeeding, renal dialysis and

[107] Tilli Tansey, "Witness seminars – a new way of making history," Queen Mary, University of London https://www.qmul.ac.uk/research/news/features/2012/witness-seminars--a-new-way-of-making-history.html [accessed 6 February 2020].

air pollution.[108] Witness seminars have also been convened by the Centre for History in Public Health at the London School of Hygiene and Tropical Medicine into a range of areas including health policy, notably the Resource Allocation Working Party (appointed 1975) and 1983 Griffiths Management Inquiry.[109] Sally Sheard at the University of Liverpool has also convened witness seminars as part of the Wellcome Trust funded research project 'The Governance of Health: Medical, Economic and Managerial Expertise in Britain Since 1948', subjects have included the 1974 NHS reorganisation, the Mersey Regional Health Authority, and the introduction of the NHS internal market.[110]

The group interviews convened for this study took elements of the witness seminar structure (clear starting points: the hospital system and medical teaching), however limited participation to medical practitioners. This decision was informed by the limited scope of the study to the local medical community (defined as active medical practitioners), and while professional perspectives on nonmedical management and changes to the NHS administration

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[108] History of Modern Biomedicine, "Wellcome Witnesses Volumes" http://www.histmodbiomed.org/article/wellcome-witnesses-volumes.html [accessed 6 February 2020].

[109] Centre for History in Public Health, London School of Hygiene and Tropical Medicine, "Witness seminars archive" https://www.lshtm.ac.uk/research/centres/centre-history-public-health/witness-seminars-archive [accessed 6 February 2020].

[110] University of Liverpool Institute of Population Health Sciences, "The Governance of Health: Medical, Economic and Managerial Expertise in Britain Since 1948" Witness seminars. https://www.liverpool.ac.uk/population-health-sciences/departments/public-health-and-policy/research-themes/governance-of-health/witness-seminars/ [accessed 6 February 2020]; Michael Lambert, Philip Begley and Sally Sheard (eds.), University of Liverpool Department of Public Health and Policy, *Mersey Regional Health Authority, 1974-1994*, *Witness Seminar,* held 13 June 2019 at the University of Liverpool. (Liverpool: Department of Public Health and Policy, University of Liverpool, 2020).

were sought, it was not considered to expand the definition of ‘local medical community’ beyond active medical practitioners.

Figure 1.3. Group interviews conducted for this project

1: Hospitals in Liverpool before 1978 (opening of the Royal Liverpool)

Name	**Qualified**	**Specialism**
Evans, Chris	1964, Liverpool	Chest Medicine
Evans, Susan	1964, Liverpool	Dermatology
Taylor, Bill	1969, Liverpool	Pathology
Turner, John	1966, London	Geriatrics

2: Medical Teaching in Liverpool

Name	**Qualified**	**Specialism**
Brace, Christine	1968, Liverpool	General Practice
Coakley, John	1980, Liverpool	Intensive Care
Evans, Chris	1964, Liverpool	Chest Medicine
Evans, Susan	1964, Liverpool	Dermatology
Martlew, Vanessa	1975, Liverpool	General Medicine
Ridyard, John	1968, Liverpool	Respiratory Medicine

Coding

All oral history interviews were recorded using a small portable voice recorder and transcribed as soon as possible, the transcription process offered a useful opportunity to reflect on the content of the interview. Individual interview transcripts were then imported to dedicated qualitative data analysis software (NVivo 12) ready for coding (the transcripts of the 11 interviews conducted by external research projects were also coded in NVivo). Coding involves the categorization of unstructured qualitative material into a set of criteria that can be analysed either individually or alongside other coded material, and the process develops as the data is analysed.[111] The individual interviews were coded into general categories (such as 'family background' 'education' 'social relationships) and specific people, places and professional groups (all codes are provided as an appendix).

Leading practitioner and theorist of social research methodology Alan Bryman highlighted the inherent 'messiness' in social research, attached to the uncertain outcomes when interviewing subjects.[112] Coding of interview transcripts with dedicated software provided the tools to scrutinise a large quantity of material and provide general insights. The frequency and range of interviews during which individuals and institutions were mentioned gave some indication of their significance to the sample, but the coding process could not distinguish whether the individual or institution was referenced in a positive or negative light. Coding can nonetheless be used to help organise collections of interviews and focus on how

[111] Cynthia Weston, Terry Gandell, Jacinthe Beauchamp, Lynn McAlpine, Carol Wiseman, and Cathy Beauchamp, "Analyzing interview data: The development and evolution of a coding system," *Qualitative sociology* 24.3 (2001), 397.
[112] Bryman, *Social Research Methods*, 15.

participants recognise, challenge, and respond to key topics of discussion.[113]

The overall frequency and range of specific people and places across the individual interviews provided some indication of the sources of influence on participants: 326 separate individuals and 35 hospitals were mentioned (see Figures 1.4 and 1.5). This was attributed to participants being asked for details of individuals they felt influenced by or worked with during their careers, and in the course of discussion over work experiences. The total frequency of references included multiple mentions within the same interview, and the total number of interviews in which the individual or hospital was discussed is indicative of breadth of influence. The collective testimony of the two group interviews was less well-suited to the coding process followed for individual interviews. The group interviews followed a more conversational format between participants, and minimal intervention was designed to allow discussion to develop naturally. Group interviews were similarly transcribed using NVivo software, and the specific focuses on medical teaching and hospital reform meant they could be drawn upon alongside archival sources at key points in the thesis.

[113] Alan Bryman and Bob Burgess, *Analyzing Qualitative Data* (Abingdon: Routledge, 2002), 47.

Figure 1.4. Hospitals referenced in 5 or more separate interviews (and total number of references across all interviews).

Hospital Name	**No. of Interviews**	**References**
Royal Liverpool University Hospital	27	64
Broadgreen Hospital	17	36
Liverpool Royal Infirmary	16	20
Sefton General Hospital	15	24
Royal Southern Hospital	15	21
Walton Hospital	13	19
David Lewis Northern Hospital	9	16
Alder Hey Children's Hospital	8	9
Whiston Hospital	7	13
Fazakerley	6	12
Liverpool Women's Hospital	5	7

Figure 1.5. Individuals referenced in more than 5 separate interviews (and total number of references across all interviews).

Name	**No. of Interviews**	**References**
Cohen, Henry	22	42
Clarke, Cyril	17	25
Gray, Thomas Cecil	12	34
Robertson, Alick John	12	21
Baker-Bates, Eric	10	16
Evans, Chris	10	13
Finn, Ronald	8	14
Jeffcoate, Norman	8	10
Ogilvie, Colin	8	13
Sells, Robert	8	9
Breckenridge, Alasdair	7	8
Carty, Austin	7	7
Gilmore, Ian	7	7
Hussey, John	7	7
Orme, Michael	7	8
Rees, Gordon Jackson	7	15
Utting, John	7	17
Weatherall, David	7	9
Evans, David Price	6	7
McConnell, Richard	6	10

1.3. Summary and thesis structure

The mixed methods approach employed in this study includes both written archival sources and oral histories, in order to incorporate the personal testimony of medical practitioners with the published historical record. Academic studies of the NHS often lack a detailed consideration of the impact of professional and policy change on local medical communities. Charles Webster's comprehensive and exhaustive critiques of the political background to the history of the NHS is not positioned to discuss how changes to policy were experienced by rank and file practitioners.[114] Similarly, Nicholas Timmins' 'biography of the welfare state' provides detailed information on the professional and governmental wrangling around health service reform, but is not able to consider its impact on local medical systems.[115] This study is indebted to these works, and seeks to add nuance through a specific local focus and the gathering of oral histories. Anna Green claimed, 'the specific content unique to personal memory' provides 'the means through which historians can test grand narratives against personal memory or measure history from above against history from below.'[116]

This thesis is divided into three chronological parts, each including chapters relating to hospital medicine, general practice, and local medical networks, alongside a consideration of how national political and professional changes were experienced at local level. Part 1 (1930-1948) introduces the local medical community in Liverpool in the years preceding the creation of the NHS. Medical practitioners from this period are essentially beyond the range of oral history interviews, however a number of these figures were the teachers and employers of interviewees. Part 2 (1948-1978) considers

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[114] Webster, *The Health Services Since the War. Volume 1*; *The Health Services since the War, Vol. II*.

[115] Timmins, *The Five Giants*.

[116] Anna Green, "Can Memory be Collective?" in *The Oxford Handbook of Oral History* ed. Donald Ritchie (Oxford: Oxford University Press, 2011), 107.

the impact of NHS organisation on the local medical community, and ends with the opening of the Royal Liverpool University Hospital in 1978. This allows discussion of changing medical practice following the creation of the NHS and the development of Liverpool's medical system. Many interviewees were studying or beginning their careers during this period, and reflected on this period of transition within the local medical community. Part 3 (1978-1998) outlines the NHS reforms implemented by Conservative governments between 1979 and 1997, the development of NHS management and the internal market during the 1980s and 1990s had a substantial effect on local medical networks, and interviewees shared their experiences of these changes.

Part 1: Liverpool's Medical Community 1930-1948

Chapter 2
Medical professionalisation, 1858-1948

Introduction

British medical practitioners constituted a mature professional community at the time of the creation of the National Health Service (NHS) in 1948. Their status was recognised through registration with the General Medical Council (GMC), and optional membership of profession-wide organizations such as the British Medical Association (BMA, established 1832), the 'doctors' union'. The medical royal colleges, accessed through examination, perpetuated distinctions between the branches of the profession, while smaller groups such as the Medical Practitioners' Union (MPU, established 1914) and Socialist Medical Association (SMA, established 1930) provided alternative platforms for discussion and debate. Practitioners also participated in a range of smaller networks at hospitals, medical schools and medical societies, which contributed to a sense of local professional community.

This chapter outlines the professionalisation of medical work in Britain before 1948, with reference to Liverpool's medical community, in order to foreground subsequent analysis of how local medical networks responded to the creation the NHS in 1948. Prior to the establishment of the NHS, practitioners were obliged to consider the entrepreneurial dimensions of their professional decisions. These included the business model and patient list of their practice, the pursuit of honorary or paid hospital appointments, and developing areas of specialist clinical expertise. Supportive and mutually-beneficial relationships between individual practitioners was essential to the development of the profession before 1948, and the structures established during this period were inherited by subsequent generations of practitioners working under the NHS.

Liverpool's medical community felt an acute sense of local heritage, manifested at historic hospitals and other services

(introduced in Chapter 3) and professional organizations (Chapter 4), and custodianship of these institutions continued to influence local medical networks during the twentieth century. Section 1 of this chapter examines the development of the medical profession before the 1858 Medical Act, in order to establish key elements of both professional identity and sources of intraprofessional tension. Section 2 considers the impact of the 1858 Act and subsequent legislation introduced before 1948 on the profession, notably the 1911 National Health Insurance Act and the 1929 Local Government Act, both of which brought practitioners into greater involvement with the state. This chapter provides essential national context for subsequent discussion of Liverpool's pre-NHS medical community, which both manifested and responded to broader professional concerns with reference to specific local issues.

2.1: The origins of medical professionalism

British Medical Practitioners before 1858

Prior to the Medical Act of 1858, orthodox medical practitioners in Britain worked within a hierarchical, tripartite system of physicians, surgeons and apothecaries. Physicians were at the top of this hierarchy; they possessed university degrees and were members of the various medical colleges, including the Royal College of Physicians of London (established in 1518), Edinburgh (1681), and Ireland (1654).[117] Physicians prescribed medicines, however as Irvine Loudon noted they '[kept] their distance both literally and metaphorically' from the body of the patient, and instead directed the work of surgeons, who performed operations, and apothecaries, who dispensed medicines.[118] Physicians treated wealthy patients and enjoyed prestige and elite status, however membership of the RCP

[117] Medical colleges were also established in Scotland prior to the Acts of Union in 1707, including the Royal College of Physicians of Edinburgh (1681) and the Royal College of Physicians and Surgeons of Glasgow (1599).

[118] Loudon, *Medical Care and the General Practitioner,* 19-20.

was limited to graduates of Oxford and Cambridge universities, undermining innovation and leading William Bynum to describe the corporation as a 'prestigious if introverted institution' by 1790.[119]

Scottish universities were less constrained by the religious and intellectual conservatism of Oxford and Cambridge, and a new type of scientific medicine focused on anatomy, surgery, botany and pharmacology emerged during the mid-eighteenth century.[120] The Guild of Barber Surgeons in Edinburgh had been established in 1505, and following the rapid development of surgery in the city following the foundation of the University of Edinburgh Medical School in 1726, the Royal College of Surgeons of Edinburgh was established in 1778. The Royal College of Physicians and Surgeons of Glasgow (founded in 1599 as the Glasgow Faculty, becoming the Royal Faculty of Physicians and Surgeons of Glasgow in 1909 and renamed in 1962) began offering surgical licenses in 1785. The London Company of Surgeons was established in 1745, having originated as the Company of Barber-Surgeons (established in 1540), and became the Royal College of Surgeons in London (RCS) in 1800.[121] The Royal College of Surgeons in Ireland was established in 1784 (formerly it had been a guild of barber-surgeons, founded in 1446).

Glasgow and Edinburgh became recognised as centres of excellence for surgical training by the 1750s, when some leading Scottish surgeons opened anatomy schools in England. Leading practitioners included the (Scottish) patriarch of anatomy John Hunter (1728-1793), who taught at St George's Hospital and his own private school in London. Anatomy schools provided attendees with licenses and certificates of attendance (not medical degrees), which could be used to prove experience, and rose in popularity throughout Britain to

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[119] Bynum, *Science and the Practice of Medicine*, 3.

[120] Prior to the 1871 Universities Tests Act, Catholics, non-conformists and other non-Christians were barred from fellowships at Oxford, Cambridge, London and Durham universities.

[121] Bynum, *Science and the Practice of Medicine*, 5; The Royal College of Surgeons of England (after 1843).

the extent that the Anatomy Act of 1832 was implemented to control the trade of dead bodies. Hunter encouraged his students to identify with the professional scientist, not the tradesman-like barber-surgeons, who for centuries had been junior partners to physicians, carrying out medical operations alongside barbering and other activities.[122]

Apothecaries comprised the most junior branch of the tripartite system, their work was limited to the preparation and dispensing of medicines, and they were administered by the Worshipful Society of Apothecaries (established in 1617).[123] The strict RCP monopoly over medical consultations was undermined by the small number of physicians and growing demand for treatment, and apothecaries offered (unsanctioned) medical advice to patients unable to afford a physician's fees.[124] In 1703 the apothecary William Rose was successfully prosecuted by the RCP for accepting payment for medical advice, however the judgement was reversed the following year, a decision described by Roger Jones as 'the basis for the legal recognition of apothecaries as doctors, and…the beginning of the general practice of medicine.'[125]

The undermining of the RCP monopoly on medical advice contributed to the emergence of general medical practitioners, and by the end of the eighteenth century the majority of British doctors identified as 'surgeon-apothecaries.'[126] Surgeon-apothecaries sought formal distinction from irregular practitioners, and to clarify their position in law by forming a new licensing body comparable to the medical colleges, alongside a public register of licensed practitioners. The 1815 Apothecaries Act introduced a license, issued on completion of an apprenticeship, however licentiates continued to join

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[122] Bynum, *Science and the Practice of Medicine*, 6.
[123] Berlant, *Profession and Monopoly*, 143.
[124] Berlant, *Profession and Monopoly*, 145.
[125] Roger Jones, "Apothecaries, Physicians and Surgeons,' *The British Journal of General Practice* 56.524 (March 2006), 232–33.
[126] Loudon, *Medical Care and the General Practitioner,* 26, Table 1.

the Society of Apothecaries, a guild distinct from the medical colleges, and were still prohibited from charging for consultations. Loudon described the Act as 'trying to ensure that although the general practitioner had a new title, he was no more than the old apothecary in a new coat.'[127]

A range of irregular medical practitioners operated outside the system of orthodox physicians, surgeons and apothecaries. Noel and José Parry described the nineteenth-century medical marketplace as a 'battleground' between the genders, with male physicians claiming access to elite medical knowledge despite the traditional rhetoric and folk associations of female midwives (the first woman member of the RCP admitted in 1909).[128] By the 1850s and 1860s, obstetrics and gynaecology taught in (gender restricted) universities developed into a major hospital specialty, and midwifery was incorporated into a male-dominated professional elite.[129] The aspirations of women practitioners were also obstructed by broader Victorian notions of femininity, which opposed the presence of women in the highly problematic spaces of the dissecting room and anatomy school.[130]

Medical Practitioners and the state

Medical practitioners became increasingly involved in the machinery of the British state during the nineteenth century. The 1834 Poor Law Amendment Act redrew former parish boundaries into Poor Law Unions, which administered public assistance and employed medical practitioners at workhouse infirmaries.[131] The Act did little to materially improve the working conditions of practitioners, however the growing number of public posts tentatively enhanced their

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[127] Loudon, *Medical Care and the General Practitioner*, 163.
[128] Parry and Parry, *The Rise of the Medical Profession*, 112.
[129] Bynum, *Science and the Practice of Medicine*, 176; 191.
[130] Michael Sappol, *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth-Century America* (New Jersey: Princeton University Press, 2002), 90.
[131] Bynum, *Science and the Practice of Medicine*, 71.

professional status.[132] The founding of the British Medical Association in 1832 (as the Provincial Medical and Surgical Association) by Charles Hastings (1794–1866), a surgeon from Worcester, offered practitioners a professional body that welcomed members from across the tripartite hierarchy, and the BMA had become the 'voice of the profession' by the start of the twentieth century.[133] The BMA was open to all practitioners (unlike the medical colleges joined through examination) and challenged the dominance of a London-based professional elite.

Legislation to govern medical registration was first drafted in 1840, and after many revisions (and sustained opposition from the RCP) the sixteenth version of the bill became law as the Medical Act of 1858. The Act created the General Council of Medical Education and Registration (GMC), which administered a public register of all qualified practitioners. Practitioners paid a fixed fee to appear on the register, and distinctions between physicians, surgeons and apothecaries were not recognised, demonstrating the legal unity of the growing profession (see Figure 2.1).[134] Nonetheless, practitioners across Britain continued to operate within smaller networks defined by location, special clinical interest, and in the form of social clubs.

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[132] Loudon, *Medical Care and the General Practitioner*, 239.
[133] Harry Eckstein, *Pressure Group Politics: The Case of the British Medical Association*. (London: Allen & Unwin, 1960), 66-67.
[134] Parry and Parry, *The Rise of the Medical Profession*, 125-6.

Figure 2.1: Doctors and Population in Great Britain, 1783-1979.[135]

Year	Population (Millions)	Number of Doctors (Thousand)	Doctors per 10k Population	Population per Doctor
1783	9.347	5.3	5.7	1764
1841	18.551	16.8	9	1107
1851	20.879	17.3	8.3	1205
1861	23.129	20.5	8.9	1128
1901	37	23.5	6.4	1574
1911	40.831	26.7	6.5	1529
1921	42.769	27.8	6.5	1538
1931	44.795	33.4	7.5	1341
1951	48.854	48.2	9.9	1014
1961	51.284	59.2	11.5	866
1974	54.376	60.2	11.1	903
1978	54.296	66.5	12.2	816
1979	54.338	67.3	12.4	807

[135] Adapted from Charles Webster, *The Health Services since the War (II)* Appendix 3.28.

2.2: Medical Reform 1858-1948

General medical practice

Medical practitioners were obliged to adopt an entrepreneurial approach to practice before 1948, competing for hospital appointments, private practice, and posts with various health insurance schemes. Friendly societies and sick clubs offered a form of mutual insurance to their members, and these groups provided an important source of income for the practitioners they retained. Pat Thane suggested the 'sense of comradeship and obligation' in friendly societies helped them flourish until the turn of the twentieth century, when commercial insurance companies provided a more attractive alternative to younger members more interested in the security of the fund than its comradely nature.[136] The appointment to a post as a club doctor could prove a mixed blessing for practitioners: patients were conscious of the financial dimensions of their consultation, and club practitioners did not enjoy the respect attached to honorary hospital posts. Nonetheless, if difficult patients and a low salary could be tolerated the club offered a means of establishing a reputation, and could lead to more financially rewarding and respectable private practice.[137]

As early as 1909, social reformer Beatrice Webb (1858-1943) advocated a state health service, and the Liberal government introduced legislation for school meals for undernourished children (in 1906), old age pensions (in 1908), and labour exchanges (1909).[138] State health insurance was introduced in the 1911 National Health Insurance (NHI) Act, which initially insured manual workers earning under £160 a year. NHI was far from comprehensive: it privileged

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[136] Pat Thane, *The Foundations of the Welfare* State (Harlow: Longman, 1996), 27-8.

[137] Loudon, *Medical Care and the General Practitioner*, 255-6.

[138] Timmins, *The Five Giants*, 108; John Davis, "Webb, (Martha) Beatrice (1858–1943)", *Oxford Dictionary of National Biography*, May 2008, http://www.oxforddnb.com/view/article/36799, [accessed 15 Nov 2017].

men (benefits to women were cut in 1915 and 1932) and dependents were not covered. Anne Hardy described the legislation as a 'half-way house, in terms of provision, between the negative and deterrent Victorian Poor Law and the positive and democratic post-1945 Health Service.'[139] In spite of its limitations, the social effects of national insurance were profound for patients, William Bynum suggested that the legislation ultimately 'made a visit to the doctor rather more ordinary'.[140]

The insurance 'panel' paid practitioners on a capitation basis, however usage exceeded estimates and the high patient workload compromised standards of care. Capitation meant that incomes from panel practice were dictated by list sizes, not quality of care, and the Ministry of Health (established in 1919) subsequently set limits on patient list sizes to combat abuses of the system (see Figure 2.2).[141] Frank Honigsbaum claimed that the demands of panel practice 'confined [insurance practitioners] within the narrow bounds' of what was essentially an extension of the earlier club system.[142] The nature of panel practice was informed by demographic considerations, it was most popular in industrial areas and large towns, however there was no requirement for practitioners to exclusively treat either panel or private patients.[143] Anne Digby noted how some general practitioners, especially those in urban and suburban areas, 'responded positively to the entrepreneurial openings of an expanding medical market' during the inter-war period.[144] Local Medical and Panel Committees (LMPCs) were established in 1911 to represent practitioners treating insured patients, and provided a forum for GPs to meet and discuss professional concerns. The Liverpool LMPC met at the Liverpool

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[139] Anne Hardy, *Health and Medicine in Britain since 1860* (Basingstoke: Palgrave, 2001), 79-80.
[140] Bynum, *Science and the Practice of Medicine*, 202.
[141] Hardy, *Health and Medicine in Britain since 1860,* 82.
[142] Honigsbaum, *The Division in British Medicine*, 21.
[143] Digby, *The Evolution of British General Practice*, 312.
[144] Ibid, 124.

Medical Institution, where discussions before 1948 ranged from the management of complaints from patients, arbitration over legal claims, and the everyday challenges of maintaining a profitable practice.[145]

Hospitals remained independent of the National Health Insurance Act, contributing to the increasing separation between general practice and hospital medicine. Established practitioners who could afford not to take panel patients enjoyed the greater autonomy (and financial rewards) of private practice and time to pursue prestigious hospital posts.[146] NHI nonetheless had a major impact on hospital work, as outpatient departments at voluntary hospitals (which offered free treatment for minor ailments and were sometimes accused of taking business from general practitioners) declined in relevance. Anne Hardy observed that the availability of medical consultation by insurance practitioners meant that 'the hospitals had less and less to do with the routine maintenance of health… and more and more to do with its restoration…in the seriously sick' during the interwar period.[147]

The narrowing of hospital medicine to focus on serious illness had implications for medical teaching, which had focused on voluntary hospitals since the seventeenth century as honorary physicians and surgeons were permitted to bring their fee-paying pupils on ward rounds.[148] The 1815 Apothecaries Act mandated six-months of hospital attendance prior to the awarding of a license, and the growing voluntary hospital sector offered aspiring medical practitioners access to bedside experience.[149] The declining relevance

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[145] Access to historic LMC material was made available at Greenbank Road Surgery, Liverpool, courtesy of Rob Barnett.
[146] Bynum, *Science and the Practice of Medicine*, 202.
[147] Hardy, *Health and Medicine in Britain since 1860*, 84.
[148] Jonathan Reinarz, "Corpus Curricula: Medical Education and the Voluntary Hospital Movement," in *Brain, Mind and Medicine: Essays in Eighteenth-Century Neuroscience,* eds. Harry Whitaker, Christopher Smith and Stanley Finger (Boston: Springer, 2007), 48.
[149] Waddington, "Mayhem and medical students," 48.

of hospital outpatients departments after 1911 meant medical students had fewer opportunities to see common complaints, and were forced to learn general practice medicine from emergency cases. Brian Abel-Smith noted after the introduction of health insurance, 'trivial cases were to be kept away from the hospital.'[150]

[150] Brian Abel-Smith, *The Hospitals, 1800-1948: A Study in Social Administration in England and Wales* (Cambridge, MA: Harvard University Press, 1964), 245-6.

Figure 2.2: National Health Insurance in England and Wales, 1929-1939[151]

Year	Doctors in insurance practice	Insured persons entitled to medical benefit
1929-30	14600	14,000,000
1930-31	14700	14,500,000
1931-32	14840	15,000,000
1932-33	15860	15,100,000
1933-34	15500	15,150,000
1934-35	15500	14,973,000
1935-36	16000	14,994,000
1936-37	16000	15,403,000
1937-38	16000	16,138,000
1938-39	16200	16,840,000

[151] Source: Ministry of Health Annual Reports, (London: HMSO, 1929-1939).

Bertrand Dawson (Lord Dawson of Penn, 1864-1945), royal physician and president of the RCP (London) between 1931 and 1937, recommended building on the foundations of NHI, and in 1918 outlined plans for a comprehensive state health service in a series of lectures to the West London Medico-Chirurgical Society (subsequently published as a pamphlet in the *Lancet* and *BMJ*). Dawson subsequently chaired a committee of investigation into medical services, reporting in 1920 to Minister of Health Christopher Addison (1869-1951).[152] He recommended comprehensive state control of the health services through an integrated system of 'primary' preventive and 'secondary' acute care (borrowing terminology from the education system) to address the divisions between hospital medicine and general practice.[153]

Dawson envisaged a system of 'primary health centres' staffed by general practitioners working alongside dentists, nurses and other allied professions, that would refer patients to 'secondary health centres' (adapted from general hospitals) mainly staffed by specialist consultants. Secondary health centres would in turn refer cases to teaching hospitals linked to medical schools, which would give "medical men attached to the Primary and Secondary Centres…the opportunity to follow the later stages of an illness in which they have been concerned at the beginning."[154] The service and its institutions were to be coordinated by local health authorities (see Figure 2.3).

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[152] 'Dawson, Bertrand Edward, Viscount Dawson of Penn (1864–1945)', entry by Stephen Lock. Published in print 23 September 2004, published online 23 September 2004, version: 29 May 2014. <http://www.oxforddnb.com/view/article/32751> [accessed 6 February 2020].

[153] Webster, "Conflict and consensus," 123.

[154] "Interim Report on the Future Provision of Medical and Allied Services 1920 (Lord Dawson of Penn)" (Dawson Report), at Socialist Health Association https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/interim-report-on-the-future-provision-of-medical-and-allied-services-1920-lord-dawson-of-penn/ [accessed 1 October 2019].

Some practitioners drew links between ill health and other social issues, including housing, nutrition and sanitation, issues that would be best tackled by broad social reform.[155] The State Medical Service Association (SMSA), founded in Liverpool in 1912, advocated building on NHI through a salaried GP service entered via state-administered examinations, and unification between the Poor Law and public health services.[156] Left-wing pressure groups such as the Socialist Medical Association (SMA) also embraced Dawson's recommendations, however the BMA was hostile to the idea of a comprehensive state service (despite recognising the need for reform and a 'planned national health policy').[157] Digby claimed the BMA was viewed by some wings of the profession as the ''petty bourgeois' of medicine – the traditional independent entrepreneur in general practice' that adopted an 'anti-government and anti-NHS stance'.[158]

Professional opposition to a state medical service was informed by the reluctance to cede independence to nonmedical local authorities. Despite its limited immediate effect in changing policy, Nicholas Timmins described Dawson's contribution as 'one of the many streams which combined into the flood that made the National Health Service inevitable.'[159]

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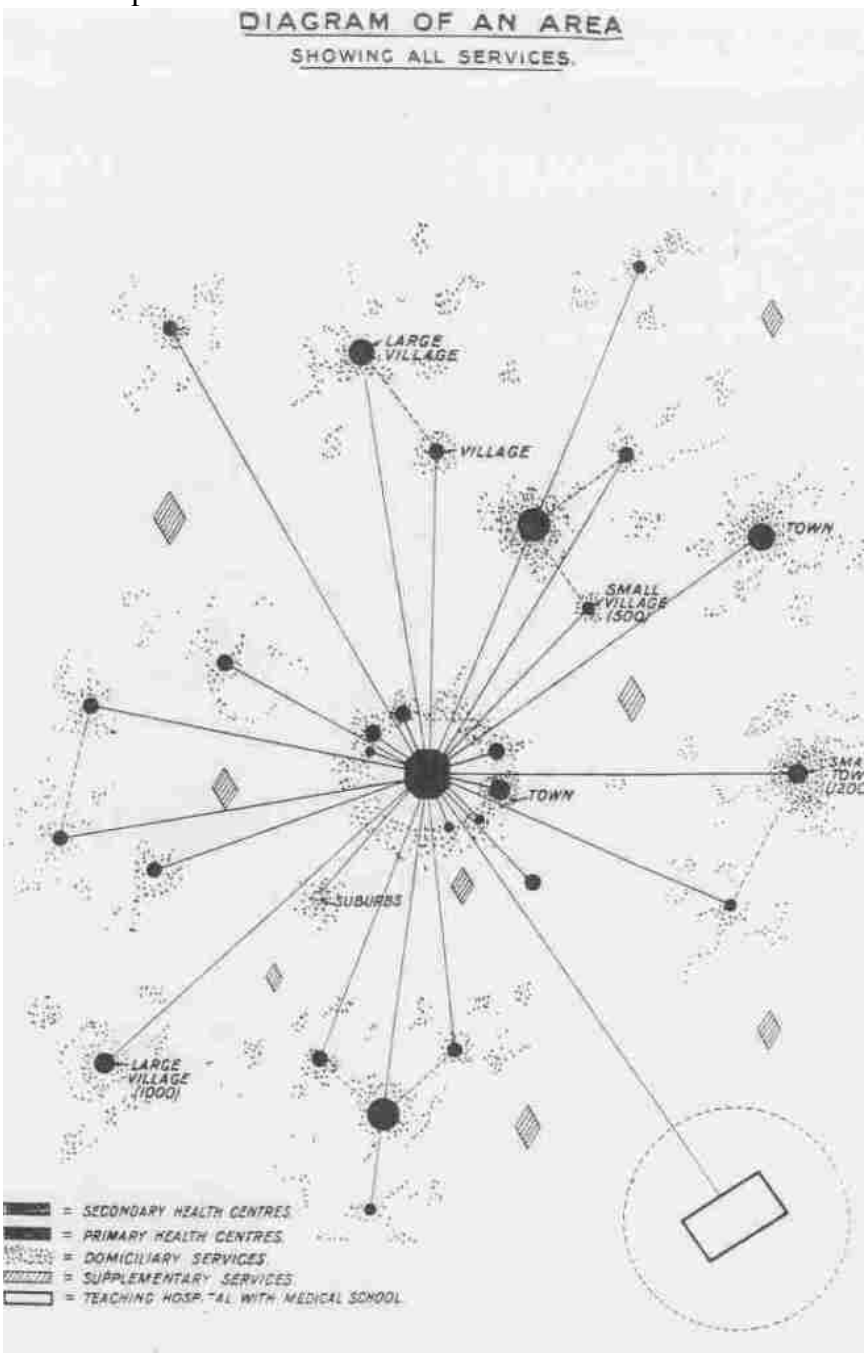
[155] Drury and Hull, *Introduction to General Practice*, 40.
[156] Gordon Lawson, "Benjamin Moore, Science, and Medical Planning in Early Twentieth-Century Britain," *Annals of Science* 65.4 (October 1, 2008), 502.
[157] Eckstein, *The English Health Service*, 116-118.
[158] Digby, *The Evolution of British General Practice*, 329.
[159] Timmins, *The Five Giants*, 108.

Figure 2.3: Diagram of proposed health service provided in 1920 Dawson Report[160]



[160] "Interim Report on the Future Provision of Medical and Allied Services 1920 (Lord Dawson of Penn)" (Dawson Report), Socialist Health Association https://www.sochealth.co.uk/national-health-service/healthcare-generally/history-of-healthcare/interim-report-on-the-future-provision-of-medical-and-allied-services-1920-lord-dawson-of-penn/ [accessed 1 October 2019].

Hospital medicine

The Medical Act of 1858, which presented the historically divided medical workforce as a legally united profession, initiated a shift from the tripartite structure of physicians, surgeons and apothecaries to a new intraprofessional division between hospital consultants and general practitioners.[161] Noel and José Parry described how the hospital became the 'bastion from which the consultant surgeons and physicians could reach out to dominate the profession as a whole.'[162] Hospitals were transformed from institutions for the care of the destitute poor to sites of elite clinical medicine during the nineteenth century, as standards of hospital hygiene and nursing surpassed what could be achieved in private homes.[163] Some practitioners recognized the intellectual capital to be gained from allying hospital medicine to the ascendant scientific culture of the period (despite the sometimes negligible relevance of scientific training to clinical practice).[164] Christopher Lawrence noted the contested role of scientific medicine at the turn of the twentieth century, as the notion of medicine as a clinical 'art' (rather than a branch of science) was essential to professional identity.[165] Hospital-centrism affected the entire profession, however only 1,200 of 15,000 registered practitioners were working in large hospitals in 1860, of which only 579 were listed as 'physicians and surgeons who have charge of in-patients' (with the rest employed as assistants and junior staff).[166]

British hospitals before 1948 were divided into the voluntary and public sectors. Voluntary hospitals were founded and supported

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[161] Parry and Parry, *The Rise of the Medical Profession*, 139.
[162] Parry and Parry, *The Rise of the Medical Profession*, 139.
[163] Pickstone, *Medicine and industrial society*, 151.
[164] Lisa Rosner, "The Growth of Medical Education and the Medical Profession" in *Western Medicine: An Illustrated History,* ed. Irvine Loudon (New York: Oxford University Press, 2001), 157.
[165] Lawrence, "Incommunicable Knowledge," 503–20.
[166] Parry and Parry, *The Rise of the Medical Profession*, 138.

by charitable bequests, public subscriptions, and fundraising. Voluntary hospitals were important vehicles for public displays of philanthropy, John Pickstone described the interest in hospital building in Manchester from paternalistic industrial employers and an image-conscious provincial elite.[167] They administered free care to poor patients, and the staff of honorary consultants could choose to admit patients based on medical interest and for the purpose of teaching students (for which they charged a fee).[168] The prestige attached to highly competitive honorary consultant appointments at voluntary hospitals could lead to lucrative private practice, however due to their unpaid status such posts were often limited to practitioners of independent financial means.

The financial viability of the voluntary hospital system prior to the creation of the NHS has been a subject of academic debate. Charles Webster claimed voluntary hospitals clung to their independence 'even when on the verge of insolvency' and refused to co-operate either with each other or the local authority before 1948.[169] Barry Doyle has countered this analysis, building on work by Steven Cherry and Martin Gorsky to argue that the established narrative of 'undemocratic, patronising and financially precarious' voluntary hospitals ignores the inter-war shift towards a model of financial contributions by patients.[170] Nonetheless, Gorsky suggested that 'far from being embraced by the organized working class, the contributory scheme movement was widely viewed as a temporary expedient': in 1928, the Chair of the Merseyside Trades Council begrudgingly encouraged workers to contribute to a hospital scheme

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[167] Pickstone, *Medicine and industrial society*, 81; 99; 110.
[168] Steven Cherry, "The Modern Hospital in history, c.1720-1948" *Refresh* 26 (Spring 1998), 6.
[169] Webster, "Conflict and Consensus," 127; Sally Sheard, "A Creature of Its Time: The Critical History of the Creation of the British NHS," *Michael Quarterly* 8 (2011), 430
[170] Doyle, "Power and accountability in the voluntary hospitals of Middlesbrough," 207.

as a 'short-term measure' in anticipation of a future national health service financed from taxation.[171] Nick Hayes and Barry Doyle noted that provincial voluntary hospitals became less dependent on 'elite contributions' during the interwar period, and instead 'all members of society were encouraged to contribute time and money to generate common public resources.'[172] The notion of voluntary hospitals as 'common public resources' supported by the local community raised their profile, and enhanced the professional cachet attached to honorary medical posts.

Alongside the prestigious voluntary hospitals, the nineteenth century British hospital system included state-funded Poor Law infirmaries, which cared for patients who fell sick while resident at the workhouse or were otherwise destitute, and employed paid medical staff (see Figure 1.4).[173] The 1929 Local Government Act empowered Local Authorities to appropriate Poor Law infirmaries and convert them to general use as municipal hospitals. Municipal hospitals ceased to care solely for the poor and destitute, and instead became large general hospitals employing a paid medical staff.[174] The hospitals available for appropriation by local authorities in 1929 reflected dramatic variations in development between regions; forty per cent of Poor Law hospitals were taken over in the first year after the act, some of which were described by Alysa Levene, Martin Powell, John Stewart and Becky Taylor as 'outdated, crowded, and unfeasibly expensive to equip for modern medicine and surgery.'[175] In Liverpool, several large workhouse infirmaries and public hospitals

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[171] Martin Gorsky, "Community Involvement in Hospital Governance in Britain: Evidence from before the National Health Service," *International Journal of Health Services: Planning, Administration, Evaluation* 38.4 (2008), 762.
[172] Hayes and Doyle, "Eggs, Rags and Whist Drives," 714.
[173] Cherry, "The Modern Hospital in history," 7.
[174] Martin Gorsky and Sally Sheard, "Introduction," in *Financing Medicine: The British Experience since 1750*, eds. Martin Gorsky and Sally Sheard (Abingdon: Routledge, 2006), 10.
[175] Levene, Powell, Stewart and Taylor, *Cradle to Grave*, 77.

were appropriated by the local authority during the 1930s (see Figure 1.5).

Anne Hardy described the municipal hospitals that emerged from the former infirmaries as resembling an 'acute voluntary hospital', and Local Authorities were keen to disassociate them from their origins as workhouse infirmaries.[176] Paid appointments at municipal hospitals were less prestigious than those at the independent voluntary hospitals, however as discussed in Chapter 3 in relation to Walton Hospital (a former workhouse) in Liverpool, ambitious practitioners at these institutions sought to emulate and improve upon the voluntary hospital model (see Figure 1.6). Municipal hospital beds comprised 59 per cent of the national total in 1948, with the remainder at voluntary hospitals.[177]

[176] Hardy, *Health and Medicine in Britain since 1860*, 83; Levene, Powell and Stewart, "The Development of Municipal General Hospitals," 3-4.
[177] Gorsky, "Community Involvement in Hospital Governance," 755.

Figure 2.4: Beds in voluntary and public hospitals in England and Wales, 1861-1938.[178]

Year	Voluntary	Public	Total
1861	14772	50000	65000
1891	29520	83230	112750
1911	43221	154273	197494
1921	56550	172006	225556
1938	87235	175868	263103

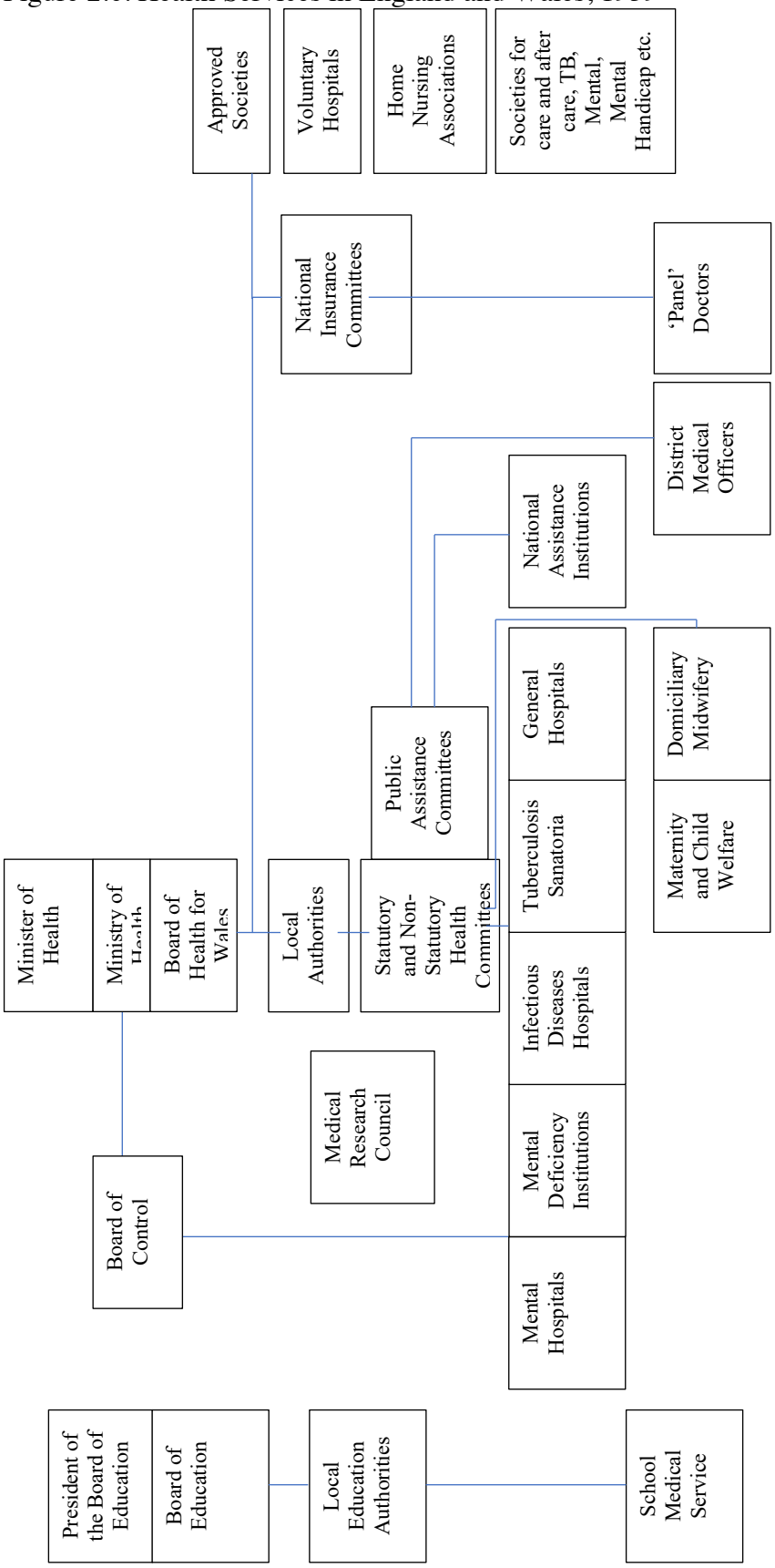
[178] Adapted from Robert Pinker, *English Hospital Statistics 1861-1938* (London: Heinemann, 1966), 49.

Figure 2.5: Hospitals appropriated by Liverpool County Borough.[179]

Hospital	**Beds in 1929**	**Year of Appropriation**
Mill Road Hospital	750	1931
Alder Hey Hospital	900	1932
Belmont Road PAI		
Walton PAI	1661	1935
Smithdown Road mixed PAI	800	1938

[179] Data from Levene, Powell and Stewart, "The Development of Municipal General Hospitals," 26. (PAI = Public Assistance Institution).

Figure 2.6. Health Services in England and Wales, 1939[180]



[180] Adapted from Webster, *The Health Services since the War (II)*, 786.

The Beveridge Report

The Nuffield Provincial Hospitals Trust (NPHT) was established in 1939 by philanthropist and motor manufacturer William Richard Morris (Viscount Nuffield, 1877-1963) with the aim of better coordinating hospital services outside London. Henry Cohen (1900-1977), professor medicine at the University of Liverpool, sat on the medical advisory council of the trust, and contributed to a 1941 report calling for greater coordination between voluntary and local authority hospitals (but stopping short of recommending the nationalisation of the entire system).[181] The NPHT identified the need to comprehensively survey national hospital services in order to recommend future improvements, and in collaboration with the Ministry of Health began a comprehensive survey into hospital services, published as *The Hospital Survey* in 1946.[182] The survey outlined inadequacies in both voluntary and municipal hospitals, including problems with capacity, staffing, and bureaucratic barriers to efficiency, Geoffrey Rivett claimed the survey simply revealed 'there was no system.'[183]

The survey was conducted following the outbreak of WWII in 1939, which had necessitated an unprecedented level of centralized planning of national resources. Hospitals were administered by the Emergency Medical Service (EMS), described by Daniel Fox as a wartime 'national hospital service'.[184] Harry Eckstein suggested that the wartime management of medical services by one body 'quickly produced overwhelming sentiment for a large-scale public

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[181] Nuffield Provincial Hospitals Trust, 'A National Hospital Service: a memorandum on the coordination of hospital services' (Oxford: Nuffield Provincial Hospitals Trust, 1941).

[182] Gordon McLachlan, *A History of the Nuffield Provincial Hospitals Trust 1940-1990,* (London: Nuffield Trust, 1992), 37-38.

[183] Sheard, "A Creature of Its Time," 432; Levene, Powell, Stewart and Taylor, *Cradle to Grave*, 67;. Geoffrey Rivett, *From Cradle to Grave,* 26.

[184] Daniel Fox, "The Administration of the Marshall Plan and British Health Policy," *Journal of Policy History* 16.3 (2004), 191–211.

reorganization of the existing services'.[185] In June 1941 William Beveridge (1879-1963) was assigned by the wartime government to chair an interdepartmental committee on social insurance. Beveridge was instructed to draft recommendations for administrative improvement of existing services, and not stray into policy. Nicholas Timmins described Beveridge as an 'egotistical sixty-two-year-old civil servant' who believed it was his 'destiny… to organise key parts of Britain's war effort'.[186]

The report of the interdepartmental committee, *Social Insurance and Allied Services,* was published on 1 December 1942. Beveridge had gone far beyond his modest brief and instead identified 'five giant evils' in contemporary British society; want, disease, ignorance, squalor and idleness, and five government programmes to address them; social security, health, education, housing and a policy of full employment.[187] José Harris described the report as a 'Bunyanesque vision' of the confrontation of modern evils through radical social reform, that Beveridge proposed to tackle through policies to 'cover all social contingencies from the cradle to the grave'.[188] The Treasury reacted with dismay to the report, and was initially unwilling to act upon Beveridge's bold and unsolicited proposals.[189] The report was hugely popular with the general public, and Clement Attlee's Labour Party was elected in 1945 a landslide general election victory on a platform of implementing its recommendations.

Aneurin Bevan (1897-1960), the son of a Welsh coal miner, was appointed health minister with the task of creating the new

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[185] Eckstein, *The English Health Service*, 88-89.
[186] Timmins, *The Five Giants*, 11-12.
[187] Timmins, *The Five Giants*, 24.
[188] 'Beveridge, William Henry, Baron Beveridge (1879–1963)', entry by José Harris. Published in print 23 September 2004, published online 23 September 2004, version: 5 January 2011. <http://www.oxforddnb.com/view/article/31871> [accessed 6 February 2017].
[189] Sheard, "A Creature of Its Time," 432.

national health service. Bevan had ambitious hopes for a truly national service, comprehensive and free at the point of use, however he was prepared to negotiate with key interest groups in order to realize his plans.[190] He envisaged a regionally administered hospital system, and salaried general practitioners employed by the state, on organizational principles described by Rudolf Klein as 'paternalistic rationalism.'[191] Left-wing professional groups including the Socialist Medical Association and Medical Practitioners' Union (established as the Medico-Political Union in 1914, renamed in 1922) had agitated for health service reform before 1948. Charles Brook (1901-1983), the first secretary of the SMA, was a medical practitioner and councillor in London who established links with the Labour Party, and John Stewart claimed that 'by the 1945 general election Labour's health policy was, effectively, written by SMA members.'[192] This support was not shared across the profession however, and Bevan was forced to make fundamental concessions in order to convince practitioners to work within the new service.

The passing of the National Health Service Act of 1946 began a period of ill-tempered disagreement between the government and the medical profession. Medical practitioners had deeply-held reservations about Bevan's plans, especially the perceived loss of professional autonomy, and felt future medical organization should be

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[190] 'Bevan, Aneurin (1897–1960)', entry by Dai Smith. Published in print 23 September 2004, published online 23 September 2004, version: 6 January 2011. <https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-30740?rskey=pj3gyg&result=2> [accessed 6 February 2020].

[191] Klein, *The New Politics of the NHS*, 17-18.

[192] Stewart, "Ideology and Process," 117. Brook was a lifelong socialist involved in supporting Republican and International brigades during the Spanish Civil War, "Charles Wortham Brook CBE," Socialist Health Association, https://www.sochealth.co.uk/the-socialist-health-association/members/distinguished-members/dr-charles-wortham-brook-cbe-1901-1983 [accessed 17 January 2019].

directed by the profession.[193] The defensive attitudes of general practitioners are outlined in Drury's analysis of GP correspondence with the *BMJ* in opposition to the introduction of salaries and feared reduction of autonomy.[194] Two BMA plebiscites were held in 1948; the first showed as many as 90 per cent of members were opposed to the state service, prompting Bevan to abandon salaried status for GPs, offer greater independence to teaching hospitals, and retain private beds in NHS hospitals. These concessions won the support of influential figures in the medical colleges, who interceded with the BMA to secure their support for the revised plan.

[193] Eckstein, *The English Health Service*, 158.

[194] Michael Drury, "The General Practitioner and Professional Organizations" in *General Practice under the National Health Service 1948-1997*, eds. Irvine Loudon, John Horder and Charles Webster (Oxford: Oxford University Press, 1998), 206.

Conclusion

The professionalisation of medicine in Britain manifested through adapting internal structures and an evolving relationship between practitioners and the state. The diversity of working arrangements across the profession led to tension, notably between the tripartite branches of the pre-1858 system of physicians, surgeons and apothecaries, and after the passing of the Medical Act in the emerging division between hospital consultants and general practitioners. The 1858 Act nonetheless conferred legal unity upon the profession, and medical practitioners occupied a growing number of state appointments following the introduction of National Health Insurance and local government appropriation of municipal hospitals.

Legislative reform altered medical practitioners' interactions with patients, institutions and the state, however groups such as the BMA were keen to secure the continued autonomy of the profession in the face of growing momentum towards a national health service. The importance of professional organizations in the development of national healthcare reform, and the concessions elicited during negotiations of the creation of the NHS, are indicative of the strength of these groups before 1948. Of central importance to this thesis is the cohort of practitioners who trained, worked and participated in the medical community prior to the establishment of the NHS. Alongside their own experiences of the transition to the new state service, these practitioners oversaw the education and introduction to the profession of a generation of practitioners with no direct experience of the pre-1948 medical marketplace.

At national level, established professional organizations such as the medical royal colleges and BMA provided platforms for professional leaders to influence national discussion. At local level, senior figures at individual hospitals, universities, and a range of professional organizations, medical societies and clubs were able to influence and direct developments. The following chapter introduces medical services in Liverpool before 1948, including general medical

practice, hospital medicine and medical education. This is followed in Chapter 4 with the introduction of independent medical networks in the city at clubs, specialist societies, and the Liverpool Medical Institution, the foremost medical society in the city.

Chapter 3
Liverpool's Medical Community before 1948

Introduction

The professionalisation of medical work described in Chapter 2 was supported at local level by a range of structures and institutions, and this chapter explores how local medical culture developed in Liverpool within the diverse pre-NHS medical marketplace. This chapter also considers the emergence and consolidation of local intraprofessional hierarchies, informed by the nature of hospital and university appointments, practitioners' backgrounds, and patient populations. Practitioners working before 1948 are largely inaccessible through oral history, however many individuals from this period accrued legendary status in the local medical community. The university medical school and teaching firms at hospitals constituted key points of contact between experienced practitioners and younger colleagues. These spaces represent institutional networks that facilitated communication between established and newly-qualified practitioners around medical practice and professional expectations.

Medical practitioners in Liverpool nurtured a distinct professional identity before 1948, and sought to highlight the social benefits of modern medicine to the local community in order to cement their status. The cherished autonomy of the profession informed attitudes towards the creation of the NHS, Rudolf Klein described medical practitioners as 'intensely individualistic…[seeing] themselves as accountable only to their professional peers' and Charles Webster claimed their aspirations for the new service were 'shaped by their financial self-interest and ideologies rooted in the distant past'.[195] The resilience of such attitudes after 1948 reflected the durability of traditional professional values: the creation of the NHS did not constitute a radical break with the past but instead was

[195] Klein, *The New Politics of the NHS*, 40; Webster, *The National Health Service: A Political History*, 8.

part of a gradual process of professional evolution.[196] Awareness of the structures and institutions of Liverpool's medical community before 1948 is therefore essential to developing an understanding of how practitioners responded to subsequent reform.

This chapter is organized into three sections. Section 1 provides an overview of general medical practice and urban development in Liverpool before 1948. This enables a greater understanding of the specific challenges and opportunities facing local practitioners, and the broader environment in which they worked. Section 2 introduces the Liverpool hospital system, and outlines the hierarchy of prestige attached to hospital appointments that remained significant after 1948. Section 3 explores the role of the medical school at the University of Liverpool, and the interactions it facilitated between senior figures in the local professional establishment with medical students and younger members of the profession. In 1948, the NHS was essentially configured into a professional and institutional landscape influenced by preceding generations of practitioners, and this legacy exerted a major influence on the subsequent development of the medical community.

3.1: Medical Practitioners in Liverpool before 1948

Liverpool's medical community

Liverpool was a thriving, cosmopolitan city at the start of the twentieth century, and the local medical community benefited from this vibrant economic and social environment. The development of consumer society in Britain transformed the medical marketplace, and facilitated the emergence of a professional elite, and this phenomenon was clearly visible in Liverpool.[197] The local professional elite held appointments at voluntary hospitals, managed lucrative private practices and reaped substantial financial and social rewards as a

[196] Klein, *The New Politics of the NHS*, 23.
[197] Digby, *Making a Medical Living*, 26; 32.

result of their interaction with wealthy patients and prominent citizens involved with voluntary hospital administration.[198]

Medical practitioners in Liverpool treated a diverse patient population through insurance and private practice, and factors such as the location, social background and size of their patient lists informed a hierarchy of status. Paid posts at the city's municipal hospitals provided another potential income channel, while competitive honorary positions at voluntary hospitals offered greater prestige and could unlock private practice opportunities among the local elite. Digby claimed voluntary hospital appointments 'provided an important key to expanding a physician's [private] practice' and 'enhanced public visibility and increased social contacts' by putting them in contact with leading figures in the community who sat on hospital boards.[199]

A key source of information on medicine in nineteenth-century Liverpool is the history published by Thomas Herbert Bickerton (1857-1933). The son of a local surgeon, Bickerton completed his medical training in Liverpool and London before securing surgical appointments at the Liverpool Royal Infirmary, the city's pre-eminent voluntary hospital. Bickerton was active in local intellectual and civic life, variously president of the Liverpool Royal Infirmary, Liverpool Medical Institution, and Liverpool Medical and Literary Society. Bickerton's *Medical History of Liverpool from the Earliest Days to the Year 1920* was published posthumously in 1936, and provides a (largely uncritical) survey of local professional heritage.[200] Bickerton provided examples of how medical concerns

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[198] Stevens, *Medical Practice in Modern England*, 34; Medical practitioners were involved in a range of community activities, see Neil Carter, "Mixing Business with Leisure? The Football Club Doctor, Sports Medicine and the Voluntary Tradition," *Sport in History* 29.1 (2009), 69–91.

[199] Digby, *Making a Medical Living,* 125; 171.

[200] Limitations on the use of histories 'from within' the profession are outlined in Shortt, "Physicians, Science, and Status," 51.

were connected to the broader social history of the city, such as epidemics related to overcrowding and mass immigration, and celebrated local medical pioneers such as John Rutter (1762-1838), who secured permanent premises for the Liverpool Medical Institution in 1837, and William Henry Duncan (1805-1863), the first Medical Officer of Health in Britain.[201]

The local professional elite held honorary posts in the voluntary hospitals, and managed private practices from consulting rooms on Rodney Street in the rarefied Georgian quarter of the city. Gore's *Liverpool Directory* for 1918 revealed the residents of Rodney Street were almost exclusively doctors and dentists, and by 1932 its ubiquity to Liverpool's medical community was such that it was marked on maps of the medical school.[202] Local practitioners also celebrated Liverpool's public health traditions, as both the first urban area in Britain to appoint a Medical Officer of Health and the home of the first school of tropical diseases, the Liverpool School of Tropical Medicine, established in 1898. By 1948, a sense of local professional tradition was well-developed among Liverpool's medical practitioners, informed by established hospitals, celebrated medical pioneers, and professional clubs and societies (discussed in Chapter 4).

Liverpool's medical community included practitioners from a range of backgrounds, following different working practices and harbouring different professional concerns. Steve Watkins described the medical profession as a 'contingent and non-monolithic' group, defined as much by internal divisions and differences as external

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[201] Thomas Herbert Bickerton, *A Medical History of Liverpool from the Earliest Days to the Year 1920*. (London: John Murray, 1936), 64; 168.

[202] Edna Rideout, "Rodney Street, Liverpool," *Transactions and Report of the Historical Society of Lancashire and Cheshire* (1932), 73; Weatherall, *Gentlemen, Scientists, and Doctors*, 210-211.

threats to professional status and legitimacy.[203] Medical practitioners' earnings rose during the interwar period, and income security was facilitated by the introduction of National Health Insurance in 1911.[204] Nonetheless, major financial rewards were still reserved for practitioners with wealthy private patients, who enjoyed a prominent public profile as a result of honorary posts at voluntary hospitals. In Liverpool, the coexistence of 'small shopkeeper' general practitioners, offering singlehanded practice from residential homes, with prestigious voluntary hospitals and the exclusive medical precinct on Rodney Street, is illustrative of the diversity of the local medical community (see Figure 3.1). In spite of the varying medical careers pursued throughout the city, local practitioners were nonetheless united in various professional and social networks, discussed in the following chapter.

[203] Steve Watkins, *Medicine and Labour: The Politics of a Profession* (Lawrence & Wishart, 1987), 19.
[204] Digby and Bosanquet, "Doctors and Patients in an Era of National Health Insurance," 77-80.

Figure 3.1 Practitioners appearing on GMC local list for 'Liverpool'[205]

Year	Practitioners on Local List
1900	428
1910	495
1920	486
1930	652
1935	649
1940	807
1945	707
1950	842
1955	1035
1960	1055
1965	1078
1970	1052
1975	1173
1980	1104
1985	1109
1990	1341
1995	1486
2000	1638

[205] Source: General Medical Council, *The Medical Register* (London: General Medical Council, 1900-2000), the GMC provides details of practitioners working within individual towns and cities as an appendix to the printed *Medical Register*.

General medical practice and the business of medicine

Medical practitioners in Liverpool before 1948 made a living through private and insurance practice, paid appointments at local hospitals, sanatoria and other institutions. As outlined in Chapter 2, maintaining a viable practice required practitioners to make entrepreneurial decisions around its size, location and patient population. Practitioners were responsible for collecting fees from paying patients, and these interactions could shape the doctor/patient relationship. In poor areas, GPs had to navigate economic necessity and patients' ability to pay. A participant in a 1980 oral history study of the Lancashire working class recalled a doctor's visit in 1919.

> A young doctor came… he'd just qualified and he walked in and played on the piano as he went past. He said, 'My word a piano, another bob on your visit.[206]

There was clear potential for problematic exchanges regarding payments, as practitioners often prescribed and dispensed the medicines for which they collected a fee.[207] Ear, nose and throat surgeon Ivan Alexis Tumarkin (1901-1990) was described in an obituary published by the Liverpool Medical Institution as having been 'banished' to the peripheral Bootle General Hospital as a result of his public opposition to 'routine' operations to remove tonsils and adenoids, a position that 'angered many of his colleagues', presumably those practitioners charging for such operations.[208]

Traditional forms of practice proved resilient, and in 1981 left-wing GP Julian Tudor Hart (1927-2018) described the tradition of British general practice as 'the local sick shop, wherein the doctor,

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[206] Elizabeth Roberts, "Oral history investigations of disease and its management by the Lancashire Working Class 1890-1939" in *Health, Disease and Medicine in Lancashire 1750-1950: four papers on sources, problems and methods,* ed. John Pickstone (Manchester: UMIST, 1980), 40.

[207] Mildred Peterson, *The Medical Profession in Mid-Victorian London* (Berkeley: University of California Press, 1978), 285.

[208] 'Ivan Alexis Tumarkin' Obituary (without attribution) *LMI Transactions and Report* 1991, 59.

thinly disguised as a scientific gentleman, remains a shopkeeper.'[209] Liverpool's port economy meant large numbers of patients arrived at city surgeries from abroad; John Coakley (b. 1955), a third generation Liverpool doctor, described his grandfather's experiences of working with this patient population. T.L. Coakley (c. 1896 -1951) qualified in Ireland in 1920 and moved with his family above a practice in Liverpool's Chinatown, where proximity to the docks meant a 'constant churn of people from all over the world popping into the practice.'[210]

Concerns over the business of medicine informed practitioners' allegations of professional malpractice within the local medical community, and disputes of this nature were handled in the first instance by local professional networks such as the Local Medical and Panel Committee (LMPC). In September 1937 the honorary secretary the Liverpool LMPC circulated a letter concerning emergency treatment of patients on other doctors' lists.

> While the Regulations provide for the payment of a fee for the service rendered to the patient of another practitioner in the case of accident or sudden emergency, the Panel Committee is strongly of the opinion that such services might well be rendered as a matter of courtesy between neighbouring practitioners, and that no fee should be claimed or expected.[211]

Some practitioners felt that their professional peers were 'poaching' patients and claiming payment, an issue Digby described as a 'vexed

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[209] Julian Tudor Hart, "A new kind of doctor." *Journal of the Royal Society of Medicine* 74.12 (1981), 875.

[210] General Medical Council, *The Medical Directory* (London: General Medical Council, 1942); Liverpool Insurance Committee, 'List of Insurance Medical Practitioners, Chemists, etc., 1943' [LRO HQ 610.58]; John Coakley, 31 May 2018; Group Interview on Medical Teaching, 28 January 2019.

[211] Letter from Miller Watson to members of the Local Medical Practitioner Committee, 30 September 1937. [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

area of etiquette' in the competitive market for patients before 1948.[212]

Individual practitioners also faced the possibility of missing out on fees for treatment as a result of the provision of free care at hospital outpatient departments. As with disputes between individual practitioners, the LMPC addressed these issues: in 1937, a representative of Liverpool's David Lewis Northern Hospital apologized to local general practitioners through the LMPC for the provision of treatment to non-emergency patients at its outpatient department. Such intrusions upon the professional domain of general practitioners undermined their economic foundation, and assurances were made that future patients would only have their emergencies addressed.[213] Clarity over the boundaries between acceptable hospital outpatient care and general practitioner appointments was a key concern for local practitioners, as the possibility of patients avoiding a paid consultation threatened to compromise the viability of general practices as businesses. The LMPC provided a forum for such issues to be resolved through independent professional forums.

The business element of traditional general practice was criticised by some progressive figures within the profession, and during the interwar period supporters of the health centre model experimented with new forms of organisation distinct from singlehanded 'small shopkeeper' style practices. Health centres, notably the Pioneer Health Centre (commonly referred to as the 'Peckham Experiment') established in 1926 in London by George Scott Williamson and Innes Pearse, attracted considerable interest for their support of progressive attitudes towards preventive medicine, pregnancy and women's health, and encouraged the concept of

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[212] Digby, *Making a Medical Living,* 51.

[213] Letter from T. Gibson, Secretary Superintendent, David Lewis Northern Hospital to LMPC 16th December 1937 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

practitioners working together cooperatively from one premises.[214] The longevity of traditional GP culture after 1948 is explored in Part 2 of the thesis.

Urban development in Liverpool

Liverpool enjoyed a period of sustained economic prosperity during the nineteenth century, the local economy was based on the port and its associated industries, which arguably allied it more with other port-cities around the world than elsewhere in the British provinces.[215] Margaret Simey suggested that 'what was elsewhere a process of more or less gradual industrialisation of an established community was thus reversed in Liverpool, so that industry preceded the town, and the town was only called into being by the demands of industry.'[216] Victorian Liverpool was susceptible to public health crises, a consequence of the large working class population resident in slum housing as a result of low income and the employment conditions of dock labour, which forced working class families into these conditions. The bustling port economy facilitated disease transmission, and Liverpool was the first urban area in Britain to appoint a medical officer of health, the Scottish medical practitioner William Henry Duncan, in 1847. Duncan had worked in Liverpool

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[214] The health centre in Peckham was open between 1926-1930, 1935-1939 (in new premises) and 1945-50, see Jane Lewis and Barbara Brookes, "A Reassessment of the Work of the Peckham Health Centre, 1926-1951," *The Milbank Memorial Fund Quarterly. Health and Society* (1983), 307; Jane Lewis and Barbara Brookes, "The Peckham Health Centre, 'PEP', and the Concept of General Practice during the 1930s and 1940s," *Medical History* 27.2 (1983), 151; Kenneth Barlow, 'The Peckham Experiment.' *Medical History* 29.3 (1985), 264–71.

[215] Graeme Milne, "Maritime Liverpool" in *Liverpool 800: Culture, Character and History,* ed. John Belchem (Liverpool: Liverpool University Press, 2006), 257.

[216] Simey, *Charity Rediscovered*, 7.

during the 1832 cholera epidemic, and drew connections between Liverpool's unsanitary urban environment and outbreaks of disease.[217]

At the start of the twentieth century, both the infant mortality rate and birth rate in Liverpool were above the national average, and it had a higher population density between 1911 and 1949 than comparable industrial cities such as Manchester and Birmingham (see Figures 3.2 and 3.3). Liverpool was the first local authority in Britain to provide council housing (in 1869), and by 1918 the city had probably the largest proportion of council houses outside London.[218] Subsidies introduced in 1919, conditional on a maximum density of new dwellings, sought to tackle the issues of neglected urban residential areas through the relocation and suburbanization of inner-city communities. The local authority purchased land across the city in 1919 and 1920, and new housing estates were built at Edge Lane, West Derby, Mossley Hill, Allerton, the Springwood Estate and Walton-Clubmoor (see Figure 3.4). By the time the government building support scheme introduced in 1919 was terminated in 1923 Liverpool had built 5809 houses, more than any other municipality.[219] Madeline McKenna described how the extensive damage to areas of central Liverpool during the 'Liverpool Blitz' of 1940/1941 'helped many ex-slum dwellers accept their enforced suburbanisation' in spite of the problems poor transport, utilities and welfare provision at the new housing estates.[220]

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[217] "Duncan, William Henry (1805–1863), physician and medical officer of health." *Oxford Dictionary of National Biography* (Online) http://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-37375. [Accessed 12 March 2018].
[218] Colin Pooley, "Housing for the Poorest Poor: Slum-Clearance and Rehousing in Liverpool, 1890-1918," *Journal of Historical Geography* 11.1 (1985), 70; Charlotte Wildman, *Urban Redevelopment and Modernity in Liverpool and Manchester, 1918-1939* (London: Bloomsbury, 2016), 2-3.
[219] McKenna, "Municipal Suburbia in Liverpool," 288.
[220] Ibid, 301.

Figure 3.2: Population and Health in Liverpool 1930-1948.[221]

Year	Pop. (000s) England & Wales	Pop. Liverpool	IMR (E&W)	IMR (L'pool)	BR (E&W)	BR (L'pool)
1930	39,952	855,539	67	93	15.8	21.7
1932	40,201	861,935	65	91	15.3	21
1934	40,467	866,013	59	81	14.8	20.3
1936	40,839	867,110	62.1	75	14.8	20.1
1938	41,215	864,000	55.5	73	15.1	18.7
1940	41,642	752,800	61	84	14.1	19.9
1942	41,748	-	52.9	76	15.6	20.5
1944	42,259	-	47.6	57	17.7	23.1
1946	42,636	734,620	42.7	74	19.2	25.2
1948	43,050	791,800	36	54	17.8	22.3

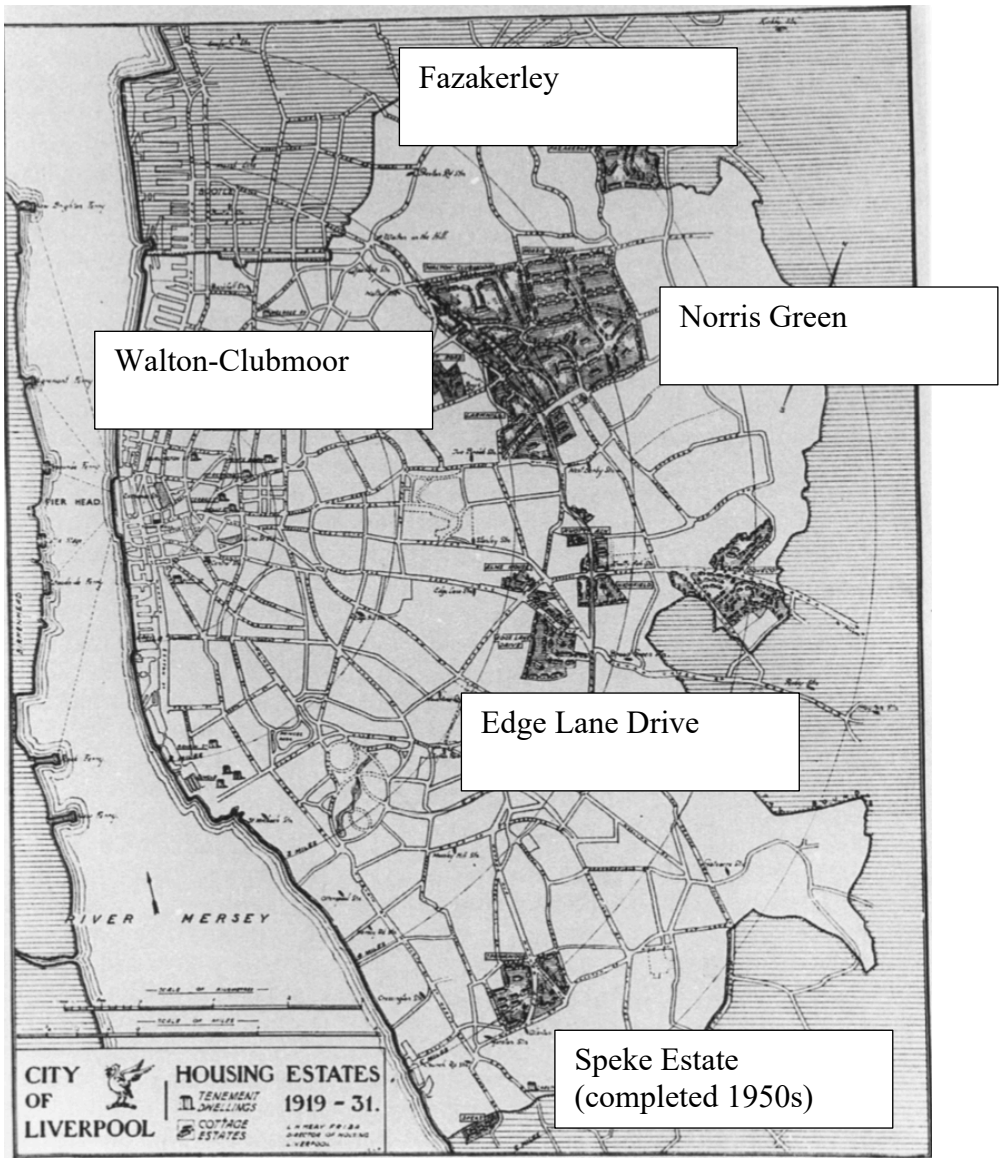
[221] Sources: Office for National Statistics, *Annual Abstract of Statistics* (London: HMSO, 1930-1948); Liverpool Medical Officer of Health, *Report of the Health of the City of Liverpool* (Liverpool: Tinling, 1930-1948).
Pop. = Population
IMR = Infant mortality rate
BR = Birth rate

Figure 3.3: Population Density in Liverpool, Manchester and Birmingham, 1930-1948[222]

Year	Population Density (000s per square mile) Liverpool	Population Density Birmingham	Population Density Manchester
1911	17.7	10.54	16.88
1921	18.85	11.54	17.28
1931	20.05	12.55	17.98
1941	18.78	13.85	16.46

[222] Source: Office for National Statistics, *Annual Abstract of Statistics* 87, 1938-1949 (London: HMSO, 1951).

Figure 3.4. New municipal housing estates in Liverpool 1919-1931[223]



[223] Liverpool City Housing Department, *Housing* (Liverpool: 1931), Fig. 3a on p. 22, adapted from McKenna, "Municipal Suburbia in Liverpool," 315, Fig 10.

3.2: The Liverpool hospital system before 1948

Municipal hospitals in Liverpool

The development of Liverpool's hospitals before 1948 was influenced by the city's economy and demography; the largest hospitals in the city were the former Poor Law infirmaries at Walton, Smithdown Road and Belmont Road, which were converted to municipal general hospitals following the 1929 Local Government Act. A range of specialist hospitals were also taken into the ownership of the local authority in 1929, including the Alder Hey Children's Hospital, tuberculosis sanatoria at Fazakerley and Broadgreen, and infectious diseases hospitals at Fazakerley and in the city centre. The largest of the municipal general hospitals were located on the periphery of the city centre, reflecting their original usage as workhouses, and a large number of small voluntary hospitals were located in the city centre (see Figures 3.5 and 3.6).

Senior medical staff at Liverpool's municipal hospitals became established figures of the local medical establishment, and oversaw the transition from workhouse infirmaries to municipal hospitals. Henry MacWilliam (1886-1969) qualified in Belfast and held appointments at the Liverpool Eye and Ear Infirmary and David Lewis Northern Hospital before becoming a medical officer at Walton in 1913 (when it was still a workhouse infirmary, constructed 1864-9).[224] MacWilliam stayed at Walton until his retirement in 1952, where he rose to the position of medical superintendent, and was a vocal critic of the second-class status attributed to municipal hospitals during the 1920s by the medical profession. He claimed that Walton Hospital followed many of the organisational principles of the voluntary sector.

