

# RES MEDICA

Journal of the Royal Medical Society



## The National Health Service - The Appointed Day; Before and After

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### Abstract

I wonder whether being in my eighties is an excuse or a recommendation for offering an article to Res Medica; however, it is said that the recall of memory is easier for earlier than for later years. My comments may be colloquial and informal rather than statistical and academic and of necessity they will be of a biographical flavour. My experience of Medicine, pre and post NHS, falls between four dates; Qualification 1944, Consultant Appointment 1963, Retirement 1984 and today 2005. The Appointed Day for the inauguration of the National Health Service in England, Scotland, Wales and Northern Ireland was the 5th July, 1948.

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ISSN: 2051-7580 (Online) ISSN: ISSN 0482-3206 (Print)

Res Medica is published by the Royal Medical Society, 5/5 Bristo Square, Edinburgh, EH8 9AL

Res Medica, Volume 268, Issue 2, 2005: 47-48

doi:[10.2218/resmedica.v268i2.1028](https://doi.org/10.2218/resmedica.v268i2.1028)

# The National Health Service - The Appointed Day; Before and After

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I wonder whether being in my eighties is an excuse or a recommendation for offering an article to *Res Medica*; however, it is said that the recall of memory is easier for earlier than for later years. My comments may be colloquial and informal rather than statistical and academic and of necessity they will be of a biographical flavour. My experience of Medicine, pre and post NHS, falls between four dates; Qualification 1944, Consultant Appointment 1963, Retirement 1984 and today 2005. The Appointed Day for the inauguration of the National Health Service in England, Scotland, Wales and Northern Ireland was the 5<sup>th</sup> July, 1948.

The medical