> The consultants have wards allocated to them, and, subject to the general responsibility of the medical officer,

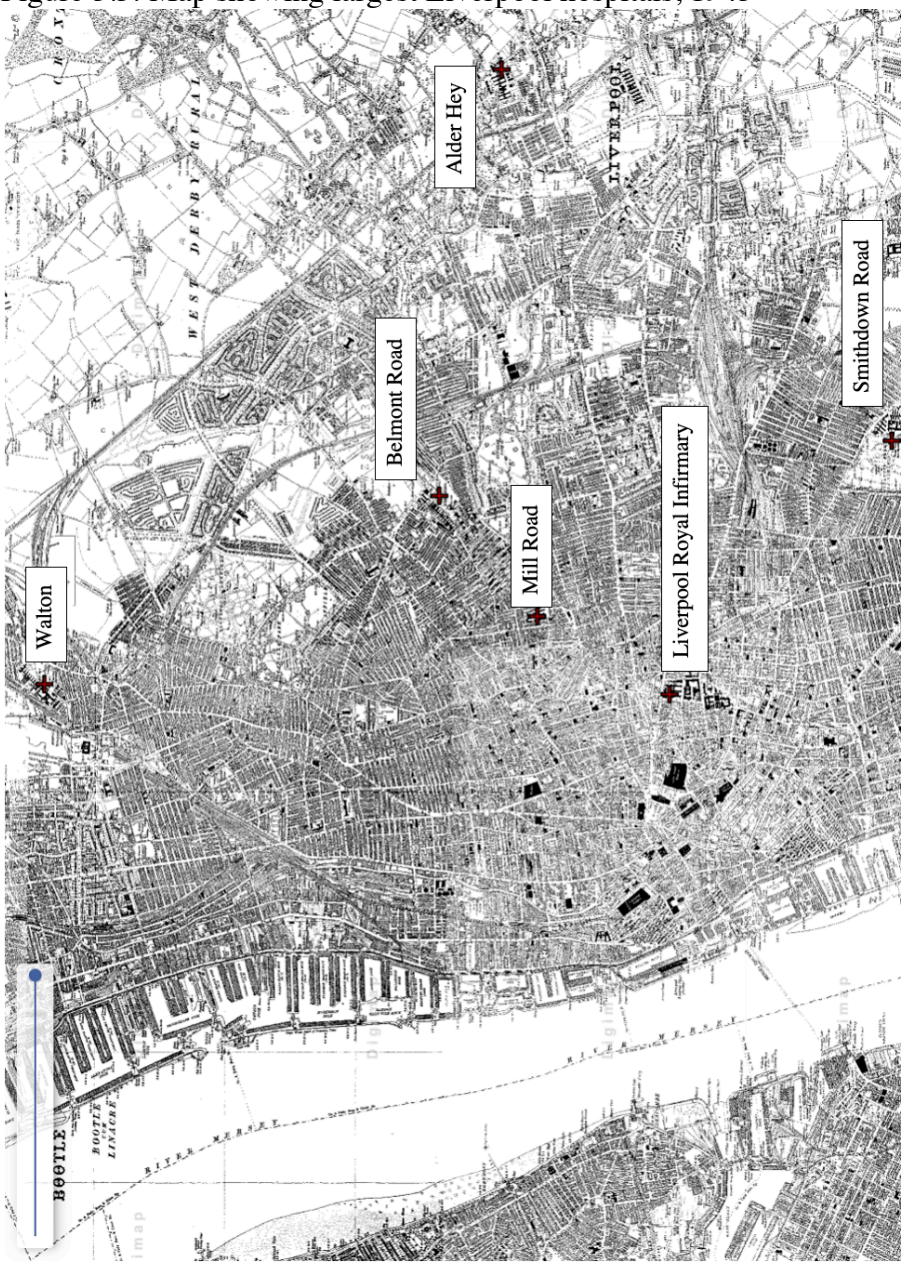
[224] Doreen McGiveron, "The Walton experience: contributions to local and national developments in health care, 1915 to 1945," *Medical Historian* 14 (2002-2003), 8.

> carry as much responsibility for their patients as in voluntary hospitals. They are not called in merely to give opinions on selected cases. They are assisted by residents who have all had experience as residents in voluntary hospitals.[225]

MacWilliam later recalled the 'contempt' of staff at Liverpool's voluntary hospitals towards chronic and elderly patients, and reflected on the benefits of senior staff residing on hospital grounds, a system that offered 'something like the atmosphere of an Oxford college.'[226]

[225] Henry MacWilliam, "The relation between municipal and voluntary hospitals" *BMJ*, 20 July 1929.
[226] MacWilliam, *Memories of Walton Hospital,* 23; 36.

Figure 3.5: Map showing largest Liverpool hospitals, 1945[227]



[227] Map adapted from British National Grid (EPSG:27700), 1930, scale: 1:20,000. Accessed at www.digimap.edina.ac.uk.

Figure 3.6: Liverpool Hospitals with more than 100 Beds, 1945. [228]

Hospital	Category	Ownership	Beds
Walton	General Hospital	Liverpool County Borough	1741
Smithdown Road	General Hospital	Liverpool CB	1208
Belmont Road Institution	Public Assistance Institution	Liverpool CB	1170
Alder Hey	Children's Hospital	Liverpool CB	930
Mill Road	General Hospital	Liverpool CB	690
Kirkdale Homes	Public Assistance Institution	Liverpool CB	469
Liverpool Royal Infirmary	General Hospital	Voluntary	366
Fazakerley City	Infectious Diseases	Liverpool CB	364
Broadgreen Sanatorium	Pulmonary Tuberculosis	Liverpool CB	350
Fazakerley Sanatorium	Pulmonary Tuberculosis	Liverpool CB	309
Royal Southern	General Hospital	Voluntary	232
Olive Mount	Children's Hospital	Liverpool CB	230
David Lewis Northern	General Hospital	Voluntary	220
City Hospital North	Infectious Diseases	Liverpool CB	182
City Hospital East	Infectious Diseases	Liverpool CB	174
Royal Liverpool Children's	Children's Hospital	Voluntary	140
Stanley Hospital	General Hospital	Voluntary	120
Fazakerley Annex	Infectious Diseases	Liverpool CB	118
Liverpool Women's	Women's Hospital	Voluntary	118
City Hospital South	Infectious Diseases	Liverpool CB	110
Bootle General	General Hospital	Voluntary	104

[228] Source: Ernest Rock Carling and Thomas Steven MacIntosh. *The Hospital Services of the North-Western Area,* (London: HMSO, 1945).

Voluntary hospitals in Liverpool

The accumulation of substantial wealth among the city's merchant class facilitated the development of a large number of voluntary hospitals. The selective admission policy of the voluntary hospitals, based on the clinical interest or teaching potential of cases, was occasionally a source of conflict: news of the Liverpool Royal Infirmary's refusal to admit accident patients (and their subsequent admission to the Mill Road Poor Law Infirmary) provoked cries of 'shame!' at a public meeting of the Poor Law guardians in 1907.[229] Henry Burdett, founder of the British Hospitals Association, inflamed tensions further three years later with a highly partisan review of local hospitals in his newspaper *The Hospital*. Burdett described the Brownlow Hill Poor Law Infirmary as presenting a 'scandalous contrast' to the 'up-to-dateness of the Royal Infirmary,' and declared the former workhouse infirmary (closed in 1928) deficient on 'moral and hygienic grounds.'[230] The furious response of the Liverpool Workhouse Committee was recorded in the local press, with Burdett accused of being a 'glorified penny-a-liner' guilty of 'extravagant' and 'unmanly exaggerations.'[231]

The voluntary hospitals were reliant on patient payments by the 1930s, supporting John Mohan's analysis of broader trends in the sector that by the 1930s 'the principal feature [of voluntary hospital funding] in all the English regions is the significance of payment by patients' (see Figure 3.7).[232] The proportion of hospital income from paying patients more than doubled between 1920-9 and 1930-6 (from

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[229] *Liverpool Daily Post*, 17 October 1907 [LRO 614 INF 8/3].
[230] Henry Burdett, "Reports on the Hospitals of the United Kingdom, XVII Brownlow Hill Poor Law Infirmary, Liverpool," *The Hospital,* 1 January 1910, 365.
[231] *Liverpool Courier,* 7 January 1910 [LRO 614 INF 8/3].
[232] John Mohan, "'The Caprice of Charity' Geographical Variations in the finances of British voluntary hospitals before the NHS" in *Financing Medicine: The British Experience since 1750*, ed. Martin Gorsky and Sally Sheard, 86.

fifteen per cent to thirty-six per cent).[233] The leading voluntary hospitals in the city, the Liverpool Royal Infirmary (established in 1749 and relocated in 1823 and 1890), David Lewis Northern Hospital (1834), Royal Southern Hospital (1842), and Liverpool Stanley Hospital (1867), amalgamated in 1938 to form the Royal Liverpool United Hospital (see Figure 3.8). Alongside these general hospitals, a number of smaller specialist hospitals also operated within the voluntary sector, including the Liverpool Maternity Hospital, Liverpool Eye, Ear and Throat Infirmary, Hahnemann Hospital, and Liverpool Radium Institute, all located in a central location close to the Liverpool Royal Infirmary, University of Liverpool, and Liverpool Medical Institution (see Figure 3.9).

Hospitals in both the public and voluntary sectors were criticised in the 1942 survey by representatives from the Nuffield Provincial Hospitals Trust. The NPHT survey described Walton Hospital (held up by MacWilliam as an example of a successful municipal hospital) as 'cheerless, forbidding, [and] unsatisfactory' and similarly criticised the former workhouse infirmary at Smithdown Road.[234] The city-centre location of many of the smaller voluntary hospitals was judged to be quite unsuitable for modern treatment, and the inspectors claimed Liverpool provided a clear example of irrational hospital development, claiming 'it is high time that the organisation and development of Liverpool's hospital services were comprehensively planned.'[235]

In spite of the criticism of the NPHT, the Royal Liverpool United Hospital continued to oppose any major changes to the system

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[233] Cherry, "Accountability, Entitlement, and Control Issues," 216, 233.

[234] Peter Higginbotham, "West Derby, Lancashire" *Workhouses* http://www.workhouses.org.uk/WestDerby/ [accessed 12 March 2018]; Ernest Rock Carling and Thomas Steven MacIntosh. *The Hospital Services of the North-Western Area,* (London: HMSO, 1945), paragraph 525-6.

[235] Rock Carling and MacIntosh. *The Hospital Services of the North-Western Area*, 49.

of hospital administration. Liverpool's largest voluntary hospitals were solvent prior to nationalisation as a result of adapting their income model to rely on patient payments, and representatives of the United Hospital proposed a continued role following the changes advocated in the Beveridge Report. The chairman of the hospital committee conceded in 1943 that while 'standardisation is a laudable and positive objective,' the expertise of voluntary hospitals, unable to provide services on a scale large enough to compete with a publicly funded alternative, 'cannot provide the whole loaf, but if they preserve their vitality they can be the leaven within it.'[236]

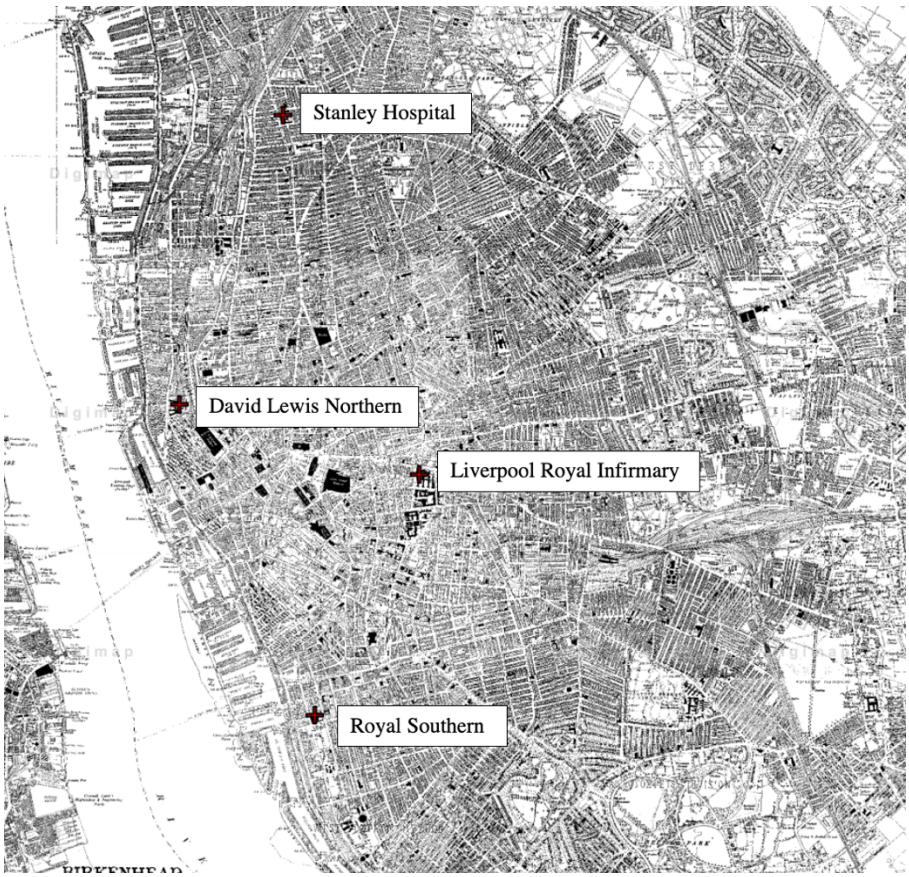
[236] The Royal Liverpool United Hospital, *Sixth Annual Report and Statement of Accounts for the Year Ended 31st December 1943,* 13. [LRO: INF 15/6].

Figure 3.7: 1945/6 Funding sources for the three largest voluntary hospitals in Liverpool.[237]

Hospital	**Available Beds**	**Voluntary Gifts per Bed *(£)***	**Patient Contributions per Bed *(£)***	**Surplus per Bed *(£)***
Royal Liverpool United Hospital	1003	15.67	119.86	21.28
Royal Liverpool Children's	341	13.55	56.57	28.38
Liverpool Maternity Hospital	105	19.19	200.77	60.02

[237] Data from British Hospitals Association, *The Hospitals year-book 1945-6. An annual record of the hospitals of Great Britain & Ireland incorporating 'Burdett's hospitals & charities* (London: British Hospitals Association, 1946). Royal Liverpool United Hospital includes Liverpool Royal Infirmary, Royal Southern, David Lewis Northern and Stanley Hospitals.

Figure 3.8: Hospitals in the Royal Liverpool United Hospital[238]



[238] Map adapted from British National Grid (EPSG:27700), 1930, scale: 1:20,000. Accessed at www.digimap.edina.ac.uk.

Figure 3.9: Liverpool Hospitals with Fewer than 100 Beds, 1945.[239]

Hospital	Category	Ownership	Beds
Bootle Isolation Hospital	Infectious Diseases	Bootle CB	87
Liverpool Maternity	Maternity	Voluntary	86
St Paul's Eye Hospital	Eye	Voluntary	83
Liverpool Eye, Ear and Throat Infirmary	Eye, Ear and Throat	Voluntary	80
Sparrow Hall	Infectious Diseases	Liverpool CB	68
Home for Incurables	Chronic	Voluntary	66
Royal Liverpool Babies'	Babies	Voluntary	65
Hahnemann	General	Voluntary	54
Crofton Recovery Hospital	General	Voluntary	50
Waterloo and District	General	Voluntary	50
Liverpool Radium Institute	Cancer and Skin Diseases	Voluntary	44
Hospital for Consumption and Diseases of the Chest	Pulmonary Tuberculosis	Voluntary	40
Sir Alfred Jones Memorial	General	Voluntary	35
Liverpool and District Hospital for Diseases of the Heart	Heart Disease	Voluntary	30
Bootle Sanatorium	Pulmonary Tuberculosis	Bootle CB	22

[239] Source: Rock Carling and MacIntosh, *The Hospital Services of the North-Western Area*.

3.3: Medical Education in Liverpool before 1948

Medical teaching in various forms had been taking place in Liverpool since the late eighteenth century, when it was mandatory for surgeons on ships carrying slaves to hold qualifications from the medical colleges or pass examinations at a county hospital. In 1818, Liverpool-born Richard Formby (1790-1865), opened an anatomy school in Bold Street, relocating to the Liverpool Royal Institution (the home of a learned society established in 1814) on nearby Colquitt Street in 1821. A second anatomy school was opened in 1827 by William Gill (1781-1846) on Seel Street, in close proximity to Formby's school, however rising demand for medical education led to the establishment of the Liverpool Royal Institution School of Medicine and Surgery in 1834. Formby was appointed as lecturer in anatomy and medicine, and Gill closed his school to join the school as a lecturer in anatomy.[240]

A range of medical qualifications were issued by the national medical colleges, private medical schools and other certificating bodies prior to the 1858 Medical Act. The Medical Register created following the Act provided the first formal distinction between regular and irregular medical practitioners, however its impact on the culture of medical education has been contested. Irvine Loudon claimed the register simply confirmed the status of the medical corporations as qualifying bodies, merely adding 'the element of legal compulsion to what had already become so commonplace as to be customary.'[241] Stella Butler described changes to medical education after 1858 as a 'gradual revolution,' as the nepotism of the medical corporations was progressively undermined and 'institutions rather than individuals' began to assume greater responsibility for the

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[240] Thomas Cecil Gray and Sally Sheard, *A Brief History of Medical Education in Liverpool* (Liverpool: Liverpool University Press, 2001), 4-5.

[241] Irvine Loudon, "Medical education and medical reform" in *The History of Medical Education in Britain*, ed. Vivian Nutton and Roy Porter (Amsterdam: Rodopi, 1995), 244.

monitoring of educational standards.[242] The national reach of the GMC, and the greater number of medical students during the interwar period, necessitated increased standardisation of medical teaching; Keir Waddington argued that individual medical schools could no longer be 'self-contained worlds.'[243]

Clinical teaching at the Liverpool Royal Institution School of Medicine and Surgery was delivered at the Liverpool Royal Infirmary and Northern Hospital, and in 1844 the school relocated to a new building opposite the Royal Infirmary, reopening as the Liverpool Infirmary School of Medicine.[244] The school initially remained independent of the University of Liverpool (established in 1881 as University College Liverpool, part of the federal Victoria University, which existed between 1880-1904), however it became part of the university in 1884 when an amendment to the charter of Victoria University gave it the authority to grant medical degrees.[245] Several provincial universities embraced the opportunity to develop medical faculties, and joined with independent hospital medical schools in large towns and cities. The union between universities and medical schools offered mutual benefits: the rise of scientific medicine had expanded the medical curriculum, and collaboration offered provincial medical schools access to laboratory facilities, while the universities expanded student intake and were able to offer a broader syllabus.[246] Faculties of medicine were established at Owens College

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[242] Stella Butler, "A Transformation in Training: The Formation of University Medical Faculties in Manchester, Leeds, and Liverpool, 1870–84," *Medical History* 30. 2 (1986), 131.
[243] Waddington, *Medical Education at St. Bartholomew's Hospital*, 5.
[244] Arthur Gemmell, *The Liverpool Medical School, 1834-1934, a brief record*, (Liverpool: University Press of Liverpool, 1934), 7.
[245] Thomas Kelly, *For Advancement of Learning: The University of Liverpool, 1881-1981* (Liverpool: Liverpool University Press, 1981), 77-80.
[246] Butler, 'A Transformation in Training," 123; Waddington, *Medical Education at St. Bartholomew's Hospital,* 147; Bonner, *Becoming a Physician,* 260.

in Manchester (1873) and Yorkshire College, Leeds (1884) (the two other constituent colleges of Victoria University).

The provincial medical schools grew quickly, partly as a result of some of the inadequacies of medical teaching in London, where Bonner claimed the established hospital medical schools struggled to find consultants 'willing to sacrifice large incomes from practice to conduct teaching and research as full-time university professors.'[247] The lack of high quality teaching, high living costs and difficulty of the London degree courses further boosted the popularity of the provincial schools, where medical student numbers had overtaken those in the capital by 1915 (see Figure 3.10).[248] The University of Liverpool, which had initially offered an arts-focused curriculum, was undergoing a transformation in its identity: by 1900 the university had expanded 'in support of the city's commercial interests' to offer a range of courses in technical and scientific subjects (including medicine, see Figure 3.11).[249] As a distinct faculty within the university, the medical school at Liverpool retained considerable independence and control over its affairs, while staff and students benefitted from administrative support, university-wide social and academic societies, sports clubs and other activities.

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[247] Bonner, *Becoming a Physician,* 330.

[248] Butler, "A Transformation in Training," 126-7.

[249] June Jones, "Science, Utility and the 'Second City of the Empire': The Sciences and Especially the Medical Sciences at Liverpool University, 1881-1925" (PhD Thesis: University of Manchester, Institute of Science and Technology, 1989), 22-3; 28.

Figure 3.10: Total number of registered medical students in England and Wales, 1900-1935[250]

Medical School	**1900**	**1905**	**1910**	**1915**	**1920**	**1925**	**1930**	**1935**
Birmingham	15	13	27	27	20	10	21	62
Bristol			12	10	3		19	32
Durham	29	27	30	55	55	26	59	70
Leeds		20	24	28	26	26	36	77
Liverpool	**26**	**22**	**29**	**48**	**13**	**3**	**72**	**131**
Manchester		49	30	75	95	50	55	85
Sheffield	10	3	7	6	1	12	9	31
Cardiff	18	14	13	27	29	1		52
Total Provinces	98	148	172	276	242	128	271	540
Total London	265	247	233	204	221	142	153	344

[250] General Medical Council, *Medical and Dental Students Register* (London: General Medical Council, 1900-1935).

Figure 3.11. Building development at University of Liverpool 1886-1938[251]

Year	Building
1886	Chemical Laboratories
1889	Walker Engineering Laboratories
1892	Victoria Buildings, Tate Library, Jubilee Memorial Tower
1895	Museums of Natural History and Sanitary Science, Medical School outbuildings
1896	Gossage Chemical Laboratory
1898	Thompson Yates Laboratories of Pathology and Physiology
1901	New Medical School Buildings (First Block, Department of Anatomy)
1902	Hartley Botanical Laboratory
1903	Johnson Laboratories (Tropical Medicine, Biochemistry and Experimental Medicine)
1903-4	George Holt Physics Laboratory, School of Veterinary Sciences
1905	New Medical School Buildings Completed, New Zoology Laboratory
1911-12	Harrison-Hughes Engineering Laboratories
1920	School of Tropical Medicine Laboratories
1938	Harold Cohen Library

[251] University of Liverpool, "Statistics relating to student numbers and Accommodation, etc. - 1903-1962," [SCA: S.3130].

Keith Vernon claimed that provincial universities were part of a 'changing cultural hierarchy' during the interwar years, which resulted in the 'destabilizing of the class relationship within the professions.'[252] As a merchant city with a comparatively recent history of national economic and social significance, Liverpool exemplified the wave of new universities seeking to establish educational alternatives to London, Oxford and Cambridge, and total student numbers rose from under 900 in 1914 to 2600 in 1919.[253] Steve Sturdy described the 'identity-forming function' of medical schools, which served as an 'institutional base' for the local professional community.[254] The support of established local practitioners was essential to the success of the Liverpool medical school during its early years, and Thomas Kelly described the necessary 'goodwill of the town's physicians and surgeons' who undertook teaching responsibilities.[255]

Medical schools adhered to national guidelines issued by the General Medical Council, however hospital consultants with teaching responsibilities enjoyed substantial autonomy over their delivery, and exercised a great degree of influence over medical students. The clear professional hierarchies between hospital practitioners encouraged deference to superiors, and students and juniors were necessarily implicated at an early career stage in the professional networks within hospitals, as well as the wider medical community, through teaching

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[252] Keith Vernon, "A Healthy Society for Future Intellectuals: Developing Student Life at Civic Universities" in *Regenerating England: Science, Medicine and Culture in Inter-War Britain,* 179.
[253] 'Adami, John George (1862–1926)', entry by H. B. Grimsditch, revised by Geoffrey L. Asherson. Published in print 23 September 2004, published online 23 September 2004. <https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-30332> [accessed 6 February 2020].
[254] Sturdy, "The Political Economy of Scientific Medicine," 135.

[256] Heaman, *St Mary's*, 236; 247-8; 348.

on hospital firms. Medical schools before 1948 were often sites of prejudice and discrimination: Charles Wilson, Winston Churchill's private physician, enjoyed almost dictatorial control over undergraduate admissions to St Mary's Hospital medical school during his time as dean between 1920-1945. Elsbeth Heaman claimed he was often more interested in candidates' rugby skills than their professional prospects, and worried that admitting women would discourage applications from the all-male Oxbridge colleges.[256]

This autonomy began to decline after WWII, when the University Grants Committee assumed greater responsibility for directing funds to universities and sought to eliminate the nepotistic culture at some medical faculties.[257] The report of the Inter-Departmental Committee on Medical Schools, chaired by Sir William Goodenough, published its recommendations in 1944, and recommended a quota of places at medical schools for women students. In spite of opposition from the traditionally single-sex medical schools, the University Grants Committee made funding conditional on such quotas (a minimum target of 15 per cent women students was initially set), by the end of 1948 every medical school had admitted at least one woman.

Medical students in Liverpool gained practical experience at the teaching hospitals of the United Liverpool Hospital within the system of clinical firms. Students joined firms after a period of pre-clinical study, and observed hospital medicine under the supervision of consultants, providing an insight into the environment in which they hoped to work. Steve Watkins described firm teaching as part of the 'anticipatory socialisation' of students, where clear hierarchies were in place and disagreement with the consultant would be highly unlikely.[258] Experiences at medical school provided students with a

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[256] Heaman, *St Mary's*, 236; 247-8; 348.

[257] Brian Windeyer, "University education in the twentieth century" in *The Evolution of Medical Education in Britain,* ed. Noël Poynter (London: Pitman Medical, 1966), 221.

[258] Watkins, *Medicine and Labour*, 29.

common bond, and established a peer network for students that could be sustained after graduation through various local professional societies and associations (discussed in the following chapter). The intellectual and emotional challenge of the medical course, which involved rigorous work schedules, an introduction to anatomical work and dissection, and frequent and unforgiving examinations, established strong bonds among students and between students and staff (see Figure 3.12).

Figure 3.12: University of Liverpool medical school dissecting room, 1931[259]

[259] Liverpool Medical Institution, *Transactions and Report* 2007-2008 (Liverpool: Liverpool Medical Institution, 2008), 84.

Conclusion

Economic prosperity and a large urban population contributed to the development of a vibrant medical marketplace in Liverpool before 1948, populated by practitioners working from private homes, dedicated consulting rooms, and at a large number of municipal and voluntary hospitals. A medical precinct on Rodney Street, close to the Liverpool Royal Infirmary and University of Liverpool, was firmly established by the interwar period, and represented the pinnacle of private practice in the city. The Liverpool hospital system included large municipal hospitals, often former workhouse infirmaries, situated on the outskirts of the central urban area, alongside the four voluntary hospitals of the Royal Liverpool United Hospital, which was administratively unified in 1938.

Medical education in Liverpool reflected the prosperous medical community and formed an integral part of local professional culture. The establishment of independent anatomy schools and their subsequent transfer to the Liverpool Royal Infirmary School of Medicine was led by ambitious practitioners keen to develop local medical education. A major milestone was achieved with the integration of the medical school with the University of Liverpool in 1884, when it was empowered to grant medical degrees for the first time. Relationships established at the medical school provided the foundations for professional and social contacts upon qualification, and clinical teaching at local hospitals acculturated aspiring practitioners to local institutions, personalities and practices.

This chapter has outlined the development of a vibrant professional culture in Liverpool before 1948, informed by general medical practice, hospital medicine and medical education. Independent professional groups managed the affairs and disputes of practitioners before the establishment of the NHS, notably through the conflict-resolution responsibilities of the Local Medical and Panel Committee, while hospital consultants enjoyed substantial freedom of action during medical teaching. Alongside these institutional and

administrative bodies, a number of clubs, societies and other organizations emerged to inform, entertain and facilitate professional interactions between local practitioners. The following chapter explores the origins and function of these groups, and their contribution to professional culture in Liverpool prior to the creation of the NHS.

Chapter 4
Medical networks in Liverpool before 1948

Introduction

Medical practitioners in Liverpool were active across a range of professional networks before 1948. This chapter introduces Liverpool's largest medical society, the Liverpool Medical Institution (LMI, established 1837), alongside a number of specialist societies and clubs. Medical societies were central to local medical culture, and provided an important channel for intraprofessional interaction. The oldest medical societies in Britain were established during the eighteenth century and by 1968 over 200 were listed in an appendix to the annual *Medical Register* published by the General Medical Council (see Figure 4.1).[260] Organizations such as the Medical Society of London (1773) united practitioners beyond the exclusive boundaries of the medical colleges, and encouraged discussion between different branches of the profession.[261] Medical societies fulfilled an important educational function, and the development of a society library was often central to their function (see Figure 4.2).[262] Medical society meetings also provided an opportunity for the discussion of the business of medicine and the resolution of professional disputes.

Several historical accounts of British medical societies have been published by their members, however these are often limited by

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[260] Poynter, "British Medical Societies 1868-1968," 238, Noël Poynter (1908-979) was former director of the Wellcome Institute for the History of Medicine.

[261] Hunting, "The Medical Society of London," 350-354; Shaw, "The oldest medical societies in Great Britain," 233.

[262] Shaw, "The oldest medical societies in Great Britain," 240; Marland, *Medicine and Society in Wakefield and Huddersfield*, 306; Bishop, "Medical Book Societies," 337-9; Valerie Ferguson, "The Professionalization of Health Librarianship in the UK between 1909 and 1978," *Health Information and Libraries Journal*, 22 (Supplement 1) (2005), 8–19.

the issues of uncritical internalist scholarship. Bickerton's 1936 medical history of Liverpool described in reverential terms the nineteenth century origins of the Liverpool Medical Institution, and in 1979 the institution published a similarly hagiographic history by former president (in 1976) John Shepherd (1913-1992).[263] John Burnham described such histories as a 'public relations campaign to establish the prestige and authority' of the local professional establishment, which served to 'socialise' medical students and younger practitioners into an idealised professional community.[264]

A modest but rich academic historiography of medical societies also exists, although their activity under the NHS remains largely unexamined. In her study of nineteenth century medical societies in Yorkshire, Hilary Marland described them as 'one of the most important mediums through which attempts were made by medical men to further their professional aims'.[265] Martin West asserted medical societies 'provided marginal groups with a means to promote cohesion or shared values' and allowed practitioners to 'affirm their growing independence and identity.'[266] Published proceedings of society meetings allowed members to act as producers and mediators of both scientific and professional knowledge. Joris Vandendriessche described nineteenth century Belgian medical societies as 'gatekeepers of the medical community, establishing

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[263] Jennifer Connor, "Medical Library History : A Survey of the Literature in Great Britain and North America," *Libraries & Culture*, 24.4 (Fall, 1989), 459; Bickerton, *A Medical History of Liverpool*; John Shepherd, *A History of the Liverpool Medical Institution* (Liverpool: Liverpool Medical Institution, 1979).

[264] John Burnham, "A Brief History of Medical Practitioners and Professional Historians as Writers of Medical History," *Health and History* 1.4 (December 1999), 254.

[265] Marland, *Medicine and Society in Wakefield and Huddersfield*, 304.

[266] Martin West, "One Hundred Years of an Association of Physicians," *Quarterly Journal of Medicine* 100.3 (2007), 152.

boundaries between orthodox and unorthodox medicine.'[267] In spite of their often broad membership, Roy MacLeod claimed learned societies 'almost always reflected the attitudes and assumptions of small, often obscure and sometimes anonymous, clusters or networks of individuals'.[268]

The groups discussed in this chapter vary widely in both their ambitions and structure. In her study of Scottish medical societies between 1730 and 1939 Jacqueline Jenkinson distinguished between 'general interest' and 'specialist' societies: general interest societies aimed to recruit a broad membership from across the medical community, while specialist societies were 'devoted to a single discipline or branch of medicine and frequently exclusive in membership.'[269] This chapter contains two sections, section 1 outlines the origins and function of the Liverpool Medical Institution, a 'general interest society' to which all local practitioners were eligible for membership. Section 2 discusses the specialist societies and clubs established by local practitioners before the creation of the NHS, which provided professional and social support to their members. This chapter establishes a starting point for discussion of the changing role of the LMI and other professional networks in Liverpool's medical community after 1948.

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[267] Joris Vandendriessche, "Setting Scientific Standards: Publishing in Medical Societies in Nineteenth-Century Belgium," *Bulletin of the History of Medicine* 88.4 (2014), 629; West, "One Hundred Years of an Association of Physicians," 152.
[268] MacLeod, "The X-Club," 305.
[269] Jenkinson, "The Role of Medical Societies," 266.

Figure 4.1: British Medical Societies founded before 1850.[270]

Year	Medical Society	Location
1737	Royal Medical Society, Edinburgh	Scotland
1773	Medical Society Of London	London
1774	Middlesex Hospital Medical Society	London
1774	Colchester Medical Society	Provinces
1789	Aberdeen Medico-Chirurgical Society	Scotland
1794	Plymouth Medical Society	Provinces
1795	Abernethian Society, St Bartholomew's Hospital	London
1800	Leicester Medical Society	Provinces
1802	Glasgow University Medico-Chirurgical Society	Scotland
1805	Medico-Chirurgical Society Of London (1907 Royal Society Of Medicine)	London
1814	Royal Medico-Chirurgical Society Of Glasgow	Scotland
1814	Huddersfield Medical Society	Provinces
1819	Hunterian Society Of London	London
1821	Edinburgh Medico-Chirurgical Society	Scotland
1826	St Helens Medical Society	Provinces
1828	Nottingham Medico-Chirurgical Society	Provinces
1830	Pupil's Physical Society, Guy's Hospital	London
1831	Harveian Society Of London	London
1832	Hunterian Society Of St George's Hospital Medical School	London
1832	York Medical Society	Provinces
1833	Listerian Society, King's College Hospital	London
1834	Manchester Medical Society	Provinces
1834	University Of Birmingham Medical Society	Provinces
1836	Medical And Physical Society, St Thomas' Hospital	London
1837	**Liverpool Medical Institution**	**Provinces**
1830	Edinburgh Obstetrical Society	Scotland
1841	Reading Pathological Society	Provinces
1842	Torquay And District Medical Society	Provinces
1847	Brighton And Sussex Medico-Chirurgical Society	Provinces
1849	North Staffordshire Medical Society	Provinces
1849	West Hertfordshire And Watford Medical Society	Provinces

[270] Data from Shaw, "The Oldest Medical Societies in Great Britain," 232–44.

Figure 4.2: British Medical Libraries with ≥ 5000 Volumes, 1909[271]

Library	**Location**	**Vols.**	**Type**
Royal College Of Physicians Of Edinburgh	Edinburgh	80000	Medical College
Royal Society Of Medicine	London	70000	Medical College
Royal College Of Surgeons Of England	London	60000	Medical College
College Of Physicians and Surgeons of Glasgow	Glasgow	50000	Medical College
Manchester Medical Society	Manchester	39012	Medical Society/ University
Royal College Of Surgeons Of Ireland	Dublin	30000	Medical College
Royal Medical Society	Edinburgh	30000	Medical Society
Medical Society Of London	London	25000	Medical Society
Royal College Of Physicians Of London	London	25000	Medical College
Bristol Medical Library, University College, Bristol	Bristol	21000	Medical School
British Medical Association	London	20000	Medical Association
Royal College Of Physicians Of Ireland	Dublin	15000	Medical College
Royal College Of Surgeons, Edinburgh	Edinburgh	15000	Medical College
Birmingham Medical Institute	Birmingham	14300	Medical Society
St Bartholomew's Hospital College	London	14000	Medical School
East Sussex Medico-Chirurgical Society	Hastings	13000	Medical Society
Liverpool Medical Institution	**Liverpool**	**12000**	**Medical Society**
University College Hospital	London	8000	Hospital
Leeds And West Riding Medico-Chirurgical Society	Leeds	7500	Medical Society
London Hospital Medical College	London	7500	Medical School
Willis Library, Guy's Hospital	London	7000	Hospital
Manchester Royal Infirmary	Manchester	6200	Hospital
New Medical Schools	Cambridge	5500	Medical School
Leicester Medical Society	Leicester	5000	Medical Society
Medical School Of Charing Cross Hospital	London	5000	Medical School
York Medical Society	York	5000	Medical Society

[271] Data from New York Academy Of Medicine and Royal College of Surgeons Of England, *Medical Libraries, Volume II* (reprinted from

4.1: The Liverpool Medical Institution

The origins and function of Liverpool's medical society

The Liverpool Medical Institution originated as the Liverpool Medical Library, founded in 1779 by a group of practitioners at the Liverpool Royal Infirmary and Liverpool Dispensary.[272] Library members shared the cost of books and held regular Saturday evening discussions, resulting in the formation of the Liverpool Medical Society in 1833. The society met at rooms close to the Royal Infirmary, and briefly moved to the Liverpool Royal Institution before securing a property lease at the corner of Hope Street and Mount Pleasant in 1835, which opened as the Liverpool Medical Institution in May 1837 (see Figure 4.3).[273] Bickerton claimed the 126 founding members of the institution represented 'considerably more than half of the total number of medical men residing in Liverpool and district'.[274]

The founding aims of the LMI, published in the *London Medical Gazette*, were 'the advancement of medical science and the cultivation of friendly intercourse among members of the profession'.[275] The institution supported professional interaction, medical education through its large library and program of clinical meetings, and offered a platform from which local practitioners could

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Medical Record September 25, 1909*)* at Wellcome Library https://Wellcomelibrary.Org/Item/B22410491 [accessed 9 July 2019).

[272] Liverpool was also home to a number of non-medical learned societies, see O'Brien, "The Origins and Originators of Early Statistical Societies," 52; Shortt, 'Physicians, Science, and Status," 51–68; Gerard Sanderson, "A note on the Liverpool Medical Institution," *Medical Historian* 16 (1972), 384; Bickerton, *A Medical History of Liverpool*, 50-51.

[273] The Liverpool Medical Library immediately occupied the new building, however the Liverpool Medical Society remained at the Royal Institution until 1839. Bickerton, *A Medical History of Liverpool,* 64.

[274] Bickerton, *A Medical History of Liverpool*, 70.

[275] Quoted in Sanderson, "A note on the Liverpool Medical Institution," 385.

communicate with the non-medical community. A report of LMI centenary celebrations published in the *BMJ* in 1937 described a banquet at the Adelphi Hotel 'attended by many distinguished guests representative of all forms of public service on Merseyside' during which speeches 'emphasized the need for closer and more active co-operation between voluntary and municipal medical services.'[276] Submitting reports to the *BMJ,* the widely-read and influential weekly journal of the BMA, indicated the aspirations of the LMI to identify with the values of the national professional establishment. Elizabeth Berman noted the importance of societies to doctors' claims to professional status; the foremost membership organisation, the BMA, sought to protect the 'honour and respectability' of the profession through 'friendly intercourse and free communication'.[277] The grand institution building was a tangible base for Liverpool's medical practitioners, who were able to cultivate personal and professional relationships with their peers in an independent society.[278]

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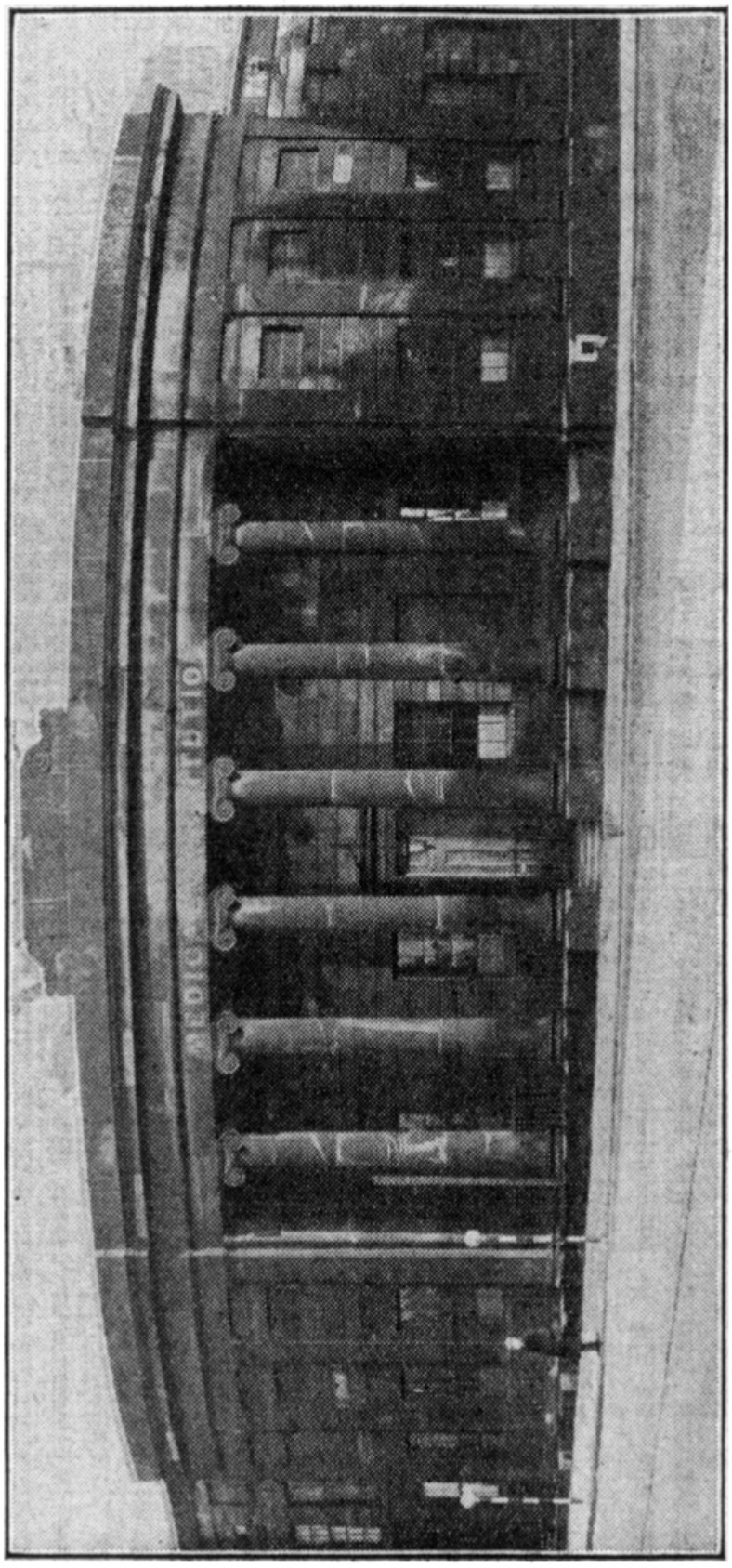
[276] 'Centenary of Liverpool Medical Institution' *BMJ* 12 June 1937, 1209.

[277] Elizabeth Berman, "Before the Professional Project: Success and Failure at Creating an Organizational Representative for English Doctors," *Theory and Society* 35.2 (2006), 176.

[278] A pre-WWI 'Members' Book' with photographs and a brief biographies was essentially a directory for local doctors, [LMI: LMI 2/3/1/1].

Figure 4.3: 1937 Image of Liverpool Medical Institution[279]



The Liverpool Medical Institution

[279] Published in *BMJ* 12 June 1937, 1208.

Annual sessions at the LMI began with an inaugural meeting in the 120-seat lecture theatre, during which the president and members of council were formally invested and a presidential address was delivered to members. Council held monthly meetings to discuss the business of the institution and address issues raised by members, and alongside the institution president and vice president, an honorary treasurer and librarian represented the financial interests and concerns of the library. The October inaugural meeting was followed by a series of weekly ordinary meetings during January, February and March where clinical cases were presented, followed by discussion and the opportunity for social interaction.

The LMI nurtured channels of communication with between the local medical community and regional or national professional figures. Honorary membership was conferred upon Bertrand Dawson, (Lord Dawson of Penn, 1864-1945, author of the 1920 Dawson Report), who visited Liverpool and spoke at the 1932 annual dinner of 'the great advantages of a medical society' and claimed 'there was no place like a medical society for giving the truth a free road and falsehood the go-by.'[280] Other leading medical figures visited Liverpool to receive honorary membership, including Lord Moynihan of Leeds (1865-1936, founder of the Moynihan Chirurgical Club), in 1933 and surgeon and medical historian Sir D'Arcy Power (1855-1941) in 1934.

The institution held joint meetings with the Chester, Birkenhead and Manchester medical societies, local medical students were first welcomed as visitors during the 1930s, and later began the tradition of hosting an annual graduation reception for medical students at the University of Liverpool.[281] The social dimensions of the LMI provided the opportunity for students and young practitioners to interact with senior figures in the professional community, and for

[280] *Liverpool Medico-Chirurgical Journal* (1932), 192.
[281] Minutes of LMI Council Meeting 14/10/1931, [LMI: LMI 2/1/3/1/8].

the LMI to promote the 'advantages of joining the institution… [to] the newly qualified.'[282] The LMI employed a small full-time staff, including a resident librarian (who lived in an adjoining flat), porter, cleaner and, during the winter, a boiler attendant.

Access to medical literature before 1948 was an essential requirement for continuing study for research purposes or to support professional examinations, and custodianship of this resource was an important responsibility of the LMI. The library was a key educational resource for the local medical community, and before WWII was regularly lending more than 300 items annually. The LMI library also loaned and borrowed items from the University of Liverpool, and in 1934 became a member institution of the National Central Library.[283] In the diverse British medical marketplace before 1948, the LMI provided the local medical community with an independent space for professional, social and intellectual exchange.

Medical education was central to the role of the LMI, and clinical lectures and demonstrations were held both at the institution and at voluntary and municipal hospitals across the region. These sessions were a form of postgraduate education delivered independently by the profession, and attendance could exceed 100 in the years before WWII (see Figures 4.4 and 4.5). Institution activity was largely suspended during WWII, as members served abroad or were assigned special domestic responsibilities, and attendance at meetings fell as a result, and the institution building became the Group Office of the Emergency Medical Services until March 1946, under the command of former president (in 1930) Keith Monsarrat (1872-1968).[284] The LMI also organised formal joint meetings with a number of specialist medical clubs and societies during the twentieth

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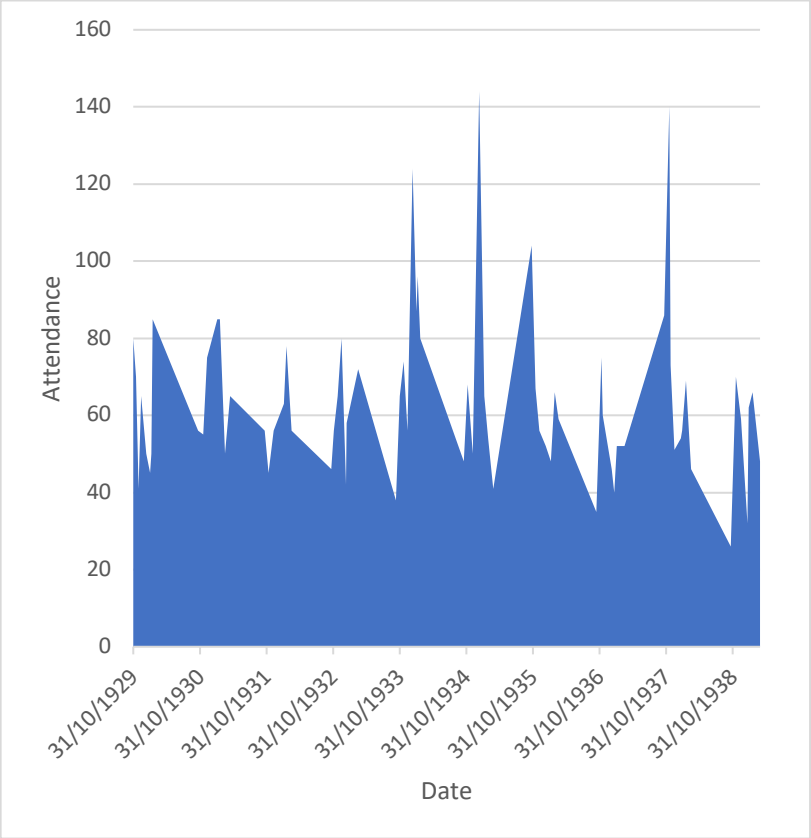
[282] Minutes of LMI Council Meeting 18/11/1936 [LMI: LMI 2/1/3/1/8].
[283] The National Central Library was founded in 1916 with funds from the Carnegie Trust as an inter-library loans service, and in 1972 was one of the bodies that joined to form the British Library.
[284] "KW Monsarrat" (Obituary) *BMJ* 11 May 1968, 369.

century, including the Liverpool Paediatric Club, Liverpool Society of Anaesthetists, Liverpool Psychiatric Club and the local branch of the College of General Practitioners. The popularity of these meetings varied, however popular joint sessions with the Liverpool Society of Anaesthetists, Paediatric Club and College of General Practitioners consistently attracted over 100 members. Specialist societies and medical clubs are discussed in Section 2 of this chapter.

Figure 4.4: Attendance at LMI ordinary meetings 1929-1939 (total of 72 meetings)[285]



[285] Data from LMI meeting minute books, [LMI: LMI 2/1/4/1].

Figure 4.5: Total practitioners in Liverpool and LMI members, 1930-1950.[286]

Year	Doctors on GMC Local List	LMI Members
1930	652	300
1935	649	284
1940	807	248
1945	707	187
1950	842	439

[286] Source: General Medical Council *Medical, Register* (London: General Medical Council); Liverpool Medical Institution *Transactions and Report and Annual Report* (Liverpool: Liverpool Medical Institution, 1930-1950).

Medical practitioners played important roles in a range of provincial learned societies; Arnold Thackray's study of the Manchester Literary and Philosophical Society, established in 1781, found that medically qualified individuals accounted for sixty per cent of the founding membership.[287] Medical practitioners were valued members of such societies due to their social respectability, educational credentials and status as 'the true cosmopolitans in provincial English culture.'[288] Provincial societies were established across the country during the nineteenth century, and tended to focus on ensuring harmonious professional relations between members, rather than engaging in the rigorous intellectual exchanges taking place in their London equivalents.[289]

Provincial societies were obliged to retain a more inclusive character as a consequence of having to accommodate all specialties in a single association.[290] Among the key aims of provincial medical societies was the support of educational activity and the promotion of intraprofessional harmony. Ten medical practitioners established the Leicester Medical Book Society (1800) with the aim of preventing 'acts of discourtesy and unprofessional conduct', the membership was 43 in 1867, rising to 109 in 1907 and 505 in 1993 (women were first admitted in 1919).[291] The Reading Pathological Society (1841) was

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[287] Thackray, "Natural Knowledge in Cultural Context," 684.
[288] Thackray, "Natural Knowledge in Cultural Context," 685; Medical figures were represented in a range of associations: William Henry Duncan (1805-1863), later Britain's first Medical Officer of Health, was one of the founding secretaries of the Liverpool Statistical Society (1838) see Christopher O'Brien, "The origins and originators of early statistical societies: a comparison of Liverpool and Manchester," *Journal of the Royal Statistical Society: Series A (Statistics in Society)* 174.1 (2011), 53.
[289] Stephanie Snow, "John Snow 1813-1858: the emergence of the medical profession" (Ph.D. Thesis, Keele University, 1995), 169.
[290] Power, *British Medical Societies*, vii-ix.
[291] University of Leicester, 'History of the Leicester Medical Society' https://le.ac.uk/medicine/about/leicester-medical-society/about/history [accessed 17 February 2020].

similarly founded to prevent 'envy, hatred and malice, and all uncharitableness' between its members.[292] Medical societies also formed in response to local health crises, the York Medical Society (1832) was founded during a cholera epidemic, and its first nine meetings were devoted to discussion of the disease.[293] The York Medical Society remained after the epidemic, and at its centenary Lord Moynihan of Leeds (1865-1936), founder of the Moynihan Chirurgical Club (1909) for provincial surgeons, commended it for providing 'the means of bringing specialists and general practitioners together'.[294]

Not all provincial centres developed active medical societies, the Manchester Medical Society (1834) failed to thrive in its early years, and specialist groups such as the Odontological Society (1885), Pathological Society (1885), Surgical Society (1922) and Society of Anaesthetists (1946) developed independently in the city before merging in 1950.[295] The amalgamated Manchester society boasted 1500 members, second in size only to the Royal Society of Medicine.[296] Twenty nine doctors founded the Bristol Medico-Chirurgical Society in February 1874, where women were first admitted in 1912.[297] Small general medical societies were established across the North West of England at St Helens (1826), Birkenhead (1856) and Chester (1883).

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[292] Hurry, *A History of the Reading Pathological Society*, 2.
[293] Margaret Barnet, "The 1832 Cholera Epidemic in York," *Medical History* 16.1 (January 1972), 27-28; Power, *British Medical Societies*, 110.
[294] "Centenary of the York Medical Society," *BMJ,* 7 November 1931.
[295] Willis Elwood and Felicite Tuxford, *Some Manchester Doctors: A Biographical Collection to Mark the 150th Anniversary of the Manchester Medical Society* (Manchester: Manchester University Press, 1984), 1, 4; Power, *British Medical Societies*, 130-4.
[296] Shaw, "The oldest medical societies in Great Britain," 230.
[297] Bruce Perry, "The history of medicine in Bristol and of the Bristol Medico-Chirurgical Society," *Bristol Medico-Chirurgical Journal* 89 (1974), 28-29.

Practitioners in Liverpool were fortunate to have a large building situated close to the medical precinct of Rodney Street, the medical school and a number of city-centre hospitals (see Figure 4.6). Many provincial societies lacked a building of their own and met at local hospitals, private members' clubs, and universities. Close affiliation between hospitals or medical schools and medical societies indicated their overlapping interests, however threatened to undermine the independence of the society. The Birmingham Medical Institute was founded in 1875 at Queen's College (a forerunner of the University of Birmingham), before moving to its own premises five years later.[298] The Manchester Medical Society developed strong links with the medical school at Owens College, where its library moved in 1930 in exchange for permanent use of rooms.[299] The Bristol society's library was kept at the Scientific and Literary Club before moving to the medical school in 1892, and when new medical school buildings were completed in 1959 it secured the use of rooms for society meetings.[300] The York society's large library was initially held at the County Hospital, before moving to society premises in the city centre in 1890 and York University in 2004.[301]

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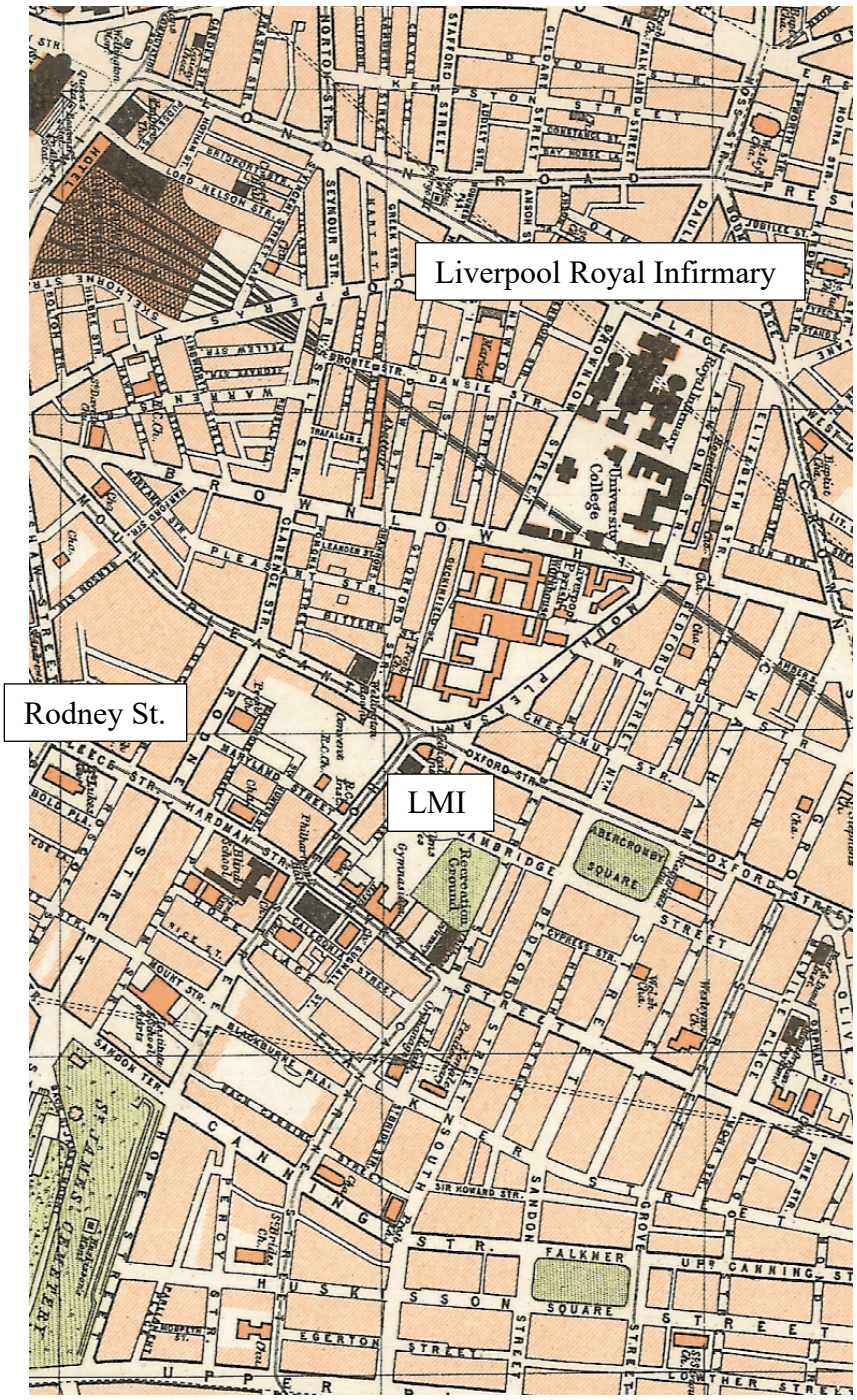
[298] Birmingham Medical Institute, 'Our History' http://www.bmedi.org.uk/index.php?page=home [accessed 17 February 2020].

[299] Elwood and Tuxford, *Some Manchester Doctors,* 8, 44.

[300] Perry, "The history of medicine in Bristol," 28-29.

[301] "York Medical Society Collection" University of York Library https://www.york.ac.uk/library/collections/named-collections/yorkmedicalsociety/ [accessed 17 February 2020]; York Medical Society, "History of 23 Stonegate", https://www.yorkmedsoc.org/history-of-23-stonegate/ [accessed 1 October 2019].

Figure 4.6: LMI in relation to other medical sites in Liverpool[302]



[302] Detail from 'Plan of Liverpool – Royal Atlas of England and Wales, 1898', held at Historic Liverpool, https://historic-liverpool.co.uk/ [accessed 17 February 2020].

Professional culture at the LMI

The atmosphere cultivated at the LMI before 1948 was reminiscent of a private members' club; subscriptions were taken for *Country Life, the Illustrated London News, Punch* and the *Spectator*, and formal dress codes were observed at various institution functions.[303] The building was decorated with portraits of notable former members, and the names of presidents, visiting speakers and other senior office holders were commemorated on honours boards. The various achievements of LMI members were celebrated by the institution, and it was noted during the oration to mark the conferring of life membership upon prominent chest surgeon (and 1951 LMI president) Robert Coope (1892-1972) in 1965 that 'the prestige of the Institution is the prestige of its individual members.'[304] The institution amassed (primarily through donations from members) a collection of valuable books, art and antiques, and its neoclassical exterior and rod of Asclepius on its crest and bookplate further indicated its adherence to established professional traditions and symbols (see Figure 4.7).[305]

The LMI claimed to be apolitical during the pre-NHS period, and this was demonstrated by the refusal of council to sign a 1937 petition from a pacifist group, explaining that the constitution forbade 'participation in religious or political matters', and the request to publish a manifesto from the Medical Peace Campaign was refused on the same grounds in 1939.[306] Nonetheless, medico-political groups such as the BMA, MPU and Medical Women's Federation regularly met at the institution. The local branch of the BMA debated the NHS bill at the LMI in 1946 (council had sought assurances that meetings

[303] Minutes of LMI Council Meeting 1/11/1933 [LMI: LMI 2/1/3/1/8].
[304] Life membership oration for Robert Coope, delivered by Gerard Sanderson, *LMI Transactions and Report*, 1965, 14.
[305] Henry Cohen, "The Liverpool Medical School And Its Physicians (1642–1934)," *Medical History* (1972), 310.
[306] Minutes of LMI Council Meeting 3/2/1937 [LMI: LMI 2/1/3/1/8].; Minutes of LMI Council Meeting 21/6/1939 [LMI: LMI 2/1/3/1/8].

would not be political, but this was not enforced).[307] Surgeon Robert Kelly (1879-1944), LMI president in 1932 and 1937, was also BMA president during his second term of office in Liverpool, and there was substantial collaboration between the two organizations. As an independent professional society, the LMI exercised discretion over its degree of involvement in political debates and selectively provided a platform for external groups, and judged the internal politics of the medical profession to be a valid area for institution activity.

LMI membership was overwhelmingly male before 1948, and was restricted to qualified medical practitioners (although 'wives and non-medical guests' were invited to certain social functions).[308] The first female member, Lucy Cradock (1870-1903) was elected, despite opposition from some members, in 1888.[309] Presidents of the institution were elected from the local professional elite; they were predominantly Liverpool graduates with hospital appointments, and tended to be active in other local and national medical clubs and societies. LMI presidents between 1930 and the creation of the NHS in 1948 held a range of local and national appointments (see Figure 4.8). The majority of presidents held medical or surgical appointments at the teaching hospitals, however Herbert Hurter (president in 1933) and Clare Oswald Stallybrass (president in 1935) illustrated the potential for a general practitioner and public health specialist to be elected at the LMI.

Profiling of LMI presidents during this period reveals their membership of various local and national networks. The vast majority held some form of teaching appointment at the University of Liverpool Medical School, alongside clinical appointments at the constituent hospitals of the Royal Liverpool United Liverpool

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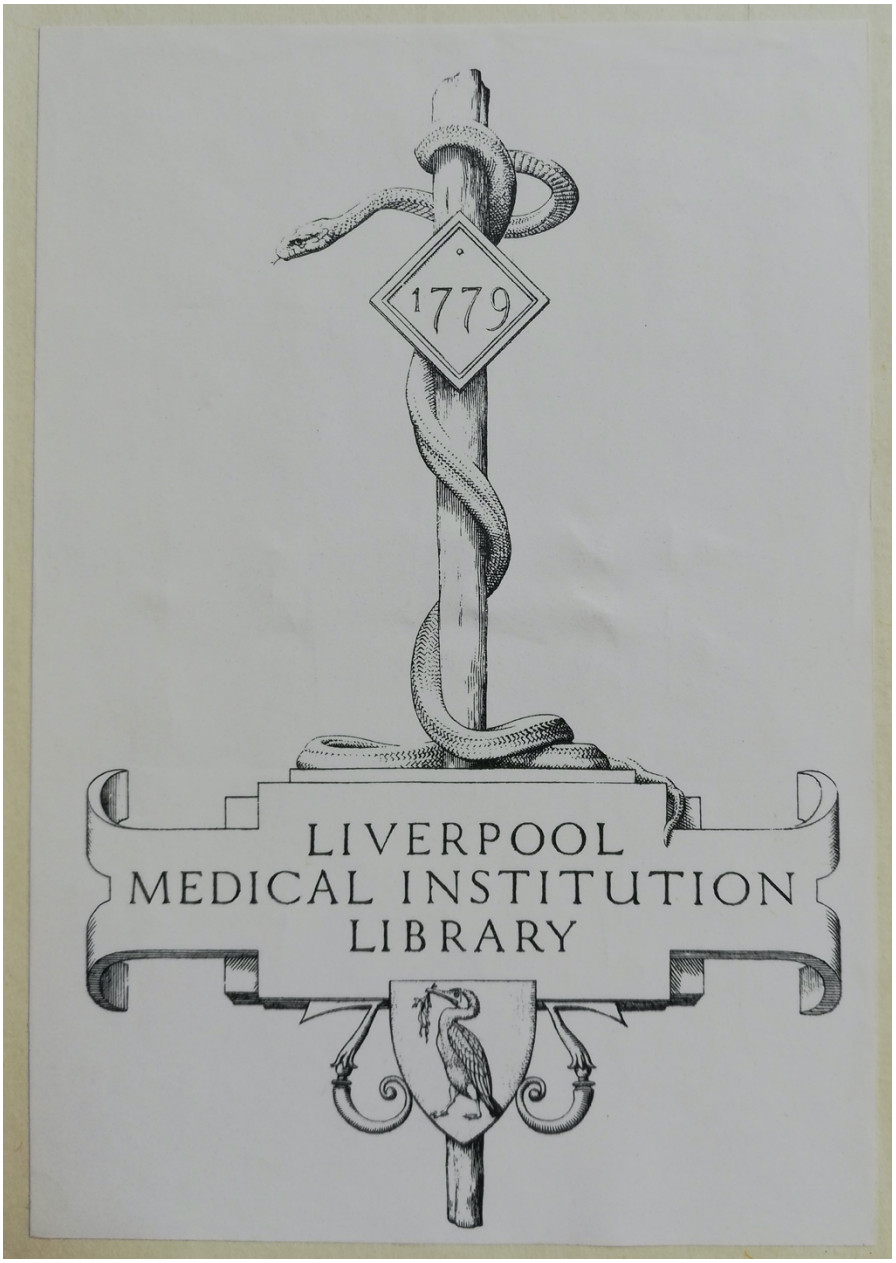
[307] Liverpool Divisional Branch of the British Medical Association, "Minutes, 1946-58" [BMA Archive: D-15-1-2-3].

[308] "Report of Council", LMI *Transactions and Report and Annual Report* (1951), 5.

[309] Alan Sykes, "Dr William Carter – a Medical Life in Victorian Liverpool," *Medical Historian* 21 (2009), 53.

Hospital teaching group. It is perhaps unsurprising therefore that medical students were made aware of the institution, and the LMI schedule of activities corresponded to the academic calendar. Alongside their academic and hospital appointments, LMI presidents during this period were leading members of specialist societies and dining clubs in the city: the exclusive XX ('Twenty') Club, a consultants' dining club discussed in the following section, counted several LMI presidents among its membership. Leading figures at the institution also held senior positions in national medical networks, both in the medical colleges and national specialist societies. Members of national importance during this period included paediatric physician Charles McNeil (1881-1964), who was president of the Royal College of Physicians of Edinburgh between 1940 and 1943. The interests and responsibilities of these individuals, across academic, clinical, administrative and military fields, is indicative of the interconnected nature of leading medical figures during this period (see Figure 4.8).

Figure 4.7. Liverpool Medical Institution bookplate, showing rod of Asclepius



The LMI fostered close links with the Liverpool Medical Students' Society (LMSS, first established as the Liverpool Royal Infirmary School of Medicine Debating Society in 1874), and LMI members regularly addressed students.[310] Laura Kelly described medical school alumni as 'inextricably linked by this association for the rest of their lives', and LMI members took a close interest in the fortunes of the medical school. [311] LMI members had long associations with the student society, and many had been enthusiastic members, such as dermatologist Richard Stopford-Taylor (1885-1965), who graduated from Liverpool in 1907 'without mishap, in spite of the attractions of rugger and duties as President of the Medical Students Debating Society; at whose Annual Smoker [smoking concert] he played the violin.'[312]

Senior figures from the LMI contributed to *Sphincter,* the LMSS magazine, in order to try and attract students to institution activities (students were however limited to the gallery of the lecture theatre and not entitled to refreshments). In 1940 Robert Kelly (president in 1933 and 1937) published an invitation to local students.

> It is…an indication of the spirit of co-operation which exists in Liverpool between students of medicine, qualified and unqualified, that final-year students are made welcome at the Ordinary and Pathological Meetings held at the Institution.[313]

The state of the medical profession both locally and nationally was a favourite topic for discussion in *Sphincter,* which provided a channel of communication between consultants and undergraduates. Charles Wells (1898-1989), professor of surgery and LMI president in 1949 (and described by LMI colleagues as 'dauntless, debonair and

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[310] "General Practice," Sphincter 1.3 (Summer, 1938) [SCA: PUB/3/8]; 18.
[311] Kelly, *Irish Medical Education and Student Culture*, 10.
[312] "Richard Stopford-Taylor" Obituary by Stanley Vincent Unsworth, *LMI Transactions and Report,* 1964, 16.
[313] *Sphincter* 3.2 (Spring 1940) [SCA: PUB/3/8].

wonderfully deft'), contributed an article on professional standards in 1943, which prompted a student to complain that classmates 'entirely lacking in personality and character' had been admitted on the basis of academic merit and risked 'defiling an honoured profession.'[314]

Sphincter regularly featured misogynistic and racist material, a 1943 piece complained of the 'steady infiltration of woman into what used to be regarded as the peculiar and sacred haunts of man' amid sexist jokes, innuendo and jibes at female nurses.[315] Senior consultants introduced students to Liverpool's professional geography through the magazine; Clifford Brewer (1913-2017) provided a short history of the Liverpool Royal Infirmary in 1937, where he worked as a surgeon, and physician Gerard Sanderson (1912-1987) wrote about 'his' hospital, the Royal Southern Hospital, in 1951.[316] *Sphincter* also profiled prominent local figures, most notably Henry Cohen (1900-1977), who became professor of medicine in 1934. A gushing 1950 editorial claimed that 'to describe our Medical School without his [Cohen's] name would be like describing this city without its Mersey or its Playhouse.'[317]

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[314] Life membership oration for Charles Alexander Wells, delivered by William Smellie, *LMI Transactions and Report*, 1969, 25; Charles Wells, "Privilege and Obligation," *Sphincter* 6.2 (Summer 1943), 17-18 [SCA: PUB/3/8]; "Correspondence" *Sphincter* 7.1 (Autumn 1943), 23 [SCA: PUB/3/8].

[315] "Correspondence," *Sphincter* 7.1 (Autumn 1943), 23 [SCA: PUB/3/8]; a 1938 article optimistically claimed, 'most of the old prejudices have been swept away,' followed overleaf by a racist satire. 'Women in Medicine' *Sphincter* 2.1 (Autumn 1938), 12-13 [SCA: PUB/3/8]; 'Black Practice' *Sphincter* 2.1 (Autumn 1938), 14-16 [SCA: PUB/3/8]; the racist cartoons accompanying this article were reused in *Sphincter* in 1947.

[316] Brewer "A brief history of the Liverpool Royal Infirmary," 10; Gerard Sanderson, "The Royal Southern Hospital," *Sphincter* 13.2 (Spring 1951), 70 [SCA: PUB/3/8].

[317] "Editorial," *Sphincter* 12.2 (Spring 1950) "*Sphincter*: Magazine of Liverpool Medical Students' Society: Bound Vols - 1937-2008" [SCA: PUB/3/8]; 39.

Figure 4.8: LMI presidents 1930-1948

Year	President	Qualified	Local Roles	National
1930	Keith Monsarrat	Edinburgh	Group Officer, EMS; Teaching Hospitals; Dean of Faculty	Founder Member, Moynihan Club; Wayfarer's Club
1931	William Blair-Bell	London	Pres., LRI Charity; Prof., Obstetrics and Gynaecology	Founder Member, GVS; Founder Member, College of Obstetricians and Gynaecologists
1932	Robert Kelly	Liverpool	Surgeon, LRI; Philharmonic Society; Prof., Surgery	Council, RCS; Pres., BMA (1937), Liverpool University Rep, GMC
1933	Herbert Hurter	Liverpool	GP; Pres., XX Club	Captain, RAMC
1934	John Bligh	Liverpool	Physician, David Lewis Northern Hosp.; Pres., XX Club; Lecturer, Diseases of Children	Member, Assoc. of Physicians; British Paediatric Assoc.; Guild of St. Luke and SS. Cosmas and Damian
1935	Clare Oswald Stallybrass	London	Deputy MOH Liverpool; Chair, Liverpool Children's Hosp. Management Committee; Pres., XX Club; Lecturer, Public Health Admin.	Divisional Rep, BMA; Public Health Committee; Society of MOHs
1936	George Simpson	Cambridge	David Lewis Northern Hosp.; St John's Ambulance Brigade; Pres., XX Club; Prof., Human Anatomy	Colonel, RAMC
1937	Robert Kelly (2)	Liverpool		
1938	Ernest Bark	London	Surgeon, Victoria Central Hosp. (Wallasey)	
1939	William Johnson	London	Physician, Royal Southern Hosp., RLCH.; Chairman, Faculty of Medicine	Pres., Sec. of Neurology, RSM; Censor, RCP
1940	Arthur Robinson	London	Women's Hospital; Maternity Hosp.; Pres., North of England Gynaecological Soc.; Prof.,	Major, RAMC

			Midwifery and Gynaecology	
1941	Owen Williams	Edinburgh	Surgeon, Royal Southern Hospital; Prof. of Surgery	Major, RAMC; Welsh National Sch. of Medicine
1942	R Glover Wills	London	Surgeon, LRI	
1943	Edmund Spriggs	London		High Sheriff of Denbighshire; KCVO; Examiner, RCP
1944	Richard Stopford-Taylor	Liverpool	David Lewis Northern Hosp.; LRI; Clatterbridge Hosp.; Pres., XX Club; Lecturer, School of Tropical Medicine	Pres., Brit. Assoc. Dermatology; North of England Dermatological Soc.
1945	Robert Kennon	Liverpool	LRI; Pres., XX Club; Lecturer, Surgery	Captain, RAMC
1946	George Francis Rawdon Smith	Liverpool	Anaesthetist, LRI	Commander, 16th Field Ambulance
1947	Henry Wallace-Jones	Liverpool	LRI	Captain, RAMC
1948	Thomas McMurray	Belfast	Surgeon, Royal Southern Hosp., David Lewis Northern Hosp., LRI; Liverpool Orthopaedic Circle; Prof., Orthopaedic Surgery	Hon. member, American, Australian, French orthopaedic societies.

4.2: Medical Clubs and Specialist Societies in Liverpool

Specialist medical societies in Liverpool

Medical practitioners in Liverpool were involved in a number of clubs and specialist societies alongside the Liverpool Medical Institution. Specialist societies were often exclusive, and counted leaders in the university and hospital system among their members. Several specialist societies in Liverpool also contributed directly to the establishment of academic departments, regional and national organisations. Personal relationships were instrumental in the development of these groups, and the examples below indicate the extent to which patronage and sponsorship informed the selection of new members. Some societies became obsolete as specialist departments provided alternative spaces for clinical discussion, however many continued to serve an important social function, and offered a more specific forum than profession-wide associations such as the LMI.

Specialist societies before 1948 helped practitioners tackle what George Weisz described as the 'profound medical mistrust of specialization…shared by both the organized profession and… the medical elite.'[318] Specialist qualifications (with the exception of public health and state medicine) did not appear on the Medical Register, reflecting the ambivalence towards specialist training among the medical elite, where 'clerkships, honorific titles, and posts in hospitals' were the dominant indicators of professional standing.[319] Incentives for practitioners to pursue greater specialism also declined with the introduction of National Health Insurance in 1911, as the capitation system did not reward specialist skills, and disincentivised the time and money required for further training.

Specialist societies offered ambitious practitioners the opportunity to assemble a close network of likeminded colleagues with the aim of developing their interests. This is evident in the

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[318] Weisz, *Divide and Conquer*, 40-42.

[319] Ibid, 167.

development of orthopaedic surgery in Liverpool, which was advanced by a closely connected group of practitioners beginning with Hugh Owen Thomas (1834-1891), a descendant of the 'Anglesey bonesetters' and founding figure of modern orthopaedics.[320] Thomas' father Evan (1804-1884) arrived in Liverpool in 1830 with no formal medical qualifications and began treating dockers' injuries, his son succeeded him and established a wide reputation, developing his own orthopaedic supports (notably the 'Thomas splint').[321] Thomas' nephew Robert Jones (1857-1933) qualified in Liverpool in 1878 and was appointed surgeon-superintendent of the Manchester Ship Canal (constructed 1887-1894), where he developed new surgical techniques on injured workers, later becoming the first lecturer in orthopaedic surgery at Liverpool. Jones was elected president of the Orthopaedic Section of the International Congress of Medicine in 1909, and was the inaugural president of the International Society of Orthopaedic surgery in 1929.[322] He was also among the founder members of the Moynihan Chirurgical Club, which led to the establishment of the Association of Surgeons of Great Britain and Ireland in 1920.

Jones identified his own protégé, Thomas Porter McMurray (1887-1949), a Northern Irish graduate, while they were both working at the Royal Southern Hospital. McMurray took over Jones' practice

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[320] Goronwy Thomas, "From Bonesetter to Orthopaedic Surgeon," *Annals of the Royal College of Surgeons of England* 55.3 (1974), 134.
[321] "The Bonesetters of Anglesey and Hugh Owen Thomas" The Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust August 2011 https://rjah.nhs.uk/RJAHNHS/files/42/42af999a-472b-4b22-8085-2c21087da1a7.pdf [accessed 1 October 2019].
[322] Mark Hagy, "Keeping up with the Joneses'—the story of Sir Robert Jones and Sir Reginald Watson-Jones," *Iowa Orthopaedic Journal* 24 (2004), 134; "Sir Robert Jones" *Dictionary of Welsh Biography*; Charles Sorbie, "The known history and origins of SICOT," *Société Internationale de Chirurgie Orthopédique et de Traumatologie/ International Society of Orthopaedic Surgery and Traumatology*, http://www.sicot.org/history [accessed 1 October 2019].

(first established by Hugh Owen Thomas), was elected president of the British Orthopaedic Association in 1940, and president-elect of the BMA (at the time of his death).[323] McMurray drew Bryan McFarland (1900-1963), similarly of Northern Irish heritage, into the network and in 1926 McFarland was among the first practitioners to be awarded the master's degree in orthopaedic surgery at Liverpool.[324]In 1945, McFarland arranged a meeting of six local orthopaedic surgeons at the University Club to discuss forming a local specialist society to discuss 'subjects of orthopaedic interest.' [325] McMurray, by then professor of orthopaedic surgery, became the first chairman of the new society, the Liverpool Orthopaedic Circle (LOC).

The LOC remained an exclusive group and attendance at meetings, held at the University Club, rarely exceeded ten practitioners. Orthopaedic surgeons held positions of influence across the local medical community: McMurray and McFarland were both LMI presidents (in 1948 and 1956), and McFarland was president of the elite Twenty dining club in 1947 (discussed below). The self-definition as a 'circle', rather than club or society, is indicative of an intimate group, concerned with the nurturing of a friendly and connected group of professional peers.

The Liverpool Orthopaedic Circle developed as an intimate specialist society of practitioners connected through both family and professional relationships, however practitioners from Liverpool also contributed to the development of regional and national organisations. The North of England Obstetrical and Gynaecological Society was

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[323] 'McMurray, Thomas Porter (1887 - 1949)' Obituary by Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 30 September 2013).

[324] "BL McFarland (Obituary)" *BMJ,* 2nd February 1963, 335; 'McFarland, John Bryan (1930 - 2013)' Obituary by Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 16 December 2013, modified 7 March 2014).

[325] Papers of the Liverpool Orthopaedic Circle, [LMI: LOC 1/1].

founded in 1889 by William Japp Sinclair (1846-1912), a professor at Owens College in Manchester, and the three constituent colleges of the federal Victoria University all contributed members. Percy Malpas (1901-1980), who joined the society in 1928 after graduating in Liverpool in 1923, claimed the society played a 'valuable and intimate part in the training of the young postgraduate'.[326] John Wallace (1867-1913) of Liverpool was the first president, and William Blair-Bell (1871-1936) became president in 1923, having already been active in establishing a separate body, the Gynaecological Visiting Society of Great Britain (GVS), in 1911 (the GVS was originally limited to twenty members but expanded to become the national College of Obstetricians and Gynaecologists in 1929).[327]

Blair-Bell was involved in a range of local professional networks, alongside the GVS he established the Liverpool Medical Research Organisation (LMRO) following his appointment to the university chair in Midwifery and Gynaecology in 1921. The LMRO was an interdisciplinary group of around thirty active members including Liverpool University Vice Chancellor (and pathologist) John George Adami (1862-1926), orthopaedic surgeon Robert Jones and neurologist Charles Scott Sherrington (1857-1952), and Blair-Bell compared it to leading American research centres such as the Rockefeller Institute and Mayo Clinic.[328] Members of the LMRO provided Blair-Bell with much-needed public support during his controversial research into the use of lead in cancer treatment, and

[326] Life membership oration for Percy Malpas, delivered by James Cosbie Ross, *LMI Transactions and Report*, 1970, 15.
[327] John Peel, *William Blair-Bell – Father and Founder* (London: Royal College of Obstetricians and Gynaecologists, 1986), 46-47; 58.
[328] William Blair-Bell, "The Liverpool Cancer Research Organisation," *BMJ,* 20th November 1926, 919.

Adami assured a 1926 BMA symposium of the 'strictly scientific attitude' of the work in response to criticism from some delegates.[329]

Local relationships informed the development of both individual careers and specialist societies. Ruth Nicholson (1884-1963), the first woman president of the North of England Obstetrical and Gynaecological Society (in 1938), was also a founder member of the College of Obstetricians and Gynaecologists. Nicholson trained at Durham and worked with Frances Ivens (1870-1944), the first female consultant appointed in Liverpool, at a military hospital in France during WWI. She followed Ivens back to Liverpool after the war, becoming a surgeon and lecturer, and was nominated by her mentor for fellowship of the national college in 1931.[330]

Family connections also featured in appointments to local obstetrical and gynaecological societies; Arthur Gemmell (1892-1960) followed his father John (1864-1931, president in 1903) to the presidency of the North of England Obstetrical and Gynaecological society in 1945, and became president of the national College of Obstetricians and Gynaecologists in 1952.[331] In common with the Liverpool Orthopaedic Circle, local practitioners relied upon close working and family relationships in the development of the specialty. Unlike the orthopaedic surgeons however, figures such as Blair-Bell used established local networks as a platform to develop a national specialist organisation.

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[329] "Liverpool Medical Research Organization" LMI: HV 15/1; "Proceedings of the Annual General Meeting, Nottingham, 1926," *BMJ,* 20th November 1926, 919; Arthur Gemmell, "Some contributions to obstetrics and gynaecology in Liverpool, 1895–1945," *British Journal of Obstetrics and Gynaecology: An International Journal of Obstetrics & Gynaecology* 67.3 (1960), 390-391.

[330] Royal College of Obstetricians and Gynaecologists "Pioneers: Ruth Nicholson, FRCOG 1931" https://rcogheritage.wordpress.com/2017/07/21/pioneers-ruth-nicholson-frcog-1931/ [accessed 1 October 2019].

[331] "Sir Arthur Gemmell," *BMJ*, 1 October 1960, 1024.

The final specialist society discussed in this section is the Liverpool Society of Anaesthetists (LSA). Anaesthetics were generally administered by GPs during the interwar period, and research and training in the field was undertaken at the discretion of individual practitioners.[332] Robert Minnitt (1889-1974), the first lecturer in anaesthesia at Liverpool (appointed 1933), was a founder member of the LSA in 1930, and later the national Association of Anaesthetists in 1932 before becoming president of the Section of Anaesthetists of the Royal Society of Medicine in 1943.[333] Minnitt was elected honorary secretary of the LSA upon its creation, a post that his student and successor Thomas Cecil Gray (1913-2008) claimed provided him with a 'longer lasting opportunity to influence developments' than the presidency (which he was nonetheless awarded in 1951).[334]

Cecil Gray qualified in Liverpool in 1937 and completed his anaesthetics training in 1941 while working as a GP, the following year he became a full-time anaesthetist and demonstrator at the university. Minnitt refused to work under the NHS, a decision Gray claimed was informed by his sense of 'independence and concept of the traditional relationships of medicine', and resigned from his hospital and university appointments in 1948 to focus on private

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[332] John Ballance, "Thomas Cecil Gray CBE KCSG FRCP FRCS FRCA and Gordon Jackson Rees FRCA FRCP FRCPCH: Major Contributors to Post-Resuscitation Care," *Resuscitation* 71 (2006), 133; Thomas Cecil Gray, "Two nudges at progress," *Proceedings of the History of Anaesthesia Society* 21 (Liverpool meeting 27th and 28th June 1997), 11.

[333] Ellen O'Sullivan, "Dr Robert James Minnitt 1889-1974: a pioneer of inhalational analgesia," *Journal of the Royal Society of Medicine* 82 (April 1989), 221-222; the Society of Anaesthetists was formed in London in 1893 and joined the Royal Society of Medicine in 1908 as the Section of Anaesthetics, see Royal College of Anaesthetists, "The Origins of the RCoA and its Fellowship," https://www.rcoa.ac.uk/college-heritage/origins [accessed 1 October 2019].

[334] Gray, "Two nudges at progress," 11.

practice.[335] Consequently, it was Gray that was appointed as the first head of the new university department of anaesthesia in 1947, becoming dean of the faculty of medicine in 1970.[336] As discussed in Part 2 of this thesis, close links between senior university staff (including Cecil Gray) and the LSA ensured the continued growth of the society, and contributed to the development of Liverpool's national reputation as a leader in anaesthetics training. Through a policy of inclusivity and tacit expectation of membership among local anaesthetists, the LSA became an independent but highly influential local professional organisation.

Specialist societies in Liverpool constituted important networks within the medical community before 1948. These groups owed their establishment to influential figures who would later go on to achieve national recognition in their respective specialties. In some cases, the establishment of a specialist society later led to the founding of a new academic position or department, and provided a network for doctors working across a range of hospitals to meet and discuss developments in the field. Family links and local patronage were of key importance, as specialist societies enjoyed considerable independence and were self-selecting groups. The development of these societies also demonstrates the importance of independent professional networks to intellectual exchange, career advancement, and access to regional and national organisations.

'Convivial' societies: Liverpool's medical clubs

Medical clubs began to appear in Liverpool at the end of the nineteenth century, and are defined in this thesis as groups which fall broadly into Jacqueline Jenkinson's category of 'convivial' societies,

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[335] O'Sullivan, "Dr Robert James Minnitt 1889-1974," 222; 'Robert James Minnitt' Obituary by Thomas Cecil Gray, *LMI Transactions and Report*, 1974, 42.

[336] Steven Shafer, "From D-Tubocurarine to Sugammadex: The Contributions of T. Cecil Gray to Modern Anaesthetic Practice," *British Journal of Anaesthesia* 107.1 (2011), 97.

predominantly social in nature but also committed to encouraging 'professional fellow feeling'.[337] The Liverpool Junior Medical Society first met in the winter of 1884, and comprised just four medical students encouraged by the eminent orthopaedic surgeon Hugh Owen Thomas (who remained honorary treasurer until his death in 1891).[338] The stated purpose of the society was 'enabling its members to learn the art of speaking in public', it became the Liverpool Medical and Literary Society in 1887, admitting lay members and imposing a membership limit of thirty.[339]

The Twenty Club (limited to twenty elected members, alongside retired members), the oldest dedicated medical dining club in Liverpool, grew out of the Medical and Literary Society: nine practitioners attended the first meeting at 62 Rodney Street, the house of physician Ernest Glynn (1873-1929), in January 1908.[340] Glynn had an impeccable social and professional pedigree; his father Thomas (1841-1931) was the first professor of medicine at Liverpool, and he had studied at Cambridge before returning to Liverpool for clinical training.[341] Other founding members included Glynn's brother in law Alexander Arkle (1871-1948) and cardiologist John Hay Snr. (1873-1959), who was later a founder member of the Association of Physicians of Great Britain and Ireland (1907) and Cardiac Club (1922).

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[337] Jenkinson, *The Role of Medical Societies*, 257.

[338] Shepherd A *History of the Liverpool Medical Institution*, 167; The four were Robert Jones, Charles Steele, William Kelly and James Rose.

[339] Papers of the Liverpool Medical and Literary Society, (LMI: MLS); Shepherd *A History of the Liverpool Medical Institution*, 167.

[340] The address was 62 Rodney Street, the birthplace of Liberal Prime Minister William Gladstone in 1809.

[341] The professorial post was created when the Liverpool Infirmary medical school amalgamated with University College, TR Glynn held it from 1884-1922; 'Ernest Edward Glynn (1873-1929)' Obituary by GH Brown, *Munk's Roll* Volume IV, page 530; 'Thomas Robinson Glynn (1841-1931)' Obituary by GH Brown, *Munk's Roll* Volume IV, page 288.

Clubs of professional and intellectual peers have been in existence since the eighteenth century, often forming within larger organisations, such as the dining club of the RCP (the Sydenham Club), founded in 1764. Thomas Allibone, a fellow and historian of the Royal Society, claimed such clubs 'played an important part in the social life of the period' and cited the Royal Society Club (1743) and Literary Society (1807) as examples.[342] Nine of the fourteen founding members of the RCP dining club had dined at the Royal Society Club, and Allibone suggested that this experience may have led college members to feel "they might the better pursue their medical discourse in a more intimate manner" in a club of their own.[343] Similarly, the Twenty Club in Liverpool emerged as a small group of medical practitioners from within the Medical and Literary Society (which drew members from a range of professional backgrounds).

Provincial medical clubs provided a platform for local medical elites to meet in a private social setting. The York Doctors' Club, which met weekly during the 1780s, was described by Michael Brown as reflective of 'the polite and civil values of cosmopolitan inclusivity and congenial clubbability' that members of the local medical profession sought to promote.[344] Liverpool was an economically successful and socially cosmopolitan city by the end of the nineteenth century, and several clubs, including the Athenaeum (1797), Racquet Club (1874-1981), Artists' Club (1877), and University Club (1896) drew their members from the local professional classes.[345] Smaller groups, such as the short-lived XY Club (in existence during the 1870s), provided a more informal offering, and were little more than small discussion groups. Medical

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[342] Allibone, "The Club of the Royal College of Physicians," 186-7; John Timbs, *Clubs and Club Life in London* (London: Richard Bentley, 1866), 66-7.
[343] Allibone, 'The Club of the Royal College of Physicians," 188.
[344] Brown, *Performing Medicine*, 26.
[345] Colin Pooley, "Living in Liverpool: The Modern City," in *Liverpool 800* ed. John Belchem, 181.

practitioners also showed an interest in such clubs, and Liverpool-born chemical industrialist Edmund Knowles Muspratt (1833-1923) recalled the XY club included 'clergymen, lawyers, medical men, bankers, merchants, brokers and manufacturers'.[346]

Liverpool's medical clubs were elitist and nepotistic: the limited membership of the Twenty Club was all-male, and the group met at members' homes (predominantly on Rodney Street, see Figure 4.9) and at the University Club. Discussion at early meetings was predominantly medical, and surviving minutes reveal the group discussed issues ranging from medical education and the panel system. The club calendar followed the academic year; an inaugural meeting in the autumn was followed by a session of monthly meetings and a summer recess, meetings featured the presentation of a ten minute 'note' followed by a longer paper. In 1944 gynaecological surgeon Morris Datnow (1901-1962) presented a paper on William Blair-Bell, drawing on records he had found after moving into his subject's former Rodney Street consulting rooms.[347] This case is indicative of the spatial, institutional and social connections between the local medical elite during the interwar period.[348]

The medical dining clubs were forums for a range of views, and were not uniformly conservative; Henry Herbert MacWilliam, physician superintendent at Walton Hospital and Twenty Club president in 1938, participated in BMA discussions on a future health service in 1941, and opposed the desire of the professional

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[346] Alexandra Mitchell, "Middle-Class Masculinity in Clubs and Associations: Manchester and Liverpool," (Unpublished PhD Thesis, The University of Manchester, 2011), 70.

[347] 'Twenty Club Minutes (XX Club)' Minutes 5th November 1944, [LMI: TCM]; 'Blair-Bell, William (1871 - 1936)' Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 10 April 2013).

[348] "Personal and professional papers of William Blair-Bell (the 'Datnow Papers')," [Royal College of Obstetricians and Gynaecologists: GB 1538 S10].

establishment to continue with the 'teaching hospital – private practice – consultant structure' instead of pushing for major structural change.[349] MacWilliam developed his own 'Walton Plan', published in 1938 and described by the second president of the Socialist Medical Association David Stark Murray (1900-1977) as an 'historic document'.[350] The plan focused on the role of the hospital, and echoed elements of the Dawson report in advocating the development of district general hospitals connected to primary health centres. MacWilliam also argued that all doctors in a national service should be whole time salaried employees, a critical departure from the BMA position, and the Walton plan was reprinted in the March 1939 edition of *Medicine Today and Tomorrow*, the socialist medical journal edited by Murray.[351] Despite its inception and dominance by the local professional elite, the Twenty Club was a network that engaged leading practitioners with a broad spectrum of professional interests.

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[349] MacWilliam, *Memories of Walton Hospital,* 57.

[350] David Stark Murray, *Why a National Health Service?: The Part Played by the Socialist Medical Association*. (London: Pemberton Publishers, 1971) Chapter 3, Socialist Health Association https://www.sochealth.co.uk/national-health-service/the-sma-and-the-foundation-of-the-national-health-service-dr-leslie-hilliard-1980/why-a-national-health-service/why-a-national-health-service-chapter-3-1937-1942/ [accessed 1 October 2019].

[351] Murray, *Why a National Health Service?,* Chapter 3.

Figure 4.9: Twenty Club original members

Name	Address	Date of Registration	Qualifications
Alexander Arkle	24 Rodney Street	1899	MRCS, LRCP (Cambridge and St Thomas')
D. Moore Alexander	102 Bedford Street	1901	MBBS (Victoria), MD Liverpool
Herbert Bates	Wavertree	1901	MBChB (Victoria)
Arthur Evans	83 Canning Street	1899	MRCS, LRCP
Ernest Glynn	62 Rodney Street	1899	MRCS, MRCP (Cambridge and Liverpool)
John Hay	7 Rodney Street	1895	MRCS, MRCP (Victoria)
W. Henderson	63 Rodney Street	1899	MBBS, MRCS, LRCP (Victoria)
Robert Kelly	42 Rodney Street	1901	MBBS, FRCS (Victoria)
Leith Murray	11 Rodney Street	1901	MBChB (Aberdeen)
Paget Moffatt	North Dispensary	1904	MRCS, LRCP (Cambridge)
Frank Medwin	Wavertree	1903	MRCS, LRCP (Cambridge and St Bartholomew's)
John Owen	13 Rodney Street	1897	LSA, MB (London)
Adam Simpson	25 Croxteth Road	1898	MRCS, LRCP (London)
O.T. Williams	51 Rodney Street	1902	MRCSE, LCRCP, MD (London)
Frederick Wilson	1 Rodney Street	1901	MBBS (Victoria)

A second dining club, the Innominate, was established in 1930 with rules and regulations comparable to the Twenty Club, membership was limited to twenty and topics for discussion were strictly non-medical. Various topics of discussion recorded in the minutes of club meetings reveal the interests of members: in 1931, the presidential address was given by Thomas Davie (1895-1955) who had received his medical degree in Liverpool at the age of 33, having previously worked as a schoolteacher in his native South Africa.[352] Davie discussed South African students studying medicine at Liverpool, and explained their 'aversion, proclaimed or subconscious, to having any personal dealings with black men,' describing black South Africans in racist language.[353] Davie became the first full-time dean of the medical faculty at Liverpool between 1945-7, and his reputation as a capable administrator led to his appointment as principal and vice-chancellor of the University of Cape Town in 1948.[354]

Oral history interviewees subsequently described a hierarchy of status between the two clubs, with the older Twenty Club considered to have more cachet among the local professional

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[352] 'Davie, Thomas Benjamin (1895-1955)', *Oxford Dictionary of National Biography* entry by Howard Phillips and Harriet Deacon. Published in print 23 September 2004, published online 23 September 2004. Version: 25 May 2006. <https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-32734?rskey=uLfUrY&result=1> [accessed 6 February 2020].

[353] 'Innominate Club Vol. II (1931-1932) [LMI: ICP].

[354] Davie led the (ultimately unsuccessful) opposition to apartheid in South African 'open' universities during the 1950s, see 'Davie, Thomas Benjamin (1895-1955)', *Oxford Dictionary of National Biography* entry by Howard Phillips and Harriet Deacon. Published in print 23 September 2004, published online 23 September 2004. Version: 25 May 2006. <https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-32734?rskey=uLfUrY&result=1> [accessed 6 February 2020].

community. Despite their predominantly informal nature, medical dining clubs also discussed professional issues: Robert MacKenna (1903-1984), the son of two local physicians, delivered a 1932 paper at the Innominate lambasting the 'commercially-minded' proprietors of nursing homes who he alleged were profiting from poorly-run institutions hated by 'middle and upper class patients.'[355] The dining clubs were concerned with the business of medicine, and were alert to the potential implications of any transition to a state system.

The Twenty and Innominate clubs both discussed the future of medical practice during the interwar period, and the representation of senior local doctors in the clubs suggests they were influential forums for discussion and debate. A key point of difference between larger medical societies such as the LMI and the dining clubs described above is the far greater level of exclusivity of the latter. Their limited size meant a far greater degree of self-selection in both specialist societies and the medical dining clubs, leading to the development of clusters of homogenous individuals. In spite of their exclusivity, the involvement of leading practitioners in these groups meant their influence was often disproportionate to their small size, and membership in a dining club was considered an important indicator of local professional advancement.

Medical Women in Liverpool

Medical societies and clubs in Liverpool before 1948 were dominated by men. Lucy Cradock was the first female member of the LMI (in 1888), and the number of women members passed 50 in 1930 (see Figure 4.9), however Ruth Nicholson was the only woman to sit on council between 1930 and 1948. During a 1976 speech to confer life membership of the LMI upon GP Gladys Unsworth (1897-1977), the orator described as 'awful wastage' the frequency of women practitioners marrying shortly after qualification and ceasing to practice (Unsworth graduated from Liverpool in 1922, and had a

[355] 'Innominate Club Vol. II (1931-1932) [LMI: ICP].

successful career as a single-handed GP and anaesthetist alongside her husband, surgeon Stanley Vincent Unsworth (1901-1964).[356] Some specialist societies, notably the North of England Obstetrical and Gynaecological Society and the Liverpool Society of Anaesthetists admitted women, however they remained ineligible for membership to both the Twenty and Innominate Clubs.[357]

The national Medical Women's Federation (MWF) was established in 1916, developing from the Association of Registered Medical Women founded in 1879, and the starting membership of 190 surpassed 1000 in 1925. The MWF campaigned on issues including mental health, contraception, and exclusion of women from medical schools, and by 1971 there were 25 local associations of the MWF operating across the country. In Liverpool, fourteen female practitioners met on Rodney Street to form the Liverpool Association of Registered Medical Women in 1909. Frances Ivens, the city's first female consultant, chaired the group, which aimed 'to safeguard and promote the interests of medical women and to take action when necessary in any matter that may concern them.'[358]

The group formally affiliated with the MWF as the Liverpool and District Association in 1918, and held meetings at the LMI. The group arranged social events such as the cocktail party for women delegates at the 1950 BMA conference in Liverpool, and dinners with sister organisations from Manchester and North Wales. Presidents of the association were active in their own specialties, notably Frances Ivens, a founder member of the College of Obstetricians and Gynaecologists and the first female vice president of the LMI in 1929. Margaret Thomas, who was Liverpool MWF president in 1950, became the first woman president of the LMI in 1957.

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[356] Life membership oration for Gladys Unsworth, delivered by John McFarland, *LMI Transactions and Report*, 1977, 19.
[357] The Innominate Club later admitted women (although cardiologist Stephen Saltissi recalled it was still male-only when he arrived in Liverpool in 1984), the XX Club remains male-only.
[358] Medical Women's Federation records at [LMI: MWF 1/1].

Figure 4.10: Women members at the LMI 1901-1943

Year	Number of women members
1901	5
1921	11
1931	56
1943	65

The number of women medical practitioners in Britain grew rapidly during the interwar period, from 2,100 in 1921 to 6,300 at the outbreak of WWII.[359] The rising number of women in the profession provoked what Carol Dyhouse described as a 'backlash' from the male-dominated medical establishment, and a number of medical schools barred female entry during the 1920s. Dyhouse proposed that it was during this period that the 'concept of male professionalism in medicine, with an emphasis on rugby, athleticism, and the values of the boys' public school' emerged.[360] Women remained firmly in a minority in British medical schools before 1948. However, Stephen Cole suggested that women applicants were in fact sometimes more likely to be accepted for a place at medical school than men before 1948, and the low numbers of applicants was rooted more in sociological factors than discrimination among medical school admissions processes.[361] Lesley Hall outlined the systemic challenges facing women medical practitioners in this period, when some local authorities and employers imposed marriage bars on women's employment, frustrating 'a generation which no longer believed that celibacy was the necessary price to be paid for being allowed to pursue a profession.'[362]

At the level of individual practices, cases also emerge of women practitioners choosing other women to succeed them. In 1930,

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[359] Carol Dyhouse, "Driving Ambitions: Women in Pursuit of a Medical Education, 1890-1939," *Women's History Review* 7.3 (1998), 321-322.

[360] Dyhouse, 'Driving Ambitions," 334.

[361] Stephen Cole, "Sex discrimination and admission to medical school, 1929-1984," *American Journal of Sociology 92.3* (1986), 565.

[362] The first women were appointed to BMA council in 1946, however a most medical schools continued to apply a quota of 20 per cent on admissions of women for decades, see Lesley Hall, "80 years of the Medical Women's Federation," first published in *Medical Woman* 16.2 (Summer 1997), 6-9. (revised and republished at http://www.medicalwomensfederation.org.uk/about-us/our-history [accessed 1 October 2019].

Joan Watkins (1903-1987), an 'active Soroptimist' and MWF member, took over the former practice of Frances Mary Bowles Price (1888-1973), illustrative of the opportunity for women practitioners to support the professional aspirations of other medical women.[363] The development of the Liverpool branch of the MWF, under the initial stewardship of Frances Ivens, the first female consultant appointed in the city, is indicative of the perceived need for a dedicated society to support local female practitioners. This is perhaps unsurprising in light of the simultaneous presence of both discriminatory professional practices and under-representation at national level, and also in the male-dominated societies and clubs in operation at local level.

Medical practitioners and freemasonry

Alongside exclusively medical societies and clubs, local practitioners were desirable members of nonmedical organizations as a result of their intellectual and social status in the wider community. Liverpool was a popular centre for freemasonry during the nineteenth century, and the Masonic Hall on Hope Street (built in the 1850s) was the administrative headquarters of the West Lancashire masonic province until 2015.[364] In 1921, Robert Buchanan (1864-1925), professor and physician at Liverpool Royal Infirmary, was approached by two student freemasons to propose establishing a

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[363] Life membership oration for Joan Watkins, delivered by AH Cruickshank, *LMI Transactions and Report*, 1973, 14.

[364] West Lancashire Freemasons, "List of lodges by group," https://www.westlancsfreemasons.org.uk/list-of-lodges-by-group/ [accessed 1 October 2019]; "Masonic Hall, Liverpool," Historic England (Online) https://historicengland.org.uk/listing/the-list/list-entry/1343611 [accessed 1 October 2019]; Connections between medicine and Freemasonry existed during the nineteenth century, when lodges established mutual aid schemes, the NHS essentially ended this practice, see Daniel Weinbren, "Freemasonry and Friendly Societies" in *Handbook of Freemasonry,* ed. Henrik Bogdan and Jan Snoek (Leiden: Brill, 2014), 393; Mary Clawson, *Constructing Brotherhood: Class, Gender, and Fraternalism* (Princeton University Press, 2014), 14.

university lodge.[365] The plan was supported by Vice Chancellor John George Adami, who had become a freemason while working in Montreal, Canada.[366] Medical practitioners were heavily involved in the University Lodge of Liverpool from its establishment in 1921, eleven of the thirty founders were medically qualified and during its first fifty years eight masters of the lodge were medical practitioners.

The First World War interrupted the studies of students across all faculties, many of whom returned to university after demobilisation. These included the president of the university Guild of Undergraduates, medical student Andrew McKie Reid (1893-1973), who qualified in 1921.[367] McKie Reid was initiated at the first meeting of the university lodge (and became master in 1934) and was a leader in medical and lay networks throughout his life, elected president of the Liverpool Medical Institution in 1959 and a Conservative city councillor in 1961.[368] Not all medical freemasons were as adept at cultivating professional and social links as McKie

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[365]A history of the Liverpool university masonic lodge was published to celebrate its fiftieth anniversary in 1971 by Frank Fowweather, a local medical practitioner who was elected master in 1943, available at University Lodge of Liverpool https://universitylodgeliverpool4274.org/history/ [accessed 1 October 2019]; 'Frank Scott Fowweather (1893-1980)' Obituary by AT Howarth, *Munk's Roll* Volume VII, 194; 'Robert James Mclean Buchanan (1864-1925)' Obituary by GH Brown, *Munk's Roll* Volume IV, 488.

[366] 'Adami, John George (1862–1926)', entry by H. B. Grimsditch, revised by Geoffrey L. Asherson. Published in print 23 September 2004, published online 23 September 2004. <https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-30332> [accessed 6 February 2020]; Fowweather, *University Lodge of Liverpool*.

[367] 'Reid, Andrew McKie (1893 - 1973)' Obituary by Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 2 October 2014).

[368] Fowweather, *University Lodge of Liverpool*; 'Reid, Andrew McKie (1893 - 1973)' Obituary by Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 2 October 2014).

Reid: lodge historian and medical practitioner Francis Fowweather (1893-1980) was remembered for his 'lack of ability as a negotiator, committee man and diplomat', a consequence of which was that 'he numbered few of his clinical or university colleagues as close friends.'[369] The absence of any formal clinical dimension to masonic meetings distinguished the group from other specialist societies and consultant dining clubs, however the evidence of strong medical participation is indicative of the overlapping networks of elite medical and lay communities.

Conclusion

Medical societies and clubs served a key function in the local medical community before 1948, offering practitioners access to educational resources and the opportunity to interact with professional peers. In spite of their diversity, the groups included in this chapter all operated on a specifically local level; society members held roles in hospitals, conducted clinical teaching, and owned general practices. The LMI was the largest medical society in Liverpool, and counted leading hospital and university figures amongst its leaders. Smaller specialist societies offered support to practitioners during a period of intraprofessional tension over the place of medical specialism, and provided the opportunity for likeminded individuals to collaborate, in some cases leading to the establishment of academic departments and national societies.

The involvement of senior university and hospital figures at the Liverpool Medical Institution ensured that the society loomed large before medical students and younger practitioners. The LMI was also a custodian of important educational resources, providing further encouragement for practitioners to join and giving the society greater authority as a gatekeeper to professional development. Liverpool's medical elite led the range of specialist societies and

[369] 'Frank Scott Fowweather (1893-1980)' Obituary by AT Howarth, *Munk's Roll* Volume VII, 194.

dining clubs that catered to both the professional and social ambitions of the medical community. Such groups constituted influential networks of ambitious practitioners which were free to observe more restrictive or nepotistic admission policies than larger societies.

Medical societies served an influential role in informing generations of practitioners of local professional expectations, heritage and identity. Independence from nonmedical oversight was a defining characteristic of medical societies, and such self-regulation was representative of the mature professional status claimed by the profession more broadly before 1948. The following section of this thesis considers the response of the local medical community to the establishment of the NHS in 1948, including the impact of the new service on hospital medicine, general practice, and independent professional organizations.

Part 2: Liverpool's Medical Community 1948-1978

Chapter 5
The National Health Service in Liverpool

Introduction

The creation of the National Health Service in 1948 brought the diverse and uncoordinated range of medical services in Liverpool within a new system of administration. Teaching hospitals retained substantial independence and were accountable directly to the Ministry of Health, while the majority of hospitals came under the control of Regional Hospital Boards. Hospital practitioners were salaried under the NHS, however general practitioners continued to be remunerated through the capitation system, overseen by new Executive Councils, and public health and other community services came under local authority control. Professional intransigence during negotiations over the new service ensured significant continuities after 1948, and elements of pre-NHS practice and professional culture were also sustained at local level by individuals, institutions and networks seeking to influence future developments.

The NHS reshaped established professional norms in a number of ways. The introduction of salaried posts at prestigious teaching hospitals, replacing the system of honorary appointments at voluntary hospitals, further distinguished hospital practitioners from GPs, who remained independent entrepreneurs. Intraprofessional animosity between hospital practitioners and GPs surfaced following their administrative separation, as salaried hospital consultants ceased to rely on GP referrals for income. These tensions were rooted in the perceived professional and intellectual inferiority of general practitioners, who were not obliged to complete vocational training and were free to continue along the 'small shopkeeper' practice model.[370]

The independent status of teaching hospitals under the NHS resulted in the continued dominance of the Liverpool hospital system

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[370] Drury, "The General Practitioner and Professional Organizations," 211.

by a small professional elite based at the former voluntary hospitals of the United Liverpool Hospital. Consultant-led medical teaching during this period encouraged the survival of professional practices that reflected pre-1948 resources and demands, and were unsuited to the changing local demography. In Liverpool, the period between the creation of the NHS in 1948 and its first major reorganisation of in 1974 saw substantial economic decline. Jon Murden claimed the 'golden age' of the city came to an end around 1965; over 350 factories were closed or relocated during the following decade amid a national migration of 'manufacturing, population and wealth' to the south east of England (see Figure 5.1).[371]

As outlined in Part 1, the independent status of influential professional networks helped to insulate the local medical community from some of the major changes occurring in the administration of health services. Academic analysis of the use of medical resources in Liverpool during this period revealed a number of lingering inefficiencies. This chapter outlines the transition to the NHS in Liverpool, and foregrounds subsequent analysis of how rationalization of the hospital system and changes to general practice affected local professional networks. Section 1 of this chapter considers how medical services in Liverpool were brought within the NHS administration, and argues that despite the transition to the state service a number of clear hierarchies remained evident. Section 2 demonstrates the resilience of pre-NHS professional culture facilitated by medical teaching, and the continued influence exerted over medical students and younger practitioners by members of the local professional establishment.

[371] Jon Murden, "'City of Change and Challenge': Liverpool since 1945," in *Liverpool 800* ed. John Belchem, 429.

Figure 5.1: Population, Liverpool and England and Wales 1950-1972[372]

Year	England and Wales (000s)	Liverpool
1950	43,758	802,300
1952	43,955	791,500
1954	44,274	786,100
1956	44,667	773,700
1958	45,109	762,400
1960	45,775	754,670
1962	46,640	745,230
1964	47,219	729,140
1966	47,824	712,040
1968	48,346	688,010
1970	48,680	667,000
1972	49,038	588,600

[372] Sources: *Annual Abstract of Statistics* (London: HMSO, 1950-1972); *Report of the Health of the City of Liverpool* (Liverpool: Tinling, 1950-1972).

5.1: The National Health Service in Liverpool 1948-1974

The transition to NHS organisation

The NHS was created on 5th July 1948, with a structure described by Daniel Fox as 'hierarchical regionalism', premised on elite teaching hospitals disseminating benefits to the surrounding geographical area (see Figure 5.2).[373] The new service perpetuated and formalized existing divisions within the profession: Charles Webster argued the tripartite structure of hospital medicine, independent GPs, and community services resulted in 'entirely separate and incompatible forms of administration' which created 'impossible barriers'.[374] The medical profession drew major concessions from Bevan in the final structure of the NHS, notably the survival of the capitation system of payment, a separate administrative machinery of Local Executive Councils for GPs, the continued right to treat private patients, and independent status for teaching hospitals.[375] Webster claimed GPs had not had to sacrifice their 'traditional freedoms,' and NHS general practice, far from signalling a major break with the past, represented an 'ossification of the less desirable features of insurance medical practice.'[376]

The October 1951 general election returned Conservative Winston Churchill as Prime Minister, and the new government was ideologically opposed to expansion of the welfare state. In 1953 economist Claude Guillebaud (1890-1971) was instructed to review

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[373] Fox, *Health Policies, Health Politics*, 210.

[374] Webster, "Conflict and Consensus," 131.

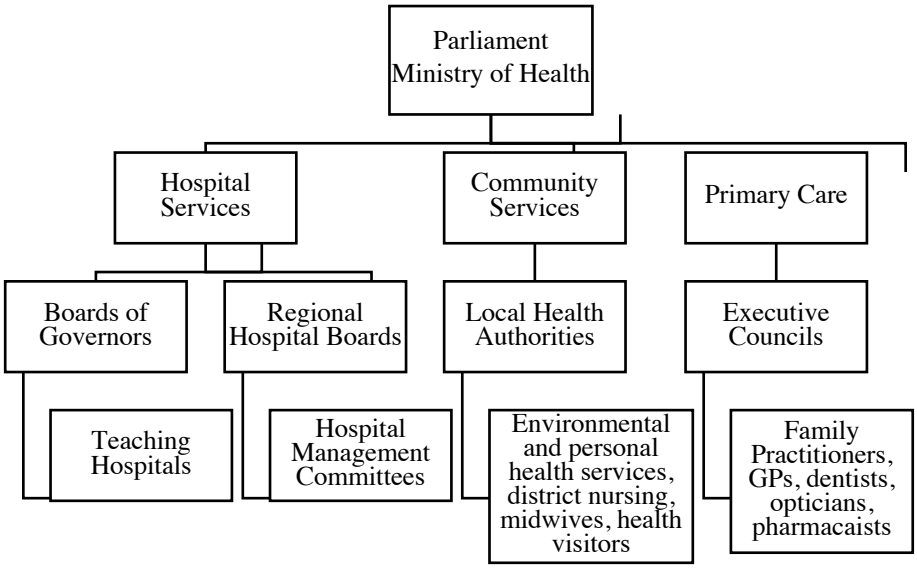
[375] Patricia Day and Rudolf Klein, "Constitutional and Distributional Conflict in British Medical Politics: The Case of General Practice, 1911–1991," *Political Studies* 40.3 (1992), 467; Digby, *The Evolution of British General Practice,* 312-314; Honigsbaum, *The Division in British Medicine*, 21.

[376] Webster, "Doctors, Public Service and Profit", 213-214. The Danckwerts award was endorsed at a meeting of the Local Medical Committee in June 1952, the LMC suggested it be implemented 'at the earliest possible date'. LMC Committee Meeting 10 June 1952. [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

NHS expenditure, with the expectation that the service would be exposed as inefficient and expensive.[377] When the report was published in 1956, Guillebaud stated that the government's charge of 'widespread extravagance' was not borne out by evidence, instead, inflation-adjusted spending on the NHS had actually *declined* slightly since 1948, and increases were related to external factors such as inflation and the price of goods and services.[378] The Guillebaud report indicated the financial viability of the service, however it also led to closer monitoring of expenditure. This was felt acutely in hospitals, where Rudolf Klein described consultants 'pursuing a perfectionist policy without regard to the financial limits'.[379]

[377] Sheard, "A Creature of Its Time," 437.
[378] Webster, *The Health Service Since the War*, 207-8; Rivett, *From Cradle to Grave*, 113.
[379] Klein, *The New Politics of the NHS*, 31-33.

Figure 5.2: The structure of the National Health Service in 1948[380]



[380] Adapted from Rivett, *NHSHistory* http://nhshistory.net/Chapter%201.htm [accessed 11 July 2019].

Medical services in Liverpool between the creation of the NHS and its first major reorganisation in 1974 were defined by their pre-1948 origins. The newly-created Liverpool Regional Hospital Board administered the former municipal hospitals, while the former voluntary hospitals of the Royal Liverpool United Hospital remained a distinct administrative unit, the United Liverpool Hospitals (ULH) (see Figure 5.3).[381] The Senior Administrative Medical Officer of the RHB from the time of its inception until his death in 1964 was Trevor Lloyd Hughes (1909-1964), who had the difficult task of accommodating the demands of the new NHS with the expectations of his professional peers in the city. In an obituary published in the *Transactions* of the Liverpool Medical Institution, Lloyd Hughes was commended for his ability 'to serve two masters with outstanding success' and despite being 'primarily a servant of the Ministry of Health, his interest remained predominantly in doctoring'.[382] The ULH was designated as a teaching hospital and therefore retained a substantial degree of independence, and fostered ambitions for a new central hospital to replace and unite its separate units. Nonetheless, a series of challenges at both local and national level obstructed the rationalisation of the Liverpool hospital system until the 1970s, and the ULH failed to amalgamate at a single site until 1978 (this process is discussed in the following chapter).

The attitudes of general practitioners towards the NHS were partly informed by their experience of National Health Insurance. Insurance practice had grown rapidly during the interwar period, and by 1938 between two thirds and three quarters of medical practitioners had 'panel' patients on their lists.[383] While insurance

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[381] 'City of Liverpool, National Health Service; a guide' (1948) [LRO: 614 AHA/8/3/18].

[382] 'Trevor Lloyd Hughes' Obituary by Goronwy Thomas, *LMI Transactions and Report,* 1964, 11. An annual Trevor Lloyd Hughes memorial lecture, focusing on medical administration, was later established at the LMI (discussed in chapter 3).

[383] Digby, *The Evolution of British General Practice,* 307-311.

practice offered income security, practitioners in areas with limited opportunities for private practice were pressured into taking panel patients, leading to a decline in professional autonomy.[384] Following the publication of the NHS Bill in 1946 some practitioners feared that salaried status (the system of payment preferred by Bevan and left wing professional bodies) would further undermine professional independence. Professional opposition to the Act was not representative of the entire GP community, and hostility towards a salaried service was instead reflective of influential BMA figures whose age, affluence and practice model would see them lose out most from such a change.[385]

GPs entered a working relationship with the NHS described by Geoffrey Rivett as 'a contract for services rather than a contract of service'.[386] Practitioners were no longer able to sell the 'goodwill' of established practices (instead, a fund was established to compensate retiring practitioners) or set their own fees, and payment was through capitation, which was most lucrative for practitioners with large lists and low expenditure.[387] The capitation system enabled unscrupulous GPs to underinvest in their practices, and in 1950 the Nuffield Provincial Hospitals Trust commissioned Australian doctor Joseph Collings to investigate the situation. He visited 55 practices at random from three regions outside London, and his findings were published in the *Lancet*. Collings' report was a damning indictment of British general practice, he uncovered a widespread inadequacy of services, and described inner-city practice as 'at best…very unsatisfactory and at worst a… public danger'.[388] The BMA rejected Collings' findings,

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[384] Digby, *Making a Medical Living*, 169.
[385] Eckstein, "The Politics of the British Medical Association," 357-358.
[386] Rivett, *From Cradle to Grave*, 80.
[387] Timmins, *The Five Giants*, 218.
[388] Martin Powell, *Evaluating the National Health Service* (Open University Press, 1997), 16.

however general practice reform was placed at the centre of discussions of improvement to the service.[389]

The Central Health Services Council, a body established by the NHS Act to advise the Minister of Health, set up a committee to review general practice in 1950 chaired by Henry Cohen, professor of medicine at the University of Liverpool. The Cohen committee supported the development of group practices and greater exposure of students to general practice, but fell short of advising more substantial changes such as merit awards for GPs (which remained reserved for hospital consultants), or undergraduate teaching by GPs.[390] The 1952 report by judge Harold Danckwerts (1888-1978) into the financing of general practice led to the introduction of maximum list sizes for single-handed practitioners (3,500 patients), a practice allowance for those establishing new practices, and interest-free loans for those wishing to invest in their facilities.[391]

A manifesto for reform to general practice began to emerge during the 1950s, led by practitioners such as John Hunt (1905-1987). Hunt was secretary of the steering committee under Henry Willink (1894-1973) that led to the establishment of the College of General Practitioners in 1952.[392] Membership of the college passed 4000 within five years of its creation, and John Horder (1919-2012), president between 1979 and 1982, stated 'there has been, since the end of the Second World War, a revival—a renaissance—in this part of the service, after a period of stagnation'.[393] The college constituted a progressive voice amongst the GP community, and encouraged postgraduate education, group working, and greater cooperation with

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[389] Webster, *Problems of the National Health Service before 1957,* 356-7; Rivett, *From Cradle to Grave*, 85.
[390] Rivett, *From Cradle to Grave*, 87.
[391] Rivett, *From Cradle to Grave,* 89.
[392] 'John Henderson, Lord Hunt of Fawley Hunt (1905-1987)', Obituary by M Linnett, *Munk's Roll* Volume VIII, 234.
[393] John Horder, "Conclusion" in *General Practice under the National Health Service 1948-1997*, ed. Irvine Loudon, John Horder and Charles Webster (Oxford: Oxford University Press, 1998), 278.

auxiliary staff. College members tended to be younger and better educated than non-members, and GP and former GMC president Donald Irvine (1935-2018) later described it as part of a 'protest movement about poor standards'.[394] Tudor Hart contrasted the progressiveness of the college with the conservatism of the BMA, which remained 'heavily influenced by GPs who hankered for a return to private practice, and could not accept the finality of the NHS'.[395]

General practitioners and hospital consultants came into contact through referrals and domiciliary visits, where GPs requested (and paid) for a consultant to visit a patient at home.[396] Liverpool physician Cyril Clarke (1907-2000) reflected on etiquette during such visits in 1957, noting common complaints against GPs, such as absence during visits and poor communication, and hospital consultants, who manipulated cases to arrange further visits (and fees). Clarke cautioned that a poorly managed relationship would lead to 'an embittered attitude' between the two branches of the profession.[397] Julian Tudor Hart, an influential GP and advocate of reform, recalled the pervasive view that 'GPs were men who had failed to become specialists and were unable to work in a hospital'.[398] In 1957, Lord Moran famously outlined the feeling among the professional elite that GPs had fallen off the medical career 'ladder',

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[394] Anne Cartwright, *Patients and Their Doctors: a study of general practice* (London: Routledge & Kegan Paul, 1967), 179; John Chisholm, "Memories: Standing on the Shoulders of Giants," *British Journal of General Practice* 63.612 (July 1, 2013), 376.
[395] Tudor Hart, *A New Kind of Doctor*, 86.
[396] Anne Long and J.B. Atkins, "Communications between General Practitioners and Consultants," *BMJ* 23rd November 1974, 456; Graham Mulley, "Home Visiting by Consultants," *BMJ (Clinical Research Ed.)* 20th February 1988, 515.
[397] Cyril Astley Clarke, "Medical Etiquette and the Consultant," *The Practitioner* 179.1069 (1957), 5-9.
[398] Tudor Hart, *A New Kind of Doctor*, 84.

and this intraprofessional tension remained unresolved by the structure of the NHS.[399]

[399] Rivett, *From Cradle to Grave*, 163.

Figure 5.3: Hospitals in the Liverpool city area.[400]

Hospital Management Committee	Hospital	Beds 1951	Beds 1970
United Liverpool Hospitals (Teaching)	Liverpool Royal Infirmary	374	366
	David Lewis Northern Hospital	208	201
	Royal Southern Hospital	242	217
	Liverpool Stanley Hospital	135	105
	The Royal Liverpool Children's Hospital: City Branch	136	150
	RLCH: Heswall Branch	238	173
	RLCH: Thingwall Branch	26	
	The Women's Hospital	122	119
	Liverpool Maternity Hospital	100	149
	Liverpool Maternity Hospital (Hesketh Annexe)	25	
	Ear, Nose And Throat Infirmary	90	78
	St Paul's Eye Hospital	116	112
	Liverpool Dental Hospital	88 Chairs	150 Chairs
North Liverpool	Walton Hospital (General)	1351	1048
	Bootle Hospital (General)	119	113
	Waterloo Hospital (General)	50	50
	City Hospital North	162	
	Bootle Maternity Home	28	
	North Chest Clinic	-	
	Bootle Chest Clinic	-	
	Waterloo Chest Clinic	-	
Liverpool And District Eastern	Broadgreen Hospital (General)	603	603
	Newsham General Hospital	1316	965
	Rathbone Hospital	144	172
	Mill Road Maternity Hospital	142	214
South Liverpool	Sefton General Hospital	1028	847
	Sir Alfred Jones Memorial Hospital (General)	38	50
	Liverpool Homeopathic Hospital (General)	54	55
	Liverpool Chest Hospital (Special)	78	
	Home For Invalid Women (Chronic)	93	

[400] Liverpool Regional Hospital Board, *Report for the Year ended 31st March 1951"* [LRO HQ362.061]; Liverpool Regional Hospital Board, *Report for the Year ended 31st March 1970* [LRO: M614 WAL/18/12].

	Heart Hospital Outpatient Clinic	-	
	Crofton Recovery Hospital (Convalescent)	57	57
	Seamen's Dispensary And VD Clinic	-	
	Liverpool Psychiatric Clinic	-	
	South Tuberculosis Clinic	-	
	Central Tuberculosis Clinic	-	
Fazakerley Group	Aintree Hospital (Tuberculosis)	497	533
	Fazakerley Hospital (Infectious)	368	202
	Fazakerley Annexe	48	132
	New Ferry Smallpox Hospital		
Liverpool Region Children's	Alder Hey Hospital (Special)	661	579
	Royal Liverpool Babies' Hospital	53	
Liverpool Radium Institute	Liverpool Radium Institute	-	
Grand Total		8702	8186

Momentum for reform to the original structure of the NHS continued to build during the 1960s. Arthur Porritt (1900-1994), president of the RCS and BMA, presented the report of the Medical Services Review Committee in 1962. Geoffrey Rivett claimed that while Porritt began his review as a 'sceptic' towards the service, he finished 'convinced that the NHS had to continue and be improved'.[401] Porritt criticised the tripartite system, which had resulted in differences in national and regional decision-making: central government resented regional autonomy, while the regions opposed what they felt was excessive government interference.[402] The report demonstrated professional sympathy with greater integration of the health service, however it ultimately trod little new ground, Charles Webster suggested Porritt simply restated earlier recommendations that the health service be administered centrally, instead of continuing with the 'notorious lack of uniformity' that resulted from local authority management.[403]

Labour Minister of Health Kenneth Robinson (1911-1996) published the first consultative document on a comprehensive reorganization of the NHS in 1968, and Klein reflected that the need for restructuring had 'become part of the conventional wisdom'.[404] The document, *Administrative structure of the medical and related services in England and Wales*, criticised the tripartite structure and recommended replacing with it with local area boards responsible for all services in each administrative area.[405] The same year, the Ministry of Health and Ministry of Social Security merged to form the new Department of Health and Social Security (DHSS), with Richard

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[401] Judith Allsop, *Health Policy and the NHS: Towards 2000* (Harlow: Longman, 1995), 42.; Rivett, *From Cradle to Grave*, 191.
[402] Klein, *The New Politics of the NHS*, 72-73.
[403] Webster, *The National Health Service: A Political* History, 89.
[404] Klein, *The New Politics of the NHS*, 82.
[405] Minister of Health, *National Health Service: the Administrative Structure of the Medical and Related Services in England and Wales* (London: HSMO; 1968).

Crossman (1907-1974) as the first Secretary of State. Crossman revised Robinson's 1968 proposals, and the second Green Paper, *The future structure of the National Health Service in England* was published in 1970, abandoning Robinson's plans to cede all responsibility for health services to local authorities (instead, area health authorities would report directly to the Secretary of State).[406] Labour plans for NHS reform were halted by the surprise victory of the Conservatives under Edward Heath in June 1970. Sir Keith Joseph (1918-1994) replaced Crossman as Secretary of State, and published the White Paper on NHS reorganisation in August 1972, which became law as the National Health Service Reorganisation Act in 1973. The implementation of the NHS reorganisation, and its implications for Liverpool's medical community, is discussed in Part 3 of this thesis.

Medical services in Liverpool 1948-1974

The Nuffield Provincial Hospitals Trust outlined the problems encountered by voluntary hospitals 'dealing with conditions for which they are neither designed nor organised' in a report produced prior to the creation of the NHS in 1941.[407] After 1948, uncoordinated local medical systems across the country were configured into the new administrative apparatus of the NHS, revealing considerable regional variation in the availability of medical services that persisted during the first decade of the service (see Figures 5.4 and 5.5). This process revealed areas of inefficiency, and in 1962, Conservative Minister of Health Enoch Powell (1912-1998) published the influential *Hospital Plan for England and Wales*, which introduced regional bed targets

[406] Department of Health and Social Security, *The Future Structure of the National Health Service*. (London: HMSO, 1970).
[407] Nuffield Provincial Hospitals Trust, 'A National Hospital Service: A memorandum on the co-ordination of hospital services' (Oxford: Nuffield Provincial Hospitals Trust, 1941), 8.

with the hope of linking the provision of services with local need.[408] At national level, the plan called for a reduction in beds from 3.9 to 3.4 per 1000 population (about 12 per cent). Regions that had inherited fewer beds in 1948 faced a modest reduction in capacity, however Liverpool's plentiful hospital inheritance and falling population meant a reduction of thirty-nine per cent, the most dramatic in England and Wales.[409]

[408] Ministry of Health, *A hospital plan for England and Wales*. (London: The Stationery Office, 1964).
[409] Logan, *Dynamics of Medical Care,* 1.

Figure 5.4: Regional Allocation of Hospital Beds, Great Britain, 1948[410]

Region	Number of Beds		Beds per 1000 Population	
	General & Special	Mental and Mental Deficiency	General & Special	Mental and Mental Deficiency
Newcastle	17,407	9,505	6.08	3.32
Leeds	20,801	14,093	6.87	4.65
Sheffield	23,087	13,524	5.69	3.33
E Anglian	8,867	5,522	6.37	3.97
NW Metropolitan	21,763	14,616	5.7	3.83
NE Metropolitan	23,554	11,631	7.97	3.94
SE Metropolitan	27,732	13,599	8.93	4.38
SW Metropolitan	29,675	35,668	6.74	8.1
Oxford	8,055	5,635	5.94	4.15
S Western	18,369	16,052	6.93	6.06
Birmingham	25,629	17,079	5.91	3.94
Manchester	29,535	17,248	6.77	3.96
Liverpool	**15,887**	**7,645**	**7.71**	**3.71**
England	270,361	181,817	6.69	4.5
Wales	14,960	9,793	5.86	3.84
Scotland	37,816	16,164	7.34	5.08

[410] Adapted from Webster, *The Health Services Since the War, Vol II,* Appendix 3.14.

Figure 5.5: Regional Allocation of Hospital Beds, Great Britain, 1958[411]

Region	**Number of Beds**		**Beds per 1000 Population**	
	General & Special	**Mental and Mental Deficiency**	**General & Special**	**Mental and Mental Deficiency**
Newcastle	8,998	11,269	3.04	3.81
Leeds	10,764	15,412	3.49	5
Sheffield	11,604	14,745	2.72	3.45
E Anglian	5,092	6,303	3.38	4.19
NW Metropolitan	12,565	16,883	3.12	4.19
NE Metropolitan	12,221	12,007	3.84	3.77
SE Metropolitan	12,053	14,323	3.73	4.44
SW Metropolitan	15,879	36,400	3.34	7.66
Oxford	4,663	6,002	3.04	3.92
S Western	9,770	11,166	3.49	3.99
Birmingham	14,323	18,948	3.12	4.13
Manchester	14,410	19,360	3.28	4.4
Liverpool	**9,197**	**8,569**	**4.31**	**4.01**
England	141,539	191,387	3.33	4.51
Wales	9,390	16,631	3.59	6.36
Scotland	37,326	26,770	7.26	5.21

[411] Adapted from Webster, *The Health Services Since the War, Vol II,* Appendix 3.15.

Following the publication of the plan, the Joint Research Committee of the United Liverpool Hospitals and the Liverpool Regional Hospital Board sought the advice of the Medical Care Research Unit at the University of Manchester, which led to the establishment in 1964 of a four-year research study into the 'dynamics of medical care on Merseyside' sponsored by the local hospital authorities, Ministry of Health and Nuffield Provincial Hospitals Trust.[412] The study was led by Robert Logan (1917-2016), a professor at Manchester (who moved to the London School of Hygiene and Tropical Medicine before the study was completed) and was published in 1971 as *The Liverpool Study - an enquiry into the dynamics of medical care and use of hospital resources in a region*. The study set out to scrutinize the pervasive view that high resource-use in the city was linked to adverse social conditions.[413]

The *Liverpool Study* offered several explanations for local inefficiency; a plentiful supply of hospital beds had been inherited in 1948, and overcapacity enabled patients to be treated slowly and remain in hospital longer than necessary.[414] Liverpool topped national league tables for both surgical and medical admissions in 1968, with surgical specialties 17% above the average and medical specialties an astonishing 35% per cent above, the city also had the longest hospital stays for general medical visits of any region (see Figures 5.6 and 5.7). These data were a reflection of the generous inheritance of hospital beds in 1948 as a result of the large number of voluntary and municipal hospitals, which had undermined incentives to more

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[412] Ibid, Chapter 2, 3.

[413] Claudine McCreadie, "R. F. L. Logan, J. S. A. Ashley, R. E. Klein and D. M. Robson, Dynamics of Medical Care: The Liverpool Study into Use of Hospital Resources, London School of Hygiene and Tropical Medicine, London, 1972, Memoir No. 14. Xvi 152 Pp. £3.00." *Journal of Social Policy* 3.1 (1974), 89.

[414] This phenomenon was common to other over-bedded areas, such as London, see Logan, *Dynamics of Medical Care,* 48-9.

efficient inpatient care.[415] In Liverpool, the largely Victorian hospital estate was unsuited to the social, economic and demographic conditions of the 1960s: the research team described Liverpool as a 'victim of its history'.[416]

[415] Martin Buxton and Rudolf Klein. "Distribution of hospital provision: policy themes and resource variations." *BMJ* 8th February 1975, Supplement, 347.

[416] "The Liverpool Study - an Enquiry into the Dynamics of Medical Care and Use of Hospital Resources in a Region" (London School of Hygiene and Tropical Medicine Medical Care Unit, Department of Public Health, 1971), 1 [LRO: M614 RHA/5/1].

Figure 5.6: Bed targets (beds per 000 population) outlined in the 1962 Hospital Plan.[417]

Region	**1960 (Actual)**	**1975 (Target)***	**1967 (Achieved)**
Newcastle	3.8	3.4 (10)	3.4
Leeds	3.8	3.4 (10)	3.5
Sheffield	3.1	3 (3)	2.5
East Anglia	3	2.9 (3)	2.4
Metropolitan Regions	4.2	3.6 (14)	3.7
Oxford	3.3	3.3 (0)	2.6
South Western	3.7	3.3 (10)	2.5
Wales	4.5	3.5 (22)	3.7
Birmingham	3.3	3.1 (6)	2.8
Manchester	3.6	3.4 (5)	3.3
Liverpool	**5.6**	**3.5 (39)**	**4.6**
Wessex	3.6	3.3 (8)	2.5
England and Wales	3.9	3.4 (12)	3.2

[417] Source: "The Liverpool Study - an Enquiry into the Dynamics of Medical Care," 2.2, *Number in brackets indicates required reduction in beds (as a percentage).

Figure 5.7: General Medicine: Mean length of stay and throughput - 1968[418]

Region	**Mean Length of Stay (days)**	**Throughput per bed**
Newcastle	13	21.9
Leeds	15.5	20
Sheffield	13.2	24.1
East Anglian	13.8	23.1
NW Metropolitan	17.2	19.8
NE Metropolitan	18.5	17.7
SE Metropolitan	18.2	18.7
SW Metropolitan	17.2	19.6
Oxford	12	26.6
South Western	14.2	21.5
Wales	15.6	20.1
Birmingham	14.7	22.3
Manchester	16.1	20
Liverpool	**18.6**	**16.5**
Wessex	15.6	22
England and Wales	15.9	20.2

[418] Source: "The Liverpool Study - an Enquiry into the Dynamics of Medical Care," Table 10.5.

Liverpool also distinguished itself for having, by a considerable distance, the highest proportion of 'home-trained' consultants in both medical and surgical specialties for any region in the country outside London (see Figure 5.8). This insularity can be interpreted as reflective of a close and supportive professional community, or as an excessively homogenous group liable to sustain unsuitable local practices due to a lack of external input. In 1948 Liverpool had the highest number of consultants (per 100,000 population) of any provincial region except for Oxford, a situation that changed during the following decade, when it actually fell below the national average (see Figures 5.9 and 5.10). The insularity of the Liverpool hospital system was felt by some oral history interviewees; Roger Armour (b. Roger Ahmed, 1934) was born to English and Indian parents in present-day Pakistan, he qualified in India in 1956 and came to Liverpool to begin a master's degree in surgery. Armour was frustrated at the difficulty of securing a post as senior surgical registrar in Liverpool.

> I discovered that the last nine successful applicants (I did not go back any further) for the post…were all working in Liverpool and most had qualified there. I told my highly influential boss that the posts should be advertised only in the *Liverpool Echo* and not in the *BMJ*. He was not amused and said that the Liverpool consultants knew which registrar was the best one for the next senior registrar post.[419]

This insularity ensured that large cohorts of medical practitioners trained under the direction of senior figures in the local medical establishment, and were introduced at an early career stage to traditional structures and values.[420]

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[419] Written correspondence from Roger Armour.

[420] The difficulty of penetrating such networks for outsiders are considered in Julian Simpson, *Migrant architects of the NHS: South Asian doctors and the reinvention of British general practice (1940s–1980s* (Oxford: Oxford University Press, 2018), 126.

The firm system of medical education ensured close contact between students, junior doctors, and consultants, and in many cases interviewees recalled the extravagant behaviour of consultants which, either for good or ill, influenced their impression of the profession. An Irish-trained radiologist, who arrived in Liverpool in 1973, recalled a similar experience.

> I applied for the job, there was a local candidate, and the general feeling was I was wasting my breath because Liverpool always appointed local people, but the local candidate pulled out and they couldn't cancel the job because I had all the qualifications.[421]

[421] Anonymous Interviewee 2, 24 May 2018.

Figure 5.8: Proportion of Consultants (%) Trained in the Same Region, 1972*[422]

Region	Medical Specialties	Surgical Specialties	Total
Liverpool	**48.7 (1)**	**45.8 (1)**	**42.9 (1)**
Manchester	24.8 (3)	31.4 (2)	28 (2)
Wales	25.8 (2)	25.7 (4)	26.6 (3)
Newcastle	23.6 (5)	19.5 (6)	22.9 (4)
Leeds	24.3 (4)	29.1 (3)	20.8 (5)
Birmingham	16.2 (6)	22.7 (5)	17.5 (6)
Sheffield	10.3 (7)	7.3 (7)	8.1 (7)
South Western	2.9 (8)	3.8 (8)	4.9 (8)

[422] Source: "The Liverpool Study - an Enquiry into the Dynamics of Medical Care", appendix 7. *(Number in brackets denotes rank in regional table).

Figure 5.9: Regional Distribution of NHS consultants, Great Britain, 1948[423]

Region	**Population (million)**	**Consultants**	**Consultants per 100,000 population**
Newcastle	2.862	280	9.8
Leeds	3.03	295	9.7
Sheffield	4.058	332	8.2
East Anglian	1.391	168	12.1
NW Metropolitan	3.821	675	17.7
NE Metropolitan	2.955	467	15.8
SE Metropolitan	3.107	461	14.8
SW Metropolitan	4.402	679	15.4
Oxford	1.357	179	13.2
S Western	2.65	301	11.4
Birmingham	4.335	433	10
Manchester	4.36	326	7.5
Liverpool	**2.061**	**255**	**12.4**
Total England	**40.389**	**4851**	**12**

[423] Adapted from Webster, *The Health Services Since the War, Vol II,* Appendix 3.23.

Figure 5.10: Regional Distribution of NHS consultants, Great Britain, 1958[424]

Region	**Population (million) July 1956**	**Consultants**	**Consultants per 100,000 population**
Newcastle	2.912	457	15.7
Leeds	3.058	369	12.1
Sheffield	4.189	453	10.8
East Anglian	1.476	209	14.3
NW Metropolitan	3.89	740	19
NE Metropolitan	3.063	576	18.8
SE Metropolitan	3.197	610	19.1
SW Metropolitan	4.616	822	17.8
Oxford	1.471	256	17.4
South Western	2.752	381	13.8
Birmingham	4.49	610	13.6
Manchester	4.38	498	11.4
Liverpool	**2.601**	**347**	**13.3**
Total England	42.095	6328	15

[424] Adapted from Webster, *The Health Services Since the War, Vol II,* Appendix 3.23.

General practice in Liverpool after 1948 was inseparably linked to changing social and economic conditions. The city council revived the interwar slum clearance effort in 1966 with a new plan to clear 33,000 dwellings deemed unfit for habitation. Despite high hopes for urban renewal, the council reported in 1972 that the scheme had 'done little to alleviate handicaps and difficulties' in the inner-city.[425] Liverpool's economy was weakened on a number of fronts after WWII. Traditional reliance on the port undermined the development of a local manufacturing base, and impermanent plants had emerged in the area instead of stable local employment. The Merseyside Socialist Research Group claimed the city had developed as a 'commercial rather than an industrial centre' and lacked a self-supporting local economy.[426] The origins of Liverpool's economy as an international trading port contributed to the development of a vibrant multiracial population, with the local black community predominantly living in the inner-city particularly vulnerable to the effects of economic depression.[427] A confidential study by the council published in 1972 offered a 'firm factual basis to what are usually general impressions' about protracted social and health problems in the city.[428]

Sustained population decline after the 1930s contributed to falling GP list sizes (see Figure 5.11), and local practitioners were aligned to the BMA position to threaten to withdraw from the NHS until a new contract was secured in 1966.[429] The overcapacity of

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[425] Francis Amos, *Social Malaise in Liverpool* (Liverpool: Liverpool Corporation, 1972), 5; 18; Mersey Regional Health Authority, "Area Profiles, volume 1", 5 [LRO: 362.1094275 MER].
[426] Merseyside Socialist Research Group, "Merseyside in Crisis," (Liverpool: Merseyside Socialist Research Group, 1980), 27, 41.
[427] Gideon Ben-Tovim, "Racial Disadvantage in Liverpool: An Area Profile" (Liverpool: Merseyside Area Profile Group, 1980).
[428] Amos, *Social Malaise in Liverpool*, 4.
[429] Minutes of emergency meeting of GPs in Liverpool, 19th February 1965, [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

hospital medicine in Liverpool during the 1960s (leading to a low threshold for admission) compensated for woefully underdeveloped general practice.[430] One in three local GPs were in single-handed practice (the national average was one in seven) and single-handed practices were most common in the city (group practices of three were most common nationally). Liverpool GPs also had less postgraduate hospital experience than the national average, and held fewer clinical assistant posts (5% holding posts compared to the national average of 22%).[431] The number of older GPs was especially pronounced in Liverpool, with roughly a quarter aged over sixty (compared with only 9 per cent in nearby Cheshire).[432] The independent status of general practitioners ensured that, despite a broader reforming movement represented by the 1966 charter and the national 'renaissance' of general practice, individual doctors were not obliged to participate in the cultural shift within the branch of the profession.

In common with hospital medicine, appointments to partnerships in general practice appointments could be highly insular, and local reputation could be a significant asset. An interviewee reflected applying for a job outside Liverpool.

> I went to Bristol and went for a job at one place they said, 'oh well this Mr. Lothian says that you're very good – but we don't know who Mr. Lothian is, what does that mean to us?

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[430] Charles Frost, "Clinical decision-making and the utilization of medical resources." *Social Science & Medicine (1967)* 11.17-18 (1977), 798.

[431] "The Liverpool Study - an Enquiry into the Dynamics of Medical Care," Chapter 11; the clinical or medical assistant grade was introduced as part of the Platt Report into medical staffing, published in 1961, and proposed a part-time role in hospital medicine for general practitioners that had experience as medical registrars, see *Report of the Joint Working Party on the Medical Staffing Structure in the Hospital Service* (London: HMSO), para. 122-133.

[432] Ben-Tovim, "Racial Disadvantage in Liverpool," 56-57.

The same interviewee had a very different experience when applying to join a GP practice in Birkenhead in the 1970s, when she encountered familiar figures who were happy to support her application.

> One of the doctors there showed me round, and said 'this is where we're working, these rooms belong to my partners', and one of them said 'Dr Brian Hawe', and I said, 'is that Brian Hawe who used to work…?' I said, 'I know him very well I used to work with him, you ought to ask him for a reference.[433]

Local reputation helped medical practitioners secure appointments, and a negative reputation could also exclude them from promotion. The high degree of local professional insularity arguably raised the significance of professional networks, as interviewees reflected that securing appointments and career progression was linked to local recognition.

[433] Christine Brace, 27 March 2018.

Figure 5.11: GPs in the Liverpool City and County Borough 1943-1973.[434]

Year	GPs	% Female	% providing partnership details	Patients Per Doctor
1943	276	8	20	2980
1948	309	8	31	2562
1958	400	12	59	1906
1968	408	14	56	1686
1973	357	15	66	1609

[434] Source: Liverpool Executive Council *Interim Report* (1948) and *Annual List of Medical Practitioners* (1958, 1968, 1973). [LRO: HQ610.58 NAT].

The inferior intraprofessional status of general practice was reflected in the medical school curriculum, which remained focused on hospital medicine. Anne Digby claimed the syllabus was 'geared far too much to the needs of a small minority of potential specialists to provide adequately for the three quarters of…graduates who would become generalists'.[435] The 1944 Goodenough Committee on Medical Education had advocated a compulsory year of hospital-based training, however this was resisted by GPs who considered such training incurred a 'double financial penalty' of lost income and confinement in junior hospital posts.[436] The Liverpool Local Medical Committee enthusiastically greeted recognition of general practice as a 'special branch of medicine' at a 1953 meeting, despite remaining 'opposed to any form of compulsion' in postgraduate training.[437] Optional training was organised by the College of General Practitioners after its foundation in 1952, and was popular during the 1950s (peaking at 400 trainees nationally in 1957), however falling competition for posts led to a major decline (just 150 trainees in 1968).[438]

The merit awards system for hospital consultants, conceived in the first years of the NHS to entice high-earning consultants to join the service, further demonstrated how 'prestige [hospital] specialties' remained at the top of the professional hierarchy under the NHS. These financial awards were assigned to consultants on the recommendation of Regional Awards Committees and the Advisory

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[435] Bloom, "Structure and Ideology in Medical Education", 303; Digby, *The Evolution of British General Practice*, 63.

[436] Royal College of General Practitioners, "The Future General Practitioner, the report of a working party," (Torquay: Council of the Royal College of General Practitioners, 1971), 6.

[437] Drury, "The General Practitioner and Professional Organizations," 212-213; Liverpool LMC Committee Meeting 19 May 1953 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

[438] Rivett, *Cradle to Grave,* 240-241; the number of GPs per 100,000 population had risen from 42.3 in 1949 to 48.7 in 1959, see Stevens, *Medical Practice in Modern England*, 167, table 9.

Commission on Distinction Awards (ACDA), and were devised by Bevan and Charles Moran to induce the medical Royal Colleges to lend their support to the NHS.[439] The independent status of teaching hospitals before the 1974 reorganisation further enabled the preservation of a rigid intraprofessional hierarchy dominated by hospital practitioners.[440]

GPs vented their frustrations with the privileging of hospital investment instead of a much-needed plan for community medicine at the 1963 BMA meeting in Oxford.[441] In 1965, in the wake of a crisis that saw doctors threaten to resign *en masse* over their grievances, the BMA presented its 'Charter for the Family Doctor Service', which was signed the following year.[442] Labour Minister of Health Kenneth Robinson described the charter as 'the culmination of the first major review of the family doctor service since the start of the National Health Service'.[443] The charter introduced a practice allowance, loans to support group practices, building projects and administrative and nursing staff, alongside incentives to bring practitioners to areas of greatest need. The financial elements of the charter led Nicholas Timmins to claim GPs, who had long cherished their independence, were bound 'lock, stock, barrel and mortgage, to the NHS'.[444]

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[439] Ieuan Davies, "The National Health Service Consultants' Distinction Award Scheme-history and personal critique," *Proceedings of the Royal College of Physicians of Edinburgh*, 28.4 (1998), 517.

[440] Alec Merrison, *Royal Commission on the National Health Service* (London: HMSO, 1979_, 236; James Raftery, "Distinction and Merit Awards: A 100m Pound Management Tool?" *BMJ* 8th April 1989, 946; Davies, "The National Health Service Consultants' Distinction Award Scheme," 517–34; Klein criticised the merit awards system for privileging 'the most prestigious specialties where private practice flourished', Klein, *The New Politics of the NHS*, 109.

[441] Fox, *Health Policies, Health Politics*, 182.

[442] Timmins, *The Five Giants,* 218-224.

[443] "Annual Report of the Ministry of Health for the year 1966." (London: HMSO, 1967), 5-6.

[444] Timmins, *The Five Giants,* 222.

The modernisation of British general practice accelerated following the charter: only 28 health centres had been built since 1948, however over 700 were built in the decade after 1966, and the number of single-handed GPs declined by three quarters during the following 25 years.[445] Tudor Hart recalled the 'atmosphere of goodwill' which replaced the animosity between GPs and the NHS administration, as GPs were encouraged to take on secretarial staff, freeing them from unwanted administrative responsibilities to focus on areas such as preventive medicine and health monitoring.[446] Fifty years after the charter, Stephen Gillam claimed it was arguably of greater significance for GPs than the creation of the NHS itself.[447] Despite the changing dynamics of general practice, the autonomous status of GPs meant innovations were adopted at a varying rate across the medical community, and practitioners were able to insulate themselves from national reform.[448] This process is discussed in Chapter 7.

5.2: Local professional culture after 1948

Medical teaching

Continuities in the medical system after 1948 enabled key elements of local professional culture to remain largely unchanged during the early years of the NHS in Liverpool. Medical teaching provided an important channel for established members of the local professional community to influence students and young practitioners. Senior hospital consultants continued to enjoy considerable independence at the teaching hospitals, and provided an aspirational model for medical students on teaching firms. Keir Waddington highlighted the importance of student experience on later

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[445] Stephen Gillam, "The Family Doctor Charter: 50 Years On," *British Journal of General Practice* 67.658 (2017), 227.
[446] Gillam, "The Family Doctor Charter," 227; Tudor Hart, *A New Kind of Doctor*, 95.
[447] Gillam, "The Family Doctor Charter," 228.
[448] Rivett, *From Cradle to Grave*, 241.

professional identity, and oral history interviewees often reflected on their formative encounters with figures from the local professional establishment.[450]

The atmosphere on teaching firms was influenced by the consultant in charge, and oral history testimony revealed the survival of pre-NHS professional behaviour after 1948. Chest physician Anthony Seaton recalled the firm of physician Ronald Brookfield (1902-1974) during the late 1950s, Brookfield was born and educated in Liverpool and became honorary physician at the Royal Southern Hospital in 1945.

> We had to wait for him at the front door… He would come in, take his hat off and give it to one of us, his coat off and give it to another, we would hang it up in the consultants' cloakroom… He barely spoke to the houseman; he spoke mostly to the registrar and the registrar would then pass the message on to the houseman. He was very formal.[451]

Established figures in the local medical community (Brookfield arrived at the Southern in 1929) continued traditions from the voluntary hospitals after 1948.[452]

Some senior consultants acquired mythical status among students and junior colleagues, and several interviewees shared stories of the eccentricities of their teachers. Intensive care physician Anthony Gilbertson described the long-serving physician Eric Baker-Bates (1905-1986).

> [Bates was] a brilliant diagnostician, I don't remember him writing anything at all [publishing research] but he had sessions in 13 different places, we would go in the back of his Rolls Royce and he would slide the shutter

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[450] Waddington, "Mayhem and Medical Students," 45–64.
[451] Anthony Seaton, 22 August 2018.
[452] 'Ronald Winston Brookfield (1902-1974)' Obituary by ID Hay, *Munk's Roll* Volume VI, 66.

> shut if he wanted to concentrate on something or open it up and talk to us.[453]

Mike Cranney, a GP who trained in Liverpool in the 1970s, also recalled Baker-Bates.

> In my pre-registration house officer job in a little hospital called the Providence Hospital, St Helens… he was there and I was in the clinic talking to the registrar and he took a revolver out of his bag and said "if you don't shut up I'm going to shoot you" so we shut up.[454]

Such characters defined students and junior doctors' formative experiences of hospital practice, and informed notions of local professional identity. Intensive care physician John Coakley, who came from a medical family and began his studies in 1975, described these figures.

> In my time all these figures were legendary, Baker Bates…Eric Baker Bates evoked affection, what a great guy, great fun, made things fun.[455]

Some members of the local medical establishment had risen to positions of national leadership within the profession, and students were impressed by the achievements of their teachers. Urological surgeon Keith Parsons, who studied in Liverpool during the 1960s, recalled the feeling of entering a professional community with prominent leaders.

> It wasn't until we went into the hospitals that we really rubbed shoulders with the great and the good in Liverpool, there were three medical knights who were

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[453] Anthony Gilbertson, 20 August 2018. This story is corroborated in Baker-Bates' obituary, 'early every morning, Sundays included, he would set off in his Rolls Royce accompanied by as many students as the vehicle would hold.' 'Eric Tom Baker-Bates (1905-1986)' Obituary by Sir Gordon Wolstenholme and V Luniewska, *Munk's Roll* Volume VIII, 14.

[454] Mike Cranney, 25 May 2018.

[455] John Coakley, 31 May 2018.

> presidents of their respective royal colleges when we were there.[456]

John Coakley described similar experiences.

> I remember the physicians, I remember their names, their qualifications. One had MA, MB, MC, MD. He was at Oxford, so he got an MA as part of the medical degree, and MB for his medicine, an MC for his military cross from the war, and an MD.[457]

Professional memberships, college and BMA roles, and postgraduate qualifications all contributed to an intraprofessional respect. A scale of prestige also operated at local level, and therefore when Cyril Clarke replaced Henry Cohen as professor of medicine in 1963 he also moved hospital.

> There was no doubt that the Royal [Liverpool Royal Infirmary] was the top one in the pecking order, when Cyril Clarke became reader in 1958 he moved to the university then, he gave up his beds at the Northern [David Lewis Northern Hospital].[458]

The firm system introduced medical students to a particular conception of professional success, characterized by the dominance of hospital medicine and an awareness of the competitive aspects of the local medical community.

Consultants enjoyed almost dictatorial control over their teaching firms, and several interviewees recalled the occasionally hostile atmosphere this engendered. The 1942 Goodenough Committee had restricted exchequer grants to co-educational medical schools, and criticized the (often single-sex) London medical schools allied not to universities but to hospitals, which remained bastions of the male-dominated medical establishment.[459] In spite of these

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[456] Keith Parsons, 4 June 2018; the medical knights were Norman Jeffcoate, Cyril Astley Clarke and Arthur Gemmell.
[457] John Coakley, 31 May 2018.
[458] Bill Taylor, 14 March 2018.
[459] Rivett, *From Cradle to Grave,* 98-99.

changes, teaching in the early years of the NHS was still dominated by male consultants. A female GP who trained during the 1960s recalled the dearth of women in senior positions in the Liverpool hospital system.

> On the whole, surgeons and doctors were mythical figures… at the Mat [Liverpool Maternity Hospital) was Winnie Francis [1919-2011], she was a woman I could look to as a role model, there weren't many role models for us lady medical students in our year …none of them particularly inspired me… I was already married by the time I left.[460]

Institutional change was slow, and traditional figures such as Brookfield (who qualified in 1923) and Baker-Bates (1928) continued to influence medical students during the 1950s, 1960s and even 1970s.

Julian Tudor Hart claimed that 'hospital doctors felt no need for a new ideology' following the creation of the NHS, and recalled the 'feudal' relationships between consultants and juniors during the 1950s (Hart qualified from Cambridge and London in 1952).[461] Reflecting on her experiences of a teaching firm in Liverpool during the late 1970s, a female interviewee recalled the strange demands of a consultant.

> He explained to us that the idea was to see what a consultant lifestyle is like. [One student] had to chop firewood in [the consultant's] garden… This was just completely bonkers, lifestyle of a consultant yes- maybe some validity at that point, but what he was dragging us through was just, I don't know, I think he got some joy out of seeing our discomfort, it was so bizarre.[462]

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[460] Christine Brace, 27 March 2018.

[461] Tudor Hart, *A New Kind of Doctor*, 82.

[462] Janice Fazackerley, 9 May 2018; Rivett also discusses a culture of 'teaching by humiliation' which he argues may have

Several interviewees parodied the snobbishness of London medical schools, where attendance at an elite public school and sporting ability was considered necessary to succeed, however some consultants in Liverpool also conformed to these stereotypes. Anthony Seaton described his rapport with Liverpool's first professor of obstetrics and gynaecology Norman Jeffcoate (1907-1992).

> [Jeffcoate] played rugby in his younger days, had played scrum half for Cheshire…, he was always very happy if you were on his firm – I was on his firm – asked him if I could have an afternoon off to play rugby 'of course you can!'[463]

The social and sporting side of student life offered a conduit between male students and the predominantly male consultant community.

Several interviewees recalled an infamous local teaching tradition known as 'the circus', developed by chest physician Alick John Robertson (1919-2006, known to students and colleagues as 'Black Jack'), who graduated from Liverpool in 1942 and was appointed consultant at the Liverpool Royal Infirmary in 1954.[464] Undergraduates were assembled on Friday afternoons in the Liverpool Royal Infirmary, and two students selected at random would present a 'long' and 'short' case in front of their fellow students and a panel of consultants led by 'Black Jack'.[465] Interviewees described the terrifying atmosphere during these sessions, where Robertson and others subjected students to what Ian Gilmore described as 'teaching by ritual humiliation'.[466]

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disproportionately affected women, Rivett, *From Cradle to Grave*, 445.

[463] Anthony Seaton, 22 August 2018; general practitioner RA Yorke (interviewed 8th February 2018), recalled Jeffcoate as an avid sailor.

[464] 'Alick John Robertson (1919-2006)' Obituary by RCP Editor, *Munk's Roll* Volume XII, (web).

[465] Chris Evans, 6 March 2018.

[466] Ian Gilmore, 24 July 2018.

Anthony Seaton, who later followed Robertson as a chest physician, completed his clinical years in Liverpool before returning to Cambridge University to graduate in 1962, described the circus as a 'Liverpool invention'.

> There was certainly an attitude that you should beat someone into submission when you were teaching them – among some people.[467]

Chris Evans, who graduated from Liverpool in 1964, later joined Robertson on the panel of consultants alongside Robertson.

> I could not stand the pressure that Black Jack put on the students, he was brutal with them, not to say he wasn't right - because he was teaching them – but it was, *he* was brutal.[468]

John Ridyard, who graduated from Liverpool in 1968 recalled how "Black Jack used to screw people into the ground" during the sessions.[469]

Robertson held legendary status in the minds of many interviewees, either as a strict but effective teacher or intimidating bully. An anonymous interviewee who graduated from Liverpool in 1979 described a meeting of the circus during which a student was tasked with presenting a case of a man who "obviously had the beginnings or mid stage Parkinson's Disease" but was reluctant to give the diagnosis in front of the patient.

> AJ Robertson said 'well, what is the diagnosis?' Pushed and pushed him until the student said, 'Parkinson's disease' and Robertson said 'Yes, about time' and the patient said 'Doctor, please tell me I haven't got Parkinson's disease!' and went into a meltdown.[470]

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[467] Anthony Seaton, 22 August 2018.
[468] Chris Evans, 6 March 2018.
[469] John Ridyard, 31 May 2018.
[470] Anonymous Interviewee 4, 6 November 2018.

Janice Fazackerley, who graduated in 1979, described Robertson as 'very old and incredibly nasty' and the circus as 'a horrible experience. It was foul, I'm not sure that it really served a purpose.'[471]

Several interviewees reflected on the character-building nature of such teaching by humiliation. Rob Barnett, who graduated from Liverpool in 1983, described the circus as 'something that you dreaded' and claimed that 'in some ways it was cruel and probably sadistic'.

> In some ways it probably taught you a lot. Because you were torn to shreds you actually couldn't be humiliated any worse than that, you knew what was coming – if you survived that you were probably okay.[472]

Defenders of the circus claimed that such public testing introduced students the forms of assessment they would encounter later in their career. Ian Gilmore claimed the ordeal was suitable preparation for later professional examinations.

> I wouldn't have got through my MRCP so quickly in London had I not been taught by ritual humiliation![473]

The division between hospital medicine and general practice was formalized under the NHS. Frank Honigsbaum claimed that 'as the years [following the establishment of the NHS] passed, more and more GPs came to like the role which not only consultants but they themselves had fashioned'.[474] The firm system supported the division, and encouraged students to consider hospital appointments as the pinnacle of the profession. Alex Scott Samuel reflected on the perceived inferiority of general practice at the medical school.

> When I was a student, between 1966 and 1971, I don't think there was a department of general practice [this was

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[471] Janice Fazackerley, 9 May 2018.
[472] Rob Barnett, 6 July 2018.
[473] Ian Gilmore, 24 July 2018.
[474] Honigsbaum, *The Division in British Medicine*, 315.

> correct]. I think general practice was kind of a subsection of general medicine and not taken very seriously.[475]

Rob Barnett, who subsequently became a GP, recalled a similar environment.

> It wasn't a substantial part of the set-up [at the medical school]. General practice was definitely the poor relation, 'why would anyone want to do general practice?' was often the comment. When patients were referred in from GPs into hospital, the GP was looked down upon – there was no doubt about it.[476]

These traditions were fundamentally challenged by inquiries into the future of medical education. The 1968 Royal Commission on Medical Education, led by Lord Todd (1907-1997), questioned the hospital-centrism of the traditional medical curriculum, and advocated a new syllabus including sociological subjects, community medicine and general practice.[477] Todd addressed low levels of interest in GP careers among students: only about a quarter of final year students wanted to be a GP, despite the fact that about half would end up in the role.[478] The report recommended making medical education a university responsibility (rather than a duty of the hospital medical schools), and extending post-qualification professional training, and advocated the establishment of new medical schools, increasing the number of medical students, and placing teaching hospitals (which had enjoyed exceptional autonomy and prestige) under the control of the regional hospital service. Medical education remained central to the induction of students and practitioners into the local medical community, and the introduction and reinforcement of professional traditions.

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[475] Alex Scott-Samuel, 1 May 2018.
[476] Rob Barnett, 6 July 2018.
[477] Levitt, *The Reorganised National Health Service,* 93.
[478] Tudor Hart, *A New Kind of Doctor,* 90.

Private practice

Ongoing permission to engage in private practice was part of the settlement reached between the medical profession and Bevan in 1948 (he later claimed he had 'stuffed their mouths with gold').[479] Rudolf Klein described the resulting tension between 'institutionalised' private practice and the 'first article of faith' of the NHS that the 'delivery of healthcare should be divorced from the ability to pay.'[480] Private practice was the norm before 1948, and three quarters of consultants opted for part-time contracts at the start of the NHS.[481] The terms and conditions of private practice related to income, and consultants could remain full-time as long as their private practice income did not exceed ten per cent of their NHS salary (following which NHS pay was reduced to a 'ten elevenths' of full time – calculated as a proportion of the traditional five and a half day working week).

Young practitioners were aware of the range of commitments held by the preceding generation; John Bennett (b. 1934) recalled that prominent figures like Henry Cohen juggled professorial responsibilities, government and college roles, and a booming private practice.[482] Defenders of private practice claimed that the two systems complimented one another, with private provision meeting excess NHS workload and staffed by consultants operating around their NHS commitments.[483] Gordon Forsyth claimed in 1966 that 'the two

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[479] Quoted in Sheard, "A creature of its time," 435; Audit Commission for Local Authorities, and the National Health Service in England, *The doctors' tale: the work of hospital doctors in England and Wales* (London: HMSO, 1995), 38.

[480] Rudolf Klein, "The public-private mix in the UK" in *The public-private mix for health: plus ça change, plus c'est la même chose?* Ed. Alan Maynard (Oxford: Radcliffe Publishing, 2005), 44.

[481] Klein "The public-private mix in the UK", 45.

[482] Royal College of Physicians Interview with John Bennett, 7 May 2015; interviewees claimed Cohen had a huge and highly lucrative private practice in London and Liverpool.

[483] Yvonne Doyle, Justin Keen, and Adrian Bull, "Role of private sector in United Kingdom healthcare system" *BMJ* 2nd September

sectors are so intertwined as to be inseparable.'[484] Anonymous interviewee 2, who established a practice on Rodney Street during the 1970s, reflected on local attitudes towards private practice.

> There was a lot of lofty disdain for private practice in the NHS, as if you weren't earning the full shilling in your NHS work if you were preoccupied with private practice. I found it gave me a standard of personal behaviour, that you have to polite to people, or they won't pay you![485]

Elite private practice in Liverpool centred on Rodney Street, a terrace of Georgian townhouses that mirrored London's Harley Street as a 'medical precinct.'[486] Charles Herbert Reilly (1874-1948), professor of architecture at the university, wrote that the doctors 'have chosen…the one street in Liverpool in which we ordinary mortals would most like to live.'[487] Local practitioners continued to hold Rodney Street in high esteem and it remained synonymous with private medicine after 1948. Miles Irving (b. 1935), a Liverpool-trained professor of surgery at Manchester, described it as the 'fashionable district…which, both professionally and architecturally, was very much a rival to Harley Street'.[488] Comparisons with Harley Street were indicative of the local ambition to sustain a medical precinct in Liverpool, substantial status was attached to a Rodney Street practice, and provided important exposure for new arrivals to

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2000, 563; John Yates, *Why are We Waiting?: An Analysis of Hospital Waiting-lists* (Oxford: Oxford University Press, 1987), 54.

[484] Gordon Forsyth, *Doctors and State Medicine. A Study of the British Health Service*. (London: Pitman. 1966.), 180.

[485] Anonymous Interviewee 2, 24 May 2018.

[486] Charlotte Humphrey, "Place, Space and Reputation: The Changing Role of Harley Street in English Health Care," *Social Theory & Health* 2.2 (2004), 155; Shepherd, *A History of the Liverpool Medical Institution*, 48.

[487] Charles Reilly, *Some Liverpool Streets and Buildings in 1921* (Liverpool: Liverpool Daily Post and Mercury, 1921), 52.

[488] 'Lloyd Jones, William (1940 - 2013)' Obituary by Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 8 November 2013, modified 24 September 2014).

the city. Chest physician Chris Evans suggested establishing a private practice could be an important way of establishing local reputation.

> If you were not a Liverpool graduate… unless you had a plate [nameplate on Rodney St] how would people get to know you?[489]

Many leading consultants maintained lucrative private practices alongside their hospital and teaching appointments. This occasionally led to tension within the local medical community, and the perception that they were neglecting their NHS responsibilities. Younger practitioners that trained and worked solely within the NHS were less ready to accept the attitudes of senior colleagues towards the profession. Interviewees with no experience of the pre-1948 medical economy instead developed a professional identity influenced by broader social and cultural framing of medical work following the nationalisation of the service. John Yates outlined the number of 'fiddles' that had in some cases reached the status of 'NHS folklore' whereby consultants exploited NHS waiting times to encourage patients to receive private treatment, or failed to fulfil their contractual obligations within the health service.[490] A popular 'fiddle' was appropriating NHS equipment (or staff resources), to cover private practice commitments, Janice Fazackerley, who graduated in 1979, recalled working as a house officer for a consultant.

> He brought a great big bag of blood specimens with him and put them on the bench and we had to write names on them…this was putting the private bottles through on the National Health, I can appreciate now that he may have had some arrangement with the lab and was paying for it, but it's not the impression I got.[491]

Perhaps most importantly for this study, Yates noted cases of consultants 'who consistently delegate the running of the [NHS]

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[489] Chris Evans, 6 March 2018.
[490] Yates, *Why are We Waiting?* 55.
[491] Janice Fazackerley, 9 May 2018.

clinic to their juniors, rather than attend themselves.[492] Chris Evans remembered working for physician Gerard Sanderson (1912-1987) at the Southern Hospital in the late 1960s.

> He would do a ward round - let's say on a Wednesday afternoon at 2 o clock - at half past one I went down to the front door, he had just driven down from his rooms on Rodney Street, and would take his coat, pick up his case. I was a registrar, and I took it up to the ward, where Sister Noble had his egg sandwiches and coffee ready. He would walk on the ward and say, "is anybody ill?" he would have a fag and talk.[493]

Anthony Seaton remembered a disagreement with a neurological consultant for whom he was working in the 1960s.

> I rang RR Hughes [Robert Hughes, 1911-1991] up before the clinic and said, "my wife's in labour sir, do you mind if I get home a little early from the clinic so I can see her?" "I'm sorry Seaton, I can't come in and do my clinic today." I knew the b****** was in [his] Rodney Street [rooms].[494]

Donald Light provided a robust criticism of private practice within the NHS, describing the system of paying practitioners ten elevenths of a full time salary alongside their income from private work as a 'maximum-fudge contract' constituting a 'back-door strategy for expanding two-tier medicine.'[495] The coexistence of private and NHS practice, performed by the same practitioners, resulted in 'erosion of coverage, rationing behind closed doors, and reduced support for the NHS.[496] Writing in 1996, Light claimed that,

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[492] Yates, *Why are We Waiting?* 56.
[493] Group Interview on Medical Teaching, 28 January 2019.
[494] Anthony Seaton, 22 August 2018.
[495] Donald Light, "Betrayal by the surgeons," *Lancet*, 347(9004) (1996), 812.
[496] Donald Light, "From managed competition to managed cooperation: theory and lessons from the British experience," *The Milbank Quarterly* 75.3 (1997), 325.

> The NHS seems to be structured to encourage, through deliberate underservice, the managerial and professional classes to build up a parallel and parasitic set of private services. This practice has been allowed since its founding, but now the private loophole is being used more and more to facilitate short funding.[497]

Unsurprisingly, this perspective elicited a fierce response from practitioners engaged in private practice, a correspondent (from a Harley Street address), described Light's piece, published in the *Lancet*, as 'scurrilous'.[498] Nonetheless, interviewees did share cases of unscrupulous practitioners exploiting private practice for financial gain, anaesthetist Anthony Gilbertson described what he felt was unethical behaviour by a local practitioner.

> One of the worst ENT surgeons I ever met, his kids went to the same school as mine, the nuns worshipped him because he had a Rolls Royce, ninety per cent of his income was doing unnecessary tonsillectomies on children.[499]

The attempt in 1974 of Labour health secretary Barbara Castle to undermine private practice by offering a pay rise to full-time NHS consultants led to sixteen weeks of industrial action during which many consultants 'worked to rule'. Klein described the response of the consultants as reflective of the fact that 'private practice was a symbol of independence, reflecting their status as professionals as distinct from hired hands' (a conviction reinforced by the fact that at the time of the pay bed battle, part- time consultants earned some 20% more than full-timers).[500] The majority of interviewees were critical of what they felt to be the 'fiddles' employed by senior consultants during their time in training posts at Liverpool's NHS hospitals, nonetheless influential members of the local professional

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[497] Light, "Betrayal by the surgeons," 813.
[498] Leon Kaufman, "Betrayal by the surgeons (letters)." *The Lancet*, 347(9012), 1405.
[499] Anthony Gilbertson, 20 August 2018.
[500] Klein 'The public-private mix in the UK", 46.

establishment continued to sustain the traditions of private medicine in the city.

Conclusion

The introduction of the NHS in Liverpool exposed a number of tensions among the local medical community. The NHS remained a contested institution during its early years, with concessions to the medical profession over its structure and political disagreement influencing its early development.[501] The new service sustained intraprofessional divisions, notably through the continued independence of teaching hospitals and general practitioners. Liverpool's medical community retained various pre-NHS professional practices after 1948, and the local medical system perpetuated historic inefficiencies. John Welshman noted the Treasury's refusal to accept the remnants of the pre-NHS period as an 'immutable inheritance', however delays and financial issues obstructed hospital rationalisation in Liverpool until the 1970s (discussed in the following chapter).[502]

General practice in Liverpool after 1948 was defined by social and economic conditions in the city; economic decline, inadequate housing and underemployment contributed to poor health outcomes. The local GP community was dominated by older practitioners, and a large number of single-handed practices. The firm system of medical teaching ensured the local medical establishment continued to enjoy substantial influence over junior colleagues and medical students. Consultants had control over the promotion of junior practitioners, providing further disincentive for dissent, and the importance of references during the early stages of medical careers encouraged sycophantic behaviour. Interviews conducted by Isobel Allen for the

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[501] Webster, "Conflict and Consensus," 151.

[502] John Welshman, "Inequalities, regions and hospitals: The Resource Allocation Working Party," in *Financing Medicine* eds. Martin Gorsky and Sally Sheard, 227.

Department of Health with medical graduates from 1966, 1976 and 1981 revealed that a system of 'patrons' and 'sponsors' remained evident across the period.[503] Interviewees reflected on working for consultants during this period who engaged in private practice at the expense of their NHS commitments, and appeared to barely acknowledge the transition to the new state service (aided by the retention of considerable independence at the teaching hospitals).

This transition to the NHS did not bring about any immediate transformation of local professional culture in Liverpool, which instead continued to be influenced by local conditions and the professional establishment at the teaching hospitals and medical school. Nonetheless, interviewees' criticisms of what they considered to be questionable behaviour by senior colleagues is indicative of a cultural shift between practitioners 'native' to the NHS and older practitioners that had trained and worked before 1948. The rigid internal hierarchies of the hospital system were central to the maintenance of traditional professional culture, and members of the local professional establishment were able to exert considerable influence from positions of authority in Liverpool's teaching hospitals. The teaching hospitals continued to enjoy the same prestige (and occupied the same buildings) as they had as voluntary hospitals before 1948. The following chapter considers the attempt to rationalise the Liverpool hospital system during the first thirty years of the NHS, and the reaction of the local medical community to the implementation of ambitious government planning of medical services.

[503] Isobel Allen, *Doctors and Their Careers*, 116.

Chapter 6
Rationalizing Liverpool's hospitals, 1948-1978

Introduction

Liverpool's predominantly Victorian hospital buildings remained in use for decades after 1948, and the administrative separation between Regional Hospital Board and teaching hospitals under the NHS enabled the survival of a two-tier system. As the previous chapter indicated, senior consultants at the teaching hospitals continued to foster a traditional atmosphere of elitism and deference, and there was little evidence of substantial change resulting from the creation of the NHS. An outdated and uncoordinated national hospital estate was inherited in 1948: of a total of 2,800 hospitals, 45 per cent had been built before 1891 and 24 per cent before 1861.[504] The 1956 Guillebaud report revealed NHS expenditure was inadequate to maintain, let alone improve, the hospital system, however the absence of a coordinated plan resulted in the pursuit of small projects, and not a single new hospital was built in England and Wales during the first decade of the NHS.[505]

The Ministry of Health sent a team to the USA to study hospital design in preparation for a program of new hospital building in 1960, with the hope of boosting managerial expertise prior to new investment.[506] Ambitious rationalisation of the national hospital system followed the 1962 publication of the *Hospital Plan for*

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[504] David Allen, "An Analysis of the Factors Affecting the Development of the 1962 Hospital Plan for England and Wales," *Social Policy & Administration* 15.1 (1981), 3-4; Alistair Fair, "'Modernization of Our Hospital System': The National Health Service, the Hospital Plan, and the 'Harness' Programme, 1962–77," *Twentieth Century British History* 29.4 (December 2018), 548.
[505] Tony Cutler, "Economic Liberal or Arch Planner? Enoch Powell and the Political Economy of the Hospital Plan," *Contemporary British History* 25 (2011), 472.
[506] Allen, "An Analysis of the Factors Affecting the Development of the 1962 Hospital Plan," 9.

England and Wales published by Conservative Minister of Health Enoch Powell (1912-1998). Rudolf Klein described Powell's hospital plan as 'the child of a marriage between professional aspirations and the new faith planning' that was nonetheless burdened by politically toxic hospital closures and the 'social costs of building large technological palaces'.[507] Hospital rationalisation in Liverpool was influenced by leading professional figures and a range of national considerations, notably the 1974 NHS reorganisation and reports of the Resource Allocation Working Party in 1975 and 1976.

Hospital rationalisation had substantial implications for the local medical community, as established hospitals were bastions of professional prestige, medical teaching, and felt to be representative of local professional heritage. The replacing of the former voluntary hospitals in 1978 provided a point of departure with established institutional networks, and changes throughout the city provided the opportunity to consider the future direction of local professional culture. Section 1 of this chapter considers the plans for hospital reform developed by local practitioners and submitted to government, and their modification and refinement in response to the 1962 hospital plan. Section 2 explores the challenges faced during the implementation of hospital rationalisation in Liverpool, and the concerns of the medical profession around site closures, relocation of staff, and uncertain future of hospital medicine in the city.

6.1: Hospital Planning in Liverpool

Early plans for the Liverpool hospital system

Liverpool's voluntary hospitals amalgamated as a single administrative unit, the 'Royal Liverpool United Hospital', in 1938, and immediately published plans for a new central hospital. The chairman introduced the first annual report by outlining how a new hospital, 'in which all that is best in the existing four hospitals will be renewed and revitalized, is the inspiration of all our present

[507] Klein, *The New Politics of the NHS*, 67-68.

labours'.[508] The Royal Liverpool United Hospital was supported by the city's leading medical practitioners, nonmedical figures and representatives from funding bodies such as the Merseyside Hospitals Council and the London, Midland and Scottish Railway Hospital Fund. The voluntary hospitals were the focus of substantial professional and civic pride for both medical practitioners and nonmedical citizens, the proposal for a new hospital therefore drew the interest of a range of stakeholders. The outbreak of WWII prevented any action being taken on the plans however, and in 1948 the Royal Liverpool United Hospital was brought under the control of an NHS Board of Governors and renamed the United Liverpool Hospitals (ULH).

As a teaching hospital group, the ULH enjoyed administrative separation from the Liverpool Regional Hospital Board, and was accountable directly to the Ministry of Health. Among the final actions of the Royal Liverpool United Hospital (on 28th June 1948, mere days before the creation of the NHS on 6th July), was the publication of a development plan for a new hospital, which was approved in principle by the NHS Board of Governors in September 1949.[509] The plan, *A Medical Teaching Centre for Liverpool,* repeated aspirations for a single teaching hospital, and its approval in principle by the Board of Governors indicated the continued viability of the pre-NHS document. The plans were expanded with the support of other stakeholders to produce a city-wide vision of hospital reform, and in 1955 a joint committee of the Board of Governors, Liverpool RHB and the university issued the Ministry of Health with their *Statement of a Liverpool Area Twenty-five Year (1955-1980) Hospital Development Plan*.[510]

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[508] Royal Liverpool United Hospital, "1938 Annual Report" [LRO: 362.115 ROY].

[509] United Liverpool Hospitals, *A Medical Teaching Centre for Liverpool* (Liverpool: Tinling, 1949), Preface.

[510] Liverpool Regional Hospital board, United Liverpool Hospitals, and University of Liverpool, 'Statement of a Liverpool Area Twenty-

The revised and expanded plan reiterated the need for a new teaching hospital to replace the four 'obsolescent' former voluntary hospitals, alongside a consideration of how services in other areas of the city might be coordinated.[511] The first stage of the plan was to move 250 beds from Walton to Fazakerley hospitals (in north Liverpool), the conversion of 200 beds at Alder Hey Children's Hospital to adult use, and the first instalment of the new teaching hospital (which would 'release' the Stanley and Northern hospitals) by 1965. The second stage involved the completion of another 200 beds at the new hospital, thereby 'releasing' the Southern and enabling the Liverpool Royal Infirmary to reduce in size to 300 beds, achieving an 800-bed split-site hospital by 1970. The final stage involved building a new 600-bed hospital at Speke to serve the new residential areas of South Liverpool, enabling the reduction in size of Sefton General Hospital.[512]

The Ministry of Health responded in May 1956, informing the committee that while they welcomed the attempt at planning (and that Liverpool was the only region to have submitted such detailed proposals) the sheer scale and cost of the scheme precluded immediate action. They acknowledged that the 'dispersal of teaching facilities' across four hospital sites in Liverpool was far from ideal, and advised the committee to consider how the plans might be

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five Year (1955-1980) Hospital Development Plan, Jointly approved by the Liverpool Regional Hospital Board, the Board of Governors of the United Liverpool Hospitals and the University of Liverpool and submitted to the Minister of Health', (September 1955), 6. [LRO: 362.061 REG].

[511] "Statement of a Liverpool Area Twenty-five Year (1955-1980) Hospital Development Plan," 10.

[512] "Statement of a Liverpool Area Twenty-five Year (1955-1980) Hospital Development Plan," 11-12; The dire condition of some wards at Sefton General Hospital had been raised in the House of Commons in 1970 by local Conservative MP Tim Fortescue (1916-2008), HC Deb 11 May 1970 vol. 801, col. 800.

implemented in smaller instalments.[513] The new teaching hospital was identified as the first priority, estimated to cost around £1.4 million, accommodating a gynaecological unit, two medical and two surgical firms.[514]

Local surgeon John Howell Hughes (1908-1998) was selected as chairman of the project and commissioning team for the new hospital. Hughes was one of four consultants who met weekly to discuss progress during 1959-60 and travelled monthly to London to liaise directly with the Ministry.[515] Liverpool-trained architect William Holford (1907-1975) was instructed to design the new hospital, McAlpine and Son won the building contract in 1965, and a completion was date set for 1972, however financial woes at McAlpine led to the transfer of the contract to another firm in 1968 (which collapsed in 1975), before Bovis Ltd were brought in to complete the project. The Royal Liverpool University Hospital finally opened in October 1978.[516] The challenging task of completing the new hospital is discussed in Section 2 of this chapter.

The 1962 Hospital Plan

The Ministry of Health rejected the ambitious initial proposals from the ULH for major hospital building in Liverpool in 1955-6, several years before the appointment of Enoch Powell as Minister in 1960. Powell published his ambitious *Hospital Plan for England and Wales* in 1962, outlining hopes for increased efficiency through modern design and administration, and part of broader government 'planning' during the period, characterized by Glen O'Hara as having

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[513] United Liverpool Hospitals, "Report of the Joint Planning Committee on the Proposed New Teaching Hospital" (April 1957) [LRO: 614 AHA/6/2/9].

[514] United Liverpool Hospitals, "Preliminary Schedule of Requirements for the New Teaching hospital" (February 1960) [LRO: 362.11 UNI].

[515] John Howell Hughes, *A Surgeon's Journey* (Denbigh: Gee & Son Ltd., 1989), 127-128.

[516] Howell Hughes, *Surgeon's Journey*, 128-130.

a 'long time-span, universal coverage, and a large degree of optimism concerning delivery'.[517] The hospital plan called for 90 new hospitals (alongside upgrading a further 134) and introduced the district general hospital (DGH) model of 600-800 bed hospitals serving a population of 100,000 to 150,000. The plan also proposed a reduction in the number of hospital beds from the pre-1962 average of 3.9 (per 1000 population) to 3.3, a figure that was lowered again in 1966, Liverpool faced a reduction in bed numbers of 39 per cent, the highest proportion in the country (discussed in the previous chapter).[518]

At local level, Regional Hospital Boards were often resentful of government intrusion into the organization of local services. High initial costs became difficult to defend in the economic recession of the mid-1970s, and standardized buildings designed by technocratic planners fell from favour.[519] Low-cost, 'Best Buy' hospitals provided an alternative to more ambitious designs, and a less prescriptive 'Nucleus' model, which was more palatable to local administrators, grew in popularity during the 1980s.[520] Charles Webster condemned Powell's ambitious plan as unrealistic, and built on 'slender intellectual foundations' which understated required expansion and overstated prospective gains.[521] Ultimately, rising costs eventually

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[517] Glen O'Hara, *From Dreams to Disillusionment: Economic and Social Planning in 1960s Britain*. (Basingstoke: Palgrave Macmillan, 2007), 1-3; Richard Biddle, "From Optimism to Anger: Reading and the Local Consequences Arising from the Hospital Plan for England and Wales, 1962," *Family and Community History* 10 (2007), 7.
[518] Rivett, *From Cradle to Grave,* 175-177, (The downward revision in bed allocation was due to falling lengths of stay resulting from new treatments and drugs); "The Liverpool Study - an Enquiry into the Dynamics of Medical Care," Table 2.2.
[519] Biddle, "From Optimism to Anger," 15; Fair, "'Modernization of Our Hospital System,'" 572.
[520] Fair, "'Modernization of Our Hospital System,'" 574.
[521] Webster, *The National Health Service: A Political History*, 45.

resulted in the scaling-down of the 1962 hospital plan to a more modest 'programme' of development.[522]

6.2: Rationalising the local hospital system

Coordinating Liverpool's hospitals

The detailed city-wide plans submitted by the teaching hospital Board of Governors, RHB and university (that were rejected by the Ministry of Health in 1956) were revised to a more modest focus on the new teaching hospital. The Logan study into the use of health resources in Liverpool, discussed in the previous chapter, identified major problems: Liverpool's hospitals were over-bedded and over-staffed, which led to high rates of admission and overlong hospital stays, and the ready availability of beds relieved pressure on general practice, which was allowed to stagnate as a result.[523] The outdated condition of the hospitals was a matter of public knowledge. An article published in the local press in 1962, the year of Powell's hospital plan, described the 'time-wasting, improvised conditions' at the old buildings that imposed limits on effective medical practice.[524]

In 1970, the RHB circulated plans for hospital rationalisation in North Liverpool, an area divided between two hospital management committees and containing many small hospitals alongside the large former workhouse infirmaries. The North Liverpool HMC included the Walton, Bootle, Stanley, Waterloo, and John Bagot Hospitals, with a combined total of 1324 beds. The

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[522] Cutler, "Economic Liberal or Arch Planner? Enoch Powell and the Political Economy of the Hospital Plan," 483.

[523] "The Liverpool Study - an Enquiry into the Dynamics of Medical Care," 5.

[524] "A Century of Medical Progress" (Supplement) *Liverpool Daily Post* September 10, 1962; the embrace of the 'planning' philosophy towards human resources in post-WWII hospital design is discussed in David Theodore, "'The Fattest Possible Nurse': Architecture, Computers, and Post-War Nursing" in *Hospital Life: Theory and Practice from the Medieval to the Modern*, eds. Laurinda Abreu and Sally Sheard (Oxford: Peter Lang, 2013).

nearby Fazakerley and District HMC contained the Fazakerley Maternity Unit, Fazakerley, Aintree and Sankey Hospitals, with a combined bed total of 806. The RHB sought to unify the two HMCs and rationalise services at Walton and Fazakerley, which were to be considered as one District General Hospital on two sites (see Figure 6.1).[525] The RHB was able to gradually phase out several small, outdated hospitals in favour of the larger DGH. The Stanley Hospital (which closed in 1976) was a priority for closure due to the high cost of maintaining a small site with a mere 49 acute beds. The least integrated hospital in the area was the John Bagot, with no acute beds and 184 geriatric/psychiatric long-stay beds.[526]

The RHB submitted rationalisation plans for the Central and Southern districts of Liverpool to the DHSS in 1972, in anticipation of the new teaching hospital, and considering its effect on the existing system.[527] The report began with an outline of how the existing hospitals were unsuited to changing local demography.

> Hospitals…tended to be concentrated in the centre of the city where they were within easy reach of the densely populated but poorly housed areas and close to the industrial complexes which supported them…Since the 1950s there has been a progressive outward migration of the population to new housing and industrial developments in the North, South and East of the

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[525] Liverpool Regional Hospital Board, "Rationalisation of Services in North Merseyside Hospital Management Committee, report of the senior administrative medical officer" (November 1970) [LRO: 614 WTL/6/1].

[526] Liverpool RHB, "Rationalisation of Services in North Merseyside Hospital Management Committee." [LRO: 614 WTL/6/1].

[527] Liverpool Regional Hospital Board and Board of Governors, United Liverpool Hospital, "Reorganisation and Rationalisation of Hospital Services in Southern and Central Liverpool," (1972) [National Archives, Kew. Department of Health and Social Security: BN 13-249 - Minister of Health, Closure or change of use of hospitals, 1970-72].

> city…leaving the centre …with a surplus of hospital facilities.[528]

Falling population in the city centre led the RHB to recommend the administrative unification of the Central and Southern districts, while increased capacity at Fazakerley DGH would enable a reduction of beds at Sefton General and the closure of the small Crofton and Hahnemann hospitals. The new teaching hospital would replace the Northern, Southern, and Royal Infirmary, and any adverse effects of the closures were promised to be offset by the development of 'comprehensive community health services' that would relieve pressure on admissions (see Figure 6.2).

The DHSS cautioned in 1972 that the plans were heavily reliant on the timely opening of the new hospitals, and suggested any closures should wait. Nonetheless, George Godber, Chief Medical Officer, noted the urgent need for reform in Liverpool, claiming that 'apart from South Wales I do not know of another part of the country where everything was bad with quite the same monotony at the beginning of the health service'.[529]

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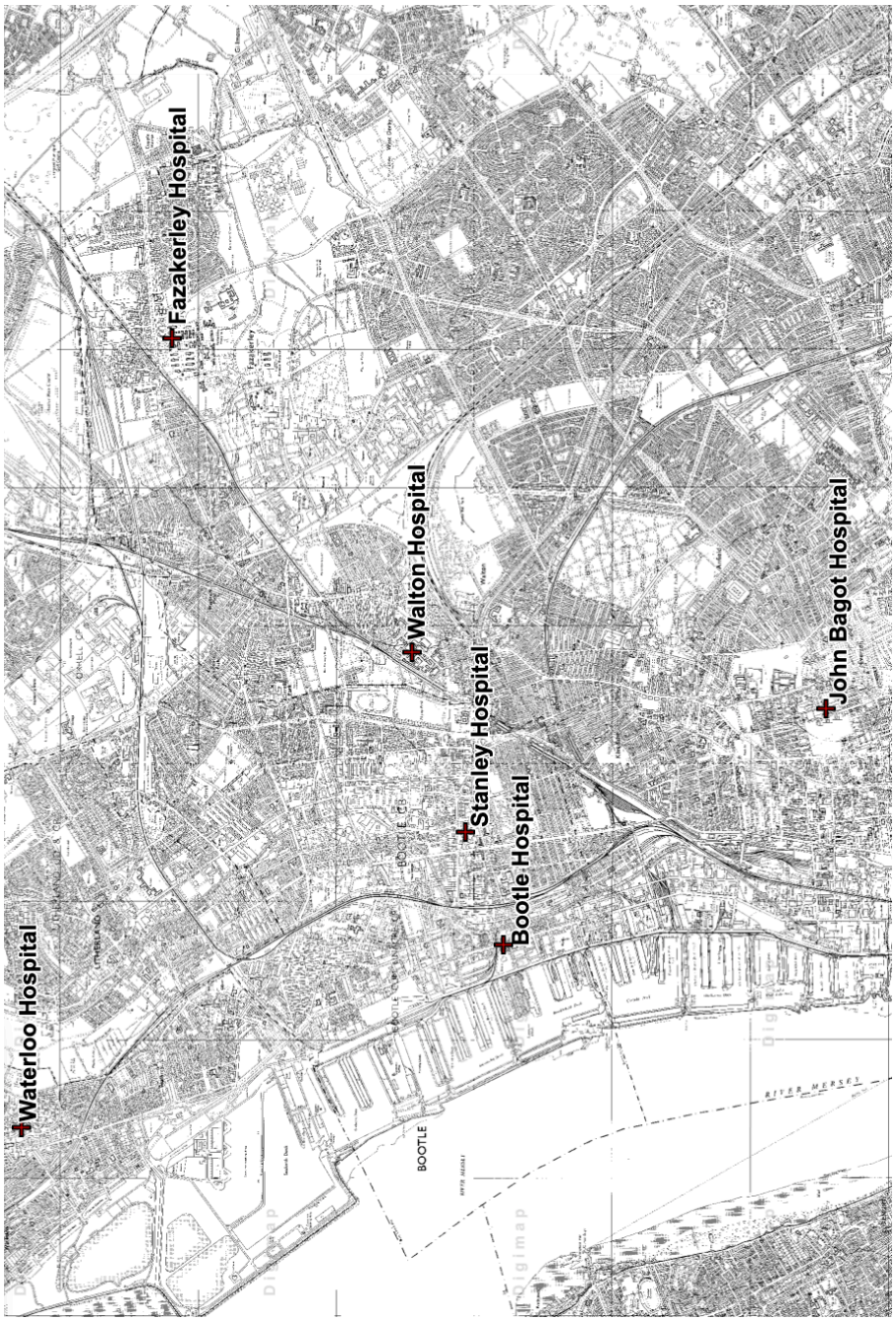
[528] Liverpool RHB and Board of Governors, United Liverpool Hospital, "Reorganisation and Rationalisation of Hospital Services," para. 1.3. [National Archives, Kew. Department of Health and Social Security: BN 13-249 - Minister of Health, Closure or change of use of hospitals, 1970-72].

[529] Letter from George Godber to Sir Philip Rogers, 5 September 1972 (appended to LRHB Report 31st August 1972 [National Archives, Kew. Department of Health and Social Security: BN 13-249 - Minister of Health, Closure or change of use of hospitals, 1970-72].

Figure 6.1: Map of North Liverpool hospital rationalization[530]



[530] Map adapted from British National Grid (EPSG:27700), 1970, scale: 1:20,000. Accessed at www.digimap.edina.ac.uk.

Figure 6.2: Map of Central and Southern Liverpool hospital rationalization[531]

[531] Map adapted from British National Grid (EPSG:27700), 1980, scale: 1:10,000. Accessed at www.digimap.edina.ac.uk.

Planning in the reorganized NHS

Repeated delays meant that the new Royal Liverpool University Hospital was still under construction at the time of the 1974 NHS reorganization, which established new administrative structures that led to a final round of revisions to local rationalization plans. The reorganised NHS replaced the 14 Regional Hospital Boards and 36 teaching hospital Boards of Governors (which lost their special status) with 14 Regional Health Authorities, 90 Area Health Authorities and 192 districts (see Figure 6.3). In June 1976, the Liverpool AHA circulated an ambitious revision of earlier rationalisation plans, and drew particular attention to the massive disparity in investment between hospital and community medicine. Hospital expenditure in 1972/73 was £43.99 per capita, the highest in England, whilst expenditure on community services was £2.73, 'next to the lowest in the country'.[532]

The AHA document led to concern among the local medical community, especially in relation to the renewed commitment to close hospitals (despite the delayed opening of the Royal Liverpool). The ending of special status for the teaching hospitals also implicated the local professional elite in regional planning to a greater degree than had been the case under the two-tier system of Regional Hospital Boards and teaching hospital Boards of Governors. Cecil Gray, Dean of the Faculty of Medicine (1970 - 1976), opposed the reallocation of funding (despite the huge imbalance) from hospitals to community medicine, and argued for continued investment in the teaching hospitals.

> The concentration of hospital and medical manpower in the teaching district of Liverpool [is] a prerequisite to the standard of excellence which is expected and must continue to be expected in a teaching district… The

[532] Liverpool Area Health Authority (Teaching): **"**A Framework for an Area Strategic Plan: A document for consultation" (June 1976), paragraph 5.

> tendency to aim for equality at the expense of excellence can only result in a generalized decline of service in all parts of the National Health Service.[533]

Calls for special treatment of the teaching hospitals indicated the desire among some consultants to preserve the autonomy they enjoyed before 1974, and university figures framed hospital spending as necessary in order to meet the needs of medical teaching.[534] In spite of their protestations, university figures agreed that the need to modernise hospitals 'antiquated in structure' remained as relevant in 1976 at it had been in 1938, and were keen to show their support for increased investment in community care and general practice.

Hospital staffs at the various sites scheduled for closure were concerned by the immediate consequences of the AHA plan. Representatives from the Central and Southern Hospital District were keen to 'avoid a deterioration of staff morale' by ensuring clarity over their future as soon as possible. Demoralisation had already set in at the David Lewis Northern Hospital, where the medical board convened an emergency meeting in August 1976 to plead for the postponement of its closure until the Royal Liverpool was operational, and regretting that 'the mere reference to closure has started a train of rumours which can only lead to…loss of staff morale.'[535] The Eastern District reminded the AHA of the troubled history of hospital planning in Liverpool, warning that 'any plan which is alleged to last for 10 years will never be fulfilled in more

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[533] Liverpool Area Health Authority (Teaching), "Comments on the Liverpool Area Health Authority Consultative Document: 'A Framework for an Area Strategic Plan 1976-1986," (Introduced with letter from Cecil Gray, dean of the Faculty of Medicine) – approved by the Board of Clinical Studies and the Board of the Faculty: 20th October 1976, Introduction [LRO: 362.10942753 LIV].

[534] "Comments on the Liverpool Area Health Authority Consultative Document," paragraph 4.

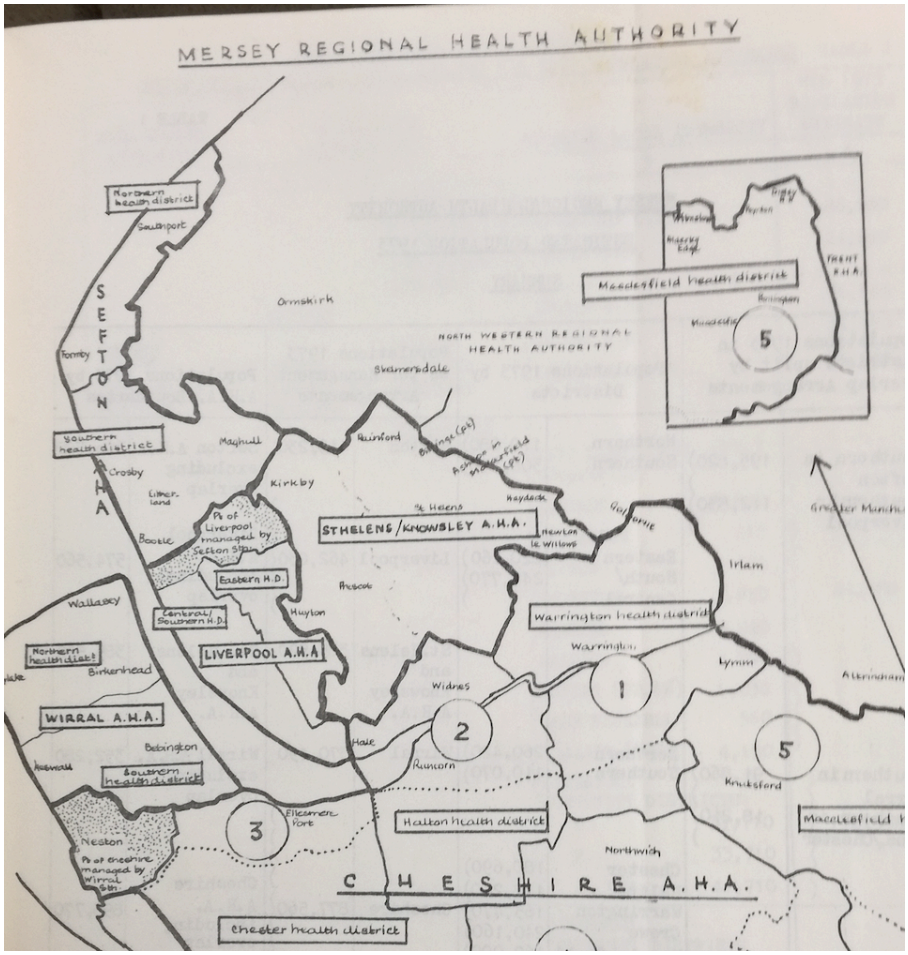
[535] David Lewis Northern Hospital, "Memorandum concerning the Area Strategic Plan 1976-1986 from the Medical Board of the David Lewis Northern Hospital" [LRO: 362.10942753 LIV].

than a small percentage of its ideals and hopes' (the Medical Executive Committee noted that '10 wards at Broadgreen [Hospital] were built in 1941 with a 10-year life… they are still, 35 years later, in use'.)[536]

The newly-established AHA was faced with the daunting task of coordinating the new teaching hospital (already a delayed and over-budget work in progress), with city-wide plans that had originated with the RHB. The introduction of new tiers of management following the 1974 reorganisation represented another step in the iterative process of medical practitioners, especially the elite at teaching hospitals, being drawn into local medical administration.

[536] Liverpool Area Health Authority (Teaching) Eastern District, "Comments of Divisions of the Medical Executive Committee relating to 'A Framework for an Area Strategic Plan 1976-1986" [LRO: 362.10942753 LIV].

Figure 6.3: Mersey Regional Health Authority[537]



[537] Mersey Regional Health Authority, "Year Book" (1975) [LRO: HQ 362.061 MER].

Practitioners' responses to rationalisation

One of the key aims of the rationalisation of Liverpool's hospital system was the coordinated distribution of specialist departments. The Royal Liverpool University Hospital was equipped with a range of specialist departments, in contrast to the tradition of general medicine-focused hospitals of the United Liverpool Hospitals. The specialisation of hospital medicine was a source of tension amongst practitioners, as some traditionalists felt specialism threatened to fragment the profession.[538] Marian Döhler described the reservations of the medical establishment, who valued the 'homogeneity, and not internal differentiation' of the profession, and favoured traditional bedside diagnosis, in contrast with innovators advocating specialized, scientific medicine.[539] This tension was observable in Liverpool, where some practitioners with specialist inclinations were obstructed by the local professional establishment. David Bowsher (1925-2011) described fellow neurologist Robert Hughes' struggles to develop his specialty after being appointed to the Royal Southern Hospital (one of the United Liverpool Hospitals) in 1946.

> The Liverpool medical establishment held to the tradition of the general physician who could deal with any disorder of any system; the notion of specialists…was heavily frowned upon.[540]

This atmosphere influenced the succeeding generation. Chest physician Anthony Seaton recalled working as a junior doctor during the 1960s.

> Most of us who chose to go in for medicine saw ourselves as becoming general physicians but with an interest in

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[538] Casper and Welsh, "British Romantic Generalism", 154.
[539] Döhler, "Comparing National Patterns of Medical Specialization," 186; Christopher Lawrence, "Introduction" in. *Regenerating England: Science, Medicine and Culture in Inter-War Britain,* ed. Lawrence and Mayer, 11.
[540] 'Robert Roland Hughes (1911-1991)' Obituary by D Bowsher, *Munk's Roll* Volume IX, 253.

> something, in those days you had to make your own training plan… You just applied for jobs and if you got them you then learned about that specialty.[541]

The model provided by leading consultants was that of the *general* physician or surgeon, however the pace of growth in hospital specialism fundamentally undermined the viability of this way of working.[542]

> Most people were general physicians who knew a bit more about one aspect of medicine and you wouldn't call them specialists nowadays. They knew a bit more about kidneys or a bit more about the liver or something like that…it was becoming more technological and so to become a proper specialist you had to master some special thing…The sixties was the start of that specialism.[543]

Despite the reservations of some figures in the professional establishment, the growth of medical specialization proved exponential, and the increasing volume of specialist research publications demanded practitioners spend more time studying to keep up to date.[544] It became increasingly clear that only exceptional individuals, such as David Weatherall (1933-2018) who graduated from Liverpool in 1956 and was appointed Regius Professor of Medicine at Oxford University in 1992, were able to excel as both general clinicians and specialized academic researchers. Physician John Turner reflected on the

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[541] Anthony Seaton, 22 August 2018.

[542] Stanley Reiser, *Medicine and the Reign of Technology*. (Cambridge: Cambridge University Press, 1981).

[543] Anthony Seaton, 22 August 2018.

[544] Research funding, either by bodies such as the Medical Research Council (UK) or National Institutes of Health (US) or a number of pharmaceutical firms, boomed during this period, see George Mandel and Elliot Vesell, "From Progress to Regression: Biomedical Research Funding," *Journal of Clinical Investigation* 114.7 (October 2004), 872–76.

transition between generalism and specialism during this period.

> That tradition [of general medicine'] is still there with somebody like Weatherall, who managed to be an Osler-type clinician alongside a leading molecular medicine scientist.

William Bynum described Canadian physician William Osler (1849-1919) as a man of 'clubbable instincts', with broad cultural and intellectual interests alongside medicine, and a polymathic figure that represented the 'old school'.[545] The rise of specialism led to a crisis of identity between traditional indicators of professional expertise and the new interest in clinical research. Turner described the transition as a 'paradigm shift.'

> It was very difficult if you were Lord [Henry] Cohen, or Keith Brown [Ian Keith Brown, 1929-1988]. Keith Brown was the nicest, most loved and revered physician…and very good because he had time for administration and time for management and time for teaching… In a pure academic environment if your research output is not up to it, it doesn't matter how good a teacher you are, it's the research output that dominates… [It was] almost a paradigm shift in what is valued.[546]

Local medical leaders exerted substantial influence over the development of the hospital system prior to rationalisation. Foremost among them was Henry Cohen, described by Cecil Gray as the 'kingpin of Liverpool', he was knighted in 1949 and entered the

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[545] John Turner, 21 August 2018; 'Osler, Sir William (baronet) (1849-1919)', entry by WF Bynum. Published in print 23 September 2004, published online 23 September 2004. Version: 24 May 2008. <http://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-35340?rskey=z1BKCx&result=6> [accessed 6 February 2020].

[546] John Turner, 21 August 2018.

House of Lords (the first provincial physician to do so) in 1956.[547] A local rumour, repeated by many interviewees, suggests Cohen made a life-saving diagnosis on a relative of Bevan, which won his enduring favour; among Cohen's many professional honours was the presidency of the BMA (1951), GMC (1961-1973) and RSM (1964).

Cohen was widely regarded as an opponent of specialisation, and obstructed the development of a central hospital that accommodated specialist units in Liverpool. Cohen outlined his views during the presidential address to the annual meeting of the BMA in 1950, held in Liverpool, claiming that with 'narrower and more rigid specialisation… the interests of our consultants are becoming more and more confined.'[548] Cohen's outlook, informed in part by his own extraordinary clinical ability, echoed earlier professional concerns with the perceived intrusion of specialism into the 'clinical art' of medicine, and in his 1966 Nuffield lecture to the Royal Society of Medicine he reiterated his belief in 'the creative imagination which the great scientist shares with the great artist'.[549]

Cohen conferred considerable prestige on Liverpool's medical community as a result of his national fame, and effectively silenced opponents of his generalist philosophy of hospital medicine. John Turner described him as a 'dominant figure, there's no doubt about it – a very, very powerful figure and certainly helped Liverpool's development and reputation.'[550] Chris Evans, a chest physician at the

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[547] The Royal College of Physicians and Oxford Brookes University Medical Sciences Video Archive, MSV A 138, "Professor T Cecil Gray CBE KCSG FRCP FRCS FRCA in interview with Dr Max Blythe, Oxford, 28 August 1996, Interview One."

[548] Henry Cohen, "Medicine, science, and humanism: Reflections on the first half of the twentieth century" (Presidential Address to BMA annual meeting Liverpool and Southport, 1950), printed in *BMJ*, 20th July 1950, 182.

[549] Henry Cohen, "The Fruits of Error and False Assumption" (Nuffield Lecture), *Proceedings of the Royal Society of Medicine* 60 (July 1967), 682.

[550] John Turner, 21 August 2018.

Royal Southern Hospital and later at the Royal Liverpool Hospital, claimed Cohen had stifled the rational development of Liverpool's hospitals.

> The Liverpool hospital system remained shambolic…because Cohen was of such great influence that at the old Royal Infirmary, where he reigned supreme on account of his great clinical skills and his great political skills and his name, he had to remain the boss. So he absolutely eschewed specialization.[551]

As a result of Cohen's opposition, specialist units were instead established at various hospitals peripheral to the Royal Infirmary. An anonymous interviewee recalled that while the Royal Infirmary 'had the great names like Henry Cohen, and then [Cyril] Clarke' it nonetheless remained 'a central hospital without specialties'[552] David Wong, an ophthalmic surgeon at St Paul's Eye Hospital (which relocated to the Royal Liverpool in 1992), shared this impression.

> Liverpool was, from the days of Lord Cohen, all over the place: cardiac in Sefton, cardiac surgery and chest surgery at Broadgreen, neuro at Walton, and the Women's separate as well – there was no single unit.[553]

Urological surgeon Keith Parsons, who became chief executive of the Royal Liverpool University Hospital between 1995-1999, asserted that the unsatisfactory state of affairs reflected Cohen's philosophy that, 'the generalist was king, and the specialist was his servant'.

> [It was] completely the wrong way round, in other cities all the specialties came in to make up the big hospital in the middle, and generalists were left out on the edge because that was all they were good for, the model we got was different, it was kind of an inverted model. Solely on the personality and

[551] Chris Evans, 6 March 2018.
[552] Anonymous Interviewee 5, 3 April 2019.
[553] David Wong, 3 August 2018.

forcefulness of Lord Cohen, that's why the hospitals were where they were.[554]

The growth of specialization was a gradual process across Britain, nonetheless the opening of the new teaching hospital (a year after Cohen's death) offered a clear point of departure from earlier practices. The opening of the Royal Liverpool in 1978 was a departure from the local tradition of relegating specialties to peripheral hospitals, and was indicative of the growing influence of national and regional planners, rather than the views of local professional elites.

Opening the Royal Liverpool

In 1977, and amid continued delays to opening of the Royal Liverpool University Hospital, the newly created Mersey Regional Health Authority commissioned an inquiry into the Liverpool AHA . The inquiry was chaired by Roger Dyson, professor of adult education at Keele University, and collected evidence from local practitioners, professional bodies, Community Health Councils (the patients' groups created in 1974) and trades unions.[555] The timely opening of the new hospital was obstructed by the atmosphere of 'guerrilla warfare' between AHA management and hospital staff: between June 1976 and September 1977 there were more than thirty strikes among members several unions, including NUPE (National Union of Public Employees), NALGO (National Association of Local Government Officers), COHSE (Confederation of Health Service Employees), GMWU (General and Municipal Workers Union) and ASTMS (Association of Scientific, Technical and Managerial Staffs).[556] One of the key terms of reference of the Dyson inquiry was

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[554] Keith Parsons, 4 June 2018.

[555] "Report of a committee of inquiry to examine the management and development of health service resources and the conduct of industrial relations in Liverpool Area Health Authority (Teaching)" [LRO: 362.061 MER, 1978].

[556] Dyson Inquiry, 44.

to make recommendations on how to improve industrial relations between the AHA and trades unions.[557]

Dyson claimed that the disintegration of industrial relations was, alongside national economic conditions, related to the planning and delivery of hospital rationalisation in Liverpool. The local hospital system remained dogged by historic inefficiencies, and suburbanisation had resulted in the decline of the inner city, leaving a greater proportion of elderly, unskilled and unemployed residents in the central urban area making greater demands on services.[558] Over-use of existing hospitals was attributed to a moribund culture of local general practice; almost a third of GPs in Liverpool were working single-handedly, and a fifth were aged over 60.[559] These issues were compounded by the lack of support for general practice at the university, especially in the inner-city,

> The University was proud of the high proportion of its graduates that worked within a 40-mile radius of the city centre. It should be seeking to encourage a few more of its graduates to work within a 10-mile radius.[560]

The lack of academic interest in general practice undermined local reform, and Dyson claimed the 'Liverpool Dilemma' lay in the difficulty of invigorating primary care when all investment and energy was occupied with the opening of the new teaching hospital.

The financial decisions of the AHA were further complicated by the reports of the Resource Allocation Working Party (RAWP), a new funding formula announced by the Labour government in July 1975. Geoffrey Rivett described the function of RAWP as the reallocation of 'regional resources in relation to health care need,

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[557] Charlotte Gray, "The Liverpool hospital scandal: Can Canada escape the problems of Britain's medicare system?" Canadian Medical Association Journal 118 (4 March 1978), 574; Dyson Inquiry, 2.
[558] Dyson Inquiry, 5.
[559] Dyson Inquiry, 7.
[560] Dyson Inquiry, 38.

rather than supply, demand and historical factors'.[561] RAWP published an interim report in August 1975, and its main report in September 1976, the timing of these reports was significant for Liverpool, as the interim report informed regional resource allocation for 1976/1977. A lack of data on morbidity meant that 'centres of urban stress' such as Liverpool actually appeared as *over*-funded in the interim report. The main RAWP report applied a revised formula (that found the Mersey RHA to be *under*-funded), however it was published too late to be incorporated into Liverpool AHA financial planning for 1977/1978.

Dyson claimed the 'excessive caution' of the RHA in response to the interim RAWP report resulted in it becoming 'cost-conscious in a way that involved a considerable change in outlook for many managers and staff.'[562] While the interim RAWP report placed external pressure on the AHA, Dyson also criticised the leak of its 1976 strategic plan (discussed above). Hospital staff feared for their positions amid the threat of closures, which had appeared as 'major headlines in the local press before the bulk of staff, often including senior officers in the units concerned' were aware of them.[563] Liverpool's demographic challenges intensified during the protracted process of hospital rationalisation, and local general practice deteriorated through the university's refusal to take a lead in the promotion of primary care. Finally, the AHA underestimated the level of opposition to rapid and radical hospital closure outlined in its strategic plan, which led to the disintegration of morale among the workforce and a series of strikes.

Delays to the opening of the Royal Liverpool led to a huge overspend, and initial budgets of around £12 million ballooned to an eventual cost of over £50 million. A 1977 investigation by the Public Accounts Committee led to the new hospital being unflatteringly

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[561] Rivett, *From Cradle to Grave*, 277.
[562] Dyson Inquiry, 15.
[563] Ibid, 18.

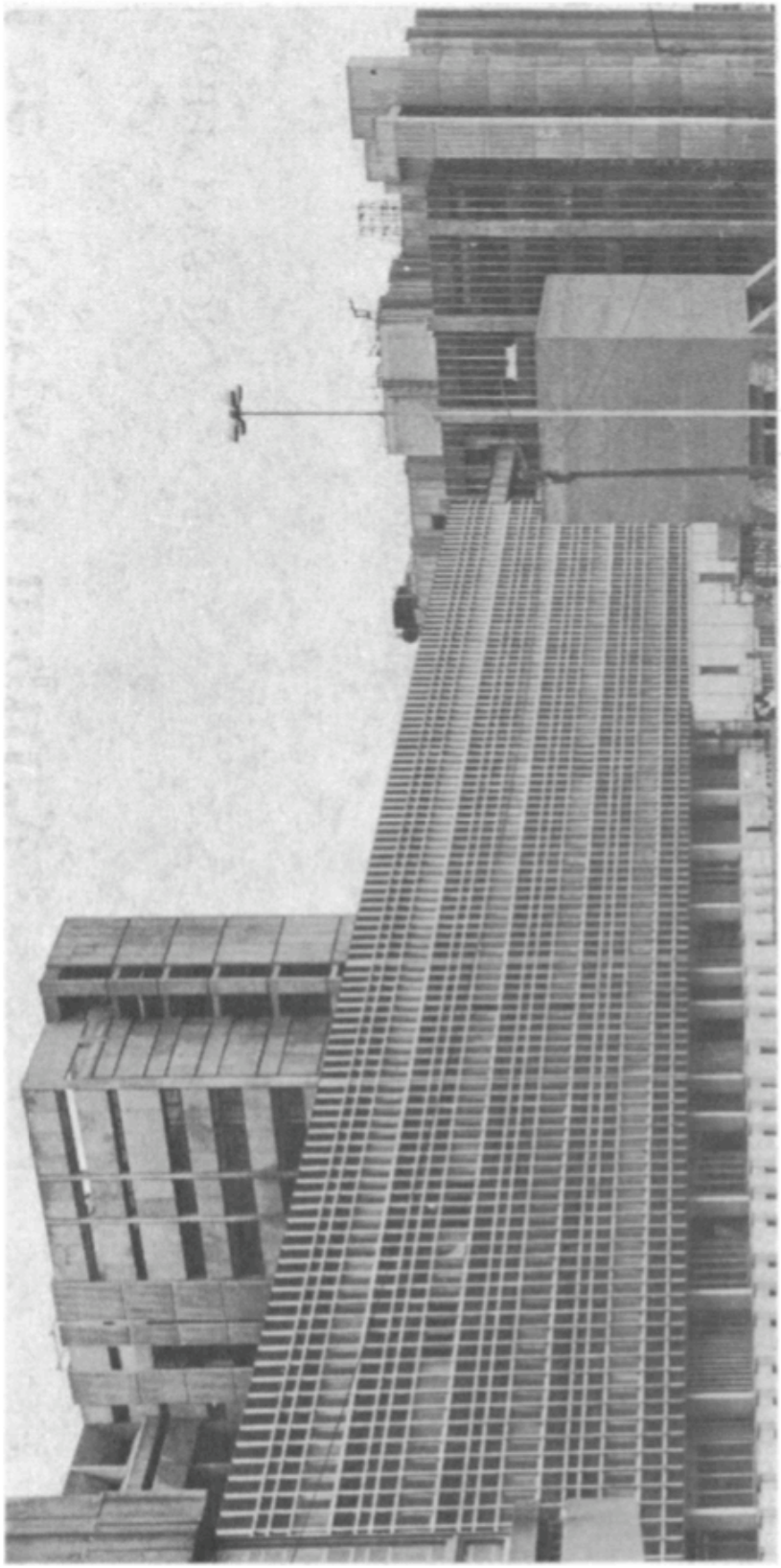
described in the House of Commons as representative of chronic NHS mismanagement. In 1978 David Crouch, a Conservative MP, described the fiasco.

> The remarkable case of bad management in the building of the Liverpool teaching hospital, when costs escalated from an original estimate of £11.8 million rising eventually to over £54 million. Some mistake! Some bad management![564]

The conditions under which the new teaching hospital opened did not endear it to local medical practitioners, and compounded disappointment at the closure of the Victorian hospitals to which many in the medical community held long and emotional connections (see Figure 6.4). The response of practitioners who moved to the new hospital are discussed in Chapter 10.

[564] HC Deb 9 January 1978 vol. 941 col. 1373.

Figure 6.4: The Royal Liverpool University Hospital[565]



[565] Image from Roger Dyson, "The Liverpool Inquiry," *BMJ* 11th February 1978, 384.

Conclusion

Pre-NHS plans for comprehensive hospital reform in Liverpool were swiftly adapted into an ambitious 25-year scheme and sent to the Ministry of Health in 1955, prior to the publishing of Powell's ambitious 1962 hospital plan, and were rejected on the grounds of scale and cost. Subsequent attempts at planning were more modest, and reflected the two-tier administration of local hospitals between the teaching group and RHB; work began on the Royal Liverpool to replace the teaching hospitals of the ULH, while the RHB began work on the rationalization of hospitals in the North and Central and Southern areas of the city. Liverpool's experience of hospital rationalization was a chastening example of how poor management, compounded by major structural change nationally, undermined the efficient delivery of new services. The fiasco of the Royal Liverpool was the subject of a special dispatch in the *Canadian Medical Association Journal* under the title 'The Liverpool Hospital Scandal'.[566] Geoffrey Rivett described hospital reform during the 1960s and 1970s as a 'time to test new ideas', which in Liverpool resulted in nothing less than a 'financial horror story'.[567]

The upheaval of the Liverpool hospital system unsettled established institutional cultures and prepared the way for a renegotiation of professional networks at the new sites. Rationalization presented the local medical community with the institutional break that had failed to materialize with the creation of the NHS. Hospitals across all sectors were reorganized along the principles of planning and coordination, in which the medical profession were only one of many competing voices. The RAWP interim report influenced funding decisions in the crucial completion stages of the new teaching hospital, which finally opened forty years after initial proposals to amalgamate the voluntary hospitals. In North

[566] Gray, "The Liverpool hospital scandal," 574.
[567] Rivett, *From Cradle to Grave*, 246.

Liverpool, hospital services were similarly consolidated at Fazakerley DGH, however many practitioners retained a strong sense of institutional loyalty to the hospitals scheduled for closure.

The reorganisation of the hospital system marked a fundamental break with the traditional institutional landscape of Liverpool's medical community. The new hospitals were unburdened by the legacy and influence of senior consultants, who sometimes appeared to regard the old hospitals as vehicles of traditional professional culture. This chapter has demonstrated the scale of the task of rationalising the Liverpool hospital system, which as Chapter 5 demonstrated was particularly ill-suited to the needs of the rapidly changing local population. In spite of the challenges of their implementation, the amalgamation of smaller units at both the Royal Liverpool and Fazakerley DGH precipitated a fundamental renegotiation of institutional culture at Liverpool's hospitals, this process is explored in Chapter 10.

Chapter 7
General Practice in Liverpool 1948-1978

Introduction

General practitioners sustained many elements of pre-NHS practice after 1948 as a result of concessions elicited by the profession during negotiations over the new service. Anne Digby described the creation of the NHS as the beginning of an 'evolutionary transition rather than a radical disjuncture' in British general practice.[568] Both Logan and Dyson had observed a dismissive attitude towards general practice at the Liverpool teaching hospitals during their investigations in the 1960s and 1970s, and this was reflected in the absence of an academic department of general practice at the medical school until 1985. Nonetheless, the attraction of general practice to politically active practitioners led to the emergence of a radical subsection of the local medical community intent on challenging what they perceived to be conservative hospital-centrism.

The Liverpool Local Executive Council (LEC) replaced the Liverpool Insurance Committee in 1948 as the administrative body responsible for GP services, and published a record of licensed practitioners (see Figure 7.1). Regional comparisons indicate GPs in the North West of England remained likely to have larger list sizes than the national average, which was reflected in the fewer practitioners per 100,000 population in the region than the national average (see Figures 7.2 and 7.3). Prior to 1948, newly qualified practitioners could enter practice by simply 'putting up a [name] plate and waiting for a clientele of patients', alternatively they could purchase the goodwill of a practice and replace an established GP or acquire a partnership share in an established practice (vacancies were

[568] Digby, *The Evolution of British General Practice*, 342.

advertised in medical journals).[569] The sale of 'goodwill', usually priced at one and a half times the annual income of a practice, was banned after 1948, and GPs were instead compensated by the government on retirement.[570] Practice organisation under the NHS continued to resemble the small business tradition, with practitioners owning or renting premises, hiring assistants, and managing finances.

As outlined in Chapter 5, a national 'renaissance' in general practice began after WWII, and trends during the 1950s and 1960s reveal a steady decline in total numbers of singlehanded GPs, however the development of health centres was slow (only 28 were built between 1948 and 1967).[571] The slow pace of development was partly a result of the inherent conservatism of patients, Ann Cartwright suggested in 1967 that the 'image of the singlehanded family doctor dies hard' while practitioners feared a threat to professional autonomy implicit in local authority-owned health centres.[572]

In common with the local hospital system, general practice in Liverpool after 1948 strongly resembled pre-NHS conditions, and the independent status cherished by GPs enabled many practitioners to insulate themselves from the national conversation around reform. This chapter demonstrates the range of working models across Liverpool's GP community, and the often formative influence of established practitioners on younger members of the profession.

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[569] Political and Economic Planning, "Report on the British Health Services; a Survey of the Existing Health Services in Great Britain with Proposals for Future Development. December 1937" (London: PEP, 1937), 143; Digby and Bosanquet, "Doctors and Patients in an Era of National Health Insurance," 81.

[570] Rivett, *From Cradle to Grave,* 80; British Medical Association, "Focus on sale of goodwill" https://www.bma.org.uk/advice/employment/gp-practices/premises/focus-on-sale-of-goodwill [accessed 17 January 2019].

[571] Ministry of Health, *Annual Reports*, (London: HMSO).

[572] Cartwright, *Patients and Their Doctors*, 165-166.

Section 1 explores the main entry routes into general practice in Liverpool, and the role of personal relationships, family links and other networks in securing a post. Section 2 considers local responses to general practice reform, through discussion of the establishment of an academic department of general practice and the experiences of women practitioners.

Figure 7.1: GPs in the Liverpool City and County Borough 1943-1973.[573]

Year	GPs	% Female	% providing partnership details	Patients per Doctor
1943	276	8	20	2980
1948	309	8	31	2562
1958	400	12	59	1906
1968	408	14	56	1686
1973	357	15	66	1609

[573] Source: Liverpool Executive Council *Interim Report* (1948) and *Annual List of Medical Practitioners* (1958, 1968, 1973). [LRO: HQ610.58 NAT].

Figure 7.2: Regional Distribution of General Practitioners, Great Britain, 1952[574]

Region	**Population (million)**	**Number of GPs**	**Number of GPs per 100,000 Population**	**Average List Size**
Northern	3.118	1135	36.6	2732
Yorkshire and Humberside	4.476	1551	38.16	2620
E Midlands	2.917	1196	37.7	2652
E Anglia	1.408	565	41.36	2417
S Eastern	15.238	6350	43.14	2318
S Western	3.269	1512	45.35	2205
W Midlands	4.426	1568	35.95	2782
N Western	**6.437**	**2347**	**37.68**	**2654**
England	41.289	17298	42.87	2548
Wales	2.565	1074	43.89	2278
Scotland	5.079	2310	45.33	2206

[574]Adapted from Webster, *The Health Services since the War (II)*, Appendix 3.30.

Figure 7.3: Regional Distribution of General Practitioners, Great Britain, 1972[575]

Region	**Population (million)**	**Number of GPs**	**Number of GPs per 100,000 Population**	**Average List size 1972**
Northern	3.296	1348	40.9	2474
Yorkshire and Humberside	4.825	1959	40.6	2510
E Midlands	3.416	1386	40.57	2580
E Anglia	1.711	731	42.72	2321
S Eastern	17.318	7713	44.54	2367
S Western	3.833	1783	46.52	2224
W Midlands	5.152	2117	41.09	2493
N Western	**6.753**	**2738**	**40.54**	**2502**
England	46.304	19775	42.71	2421
Wales	2.735	1323	48.37	2067
Scotland	5.21	2625	50.38	1985

[575]Adapted from Webster, *The Health Services since the War (II)*, Appendix 3.31.

7.1: Entry routes to general practice in Liverpool

Assistantship

Many GPs began their careers as assistants working alongside established practitioners. Thomas Cecil Gray, who later became an anaesthetist and dean of the Liverpool medical school, found his first job after qualification in 1937 as assistant to McEwan Goodman-Jones, a South African-born GP with practices on Upper Parliament Street (in a densely-populated and poor part of Liverpool) and Sheil Road. The Upper Parliament Street practice was in a converted house on one of the main roads leading to the docks, while the Sheil Road practice was in a semi-detached house. The two practices differed markedly in their patient populations: Gray described Sheil Road as 'quite a sort of bourgeois practice…[however] the Parliament Street place was a poor practice'.[576]

Goodman-Jones struck Gray as financially successful, managing two practices and traveling between them from his home in an affluent suburb in a chauffeur driven car.[577] Gray's experiences were characteristic of the broad and often hectic nature of inter-war GP work.

> We did all our own midwifery, and it was hard work…we used to dispense our own medicines. On Saturday night, which was busy as hell, the waiting room was packed, they'd be up the stairs of the house.[578]

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[576] The Royal College of Physicians and Oxford Brookes University Medical Sciences Video Archive, MSV A 138, "Professor T Cecil Gray CBE KCSG FRCP FRCS FRCA in interview with Dr Max Blythe, Oxford, 28 August 1996, Interview One."

[577] 'Thomas Cecil Gray (1913-2008)' Obituary by RCP Editor, *Munk's Roll* Volume XII (web).

[578] The Royal College of Physicians and Oxford Brookes University Medical Sciences Video Archive, MSV A 138, "Professor T Cecil Gray CBE KCSG FRCP FRCS FRCA in interview with Dr Max Blythe, Oxford, 28 August 1996, Interview One."; Liverpool Insurance Committee, 'List of Insurance Medical Practitioners, Chemists, etc., 1943'. LRO HQ 610.58

Other practitioners reflected on the range of services provided by interwar GPs, when it was commonplace for doctors to prepare and dispense their own medicines (this was the case for the Goodman-Jones practice), and perform minor operations in the patient's home.[579]

Goodman-Jones provided the newly-qualified Gray with a model of the prosperous urban GP. He was impressed by the standard of living enjoyed by his employer, and was aware of the economic rewards that could be expected from a successful practice. Patients from a range of backgrounds were represented on the Goodman-Jones list.

> There was private practice… a lot of people were panel… and some of them were club patients. Some paid, and when they paid it was, as I say, for half a crown with a bottle of medicine, and a visit I think was two shillings or something like that, which you collected when you went.

Gray's eventual decision to buy his own practice in Wallasey (on the Wirral peninsula) in 1939 was partly driven by his dissatisfaction with the scant financial rewards for working under a principal. A 1937 Political and Economic Planning report noted the 'possible stresses' and 'risk of friction' that were liable to emerge in partnerships, and it is perhaps unsurprising that after two years as the junior partner in a busy split-site practice Gray was ready to move on.[580] His description of the purchase indicates the various dimensions of commencing traditional single-handed practice, which constituted both a residential and entrepreneurial move.

> I saw this lovely house at Liscard Road… detached, beautiful, old… it was a really nice house and a nice

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[579] Cuthbert Arthur Watts, "In my own time: general practice," *BMJ* 27 October 1979, 1055.

[580] Political and Economic Planning, "Report on the British Health Services," 143.

> practice, a rather genteel sort of practice on the whole, but some poor people. I can't remember how much I paid for it, but it included the house and the goodwill of the practice.

A range of considerations informed the decision on where and how to run a general practice. Goodman-Jones' two practices accommodated two very different patient populations, while Gray elected to move to a 'genteel' patient community on the Wirral peninsula. Single-handed GPs often played an active role in the local community, and developed a necessarily broad range of medical skills, which subsequently led to robust defences of traditional forms of practice after the assault by reformers during the 1960s and 1970s. In a 1996 interview Gray reflected on the demands of pre-NHS general practice.

> I set up there as a single-handed practitioner, and again doing all my own midwifery…general practitioners these days don't know what doctoring is.

For Gray, 'doctoring' represented more than patient consultations at the GP surgery; running a successful practice required business acumen and an entrepreneurial ability to build and maintain a patient list.

Assistantship at an established practice remained an important means of beginning a career in general practice after 1948. Reginald Yorke (1929-2018) graduated from Liverpool in 1954 and began part-time work at a practice in Maghull to boost the modest income he received as a research assistant at the university.[581] Yorke reflected on the process of joining the practice (where he became a partner in 1965).

[581] Life Membership Oration for Reginald Angelo Yorke, LMI, 2002, provided by the Yorke family.

> They needed a bit of help at weekends and on holidays, asked if I would like to use a bit of my free time, you couldn't really afford to say no.[582]

The absence of mandatory postgraduate training until 1982 meant that part-time GP work offered a straightforward way for young doctors to supplement their income immediately after graduating.[583]

The academic environment of the 1960s overwhelmingly encouraged students and junior doctors to aspire to work in hospital medicine, and contributed to the perception that entering general practice signified a failed hospital career (as late as 1979, the Royal Commission criticized the NHS for being a 'sickness' service with too little focus on community health promotion).[584] The traditional image of the GP as an independent community doctor proved resilient. Fred Nye, an infectious diseases consultant, reflected on almost becoming a GP earlier in his career.

> I suppose I've always had great respect for GPs because I know I could never be one. The nature of general practice and the need for clinical judgement and the ability to manage patients without the sort of backup of all the technology that you have in hospital is something pretty impressive.[585]

Nonetheless, there was a widespread impression that hospital appointments held more intraprofessional prestige.

> Why did I think I would end up in general practice? Because I didn't think I would make it into a specialty.[586]

Reginald Yorke's initial intention was also to remain in hospital medicine, however the demands of a growing family accelerated the urgency of finding financial security, and general practice offered

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[582] Reginald Yorke, 9 February 2018.
[583] Chantal Simon, "From Generalism to Specialty—A Short History of General Practice," *InnovAiT* 2.1 (January 1, 2009), 7.
[584] Merrison, *Royal Commission on the National Health Service*, 35.
[585] Fred Nye, 25 September 2018.
[586] Fred Nye, 25 September 2018.

greater autonomy at an early career stage than hospital posts, which involved extensive periods of 'living-in' and years spent in poorly paid training grades prior to eligibility for consultant posts. General practice, by contrast, was 'flexible in that you were running your own practice… if you don't like one practice there are plenty of others.'[587]

Efficient working relationships at partnership and group practices were a key requirement of a successful practice. Nonetheless, the continued opportunities to pursue single-handed practice under the NHS meant individuals were not obliged to work alongside colleagues. Professional or personal differences might lead partners to part ways, one interviewee claimed that 'GPs invariably were single handed because they actually couldn't work with anyone else…they had to be top of the tree'.[588] Unlike the clear hierarchies of hospital medicine, general practitioners could remain free of intrusive scrutiny from professional peers, and make decisions about recruitment, practice organization and working arrangements based on their own views on the business of medicine.

Inheriting a practice

Alongside advertising vacancies, established practitioners could find qualified assistants and partners through a range of informal networks. Michael Bevan noted that 'for the children of general practitioners, [family connections] could supply a ready-made position in the family practice'.[589] This was the case with Irish GPs Patrick Garry (1896-1952) and Charles Kelly (1894-1961), who established practices in the Edge Hill and Toxteth areas of Liverpool during the 1930s and 1940s.[590] Kelly's daughter Nuala Gallagher, who graduated in 1954, recalled taking on the surgeries, 'We inherited it all you see, from my father and the Garrys'.[591] Such cases

[587] Reginald Yorke, 8 February 2018.
[588] Interviewee with Rob Barnett, 6 July 2018.
[589] Bevan, "Family and Vocation," 40.
[590] Nuala Gallagher, 30 April 2018.
[591] Nuala Gallagher, 30 April 2018.

were indicative of the similarities between medical practices and other family businesses, and the opportunities for children or spouses of established practitioners to find employment through family ties. Other local GPs, such as Mansel Glynn Morris (1907-1969), joined their parents in the practice they would subsequently inherit, a model that was commended for allowing the maintenance of 'traditional standards of kindness, courtesy and painstaking care.'[592]

Gallagher recalled being forced to vacate the Toxteth practice [c. 1950], as '[Kelly] never bought the property, and it was taken over as a sweet shop.'[593] Doctors working from rented premises were exposed to such risks, especially if the building was liable for conversion to commercial use, and Nuala and her husband Conal Gallagher (1927-2016), also a GP, relocated the Toxteth practice to nearby Dombey Street.[594] The Dombey Street practice represented the intimacy of the traditional small surgery.

> Our patients loved our surgery, a big gas fire and they would all chat, they all knew each other.[595]

Several interviewees recalled positive aspects of traditional single-handed practice, while acknowledging the limits of working from shops or residential premises. Gallagher was unequivocal about the quality of care compared with health centres, 'I think the single-handed GPs went… all into the health centre. It is better – you can get quicker bloods done and things like that.' Other GPs such as Ruth

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[592] 'Mansel Glynn Morris' Obituary, *LMI Transactions and Report,* 1969, 52.

[593] Nuala Gallagher, 30 April 2018; details of the move were not provided at interview; however it must have taken place between 1958 and 1968 (when records show the practice was established at Dombey Street).

[594] A senior LMC figure said in interview that such husband and wife setups were common, as it 'ensured there was a reasonable income coming into the family, you didn't have to divide it with everyone else.' Rob Barnett, 6 July 2018.

[595] Liverpool Executive Council, "Interim list of medical practitioners, 1948" [LRO: HQ 610.58 NAT].

Dovey (1900-1996) were described as having 'regretted the loss of independence with the advent of the Health Service' while acknowledging the undeniable advantages it brought to the 'tough by satisfying' demands of single-handed practice.[596]

Interviewees highlighted the entrepreneurial dimensions of general practice as a business, where maintaining the patient list and controlling costs was essential to securing a steady income. One interviewee reflected the doctor's demeanour was often more important in maintaining a full list of patients than the standard of care on offer in the practice, and this was especially the case in poor areas.

> The quality of service you provided was actually irrelevant, patients were grateful that they had a doctor…. I remember going to visit a singlehanded doctor who probably had two and half thousand patients on his list, his patients thought he was the best doctor in the world, but every patient got a second opinion![597]

Defenders of the traditional organization of general practice maintained that patients' ability to choose their doctor would lead to healthy competition and the raising of standards, however the 1979 Royal Commission on the NHS found patients tended to register with the doctor closest to them, and as a result there was no incentive on GPs to improve the quality of care on offer.[598]

Local professional bodies such as the Local Medical Committee, which was adapted from the Local Medical and Panel Committee established with the introduction of National Health Insurance in 1911, demonstrated the solidarity of the GP community after 1948. The LMC respected the independent status of its members, and in October 1954 passed a resolution declaring practitioners were unwilling to inspect the surgery of fellow members

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[596] 'Ruth Dovey' Obituary (without attribution), *LMI Transactions and Report*, 1997, 71.
[597] Interviewee with Rob Barnett, 6th July 2018.
[598] Merrison, *Royal Commission on the NHS*, 232.

unless invited to do so, despite publishing guidelines on what constituted a 'reasonable standard' of practice facilities.[599] The annual bulletins of the Liverpool LMC also provided information on resignations and deaths among the GP community, alongside appointments as partners and assistants. The LMC, which met monthly at the Liverpool Medical Institution, provided a forum for discussion, and played an important role in keeping practitioners abreast of local and national developments.

7.2: GP reform in the local medical community

General practice reform

Practitioners in Liverpool engaged to varying degrees in national debates around general practice reform during the 1960s. The LMC remained an important forum for discussion of these issues, and provided local practitioners with the chance to share their views with colleagues. The LMC published an essay by local GP Cyril Taylor (1921-2000) on the merits of health centres in its 1964/5 bulletin in which Taylor, a prominent local reformer and later president of the Socialist Medical Association, acknowledged the challenges of working with the local authority, but encouraged local colleagues to 'ensure that old prejudices' did not obstruct 'the only practical solution to the problems of General Practice today.'[600]

In his capacity as secretary of the local branch of the Medical Practitioners' Union (MPU), Taylor also became involved in the acrimonious dispute over the first health centre in Liverpool. The local authority-owned centre in the Toxteth area offered consulting rooms to GPs facing eviction from their former practices as a result of slum clearances, however the practitioners felt the rental rate specified by the authority was too high and refused to commence practice. Taylor accused the council of setting the highest rental rates

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[599] LMI Minutes 19th October 1954, [LMI: LMI 2/1/3/1/9].
[600] Liverpool Local Medical Committee Bulletin 1964/5 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

in the country for inadequate facilities and the impasse continued into 1963 (the health centre began offering school, maternity and child welfare clinics in 1962). The surgeries remained inactive until a temporary agreement was reached in January 1964.[601] The incident divided the local GP community, with the MPU and local NHS Executive Committee taking different positions, and appeared to justify the suspicions held by some members of the local medical community towards health centres.

The future of practice organisation was reframed following the 1966 Family Doctor's Charter, which provided financial assistance for doctors to establish their own health centres, and led to a subsequent rise in their popularity. The College of General Practitioners, established in 1952, supported group practices and health centres, declaring in 1972 that even doctors who persisted in single-handed practice must 'work in a team and delegate when necessary.'[602] The proportion of Liverpool GPs providing details of partnership arrangements nearly doubled in the first decade of the NHS (see Figure 7.1). Nonetheless, a minority of 'small shopkeeper' traditionalists remained resistant to change, and their independent status enabled them to continue to practise as they always had: almost a third of GPs were still working single-handedly at the time of Dyson's investigation into the AHA in 1978.[603] Areas with poor general practice provision, which was partly enabled by Liverpool's overcapacity of hospital beds, informed criticism of GPs from colleagues working in general practice and the wider medical community.

General practice attracted individuals with strong political views, and several influential practitioners in Liverpool developed

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[601] "Doctors to move into health centre" *Guardian* 24th January 1964, 4.

[602] Royal College of General Practitioners, *The Future General Practitioner: Learning and Teaching* (Published for the Royal College of General Practitioners by the BMJ, 1972).

[603] Dyson Inquiry, 7.

critiques of social conditions and the medical system informed by their proximity to health issues and professional conservatism.[604] National organizations including the SMA and MPU were influenced by South Wales GP Julian Tudor Hart, who rose to prominence in 1971 with the publication of his paper in the *Lancet* on the 'inverse care law', which demonstrated that under the NHS communities most in need remained least likely to have access to medical care.[605] Similarly, a hospital practitioner who arrived in Liverpool in 1978 recalled the 'huge difference between inner city GP practice and leafy suburb practice'.[606] Tudor Hart remained in regular contact with Cyril Taylor, who became SMA president in 1980-1989, and interviewees recalled meeting him in the city (after stepping down from the presidency of the SHA in 2017, Tudor Hart proposed Liverpool public health academic Alex Scott Samuel for the role of chair, to which he was appointed).[607] Cyril Taylor's establishment of an innovative health centre in Liverpool in 1983 is discussed in Chapter 11.

Academic general practice

General practice teaching began at the University of Liverpool in 1970, when Thomas Cecil Gray, dean of the medical school, wrote to local GPs to notify them that teaching 'on an experimental basis'

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[604] Ross McKibbin, "Politics and the Medical Hero: AJ Cronin's The Citadel," *The English Historical Review* 123.502 (2008), 651–78. AJ Cronin (1896-1981) drew on his own experiences as a general practitioner in *The Citadel* (1937), as did Mikhail Bulgakov (1891-1940), author of *A Young Doctor's Notebook* (compiled 1920s), see Ivan Oransky, "Disarming Life's Invisible Enemies: Mikhail Bulgakov's *A Country Doctor's Notebook*," *Lancet* 353.9169 (1999), 2059–61.

[605] Julian Tudor Hart, "The Inverse Care Law," *Lancet* 297.7696 (1971), 405–12.

[606] Focus Group on Liverpool Hospitals, 29th January 2019.

[607] Katy Gardner 5tApril 2018; Alex Scott Samuel 1 May 2018; Sylvia Hikins 9 July 2018.

was being considered.[608] The project developed without input from the LMC (much to their disappointment) and in 1971 the university began a collaboration with a teaching practice fifteen miles from the medical school in Runcorn. Local GPs regretted that the 'department' had no campus presence, it received no financial support from the university (teaching costs were to be met from practice income), and the venture ended unsuccessfully in 1977.[609] GP academics later claimed the project was undermined by the 'neutrality – and indeed often active opposition – of…key professors in the medical faculty.'[610]

General practice subsequently constituted a division of the department of Community and Environmental Health, where it was described as little more than a 'dating agency' connecting students with GP placements until the department was revived in 1985.[611] The 1978 Dyson inquiry criticised the hospital-centrism at Liverpool medical school, and considered it partly to blame for the lacklustre state of local general practice.[612] The inclusion of general practice within the wider department of community and environmental health was further indication of the view held by leaders at the medical school that it was not an area of medicine deserving of a dedicated academic base.

The 1968 Royal Commission on Medical Education sought to address the ever-earlier inculcation of a hospital specialist mindset in

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[608] LMC Meeting 12th May 1970, Courtesy Greenbank Road Surgery; LMC Meeting 7th July 1970 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].
[609] LMC Meeting 6th July 1971 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool]; Brian McGuinness, Ian Stanley and Christopher Dowrick, "The University of Liverpool" in *Academic General Practice in the UK Medical Schools, 1948-2000: A Short History* eds. John Howie and Michael Whitfield (Edinburgh: Edinburgh University Press, 61).
[610] McGuinness, Stanley and Dowrick, "The University of Liverpool," 61-2.
[611] McGuinness, Stanley and Dowrick, "The University of Liverpool," 61-2.
[612] Dyson Inquiry Report, 38.

students, and advocated a broad undergraduate curriculum followed by specialist training.[613] The establishment of departments of general practice at British universities contributed greatly to intraprofessional legitimacy, and enabled some GPs to engage in research and teaching.[614] The first professorial chair of general practice in Britain was established at Edinburgh in 1948, however the English universities were slow to follow (see Figure 7.4), and some figures from medical and surgical departments refused to recognise the academic status of general practice; Geoffrey Rivett claimed 'long-established colleagues in other disciplines could not take them [GP academics] entirely seriously.'[615]

The introduction of mandatory vocational training in 1982 (enacting legislation passed in 1976) allowed GPs to gain both valuable experience and enhance credibility within the profession.[616] Rob Barnett, who graduated in 1983 (and subsequently became a GP) recalled a short attachment to a 'husband and wife practice' while an undergraduate, followed by a year as a GP trainee at a two-partner practice run by practitioners qualified from Liverpool and Pakistan respectively. The style of vocational training was described as a hands-on and immersive experience, and the trainee was seen as part of the practice as an extra pair of hands.

> I didn't get much training because you were there to, ultimately do a job, they couldn't have survived without

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[613] Drury and Hull. *Introduction to General Practice*, 35.
[614] John Revans, "Integration of the General Practitioner with the Hospitals," *Medical Care* 2.1 (1964), 43.
[615] Rivett, *From Cradle to Grave*, 164 Tudor Hart, *A New Kind of Doctor*, 91-92; John Howie and Michael Whitfield, "Introduction" in *Academic General Practice in the UK Medical Schools, 1948-2000: A Short History* eds. John Howie and Michael Whitfield (Edinburgh: Edinburgh University Press, 2011), XV.
[616] The Health Foundation, 'The Goodenough Committee', https://navigator.health.org.uk/content/goodenough-committee-was-published-1944 [accessed 17 January 2019]; Digby, *The Evolution of British General Practice*, 60.

> having the trainees there, you were thrown in the deep end, but it wasn't too deep.[617]

A career in general practice was the obvious choice for Barnett, who came from a family of GPs and had an assured job in his parents' practice.

The rise of academic general practice had an immediate effect on undergraduates and practitioners engaged in vocational training, and was also part of the broader movement to greater oversight, academic rigour, and accountability to primary care occurring nationally.

> People were beginning to start to be interested in the quality of the service that was being provided, I would say that up until that time GPs did what GPs did – an hour's surgery in the morning, an hour's surgery in the evening, and presumably on the golf course the rest of the time! I never played golf so I wouldn't know.[618]

The department of general practice at Liverpool was re-established in 1985, building on momentum following the 1981 Report into Primary Health Care in Inner London (The Acheson report) , which advocated a greater role for universities.[619] Relations between Ian Stanley (who graduated from Manchester in 1964), the new professor of general practice, and the LMC were markedly warmer than in 1971, and local GPs appreciated the invitation to participate in the department.[620] The number of academic posts grew during the following decade, and it

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[617] Rob Barnett, 6 July 2018.

[618] Rob Barnett, 6 July 2018.

[619] Brian Jarman and Nick Bosanquet, "Primary Health Care in London--Changes since the Acheson Report," *BMJ* 7th November 1992, 1131; "Primary Health Care in Inner London" (Acheson Report) *BMJ* 20 May 1981, 1814.

[620] Liverpool LMC Meeting 5th March 1985 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

became an established part of the medical school during the 1990s.[621]

The second incarnation of the department of general practice at Liverpool developed with the support of influential local GPs, notably Ian Bogle (1938-2014), a third generation Liverpool practitioner who joined his father's practice in Anfield in 1962 (originally established by his grandfather in 1911). Bogle rose to senior positions in local and national medical politics as secretary of the LMC (1973-1990) and as a negotiator and later chairman of the BMA General Medical Services Committee (1990-1997), and BMA chairman (1998-2003).[622] He was also a member of the Joint Committee on Postgraduate Training for General Practice (in operation 1974-2005), a body that united the often conflicting views of the RCGP and BMA.[623] A colleague claimed Bogle's desire to improve GP education originated during his studies at Liverpool, where the 'attitude of some of his tutors [was] that general practice was the 'sort of thing you went into if you were thick'.[624] Local professional disdain for general practice contributed to its underdevelopment, enabled by the high numbers of hospital beds inherited in 1948.

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[621] McGuinness, Stanley and Dowrick, "The University of Liverpool," 62.

[622] 'Ian Gibb Bogle,' *BMJ,* 2 September 2014 (online) <https://doi.org/10.1136/bmj.g5362> [accessed 6 February 2020].

[623] "Liverpool GP wins top BMA post" *Health Service Journal* 16th July 1998; Donald Irvine, Denis Pereira Gray, and Ian Bogle, "Vocational training: the meaning of satisfactory completion," *The British Journal of General Practice* 40.339 (1990), 434; Brian Keighley, "The JCPTGP: the passing of an era," *British Journal of General Practice 55*.521 (2005), 970-971.

[624] "Fair Play, Dr Bogle" *BMA News* September 2014 [online] https://www.bma.org.uk/news/2014/september/fair-play-dr-bogle [accessed 19 February 2020].

Figure 7.4: Departments of General Practice at UK and Ireland Medical Schools[625]

Year	Medical School
1948	Edinburgh
1965	Manchester
1967	Aberdeen, St Thomas'
1968	Cardiff, Guy's, Southampton
1969	Newcastle
1970	Dundee
1971	Belfast**, Liverpool (until 1977),** St Mary's, UCL
1972	Glasgow, Sheffield, Nottingham
1973	Trinity College Dublin
1974	Birmingham, Leeds
1975	Leicester
1976	Cambridge
1977	Charing Cross, Oxford
1978	George's, King's
1981	Middlesex
1985	**Liverpool (re-established department)**
1986	Bristol, Royal Free
1987	Royal College of Surgeons of Ireland
1991	University College Dublin
1997	UC Cork, NUI Galway, Warwick
2001	Keele
2002	Hull, York, Peninsula, East Anglia
2003	Brighton and Sussex
2004	Swansea
2007	Limerick
2008	St Andrews

[625] Data from J Howie, *Academic General Practice in the UK Medical Schools, 1948-2000: A Short History*, xii-xiii.

Women GPs

The demands placed upon the medical services during WWI brought many women into the medicine, and despite barriers to the growth of the female medical workforce during the 1920s the NHS instituted a policy of formal equality of opportunity in medical employment (despite not actively seeking to support the equal promotion of both genders). The higher incidence of married medical women pursuing discontinuous professional careers and taking part time positions undermined female representation among the traditional medical elite, membership of which was achieved through continuous, full-time hospital appointments.[626] Women remained a minority among British general practitioners, as in the medical profession as a whole, for much of the period, and women doctors' status and salaries varied widely (see Figure 7.5).[627]

General practice nonetheless emerged as the most common career destination for women achieving career posts during the 1960s. Between 1963 and 1976 the total number of women GPs rose by more than fifty per cent (while the total number of male GPs actually fell), as a result of changes to practice organization that enabled practitioners with domestic commitments to continue working.[628] The growth of group practice further enabled the rise of women among the GP workforce, as work breaks and discontinuous employment were more easily fitted around GP employment.[629] All British medical schools were forced to accept women following the 1944 Goodenough Committee report, which made funding conditional on the entry of a quota of women students (although it took until 1955 for all to comply), and the 1975 Sex Discrimination Act led to a

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[626] Mary Ann Elston, "Women doctors in the British health services: a sociological study of their careers and opportunities" (PhD Dissertation, University of Leeds, 1986), 9-10.
[627] Dyhouse, "Driving Ambitions," 322.
[628] Elston, "Women doctors in the British health services", 405.
[629] Elston, "Women doctors in the British health services", 396-7.

further rise in admissions of women.[630] Nonetheless, women practitioners continued to be disproportionately represented in junior grades until the 1990s.[631]

Christine Brace, a Liverpool trained GP (graduated 1968), reflected on the changing number of women in the profession during her career.

> I've never worked in a very female-oriented practice at all. We had no women with us until 1983. In 1983 we took on what was known as a 'married woman assistant' after about 10 years you weren't allowed to use those names![632]

Brace recalled the 'high turnover of partners… a lot of times they just fell out with [the GP Principal].'[633] Professional autonomy, mobility, and independence were attractive inducements to general practice careers, especially in the 'unreformed' GP environment prior to the 1966 charter.

An atmosphere of sexism within the profession continued to be experienced by women practitioners following the 'renaissance' of general practice after the 1960s. In 1979 Liverpool GP Katy Gardner, contributed to a slew of angry responses to an editorial in the RCGP journal that repeated notions of women doctors as 'carers' rather than 'curers'.[634] The conservatism among many traditional general practitioners came under increasing scrutiny by a cohort of doctor practicing in the city during the 1960s and subsequently. This tension is discussed in Chapter 11.

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[630] Jean Scott, "Women and the GMC," *BMJ (Clinical Research Ed.)* 22-29th December, 1984, 1767; Ministry of Health. *Report of the Inter-departmental Committee on Medical Schools* (Goodenough Report), (London: HM Stationery Office, 1944).
[631] Beulah Bewley, "Women Doctors--a Review," *Journal of the Royal Society of Medicine* 88.7 (1995), 401.
[632] Christine Brace, 27 March 2018.
[633] Christine Brace, 27 March 2018.
[634] "Letters to the editor" *Journal of the Royal College of General Practitioners* (July 1979), 433.

Figure 7.5: Active medical practitioners in Great Britain, 1881-1981[635]

Year	Men	Women	Total	% Women
1881	16965	29	16994	<1
1891	21519	113	21632	1
1901	25391	227	25618	1
1911	26090	610	26700	2
1921	26260	1500	27760	5
1931	30060	3330	33390	10
1951	40710	7520	48220	16
1961	49760	9440	59200	16
1971	55920	11970	67890	18
1981	61230	19440	80670	24

[635] Census data: 1881-1981, adapted from Elston, "Women doctors in the British health services," 63 (Table 3.5).

Conclusion

General practice in Liverpool did not undergo an immediate transformation after 1948. Entrepreneurial considerations continued to inform practice decisions, assistantships and family connections were instrumental in securing positions, and established practitioners (many of whom had trained and worked before 1948) provided the aspirational model for many new GPs. Nonetheless, records of Local Medical Committee meetings revealed a range of perspectives on the future of general practice. Some practitioners sought to expand their role to include preventive medicine, community health and embraced the health centre model, while others were satisfied with traditional 'small shopkeeper' practice, and viewed reform as a potential threat to professional autonomy.

The slow start to general practice teaching at the Liverpool medical school, and lack of enthusiasm by key figures in the local professional establishment, was reflective of the inferior intraprofessional status of general practitioners. Hospital-centrism in Liverpool was enabled by its overcapacity, and local general practice was allowed to stagnate as a result. The debacle of the first health centre in Toxteth revealed the lack of efficient coordination in the rollout of new practice models, and traditional singlehanded practice continued to be the norm. The situation began to change following legislation approved in 1976 (implemented in 1982) for mandatory vocational training for GPs, and progressive figures in the local GP community such as Taylor and Bogle sought to influence local professional culture. The tension between reforming and traditionalist general practice in Liverpool is discussed in Chapter 11.

This chapter has demonstrated the importance of family and personal networks, working relationships at individual practices, and larger groups such as the LMC to Liverpool's GP community after 1948. Local GPs were also acutely aware of the implications of changes to the local hospital system on referrals, patient experience, and the working arrangements of their colleagues. Profession-wide

groups such as the Liverpool Medical Institution, local clubs and societies provided GPs with essential points of interaction with a range of colleagues. The impact of the creation of the NHS on these groups is the focus of the following chapter.

Chapter 8
Local Medical Networks 1948-1978

Introduction

The Liverpool Medical Institution did not face any direct changes to its organisation following the creation of the NHS, and remained an independent organisation funded and administered by its members. Nonetheless, after 1948 the LMI sought to solidify its place alongside new NHS structures by capitalising on its offering of postgraduate medical education. Postgraduate medical education in Britain was heavily influenced by Canadian physician William Osler (1849-1919), who declared in 1905 that 'the hardest conviction to get into the mind of a beginner is that the education upon which he is engaged is not a College Course, not a Medical Course, but a Life Course, for which the work of a few years under teachers is but a preparation'.[636] In 1919 Osler was appointed as the first president of the amalgamated Fellowship of Medicine and Postgraduate Medical Association, and government reports published in 1921 and 1930 were followed by the foundation of the Postgraduate Medical School in 1935, the Postgraduate Medical Federation in 1945, and the introduction of a mandatory pre-registration year of postgraduate training with the 1950 Medical Act.[637]

The LMI was well placed to support Osler's call for lifelong learning, as many senior institution members held roles in the university, at hospital firms and across the local professional community. The development of postgraduate medical centres (PGMCs) at NHS hospitals during the 1960s provided medical societies with the opportunity to align their educational facilities with NHS structures, offering resources and training to local practitioners

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[636] Quoted in John Lister, "The History of Postgraduate Medicine Education," *Postgraduate Medical Journal* 70.828 (1994), 728.
[637] Gordon Cook, "History of the Fellowship of Postgraduate Medicine," *Postgraduate Medical Journal* 81.961 (2005), 673.

that was approved, and in some cases, funded, by the NHS. Medical clubs and smaller specialist societies remained active during this period, and the local professional establishment sought to exert influence over the development of local medical services in the city as they were rationalised and planned.

This chapter outlines how established professional networks maintained influence within the NHS. Section 1 outlines the LMI's pivot towards medical education, and shows how greater alignment with local, regional and national administrative structures led to formal contractual arrangements for the provision of postgraduate education services. Links with the NHS apparatus compromised the society's traditional independence, but provided an essential source of financial support. Section 2 considers smaller local medical networks after 1948, and the consolidation and emergence of groups based on specialist clinical interest and shared national or religious background. This chapter demonstrates the adaptability of traditional medical networks, and their negotiation of a position of influence alongside NHS structures.

8.1: Liverpool Medical Institution, 1948-1974

Growth at the LMI

The LMI enjoyed a sustained period of popularity after the Second World War, and council welcomed new members 'anxious to keep up-to-date with their postgraduate studies' making use of the library and educational facilities.[638] The creation of the NHS did not lead to a decline in membership, which instead grew rapidly: the 284 full members in 1935 (representing 44 per cent of the total number of practitioners on the local list) rose to 439 in 1950 (52 per cent of the local list), and the number of retired and country members not resident in Liverpool also rose (see Figure 8.1). Attendance at institution functions was healthy during the 1950s and 1960s, and numbers at the annual inaugural meeting remained steady at around

[638] Report of LMI Council, *Transactions and Report* 1946, 4.

200. Rising membership placed pressure on the library, an essential resource for members engaged in postgraduate studies. The institution took steps to address the increased membership, and a library assistant was appointed in 1947. Nonetheless two years later bundles of books lay 'unclassified and unrecorded' for want of space.[639]

[639] Report of Hon Librarian, *Transactions and Report* 1947, 8; Report of Hon Librarian, *Transactions and Report* 1949, 4.

Figure 8.1: LMI Members and total number of doctors in Liverpool[640]

Year	Practitioners on GMC Local List	Full Members	Total Members*
1930	652	300	464
1935	649	284	481
1940	807	248	451
1945	707	187	362
1950	842	439	704
1955	1035	518	928
1960	1055	522	975
1965	1078	521	937
1970	1052	665	1107

[640] * Includes 'retired' and 'country' members.

The practitioners elected to LMI council after 1948 continued to include senior figures from the local medical establishment. The majority of presidents during the 1950s also held academic appointments, and combined duties at the institution with their university and hospital responsibilities (see Figure 8.2). Continuing the precedent established before 1948, presidents were mostly Liverpool graduates with senior appointments at the university and teaching hospitals, many also held national medical offices in the RSM, BMA and specialist societies. The first women presidents, Margaret Thomas (in 1957) and Isabella Forshall (1901-1989, president in 1963), indicated the possibility of female leadership, however women constituted only fifteen per cent of the total membership in 1961. Forshall, who was the president of the Liverpool branch of the Medical Women's Federation in 1948, became a paediatric surgeon in Liverpool after training in London, and was elected president of the Section of Paediatrics at the Royal Society of Medicine in 1959.[641] In common with other early specialists in Liverpool, Forshall was alleged to have 'developed a talented line of successors who she selected, encouraged, stimulated and trained' to continue the local development of paediatric surgery.[642]

Presidents of the LMI used their national appointments to bring prestige to the institution, which offered a suitable venue for large meetings and events. The 1937 BMA meeting was held in Liverpool, the year surgeon Robert Kelly was president of both the BMA and LMI. Similarly, the 1950 BMA meeting in Liverpool coincided with Thomas Porter McMurray's position as president-elect of the BMA. LMI member and consultant otorhinolaryngologist Barbara Abercromby (1900-1977) became the first woman president

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[641] 'Forshall, Isabella (1902 – 1989)' Obituary by Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 13 May 2015).

[642] Life membership oration for Isabella Forshall, delivered by William Mackean, *LMI Transactions and Report*, 1978, 20.

of the Merseyside BMA branch in 1966, and the two organizations remained in close communication.[643] LMI figures drew other national associations to Liverpool: in 1963, James Bagot Oldham (1899-1977), former LMI president (in 1953) was elected President of the Association of Surgeons of Great Britain and Ireland, which held its annual meeting in the city. The LMI also provided a space for the medical community to celebrate the achievements of local practitioners: the institution commissioned an oil portrait of Henry Cohen to celebrate his appointment to the House of Lords in 1956, two years after his term as president of the LMI (see Figure 8.3).[644] The LMI also remained highly supportive of the Liverpool Medical Students Society, student meetings and social events were also attended by consultants, and the institution hosted the national conference of the British Medical Students Association in 1950 and 1954.[645]

[643] 'Barbara ML Abercomby' (Obituary) *BMJ*, 10 September 1977, 709.
[644] Minutes of LMI Council Meeting 13/6/1956 [LMI: LMI 2/1/3/1/9].
[645] When Cyril Clarke noticed the clash between an Institution meeting and the annual students' dinner, the LMSS was asked to rearrange. Minutes of LMI Council Meeting 11/3/1959 [LMI: LMI 2/1/3/1/9].

Figure 8.2. LMI Presidents 1948-1960

Year	President	Qualified	Local Roles	National Roles
1949	Charles Wells	Liverpool	Surgeon, Royal Southern Hosp.; Pres., XX Club; Prof., Surgery	Ministry of Health Committees; MRC Committees; Council, British Assoc. of Urological Surgeons; Vice Pres., RCS (1965); Pres., Sections of Urology and Surgery, RSM.
1950	David Johnston	Glasgow	Myrtle Street Children's Infirmary	Captain, RAMC
1951	Robert Coope	Liverpool	LRI; Pres., XX Club; Lecturer	Thoracic Soc.; Medical Pilgrims; Assoc. of Physicians; Physiological Soc.; International Soc. of Gastroenterologists
1952	Norman Capon	Liverpool	Pres., Liverpool Guild of Students; RLCH; Liverpool Paediatric Club; Prof., Child Health	Council, RCP; Hon. Member, Assoc. of Physicians; Pres., Paediatric Section, RSM, Section of Child Health, BMA, Section of Maternal and Child Health, Royal Soc. of Health; Pres., British Paediatric Assoc.
1953	James Oldham	Liverpool	David Lewis Northern Hosp.; Lecturer, Clinical Surgery	Pres., Assoc. of Surgeons GB&I; CBE
1954	Henry Cohen	Liverpool	LRI; Jewish Medical Soc.; Prof., Medicine	Pres., BMA (1951), GMC (1961), RSM (1964)
1955	Robert Minnitt	Liverpool	David Lewis Northern Hosp.; LRI; Maternity Hosp.; Lecturer, Anaesthetics	Assoc. of Anaesthetists; RSM
1956	Bryan McFarland	Liverpool	Royal Southern Hosp.; LOC; University Club; Pres., XX Club; Prof., Orthopaedic Surgery	BMA; International Orthopaedic Soc.; Orthopaedic Assoc.
1957	Margaret Thomas	Liverpool	Medical Women's Federation	Lady Woolton
1958	Andrew McKie Reid	Liverpool	Pres., Liverpool Guild of Students; LRI; St. Paul's Eye Hosp.;	Court of Examiners, RCS; Freemason; Order St John;

			Philharmonic Society; "Teaching duties"	
1959	Ernest Chamberlain	Liverpool	LRI; Royal Southern Hosp.; Pres., XX Club; Lecturer, Medicine	Assoc. of Physicians; British Cardiac Soc.; Royal Insurance Company
1960	Philip Hawe	Liverpool	RLCH and ULH; Lecturer, Clinical Surgery	Assoc. of Surgeons GB&I; International Surgical Soc.; Fellow, RSM.

Figure 8.3. Presentation of Oil Portrait to Henry Cohen, LMI, 1956.[646]

[646] Photograph from LMI archive [LMI: LMI 5/3/6/2/1].

The growing interest in postgraduate medical education, and rising number of specialist journals, led to increased demands on the LMI library. In 1938, William Le Fanu (1904-1995), librarian at the Royal College of Surgeons, claimed,

> So much has the periodical come to the fore that we now hear complaints that the merely informative journal-article, occupied with the facts of a special research, is likely to oust the wider, philosophic treatise altogether from the field of scientific literature.[647]

In 1954 it was agreed that the in-house *Liverpool Medico-Chirurgical Journal* (which had existed in various forms since 1823 and paused publication in 1948) would not be resuscitated, and instead an annual review of institution activities would appear in the form of a printed *Transactions*.[648] Shepherd reflected that 'the days of the provincial journal were numbered' with the onset of national and international specialist publications, however some regional journals such as the *Bristol Medico-Chirurgical Journal*, founded in 1883, continued as the *Medical Journal of the South West* (later the *West of England Medical Journal*), while the York Medical Society published reports and news in the *BMJ*.[649]

The inaugural address of the president was published in the annual *Transactions* of the LMI, and these speeches and other meetings held at the institution offer insights into the views and concerns of the local professional establishment. Physician and 1959 LMI president Ernest Noble Chamberlain (1899-1974) addressed the membership on the topic of 'the doctor in society', calling on the audience to 'guard jealously our right to remain a learned profession, not only for our own benefit but because the patient still has a right to expect from his doctor more than technical skill.'[650] The LMI also

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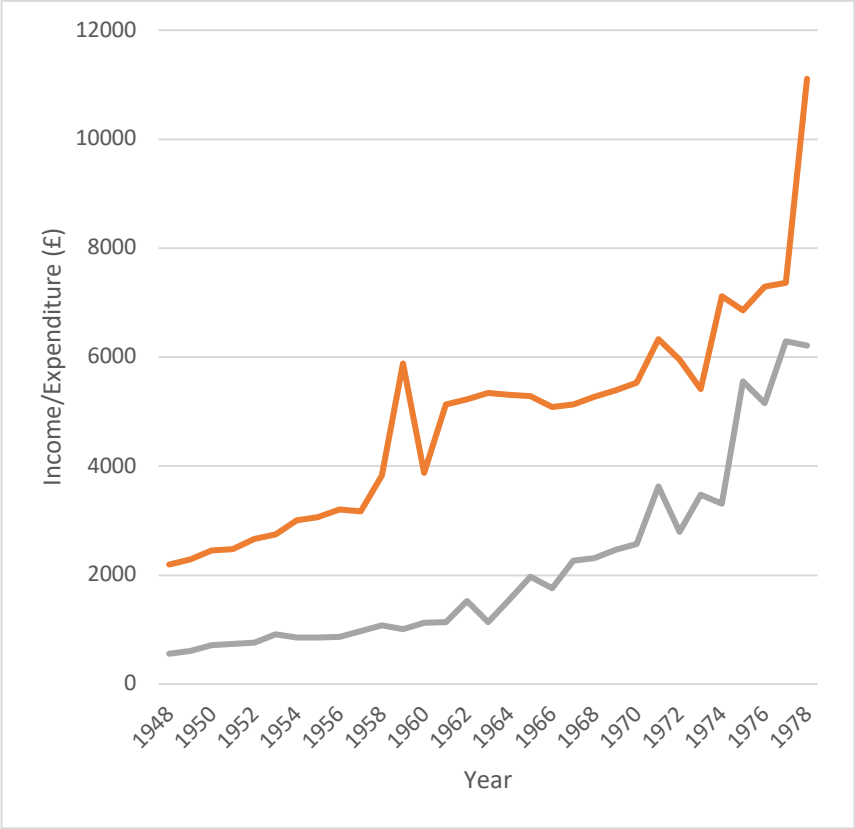
[647] LeFanu, *British Periodicals of Medicine*, 1.
[648] Bickerton, *The Liverpool Medico-Chirurgical Journal: Its past, present, and future*.
[649] Shepherd, *A History of the Liverpool Medical Institution*, 217.
[650] *Transactions and Report, 1959*, 33.

hosted symposia on various elements of professional practice; in November 1956, physician Cyril Clarke led a discussion on 'medical etiquette to-day' (his ideas were published the following year in national medical publication *The Practitioner*) in which he reflected on the challenges to professional harmony resulting from the greater separation between hospital medicine and general practice.[651]

The finances of the institution remained stable during this period, reflecting the healthy number of members. While there was not a marked increase in the proportion of the medical community that joined, the steady rise in the total number of doctors in the city led to growth. The cost of ordinary membership (paid by annual subscription) was £3.3s in 1930, rising to £4.4s in 1948, £5.5s in 1958 and £7.7s in 1961, the money raised from subscriptions comfortably covered library expenses during this period (the main expenditure of the LMI, see Figure 8.4), alongside staff wages, upkeep of the building, and miscellaneous costs associated with the programme of activities. The institution was also able to earn additional funds through sponsorship, predominantly from drug companies, of circulars and invitations to meeting.[652]

[651] *Transactions and Report, 1956*, 44.
[652] Minutes of LMI Council Meeting 13/10/1954 [LMI: LMI 2/1/3/1/9]; Minutes of LMI Council Meeting 6/4/1955 [LMI: LMI 2/1/3/1/9].

Figure 8.4: LMI subscription income (orange) and library expenditure (grey) 1948-1978[653]



[653] Source: Liverpool Medical Institution *Transactions and Report*.

Postgraduate medical education at the LMI

The original 1837 institution building was ill-suited to the demands of rising membership. Extension of the building had been proposed as early as 1938, however the outbreak of WWII and lack of available funds precluded any swift action.[654] The institution purchased adjoining property on Mount Pleasant using a grant from the City Council in 1959, and detailed extension plans were outlined in 1962 (a year after the influential Christ Church conference on postgraduate medical education that urged the development of dedicated 'postgraduate centres' for medical education, discussed below). The LMI seized the opportunity to position itself as a postgraduate centre, and the proposed extension, which offered library space, teaching rooms, and offices for the local BMA branch, was promoted as the natural 'centre for post-graduate study' in Liverpool.[655]

A subcommittee led by physician Gerard 'Sandy' Sanderson (1912-1987) oversaw the fundraising effort, and a public appeal for funds was printed in the *Liverpool Daily Post* and *BMJ* in which the LMI was described as providing 'the postgraduate educational needs of the medical profession of Merseyside and beyond'.[656] Substantial donations were received from the United Liverpool Hospitals (£12,000) and Nuffield Trust (£5,000), the support from the teaching hospital appeared to confirm the LMI's claim to be a key provider of postgraduate education (with the relationship undoubtedly bolstered by overlapping personnel at the institution and the hospitals).[657] Radiologist Percy Whitaker (1904-1976) successfully appealed to the

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[654] Minutes of LMI Council Meeting 15/5/1946 [LMI: LMI 2/1/3/1/8]; Minutes of LMI Council Meeting 11/11/1959 [LMI: LMI 2/1/3/1/9]; Documents relating to planning of extension [LMI: LMI 5/5/1].
[655] *Transactions and Report* 1962, 7.
[656] Minutes of LMI Council Meeting 9/1/1963 [LMI: LMI 2/1/3/1/10]; "Liverpool Medical Institution Development Appeal," *BMJ* 19 Jan 1963, 193.
[657] *Transactions and Report* 1961, 11; *Transactions and Report* 1963, 8; Minutes of LMI Council Meeting 14/3/1962 [LMI: LMI 2/1/3/1/10].

North West Cancer Research Fund, which approved a gift of £8,000 in 1964. Isaac Jackson-Lipkin (1895-1975), chairman of the fund, was an LMI member and elected vice president the following year.[658] Connections to the various medical services in the city enabled senior LMI figures to access valuable sources of financial support for the ambitions of the institution, and demonstrated the interconnected nature of local professional networks.

The institution was registered as a charity in 1963, with its charitable objects stated as 'the cultivation of medicine, surgery and the collateral branches of science, exclusively, together with the maintenance of a library'.[659] Charitable status offered certain tax benefits, and at a special meeting in May 1963 members agreed to submit a petition for a Royal Charter, which would confer further independent legal status. The petition was supported by Frederick Marquis, Lord Woolton (1883-1964), a former managing director of Lewis's department store and husband of 1957 president Margaret Thomas (it was later noted that the 'influential support' of Lord Woolton was essential in the development of the extension), and the charter was granted in August 1964 (shortly before Lord Woolton's death in December 1964).[660] A drug company funded the printing of a framed copy of the charter, which was on display for the formal opening of the extension on 28th October 1966 (see Figure 8.5).[661]

The LMI established several memorial lectures to celebrate the legacy of notable former members during this period. A number of high-ranking medical administrators spoke at the institution at the

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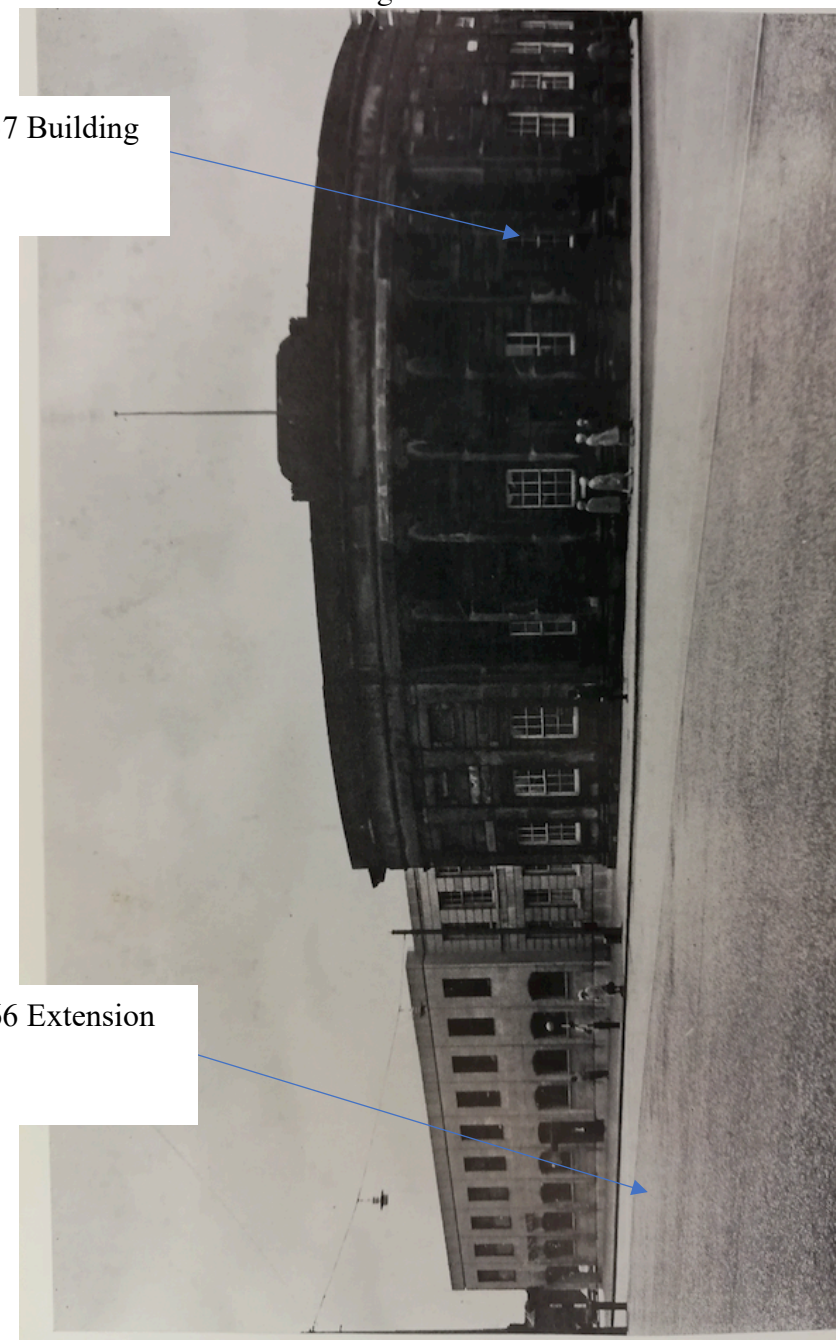
[658] "IJ Jackson-Lipkin" (Obituary), *BMJ* 12 July 1975, 104.
[659] Charity Commission, "Liverpool Medical Institution" www.charitycommission.gov.uk [accessed 19 February 2020].
[660] Minutes of LMI Council Meeting 9/12/1964 [LMI: LMI 2/1/3/1/10]; Life membership oration for Margaret, Countess of Woolton, delivered by Thomas Seager, *LMI Transactions and Report*, 1971, 24.
[661] The company also printed 1500 further copies in booklet form for members (in exchange for a free advertisement in the *Transactions and Report)*.

lecture series established in memory of Trevor Lloyd Hughes (1909-1964), Senior Administrative Medical Officer for the Liverpool Regional Hospital Board at the time of his death. Sir George Godber (1908-2009), former Chief Medical Officer (1960-1973) addressed the LMI in this capacity in 1977, and commended the role of local figures including Henry Cohen and Trevor Lloyd Hughes during the early years of the Liverpool RHB.[662] Cohen maintained a deep interest in the history of medicine, and arranged for the eighth British Congress on the History of Medicine to be held at the LMI in September 1971, followed in 1973 by a new annual history of medicine lecture named in his honour. Cohen gave the first lecture in the series, and the event was subsequently supported by an endowment from drug company ER Squibb and Sons.[663]

[662] *Transactions and Report, 1978*, 25.
[663] *Transactions and Report* 1973, 49.

Figure 8.5. Exterior of LMI showing 1966 Extension [664]



[664] Photograph of 1966 extension, [LMI: LMI 7/3/3/1/1].

The 1966 extension left the LMI better placed to meet the increasingly formalised expectations of postgraduate education. A major conference held at Christ Church, Oxford in 1961, led by Regius Professor of medicine George Pickering (1904-1980) aimed to stimulate the nationwide development of postgraduate medical centres (PGMCs).[665] The committee recommended PGMCs that provided an 'educational atmosphere in the basic local hospital unit' under the leadership of a consultant tutor.[666] Geoffrey Rivett described the conference as catching 'a tide of interest at the flood,' and it was followed by the rapid development of PGMCs at hospitals across the country.[667] Nonetheless, diabetologist and former regional postgraduate dean John Lister (1920-2013) described the 'erratic, intermittent, [and] un co-ordinated' development of PGMCs across the country after 1961.[668] The Royal Commission on Medical Education, reporting in 1968, advocated closer alignment between postgraduate institutes, medical schools and teaching hospitals, which Geoffrey Rivett claimed had remained 'united and effective in their resolve to resist' closer association.[669] In 1987, Alex Paton (1924-2015), postgraduate dean for the North East Thames Region, claimed 'complexity, confusion, and uncertainty' had replaced the 'clear sighted objectives of the early years' of postgraduate medical education.[670]

Lister described PGMCs as providing 'a meeting place where hospital staff, senior and junior, could meet on common ground with

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[665] Lister, "The History of Postgraduate Medicine Education," 729.
[666] David Patey et al "Assessment of Postgraduate Medical Education A Report to the Nuffield Provincial Hospitals Trust." *BMJ* 4th September 1965, 558.
[667] Rivett, *From Cradle to Grave*, 183.
[668] Lister, "The History of Postgraduate Medicine Education," 728.
[669] Rivett, *From Cradle to Grave,* 253.
[670] Alex Paton, "Christ Church Conference on Postgraduate Education--25 Years On," *BMJ (Clinical Research Ed.)* 14th February 1987, 393.

their general practitioner colleagues'.[671] Postgraduate teaching was conducted by consultants appointed by the university, supervised by a regional postgraduate dean, and funded by the NHS.[672] In contrast to traditional medical societies, PGMCs operated within and were accountable to the NHS. They intruded on the role the LMI had fashioned for itself, especially as PGMCs had a social as well as purely education function, as 'a friendly meeting-place for those who wish to teach and those who wish to learn more'.[673]

A number of factors obstructed the development of PGMCs, most notably a lack of financial support that led to some centres operating from converted houses, paint stores and pharmacies.[674] In Liverpool, where delays to the new Royal Liverpool hospital prevented postgraduate medical education based at a central teaching hospital, the LMI offered the Regional Hospital Board an established venue to use as its postgraduate centre. The LMI was unusual among provincial medical societies in having a (recently extended) building, complete with library and lecture theatre, in close proximity to several hospitals and the university.

Not all provincial medical societies were as adept as the LMI in finding a place within the new system of postgraduate medical education, and societies without premises such as the Manchester Medical Society (which met at the medical school) suffered declining attendance as local postgraduate centres were established during the 1960s.[675] Some societies simply folded into the PGMC structure; all post-WWII meetings of the Leicester Medical Society were held at a local hospital, and subsequently at its PGMC.[676] Evidently, the

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[671] Lister, "The History of Postgraduate Medicine Education," 730.
[672] David Innes Williams, "The Evolution of Postgraduate Medical Education," *Postgraduate Medical Journal* 61.720 (1985), 872.
[673] Patey et al "Assessment of Postgraduate Medical Education," 564.
[674] John Lister, "Regional Postgraduate Medical Centres." *BMJ* 21st September 1968, 736-7.
[675] Elwood and Tuxford, *Some Manchester Doctors*, 44.
[676] "History of the Leicester Medical Society" Leicester Medical Society (Online).

emergence of formal postgraduate medical education constituted an existential threat to the traditional medical society model.

Financing the institution

More than 70 PGMCs had been built by the time of a 1968 survey published in the *BMJ*. The results demonstrated substantial regional inequality in the uptake of PGMCs and suggested Liverpool was the only region without a single centre (see Figure 8.6).[677] The LMI contested this claim, and promptly dispatched a letter to the *BMJ,* printed the following month, stating that

> While it may well be true that there is no postgraduate centre financed in whole or in part by the hospital service, the Liverpool Medical Institution does in fact function very effectively as a postgraduate medical centre both for hospital and general practitioner branches of medicine.[678]

A year earlier, the president of the Birmingham Medical Institute had lodged a similar complaint with the *BMJ*, claiming that, although not a formal PGMC, 'since its foundation in 1875 [the BMI] provided a centre for postgraduate, vocational and continued educational activity in the Birmingham region.'[679] The independent medical societies claimed equivalent status to official PGMCs, however their lack of recognition was an ominous sign of their apparent incompatibility with the new system.

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[677] Lister, "Regional Postgraduate Medical Centres," 736.
[678] Minutes of LMI Council Meeting 9/10/1968 [LMI: LMI 2/1/3/1/10].
[679] "Birmingham Medical Institute" (Correspondence) *BMJ* 25 March 1967, 758.

Figure 8.6: Postgraduate Medical Centres in England and Wales, 1968[680]

Location	Existing PGMCs	Planned PGMCs	Total
Birmingham	12	4	16
East Anglia	3	1	4
Leeds	4	3	7
Liverpool	0	1	1
Manchester	4	3	7
NW Metropolitan	8	3	11
SW Metropolitan	5	1	6
NE Metropolitan	4	3	7
SE Metropolitan	5	2	7
Newcastle	7	3	10
Oxford	3	3	6
Sheffield	2	3	5
Wessex	5	0	5
South-Western	2	4	6
Wales	1	2	3
Scotland	6	0	6
Ireland	3	1	4

[680] Data from Lister, "Regional Postgraduate Medical Centres," 736.

The LMI maintained its independence through a collaborative relationship with the Regional Postgraduate Education Committee (PEC).[681] After 1968, LMI members who had been qualified for less than six years could recoup their membership costs from the PEC, and new incentives for GPs led to popular lunchtime meetings at the institution. PEC investment also supported the purchase of new equipment and appointment of an assistant librarian.[682] The PEC grant, alongside money from the NWCRF and BMA, meant total income from grants passed £1000 in 1970, and provided essential funding. In spite of this additional support, continued financial pressure necessitated the realisation of investment assets and 'special funds' to maintain solvency. In 1970 and 1973 the institution drew greater sums from its special funds than it received in from the total of membership subscriptions (see Figure 8.7). Its traditional role as an independent and self-directing doctors' club was at risk in light of the growing dependence on external sources of funding.

Partnership with the PEC led to a rise in the number and range of meetings at the LMI, however as early as 1963 council observed that growing specialisation made it 'increasingly difficult to devise a programme which will have a wide appeal'.[683] The problem of poor attendance was resolved with the introduction of sponsored meetings (predominantly by drug companies). A 1968 lecture by Scottish pharmacologist Sir Derrick Dunlop (1902-1980), sponsored by Bayer, proved so popular that members had to be turned away.[684] Council attributed the popularity of sponsored meetings was due in part to the free supper, and Shepherd later reflected on the 'almost embarrassing increase in interest' at meetings as a result of the free refreshments.[685]

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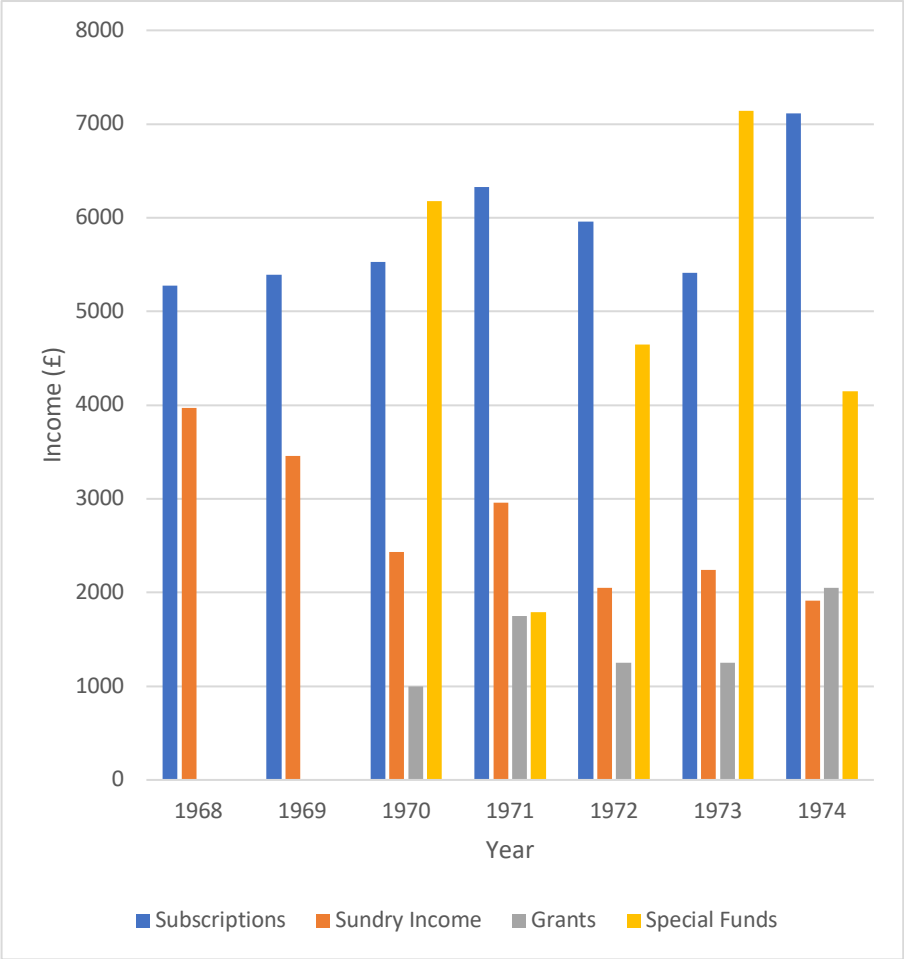
[681] *Transactions and Report* 1966, 7.
[682] *Transactions and Report* 1967, 61; *Transactions and Report* 1973/4, 34.
[683] *Transactions and Report* 1963, 7.
[684] *Transactions and Report* 1969, 59.
[685] *Transactions and Report* 1970, 42; Shepherd, *A History of the Liverpool Medical Institution*, 252.

Figure 8.7: Sources of LMI funding 1968-1974



Drug companies played an important role in the financing of PGMCs across the country, and falling levels of professional and public funding to support postgraduate education resulted in an ever greater reliance on the industry.[686] A 1967 leader article in the *BMJ* claimed doctors had 'reason to be grateful for the drug manufacturers' contribution to advances in medicine,' however despite the important revenue from drug sponsorship (and the ubiquity of drug marketing at postgraduate events), some members criticised the space given to firms during sponsored meetings.[687] Alex Scott Samuel recalled the relationship between LMI activity and drug industry funding.

> The way to get GPs to come to a meeting at the Medical Institution was for a drug company to pay for a lunch during which they would see a film or hear a talk or whatever about some new drug, or the treatment of some condition or whatever. That was all very much part of that nexus.[688]

The proliferation of new medicines after WWII contributed to the massive growth of the drug industry, which courted the medical profession with a combination of what Jane Smith described as 'food, flattery and friendship.'[689] Drug companies considered investment in medical education a key part of their marketing strategy, and sponsorship postgraduate education in Britain and the USA during the 1960s and 1970s.[690] The British drug industry was regulated by poorly defined and enforced laws around the adulteration of food and

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[686] Williams, "The Evolution of Postgraduate Medical Education," 872; Paton, "Christ Church Conference on Postgraduate Education," 393-4.

[687] "Sainsbury Report" *BMJ* 7 October 1967, 1; Minutes of LMI Council Meeting 13/4/1983 [LMI: LMI 2/1/3/1/11].

[688] Alex Scott Samuel, 1 May 2018.

[689] Jane Smith, "Food, Flattery, and Friendship," *BMJ* 29 May 2003.

[690] Smith, "Food, Flattery, and Friendship,"; Norman Kaplan, "The Support of Continuing Medical Education by Pharmaceutical Companies," *New England Journal of Medicine,* 25 January 1975, 194-196.

medicines prior to the 1968 Medicines Act, which introduced mandatory authorisation with the Medicines Division of the Department of Health (partly in response to the thalidomide scandal).

The reliance of the LMI on industry sponsorship, alongside increasing coordination with the NHS administration as a PGMC, reflected another concession to stakeholders from outside the profession. LMI Presidents during this period continued to be represented in other local and national professional organizations, and hold senior positions in local medical services and the medical school (see figure 8.8). The involvement and leadership of influential figures set standards of acceptable professional behaviour in the medical community, and the presence of drug industry marketing at the historic medical society provided a tacit endorsement of professional interactions with representatives from the industry. In 1974, following the NHS reorganisation, the LMI was approached by the local health authority to become 'landlord' to an NHS-run PGMC. This process is discussed in Chapter 12.

Figure 8.8. LMI Presidents 1961-1978

Year	President	Qualified	Local	National
1961	Percy Whitaker	Liverpool	Radiologist, ULH; Pres., XX Club	Vice Pres., Faculty of Radiologists (1959); Pres., Radiological Section RSM (1954)
1962	Ronald Brookfield	Liverpool	ULH; Chair, Liverpool Paediatric Club; Board of Governors, ULH; Lecturer; Chair, Faculty of Medicine	Evangelical Union; the Inter-Varsity Fellowship; Christian Medical Fellowship
1963	Isabella Forshall	London	RLCH; MWF	Pres., British Assoc. of Paediatric Surgeons (1958) Pres., Section of Paediatrics, RSM (1959). Hon. Member, British Assoc. Paediatric Surgeons, British Paediatric Assoc. (1963)
1964	Allan Downie	Aberdeen	Pres., XX Club; Prof., Bacteriology	FRS
1965	James Cosbie Ross	Liverpool	LRI; Royal Southern Hosp.; Lecturer; Chairman, Faculty of Medicine	Hon. Member, British Assoc. Urological Surgeons; Pres., Moynihan Chirurgical Club.
1966	Norman Jeffcoate	Liverpool	ULH; Prof., Obstetrics and Gynaecology	Pres., RCOG (1969); Knighthood
1967	John Cheetham	Liverpool	GP	
1968	Frederick Ronald Edwards	Liverpool		
1969	Goronwy Thomas	Liverpool	Pres., XX Club;	
1970	Cyril Clarke	Cambridge	David Lewis Northern Hosp.; LRI; Pres., XX Club; Prof., Medicine	KBE; FRS; Pres. RCP (1972) ; Pres., Royal Entomological Society
1971	Alan Sutcliffe Kerr	Liverpool	Walton Hosp.	
1972	John D Hay	Liverpool	RLCH; Pres., XX Club; Prof., Child Health	Lt. Colonel, RAMC; Pres. British Paediatric Assoc.
1973	Thomas Seager	Liverpool	Pres., LMSS; Founder, Liverpool Paediatric Club; Pres., XX Club	Founder Member, RCGP

1974	Thomas Cecil Gray	Liverpool	LSA; Pres., XX Club; Prof., Anaesthetics; Dean of Faculty	Founder Member, Faculty of Anaesthetists RCS, RSM; MDU
1975	Ivan Leveson	Liverpool	Psychiatrist, Royal Southern Hosp.; Sefton General Hosp.	
1976	John Shepherd	St Andrews	Broadgreen Hosp.; Liverpool RHB; Lecturer, Surgery	Vice Pres. RCSEd; Examiner, RCS
1977	Donald Watson	Liverpool	David Lewis Northern Hosp.; Royal Liverpool Hosp; Sefton General Hosp.; Lecturer, Clinical Medicine	RAMC

8.2: Medical Clubs and Specialist Societies 1948-1978

Specialist societies and professional advancement

Opportunities for practitioners pursuing specialist careers grew following the creation of the NHS, and local specialist societies continued to support their aims.[691] Some societies remained highly exclusive, such as the Liverpool Orthopaedic Circle (which proved so insular that a separate orthopaedic society with less restrictive membership was established in 1958), while others integrated with university departments or were subsumed into national specialist associations.[692] Thomas Cecil Gray was appointed head of the new academic department of anaesthesia at Liverpool in 1947, and established a popular postgraduate course the following year. By 1952, international students were arriving in the city to work in supernumerary training posts at local hospitals as part of their postgraduate studies.[693] Gray was active across local and national networks; a founder member of the Faculty of Anaesthetists at the RCS in 1948, president of the Section of Anaesthetists at the RSM (1955-56) and the Association of Anaesthetists (1956-59). In Liverpool he was president of the Liverpool Society of Anaesthetists (1962-64), the Liverpool Medical Institution (1974-75), and the exclusive Twenty Club (1956).[694]

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[691] Weisz, *Divide and Conquer,* 164.

[692] In 1976 the '58 Society began to admit senior registrars and later all orthopaedic trainees in the region, becoming part of the Mersey Orthopaedic Trainee Association, running sponsored monthly meetings, http://58society.com/ [accessed 19 February 2020].

[693] Anne Florence, "A tribute to Professor Thomas Cecil Gray, March 11th, 1913 – January, 5th 2008," *Proceedings of the History of Anaesthesia Society* 39 (2008), 12; Gordon Jackson Rees, "The Liverpool Course," *Proceedings of the History of Anaesthesia Society* 21 (Liverpool meeting 27th and 28th June 1997), 16.

[694] Ballance, "Thomas Cecil Gray CBE KCSG FRCP FRCS FRCA and Gordon Jackson Rees FRCA FRCP FRCPCH, 135; Anne Florence "Past Presidents - Thomas Cecil Gray," Liverpool Society of Anaesthetists, http://www.lsoa.org.uk/whogray2.html [accessed 19 February 2020].

Gray closely stewarded the local growth of his specialty: Jennifer Hunter, LSA president (2008-10), described him as 'a great kingmaker… he brought everyone into his department, no outsiders, everybody was under his umbrella'.[695] Clare Howard, LSA president (2016-18), recalled how during the first year of training as an anaesthetist 'you were almost pressganged into joining' the LSA.[696] Unlike some of the other specialist societies and clubs, women took a leading role in the LSA from its inception: notable early presidents included Elizabeth Hanson (1888-1962, president in 1948) and Hilda Garry (1906-1978, president in 1956), a former assistant to Minnitt at the Liverpool Maternity Hospital.[697]

Positions of authority at the university, where he became dean of the faculty of medicine in 1970, enabled Gray to take an active role across local professional life. Janice Fazackerley recalled his participation in the activities of the Liverpool Medical Students Society during the early 1970s.

> He was one of the lads…one of them [the consultants] came in in a coffin, and jumped out. Cecil used to come and sit there and have water thrown at him and take it on the nose like everybody else. If you were part of the men's medical dinner then he would go to that and he was right there, down with the kids, very much part of it.[698]

In 1977, John Utting (1932-1998) succeeded Gray as the second professor of anaesthesia at Liverpool, Utting came from an established Liverpool family (his grandfather had been Lord Mayor) and, like Gray, he was a committed Roman Catholic.[699] Jennifer Hunter claimed this shared religious background played a role in local appointments.

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[695] Jennifer Hunter 4 October 2018.
[696] Clare Howard 22 October 2018.
[697] O'Sullivan, "Dr Robert James Minnitt 1889-1974," 221.
[698] Janice Fazackerley, 9 May 2018.
[699] "John Edward Utting," *BMJ* 318, 23 January 1999, 266.

> There is no doubt that Cecil Gray, who was a very strong Roman Catholic, had set up a university department full of men of the same faith, he did say to the second professor, John Utting, when he made me a lecturer that it may be a mistake to appoint a woman who was of Protestant background![700]

Other interviewees were also recipients of Gray's sponsorship: Tony Gilbertson (b. 1932) trained under Gray and Gordon Jackson Rees (1918-2001) before establishing the intensive care unit at Sefton General Hospital.[701] Gilbertson was also from a Catholic family and his brother was Gray's godson, he admitted that his former teacher probably put in an 'extremely discreet' recommendation at the Royal Society of Medicine (where he was elected Vice President).[702] Gilbertson followed Gray as president of the Twenty Club (1988) and LSA (1990), and Gray's son David became LSA president in 2002. Anaesthesia in Liverpool provides an example of the interconnectedness of the specialist society, academic department, and wider national bodies.

Local professional networks also influenced practitioners' involvement with national societies. This was the case with the Thoracic Society (TS), founded in 1945 to bring together experts in chest diseases in a private society with a limited membership (unlike the 'open' Tuberculosis Association, of which many TS figures were also members).[703] Practitioners from Liverpool held senior roles in

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[700] Jennifer Hunter 4 October 2018.

[701] Jackson Rees was similarly involved medical societies; president of the Liverpool Society of Anaesthetists (1966-8), the Section of Anaesthetists of the RSM (1981-2), founder member and President (1976-9) of the Association of Paediatric Anaesthetists, and first President of the European Association of Paediatric Anaesthetists (1986).

[702] Anthony Gilbertson 20 August 2018.

[703] John Scadding, "The Thoracic Society: A Retrospect," *Thorax* 38.2 (1983), 88-90; this period also saw the transition from chest medicine as a specialty synonymous with tuberculosis doctors, who

the Thoracic Society from the outset: the first provincial meeting was held in Liverpool in 1946, and Robert Coope (1892-1972) became the first president from the provinces in 1951. Coope was active across a range of other societies and groups, including the Medical Pilgrims (a national society initially limited to 20 members established in 1928), the Twenty Club (president 1935) and the LMI (president 1951).[704] He forged strong connections between Liverpool and the Thoracic Society, and encouraged his students and junior colleagues to take on editorial duties at the society journal, *Thorax*. Alick John ('Black Jack') Robertson (1919-2006), Coope's former registrar, was editor between 1960-70, succeeded by Colin Ogilvie (1922-2007), another former student.[705]

Anthony Seaton (b. 1938) first encountered Robertson and Ogilvie as a student on clinical firms in Liverpool, and took over from Ogilvie as editor of *Thorax* in 1977. Seaton recalled how the editorship was passed between this group.

> Coope suggested this bright young chap John Robertson would be a suitable person…Robertson thought that Colin [Ogilvie] would be a good person to take it over, because he was a bachelor – had time on his hands…[Ogilvie] rang me and said would I mind taking over as editor, so I did', 'I did it for five years and then when I had had

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'weren't regarded as proper doctors, they were out in the periphery in sanatoria.' Anthony Seaton, 22 August 2018; The Tuberculosis Association was the result of a 1928 merger of the Tuberculosis Society and the Society of Superintendents of Tuberculosis Institutions.

[704] 'Robert Coope (1892-1972)' Obituary by AJ Robertson, *Munk's Roll* Volume VI, 114.

[705] Jadwiga Wedzicha, "Celebrating 60 Years of Thorax," *Thorax* 61.12 (2006), 1015–22; 'Robert Coope (1892-1972)' Obituary by AJ Robertson, *Munk's Roll* Volume VI, 114; 'Alick John Robertson (1919-2006)' Obituary by RCP Editor, *Munk's Roll* Volume XII (web); 'Colin Macleod Ogilvie (1922-2007)' Obituary by CC Evans, *Munk's Roll* Volume XII (web).

> enough I rang a couple of friends, one of them agreed to take it over – that's how it worked: informally.[706]

Practitioners from Liverpool were similarly involved in the editorship of the *British Journal of Anaesthesia* (the journal of the Royal College of Anaesthetists), Thomas Cecil Gray was joint editor between 1948-1964, and in 1961 passed the responsibility to John Edmund Riding (1924-2018). Riding was a graduate of Gray's anaesthetics diploma at Liverpool and became a demonstrator in his department in 1956, he remained editor of the journal until 1972.

The autonomous and self-selecting nature of specialist societies and clubs provided the opportunity for, at the very least, favouritism towards local or well-connected individuals. Isobel Allen's oral history research on doctors confirmed that 'the people who get the jobs are those who know the most people', and involvement in local networks offered significant advantages.[707] Physician John Ridyard, who arrived at Liverpool medical school in 1963, reflected on the role of such local patronage.

> You could put a good word in for them [junior colleagues]– that did happen, I can understand for people who weren't so good at networking that they were disadvantaged.[708]

Ridyard recalled securing his first consultant appointment in 1978 at Whiston Hospital as a result of such informal networks.

> In those days you were kind of invited to get a job, you know, I knew – I just got a phone call one day from David Price Evans, who was the professor of medicine at the time, he said 'John, we want to set up a teaching firm at Whiston, are you interested in this job that's coming up in respiratory?' and then that was it, I landed up as a physician in Whiston.

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[706] Anthony Seaton, August 22 2018; Keith Parsons 4 June 2018.
[707] Allen, *Doctors and Their Careers*: *A new generation*, 120-1.
[708] John Ridyard 31 May 2018.

Local societies, alongside the familiarity with local medical leaders developed during medical school, enabled familiar figures to be 'invited' to undertake new roles and responsibilities.

New specialist societies continued to be established after 1948: the Liverpool Paediatric Club (LPC) was founded in 1949 under the leadership of Norman Capon (1892-1975). Capon was president of the guild of undergraduates at Liverpool in 1914 and after qualifying became a leading paediatric physician in the city. He was appointed as the first professor of child health in 1944, elected LMI president in 1952, and was an original member and later president (1951-52) of the British Paediatric Association.[709] During the formal oration to mark Capon's life membership of the LMI (after continued membership of fifty years), he was described as 'at once one of the most distinguished and best-loved members of the Institution and our medical community.'[710]

The LPC aimed to 'encourage the study of paediatrics and promote friendship among medical practitioners having a special interest in child health,' and held joint meetings with equivalent clubs in Manchester, Belfast, Birmingham, Leeds, and Sheffield during the 1950s.[711] Bryan McFarland, the founder of the Liverpool Orthopaedic Circle, was vice-president of the LPC in 1950, a position he retained almost continuously until his death in 1963. The LPC was an inclusive society, and the involvement of figures such as McFarland in both the LPC and Liverpool Orthopaedic Circle was demonstrative of the sometimes-overlapping membership of such groups. In some instances, the networks and institutions of Liverpool's medical community collaborated to support mutually beneficial activities: the 1954 meeting of the Moynihan Chirurgical Club in Liverpool included visits to the Royal Infirmary and Southern Hospital, drinks

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[709] 'Norman Brandon Capon (1892-1975)' Obituary by JD Hay, *Munk's Roll* Volume VI, 89.
[710] Life membership oration for Norman Capon, delivered by Gerard Sanderson, *LMI Transactions and Report*, 1965, 10.
[711] Papers of Liverpool Paediatric Club, [LMI: HV6/1-2].

at the Liverpool Medical Institution and dinner at the University Club.[712]

Family and social networks: medical clubs after 1948

Social and family links, posts within the prestige specialties, and personal, religious and social backgrounds all contributed to practitioners' 'clubbability', and medical clubs continued to operate after 1948. Unlike some of the specialist societies discussed above, the medical dining clubs remained small elite networks. Several families were represented across multiple generations in the Twenty Club: 1947 president Bryan McFarland was followed by his son John (1930-2013) in 1981, while the club's founder EE Glynn was a second-generation professor at the medical school, as was 1968 president 'Little John' Hay (1909-2003), whose father John Hay Snr. (1873-1959) was a founder member of the club.

Marriages between local practitioners were commonplace, and several presidents of the Liverpool branch of the Medical Women's Federation were married to professional colleagues. Muriel Barton Hall (1893-1955, MWF branch president in 1936) was appointed consultant psychiatrist at the Royal Liverpool Children's Hospital in 1947, and became a lecturer in the department of psychological medicine established by her husband Stephen (1899-1978) in 1955.[713] Mary Macaulay (1904-1994 president in 1952) married a fellow medical student and ran a practice with her husband before entering hospital medicine.[714] Dermatologist Netta Hay (1911-1980 president

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[712] Robert Sells, "Presidential Address to LMI, 1997," 13.
[713] 'Stephen Barton Hall (1899-1978)' Obituary by JD Hay, *Munk's Roll* Volume VII, 239, Muriel Barton Hall was also involved in the development of the field of 'child guidance', which addressed psychiatric and behavioural issues in children that were neither a result of mental illness or educational ability, see John Stewart, *Child guidance in Britain, 1918–1955: the dangerous age of childhood* (Abingdon: Routledge, 2015), 8.
[714] 'Douglas Blair Macaulay (1904-1985)' Obituary by Sir Cyril Clarke, *Munk's Roll* Volume VIII, 296.

in 1957) was married to John Hay (1909-2003), professor of child health and son of the professor of medicine, and Elisabeth Rees (1918-1993) married fellow student and anaesthetist Gordon Jackson Rees (1918-2001), they were both on LMI Council and Elisabeth was elected president in 1982.[715]

The Twenty Club assumed a more social character after 1945, when only non-medical papers and notes were accepted at meetings.[716] Activities included a 1950 poetry competition, during which Henry MacWilliam, formerly medical superintendent at Walton hospital, submitted a poem on the history of the club, describing the elitist founding membership 'picked by the most stringent rule… excluding thus the snob, the prig, the fool/ Avoiding with due care the second rate.' The club's poetry prize went to Australian tropical diseases expert Brian Maegraith (1907-1989), who had been appointed to the chair of tropical medicine in 1944 at LSTM (and became Dean 1946-1975), for his romantic poem 'African Afternoon', presumably drawn from his wartime experiences as a pathologist in West Africa.[717]

The self-selecting admission policy of the Twenty Club ensured its continued homogeneity, and enabled established members to promote junior colleagues they felt conformed to their view of the profession.[718] Women were invited to the annual 'ladies' night', first held in 1947; this was a larger gathering, and in 1961 a total of 68

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[715] 'Gordon Jackson Rees (1918-2001)' Obituary by TC Gray, *Munk's Roll* Volume XI, 472.

[716] Twenty Club Minutes 7th November 1984.

[717] "Evans, Sons, Lescher and Webb," Grace's Guides to British Industrial History, https://www.gracesguide.co.uk/Evans,_Sons,_Lescher_and_Webb, [accessed 19 February 2020]; Twenty Club Minutes 1st March 1950 [LMI: TCM]; "Maegraith, Brian Gilmore," *Australian Dictionary of Biography* (http://adb.anu.edu.au/biography/maegraith-brian-gilmore-14756).

[718] Pierre Bourdieu, *Distinction—A Social Critique of the Judgment of Taste* (Cambridge, MA: Harvard University Press, 1984) 161-2.

members and guests attended.[719] As the 1960s progressed, the club was increasingly dissatisfied with the expense of the University Club as a meeting location, venues such as Staff House (at the University of Liverpool), and other local clubs were mooted.[720] In the 1970s the group met at the Athenaeum Club, Liverpool's oldest members' club, the Greenbank Club, and Staff House for a joint meeting with the Innominate Club, but by 1980 the Liverpool Medical Institution had become the venue of choice. The activities of the Twenty Club after 1948, limited to non-medical discussion and increasingly social in character, were indicative of the desire amongst the local professional elite to sustain traditional forms of association. Families with multiple practitioners provide evidence of perhaps the most intimate 'networks' in the local professional community, which provided support within academic departments, specialties, and the wider medical community.

Jewish and Welsh practitioners in Liverpool

Demographic changes within the local medical community contributed to the establishment of new medical societies during the twentieth century. A 1982 study commissioned by GP Mervyn Goodman (1928-2004) noted the rapid growth of the Jewish medical community from two practitioners in 1920 to over one hundred and fifty by the 1980s.[721] Goodman followed his father as a GP in Everton, where the slum clearances of the early 1960s contributed to his medico-political awakening. He served on the General Medical Services Committee of the BMA between 1967-1990, was a member of the Board of Deputies of British Jews, the leading representative body of the national Jewish population, and a champion of

[719] Twenty Club Minutes May 1961 [LMI: TCM].
[720] Twenty Club Minutes, January 1966 [LMI: TCM].
[721] Nikos Kokosalakis, *Ethnic Identity and Religion: Tradition and Change in Liverpool Jewry*. (Washington DC: University Press of America, 1982), 170.

Liverpool's most successful doctor, Henry Cohen.[722] The plight of Jewish refugees from Nazi Germany prompted Cohen to convene a series of meetings of local practitioners prior to the outbreak of WWII, he was arguably the most powerful practitioner in the city, and remained honorary president of the Jewish Medical Society (JMS), founded in 1947, until his death in 1977 (despite the fact that his religious convictions were more linked to the 'ethical, cultural and historical aspects' of Judaism).[723]

The JMS held monthly meetings and speakers were invited to lecture on medical topics, Jewish culture and Zionism, the society also established links with the Jewish medical communities in Manchester and Leeds.[724] Cohen enjoyed huge influence over the local medical community in his capacity as professor of medicine (between 1934-1965) and numerous national appointments. Renal physician John Goldsmith (b. 1924, JMS president 1980-1), who arrived in Liverpool in 1961, recalled that all new arrivals to hospital medicine in the city had to make a 'courtesy visit' to Cohen at the

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[722] Local GP Mervyn Goodman (1928-2004), commissioned a comprehensive survey of the Jewish community, written by Nikos Kokosalakis, *Ethnic Identity and Religion: Tradition and Change in Liverpool Jewry*. (Washington DC: University Press of America, 1982); Goodman also published his own study, Mervyn Goodman, "The Jewish Community of Liverpool," *Jewish Journal of Sociology* 38 (1996), 89; I Bogle, "Mervyn Goodman" (Obituary) *BMJ* (online) https://www.bmj.com/content/suppl/2004/12/30/330.7481.47-b.DC1 [accessed 12 March 2019].

[723] Jewish Medical Society Records, [LRO: JMS/1/1]; Mervyn Goodman, "Henry: A Physician of Distinction—the Rt Hon. Lord Cohen of Birkenhead, CH," *Jewish Historical Studies* 39 (2004), 203; 'Henry Cohen' Obituary by Gerard Sanderson, *LMI Transactions and Report*, 1978, 68.

[724] Jewish Medical Society Records, [LRO: JMS/1/2]; Other organizations, such as the Jewish Women's Personal Service Guild, established in 1937, were populated at senior levels by a number of doctors' wives, and visited patients in hospitals, delivered kosher meals to Jewish inpatients, and raised funds for medical causes. See [LRO 296 PSG/2/1].

Royal Infirmary.[725] Cyril Clarke, his successor as professor medicine, recalled that even at the end of his tenure Cohen had to be treated with deference: when the Nuffield Trust approached Clarke with funds for a medical genetics unit in 1963, passing over Cohen, he recalled the situation had to be 'adroitly managed' to avoid causing offence.[726]

Goodman described Cohen as an 'outstanding member of the local Jewish community,' nonetheless, his forceful personality sometimes led to conflict, and he had the authority to effectively ostracise colleagues from the local professional community.[727] Personal differences between Cohen and physician Maurice Pappworth (1910-1994) led to the latter's departure from the city (Pappworth left Liverpool for London, and made enemies in the RCP as a whistle-blower on unethical medical research). In her biography, Pappworth's daughter Joanna Seldon suggested that 'neither anti-Semitism nor nepotism' explain her father's ostracization; rather his 'awkward personality was as much of a hindrance as his background'.[728]

The JMS provided a support network for local Jewish doctors, and members participated in broader academic and professional networks. A Jewish physician recalled the support of the group upon his arrival in Liverpool in 1984, and that Ronald Finn 'took me under his wing…when I arrived as an isolated person.'[729] Raphael Marcus (1914-2002), described by Thomas Cecil Gray, an undergraduate contemporary, in a 1996 interview as 'a little Jewish

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[725] John Goldsmith, 28 February 2018.
[726] "Sir Cyril Clarke KBE FRS in interview with Sir Gordon Wolstenholme Oxford, 15 May 1986," The Royal College of Physicians and Oxford Brookes University Medical Sciences Video Archive. MSVA 009.
[727] 'Maurice Henry Pappworth (1910-1994)' Obituary by Stephen Lock, *Munk's Roll* Volume X, 373; Goodman, "Henry: A Physician of Distinction," 201.
[728] Seldon, *The Whistle-Blower*, 58.
[729] Stephen Saltissi, 26 February 2019.

chap', was an active member of the local intellectual community and developed a lifelong friendship with Polish physicist and Nobel prize winner Joseph Rotblat (1908-2005), who had fled the Holocaust to Liverpool in 1939. Marcus was elected JMS president in 1968 and followed Cohen as honorary life president in 1980. Other notable members included 1996 president (and Cohen's cousin) Ronald Finn (1930-2004), joint recipient with Cyril Clarke of the prestigious Lasker award in 1980.[730]

Medical practitioners were active in the wider Jewish community, physician Isaac Jacob Lipkin (1895-1975) and Goodman were presidents of the Merseyside Jewish Representative Council, and physician Julian Verbov (b. 1934) was a religious teacher at a local synagogue (his wife was the deputy headteacher of the King David School).[731] Liverpool's Jewish community shrank by more than half between 1961 and 1991, according to figures compiled by Goodman, from roughly 7500 to 3000, and the JMS similarly shrunk in terms of influence and activity.[732]

Smaller networks within the wider medical community also emerged on a more informal basis, informed by shared national or cultural heritage. As indicated by key figures in the development of orthopaedic surgery in Liverpool described in Part 1, Welsh practitioners continued enjoyed a prominent place in the local medical community during the twentieth century. Welsh practitioners were attracted to Liverpool for its proximity to North Wales, and many worked both in the city and at hospitals or in private practice across the border. Cardiologist Emyr Wyn Jones (1907-1999) was born in Caernarvonshire and qualified in Liverpool in 1928, and established a leading reputation following his appointment as a consultant to the teaching hospitals in 1935 and as physician to the Emergency

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[730] 'Ronald Finn (1930-2004)' Obituary by John Goldsmith, *Munk's Roll* Volume XI, 195.
[731] Julian Verbov, 28 August 2018.
[732] Goodman, "The Jewish Community of Liverpool," 90.

Medical Service in North Wales during WWII.[733] Anthony Seaton recalled moving to Cardiff in 1969 with a reference from Wyn Jones, who he described as the "King of Welsh medicine."

> He was a very cultured man, a bard, and well respected in Wales, if you could get a reference written in Welsh lording you to the skies then any job in Wales was yours, that's how I got the Cardiff job, it was very competitive.[734]

Wyn Jones was invited to become the first president, and was later life president, of the Y Gymdeithas Feddygol (the Welsh language medical society), alongside being appointed High Sheriff of Caernarfon (1947-1948), and a leader in the Gorsedd (community of traditional Welsh-language bards).[735]

Local practitioners embraced elements of local professional culture related to national and professional heritage, such as the 'Anglesey bone-setters' described in Part 1. William Richard Rowlands (1892-1964) left his 'treasured copies of the works of [famous orthopaedic surgeon] Hugh Owen Thomas' and related material to the Liverpool Medical Institution, and was described as 'proud of his descent' and relationships with celebrated Welsh practitioners such as Thomas and Sir Robert Jones.[736] The local associations between Welsh practitioners and orthopaedic surgery resulted in Goronwy Thomas (1907-1983) being described during his life membership oration to the LMI as 'incomprehensibly Welsh, unbelievable astute, incredibly skilful – almost the very apotheosis of

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[733] 'Emyr Wyn Jones (1907-1999)' Obituary by John G Williams, *Munk's Roll* Volume XI (web); John Stewart, 'A Welsh life, a medical life: Dr Emyr Wyn Jones (1907-1999) Interviewed,' *National Library of Wales Journal* 32.1 (2001), 107-119.

[734] Anthony Seaton, August 22 2018.

[735] Y Gymdeithas Feddygol "History" at https://ygymdeithasfeddygol.cymru/hanes/ [accessed 1 October 2019]; Life membership oration for Emyr Wyn Jones, delivered by Percy Whitaker, *LMI Transactions and Report*, 1974, 16.

[736] 'William Richard Rowlands' Obituary by Gerard Sanderson, *LMI Transactions and Report,* 1965, 24.

orthopaedics', while industrial medicine physician Albert Thelwall Jones (1908-1990) was 'related to a large section of the Welsh medical profession'.[737]

Nationality and religious background provided common ground between members of the local medical community, and could constitute informal networks between practitioners. An obituary published in the LMI *Transactions and Report* of another Welsh orthopaedic surgeon, Norman Wynne Roberts (1907-1988), described the phenomenon of a 'discreet *sotto voce* 'confab' of the 'Welsh Taffia' [a play on the slang term 'Taffy'] power brokers' among Welsh-speaking practitioners at certain Liverpool hospitals.[738] The continued importance of patronage, references and personal relationships between practitioners in securing appointments and professional advancement after 1948 conferred significant influence on these informal networks.

Conclusion

Local medical networks responded in different ways to the creation of the NHS. The Liverpool Medical Institution enjoyed a rise in membership after WWII, and practitioners evidently considered the society worthwhile as it grew in popularity after 1948. The LMI continued to count leading local medical practitioners among its membership, and involvement with medical students at the university encouraged younger doctors to participate. The substantial investment from the teaching hospitals to support the 1966 extension of the institution is indicative of its continued connectedness with hospital practice under the NHS, and the LMI was quick to rebrand its educational offering in line with the emerging interest in postgraduate

[737] Life membership orations for Albert Thelwall Jones and Goronwy Evan Thomas', delivered by Bryan Walker, *LMI Transactions and Report*, 1980, 21; 25.

[738] 'Norman Wynne Roberts' Obituary signed 'K.H.', *LMI Transactions and Report,* 1989, 51.

medical education. Nonetheless, the increasing reliance on funding from external grants and drug company threatened to undermine the traditional autonomy of the institution. Despite seeking to preserve key elements of traditional professional culture, alignment with NHS postgraduate education initiatives and reliance on external funding were indicative of the accommodations made by the institution during this period.

Specialist societies provided a platform to promote areas of clinical interest that contributed to the development of academic departments, regional and national organizations during the first thirty years of the NHS. Specialist societies in some medical areas, such as anaesthesia and thoracic medicine, were liable to domination by small cliques of individuals with close personal contact. Medical clubs embraced greater social activity after 1948, and provided the local medical elite with an opportunity to interact in a 'neutral' space disconnected from particular hospitals or specialties. These groups continued to attract local medical leaders under the NHS, and were self-regulating, often nepotistic spaces. Similarly, religious and national groups within the medical community fostered close personal and professional connections, and facilitated support and patronage between practitioners of shared backgrounds. The ongoing significance of professional networks within the NHS enabled the preservation of earlier traditions and practices, and helped shape the character of the wider professional community.

Medical networks mediated the reception of the NHS among the local professional community. Through their involvement in medical teaching, professional appointments, and medical clubs and societies, established practitioners had a range of channels through which to sustain and reproduce traditional professional values. This chapter has demonstrated how independent medical networks were recognised, supported, and accessed funding from the NHS, despite retaining a considerable degree of autonomy. A consequence of this accommodation was the retention of traditional elements of local

professional culture after 1948. Nonetheless, changes to medical services in Liverpool, notably the rationalisation of the hospital system during the 1970s, and national changes resulting from the first major reorganisation of the NHS in 1974, threatened to undermine the local medical establishment. The response of the local medical community to ongoing local and national reform is the focus of the final part of this thesis.

Part 3: Liverpool's Medical Community 1978-1998

Chapter 9
NHS reform in Liverpool 1978-1997

Introduction

Practitioners in Liverpool faced a number of new challenges as a result of the NHS reforms of the 1970s and 1980s. Hospital consultants became more deeply involved in management through clinical directorates (established following the 1986 Resource Management Initiative), and GPs were obliged to monitor the clinical and financial efficiency of their practices.[739] The 1974 NHS reorganisation introduced a three-tier system of 14 regional health authorities, 90 area health authorities and family practitioner committees, and 192 districts, with ultimate authority vested in the secretary of state (see Figure 9.1). The Mersey RHA took control of all hospitals in the region, including the former teaching hospitals (which were replaced by the Royal Liverpool in 1978), and Area Health Authorities were created for Cheshire, Wirral, St Helens and Knowsley, Liverpool and Sefton. Conservative Secretary of State Keith Joseph (1918-1994) had received advice from experts at Brunel University and management consultants McKinsey during the planning stage of the reorganisation, however Philip Begley and Sally Sheard noted that management consultants made only a 'limited contribution' to an 'ultimately imperfect compromise' in the face of practical constraints.[740]

The 1974 reorganisation was implemented with the aim of resolving structural inefficiencies in the structure of the NHS,

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[739] Wendy Button and Graham Roberts, "Communication, clinical directorates, and the corporate NHS," *Journal of Public Relations Research* 9.2 (1997), 142; Stephen Willcocks, "The clinical director in the NHS: utilizing a role-theory perspective," *Journal of Management in Medicine* (October 1994), 68.

[740] Philip Begley and Sally Sheard, "McKinsey and the 'Tripartite Monster': The Role of Management Consultants in the 1974 NHS Reorganisation." *Medical History* 63.4 (2019): 393.

however Timmins claimed it 'looked beautiful on paper while proving something of a disaster on the ground.'[741] The reorganisation has been described as a 'paper chase' of reforms, 'the most Byzantine [structure] ever imposed on a UK public service,' and simply 'a disaster'.[742] The structure was simplified in 1984, following the 1983 management inquiry by Sainsbury's supermarket chief executive Roy Griffiths. In Liverpool, the management reforms were implemented under the leadership of Sir Donald Wilson (1922-2001), chairman of the Mersey and subsequently North West Regional Health Authority (the Mersey and North Western RHAs merged in 1994) between 1982 and 1995. Wilson became the longest-serving regional chairman in the NHS, his management style was abrasive: a committed Conservative, he pursued the performance targets introduced following the Griffiths inquiry at all costs. Virginia Bottomley, Secretary of State for Health between 1992-1995, described Wilson as one her 'NHS heroes'.[743] Timmins described Wilson as 'the heart of Mersey Region for twelve of its twenty years of existence…Many of his admirers were those within the RHA who saw Mersey climb from last to first in performance tables, as well as those in the Department of Health and Social Security or Secretaries of State who saw a 'macho manager' achieve results.'[744]

This chapter outlines the administrative changes to medical services in Liverpool between 1978 and 1998. Section 1 considers

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[741] Timmins, *The Five Giants*, 293.

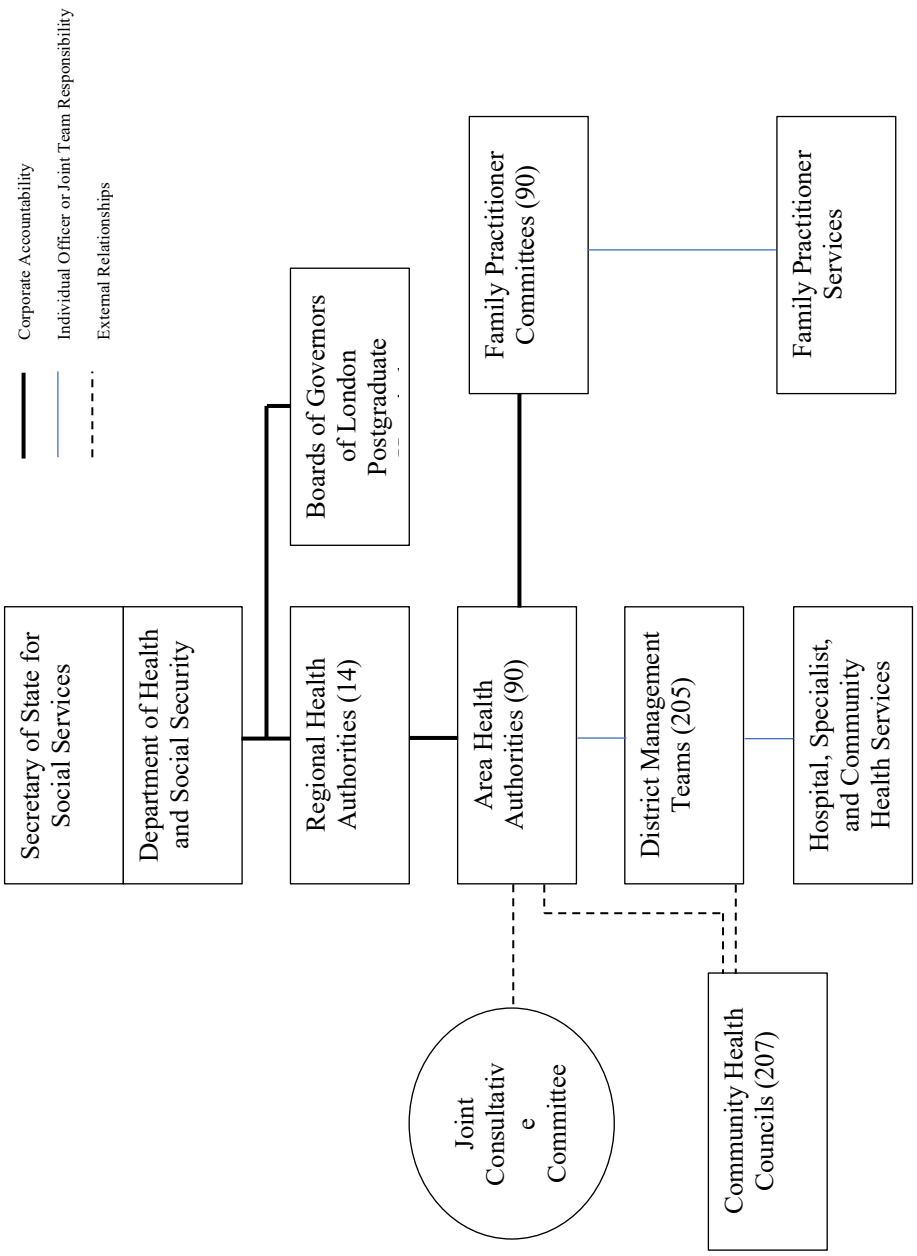
[742] Allsop, *Health Policy and the NHS,* 42; Rodney Lowe, *The Welfare State in Britain since 1945* (Basingstoke: Palgrave Macmillan, 2005), 196.

[743] Paul Smith, "A very big cheese," *Health Service Journal* (16th August 2001) https://www.hsj.co.uk/home/a-very-big-cheese/24754.article [accessed 20 February 2020].

[744] Nicholas Timmins, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, 7.

how hospital practitioners sought to guide the implementation of the market reforms in order to protect professional interests. Six leading hospital and university figures were invited by Wilson to contribute a plan for the future organisation of hospital services in the city in 1989, and the results of this exercise (completed following consultation with the rest of the local medical community) revealed local professional aspirations. Section 2 discusses how the social and economic challenges faced in Liverpool during the 1970s and 1980s informed general practice, and the reception and implementation of the 1990 NHS and Community Care Act.

Figure 9.1. The 1974 NHS Reorganisation[745]



[745] Adapted from Webster, *The National Health Service: A Political History*, 108.

9.1: Hospital Services in Liverpool after 1978

Medical reform and hospital services

As outlined in Part 2, the failure of the Liverpool hospital system to disentangle itself from its pre-NHS inheritance was exacerbated by repeated delays to the opening of the new teaching hospital. Population decline and delays to hospital rationalisation meant Liverpool topped national league tables for hospital bed numbers (per 100,000 population, see Figure 9.2), and Mike Collier, who was appointed regional treasurer of the Mersey RHA in 1978, described its reputation as 'pretty awful'.[746] When the Royal Liverpool University Hospital finally opened in 1978, within sight of its predecessor the Liverpool Royal Infirmary (in use 1889-1978), the consolidation of the United Liverpool Hospitals at a single site could begin. The Royal Liverpool incorporated a number of specialist services formerly located at other hospitals in the city and became the principal teaching hospital for the University of Liverpool Medical School. In north Liverpool the Fazakerley District General Hospital opened in 1974, after a major rebuilding programme, finally merging with the adjacent Walton Hospital (closed in 1994) in 1996, renamed the University Hospital Aintree in 1999. The Liverpool Women's Hospital (opened 1995) replaced the old Women's Hospital, Maternity Hospital and Mill Road Maternity Hospital (see Figure 9.3). Liverpool's Victorian hospitals had undermined the rational and efficient delivery of services for decades, and the consolidation of disparate services at larger sites was a significant break with the traditional organization of hospital care in the city.

[746] Mike Collier, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, 23.

Figure 9.2: Regional Allocation of Hospital Beds, Great Britain, 1979[747]

Region	**Population (million) 1979**	**Number of Beds 1979**	**Beds per 1000 Population 1979**
Northern	3.087	25,000	8.1
Yorkshire	3.577	30,000	8.39
Trent	4.544	32,000	7.04
E Anglian	1.863	13,000	6.98
NW Thames	3.433	28,000	8.16
NE Thames	3.691	30,000	8.13
SE Thames	3.542	28,000	7.91
SW Thames and Wessex	5.539	45,000	8.12
Oxford	2.283	14,000	6.13
S Western	3.208	25,000	7.79
W Midlands	5.152	36,000	6.99
N Western	4.018	31,000	7.72
Mersey	**2.485**	**22,000**	**8.85**
England	46.422	359,000	7.73
Wales	2.755	24,000	8.65
Scotland	5.167	59,000	11.42

[747] Adapted from Webster, *The Health Services since the War (II)*, Appendix 3.17.

Figure 9.3: Liverpool Hospitals Closed after 1974

Hospital	**Founded**	**Closed**
Sefton General Hospital	1859	c1990
The Women's Hospital	1883	1995
Liverpool Maternity Hospital	1841	1995
Royal Liverpool Children's Hospital (City)	1851	1994
Walton Hospital (General)	1868	1994
Mill Road Maternity Hospital	1884	1993
St Paul's Eye Hospital	1871	1992
Newsham General hospital	c.1876	1988
Liverpool Home for Invalid Women (Chronic)	1869	1986
Waterloo Hospital (General)	1910	1985
Royal Southern Hospital	1842	1979
David Lewis Northern Hospital	1834	1978
Liverpool Ear, Nose and Throat Infirmary	1820	1978
Liverpool Stanley Hospital	1867	1976
Bootle Hospital (General)	1846	1976
Liverpool Homeopathic Hospital (General)	1841	1976

Rationalization of the Liverpool hospital system was complicated by changes of government policy, professional unrest, and local and national economic factors. The Labour election victory in October 1974 meant Barbara Castle, the new Secretary of State for Social Services, was tasked with implementing Joseph's plans, complaining it was 'too late to unscramble Sir Keith's eggs'.[748] Castle was immediately confronted with a professional dispute over consultants' pay and the provision of private beds in NHS hospitals, which led to strike action in 1975. The strike was damaging for the profession; public support was undermined, and the BMA earned a reputation as an obstructive trade union.[749] Rivett concluded that 'the NHS stood in more peril than ever before,' and Timmins claimed it was 'sliding into chaos'.[750]

Prime Minister Harold Wilson established a Royal Commission into the NHS in 1975, chaired by Alec Merrison (1924-1989), to consider the 'best use and management of the financial and manpower resources of the National Health Service'.[751] Members of the Commission were sympathetic to the Labour view of the NHS; no hospital practitioners were included (an omission that incensed the professional elite), and Cyril Taylor, the socialist GP and Labour councillor from Liverpool, was invited to join.[752] The Royal Commission reported in June 1979, a month after Margaret

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[748] Quoted in Powell, *Evaluating the National Health Service*, 71.
[749] Rivett, *From Cradle to Grave*, 276; Timmins, *The Five Giants*, 339.
[750] Rivett, *From Cradle to Grave,* 269; Timmins, *The Five Giants*, 335.
[751] Merrison, *Royal Commission on the National Health Service*.
[752] Timmins, *The Five Giants*, 361; the 'hemming in' of the new government by a report commissioned by the outgoing administration perhaps contributed to the subsequent growth of 'fast government inquiry' exemplified by the 1983 Griffiths Report, see Sally Sheard, "Doctors in Whitehall: Medical Advisers at the 60th Anniversary of the NHS," *History & Policy* (2008), 4-5; Christine Farrell, "The Royal Commission on the National Health Service," *Policy & Politics* 8.2 (1980), 200.

Thatcher's first election victory, and reaffirmed 'the basic philosophy of the NHS', stating that politicians and the public remained 'agreed on the desirability of a national health service in broadly its present form'.[753] The 1974 reorganization was criticised for its complexity, which had led to conflict between the administrative tiers.[754]

The new Conservative government incorporated many of the Royal Commission's recommendations in the consultative paper *Patients First,* published in December 1979. Patrick Jenkin, the new Secretary of State, embraced calls for administrative simplification and abolished the AHA tier (described by Martin Powell as 'too small to be planning bodies' but 'too large to be operational units' in their own right).[755] In 1984, the service was restructured into 14 regional health authorities (RHAs), while 192 district health authorities (DHAs) replaced the 90 area health authorities, and 7 special health authorities (SHAs) replaced the boards of governors of postgraduate teaching hospitals.

The total number of hospitals in England and Wales fell during the 1980s, and greater coordination of remaining services was made possible through the district general hospital model and regional control of teaching hospitals.[756] The national fall in bed numbers was indicative of the changing practice of hospital medicine marked by a decline in long-stay patients and hospitalisation of the chronic sick, however Liverpool retained an above-average number of beds, as it had since 1948. The total number of hospital medical staff in Liverpool rose across during the 1970s and 1980s both at consultant and junior levels (reflecting national trends), however the regional hospital workforce reveals a staff/population ratio consistent or slightly above the national average (see Figures 9.4, 9.5 and 9.6). This

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[753] Klein, *The New Politics of the NHS,* 121; Merrison, *Royal Commission on the NHS*.
[754] Klein, *The New Politics of the NHS,* 120; Allsop, *Health Policy and the NHS*, 55.
[755] Powell, *Evaluating the National Health Service*, 74.
[756] Rivett, *From Cradle to Grave*, 172.

trend is unsurprising when considered alongside continued population decline and Liverpool's historically high levels of staff, nonetheless the total number of staff as a standalone figure indicated sustained growth above or close to the national average.

Changes to hospital services in Liverpool had significant implications for established local networks. Institutional identity and practices related to the historic hospitals informed practitioners' experiences, and hospital closures led to many practitioners relocating to work alongside new colleagues. Interviewees' experiences of the move to the new Royal Liverpool hospital after 1978 are included in the following chapter. The introduction of market principles undermined the traditional dominance of the medical profession and left practitioners increasingly accountable to professional managers, who steadily abandoned what Philip Begley described as the 'collegial relationship' with clinicians that had existed after 1948 to follow a more robust style of management.[757]

[757] Philip Begley, "'The type of person needed is one possessing a wide humanity': the development of the NHS national administrative training scheme," *Contemporary British History* (2019), 2.

Figure 9.4. Medical and Dental Hospital staffing in England and Mersey region.[758]

Year	Med Staff England (WTE)	Med Dent Staff Mersey	MD Staff WTE per 100k pop England	MD Staff WTE per 100k pop Mersey
1975	31796	1712	68.4	68.5
1980	35759 (+12.3%)	2006 (+17.2%)	82.2 (+20.2%)	82 (+19.7%)
1985	35920 (+0.5%)	2273 (+13.3%)	91.3 (+11.0%)	93.8 (+14.4%)
1990	39712 (+10.6%)	2444 (+7.5%)	98.2 (+7.6%)	101.5 (+8.2%)

[758] Data from DHSS Annual Reports (London: Department of Health and Social Security, 1975-1990).

Figure 9.5: Total number of medical practitioners in Liverpool[759]

Year	Doctors on GMC Local List
1980	1104
1985	1109
1990	1341
1995	1486
2000	1638

[759] General Medical Council, *Medical Register* (London: General Medical Council).

Figure 9.6: Regional Distribution of Consultants, England, 1979[760]

Region	**Population (million)**	**Number of (WTE) consultants 1979**	**WTE Consultants per 100,000 population**
Northern	3.087	729	23.6
Yorkshire	3.577	749	20.9
Trent	4.544	823	18.1
East Anglia	1.863	429	23
NW Thames	3.433	910	26.5
NE Thames 1979	3.691	959	26
SE Thames 1979	3.542	890	25.1
SW Thames & Wessex	5.539	1,242	22.4
Oxford	2.283	473	20.7
South Western	3.208	616	19.2
West Midlands	5.152	1056	20.5
North Western	4.018	916	22.8
Mersey 1979	**2.458**	**524**	**21.3**
Total England	46.395	10,316	22.2

[760] Adapted from Webster, *The Health Services Since the War, Vol II,* Appendix 3.23. WTE = whole-time equivalent.

NHS Management and the internal market in Liverpool

New management arrangements introduced during the 1980s undermined the autonomy traditionally enjoyed by hospital consultants, especially in hospitals with teaching status after 1948. Mark Learmonth described hospital administrators before the NHS as 'kindly technicians', far removed from the target-driven managers brought in during the 1980s.[761] The ascent of hospital managers was part of a longer shift from the passive administration of the 1950s and 1960s, when Tony Cutler claimed 'managerialism *avant la lettre'* could be observed.[762] These analyses emphasise the interconnected and overlapping traditions of early health service bureaucracy and the robust managerialism introduced under the Thatcher governments.[763]

The Conservatives won a second general election victory in June 1983, and embarked upon an ambitious programme of incorporating private sector principles into public services.[764] Thatcher invited Roy Griffiths (1926-1994), a university friend and managing director of Sainsbury's supermarkets, to conduct a short inquiry into NHS management in 1983. Timmins described the Griffiths review as 'the most unconventional NHS report of all time' in its structure, length, and lack of evidence.[765] Famously, Griffiths

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[761] Mark Learmonth, "Kindly technicians: hospital administrators immediately before the NHS," *Journal of management in medicine* 12.6 (1998), 328.

[762] Mark Learmonth, "Kindly technicians: hospital administrators immediately before the NHS," *Journal of management in medicine* 12.6 (1998), 328; Begley, "'The type of person needed," 17.

[763] Mark Exworthy, Martin Powell, and John Mohan, "Markets, bureaucracy and public management: the NHS: quasi-market, quasi-hierarchy and quasi-network?" *Public Money and Management* 19.4 (1999), 15; Ian Kirkpatrick, Peter Jespersen, Mike Dent and Indareth Neogy, "Medicine and management in a comparative perspective: the case of Denmark and England," *Sociology of health & illness* 31.5 (2009), 646.

[764] Webster, *The National Health Service: A Political History*, 164.

[765] 'Griffiths, Sir (Ernest) Roy (1926–1994)', entry by Terry Philpot. Published online 27 May 2010, version: 23 September 2010

claimed that Florence Nightingale, 'carrying her lamp through the corridors' of the NHS, would be 'searching for the people in charge'.[766] Norman Fowler, who replaced Jenkin as Secretary of State in 1981, reflected on the perceived need to replace 'consensus management' with robust 'proper' management.

> Even great people like Keith Joseph would talk approvingly of consensus management, which was so obviously inadequate – consensus management was basically a way of avoiding decisions. This is the biggest organisation in Britain to run and the idea that you can run it without proper managers is totally misjudged and misguided.[767]

Griffiths' approach was also a departure from the tradition of respectful, occasionally deferential, dialogue with professional bodies (medical practitioners were barely consulted).[768]

Donald Wilson, chair of the Mersey RHA, and Graeme Davis (b. 1937), vice-chancellor of the University of Liverpool, invited six local practitioners to conduct a survey into the 'future of medicine in the city of Liverpool' in June 1989 (the report subsequently became known locally as the 'Pan Liverpool Review').[769] The team was chaired by Frank Harris (1934-2018), professor of paediatrics at Liverpool, and comprised leading figures from the local medical community, namely Alasdair Breckenridge (1934-2019), professor of

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<http://www.oxforddnb.com/view/article/54985> [accessed 6 February 2020].

[766] "Griffiths Report on NHS, October 1983" Socialist Health Association https://www.sochealth.co.uk/national-health-service/griffiths-report-october-1983/ [accessed 29 November 2017].

[767] Quoted in Nicholas Timmins, *Rejuvenate or retire: views of the NHS at 60* (London: Nuffield Trust, 2008), 38.

[768] Klein, *The New Politics of the NHS,* 151-2; Lowe, *The Welfare State in Britain since 1945*, 330; Rivett, *From Cradle to Grave,* 348; Timmins, *The Five Giants*, 408, 466.

[769] Frank Harris (Chairman), 'The Future of Medicine in the City of Liverpool,' (Liverpool: Liverpool Health Authority, 1989).

clinical pharmacology, Ian Gilmore (b. 1947), consultant hepatologist (both were subsequently presidents of the Twenty Club), cardio-thoracic surgeon Ben Meade, Rossall Sealy, director of the regional centre for oncology, and Mike Pearson, consultant physician at Aintree Hospital and Vice Chair (1987-7) and Chair (1987-91) of the Mersey RHA Regional Medical Advisory Committee.

The team reported in September 1989, after taking oral evidence from 33 representatives of the medical school, hospitals and health authority, and written evidence from over 75 local practitioners. Recommendations included the continued distribution of 'important research programmes' and teaching commitments across multiple sites, with the overall number of hospitals in the Liverpool and South Sefton areas reduced to five; the Royal Liverpool, Alder Hey, Broadgreen, Fazakerley, and Mossley Hill. In order to ensure maximum efficiency, the team acknowledged that falling population made the 'significant' reduction in the number of hospital beds a priority, in order to divert investment to specific clinical areas.[770] Mike Pearson claimed that despite the 'Pan Liverpool' scope of the investigation, the exercise never 'had the opportunity to make a big shake up because [of] the opportunity to join…trusts' that was aggressively encouraged by Wilson shortly after its publication.[771]

A contributing factor in the commissioning of the review was the indication that several local hospitals had given that they sought self-governing status.[772] This ambition was linked to national policy changes introduced following Thatcher's third election victory in June 1987. The Prime Minister personally announced the commissioning of the White Paper, *Working for Patients* on BBC

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[770] Harris, 'The Future of Medicine in the City of Liverpool,' 27.
[771] Mike Pearson, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, 62.
[772] Harris, 'The Future of Medicine in the City of Liverpool,' 4.

television programme *Panorama* in January 1988, and the completed report was unveiled in January 1989. *Working for Patients* looked to the American health care model for inspiration, a decision Klein described as mystifying considering the massive costs of American healthcare and chronic lack of funding in Britain, 'experts on obesity advising a patient suffering from anorexia'.[773] The White Paper introduced the key concepts of patient choice and rewards for doctors 'responding to local needs and preferences', the reforms were planned 'on business lines, with executive and non-executive directors' which were to be 'rigorously audited,' reporting to an NHS Chief Executive accountable to the Secretary of State.[774]

The 1990 NHS and Community Care Act highlighted the role of consumer choice, spending was to 'follow the patient' through the introduction of 'fundholder' status for group general practices with the largest lists. Fundholders would act as proxies for patients, buying non-emergency treatments from NHS hospitals (which were to be established as independent trusts), private hospitals and local authorities. The new 'purchaser/provider split' required a new administrative structure: under the overall leadership of the Secretary of State, the Department of Health oversaw the NHS Management Executive, Regional (14), District (145), and Family Health Service (90) Authorities, and GP Fundholders (6098). These groups constituted the 'purchaser' side of the system, commissioning services from the 292 NHS Hospital Trusts and a range of private providers.[775]

The first wave of NHS trusts were established in April 1991, among them was the Royal Liverpool, which was feted by secretary

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[773] Klein, *The New Politics of the NHS,* 187.

[774] Department of Health, "Working for Patients" (HMSO London, 1989), 5-6).

[775] Allsop, *Health Policy and the NHS*, 175; The system was further refined in the following years; in 1996, the number of NHS regions was reduced to eight and health authorities to 100 (integrating the district and family health service levels).

of state William Waldegrave in October 1991 for waiting list figures that demonstrated 'one of the best performances in the country'.[776] Nonetheless, concerns over the implications of placing private sector managers in charge of medical services was articulated by local Labour MP Bob Wareing (1930-2015) who claimed the 'apparatchik manager' of Alder Hey hospital trust was being paid a bonus to do the 'dirty work' of cutting expenditure.[777] Further hospital trusts were established at Walton, Southport and Formby, Clatterbridge, Aintree and elsewhere across the region in 1991.

The Mersey RHA aggressively implemented national policy objectives relating to management, performance targets and the purchaser/provider split under the leadership of chairman Donald Wilson. Wilson was an enthusiastic advocate of hospital trusts, stating his views in a 1990 radio interview.

> I hope we will see hospitals developing their own culture, from their own colour schemes, improvement in food, improvement of time to teach, to deal with patients. I think they will be actively looking after their community.[778]

Following the amalgamation of the Mersey and North Western RHAs in 1994 (renamed North West RHA), Wilson continued to pursue efficiency targets, and adopted a competitive approach to public sector management, celebrating the fact that the region was 'at or close to the top on almost all national performance indicators'.[779]

Wilson's political sympathies to the Thatcherite health reforms and aggressive management style won the favour of senior

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[776] HC Deb 16 October 1991 vol 196 col 311-28.
[777] HC Deb 16 October 1991 vol 196 col 311-28.
[778] British Universities Film and Video Council, "Sir Donald Wilson on independent hospitals" (Interview for Radio City Liverpool, transmission date July 1990) http://bufvc.ac.uk/tvandradio/lbc/index.php/segment/0006100412001 [accessed 20 February 2020].
[779] North West Regional Health Authority, 'Regional Report, 1994/95' [LRO:362.1 NOR], Chairman's foreword.

government figures, however his convictions polarised the local medical community. Hugh Lamont, a former head of communications for the region, disputed claims of his bullying style, however some local clinicians offered different views. Physician Mike Pearson claimed that while Wilson was 'disliked almost universally by the medics he was also feared by them, because they knew if he said something he probably meant it.'[780] Left-wing figures such as public health academic Alex Scott-Samuel claimed Wilson 'met his performance targets by the most unpleasant methods' and pursued a 'Stalinist' management style.[781] John Ashton, former regional public health director, tempered such criticism by suggesting that behind his 'tough manner' Wilson displayed 'remarkable humanity' during his management of the regional service.[782] Ashton also described the 'Mersey first' policy that characterised Wilson's term of office, and the aggressive pursuit of targets and new initiatives.[783]

Several oral history interviewees remembered dealing with Wilson, especially in relation to the introduction of the NHS internal market. Ian Gilmore, one of the six clinicians who authored the Pan Liverpool Review, described Wilson's desire to maximise the number

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[780] Mike Pearson, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, 53.

[781] Alex Scott Samuel, "Sir Donald Wilson was a bully and we are well rid of his Stalinist reign-of-terror management style," *Health Service Journal* (20 September 2001) https://www.hsj.co.uk/home/sir-donald-wilson-was-a-bully-and-we-are-well-rid-of-his-stalinist-reign-of-terror-management-style/24993.article [accessed 21 February 2020].

[782] John Ashton, "Sir Donald Wilson's inspiring North West legacy," *Health Service Journal* (4th October 2001) https://www.hsj.co.uk/home/sir-donald-wilsons-inspiring-north-west-legacy/25109.article [accessed 21 February 2020].

[783] John Ashton, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, 32.

of independent hospital trusts (rather than encourage the amalgamation of complimentary units), which contributed to the survival of a widely distributed system of specialties around the city.

> Don Wilson was involved in the discussions with Margaret Thatcher and Ken Clarke. He was really in the inner coterie when they were discussing the ways to reorganise the NHS and set up trusts and his concept certainly was to maximise the number of trusts.[784]

Urologist Keith Parsons became chief executive of the Royal Liverpool in 1995, a post he held until 1999. Parsons recalled his working relationship with Wilson, and the challenges of meeting the Wilson's expectations that Liverpool remain a 'bastion of Conservative health policy' in a Labour city.

> [Wilson was] a visionary who had absolutely clear ideas of what he wanted, and he would get it. He was a bully, and people were a bit frightened of him, but he just ran it. When you negotiated with him, he'd be sitting in his desk and he'd open his desk drawer and pull a hammer out, and 'bang' this is what you're going to get.[785]

The presence of a regional chairman with such an aggressive and uncompromising commitment to adopting competition in the NHS resulted in rapid changes to the local hospital system. Mike Pearson, who secured his first consultant appointment in 1984, reflected on the changing dynamic among the local profession as a result of increasing lay management, 'it was a level where you started to be counting and detailing what was going on and that, I think to many of my senior colleagues, was quite a shock to suddenly find that someone was watching.'[786] In 1994, the North West Region employed

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[784] Royal College of Physicians Interview with Ian Gilmore, 24 September 2015.

[785] Keith Parsons, 4 June 2018.

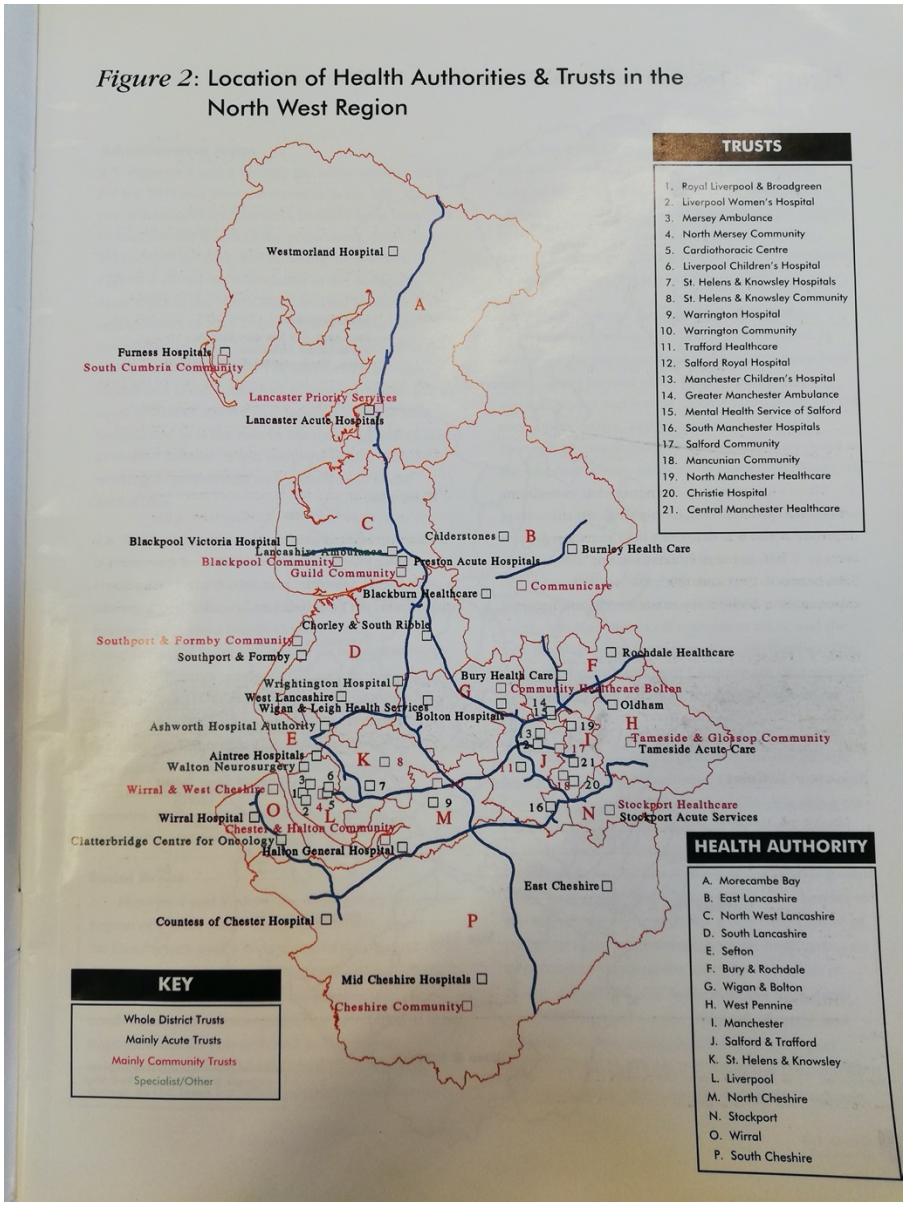
[786] Mike Pearson, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June

a staff of 125,000 working within a population of 6.8 million, and a total of 62 hospital trusts had been established within the 16 health authorities (see Figure 9.7).[787] The structures, and strong personality of senior nonmedical figures such as Wilson, governing medical services in Liverpool during the 1980s and 1990s were indicative of the declining influence of the profession. The creation of the NHS internal market replaced consultation with the medical profession with business rationale, and the encouragement of individual hospitals to pursue the status of independent trusts further undermined communication, coordination and cooperation across traditional networks.

2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, 59.

[787] North West Regional Health Authority, 'Regional Report, 1994/95' [LRO:362.1 NOR].

Figure 9.7: NHS Trusts in the North West Region, 1998[788]



[788] Flynn, Peter, and Dianne Knight, *Inequalities in health in the North West*. (Liverpool: NHS Executive North West, 1998), 9.

9.2: General Practice in Liverpool after 1978

General practice reform in Liverpool

The 1979 Royal Commission on the NHS, which included the radical Liverpool GP Cyril Taylor, repeated well-worn statements on the need to expand the service beyond merely 'curative and caring services' to include community and preventive medicine, and placed renewed emphasis on teamworking and the development of health centres in inner-city areas.[789] The Commission challenged claims that the 'small businessman' GP model encouraged competition and raised standards; in reality, there was little evidence of competition and therefore even 'the GP who provides a barely passable service, and never bothers to improve his premises is unlikely to starve'.[790] Evidence for this position had been provided in Ann Cartwright's 1967 study, which found that the majority of patients went to the doctor nearest their home (rather than making a critical assessment of available practitioners), and there was little competition to encourage improvement.[791]

As a result of high levels of local economic deprivation, several members of Liverpool's general practitioner community took an interest in the social and economic determinants of health discussed in *Inequalities in Health*, the report of a working group led by RCP president Douglas Black (1913-2002) published in 1980.[792] General practice in the city during the 1980s was inseparable from the local social and political context. Speke, one of the new housing areas in South Liverpool, became notorious for the low quality of its GPs: the 650 acre estate experienced high unemployment following the

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[789] Merrison, *Royal Commission on the NHS*, 41.

[790] Merrison, *Royal Commission on the NHS*, 231-232.

[791] Ann Cartwright, *Patients and Their Doctors: A Study of General Practice* (London: Routledge & Kegan Paul, 1967), 18-23.

[792] *Inequalities in Health, report of a research working group (Black Report)* (London: DHSS, 1980), Socialist Health Association https://www.sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/ [accessed 27 January 2020].

closure of the nearby British Leyland and Dunlop plants in 1970 and 1979 respectively.[793] Former Public Health Director John Ashton recalled the state of general practice in Speke during this period.

> There was something like seven single handed practices and that was it. One of them, notoriously, the people would have to go and knock on the lavatory window for their repeat prescriptions to be handed out.[794]

Other new residential areas on Merseyside, such as the Ford estate near Birkenhead (on the Wirral Peninsula), were built in the 1960s and 1970s to house residents from slum clearances, and suffered from high rates of heroin abuse and poor indicators of health and social inclusion.[795] Health centres, such as the one built in 1973 on the Ford estate, did not necessarily provide better practice: a local GP recalled they were 'dirty, we couldn't do certain procedures there, you wouldn't dream of doing even the most minor of surgeries because they were inherently unclean.'[796]

The 1974 reorganisation created Community Health Councils - patient representation organizations that held hospital services and GPs to account and had representation in the AHA. Local community campaigns, with support from some general practitioners, sought to highlight and address the issues of primary care across the city. These included campaigns for an abortion clinic in Liverpool (which opened in 1981) led by the Merseyside Women's Liberation Group, Merseyside Abortion Campaign, the Liverpool Community Health Councils and others, and workshops, conferences and events

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[793] McKenna, "Municipal Suburbia," 296; 316; John Boughton, *Municipal Dreams: The Rise and Fall of Council Housing* (London: Verso Books, 2018) and https://municipaldreams.wordpress.com/2017/05/02/the-speke-estate-liverpool-ii/ [accessed 12 February 2019].

[794] John Ashton, 27 June 2018.

[795] Ursula Kenny, "Enter the Dragon," *Observer*, 30th May 2004, https://www.theguardian.com/theobserver/2004/may/30/features.magazine27 [accessed 20 February 2020].

[796] Christine Brace, 27 March 2018.

discussing the perceived inadequacy of local primary care.[797] In this atmosphere, a group of practitioners led by Cyril Taylor established a highly political new health centre in Toxteth, that opened during the visit of the Royal Commission on the NHS in 1977. The experience of this group, and the confrontation between traditionalist and innovative GPs in Liverpool, is discussed in chapter 11.

Liverpool gained a reputation for political dissent and industrial unrest during the 1980s. Militant, a Trotskyist group that infiltrated the local Labour party between 1983 and 1987, took control of the city council, and the level of urban deprivation in Liverpool during the 1980s garnered international attention, especially after the 1981 Toxteth riots. A 1982 *Washington Post* feature focused on the unemployment, housing, and race issues in the city, describing Liverpool as a 'case study of modern urban blight'.[798] From a peak of 855,688 in 1931, a process of outmigration and deindustrialization contributed to Liverpool's population falling to 439,473 in 2001.[799]

General practitioners were implicated in the market reforms of the NHS during the 1980s. A preliminary report 'Primary health care: an agenda for discussion', published in 1986, outlined a consumer-oriented service, with greater patient choice and practitioners

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[797] Merseyside Women's Liberation Movement, 'Report on Merseyside Abortion Campaign Conference, 'Whose body is it anyway? Women, choice and health care on Merseyside' 26th June 1982, [LRO 305WLM/2/1].

[798] 'In Liverpool, Welfare State's Promises Fail: First of two articles Welfare State's Dreams Collapse Amid Liverpool's Urban Blight Residents of Liverpool 'Shellshocked' by Hard Times' *Washington Post* 5th September 1982.

[799] Pooley, "Living in Liverpool," 171; Dieter Rink, Annegret Haase, Katrin Grossmann,
Chris Couch and Matthew Cocks, "From Long-Term Shrinkage to Re-Growth? The Urban Development Trajectories of Liverpool and Leipzig," *Built Environment* 38.2 (2012), 165; Olivier Sykes, Jonathan Brown, Matthew Cocks, David Shaw, and Chris Couch, "A City Profile of Liverpool," *Cities* 35 (2013), 308.

encouraged to consider how best to manage their practice in order to secure optimum value for money.[800] Timmins claimed the aims of the report were 'to stimulate competition for patients among GPs, getting them to enter something more like a market'.[801] Webster described the new GP contract, introduced in 1990, as 'arguably the biggest shock to the NHS since its establishment'.[802] The contract rewarded GPs that met certain goals, such as health screening and monitoring, and encouraged part-time work (which was better suited to women practitioners and those nearing retirement). Rivett noted that even left-wing figures such as Julian Tudor Hart begrudgingly accepted the contract had achieved what prior reforms had been unable to in areas such as staffing, organisation and education.[803] Performance incentives led to the increasing significance of capitation, which had been historically opposed by groups such as the SMA and MPU (who advocated for a salaried GP service), and practices were implicitly encouraged to compete with each other for patients.[804]

The Mersey region adhered to the national trend of rising GP numbers after the 1974 reorganisation, and average list sizes also continued to fall nationally and in the Mersey/North West region (see Figures 9.8 and 9.9). Rob Barnett, chair of the Local Medical Committee, described the LMC's opposition to fundholding in opposition to the regional Family Health Service Authority, claiming the system 'resulted in a two-tier health care/delivery system which was completely unaffordable.'[805] Nonetheless, he recalled the

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[800] Klein, *The New Politics of the NHS,* 166. Great Britain Department of Health and Social Security, *Primary health care: an agenda for discussion*. (London: The Stationery Office, 1986).

[801] Timmins, *The Five Giants*, 413.

[802] Webster, *The National Health Service: A Political History*, 43.

[803] Rivett, *From Cradle to Grave*, 412.

[804] Webster, *The National Health Service: A Political History*, 42.

[805] Rob Barnett, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, Appendix 1.

'pressure' placed on local GPs to embrace fundholding, and attributed this pressure to the fact that 'managers were being performance managed to deliver a success in having more practices signed up to fundholding.'[806]

[806] Rob Barnett, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, Appendix 1.

Figure 9.8: Regional Distribution of General Practitioners, Great Britain, 1979[807]

Region	**Population (million)**	**Number of GPs**	**Number of GPs per 100,000 population**	**Average List Size**
Northern	3.087	1376	44.57	2342
Yorkshire	3.577	1620	45.29	2285
Trent	4.544	1973	43.42	2385
E Anglian	1.863	858	46.05	2175
NW Thames	3.433	1739	50.66	2263
NE Thames	3.691	1741	47.17	2299
SE Thames	3.542	1685	47.57	2256
SW Thames and Wessex	5.539	2610	47.12	2243
Oxford	2.283	1027	44.98	2316
S Western	3.208	1552	48.38	2128
W Midlands	5.152	2300	44.64	2325
N Western	4.018	1760	43.8	2347
Mersey	**2.485**	**1116**	**44.91**	**2301**
England	46.396	21,357	46.03	2286
Wales	2.775	1448	52.18	1916
Scotland	5.153	3190	61.91	1615

[807]Adapted from Webster, *The Health Services since the War (II)*, Appendix 3.32.

Figure 9.9: GPs in England and Mersey RHA[808]

Year	Number of GPs England	Average List Size	Number of GPs Mersey	Average List Size
1980	21812	2247	1131	2257
1985	24035	2068	1221	2081
1990	25622	1942	1249	1998
1995	26702	1887	1287	1911

[808]Data from DHSS Annual Reports (London: Department of Health and Social Security, 1980-1995).

Conclusion

Medical practitioners in Liverpool were confronted with major changes to their professional lives as a result of the 1974 NHS reorganisation, management reforms of the 1980s, and creation of the internal market in 1990. Regional Chairman Donald Wilson aggressively implemented the new structures, seeking to maximise the number of hospital trusts and fundholding GPs. This drive for reform was implemented during a period of sustained economic depression and social deprivation in Liverpool, and the imbalance in expenditure between hospital medicine and primary care was criticised in 1980 by a local socialist group that declared 'ironically, in a city which has just spent £43m on a new teaching hospital, the standards of health for most people…are lower than anywhere in the country'.[809]

The NHS internal market fundamentally altered intraprofessional relationships, as GPs took on new responsibilities and hospitals were established as individual trusts. The diminished voice of the profession following the Thatcherite reforms reflected a broader decline in trade union power, and the involvement of nonmedical advisers in decision-making signalled a new desire to manage the NHS along business lines. Webster argued the reforms failed to provide long-term solutions to the perpetual crisis in NHS funding, and Tony Blair inherited the NHS in 1997 in a condition 'just as unenviable' as Thatcher after the Winter of Discontent (see Figure 9.10).[810] Senior local practitioners continued to enjoy influence over local decision-making, however the influence of nonmedical management and increased scrutiny of performance to meet external targets undermined professional autonomy. The establishment of hospital trusts encouraged competition between

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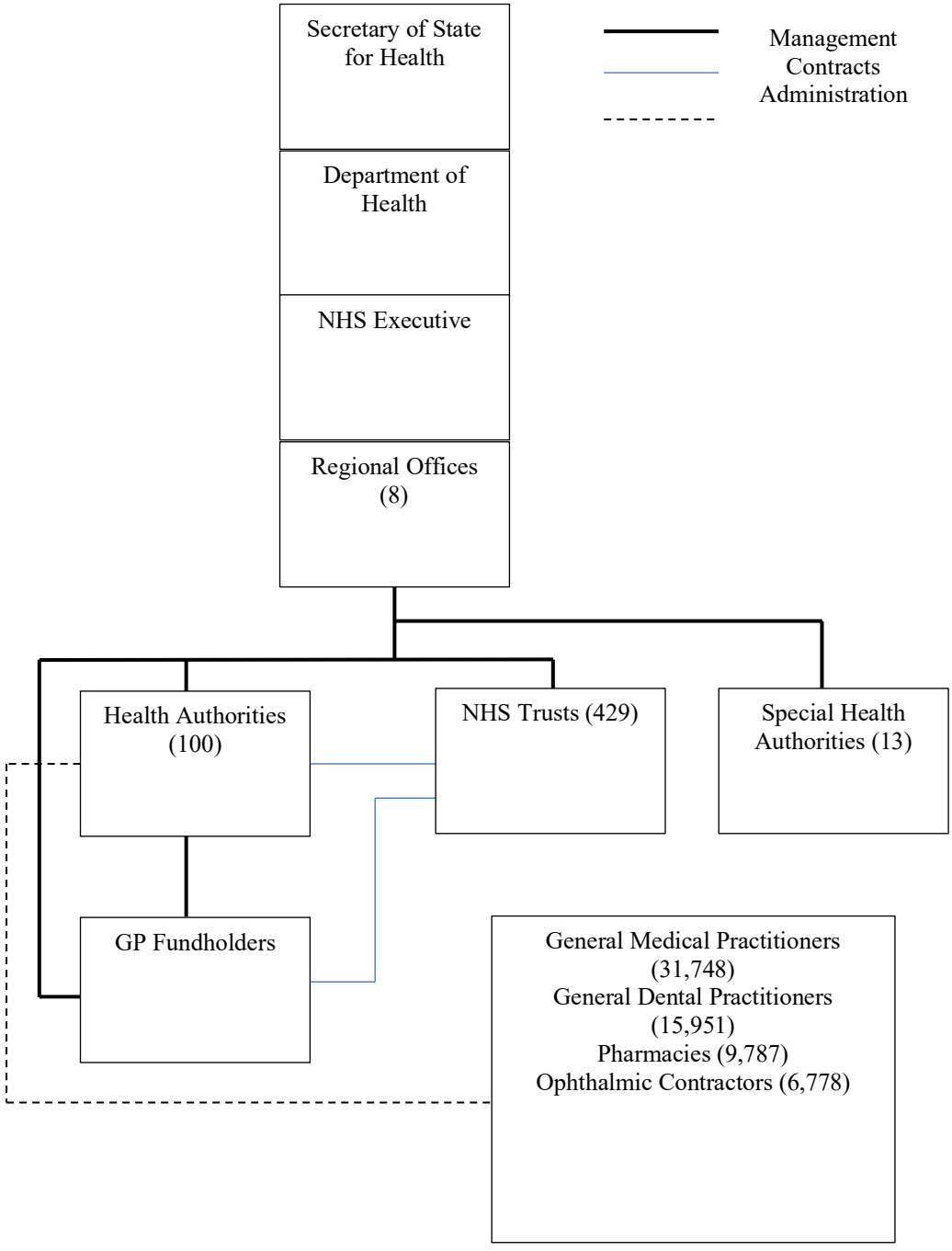
[809] Merseyside Socialist Research Group, "Merseyside in Crisis." (Liverpool: Merseyside Socialist Research Group, 1980), 57-59; Paul Farley and Niall Griffiths, "Netherley: Returning to Liverpool," *Granta* 102 (2008), 153.

[810] Webster, *The National Health Service: A Political History*, 207.

healthcare providers, and the implementation of the market reforms alongside widespread hospital closures in Liverpool resulted in a period of major turbulence for local hospital practitioners (discussed in Chapter 10). General practitioners were pressured to engage with the internal market, and this undermined traditional relationships between the two branches of the profession.

The replacing of traditional professional values with a robust managerial and market philosophy undermined established groups such as medical societies, which relied on the benevolence and traditional sense of mutual cooperation from local practitioners. The following chapter considers the how hospital consultants responded to the dual challenges of relocation to new sites (at the Royal Liverpool and Fazakerley DGH), and new NHS structures during the 1970s and 1980s.

Figure 9.10: the National Health Service, 1997[811]



[811] Adapted from Department of Health, *Departmental Report (Cm 3612)* (London: The Stationery Office, 1997), Annex E.

Chapter 10
Hospital reform and the medical community

Introduction

The NHS reforms implemented after 1974 had greater consequences for local medical networks than the establishment of the National Health Service in 1948. The rationalisation of the Liverpool hospital system provided an important break from historic institutional practices. The elite teaching hospitals were replaced by a single new hospital, the Royal Liverpool University Hospital (opened 1978), while in north Liverpool the Fazakerley District General Hospital (opened 1974) absorbed services from the surrounding area. Established professional networks at the old hospitals lost their institutional base, and were renegotiated at the new sites. The complexities of the transition were compounded by broader structural changes to the NHS, such as the introduction of medical management and the internal market.

The establishment of hospital trusts implicated hospital practitioners in a new system of competition and performance management alien to the traditional, deferential professional customs observed at the old hospitals. A large number of trusts were established across Liverpool, under the guidance of the energetic and ambitious RHA chairman Donald Wilson. Practitioners' attitudes towards both local institutional change and the systemic reform of the NHS reveal a number of concerns among different members of the local medical community. The resilience of traditional institutional networks was tested by both the closure of historic hospitals in the city and the total reassessment of hospital medicine occurring at national level.

This chapter uses oral history interviews with practitioners who worked before, during, and in the wake of hospital rationalisation to consider the implications of institutional change on the local medical community. Section 1 focuses on the opening of the

Royal Liverpool University Hospital in 1978, and outlines the sometimes uneasy accommodation of staff from different hospitals at a single site. Section 2 explores the development of medical services in north Liverpool after 1974, when the new Fazakerley hospital was completed, and the gradual process of amalgamating services and staff from nearby Walton hospital.

10.1: Moving to the Royal Liverpool

Tension at the Royal Liverpool

The Royal Liverpool University Hospital opened in October 1978, ending the United Liverpool Hospitals' tenure as the focus of elite medicine in the city. The teaching hospitals of the United Liverpool Hospitals group had developed strong institutional loyalties during their long periods of operation. Physician Cyril Clarke (1907-2000), who was professor of medicine at Liverpool after Henry Cohen between 1963 and 1972, claimed that 'the four general teaching hospitals considered themselves autonomous units' and since their first administrative amalgamation in the 1930s there had been 'little love lost between them'.[812] On completion, the huge concrete structure of the Royal Liverpool presented a major contrast to the ornate red-brick former voluntary hospitals it replaced.

The hospital met with a range of responses from the local medical community; many practitioners felt a strong sense of institutional loyalty to the old hospitals, and aired their views in interviews, memoirs and eulogistic hospital histories. The Liverpool AHA published surgeon Clifford Brewer's (1913-2017) *Brief History of the Liverpool Royal Infirmary* in 1980, two years after the opening of the new hospital. Brewer was born in Liverpool and, after a

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[812] Cyril Clarke, "Cohen, Henry, Baron Cohen of Birkenhead (1900–1977)," *Oxford Dictionary of National Biography* (Published in print 23 September 2004, published online 23 September 2004). https://www.oxforddnb.com/view/10.1093/ref:odnb/9780198614128.001.0001/odnb-9780198614128-e-30948?rskey=M9YcaF&result=2 [accessed 6 February 2020].

successful student career at the medical school, served as an RAMC surgeon during WWII. On his return to Liverpool he secured a consultant appointment at the Royal Infirmary in 1946 (when it was still a voluntary hospital). Brewer was an established member of Liverpool's medical elite by the time the new hospital opened: he was a member of the fine art committee of Liverpool University, the Furniture Society, the Twenty Club, the local Literary and Antiquarian Societies, and was an active member of the Athenaeum Club in London.[813]

Brewer was deeply affected by the closure of the Royal Infirmary, and wrote in his history that 'the building sleeps, but like a beautiful woman, its beauty still remains.'[814] Reflecting on the delayed and over-budget opening of the Royal Liverpool, he suggested the money would have been sufficient to adapt the old hospital for continued use, and refused to accept the need for the total replacement of the old hospitals. Government planning was derided for taking 'little or no account of the true state of affairs in hospital work' and sure to result in the 'continued rise in the cost of administration… borne by reduction in the available money for clinical care.'[815] The animosity with which Brewer, a pillar of the local medical establishment, greeted the new hospital is revealing: the reorganization of hospital services presented a major threat to existing professional hierarchies.

The AHA published a similar history of the David Lewis Northern Hospital (in operation 1834-1978) in 1981, written by Michael Cook, the brother of physician Wilfrid Cook (1914-1998), a consultant at the hospital since 1952 until its closure who also worked

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[813] 'Brewer, Arthur Clifford (1913 - 2017)' Royal College of Surgeons of England, *Plarr's Lives of the Fellows* (created 2 December 2015, modified 17 May 2017).
[814] Clifford Brewer, *Liverpool Royal Infirmary 1887-1978* (Liverpool: Liverpool Area Health Authority (Teaching), 1980), 1.
[815] Brewer, *Liverpool Royal Infirmary,* 113.

for a year at the Royal Liverpool before retiring in 1979.[816] The Northern was fondly described as an example of 'the old voluntary hospital' that inspired 'great loyalty from all who served it and affection from the patients for whom it cared.'[817] In light of the emotional dimensions of hospital employment, particularly at the self-reverential former voluntary hospitals, it was perhaps inevitable that there would be mixed reactions among the local medical community to the opening of the Royal Liverpool in 1978.

Interviewees' criticisms of the Royal Liverpool were compounded by the feeling of having lost the positive features of the old hospitals. In particular, practitioners lamented the loss of traditional living and dining arrangements, especially the 'doctors' mess'. These spaces enabled the performance of professional hierarchies (students, junior doctors and nurses might not have access), and provided an important space for social interaction. Two physicians formerly employed at Sefton General Hospital compared the arrangements at the Royal Liverpool.

> At Sefton we had a consultants' dining room, the maids all knew us, I missed that.[818]
>
> Everything seemed very impersonal [at the Royal Liverpool], people didn't know each other, people didn't lunch together, in Sefton we had a luncheon room for consultants…you met your colleagues.[819]

The 'doctors' mess' provided colleagues from different departments the opportunity to seek advice on clinical and professional matters, discuss cases, or arrange access to equipment. Peter Dangerfield recalled fondly the arrangements at the old hospitals.

> Myrtle Street [Royal Liverpool Children's Hospital] used to have a very friendly staff dining room, right up in the

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[816] 'Wilfrid Henry Russell Cook (1914-1998)' Obituary by PDO Davies, *Munk's Roll* Volume XI, 126.
[817] Cook, *Liverpool's Northern Hospital 1834-1978*, Foreword.
[818] Anthony Gilbertson, 20 August 2018.
[819] John Goldsmith, 21 August 2018.

> top floor, you used to go and have lunch there with people – you would sit next to someone from the pathology labs or medical records, you knew them all very well.[820]

The loss of these traditional spaces of professional networking was felt acutely by some practitioners, who felt deprived of both the comforts of a dedicated dining room and the potential opportunity to discuss work matters with colleagues.

The greater independence enjoyed by the teaching hospitals under the two-tier NHS system (abolished in the 1974 reorganisation) had also resulted in the development and consolidation of strong institutional identities: interviewees described how several individual consultants had dominated the old hospitals, aided by their relatively small size.

> The impression I get is that there were physicians who were very much 'Dr Southern' 'Dr Northern' it was their domain.[821]

The new teaching hospital was, by contrast, accountable from the outset to the local NHS administration at area and regional level, and was unburdened by the traditions and established personalities of the old hospitals.

Many practitioners moved to the Royal Liverpool after years, sometimes decades, of service at the hospitals scheduled to close, and a sense of loyalty often lingered. John Goldsmith recalled the process of transferring to the new hospital.

> When I first transferred to the Royal my loyalty for a year or two was still to Sefton [General Hospital], which didn't exist anymore. It took time to acquire a loyalty to the new hospital, and I suspect that many of the other people who came together from the old Royal, the Southern, the

[820] Peter Dangerfield, 16 July 2018.
[821] John Ridyard, 31 May 2018.

> Northern felt the same way, I expect we all did. It took time for the whole place to become cohesive.[822]

In spite of the fresh start offered by the Royal Liverpool, residual institutional attachments were evident among medical practitioners during its early years.

> It didn't transfer easily...Consultants, medical and surgical, being put together in pairs or trios that bore no relationship to their longstanding history. There remained a culture in the new Royal of the old Seftonians, old Northerns, old Southerns, and the old Royal.[823]

Another consultant shared similar memories of the transition.

> Everybody first moved in and hated it being so big, they were all comfortable in their own respective hospitals.[824]

John Coakley, who was a medical student when the Royal Liverpool opened, was put off applying to work there as a result of the 'toxic' atmosphere.

> A consultant physician from the Southern would not refer to a consultant surgeon from the Northern… The nurses all had different uniforms at the different hospitals – they insisted on maintaining this sort of separation, they weren't allowed to have different uniforms but they all retained the, in those days nurses would wear a hat… and the nurses in the end were allowed to keep their different hats.[825]

The professional networks maintained at the former teaching hospitals evidently did not disappear immediately on the opening of the Royal Liverpool, and some practitioners were reluctant to abandon their former loyalties.

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[822] John Goldsmith, 21 August 2018.
[823] Chris Evans, 6 March 2018.
[824] David Wong, 3 August 2018.
[825] John Coakley 31 May 2018; See also Pat Starkey, *Nursing Memories: From Probationers to Professors*. (Liverpool: National Museums & Galleries of Merseyside, 1994), 93.

The prejudices of the two-tier system of teaching and non-teaching hospitals (which was itself a remnant of the pre-NHS system of voluntary and municipal hospitals) also lingered at the Royal Liverpool. Some established medical practitioners continued to assess their peers on the status of their former hospital; Chris Evans claimed this influenced interactions at the new site.

> The old Royal of course, the Royal Infirmary, was in most people's eyes the blue riband…the paranoia in the others got quite evident. Most of those were generated from the Southern Hospital, which had a great *espirit de corps*, generated by Dr [Gerard] Sanderson, and others, and he retired by the time the new Royal opened.[826]

Dominant individuals such as Sanderson (1912-1987) exerted great influence over professional culture at the small hospitals, and exemplified the traditional elite that was being undermined by the modern hospital. Cecil Gray claimed Sanderson held a 'belief in apprenticeship… as firm as that of any 18th century physician. He, and only he, would choose the students for his 'firm' and his housemen; no dean or any other authority was allowed to stand in his path. Once selected, those boys and girls became his family.'[827]

Sanderson retired prior to the opening of the Royal Liverpool, and an interviewee recalled his condescending verdict on the new hospital, 'it's a medical Kirkby!' (a reference to a local council housing estate built during the 1950s and 1960s).[828] Other interviewees suggested the atmosphere at the new hospital was reflective of nonmedical politics in Liverpool at the time. Cardiologist Stephen Saltissi described the atmosphere as 'rabidly anti-private practice' and 'built on an ethos of Liverpool Militant socialism'.[829]

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[826] Chris Evans, 6 March 2018.
[827] 'Gerard Sanderson (1912-1987)' Obituary by TC Gray, *Munk's Roll* Volume VIII, 431.
[828] John Ridyard, 31 May 2018.
[829] Stephen Saltissi 26 February 2019.

The reticence of local medical practitioners to leave their former places of work contributed to criticisms of the facilities at the Royal Liverpool, and comparisons were soon made with the old hospitals. Delays to the completion of the building undoubtedly coloured practitioners' attitudes: physician Chris Evans described the new hospital as an 'absolute chaotic shambles' on its opening.[830] Evans' wife Susan Evans, a dermatologist who also trained in Liverpool, contrasted the facilities at the old Royal Infirmary with those of the new hospital.

> The consulting rooms didn't have proper windows onto outside. You didn't have natural light – for dermatology, to see the skin, you need to have good light and I just thought it was so inappropriate.[831]

Hospital design had other implications for practitioners, as Geoffrey Rivett noted in London.

> High-rise hospitals required banks of lifts that were expensive and slowed movement. Lifts affected the way staff met and talked. People did not meet each other as they did in, for example, the St Thomas' [Hospital, London] long corridor.[832]

Funding was not always available to replicate the arrangements at the old hospitals, which had often been developed over a course of many years. This was the case with the renal dialysis unit formerly located at Sefton General Hospital, and renal physician John Goldsmith recalled being confronted with immediate problems of a lack of comprehensive planning as the unit was not adequately equipped (the unit at the Royal Liverpool subsequently received funding from Ford Motor Company, which had a factory at Halewood).[833] Goldsmith, formerly of Sefton General, an old

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[830] Chris Evans, 6 March 2018.
[831] Susan Evans 20 March 2018.
[832] Rivett, *From Cradle to Grave,* 246.
[833] John Goldsmith, 21 August 2018.

Regional Hospital Board hospital that had originated as a workhouse infirmary, suggested that some colleagues brought the elitism of the former teaching hospitals to the Royal Liverpool. He recalled the snobbery of some colleagues following the amalgamation.

> Sefton was sort of squeezed in begrudgingly. There was still a lot of tribalism in the new Royal when it opened, paying service to the hospitals from which they had come. … I suppose it started to fade away a bit when I came because it had been open for a couple of years, but the 'we're from Sefton' or 'they're from Sefton, they need to go and wash behind their ears' stuff like that, it took quite a long time to settle it all down.[834]

Such testimony suggests that the smaller networks at individual hospitals, and divisions between the former teaching and RHB hospitals, survived to some degree in the early years at the Royal Liverpool.

For many practitioners, the opening of the Royal Liverpool signalled the end of the intimate, familial culture of the old hospitals. An interviewee described the opposition among some members of the profession towards the perceived loss of 'personality.'

> I remember a lot of grumbling around the place, the faults of the building and things like that … The new place, they all regarded as very impersonal – and that is what the big problem is today, impersonality of these establishments, lots of staff, you don't know who's what, who they are – you don't have a communal doctors' dining room like you used to, or staff dining room, I think people miss that.[835]

Ophthalmologist David Wong, who graduated from Liverpool in 1977, described the old hospitals as creating an atmosphere 'like a family'.

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[834] Keith Parsons, 4 June 2018.

[835] Peter Dangerfield, 16 July 2018.

> The small hospitals like the Southern and the Northern have a much smaller workforce, and the housemen are known to virtually all the staff, it's much more like a family, and the nurses look after you, sometimes I would take over the job of the switchboard.[836]

Local professional traditions and institutional networks had been enabled by the continued use of a largely Victorian hospital estate, moving to the Royal Liverpool challenged practitioners to negotiate new relationships with a larger pool of professional peers.

Practitioners' hopes for the new hospital

The opening of the Royal Liverpool unsettled established networks and traditional practices within the local medical community. Nonetheless, the new hospital also provided a major update to medical services, and some practitioners were glad to move into the new hospital *because* it was unburdened by historic traditions and impenetrable networks. For ambitious individuals looking to embrace specialism, clinical research and a greater national and international outlook, the Royal Liverpool promised a wealth of opportunities.

The sheer size of the new hospital differentiated it immediately from the small units it replaced, and many medical specialties were brought together for the first time. The post-1974 structure of the NHS meant services were coordinated with the needs of the region, rather than according to the clinical philosophy of the local medical establishment. Keith Parsons recalled how the greater size and modern structure of the Royal Liverpool had a positive impact on clinical practice.

> One of the benefits of working a big university teaching hospital is you should, and we did, have an expert opinion in every different discipline somewhere in the building. So, if you had a patient with something a bit odd, you

[836] David Wong, 3 August 2018.

> didn't just get a general physician to come and have a look - you got someone who was an expert in that field to come and treat it. It was a delight to work in the Royal, because it was like that.[837]

The presence of multiple specialties at the new hospital, an arrangement that had been resisted in the Liverpool hospital system, allowed intraprofessional contact and collaboration to proceed on a larger and more systematic basis. The importance of professional contact with hospital colleagues remained, however the increased size and range of hospital staff at the Royal Liverpool necessitated a move away from accidental encounters in the consultants' dining room. Hospital practitioners working from a single central site was a novelty in Liverpool, and undermined the role of spaces such as the LMI which had provided a meeting place for individuals from the many different city-centre hospitals.

The Royal Liverpool enabled local practitioners to embrace greater specialism in both clinical practice and research. John Coakley described the stark difference of opinion between local traditionalists who saw the opening of the Royal Liverpool as 'the end of the world' and others alert to the potential growth of the city as a 'research powerhouse' equipped with modern facilities.[838] The new hospital transformed Liverpool into a much more attractive proposition for practitioners from outside the city and ambitious local graduates who may have formerly been drawn to more established research centres. Interviewees reflected on the impact of the new hospital on recruitment to the city; Chris Evans claimed that 'when the new Royal opened we started getting consultants into the hospital who were not Liverpool trained, and that was good.'[839] The high degree of local insularity among Liverpool consultants was outlined

[837] Keith Parsons, 4 June 2018.
[838] John Coakley, 31 May 2018.
[839] Chris Evans, 6 March 2018.

by Logan in 1972, and indicated a local medical community at risk of insulating itself from the benefits of greater diversity.[840]

Some ambitious local graduates who had left the city actually returned to Liverpool as a result of the increased research potential at the new hospital. David Wong graduated from Liverpool in 1977 and secured competitive posts at Moorfields Eye Hospital and St Thomas' Hospital in London. He returned to Liverpool in 1987.

> Having had a training in Moorfields and being academic, there are certainly options, options of nicer cities or richer towns and cities that you can work in with greater prospects of private practice. Liverpool would not strike anybody as an attractive post other than the fact that it has a good reputation as an academic centre.[841]

Liverpool's growing academic reputation meant outsiders and ambitious local graduates considered the city a viable base from which to develop a research career.

The declining influence of individual consultants over medical appointments, as had been the impression at the old teaching hospitals, provided more opportunities to applicants from outside Liverpool. Competition for consultant posts across the NHS during the 1980s also encouraged external applicants to Liverpool, sometimes in the midst of broader reservations about the city. Gastroenterologist Ian Gilmore described applying for a consultant post in Liverpool, which he secured in 1980, after training in Cambridge and London.

> I was a senior registrar at Charing Cross on secondment for a year to the States and my boss said he thought I could do much better than Liverpool…I suppose if someone had come along and offered me a post at Guy's

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[840] Logan, *Dynamics of Medical Care*, 56; See also Doris Zallen, "The Power of Partnerships: The Liverpool School of Butterfly and Medical Genetics," *The British Journal for the History of Science* 47.4 (2014), 677–99.

[841] David Wong, 3 August 2018.

> or Thomas' or something I probably would have said yes, but Liverpool was the first job I applied for, and in those days they were showing people around in buses - jobs were in such short supply.

Despite his appointment as an 'external' applicant, Gilmore's impression after starting work at Broadgreen hospital and the new Royal (which he described as a 'concrete monstrosity') was of a nepotistic and insular local consultant community.

> I thought that nepotism and the like applied more to London teaching hospitals, but in fact I discovered that virtually all the consultant physicians at the new Royal had trained in Liverpool and it was quite unusual for someone to come from outside.[842]

Gilmore began a highly successful consultant career in Liverpool (he was elected president of the RCP in 2006) and was able to penetrate local medical networks, becoming president of the LMI (2011) and the Twenty Club (1998).

External arrivals to Liverpool after 1978 observed the rapid development of 'modern' hospital medicine: Cardiologist Stephen Saltissi moved to Liverpool from Newcastle (after qualifying in London) to take a consultant post in 1984.

> I came to a city without any cardiology outside of the regional centre, started to introduce it in the Royal and it's gone from strength to strength since then, done very well…when I arrived it was a bit backward.[843]

The presence of a modern teaching hospital in the city encouraged applicants from outside Liverpool, and undermined the traditional influence of conservative attitudes to specialisation that had lingered at the United Liverpool Hospitals.

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[842] Ian Gilmore 24 July 2018.

[843] Stephen Saltissi 26 February 2019.

10.2: Rationalisation in North Liverpool

The Aintree site

Medical practitioners in north Liverpool experienced the transition from two established hospitals to a single site at the Fazakerley district general hospital in Aintree. This process differed from the amalgamation of the teaching hospitals at the Royal Liverpool: services at Walton hospital, which originated as the infirmary to the Walton Poor Law Institution (established in 1868), gradually moved to the new Fazakerley site, completed in 1974 and granted NHS trust status in 1992. In spite of its physical relocation, the Walton hospital neurological service remained administratively independent, and the Walton Centre for Neurology became a separate NHS trust in 1992. All services had moved to Fazakerley by 1998, renamed the University Hospital Aintree in 1999 (see Figures 10.1 and 10.2).

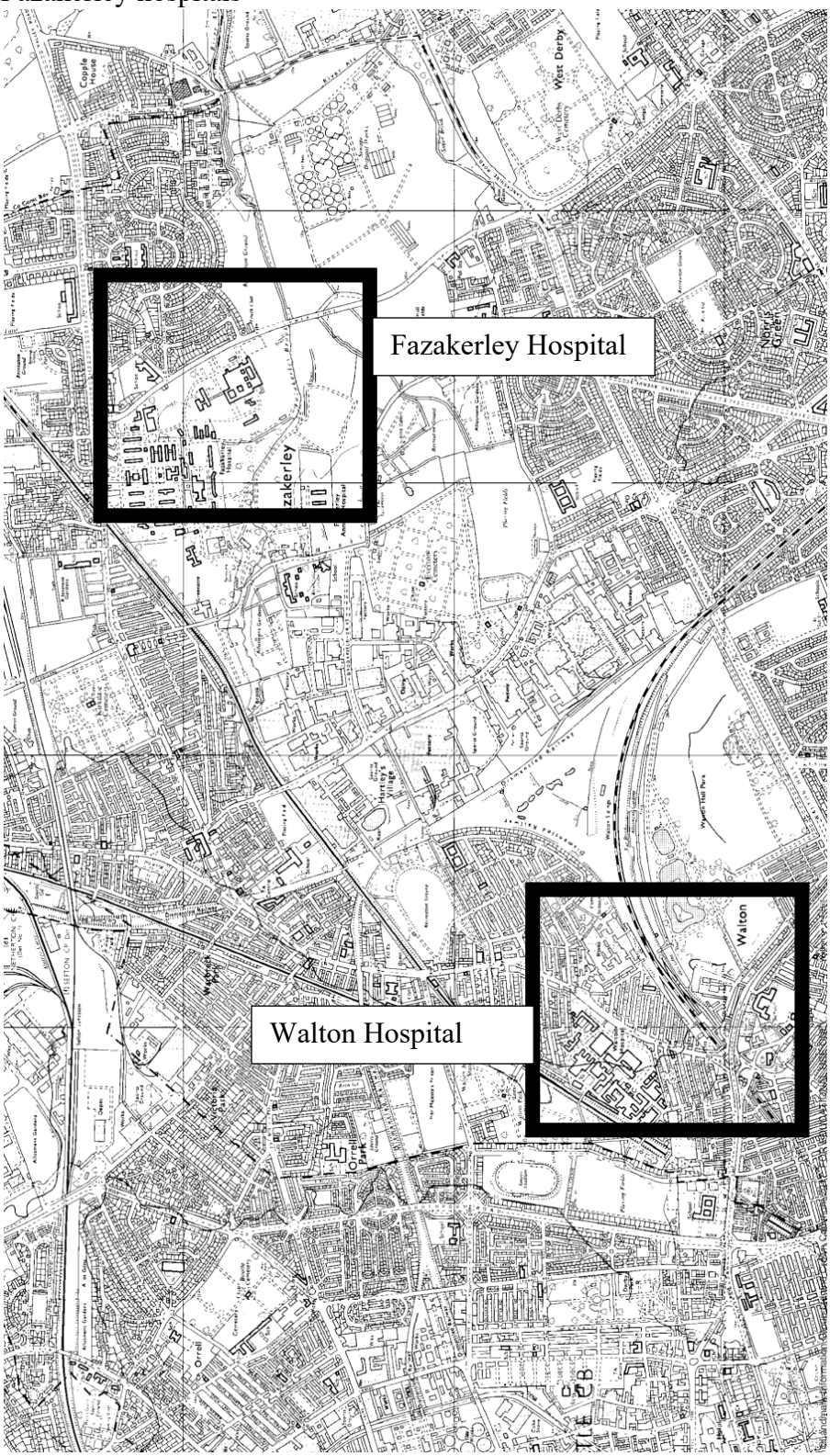
Neither Walton nor the (original) Fazakerley hospital, an infectious diseases hospital founded in 1902, were teaching hospitals prior to 1974. Nonetheless, Walton was considered to be the more prestigious hospital among the local professional community, and practitioners were disappointed when it was scheduled for closure. The impression among some interviewees was that Fazakerley had been chosen for renewal as the result of political influence: the new hospital was in Labour Prime Minister Harold Wilson's parliamentary constituency (Huyton).

> He [Harold Wilson] decreed, like Kublai Khan, that there should be a stately palace built at Fazakerley on the Aintree site, and up rose the tower block that we have today, very impersonal compared with the old days, but functionally very much better, all the services were concentrated in one area, that was how that rose.[844]

[844] Anonymous Interviewee 1, 6 June 2018.

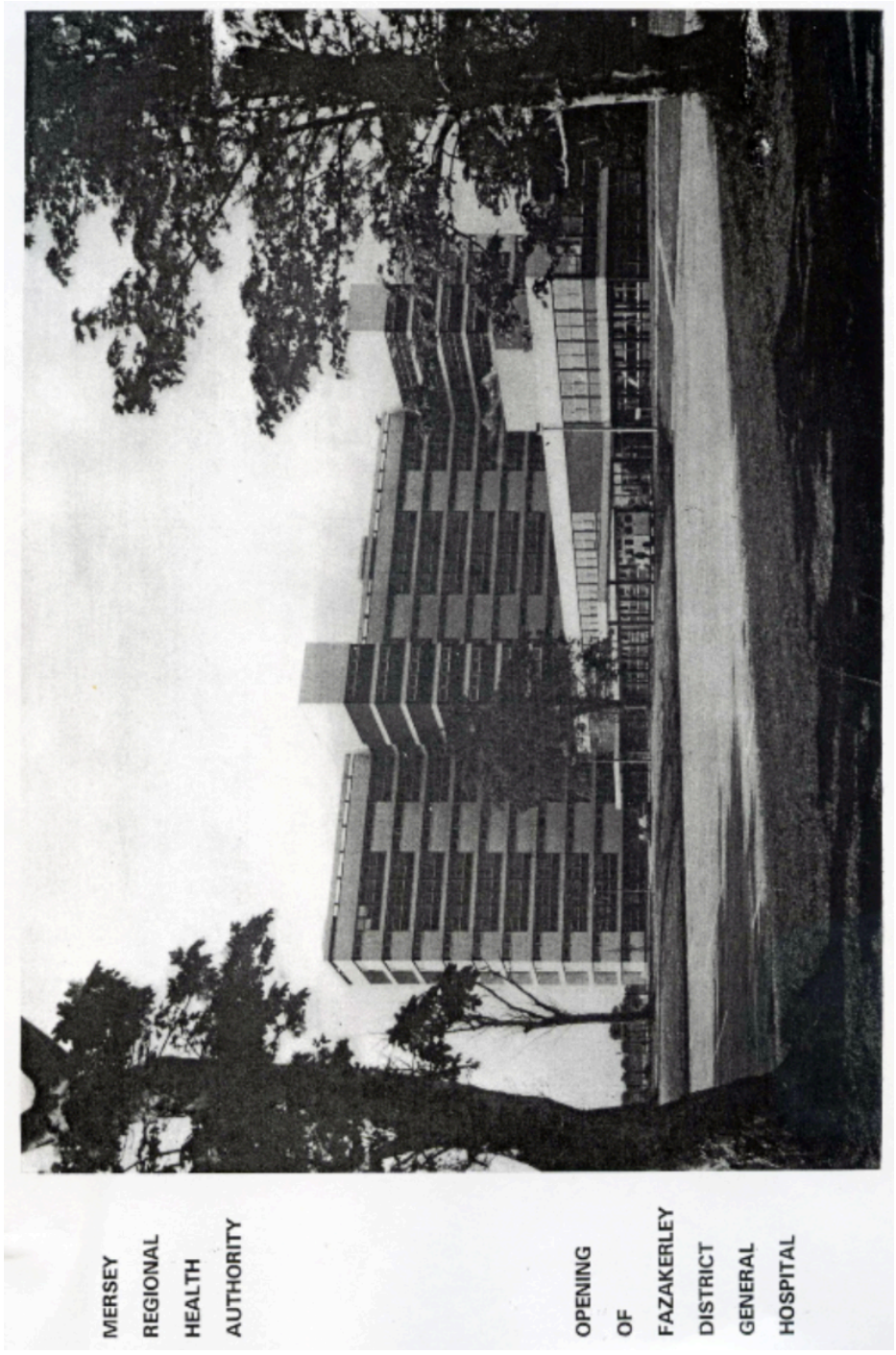
The old infectious diseases hospital was replaced in 1974 by a new district general hospital, and a process of migrating services from Walton began.

Figure 10.1: 1970 Map of Liverpool showing location of Walton and Fazakerley hospitals[845]



[845] Map adapted from British National Grid (EPSG:27700), 1970, scale: 1:20,000. Accessed at www.digimap.edina.ac.uk.

Figure 10.2: Fazakerley District General Hospital[846]



[846] Mersey Regional Health Authority, "Commemorative brochure 'Opening of Fazakerley District General Hospital'" (1974) [LRO: 614 FAZ/1/9/2].

The relationship between Walton and Fazakerley hospitals was outlined by Anonymous Interviewee 1, who secured their first consultant appointment in infectious diseases at Fazakerley in 1969 (prior to the building of the new hospital). The post included duties at the Liverpool Central Chest Clinic, and the interviewee liaised with Andrew B Semple (1912-2013), Medical Officer of Health for Liverpool between 1948 and 1974, in the deployment of the tuberculosis health visitor service. The interviewee described the relationship between Fazakerley and Walton hospitals, and the sense of institutional separation between them.

> In those days Walton and Fazakerley were separate but they [practitioners from Walton] used to come over to Fazakerley and we had a very good liaison with them…There was a certain amount of needle between Walton and Fazakerley – if you were Walton you were Walton, if you were Fazakerley you were Fazakerley, and never the twain shall meet![847]

Some established practitioners at Walton, such as physician Alfred William Howel Evans (1925-1997) were described as regarding the development at Fazakerley with 'alarm and suspicion, and these reservations were usually articulated with great feeling at the lunch table in the consultants' dining room at Walton Hospital.'[848] Despite the opening of the new Fazakerley hospital in 1974, some practitioners felt that its peripheral location remained inherently unsuitable. Fred Nye arrived at Fazakerley as an infectious diseases consultant in 1975 after training in London.

> It was clear that the isolation hospital as it were had been quite isolated, this was true of infectious diseases at the time in England certainly… these hospitals were themselves not part of the mainstream of a medical service, let alone an NHS

[847] Anonymous Interviewee 1, 6 June 2018.

[848] 'Alfred William Howel Evans (1925-1997)' Obituary by Ian Stevenson, *LMI Transactions and Report* 1998, 77.

> medical service…That isolation was clinical and academic as well as geographical.[849]

Walton hospital, by contrast, enjoyed a good reputation among the local medical community, and was affectionately recalled by several interviewees. Henry Herbert MacWilliam (1886-1969), who had been medical superintendent at Walton before 1948 and remained there until his retirement in 1952, oversaw its transition from "an old-fashioned Poor Law institution to a large efficient modern comprehensive hospital".[850] While not formally designated as a teaching hospital, Walton nonetheless hosted medical students for clinical teaching: an anonymous interviewee who graduated from Liverpool in 1979, described Walton alongside the central teaching hospitals.

> We were treated well, there was a canteen and also a doctors' mess where the qualified people could meet, and speak and refer their patients, it was a good feeling for undergraduates in Walton, in the [Liverpool Royal] Infirmary as well because there was a great sense of history there, and the Northern and the Southern too, they were happy times.[851]

Walton was recognised, at least to a far greater degree than Fazakerley, as a hospital with clinical pedigree.

> The hospital in the neighbourhood that had the reputation was Walton hospital, that's where all the well-known consultants were. Fazakerley, because of its situation and history, was seen very much as a sort of slightly sleepy convalescent hospital that looked after patients that nobody else really wanted to bother with.[852]

The perspective among the medical community was that Walton was the prestigious hospital in north Liverpool, and therefore the investment and building at the Fazakerley site mystified some

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[849] Fred Nye, 25 September 2018.
[850] *BMJ* 23 August 1969, 478.
[851] Anonymous Interviewee 4, 6 November 2018.
[852] Fred Nye, 25 September 2018.

practitioners. Consultant physician John Turner arrived in Liverpool in 1977, as services (and practitioners) were being moved to the new site, described the merger as one of "friction and difficulty and political dissent".

> The medical team at Walton hospital at that time said, 'what a ridiculous place to put a hospital, it should have been built here on our site at Walton…we are quite happy where we are'. So, for quite a long time you had a sort of begrudging attitude of beds being placed in Fazakerley hospital which had quite nice modern wards by the standards of the day, far better than the wards in Walton hospital.[853]

The 'begrudging' attitudes of some practitioners remained following the consolidation of hospital services in north Liverpool to the new site at Fazakerley. The feeling that the decision to invest in the Fazakerley site was politically motivated only contributed to the sense of professional disenfranchisement among practitioners at Walton.

Hospital trusts and hospital networks

Following the creation of the NHS internal market in 1990 separate trusts, located on the same site, were established in 1992 for both Fazakerley and the Walton Centre for Neurology (Fazakerley hospital became University Hospital Aintree in 1999, but the Walton Centre remained separate, see Figure 10.3). The administrative separation between Walton and Fazakerley was reflected in the attitudes of some practitioners, Nye recalled the atmosphere during the 1990s.

> It was hard to bring consultant colleagues together in a common cause because many of them were still quite rightly concerned with establishing their own specialties… and had to some extent to fight their own corner.[854]

[853] John Turner, 21 August 2018.
[854] Fred Nye, 25 September 2018.

The impression of a lack of cohesion between practitioners from different professional areas was echoed by Ian Gilmore, who had been tasked by RHA chair Donald Wilson with reviewing hospital services in Liverpool in 1989.

> Whether it was divide and rule or not who knows, but there's no doubt since 1991 we have had this situation where individual trusts have been digging moats and putting up drawbridges and very much focusing on their own business.[855]

Such a situation occurred following the relocation of the small St Paul's Eye Hospital (established 1871) to the Royal Liverpool in 1992. A piece published by the Foundation for the Prevention of Blindness reflected on how St Paul's was able to retain the 'ethos' of the previous 120 years of history by establishing itself as an independent trust within the Royal Liverpool in 1995, the closure was therefore sanitised as a mere 'move' that did not undermine the autonomy of the old hospital.[856]

The establishment of independent trusts provided practitioners with an opportunity to sustain exclusive networks, and undermined attempts to fully amalgamate at the new hospitals. GP and Liverpool LMC chairman Rob Barnett recalled what the 'bizarre' situation whereby multiple trusts within the same building, as was the case with Broadgreen hospital and the Liverpool Cardiothoracic Hospital.[857] Urologist Keith Parsons recalled "forcing" practitioners to

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[855] Royal College of Physicians Interview with Ian Gilmore, 24 September 2015.

[856] Royal Liverpool and Broadgreen University Hospitals, "History of St Paul's - Foundation for the Prevention of Blindness" https://www.rlbuht.nhs.uk/departments/medical-specialisms/eyes-st-pauls-eye-unit/history-of-st-pauls-eye-hospital-unit/ [accessed 20 February 2020].

[857] Rob Barnett, in Michael Lambert, Philip Begley and Sally Sheard (eds.) *Mersey Regional Health Authority, 1974-1994*, held 13 June 2019 at the University of Liverpool, published by the Department of Public Health and Policy, University of Liverpool, 2020, Appendix 1.

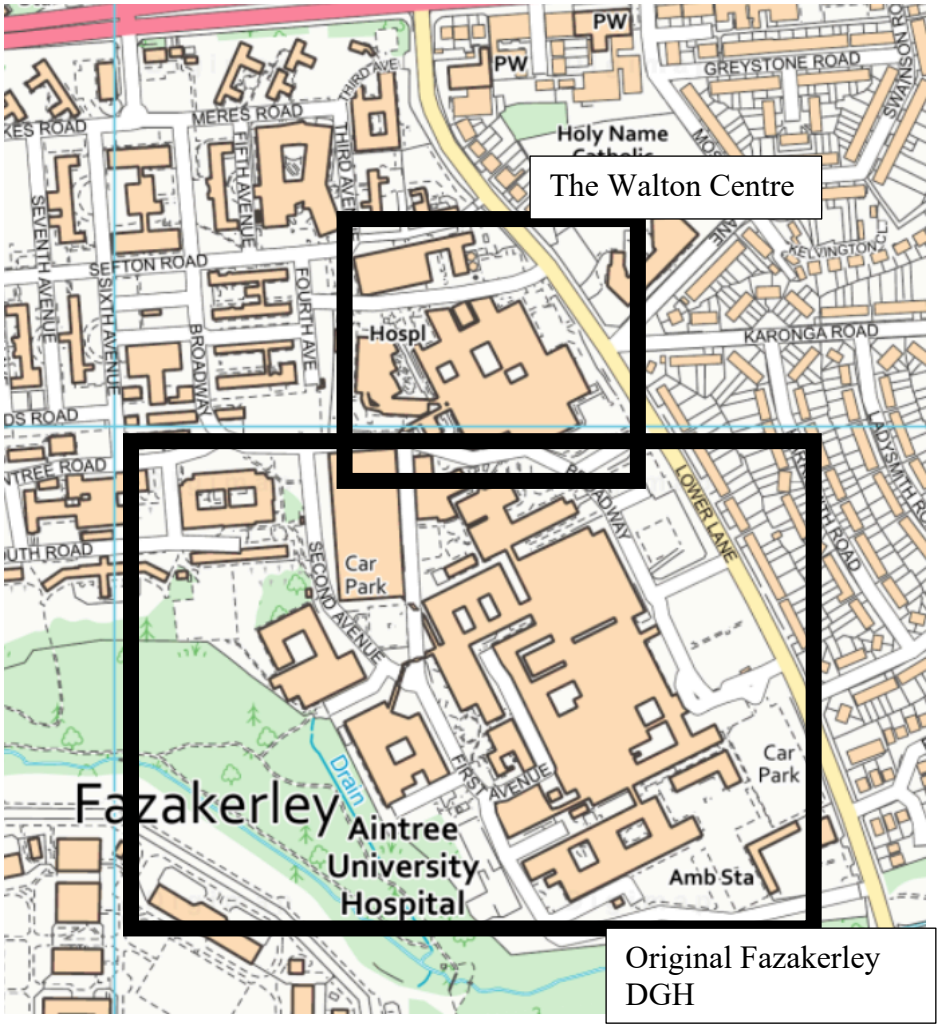
work together during the merger of the Royal Liverpool and Broadgreen hospital as a single trust in 1995.

> We were back to the old Broadgreen and the Royal people and so we had to integrate them, and rotations between the two, and the theatre staff, some were forced into joining forces and coming across, because otherwise they would have just run as two separate hospitals forever.[858]

The process of rationalising Liverpool's hospital system revealed the close institutional networks maintained at the old hospitals, and practitioners across the city were often reluctant to abandon their former affiliations. Nonetheless, strong regional direction from RHA chairman Donald Wilson, and the perceived political motivations behind the new Fazakerley hospital site, indicated the powerlessness of local professional figures to substantially affect the development of the local hospital system.

[858] Keith Parsons, 4 June 2018.

Figure 10.3: Plan of University Hospital Aintree, with the Walton Centre[859]



[859] Adapted from British National Grid (EPSG:27700), OS VectorMap Local Raster, October 2019, Scale: 1:5,000. Accessed at www.digimap.edina.ac.uk.

Conclusion

Liverpool's hospital system had proved remarkably resistant to change after 1948, and influential consultants such as Henry Cohen had exerted considerable control over the distribution of local services, in particular blocking the development of specialist departments at the central teaching hospitals. Delays to rationalisation meant many old hospitals had time to adapt and embed institutional traditions under the NHS, and some practitioners responded with hostility towards their closure. The opening of the Royal Liverpool in 1978 was particularly significant, as it replaced several historic hospitals loaded with meaning for the local medical community, while in north Liverpool disgruntled practitioners from Walton hospital continued to occupy a distinct administrative unit as a separate trust, despite being on the same site as the new Fazakerley hospital.

The price of scale and modernity at the Royal Liverpool and Fazakerley was a loss of the intimacy that defined working life at the old hospitals, where staff knew each other by name, dined together, and identified with a clear institutional culture. Interviews revealed the lingering tribalism of staff forced to assimilate, however broader changes to hospital administration, especially the increased role of nonmedical management, placed limits on the power of clinicians to dictate the direction of the new hospital. For some practitioners, the modern facilities at the Royal Liverpool and Fazakerley provided the opportunity to embrace new clinical methods that had previously been stifled. In particular, several interviewees acknowledged that the new hospitals attracted practitioners from outside the city interested in conducting research.

The establishment of hospital trusts implicated practitioners in new networks, based on competition and market principles, and changed the atmosphere of the entire medical community. Physician John Ridyard described the feeling of lost 'brotherhood' and a 'cohesive network' as a result of the creation of trusts.

> It was a totally ludicrous concept. I liked to believe that you were part of a sort of brotherhood of hospitals, which was lost, you know…you felt that following all this setting up of trust there was this sort of 'we are us, you are you' you weren't part of that sort of cohesive network that you once had been. I don't know, it just felt as if something got lost – the collegiality of medicine was lost as well with it.[860]

General practitioners were insulated to some degree from the immediate implications of hospital rationalisation. They were however confronted with an equally dramatic range of reforms, which were implemented during a time of social and economic crisis in the city. The following chapter considers how innovative GPs sought to encourage broader reforms within among their colleagues.

[860] John Ridyard, 31 May 2018.

Chapter 11
Innovative General Practice in Liverpool

Introduction

The experiences of Liverpool's general practitioners within the reorganised NHS were influenced by the specific challenges facing the local patient population. A study commissioned in anticipation of the reorganization connected high death rates on Merseyside (around 50% higher than the national average) with local problems of 'pollution, poor housing, and poverty.'[861] These conditions motivated several local GPs to become active in the national movement for general practice reform, and this led to tensions within the local professional community. This chapter considers the development of innovative general practice in Liverpool, and the resulting tensions and disagreements with more traditionally-minded colleagues, alongside the reception of changes to practice organisation resulting from national reforms.

The opening of Fazakerley DGH in 1974 and the Royal Liverpool in 1978 constituted clear points of departure from the institutional networks maintained at the old hospitals. The independent status of general practitioners meant such clear moments of transition were impossible, and changes within the GP community were felt less immediately. The Logan and Dyson reports (discussed in Part 2) had criticised Liverpool's hospital-dominated medical system for enabling a low standard of general practice, nonetheless the challenging conditions in the city also attracted a group of ambitious, ideological GPs. These practitioners engaged with national studies, such as the 1979 Royal Commission on the NHS and 1980 Black Report into health inequalities (that demonstrated the social determinants of health), and challenged what they felt to be the

[861] Mersey Regional Health Authority, "Area Profiles, volume 1" [LRO: 362.1094275 MER], 10.

regressive traditionalism among the local medical community.[862] The creation of Community Health Councils as part of the 1974 NHS reorganisation also provided a platform for some GPs to engage with representatives from the local patient community, and encourage their colleagues to embrace change.

The politicisation of general practice, and the presence of leading figures in socialist medical movements in Liverpool, led to the development of a network of innovative practitioners who styled themselves as radicals, and sought to accelerate local professional change. This chapter considers innovative general practice in Liverpool during the 1970s and 1980s, and uses a case study of practitioners at a politicised health centre to explore the tensions and interactions across the GP community. Reform was also encouraged at a national level, the 1987 White Paper, *Promoting Better Health* (which informed the 1990 GP contract) introduced new incentives for GPs to carry out health checks, improve services in deprived areas, and form group practices, further undermining the traditional model of singlehanded practice. [863] Section 1 outlines the state of general practice in Liverpool after 1974, and highlights the challenges facing advocates of reform. Section 2 discusses the Princes Park Health Centre, led by radical GP Cyril Taylor, and the attempts of a network of radical practitioners to stimulate local professional change.

11.1: General practice in Liverpool after 1978

General practice in Liverpool in the reorganised NHS

The newly-created Mersey Regional Health Authority conducted a broad survey into general practitioner services in 1974, the report provided details of a total of 28 health centres, however

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[862] *Inequalities in Health, report of a research working group (Black Report)* (London: DHSS, 1980), Socialist Health Association https://www.sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/ [accessed 27 January 2020].

[863] *BMJ*, 5th December 1987.

development had been piecemeal and irregular across the region. The majority of GP practices in Liverpool were single handed, and group practices of four or more doctors were a rarity (see Figure 11.1). The age of practitioners differed dramatically across the areas within the region: only eight per cent of GPs in the Liverpool AHA were under 35, in contrast to a regional average of fifteen per cent.[864] The local authority health centre in Toxteth (discussed in chapter 7) was the only purpose-built health centre in Liverpool.[865]

Many practitioners continued to work in poorly adapted premises. Christine Brace joined an established practice in 1973 spread over several locations.

> There was Rock Ferry, and that was a shop, basically a part of a shop and a room above it,…there was 1 Shrewsbury Road where I spent most of my time, which was the cellars of an old house, the old house had belonged to this guy who had just died on the job.[866]

Charles Webster described the 'bureaucratic obstruction' to health centre development across the English regions, in contrast to planned towns in Scotland that wholeheartedly embraced health centres.[867] The Mersey RHA described local GPs' independent contractor status as 'mystical as well as practical', and it is therefore unsurprising that few had relinquished the traditional practice model.[868]

Despite the emergence of a national 'renaissance', many GPs continued to be burdened by notions of intraprofessional inferiority during the 1970s. In a forward to Frank Honigsbaum's 1975 *The Division in British Medicine,* health economist Brian Abel-Smith

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[864] Mersey Regional Health Authority, 'General Practice in State Medical Care' (July 1974), [LRO: 614RHA/4/1].
[865] Mersey Regional Health Authority, 'General Practice in State Medical Care', Map 1.
[866] Christine Brace, 27 March 2018.
[867] Charles Webster, "The Politics of General Practice" in *General Practice under the National Health Service,* 32.
[868] Mersey Regional Health Authority, "General Practice in State Medical Care."

(1926-1996) described the relationship between hospital consultants and general practitioners as an 'ancient class division' that was maintained through their administrative separation under the NHS.[869] Alongside the College of General Practitioners, left-wing organizations such as the Labour party-affiliated Socialist Medical Association supported progressive GPs, and published a dedicated journal, *Medicine Today and Tomorrow* (1937-1965, *Socialism and Health* since 1965). In 1979, Liverpool public health practitioner and academic Alex Scott-Samuel founded the national journal *Radical Community Medicine* (now *Critical Public Health*), a 'journal of the politics of health', and remained in close contact with other progressive members of Liverpool's medical community.[870]

[869] Honigsbaum, *The Division in British Medicine,* xvi.
[870] *Radical Community Medicine* (Spring 1985).

Figure 11.1 General Practitioners in the Mersey Region: Analysis by size of practice, 1974.[871]

Area Health Authority	**Single Handed**	**2 Partners**	**3**	**4**	**5+**
Sefton	35	14	13	4	2
Overlap Zone	6	11	2	4	0
Liverpool	**70**	**42**	**23**	**6**	**1**
St Helens and Knowsley	32	14	13	6	2
Wirral	38	17	14	8	3
Cheshire	21	32	39	20	12

[871] Data from Mersey Regional Health Authority, 'General Practice in State Medical Care.'

Debating local general practice

In spite of national movements for general practice reform, the independent status of GPs enabled individual practitioners to resist change, and some resolved to work within the traditional 'small shopkeeper' model until retirement. In Liverpool, research published in 1980 revealed the continued struggle to recruit young doctors: a quarter of local GPs were aged 60 years or older (compared with a mere 9 per cent in nearby Cheshire) and there were fourteen practicing doctors over 70 years old.[872] The study suggested that poor working conditions and the overrepresentation of single handed doctors led to an inadequate service that was unlikely to bring 'young recruits' to Liverpool. Major variation in size, standards, and political outlook of general practices existed across the country, and substantial diversity could also be observed within small geographical areas.

Local Medical Committees, created in 1911 with a statutory duty to represent local GPs, remained the primary forum for debate among the local GP community.[873] Nonetheless, alternative organizations, both at local and national level, began to offer practitioners different channels to communicate and develop ideas. The College of General Practitioners represented the national 'renaissance' of the speciality, however it evidently took time for progressive ideas to be accepted in Liverpool: Alex Scott-Samuel described a delay between the creation of the college and any recognizable changes to the attitudes of the university department of general practice (which was re-established in 1985) and LMC.

> It took a long time before even the university department became truly RCGP-ish, and much, much longer before the profession in Liverpool became like that. Typically,

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[872] Ben-Tovim, "Racial Disadvantage in Liverpool," 56-57.

[873] Wessex Local Medical Committees, "GP Representation – The role of the LMC," https://www.wessexlmcs.com/gprepresentationtheroleofthelmc [accessed 20 February 2020].

> you can contrast the RCGP and that kind of influence on primary care with the Local Medical Committee…they've always tended to be relatively conservative because it's like a club for local GPs.[874]

Established groups such as the LMC were influential in mediating the local response to national initiatives, and while the university department of general practice began to embrace the reform agenda after a delay, the local GP community resisted any rapid and radical change. Scott-Samuel described the LMC as 'narrowly protecting the interests of local GPs', which remained their central function.[875]

Some members of Liverpool's GP community sought to expose what they considered to be the substandard level of care offered in some practices, and partnered with patient representation organisations to highlight their concerns. Alex Mold explored the role of the 'patient-consumer' in British medicine, and patient representation organizations such as the Patients Association (established in 1962), Community Health Councils (1974), and the College of Health (1983) were established to improve the level of 'interaction between patient groups, the state, the medical profession, and the affluent society'.[876] Nonetheless, Mold claimed that the dominance of government figures and the medical profession meant it was 'remarkable that patient organizations played any role at all' in health debates during the 1960s and 1970s.[877]

Community Health Councils (CHCs) were created as part of the 1974 NHS reorganisation with the aim of including the public in decision-making to a greater degree, and active CHCs engaged with practitioners and conducted investigations into local health services

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[874] Alex Scott Samuel, 1 May 2018.
[875] Alex Scott Samuel, 1 May 2018.
[876] Alex Mold, "Making the Patient-Consumer in Margaret Thatcher's Britain," *The Historical Journal* 54.2 (2011), 510-511.
[877] Alex Mold, "Patients' Rights and the National Health Service in Britain, 1960s–1980s," *American Journal of Public Health* 102.11 (2012), 2036.

(the 1995 Health Authorities Act replaced RHAs with new health authorities, and CHCs were ultimately abolished in 2003).[878] While CHC figures attended AHA meetings, Rivett suggested they 'they were regarded with suspicion by members of authorities and the medical profession.'[879] Patients' campaigns co-ordinated by CHCs attracted substantial local attention, and also provided a platform for GPs to act as whistle-blowers. Sylvia Hikins reflected on her period as chair of the highly political Liverpool Central and Southern CHC between 1981 and 1990.

> Health was a hot topic in Liverpool in the 80s… the public could go to meetings of the Area Health Authority…very often the public gallery would be full to overflowing with more than 100 people.[880]

The CHC offered practitioners a channel of communication with the public and administrators that circumvented traditional professional networks such as the Local Medical Committee, which were primarily concerned with deflecting criticism.

The Liverpool CHC worked collaboratively with professional groups to address widely acknowledged issues in local medical services, such as the notorious Boundary Street area of north Liverpool, which had a reputation for GP practices that exemplified the negative aspects of unreformed practice. The CHC used information shared by the LMC to highlight the issue publicly during the late 1970s, and the two bodies kept in communication through

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[878] Susan Pickard, "The Future Organization of Community Health Councils," *Social Policy & Administration* 31.3 (1997): 275; Rudolf Klein, *The Politics of Consumer Representation. A Study of Community Health Councils* (London: Centre for Studies in Social Policy, 1976), 11; Mold, "Patient Groups and the Construction of the Patient-Consumer," 505–21.

[879] Rivett, *From Cradle to Grave,* 268.

[880] Sylvia Hikins, 9 July 2018.

sharing reports and circulars.[881] Alex Scott Samuel recalled working at the Northern Hospital, which received patients referred by Boundary Street GPs.

> There were literally a number of shops with GP premises where people would queue, sometimes out into the street, to be seen by the GP! Dreadful places – and I can still remember the output of those small shopkeepers when I was on call for A&E in my house year 1972/1973.[882]

CHC chair Sylvia Hikins inspected various practices in the area.

> There was a practice on Boundary Street which was just appalling, we had constant complaints, I'll give you an example for one, one woman went in and the doctor examined her chest without her taking her clothes off, through her jacket, told her she had a lump, and when she got home it actually was a coin in her pocket.[883]

She also described surgeries with no running water and old cinema seats instead of a suitably equipped waiting room, and remembered the confrontation with the substandard GP.

> I said, 'don't you think your patients deserve somewhere decent to sit?' and the response I got was 'they don't know any better round here.[884]

Cooperation between the LMC and CHC indicated how professional groups were willing to engage with patients' organizations to encourage local professional change. In spite of the critical findings of the CHC, a clear gulf remained between local GPs willing to participate in discussions with patients' groups and those who preferred to distance themselves by maintaining what Mold

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[881] LMC Meeting Minutes 1st March; 5th April 1977; 5th December 1978; LMC Meeting 8th January 1974, [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].
[882] Alex Scott Samuel, 1 May 2018.
[883] Sylvia Hikins, 9 July 2018.
[884] Sylvia Hikins, 9 July 2018.

describes as a 'culture of paternalism' that conferred a passive role onto patients.[885]

While some practitioners in Liverpool sought to embrace the renaissance of general practice, however a substantial proportion of the local GP community remained engaged in traditional forms of practice. The 'small shopkeeper' model had proved adequate for many established local GPs, who remained uninterested in the values promoted by groups such as the College of General Practitioners. The independent status of GPs, with single-handed practitioners perhaps only employing a secretary (often a spouse), meant they could effectively insulate themselves from external professional changes. Nonetheless, the CHC highlighted professional practices deemed by fellow-practitioners to be anachronistic and inadequate, and publicised issues in the local press and with the NHS administration.

11.2: Radical general practice in Liverpool

Princes Park Health Centre

The most vocal advocate of professional reform in Liverpool during the 1970s and 1980s was Cyril Taylor (1921-2000), a polarizing and politically hyperactive figure brought up on the Wirral Peninsula who graduated from Liverpool in 1943. Taylor was politically active throughout his life, and had been part of a delegation of socialist doctors that lobbied Bevan (unsuccessfully) not to give in to demands from the profession during negotiations over the 1946 NHS Act. His entry into general practice was circuitously linked to his support for the Communist Party (which he later disavowed); a medical officer saw a poster announcing Taylor was speaking in support of the Communist candidate in the 1950 general election and immediately sacked him from his post at the Shipping Federation.

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[885] Alex Mold, "Repositioning the Patient:: Patient Organizations, Consumerism, and Autonomy in Britain during the 1960s and 1970s," *Bulletin of the History of Medicine* 87.2 (Summer 2013), 226.

Facing unemployment, Taylor set up a singlehanded practice from his home in Sefton Drive in South Liverpool.[886]

The Sefton Drive practice became a hub of left-wing politics in Liverpool during the 1960s, and attracted patients from across the local cultural scene including *Mersey Sound* poet Adrian Henri (1932-2000) and comedian Alexei Sayle (b. 1966). Taylor was a Labour party councillor for the Granby ward in Toxteth between 1965-1980, and chair of the social services committee on the city council. He was president of the Socialist Medical Association from 1980-1989, and was at the forefront of a local group of practitioners passionate about community health, preventive medicine and professional reform. John Ashton, a former public health director, described the Sefton Drive practice.

> Cyril had a big table in the house in Sefton Drive, this was Cyril's war room… and he used to have Sunday night meetings with people who were going to plot the week's politics and events in Liverpool, he was very much at the heart of it for years and years.[887]

Taylor was able to develop and lead a network of politically likeminded general practitioners, and also used his political platform to engage with wider debates on medical services in Liverpool and further afield.

Perhaps unsurprisingly, Taylor was a divisive figure in the local professional community. When he was invited to serve as a member of the Royal Commission on the NHS in 1976 the Liverpool LMC passed a resolution declaring his views were not representative of 'majority practitioner opinion' in the city.[888] Taylor was the driving force behind the Princes Park Health Centre, situated in purpose-built premises on Bentley Road in Toxteth, which was opened by Alec

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[886] "The Princes Park Health Centre – How it all Began" [LRO: 613/TAY/1/10].

[887] John Ashton, 27 June 2018.

[888] Liverpool LMC Meeting 6th July 1976 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

Merrison, chair of the Royal Commission, in March 1977. Princes Park sought to promote the principles of the 'renaissance of general practice', including teamworking, community involvement, and preventive medicine that expanded the remit of traditional general practice.[889] Katy Gardner, who had been part of a group at Cambridge University called 'Reds in Medicine' and visited Julian Tudor Hart's practice in South Wales, joined Taylor at Princes Park in 1978.

> Cyril [Taylor] was the big personality. It was his idea, and he had been a GP in Sefton Drive just around the corner for many, many years, but he had read things about the Peckham Experiment; all singing all dancing health centres.[890]

Princes Park was described by an anonymous GP interviewee as the 'jewel in the crown' of general practice in the city.[891]

The health centre housed three separate practices, with different principals and partners in each, many of whom had experience of working in traditional practices. The three GPs at practice 'A', led by Taylor, reflected that 'the commonest complaint from patients was the loss of the more friendly intimacy of the waiting room [in previous practices]', indicating the contrast between the intimate Sefton Drive 'parlour practice' and the new site.[892] Another of the practices at Princes Park was initially run single-handedly by Sheila Abdullah (b. Sheffield 1936/1938 q Sheffield 1961) before amalgamating with Taylor's practice. Gardner described Abdullah as 'a feminist and socialist and firebrand', she had actively

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[889] Malcolm Rigler and Katy Gardner, "A celebration of health through art," (Occasional paper) *Royal College of General Practitioners* 64 (1994), 17; John Ashton provided a definition of 'primary health care' in a 1989 letter, 'General Practice or Primary Health Care' published in *Journal of the Royal College of General Practitioners,* May 1989, 212.

[890] Katy Gardner, 5 April 2018.

[891] Rob Barnett, 6 July 2018.

[892] 'Princes Park Health Centre' March 2nd, 1980, [LRO: 613/TAY/1/9].

sought to work from the new health centre after experiencing 'the primitive arrangements of an isolated single-handed practice in slum-like conditions.'[893]

Alongside the position taken by the College of General Practice, by the late 1950s influential national groups such as the Medical Women's Federation were advocating that women abandon singlehanded (or women-only partner practice) in favour of group practice, thereby indicating the commitment of women practitioners to the reforming agenda.[894] For Abdullah, the advantages of working from the health centre included partnership with staff from other clinical backgrounds such as nurses, health visitors and social workers. Princes Park also enabled likeminded doctors to work together on initiatives such as the treatment of drug abuse and health fairs for the patient population, community events, health outreach and public art and theatre presentations.[895] Group practices and health centres enabled likeminded practitioners to develop their ideas in an intimate and supportive professional setting.

Conflict in the GP community

The network of ideological practitioners that coalesced around Cyril Taylor occasionally came into conflict with professional colleagues working in more traditional arrangements. The practitioners in Taylor's circle were highly sceptical of drug industry-sponsored research, favouring social prescribing instead of the questionable merits of funded trials, and staged a protest in January 1983 when an Italian drug company invited local practitioners to a lavish launch of its new arthritis drug aboard a yacht in Liverpool's

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[893] 'Princes Park Health Centre' March 2nd, 1980, [LRO: 613/TAY/1/9]; Katy Gardner, 5 April 2018.
[894] Elston, "Women doctors in the British health services", 373.
[895] Michael Ross, "Letter: treatment of heroin addiction," *Journal of the Royal College of General Practitioners* (October 1983), 683-4; Katy Gardner, "Why not organize a health fair," *Journal of the Royal College of General Practitioners* (November 1985), 543.

Princes Dock.[896] Around twenty practitioners and health workers picketed the event, among them the Princes Park GPs, Katy Gardner took part in the picket.

> I remember seeing people that I knew. I just thought, 'how could you do this?' It didn't endear me to them, or them to me.[897]

The forms of industry sponsorship varied, from financial support for meetings to 'overt marketing extravaganzas.'[898] The relationship between doctors and the industry became a subject of heated public debate, a 1983 cover story in the *Listener* magazine labelled practitioners claims of 'intellectual independence' delusional in the face of the 'generously sponsored assault' from drug companies.[899] Practitioners critical of the status quo claimed that exposure to the 'blandishments of the drug reps' began at medical school, 'to the extent that we felt that free food and drink was…part of being a grown-up doctor.'[900] Such incidents reveal the political and gulf in attitudes between general practitioners in Liverpool during the period.

In North Liverpool, GPs interacted with consultant colleagues through the informal '99 Club' (named after a form of auscultation used in physical examinations, during which practitioners listen to the patient's chest as they say 'ninety-nine'), which was described by chest physician John Turner, who arrived in Liverpool in 1977.

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[896] Katy Gardner, 5 April 2018; Cyril Taylor, "Letters: Medicines surveillance organisation," *Journal of the Royal College of General Practitioners* (January 1985), 41; "Protest as GPs board yacht" *Liverpool Echo* 28th January 1983; The event was to celebrate the launch of Flosint, the brand name of an anti-inflammatory produced by Farmitalia Carlo Erba. It was withdrawn later that year following high incidences of severe gastrointestinal bleeding.

[897] Katy Gardner, 5 April 2018.

[898] Michael Rawlins, "Doctors and the Drug Makers," *Lancet* 2.8397 (1984), 276.

[899] Tom Mangold, "Relationships between Doctors and Salesmen Are Lurching out of Control," *Listener* 110.20 (1983), 3.

[900] "Letters to the editor," *Listener* 3 February 1983.

> It was introduced to me by the physicians that I was working with on the ward that I had my first medical beds at Walton Hospital, it was sort of expected that you would become a member of the 99 club, you were proposed very informally. I can't recall whether we even had a subscription.[901]

Turner described the purpose of the club as promoting relations between consultants and GPs in North Liverpool, and meetings would regularly attract over 100 attendees. High attendance was attributed to the nature of 99 Club events, often held at the Blundellsands Hotel and West Lancashire Golf Club in Crosby, and sponsored by pharmaceutical companies, which Turner remembered were always interested in providing support.

> "[Pharmaceutical companies were] queuing to support something like the 99 club if they knew they could get an attendance of 100 or 120 consultants and GPs together."[902]

These popular meetings, which consisted of dinners preceded by a presentation from the sponsoring pharmaceutical company, demonstrated the important role played by the drug industry in facilitating communications between GPs and consultants. The lack of written records of the 99 Club make further insights difficult, however Turner suggested that it declined following the introduction of regulation pushing for greater "accountability around pharmaceutical spending" (and reflected he could not recall any activity during the last 25 years, greater oversight of the drug industry followed the establishment of the Medicines Control Agency in 1999).[903] Drug industry sponsorship was a pervasive and significant element in the networking activities between GPs and with their consultant colleagues during this period.

Tensions erupted between the radical practitioners at Princes Park and other members of the local GP community following the

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[901] John Turner, 16 April 2019.
[902] John Turner, 16 April 2019.
[903] John Turner, 16 April 2019.

release of a television documentary on medical practice in Liverpool in August 1983. 'Mission of Mersey' was the second of a three part BBC mini-series on the NHS, which aspired to show 'the health of the NHS as seen by those who work for it'.[904] The programme's producers claimed to be responding to calls from the profession to document general practice, rather than perpetuate 'television's natural obsession with the technological frontiers of medicine'.[905] 'Mission of Mersey' focused on Princes Park Health Centre, and presented Cyril Taylor as the spokesperson for community-oriented teamworking practice.[906]

The documentary included the case of a local woman whose ten-month-old baby had died following an examination by her GP (she had been told at the post-mortem that the baby's dehydrated condition should have been noticed). The woman subsequently became a Princes Park patient, and Taylor suggested that a different practitioner might have sought further advice from a colleague in a group practice or from a profession allied to medicine, as 'younger doctors feel less threatened than perhaps some of my generation do, by the concept of other professionals knowing more about an area of care than we do'.[907] The public discussion of such issues enraged some members of the medical community: a local GP proposed a resolution at LMC that 'Mission of Mersey' be condemned as 'misleading,' 'blatant advertising,' making 'disparaging reference to single handed practice as well as to older doctors' and the 'cowardly and unethical publicizing of comments by aggrieved patients.'[908]

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[904] *Mission of Mersey*, (dir. Michael McCormack, prod. Peter Lee-Wright) Courtesy British Film Institute.
[905] BBC Open Space, *The National Health Service,* Appendix 1 (Press Release), [LRO: 613 TAY/1/8].
[906] BBC Open Space, *The National Health Service,* Appendix 1 (Press Release), [LRO: 613 TAY/1/8].
[907] Transcript of 'Mission of Mersey' [LRO: 613 TAY/1/8].
[908] LMC Meeting Minutes September-October 1983 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

'Mission of Mersey' was discussed at several LMC meetings during the Autumn of 1983, and it became clear that more than half of the committee's members were unaware of its existence.[909] The resolution to condemn it was defeated, however the aggrieved practitioner personally circulated a note to local GPs, stating that the resolution condemning Princes Park had been passed at a subsequent meeting.[910] The Princes Park group wrote to LMC secretary Ian Bogle requesting he make it known that the circular was not sanctioned by the committee, highlighting the fact that the accusation of hostility towards single handed and elderly GPs ignored the fact that the 63 year old Taylor had spent most of his career as a single handed practitioner.[911] The incident put Bogle in a difficult position, as an adjudicator between two strongly held views on professional expectations, and he forbade further discussion of the matter at subsequent meetings. Sylvia Hikins, chair of the local CHC, described Bogle as a powerful figure in the local GP community.

> [Bogle was] pretty progressive, he was one of those people that on certain issues would publicly support you, on other issues would support you privately and let you do the work… He was influential.[912]

Bogle was the long-serving chair of the LMC (between 1973-1990), chaired the BMA General Medical Services Committee (1990-1997), and was elected BMA chairman (1998-2003).

Such incidents exposed tensions in the local professional community regarding changes to general practice, and the existence of clear opposition to the Princes Park group. Left wing figures such as public health lecturer Alex Scott-Samuel viewed the LMC as a

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[909] LMC Meeting Minutes September-October 1983 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].
[910] Liverpool LMC Minutes 6th September 1983; 4th October; 31st January 1984 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].
[911] Cyril Taylor to Ian Bogle, 28th February 1984 [LRO: 613 TAY/1/8].
[912] Sylvia Hikins, 9 July 2018.

conservative body, however records indicate it was far from a monolithic opponent to reform: in 1985, Bogle had another confrontation as LMC president when a doctor refused to 'relinquish' his singlehanded practice, and accused Bogle of abusing his position.[913] The LMC was faced with the difficult task of accommodating and representing a diverse range of professional viewpoints during a period of major reform to general practice. Nonetheless, the 'Mission of Mersey' incident demonstrated local practitioners were willing to use different channels to communicate with a wider audience, and were not limited to the strictly professional forum provided by the LMC.

Conclusion

Liverpool's diverse and often fiercely independent GP community responded with varying degrees of enthusiasm to the 'renaissance' of the specialty. This chapter has demonstrated the fracturing of the local GP community as a result of tensions between innovative and traditional practices. Politicised practitioners such as Cyril Taylor and the Princes Park group developed a radical practice, however they operated within a conservative local professional community that was often unwilling to accommodate or pursue rapid professional reform. The NHS reorganization led to reviews of local health services by the new administration, and also created patient representation organizations in the form of Community Health Councils. These changes, alongside the publication of the 1979 Royal Commission on the NHS and 1980 Black Report into health inequalities raised the profile of primary care nationally, and led to passionate debates in Liverpool over general practice provision.

Following the publication of the 1987 White Paper *Promoting Better Health*, Nick Bosanquet and Brenda Leese published research

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[913] Alex Scott Samuel, 1 May 2018; LMC Meeting 3rd September 1985 [LMC Archive, courtesy of Rob Barnett, Greenbank Road Surgery, Liverpool].

suggesting 'innovative' practices, which embraced multidisciplinary working, vocational training and improved premises, were more frequently found in affluent areas, while 'traditional practices' were more common in urban areas of declining population.[914] The 1990 GP contract aimed to address these issues, while failing to satisfy calls from left-wing professional organizations for salaried service, and introduced new incentives that greatly undermined the traditional model of singlehanded general practice and encouraged health promotion and screening, teamworking and practice investment. Single-handed practice continued to decline across the country, to be replaced by fundholding GPs within the NHS internal market.

GPs in Liverpool made use of a range of networks to develop their political and professional objectives, reflecting the spectrum of professional values held by different practitioners. Alternative forms of association to the traditionally dominant Local Medical Committee included group practices, the College of General Practitioners and Community Health Councils. These networks provided more fruitful channels to members of the local medical community seeking to benefit from the increasing prominence of the 'patient consumer' in the reorganised service, and draw on the influence of national organisations. Such groups provided a viable alternative to local networks that prioritised professional harmony and sought to encourage traditional values. The attempts of the Liverpool Medical Institution and other clubs and societies to meet the needs of an increasingly heterogenous medical community is considered in the following chapter.

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[914] Nick Bosanquet and Brenda Leese, "Family doctors and innovation in general practice," *BMJ* 4th June 1988, 1580.

Chapter 12

Local Medical Networks 1978-1998

Introduction

The NHS reforms of the 1970s and 1980s had significant repercussions for local professional networks. Liverpool's growing medical community was becoming less homogenous, reflecting changes to the national medical workforce, and some practitioners felt traditional forms of association such as medical societies and clubs were either irrelevant or unsuited to modern practice. The expectation of deference to senior colleagues described by interviewees who qualified during the 1960s and 1970s was less evident in later years, as the formalisation of the medical career structure negated the importance of personal patronage. Practitioners attached greater significance to the publication of research than cultivating local professional relationships, and increased national and international communication and connectivity led to a decline in the significance of local contacts. The growth of specialisation led to the list of medical societies featured in the *Medical Register* to be dominated by specialist organizations, and by 1985 the LMI was instead listed in the directory of postgraduate medical centres.

The rationalisation of Liverpool's historically disparate hospital system at a smaller number of sites undermined the traditional role of the Liverpool Medical Institution as a meeting point for practitioners with different institutional affiliations. Nonetheless, the LMI continued to enjoy the support of the local professional establishment, and secured investment from regional postgraduate education funds following the 1974 reorganisation. The creation of the NHS internal market introduced less manageable challenges; hospital trusts were less willing to invest funds in shared resources, and adopted a proprietorial attitude towards new, purpose-built postgraduate medical centres at hospitals. The history and traditions embodied by the LMI remained of interest to practitioners in Liverpool, despite not being directly important for their careers,

however the institution was increasingly forced to stake a claim to relevance based on its past achievements, rather than any potential future role in the medical community.

This chapter considers how structural changes resulting from health service reform were managed by local medical networks. Section 1 outlines how changes to professional culture following during the 1980s and 1990s influenced practitioners' interest and engagement with these organisations. Section 2 considers the decline of the LMI from a central position in Liverpool's medical community to a financially precarious and disconnected peripheral organisation, gathering interviewees' perspectives on its decline and changing role.

12.1: Professional culture and NHS reform

Professional change during the 1990s

The medical career structure underwent a number of changes during the 1980s and 1990s, reflecting the fact that the expectations and lifestyles of practitioners had altered since the NHS was created in 1948. Rivett noted how 'In 1948 junior doctors had largely been male, unmarried and had lived in the hospital. Now many had family responsibilities and wished to live out.'[915] A working group led by Kenneth Calman reported in 1993, outlining formalised specialist training, replacing the traditional system of hospital firms with a certificate of specialist training.[916] The reforms sought to address the perception among some practitioners that 'most junior doctors believe that their training consists mainly of unsupervised service; moments snatched with books and journals; and unstructured, unreliable, and invalid feedback on the grapevine.'[917]

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[915] Rivett, *From Cradle to Grave,* 340.

[916] Kenneth Calman, *Hospital Doctors: Training for the Future. The Report of the Working Group on Specialist Medical Training*. (London: NHS Executive, 1995).

[917] Stephen Hunter and Paul McLaren, "Specialist medical training and the Calman report." *BMJ* 15th May 1993, 1281.

Traditional working arrangements in hospitals were further modified with the introduction of the European Working Time Directive in 1998, establishing shift patterns (rather than long periods spent 'on call'), and described by Tim Swanwick as a move away from the 'apprenticeship model' between consultant and junior.[918] In spite of the introduction of formal guidelines for career progression, local professional networks continued to provide important opportunities for securing posts among general practitioners. Mike Cranney recalled joining a general practice after graduating in 1980 as a result of a stroke of good luck and personal connections.

> I was doing an operation… and the anaesthetist…said 'I've got a friend' - she met him in church - 'he's looking for a partner, would you like to go and see him?[919]

Local connections remained significant for GPs, and the Local Medical Committee continued to operate as an independent forum for local views. GPs also deputized for colleagues as locums. Local GP Basil John Maxwell (1926-1999, q. 1949 Liverpool) established Liverpool Locums as a non-profit alternative to national BMA schemes. Mike Cranney, who later took over as director, recalled how the role inevitably led to familiarity with other local practices.[920]

A local 'young principals' group provided further support around training and practice management, and a forum to discuss the ideas of national groups such as the Balint society. The Balint Society, founded in 1969, focused on the ideas of psychoanalysts Michael (1896-1970) and Enid (1903-1994) Balint, who ran seminars to help practitioners 'reach a better understanding of the emotional content of the doctor-patient relationship and so improve their

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[918] Tim Swanwick, "Informal Learning in Postgraduate Medical Education: From Cognitivism to 'Culturism,'" *Medical Education* 39.8 (2005), 860.

[919] Mike Cranney, 25 May 2018.

[920] Mike Cranney, 25 May 2018.

therapeutic potential'.[921] The 'renaissance' of general practice led to the formation of groups which offered targeted activities for likeminded practitioners. Alongside the established LMC and divisional branches of the BMA and SMA, young principals groups and the Balint society provided a more specific offering than traditional societies such as the LMI. The LMI offered dedicated general practitioner sessions, and the local branch of the College of General Practitioners was accommodated at the institution, however the academic requirements of modern general practice put further pressure on the LMI to purchase books and provide the resources recommended by the college at a time of financial uncertainty.[922]

Professional prejudice

Many of Liverpool's local medical networks had formed at a time when the medical community was broadly homogenous in terms of gender, class and ethnicity. International practitioners have played a major role in the British medical workforce since before 1948: the GMC recognised Indian medical degrees between 1892 and 1975, and large numbers of British practitioners emigrating to the USA, Canada and Australia during the 1950s and 1960s necessitated international recruitment.[923] In 1961 Henry Cohen suggested that the NHS 'would have collapsed if it had not been for the enormous influx [of] junior doctors from such countries as India and Pakistan'.[924] In 1972 over forty per cent postgraduate training posts were held by migrants, and by the end of the 1970s around 10,000 practitioners from the Indian subcontinent were working in Britain, albeit with substantial variation

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[921] Rosalind Bonsor, Trevor Gibbs and Roy Woodward, "Vocational Training and Beyond--Listening to Voices from a Void," *British Journal of General Practice* 48.426 (1998), 916; The Balint Society, https://balint.co.uk/ [accessed 17 January 2019].
[922] LMI Council Meeting 12th May 1993 [LMI: LMI 2/1/3/1/12]/
[923] See David J Smith, *Overseas doctors in the National Health Service*. (London: Policy Studies Institute, 1980).
[924] Aneez Esmail, "Asian Doctors in the NHS: Service and Betrayal," *British Journal of General Practice* 57.543 (2007), 830.

across regions, with the Midlands and North of England more frequent destinations for overseas doctors (see Figures 12.1, 12.2 and 12.3).

Figure 12.1: Country of Birth of GPs and Hospital Doctors (1977/8 Survey)[925]

Country of Birth	**All Doctors (%)**	**General Practitioners (%)**	**Hospital Doctors (%)**
UK or Eire	69	80	62
UK	67	76	60
Eire	2	4	2
Other European Countries	3	3	4
White Anglophone Countries	3	2	3
Indian sub-continent	17	12	20
India	12	10	14
Pakistan	2	1	2
Bangladesh	1	1	1
Sri Lanka	2	1	3
Arab Countries/Iran	3	1	5
African Countries	1	1	1
Far Eastern countries	2	1	2
Other Countries	2	1	2
Base: unweighted	**1981**	**730**	**1251**
Base: weighted	**4490**	**1923**	**2567**

[925] Adapted from Smith, *Overseas Doctors,* 8.

Figure 12.2: Proportion of hospital doctors born outside of UK and Eire by region, 1977.[926]

Regional Health Authority	**Per cent**
Northern	37
Yorkshire	39
Trent	33
East Anglia	29
NW Thames	32
NE Thames	38
SE Thames	32
SW Thames	32
Wessex	24
Oxford	28
South Western	20
West Midlands	38
Mersey	34
North Western	40
London Postgraduate Teaching Hospitals	24

[926] Adapted from Smith, *Overseas Doctors*, Appendix A, Table A5.

Figure 12.3: Proportion of GPs who first qualified outside the UK and Eire by region, 1977/1978.[927]

Region	**Per cent**
Northern and Yorkshire	12
Trent and East Anglia	10
NW and NE Thames	27
SW and SE Thames	13
Wessex and South Western	3
Oxford and West Midlands	22
Mersey and North Western	19

[927] Adapted from Smith, *Overseas Doctors*, Appendix A, Table A6.

International practitioners faced systemic prejudice in the NHS, despite its reliance on a migrant workforce, and Peter Trewby suggested that hostility reflected professional jealousy and opposition to foreign methods.[928] Aneez Esmail claimed that the decision to stop recognising foreign degrees in 1975 'institutionalised the view of overseas doctors as pariah'.[929] It was common practice during the 1970s for GP vacancies advertised in the *BMJ* to specify the desired ethnicity of applicants, and international doctors were overrepresented in traditionally undesirable 'Cinderella' hospital specialties and as GPs in deprived areas.[930] Black and minority ethnic practitioners were overrepresented among psychiatrists and geriatricians qualifying in the 1980s, and a 1997 study revealed British graduates with Asian names remained less likely to be shortlisted for Senior House Officer posts.[931]

Liverpool's medical community was clearly not immune to the prejudice evident at a national level: a senior local GP commented that foreign GPs were often forced to work singlehandedly, as local doctors were 'suspicious' of taking them on as partners.

> I got quite annoyed with the system: these doctors came over to the UK at a time when we needed doctors, and they weren't

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[928] Peter Trewby, "'… a Stranger in a Strange Land': 1 The Plight of Refugee Doctors in the UK," *Clinical Medicine* 5.4 (2005), 317.
[929] Esmail, "Asian Doctors in the NHS," 831; Roger Jeffery, "Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918–39," *Modern Asian Studies* 13.2 (1979), 301.
[930] This practice stopped following the 1976 Race Relations Act, see Esmail, "Asian Doctors in the NHS," 832; Tessa Richards, "The Overseas Doctors Training Scheme: Failing Expectations," *BMJ* 18th June 1994, 1628-1630; Julian Simpson, *Migrant architects of the NHS: South Asian doctors and the reinvention of British general practice* (Oxford: Oxford University Press, 2018), 7-9.
[931] Aneez Esmail and Sam Everington, "Racial Discrimination against Doctors from Ethnic Minorities," *BMJ* 13th March 1993, 692; Aneez Esmail and Sam Everington, "Asian Doctors Are Still Being Discriminated Against," *BMJ* 31st May 1997, 1619.

> properly supported… then, when it was convenient for the service, they started making life difficult for these doctors.[932]

In some cases, status as a foreigner and non-Liverpool graduate conspired to obstruct career advancement. After repeatedly failing to secure a consultant appointment, Roger Armour (b. Roger Ahmed, 1934) changed his name (he considered he 'looked British' as he had a British mother) and secured a consultant position in Birkenhead in 1969.[933]

Medical students continued to be exposed to the values, and sometimes prejudices, of teaching consultants during their time at medical school. Anaesthetist Janice Fazackerley, who was a medical student at Liverpool between 1974-1979, recalled various incidents of sexist bullying directed at female students by male staff.

> We were doing gynaecology [and] every bit of questioning in the teaching was referred to me, he would say 'why does *she* … what does *she*' and the blokes in the firm would have to answer. One of the questions was 'why does she have vaginal secretions?' and you think 'stop it' and again, today, can you imagine anybody even thinking of saying this?[934]

These prejudices were reproduced in the activities of the Liverpool Medical Students Society. John Coakley, who entered the medical school in 1975, recalled the culture as 'misogynistic [and] racist – it was just the way it was in those days'[935] Coakley further reflected that racist attitudes were a routine feature of the dominant culture of the 1980s.

> I remember people just saying, 'why bother listening to these GPs, they're just Pa**s what do they know about anything?' You think 'come on, you're sitting next to an

[932] Rob Barnett, 6 July 2018.
[933] Roger Armour 25 September 2018
[934] Janice Fazackerley, 9 May 2018.
[935] John Coakley 31 May 2018.

> Indian doctor who's a surgeon, talking about this' it was an unbelievable time.[936]

Some LMSS activities outraged female students: the officer roles were clearly gendered (the lady secretary was obliged to wear a garter), and sex-segregated events were a feature of the society calendar. During the group interview on medical teaching, interviewees recited the 'medical school song'.

> *Some talk of drain inspectors and some of engineers*
> *We would not give for either last week's vaginal smears*
> *But onward we go marching the pride of all the 'Pool*
> *Jack Leggate's boys, those sturdy boys of the Liverpool Medical School*[937]

Chris Evans, who as a consultant was elected president of the medical students' society during the 1980s, described such behaviour as "indicative of the lads culture that pervaded through the LMSS", and his responsibilities as president.

> Turning up to the medical students' society meetings and making an embarrassing speech at the medical dinners – which was then of course all male, a bit of a raucous event but something I managed to get through.[938]

The 1984 annual medical dinner, an all-male event attended by students and consultants, was sabotaged by protestors outraged at the presence of strippers and alleged screenings of pornography. A female medical student came to the defence of the society on the grounds that a female-only dinner was also on the calendar, and the strippers were simply 'hired to do their job'.[939] Stipulations for the notorious annual smoking concert in 1990 demanded that 'each year within the medical school must produce its own short, 30-minute X-

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[936] John Coakley 31 May 2018.
[937] Group Interview on Medical Teaching, 28 January 2019.
[938] John Ridyard, 31 May 2018.
[939] *Sphincter* (1984) [SCA: PUB/3/8].

rated pantomime' and prepare for 'inter-year drinking and eating contests.'[940]

Such activities fuelled tension between LMSS and the Liverpool Guild of Students (the body representing students from other faculties, of which LMSS remained fiercely independent), and the guild president disrupted the 1987 smoking concert in protest, leading to 'near riot conditions'.[941] *Sphincter* did gradually incorporate some feminist perspectives: Katy Gardner, a GP based at the radical Princes Park health centre, contributed an article in 1985 under the title 'Choice, Change and Chauvinism' encouraging students to get involved in debates over the role of women in the profession (the piece was positioned overleaf from an article lampooning the feminist movement).[942]

12.2: The Liverpool Medical Institution 1974-1998

Partnership with the health authority

NHS reform and broader changes to professional culture had a significant impact on the Liverpool Medical Institution. LMI council was particularly mindful of the implications of the new Royal Liverpool hospital, which replaced several older hospitals that had an established relationship with the institution, and acknowledged that 'the future role of the Institution might have to change in order to fulfil the many varied needs of postgraduate medical education.'[943] Percy Whitaker, a radiologist described as 'chairman of almost all those ULH [United Liverpool Hospitals] and Liverpool RHB committees where a medical chairman was permissible', and Gerard Sanderson, who had been instrumental in the 1966 LMI extension,

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[940] 'Smoking Concerts' *Sphincter* (Autumn 1990) [SCA: PUB/3/8].
[941] *Sphincter* 1988, 4 [SCA: PUB/3/8].
[942] Katy Gardner, "Choice, Change and Chauvinism," *Sphincter* 1985, 12-13 [SCA: PUB/3/8].; Such articles did not change the overall tone of the journal, which by the 1990s featured female undergraduates as 'page 3 girls'.
[943] *Transactions and Report* 1974/5, 49.

were appointed to lead a special subcommittee to prepare for changes resulting from the 1974 reorganisation.[944]

A key priority for the subcommittee was ensuring the LMI had a future role in the local delivery of postgraduate medical education. Sanderson was aware of the threat constituted by NHS provision of services traditionally offered by medical societies: in 1972 he wrote in a local medical history journal that the rise of hospital postgraduate medical centres threatened 'older foundations which cling to their independence'.[945] Nonetheless, discussions with the new Liverpool Area Health Authority left council confident of continued financial support for postgraduate education, albeit in an altered form. A new arrangement was proposed whereby the AHA would establish and administer a standalone PGMC at the institution building, the LMI would 'in effect be landlord to a fully-equipped postgraduate medical centre'.[946]

Accommodating an 'official' health authority PGMC promised to confirm the continued relevance of the LMI in the reorganised NHS, and, more importantly, offered much-needed financial support. Nonetheless, the decision to abdicate control over postgraduate activity at the institution to an NHS body represented a major sacrifice of its traditional independence. Some members of council greeted the AHA proposal with suspicion, declaring it 'vital that doctors should retain control' of postgraduate education.[947] Discussions took place amid a climate of transition at the institution: traditionalists had recently opposed the decision, in 1969, to discontinue the requirement for speakers to observe a formal dress

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[944] GD Scarrow, "P. H. Whitaker, M.D., F.R.C.P.(Ed.), F.R.C.R., D.M.R.E., M.R.C.S., L.R.C.P." *Clinical Radiology,* January-October 1976, 430.

[945] Sanderson, "A note on the Liverpool Medical Institution," 383.

[946] *Transactions and Report* 1974/5, 49; *Transactions and Report* 1973/4, 32.

[947] Shepherd, *History of the LMI,* 253; Minutes of LMI Council Meeting 9/10/1974 [LMI: LMI 2/1/3/1/11].

code, and alignment with the AHA signalled yet another move away from 'doctor's club' to an NHS facility.[948] On a practical level, concerns were raised that membership would fall as doctors became eligible to access LMI facilities through the AHA PGMC (it was subsequently agreed to reserve certain library privileges for full members).[949]

In spite of these reservations, the LMI membership approved the decision to house the AHA PGMC at an extraordinary meeting in December 1975.[950] The institution negotiated an initial sum of £40,000 to convert space for PGMC use, and this was received from the health authority in June 1976 to begin the refurbishment of the bar, catering and library facilities.[951] The precarious financial state of the institution was revealed by the almost complete lack of LMI funds available to contribute to the renovation, an unforeseen £9,000 shortfall left the institution in a 'grave financial situation' in October 1974 (the health authority came to the rescue) and illustrated its total financial reliance on the AHA.[952]

After 1974, income from the PGMC and grants from the NWCRF, BMA and the AHA rapidly overtook income from subscriptions of ordinary LMI members (see Figure 12.4). The institution was effectively transformed from the modified but recognisable traditional medical society into landlord of an NHS postgraduate centre. Such collaboration with the AHA confirmed some members' fears that alignment with NHS bodies would diminish the autonomy of the institution, however given its financial

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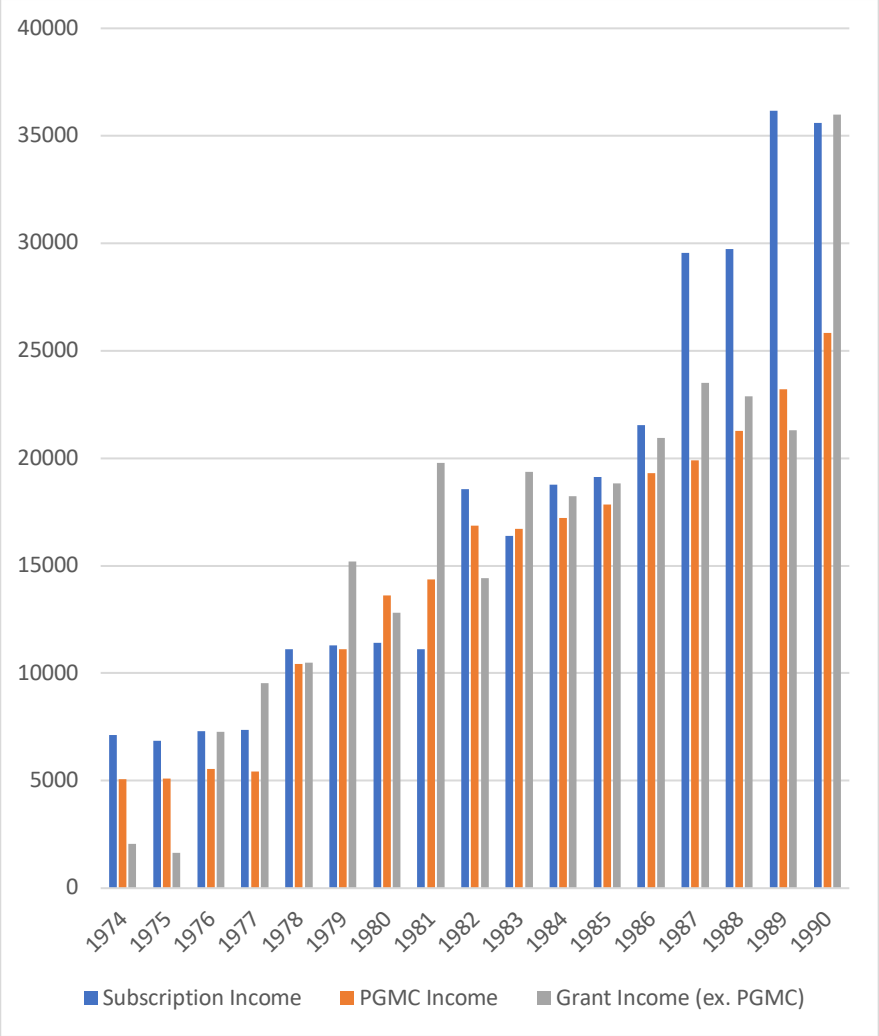
[948] 'I Leveson', *BMJ* 31 January 1981, 396; Minutes of LMI Council Meeting 7/7/1971 [LMI: LMI 2/1/3/1/10]; *Transactions and Report* 1970, 42.
[949] Minutes of LMI Council Meeting 11/12/1974 [LMI: LMI 2/1/3/1/11].
[950] Minutes of LMI Council Meeting 14/1/1976 [LMI: LMI 2/1/3/1/11].
[951] Minutes of LMI Council Meeting 9/6/1976 [LMI: LMI 2/1/3/1/11].
[952] Minutes of LMI Council Meeting 13/10/1976 [LMI: LMI 2/1/3/1/11].

position the guaranteed investment and annual grant offered an essential lifeline.

The development of postgraduate medical education at NHS hospitals challenged the traditional role of medical societies across the country. Societies had failed to be recognised as alternatives to hospital-based PGMCs following the 1962 Christ Church conference, and the LMI council therefore encouraged members to embrace the compromise offered by hosting the AHA PGMC when it opened in 1977. By 1978, when the new Royal Liverpool hospital opened, council claimed that a 'satisfactory symbiosis' had developed between the PGMC and the LMI: increased activity led to higher footfall at the institution bar and restaurant (especially during the strikes at various NHS hospitals during the Winter of Discontent of 1978/9), and the institution appeared to have found a place within the reorganised NHS.[953]

[953] *Transactions and Report* 1978/9, 57.

Figure 12.4: Main Sources of LMI Income 1974-1990[954]



[954] Source: Liverpool Medical Institution *Transactions and Report and Annual Report*.

The popularity of sponsored meetings and PGMC activity contributed to the appearance of a thriving organisation, however low attendance at traditional institution meetings remained a source of worry. Attendance at scientific meetings was described in 1983 as 'frequently embarrassingly poor', contributing to the decision in 1987 to invite dentists and 'nonmedical scientific graduates' working in the health service to join the institution for the first time.[955] The expansion of membership eligibility, a major departure from the foundation of the LMI as a society strictly reserved for medical practitioners, was a reflection of declining participation; attendance at ordinary meetings (which consistently exceeded 100 members during the 1960s), frequently struggled to reach fifty after the PGMC opened (see Figure 12.5).

In spite of the AHA grant, the financial situation at the LMI did not markedly improve following the opening of the PGMC, and by 1986 annual expenditure exceeded income by about £5,000.[956] The same year, a working party was formed to consult with members and staff in order to 'consider fully the future role of the institution in the postgraduate medical activities of the region'.[957] The investigation discovered a 'dearth of use' of the LMI by younger practitioners, who 'felt inhibited in the presence of more senior consultants.'[958] Only the institution's social functions were well attended, and these and other uses of the building were championed in the following years, including the advertisement of the building as a conference venue.[959]

The LMI had negotiated an arrangement in which it remained nominally independent, however its reliance on income from external

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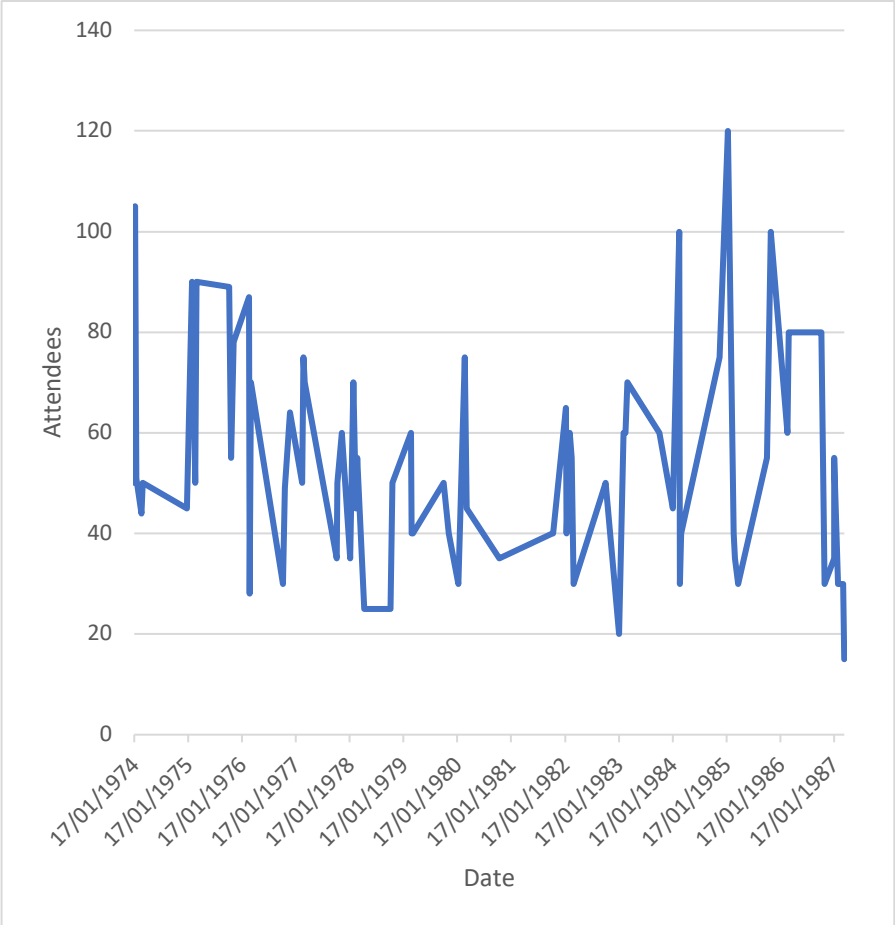
[955] *Transactions and Reports* 1982/3; *Transactions and Report* 1987/8, 62.
[956] Minutes of LMI Council Meeting 8/10/1986 [LMI: LMI 2/1/3/1/12].
[957] Minutes of LMI Council Meeting 11/12/1986 [LMI: LMI 2/1/3/1/12].
[958] Minutes of LMI Council Meeting 12/2/1987 [LMI: LMI 2/1/3/1/12].
[959] Minutes of LMI Council Meeting 13/9/1989 [LMI: LMI 2/1/3/1/12].

sources, foremost among them the health authority, severely undermined any claims to its former autonomy. Perhaps more worryingly, the lack of engagement from younger medical practitioners indicated a cultural shift away from the traditional medical society. Despite a stated membership of over one thousand at the turn of the new millennium, the LMI increasingly failed to attract either investment or local professional involvement in its activities. inWorking patterns of hospital consultants and general practitioners had changed beyond recognition since the LMI had enjoyed sustained popularity after WWII, and traditional medical societies had little to offer practitioners increasingly focused on academic research or keeping up with the commitments of more administratively complex general practices.

Figure 12.5: Attendance at LMI Ordinary Meetings, 1974-1987[960]



[960] Source: Minutes of Ordinary Meetings (LMI/2/1/4/1/9-12).

Medical societies in the reorganised NHS

The model of the traditional medical society had thrived during the nineteenth and early twentieth-centuries, and the LMI had been more successful than many provincial organizations in remaining relevant through its offering of postgraduate medical education. Nonetheless, the ingrained character of the LMI as a traditional 'doctors' club' appeared increasingly anachronistic to modern practice. The 1990 GP contract offered practitioners greater flexibility to spend periods working part-time or in job-shares, suited to women practitioners managing work and family commitments, and older practitioners nearing retirement.[961] Such arrangements were far removed from the experiences of the older generation, Thomas Cecil Gray, who first purchased a single-handed practice in 1939, shared his views of changes to the profession during a 1996 interview.

> Doctoring is a vocation. You damn well give your life to it, really. You don't think you are having a rough time when you are up at night. I mean every single practitioner would be up very often at night.[962]

GP Christine Brace, who qualified in Liverpool in 1968, recalled the feeling of having to choose between career and family.

> As a woman I realized that there were great problems- when I first wanted to do medicine because it was interesting, afterwards I realized…there were no part time jobs in those days, so how was I going to have children?[963]

Intensive care physician John Coakley recalled dividing his time between family in Liverpool and a registrar post in London in 1992.

> I… commuted as a senior registrar, weekends I would come up to Liverpool and that was a tough time – two years, on call

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[961] Rivett, *From Cradle to Grave,* 412-413.

[962] The Royal College of Physicians and Oxford Brookes University Medical Sciences Video Archive, MSV A 138, "Professor T Cecil Gray CBE KCSG FRCP FRCS FRCA in interview with Dr Max Blythe, Oxford, 28 August 1996, Interview One."

[963] Christine Brace, 27 March 2018.

> one weekend in three, one weekend in four, so three weekends out of four you would be home, with the kids. That was tough for my wife, who was also working full time.[964]

By contrast, an anonymous interviewee who graduated in Ireland and arrived in Liverpool in 1973, described their impression of medicine as a 'vocation', to be pursued single-mindedly.

> There's been a great sea change in the quality of commitment on behalf of doctors to the organisations that sustain doctors' communications. I think most doctors nowadays, as they qualify from the modern medical schools, go into their careers as they're going into a 'job', it probably sounds pompous to say we thought of it more as a vocation.[965]

Shifting perceptions about the duties of medical practitioners following a 'vocation' undermined the sense of obligation to organizations such as the LMI. A geneticist who arrived in Liverpool in 1993 decided to establish a home base in Manchester.

> We lived in Manchester, I drove over, commuted, and we had this sort of double life whereby my working life would be Liverpool 9-5, I would only see the cross section that I worked with or patients, I didn't see the city per se, then I would drive home and my social life would be developing in Manchester.[966]

When asked about potential membership or attendance at the LMI, he described the institution as offering little benefit.

> I never pursued it, partly because I hold BMA membership in London and I couldn't carry all these memberships, I thought 'what will it do for me?' when I finish in the evening I go home, I'm not going to loiter locally.[967]

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[964] John Coakley, 31 March 2018.
[965] Anonymous Interviewee 1, 24 May 2018.
[966] Anonymous Interviewee 3, 23 July 2018.
[967] Anonymous Interviewee 3, 23 July 2018.

After 1990, the implications of the NHS internal market further undermined the traditional function and financial viability of the Liverpool Medical Institution. Hospitals were eligible to apply for status as independent trusts under a team of non-executive directors, rather than NHS health authorities, and were expected to implement business strategies to boost performance. The internal market was intended to stimulate competition and lead to both greater economy and quality of care, and placed new demands on the medical profession: Rivett claimed that medical practitioners began to act in a 'more corporate and local way'.[968]

The Liverpool AHA was the main sponsor of educational activity at the LMI, however it declined in influence as the aggressive policies of regional chairman Donald Wilson resulted in the rapid local establishment of trusts, including the Royal Liverpool in 1991 and Fazakerley the following year. The LMI secured funding for the health authority PGMC in 1990, however they were warned that future investment was uncertain as local hospitals embraced greater independence.[969] By 1992-3 only £10,000 (of what was formerly a £25,000 annual budget) was forthcoming, and the LMI was forced to temporarily cancel its subscriptions to various medical journals.[970] Trevor Bayley, postgraduate dean at the Royal Liverpool (and a former member of LMI council) ensured the hospital stepped in to pay the difference. Nonetheless, faced with the loss of the health authority grant, the LMI urgently needed to secure a new patron.[971]

Fortunately for the institution, a number of members were represented on the medical boards of local hospitals, and were able to argue the case for continued support. In September 1993, Austin Carty, former LMI president and medical director at the Royal

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[968] Rivett, *From Cradle to Grave*, 423.

[969] Minutes of LMI Council Meeting 12/9/1990 [LMI: LMI 2/1/3/1/12].

[970] Minutes of LMI Council Meeting 9/9/1992 [LMI: LMI 2/1/3/1/12]; Minutes of LMI Council Meeting 14/7/1993 [LMI: LMI 2/1/3/1/12].

[971] Minutes of LMI Council Meeting 11/11/1992 [LMI: LMI 2/1/3/1/12].

Liverpool, notified council that the hospital would provide the £25,000 PGMC funding in exchange for making the 'library and meeting facilities' available to medical staff. He also cautioned that the Royal Liverpool would probably develop its own postgraduate centre and 'come to rely less and less' on the institution in the future.[972] Carty liaised with the LMI Finance and Establishment Committee throughout 1993, the year his wife Helen (1944-2017) was president of the institution, and was instrumental in securing the relationship between the Royal Liverpool and the LMI.[973] For its part, the LMI offered a convenient temporary solution to the postgraduate education needs of the new hospital trust: members of the medical board were familiar with the workings and personnel of the institution, and were able to negotiate a mutually beneficial arrangement.

The 1993 Calman Report emphasised the provision of postgraduate teaching facilities *within* hospitals, with the implication that external organizations such as the LMI might offer supplementary courses, but would no longer be recognised as PGMCs. Ian Gilmore, who followed Carty as medical director at the Royal Liverpool in 1995 (and later became LMI president) reassured the institution that the hospital was 'not looking at curtailing their investment in the Institution.'[974] The same year, the LMI stated its commitment to 'develop the library and certain postgraduate facilities' for the Royal Liverpool, and signed a three-year contract to function as its PGMC.[975] Alongside partnership with the Royal Liverpool, Trevor Bayley (appointed regional director of postgraduate medical education for Mersey in 1982) was able to secure further

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[972] Minutes of LMI Council Meeting 8/9/1993 [LMI: LMI 2/1/3/1/12].
[973] LMI Finance and Establishment Committee Minutes, 1993 [LMI: LMI 4].
[974] Minutes of LMI Council Meeting 24/9/1995 [LMI: LMI 2/1/3/1/12].
[975] *Transactions and Report* 1993/4 63; *Transactions and Report* 1994/5, 36.

investment in the LMI as the base for regional library services, on the condition that associate membership be made available to other 'health care professionals'. This proposal was approved in October 1995, with the LMI imposing the ambiguous requirement that associates be 'fully qualified members of their profession.'[976] This expansion of eligibility, mandated by the RHA, illustrated the declining influence of the LMI over its own affairs.

At a meeting in February 1996, Carty tabled a discussion document on the future of the institution. 'A Mission for the LMI' praised the fact that the institution remained 'independent of the current managerial fashion of health care delivery', exemplified by 'the increasingly sectarian business of GP fundholders, purchasers and NHS trusts'.[977] He commended the 'sensible and pragmatic' decision to host the AHA PGMC, however the development of on-site teaching facilities at hospitals left the LMI 'increasingly obsolete and redundant'.[978] Carty advocated a renewed focus on the library, the LMI's main asset, and this was discussed at a joint meeting with the management board of the Royal Liverpool in March 1996. Chris Luke, an emergency medicine consultant and LMI member who had been appointed director of postgraduate education at the Royal Liverpool in 1995, was open to the idea, and planned to use the extra space at the hospital for computer workstations.[979] This arrangement expired in 1998, and the institution entered new negotiations with a non-medical executive director of finance (rather than the director of postgraduate medical education). No longer able to rely on its network of close personal contacts, the LMI was advised to submit a

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[976] LMI Finance and Establishment Committee Minutes, 25/10/1995 [LMI: LMI 4].
[977] LMI Finance and Establishment Committee Minutes, 7/2/1996 [LMI: LMI 4].
[978] LMI Finance and Establishment Committee Minutes, 7/2/1996 [LMI: LMI 4].
[979] LMI Finance and Establishment Committee Minutes, 29/3/1996 [LMI: LMI 4].

contract with detailed items of service that it could offer the trust in exchange for further investment.[980]

A lack of revenue resulted in the deterioration of the fabric of the institution, with members and staff recalling leaks in the building and areas prone to flooding. In 1995 John Earis, a chest physician and director of finance at the LMI, commissioned plans for the comprehensive refurbishment of the building, initially costed at around £400,000.[981] The membership were notified of the plans in the annual report, and advised that major fundraising would be necessary to provide a basis from which to apply for external funding. The following year, Mair Pierce Moulton was appointed as librarian; Moulton's professional background was in public (rather than medical) libraries, and she was selected as a result of her experience in preparing bids for external funding.[982] Carty, who as honorary librarian had recruited Moulton, also 'stressed the importance of personal contacts members might have with the Medical Industry' as potential sources of money.[983]

The LMI was granted status as a grade II* listed building in 1995, and became eligible to apply for funding from the Heritage Lottery Fund (HLF), a national organisation established in 1994 to provide financial grants to not-for-profit organizations. A local fundraising appeal secured a £15,000 donation from the NHS Executive North West (council noted this windfall was thanks to Michael Orme, 1994 president and regional director of education, see Figure 12.6), and a request for £898,000 (accompanied by the requisite detailed business plan, drafted by the new librarian) was submitted to the HLF in September 1996. The full grant was awarded

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[980] LMI Finance and Establishment Committee Minutes, 4/8/1998 [LMI: LMI 4].
[981] Minutes of LMI Council Meeting 11/10/1995 [LMI: LMI 2/1/3/1/12].
[982] Mair Pearce Moulton, 30 July 2019.
[983] Minutes of LMI Council Meeting 20/3/1997 [LMI: LMI 2/1/3/1/12].

in April the following year, and the refurbished institution was formally opened on 11 November 1998.[984] The LMI had formerly been the recipient of generous funds from the regional NHS administration and hospital trusts in order to support its educational offering, and the recourse to charity for the 1998 refurbishment reveals the extent to which the institution could no longer rely on financial support from the NHS or other professional sources.

The declining significance of the institution's educational role encouraged a pivot towards social activities. As demonstrated above, presidents and LMI members sought to use their connections throughout the local medical system to support the institution (see Figure 12.6). Ian Gilmore described the greater social role of the LMI during the 1980s, 'I think it was seen more as a social gathering, or quasi-social.'[985] Despite its declining significance, some sections of the local medical community continued to take pride in the LMI. At the Liverpool meeting of the national History of Anaesthesia Society, held at the institution in 2004, it was noted that local practitioners 'enjoy showing off their listed building to visitors.'[986] Anne Florence, anaesthetist and former honorary librarian, gave an address at the meeting.

> From its foundation to the present day, the Liverpool Medical Institution has been the centre of medical life in the city and its environs, associated with the dissemination of knowledge… while providing for the social wellbeing of the members.[987]

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[984] Note appended to Council Meeting 3/6/1996 [LMI: LMI 2/1/3/1/12]; Minutes of LMI Council Meeting 11/9/1996 [LMI: LMI 2/1/3/1/12]; Minutes of LMI Council Meeting 14/11/1996 [LMI: LMI 2/1/3/1/12].

[985] Ian Gilmore 24 July 2018.

[986] Peter Drury, 'Editorial,' *The History of Anaesthesia Society Proceedings*, 35 (2004), 5.

[987] Anne Florence, "The Liverpool Medical Institution," *The History of Anaesthesia Society Proceedings* 35 (2004), 14.

Figure 12.6 LMI Presidents 1978-1998

Year	President	Qualified	Local Appointments	National
1978	Colin Ogilvie	Liverpool	LRI; Royal Southern; Pres., XX Club; Assoc. Liverpool Medical School	British Thoracic Soc. (and Ed., *Thorax*); British Lung Foundation
1979	Janet Smellie	Liverpool	Liverpool Corporation Maternity and Child Welfare Department; Daughter of Vice Chancellor	
1980	Edgar Parry	Liverpool	Broadgreen Hosp.; Bootle Hosp.; Waterloo Hosp.; Pres., XX Club; Lecturer, Surgery	
1981	James Carmichael	Liverpool		
1982	Elisabeth Rees	Liverpool		
1983	Norman Gibbon	Liverpool	Director, Liverpool Regional Urology Centre	British Assoc. of Urological Surgeons
1984	Donald Menzies	Liverpool	Sefton General Hosp.; Pres., XX Club	
1985	Richard McConnell	Liverpool	ULH	Pres., British Soc. of Gastroenterology
1986	Philip Stell	Edinburgh	Professor	Hunterian Prof., RCS; RSM, FRHistSoc
1987	Ian Keith Brown	Liverpool	Walton Hosp.; Whiston Hosp.; ULH; Broadgreen Hosp.; Chairman, Board of Faculty; Clinical Sub Dean	Regional RCP Advisor
1988	Robert Shields	Glasgow	Royal Liverpool; Broadgreen Hosp.; Chair of Surgery	Pres., Surgical Research Soc.; Soc. of Gastroenterology; Assoc. of Surgeons GB; Travelling Surgical Soc., GB&NI (2002 to 2004); Chair, British Liver Foundation; Member, MRC, GMC; Pres., RCSEd (1990)
1989	Peter Drury	Cambridge and London	Pres., XX Club	

1990	Austin Carty	Dublin	Royal Southern Hosp.; Medical director, RLUH (1991-1995); Pres., XX Club, Artists Club.	Fellow, Royal College Radiologists; RCP Dublin; Faculty of Radiologists; RCS Ireland.
1991	Chris Evans	Liverpool	Royal Liverpool; Broadgreen Hosp.; Pres., XX Club; Various teaching appointments	Academic Vice Pres., RCP (2001-3); Examiner, RCP; President, MDU
1992	William MacKean	Liverpool	GP; Merseyside and North Wales Faculty of RCGP	Fellow, RCGP
1993	Helen Carty	Dublin	Alder Hey Children's Hosp. UoL Advisor, Radiology	Pres. European Congress Radiology; Hon Fellow RCPaeds and Child Health; FRCP
1994	Michael Orme	Cambridge and London	Pres., XX Club; Dean, Faculty of Medicine (1991-1996); Regional Director, Education and Training (1996-2001)	Director, Health Care Education NHS North West; Hon. Sec., European Assoc. Clinical Pharmacology and Therapeutics (1995-1999)
1995	Andrew Zsigmond	Pecs and Liverpool	Pres,, Artists Club (1986-89); Pres., Merseyside Medico-Legal Society (2012-2014); Chairman, Liverpool Racquet Club (1999-2000); Hon. President, LMSS (1992-93)	Hon. Hungarian Consul; Chairman, Aigburth Conservative Assoc.; Conservative candidate, Liverpool Riverside (1992).
1996	Roger Cudmore	Sheffield	Alder Hey Hosp.; Pres., St Helen's Medical Soc.	
1997	Robert Sells	London	Pres., XX Club; Director, Mersey Regional Transplant Unit, RLUH; Lecturer, Surgery, (1971-1974).	Vice Pres., Transplantation Soc.
1998	Susan Evans	Liverpool		Pres., North of England Dermatological Soc. (1998)

Perspectives on the decline of professional organisations

Interviewees provided a range of perspectives on the declining role of the LMI. Intensive care physician Tony Gilbertson, who held council roles at the institution during the 1970s, reflected on the declining interest in medical libraries generally following the rise of online academic resources.

> People don't need the library and can get most of it in their own homes, it's not just the Medical Institution, it's virtually every postgraduate centre, every hospital has a postgraduate centre now, Liverpool Medical Institution was the Liverpool regional postgraduate centre, now every hospital has its own and its own library.[988]

Similarly, pathologist Bill Taylor (president in 2009) linked declining interest in the library with the growing availability of educational resources at hospitals.

> I think as medicine became more and more specialized you needed these books on your bench all the time, and people from other specialties would not look at them… Of course they'd be available in the postgraduate centres, the development of the postgraduate centres hasn't been good for the LMI.[989]

Taylor also felt that declining interest among senior figures in the local medical community influenced younger practitioners, and the dwindling importance of the informal networking opportunities offered at the LMI.

> "[Young practitioners are] reluctant to go out at night if they see the consultants aren't doing it, so they feel they don't have to be members themselves, they don't feel it's necessary."

Some practitioners regretted the loss of the informal contact available through the LMI. An anonymous interviewee who worked

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[988] Anthony Gilbertson, 20 August 2018.
[989] Bill Taylor, 14 March 2018.

hard to sustain the relationship between the institution and Royal Liverpool hospital during the 1990s , reflected on what he felt was the loss of the social interaction in medicine.

> If you put a glass of beer in their hand or a cup of coffee and they will gossip about what's going on, and that's how the exchange of views gets through – we're losing that.[990]

The changes to postgraduate medical education that supplanted the role of medical societies such as the LMI have not received a uniformly positive reception from the profession. Tom Hayes, postgraduate dean at Cardiff, declared in 1995 that postgraduate education was in a state of 'turmoil' and that 'the current fashion for formalised and policed' systems would remain inefficient 'unless it is recognised that individual needs must be taken into account'.[991] Hayes' advocacy of 'local provision' of continuing education 'linked to peer review and audit' is reminiscent of the localism of the medical society model of self-regulating professional training.[992] Other critics suggested that larger medical school classes and fewer opportunities to 'observe individual medical practitioners' had resulted in the loss of the 'informal curriculum' of the sort offered by traditional medical societies.[993] In a 1979 article in the *Bristol Medico-Chirurgical Journal*, GP and Bristol Medical Society member Donald Ratcliffe reflected on the role of such organizations.

> My own feeling is that, as medical societies, we should further reduce the number of meetings devoted to purely scientific subjects since these tend to duplicate the

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[990] Anonymous Interviewee 1, 24 May 2018.
[991] T. M. Hayes, "Continuing Medical Education: A Personal View," *BMJ* 15 April 1995, 994.
[992] Hayes, "Continuing Medical Education: A Personal View," 946.
[993] Lionel Jacobson, Kamila Hawthorne and Fiona Wood, "The 'Mensch' Factor in General Practice: A Role to Demonstrate Professionalism to Students," *British Journal of General Practice* 56.533 (2006), 978.

function of the postgraduate centres. Instead we should establish a forum where we can broaden our learning and thereby compensate for its restrictiveness in our early years. Such a professional renaissance, which would embrace the frank and informed consideration of ethical problems, could have a far-reaching effect.[994]

[994] Donald Ratcliffe, "The Evolution of Medical Societies in Britain Have They a Future?" *Bristol Medico-Chirurgical Journal* (January/April 1979), 13.

Figure 12.7: Contemporary images of LMI[995]

[995] Images from Liverpool Medical Institution https://www.lmi.org.uk/ [accessed 9 July 2019].

Changing professional values influenced the range of professional organizations in Liverpool in different ways. Membership of the elite medical dining clubs remained an important indicator of local prestige, and some practitioners considered an invitation to join the Twenty Club an indication of collegial acceptance. Chris Evans, Twenty Club president in 1994, recalled the prestige of the group when he first joined.

> I was very intimidated by the group… It was nearly all profs [professors], everyone is a pretty competent speaker… I regarded it as a feather in my cap.[996]

Nonetheless, the actual influence of the networks at the dining clubs was felt to have declined: Ian Gilmore, Twenty Club president in 1998, described the declining 'political' influence of the club.

> [It is] a place where one met colleagues outside the hospital…[it] was probably more important politically then that it is now. I think it is much more social and less political than it was thirty years ago.[997]

In many ways, the activity of elite dining clubs during the 1980s and 1990s was a return to their earlier role as social forums for local practitioners. Transplant surgeon and former Twenty Club president (1985) Robert Sells described medical clubs in his 1997 LMI presidential address as 'generally small self-perpetuating oligarchies, more interested in literature and fun than medical business' which were 'hedonistic, nepotistic and generally self-indulgent.'[998]

The Twenty Club remained an exclusively male group for the entire research period, its only forays into gender-mixed activities being the annual 'ladies' night' attended by spouses. The Innominate Club did begin to admit women members, although interviewees similarly indicated the sense that the club had declined in influence over the practising medical community, and was instead a social

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[996] Chris Evans, 6 March 2018.
[997] Ian Gilmore, 24 July 2018.
[998] Robert Sells 'Presidential Address to LMI, 1997', 6.

group for retired practitioners. An anonymous interviewee described modern activities at the Innominate Club.

> A boring old dining club of people who go and have a school dinner and talk about snails.[999]

The dining clubs lost some of the elite allure they had enjoyed previously. A physician who arrived in Liverpool in the 1980s related the following impression of a lack of diversity among the Innominate Club.

> I remember one non-white person, there may have been more than one but I can only remember one, so it was quite a WASP [White Anglo-Saxon Protestant]-y sort of thing.[1000]

The traditional forms of professional association offered at the LMI, dining clubs, and the medical students' society appeared increasingly out of touch with the diverse local medical workforce, which included greater numbers of women and doctors from BAME backgrounds. While LMSS continued to outrage fellow students and university authorities, local professional bodies were less able to court controversy. This decline was accompanied by a lack of interest among younger practitioners: when LMI president Helen Carty and Chris Evans met with junior doctors in 1993 they found that while some 'had heard of the institution… quite a number of them had no idea where it was situated.'[1001]

Conclusion

Established medical networks were undermined by both structural changes to the NHS and the changing medical workforce. The 1993 Calman report brought the NHS in line with European working time legislation, alongside formalising certification for specialist training, and Rivett noted a subsequent decline of the

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[999] Anonymous Interviewee 4, 6 November 2018.
[1000] Stephen Saltissi, 26 February 2019
[1001] Minutes of LMI Council Meeting 10/11/1993 [LMI: LMI 2/1/3/1/12].

'traditional concept of 'firm'-based care' followed by 'disillusion and disenchantment' in the increasingly competitive environment for training posts.[1002] Traditional medical societies were poorly positioned to offer relevant support to a local medical community that was rapidly ceasing to resemble previous generations of practitioners. The LMI had served variously as an unofficial, quasi-official and officially recognised postgraduate medical centre in Liverpool, however despite numerous accommodations and compromises, the educational offering of independent medical societies was increasingly relocated to on-site facilities at hospital trusts after 1990.

This chapter has demonstrated the flexible and opportunistic response of the LMI to national changes that repeatedly threatened to render its key offering of medical education obsolete. Central to the longevity of the LMI has been the development and maintenance of affiliation to the local professional elite, and connectedness with the teaching hospitals and university. Presidents and leading figures at the LMI held senior NHS appointments, and provided the institution with valuable access to potential sources of investment. The institution continued to host speakers of national significance during this period, including MP and medical practitioner David Owen (in 1979) to speak about the report of the Royal Commission on the NHS, leading general practice reformer Lord Taylor of Harlow (1910-1988) in 1981, and even Marxist GP Julian Tudor Hart (1927-2018) in 1998.

In spite of these connections, the growing influence of nonmedical managers at hospital trusts supplanted the traditional decision-making power of practitioners, who had formerly been able to secure funding for the LMI. Consequently, many medical societies assumed a greater focus on social activity and medical history.[1003] Other provincial societies with their own buildings, such as the

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[1002] Rivett, *From Cradle to Grave,* 445.

[1003] Anne Florence and Mair Pierce Moulton, "The formation of the Liverpool Medical Institution: dispersal of medical knowledge and the development of the library," *Medical Historian* 14 (2002-2003), 33-43.

Birmingham Medical Institute (BMI, founded 1875), diversified, and rebranded as a conference centre in 2009. Nonetheless, in 2012 the BMI was forced to auction its historic library amid financial problems and the society relocated to the local Chamber of Commerce in 2016 (the BMI building became a pub, 'The Physician').[1004] Smaller, informal networks such as the consultants dining clubs appeared increasingly anachronistic in the professional environment of the 1990s, as the medical workforce became more diverse in terms of gender and ethnicity, and managerialism and marketisation undermined the influence of small cliques of elite practitioners.

[1004] 'Birmingham Medical Institute to sell 5000 book library' *BBC News* 15 April 2012 https://www.bbc.co.uk/news/uk-england-birmingham-17733768 [accessed 20 February 2020].

Conclusion

Local networks were instrumental in the development of Liverpool's medical community between 1930 and 1998, and it is impossible to disentangle the implementation of national medical reform from the personalities and institutions that mediated its reception at local level. Effective social, educational and business networks were essential to intraprofessional harmony, professional development, and working relationships prior to the creation of the NHS. After 1948, practitioners continued to sustain local professional culture at hospitals, the medical school, and a range of independent medical societies, clubs and other associations. Demographic and economic decline after WWII exacerbated the challenges facing Liverpool's medical community, which echoed national professional concerns, notably division between hospital consultants and GPs, tension between teaching and non-teaching hospitals, and scepticism towards health service reform.

Analysis of professional networks contributes new insights to our understanding of how local medical communities responded to professional demands under the NHS. This thesis demonstrates how local factors exerted a key influence over the development of NHS medical practice and professional culture in Liverpool. This influence was channelled through specific individuals, historic institutions, and professional networks. This thesis notes how a range of established medical organizations, independent from the NHS, continued to play an active role in the local medical community after 1948. These organizations, from city and profession-wide groups such as the Liverpool Medical Institution to intimate dining clubs and specialist societies, sustained local traditions while adapting to new administrative structures, provided spaces for professional discussion, postgraduate education, and the advancement of medical specialism.

This thesis constitutes a new contribution to the history of medical practice under the NHS by demonstrating how local medical communities mobilised the professional autonomy secured in 1948.

Local professional organizations are an under-utilised point of entry into analysis of medical practice under the NHS, and can offer a valuable lens onto changing professional culture and practice.

Local histories of NHS medical practice

This thesis has engaged with three dynamic areas of the historiography of medical practice in Britain; a renewed focus on local and regional concerns, the role of professional organizations, and oral history methodology. Writing at the sixtieth 'birthday' of the NHS in 2008, Martin Gorsky noted the 'rich possibilities' of regional studies of the service, which can help with 'interrogating…the balance of power between clinicians and managers, the resourcing struggles between teaching, general and psychiatric hospitals, the changing fortunes of public health, and so on.'[1005] This thesis has answered this call for greater local and regional focus; the organisation of hospital services, development of general practice, and evolution of medical education in Liverpool are all proven to be influenced by specific, often interrelated, local concerns.

The authoritative general histories of the NHS published by Webster, Klein, Timmins and Rivett provide the necessary national background to the debates and struggles occurring at local level, but key areas of tension, notably delayed hospital rationalisation, the stymied development of general practice in Liverpool, and role of the LMI in facilitating postgraduate education, illustrate the importance of a local focus.[1006] Historians have begun to acknowledge the potential of regional approaches, notably in studies of the nineteenth century medical practice, and this thesis demonstrates the suitability of such a focus for histories of medical practice under the NHS.[1007]

[1005] Gorksy, "The British National Health Service", 454.
[1006] Webster, *Health Services since the War* (I and II); Klein, *The New Politics of the NHS*; Timmins, *The Five Giants*; Rivett, *From Cradle to Grave*.
[1007] Waddington, "Thinking Regionally"; Reinarz, "Towards a history of medical education in provincial England"; Marland, *Medicine and*

This thesis also sheds new light on the role of local medical organizations on the development of professional culture after 1948. These groups continued to foster important elements of professional tradition, support specialisation, collegiality and postgraduate education after 1948, often on an explicitly independent (from NHS structures) basis. Independent professional organizations in Liverpool served an important social function, and provided spaces of influence to the local professional elite. In some cases, these local groups fostered the emergence of national specialist organizations, or constituted shadow academic departments with substantial influence over appointments and working culture. The largest independent medical organisation in Liverpool, the LMI, was able to establish itself alongside the NHS, and members made use of their connections to ensure a profitable relationship with NHS structures until the internal market reforms of the 1990s.

While a rich historiography of professional organizations and professional medical culture exists with a nineteenth-century focus, there is limited engagement with the afterlife of the traditions established during this period among practitioner working under the NHS.[1008] Christopher Lawrence has made indispensable contributions to our understanding of medical identity, notably the emergence of a tension between scientifically minded hospital practitioners and traditionalists seeking to shield the profession from the risk of fracturing implicit in growing specialisation.[1009] More recently, academic focus has considered the development of medical specialism, with an international comparative focus, and the role of

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Society in Wakefield and Huddersfield; Pickstone, *Medicine and Industrial Society*.

[1008] Shortt, "Physicians, science and status'; Brown, 'Performing medicine".

[1009] Lawrence, "Incommunicable knowledge", "Edward Jenner's jockey boots"; Lawrence and Brown, "Quintessentially modern heroes".

relationships in supporting these ambitions.[1010] This thesis has demonstrated the importance of local networks in supporting specialisation, medical education and local associations pushing for reform (or seeking to retain elements of tradition).

Finally, this thesis has utilised an oral history methodology to access both independent professional groups (which often leave a limited documentary record), and the experiences of rank and file practitioners. The findings of this thesis demonstrate the continued role of intimate local networks, sponsors and systems of patronage and support that remain hidden from the archival record. This methodology allows for deeper insights to be made into the working experiences of medical practitioners operating within a rapidly changing and sometimes locally-specific professional culture.

Historians have used oral history to access traditionally under-represented branches of the medical profession, notably general practitioners, or practitioners who were geographically distant from major medical centres.[1011] More recently, historians have used oral history to access elements of medical culture and experience that fail to appear in documentary and other archival sources, such as Snow and Simpson's research into the function of laughter in the hospital setting, and Simpson's research into migrant doctors in the NHS.[1012] These studies, alongside the group oral history exercises convened by medical organizations and academic research groups, provide considerable additional insight into practitioners' experiences under the NHS. This thesis invited oral history participants to comment and reflect on key moments in the development of medical practice in Liverpool, notably hospital rationalisation and changes to medical education, to add an additional dimension to documentary sources.

[1010] Weisz, *Divide and Conquer;* Casper and Welsh, "British romantic generalism"; Casper, *The Neurologists*.
[1011] Smith, "An oral history of general practice", "Towards a public oral history"; Bevan, "Family and vocation."
[1012] Julian Simpson and Stephanie Snow, "Why We Should Try to Get the Joke: Humor, Laughter, and the History of Healthcare," *The Oral History Review* (2019), 77-93; Simpson, *Migrant Architects*.

Theoretical approaches to the history of medical practice

This thesis responds to a number of themes in the historiography of medical practice in twentieth-century Britain and addresses an absence in the academic literature related to local medical communities. A central theoretical perspective engaged with in this thesis is the notion of medical professionalism, defined in an influential 1983 article by Samuel Shortt as

> a process by which a heterogeneous collection of individuals is gradually recognized, by both themselves and other members of society, as constituting a relatively homogeneous and distinct occupational group.[1013]

Historians and sociologists have explored the broad response at national level of medical practitioners in Britain, who were recognised as a mature professional group at the time of the creation of the NHS in 1948, to working within a state system. Nonetheless, histories focusing on national professional bodies such as the British Medical Association, Socialist Medical Association, and broader professional negotiations with government fail to incorporate analysis of professional practice and culture at local level.[1014]

This thesis has engaged with the academic literature on the emergence and consolidation of professional status among British medical practitioners. It has contributed new insights to the field by exploring how local networks of individuals, at independent groups and societies, hospitals, university departments and general practices, sought to buttress and advance claims to professional status. In Liverpool, this objective was pursued through identification with local professional heritage, and encouragement to engage with and support independent professional associations. These groups, most notably the LMI, proved resilient vehicles for the preservation of

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[1013] Shortt, "Physicians, science and status", 52.

[1014] See Eckstein, "The politics of the British Medical Association" and *Pressure Group Politics*; Stewart, *The Battle for Health*; Webster, *Health Services since the War* (I and II); Timmins, *The Five Giants*.

local professional culture, which was nonetheless undermined by the increasingly marketized structure of the NHS during the 1990s.

A second key approach to the history of medical practice in Britain has been the consideration of medical specialisation, which in turn has motivated discussion of medical identity more broadly. Historians have acknowledged the perception among some practitioners that specialism risked undermining the cohesion of the profession as a whole, however there has been little attention paid to the small, often informal networks of colleagues working to establish specialist practice at local level in the early years of the NHS.[1015] Alongside hospital specialism, discussed above, a body of academic work has considered the emergence of general practice as a respected medical specialism in its own right, and as a legitimate area for research and teaching.[1016] This thesis has demonstrated the often uneven and contested reception of reforms to medical practice at local level, evident in the delayed implementation of hospital rationalisation, protracted attempts to modernise general practice, and similarly lengthy struggle to establish an academic department of general practice at the Liverpool Medical School.

This thesis has sought to place the broader narratives of the acceptance of medical specialisation and modernisation of general practice within a clearly defined local setting. This approach has demonstrated that local medical communities cannot be regarded as monolithic and uncritical receivers of national developments, and changes to professional practice were instead mediated and contested at the level of implementation by individual practitioners. Consideration of local networks, such as specialist associations and innovative general practices, provides a novel means of approach to explore the reception of national changes to medical identity.

[1015] Lawrence, "Incommunicable knowledge", Weisz, *Divide and Conquer*.
[1016] Loudon, Horder and Webster, *General Practice under the National Health Service*.

More recently, histories of medical education have provided important new insights into the pervasive influence of leading personalities in local medical communities across medical teaching, hospital medicine, and independent professional organizations (which often served a postgraduate education function). Thomas Neville Bonner's pathbreaking comparative analysis of medical education in Britain, France, Germany and the USA reveals the interconnected intellectual, political and professional concerns of medical schools during the nineteenth century, and the close relationship between provincial British medical schools, attached hospitals, and medical practitioners with teaching responsibilities.[1017] Subsequently, Jonathan Reinarz demonstrated the importance of provincial medical schools as forums for the discussion of local implementation of professional change occurring nationally, and identified the necessary scrutiny of academic historians to offset the often celebrative institutional histories emerging from these institutions.[1018]

This thesis has built upon these studies, and the issues raised in recent work by Laura Kelly exploring the acculturation of medical students into a specific set of professional expectations.[1019] Oral history testimony and the records from the Liverpool Medical School (including the revealing magazine of the medical students' society) revealed the central place of the medical school in introducing future practitioners to the personalities, institutions and professional expectations they hoped to work alongside. This thesis has demonstrated the continued importance of these sites of acculturation after 1948, and the interconnectedness of both student and professional networks.

[1017] Bonner, *Becoming a Physician*.
[1018] Reinarz, "Towards a history of medical education in provincial England", 37.
[1019] Laura Kelly, *Irish Medical Education*.

The history of Liverpool's medical community demonstrates the continued importance of local networks following the creation of the NHS. The majority of practitioners in the city were immersed in local traditions, culture and expectations during their formative years at university, and these experiences continued to inform their notions of professional identity throughout their working lives. The oral history interviews conducted for this research revealed perspectives ranging from affection, frustration, and occasionally hostility towards local professional culture. Nonetheless, all interviewees shared examples of how local considerations informed their experience of medical practice under the NHS. This thesis has demonstrated the influence of specific local factors during the planning, implementation and reform of the NHS in Liverpool, and emphasised the importance of social, professional and educational networks in the development of the local medical community after 1948.

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Appendix 1: Interview Schedule

Interview Schedule

Liverpool's Medical Community since 1930: shaping knowledge and business networks

Thank you for agreeing to participate in this research study. The questions below will guide the interview and aim to develop a broad record of your experiences. The questions are designed to expand on the responses from the previously circulated postal questionnaire, and are indicative of the subjects the interview seeks to tackle – there will be no obligation to answer all or any particular questions outlined below.

If you are uncomfortable with any areas of questioning you may request to stop the interview at any time. If you are unclear about anything you may request clarification at any time.

-Background and Education

What is your date and place of birth?

What occupation were your parent(s) employed in?

Where were you educated prior to university?

Where did you attend university?

What year did you begin and end your medical studies?

Who influenced you during your medical training (particular staff, peers etc.)?

Did you remain in contact with contacts made during medical school?

Who were the key individuals you associate with this period of your career?

-Professional Career

Who do you interact with regularly as part of your work?

Which colleagues and associates do you consider significant to your work, and in what ways does this manifest itself?

What do you consider to be the most significant interactions with others in your career?

Can you think of any particular individuals you learned from in your career?

Where were you employed and what were your experiences?

How did you find employment, what are your reflections on this process?

Who were the key individuals you associate with influencing your career?

-Peer and Social Networks

Where did you gather to discuss issues and developments at work?

Did you socialize with colleagues from the local medical community?

Did you perceive any expectations for your non-work life emerging from your experience in the medical community (e.g. decision on where to live, where to socialize, events to attend etc.)?

Who were the key individuals you associate with these aspects of your career?

Who can I contact if I have further questions?

Researcher:

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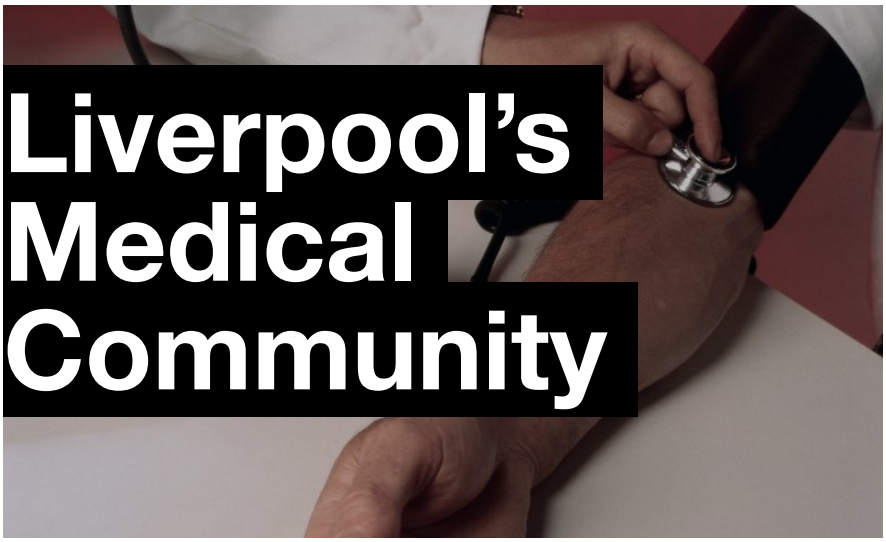
Appendix 2: Circulated invitation for oral history participants



Call for participants in historical research study

You are invited to contribute your experiences to a PhD project at the University of Liverpool investigating the practice of medicine in the Liverpool region since 1930.

The research considers the evolution of medical education, primary and secondary care, and the institutions and services in Liverpool.

Did you qualify in Liverpool?
Have you worked/ do you work in the region?
Would you like to share your views on the profession and how it has changed?

For more information please contact:
Felix Goodbody F.Goodbody@Liverpool.ac.uk
Telephone: +44 (0) 151 794 4552
Department of History,University of Liverpool
12, Abercromby Square, Liverpool L69 7WZ

Appendix 3: Invitations for group interviews

Liverpool's Medical Community
Invitation to Participate in a Focus Group on
Medical Teaching in Liverpool

After conducting a number of oral history interviews with individual participants, I will now be facilitating a number of focus groups. These will be on a range of topics, and are designed to encourage a dialogue between participants on a given subject.

The objective of the focus group is to offer participants the opportunity to share and debate their views. These sessions will be held at the University of Liverpool Whelan Building, refreshments will be provided and there is disabled access.

In this session we will be discussing the influence of medical teaching at the University of Liverpool Medical School. The following questions will direct our discussion:

1 What was your impression of the senior consultants and teachers during your time at medical school?

2 What challenges and opportunities did the firm system offer?

3 How were different hospitals regarded by medical staff and students, what influence did this exert over subsequent posts?

Any participation in this focus group is completely voluntary, and I would like to reiterate my thanks for your contribution so far, this project would not be possible without your input and goodwill.

If I can provide any further information please get in touch at F.Goodbody@Liverpool.ac.uk, Telephone: +44 (0) 151 794 4552

Felix Goodbody
Department of History
University of Liverpool

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

UNIVERSITY OF LIVERPOOL

Liverpool's Medical Community
Invitation to Participate in a Focus Group on
Liverpool's Hospitals before the 'New' Royal Liverpool

After conducting a number of oral history interviews with individual participants, I will now be facilitating a number of focus groups. These will be on a range of topics, and are designed to encourage a dialogue between participants on a given subject.

The objective of the focus group is to offer participants the opportunity to share and debate their views. These sessions will be held at the University of Liverpool Whelan Building, refreshments will be provided and there is disabled access.

In this session we will be discussing the opening of the 'new' Royal Liverpool Hospital in 1978/9. The following questions will direct our discussion:

1 Did the 'new' Royal open at the right time, how was the closure of other hospitals managed in the surrounding years?

2 What efforts were made during the opening of the new hospital to accommodate doctors from different hospitals into a united workforce?

3 How did the 'new' Royal Liverpool compare with your experiences of other hospitals?

Any participation in this focus group is completely voluntary, and I would like to reiterate my thanks for your contribution so far, this project would not be possible without your input and goodwill.

If I can provide any further information please get in touch at F.Goodbody@Liverpool.ac.uk, Telephone: +44 (0) 151 794 4552

Felix Goodbody
Department of History
University of Liverpool

E·S·R·C ECONOMIC & SOCIAL RESEARCH COUNCIL

UNIVERSITY OF LIVERPOOL

Appendix 4: All oral history interview coding nodes

Code	Files	References
Family Background	39	62
Medical Education	34	99
LMI	34	52
Liverpool Medical School	33	71
Recruitment to Liverpool	28	61
Liverpool Atmosphere	28	57
Hospital - Royal Liverpool University Hospital	27	64
Private Practice	24	40
Liverpool Medical School Firms	23	39
Liverpool Insularity	23	52
Cohen	22	42
Politics	19	54
Social Relationships	19	33
Name - Clarke	17	25
Hospital - Broadgreen	17	36
General Practice	17	47
Hospital - Liverpool Royal Infirmary	16	20
Hospital - Southern	15	21
Hospital - Sefton General Hospital	15	24
Hospital - Walton Hospital	13	19
Name - Robertson (AJ)	12	21
Name - Gray (TC)	12	34
Name - Baker-Bates	10	16
Name - Evans (Chris C)	10	13
Non-Liverpool Appointments	10	15
Hospital - Northern	9	16
Trusts	8	20
Name - Ogilvie	8	13
Hospital - Alder Hey	8	9
Name - Finn	8	14
Name - Sells	8	9
Name - Jeffcoate	8	10
Name - Gilmore	7	7
Name - Weatherall	7	9
Name - Utting	7	17
Name - Breckenridge	7	8
Name - Rees (Gordon Jackson)	7	15
Name - Hussey	7	7
RAMC	7	8
Name - Orme	7	8
Name - Carty (Austin)	7	7
Hospital - Whiston	7	13
Hospital - Fazakerley	6	12
Public Health	6	11

Socialist Medicine	6	19
LSTM	6	10
Name - Evans (David P)	6	7
Name - McConnell	6	10
Name - Walker	6	7
Name - Taylor	5	7
Name - Goldsmith	5	5
Name - Wells	5	9
Name - Brown (K)	5	7
Name - Brewer	5	5
Name - Helsby	5	5
Name - Ross	5	7
Hospital - Liverpool Women's	5	7
Cambridge University	5	10
Name - McKendrick	5	6
Name - Shields	5	5
Name - Gibbon	5	6
Name - Seaton	4	6
Name - Pappworth	4	6
Name - Fuld	4	4
Name - Sanderson	4	6
Name - Mansfield	4	5
Name - Jones (E Sherwood)	4	4
Hospital - Arrowe Park	4	4
Name - Francis (Winnie)	4	4
Name - Harrison	4	4
Name - Francis (Harold)	4	4
Name - Parry	4	4
Oxford University	4	6
Name - Temple	4	4
London Hospitals	4	4
Name - Downie	4	4
Hospital - Royal Liverpool Children's Hospital	4	4
Name - Stanley	4	4
Name - Sutton	4	5
Name - Jones (Robert)	3	3
Name - Evans (Robert)	3	3
Hospital - Clatterbridge	3	3
Name - Beattie	3	3
Name - Tudor-Hart	3	3
Name - Watson	3	3
Name - Carty (Helen)	3	3
Name - Menzies	3	3
Name - Scott-Samuel	3	3
Name - Freshwater	3	4
Name - Jones (Emer W)	3	5
Name - Gemmell	3	3

Name - Wilson	3	3
Name - de Boer	3	3
Name - Atlay	3	3
Name - Gardner	3	3
Name - Bogle	3	3
Name - Ratoff	3	3
Name - Abdulla	3	3
Specialisation	3	4
Schooling	3	8
Name - Cunningham	3	3
Name - Sheehan	3	3
Name - Gregory	3	3
Name - Bailey	3	3
Name - Semple	3	3
Newcastle Medical School	3	6
Name - Halton	3	3
Name - Parsons	3	4
Name - Gilbertson	3	5
Name - Richardson (Dickie)	3	3
Name - Doyle	3	4
Name - Harris	3	3
Name - Bennett-Jones	3	5
Name - Riding (JE)	3	6
Name - Gray (David)	3	4
Name - Hawe (Philip)	3	3
Name - Williams (Norton)	2	2
Name - Goodman	2	2
Name - Honey (Gerald)	2	2
Name - Beasley	2	2
Name - Holland	2	2
Name - McMurray (TP)	2	2
Hospital - Queen Elizabeth Hospital, Birmingham	2	2
Name - Waddington	2	2
London Medical School	2	5
Royal Navy	2	2
Hospital - Newsham	2	3
Name - McKendrick (Family)	2	2
Name - Basu	2	2
Name - Cook	2	2
Hospital - St Katherine's	2	4
Name - Stock	2	2
Name - Bush (Gordon)	2	2
Name - Annis	2	5
Name - Coulshed	2	2
Name - Thelwall Jones	2	2
Name - Leinster	2	2
St Andrew's University	2	2

Name - Crosby	2	2
Name - Pharoah	2	2
Name - Seedhouse	2	2
Name - Vithlani	2	2
Name - Minnitt	2	4
Name - Thomas (Goronwy)	2	2
Name - Hay	2	2
Name - Galloway	2	2
Name - Evans (Christine)	2	2
1974 Reorganisation	2	2
Name - Bone	2	2
Name - Whitehead	2	2
Name - Hughes (RR)	2	4
Name - Miller	2	2
Name - Macintosh	2	2
Name - Harbord (RB)	2	2
Name - MacMillan	2	2
Name - Meecham	2	3
Name - Mushin	2	2
Name - Heath	2	2
Hospital - Aintree	2	5
Name - Forshall	2	3
Hospital - Mossley Hill	2	2
Name - Drury	2	2
Name - Datnow	2	3
Name - Forshaw	2	2
Name - Roaf	2	2
Name - MacFarlane	1	1
Name - Watkins	1	1
Name - Jones (William Lloyd)	1	1
Name - Martlew (Vanessa)	1	1
Name - Theopholopolous	1	1
Name - Edwards (Richard)	1	2
Name - Antcliffe	1	1
Name - Grierson	1	1
Name - Garden (Anne)	1	1
Name - McGann	1	1
Name - Goldman	1	1
Name - Smith (John)	1	1
Name - Barlow (GP)	1	1
Tropical Medicine	1	2
Name - Jones (Reginald Watson)	1	1
Hospital - Middlesex	1	1
Name - Bambra	1	1
Name - Curley	1	1
Name - Downie (Robin)	1	1
Name - Spencer	1	1
Name - Roberts (Norman)	1	1

Name - Barich	1	1
Name - Bell (Dion)	1	1
Name - Desmond	1	1
Name - Orlans	1	1
Name - Nye (Fred)	1	1
Name - Smellie	1	1
Name - Griffiths	1	1
Name - Delaney	1	1
Name - Saltissi	1	1
Name - Sakiari	1	1
Name - Gaynor	1	1
Name - Edwards (F Ronald)	1	1
Name - Chamberlain	1	1
Name - Gradwell	1	1
Hospital - St Paul's Eye Hospital	1	5
Name - Coakley	1	1
Hospital - Guy's Hospital	1	2
Name - Kerr (A Sutcliffe)	1	1
Name - Ahearn	1	1
Name - Schofield	1	1
Name - Hamilton	1	1
Name - Franklin	1	1
Name - Evans (Frank I.)	1	1
Name - James	1	1
Name - Garry	1	1
Name - Grey ()	1	1
Name - Hobday	1	1
Name - Maegraith	1	1
Name - Oi	1	1
Name - Leighton	1	1
Name - Vickers	1	1
Name - Macaulay	1	1
Name - Christie (Barnett)	1	2
Name - McLoughlin	1	1
Name - Jones (Ewan)	1	1
Hospital - Providence Hospital St Helens	1	2
Name - Robinson	1	1
Name - Ingleby	1	1
Name - Bligh	1	1
Name - Ahmad	1	1
Name - Strack	1	1
Name - Yorke (Warrington)	1	2
Name - Channon	1	1
Name - Addison	1	1
Hospital - Rainhill	1	1
Name - Hegday	1	1
Name - Marcus	1	1
Name - Thomas (Paul)	1	1

Name - Wong (David)	1	1
Name - Molden	1	1
Name - Ballard	1	1
Name - Evans (Susan)	1	1
Name - Illich	1	1
Name - Meade, Ben	1	1
Name - Scott (Hazel)	1	1
Name - Leggate	1	1
Name - Kenyon	1	1
Hospital - Maternity Hospital	1	1
Name - Day	1	1
Name - Dalton	1	1
Name - Cawley (John Cozens)	1	1
Name - Boyle	1	1
Name - Rule	1	1
Name - Epstein	1	1
Obstetrics and Gynaecology	1	1
Name - Harding (Simon)	1	1
Dundee	1	1
Thorax (journal)	1	1
Name - Dahlgren	1	1
Name - Torkington	1	1
Name - Owen (David)	1	1
Name - Aber (Clive)	1	1
Name - Gillies	1	1
Name - Cruickshank	1	1
Name - Madison	1	1
Hospital - Smithdown Road	1	1
Name - Kalinsky	1	1
Name - Weldon	1	1
Name - Davison, Liz	1	1
Name - Davies	1	1
Name - Jones (Dudley Wallace)	1	1
Name - Oldham	1	1
Name - Ridyard	1	1
Name - Bird	1	1
Name - Halsall	1	1
Name - Gonzalves	1	1
Name - Martin (John)	1	1
Name - Loftus	1	1
Name - Bellingham	1	1
Name - Stanley (John)	1	1
Name - Forbes	1	1
Name - Foote ()	1	1
Canada	1	1
Name - Hawe (Brian)	1	1
Name - Barnett	1	1
Name - Jones (GP Wirral)	1	1

Name - Williams (GP)	1	1
Name - Tinkler	1	1
Name - McFarland	1	1
Name - St. Hill	1	1
Name - Damato	1	2
Name - Gallagher (Conal)	1	1
Religion	1	2
Name - Marsden	1	1
Name - Kashiri	1	1
Name - Mimner	1	1
Name - Rawlinson	1	2
Name - Morris	1	1
Name - Reynolds	1	1
Name - Graham (Dave)	1	1
Name - Donnelly	1	1
Name - Earis (John)	1	2
Hospital - Victoria Central Hospital	1	1
Name - Hiscott (Paul)	1	1
Name - Kelly (Charles)	1	1
Name - Dilling	1	1
Name - Caldwell	1	1
Name - Ben-Tovim	1	1
Name - Bucknell	1	1
Name - Kelly (Joan)	1	1
Name - Gibbons	1	1
Hospital - Eye and Ear Infirmary Myrtle Street	1	1
Name - Criddle	1	1
Name - Sells ()	1	1
Hospital - Mill Road	1	1
Name - Caine	1	1
Riyadh	1	1
Name - Hunt	1	2
Name - Eskin	1	1
Name - Hopkins	1	1
Name - Smith (Rawdon)	1	3
Name - Dover	1	1
Name - Hind	1	1
Royal College of Physicians	1	1
Name - Logan	1	1
Name - Hikins	1	1
Name - Smith (Jeremy)	1	1
Parry (Hugh)	1	1
Name - Smith (Phil)	1	1
Name - Verbov	1	1
Name - Shanahan	1	1
Name - Stead	1	1
Name - Smith (Alwyn)	1	1

Name - Criddle	1	1
Hospital - Chester RI	1	1
Name - Price	1	1
Name - Burt	1	1
Name - McCormack	1	1
Name - Rubin	1	1
Name - Geddes	1	1
Name - Akingbehin	1	1
Name - Moroney	1	1
Name - Mountford	1	1
Name - Duffy	1	1
Hospital - Birkenhead Children's Hospital	1	1
Name - Hobson	1	1
University of Liverpool	1	1
Name - Cochran	1	2
Name - Lynch	1	2
Name - Gray (TDH)	1	1
Name - Jones, Ron	1	1
Name - Turner	1	1
Name - Hunter (Jennie)	1	1
Name - Forrest	1	1
Name - Donaldson	1	1
Name - Weindling	1	1
Name - Wilding	1	1
Name - Forrest (Mike)	1	1
Name - Connolly	1	1
Name - Bickford	1	2
Name - Davies (Seymour)	1	1
Name - Baker (Richard)	1	1
Name - Wood (Professor of Anatomy)	1	1
Name - McKenna	1	1
Name - Ball (Fannie)	1	1
Name - Brookfield	1	1
Name - Kelly (Professor Robert)	1	1
Name - Magowan	1	1
Name - Playfer	1	1
Name - Davidson	1	1
Name - Calverley	1	1
Name - Beeching (Nick)	1	2
Name - Belchetz	1	1
Hospital - Ormskirk	1	2
Name - Bleasdale	1	1
Name - MacDicken	1	1
Name - Hawley	1	1
Name - Snowden	1	1
Name - Garry-Gibbons	1	1
Name - Steward	1	1
Name - Gosden	1	1

Name - Sachedina	1	1
Hospital - Southport	1	1
Name - Brewe (GP)	1	1
Name - Walley	1	1
Name - Conway	1	1
Name - Dangerfield (Peter)	1	1
Name - Gabbay	1	1
Hospital - Moorfields Eye Hospital (London)	1	1
Name - Preston (Liz)	1	1
Isle of Man	1	1
Name - Lothian	1	1
Hospital - St Thomas' London	1	1
Name - Capon (Norman)	1	1
Name - Kay	1	1
Name - Law	1	1
Name - Evans (Winston)	1	1
Name - McDowell (Dan)	1	1
Name - Cope	1	1
Name - Crawley	1	1
Name - Jameson	1	1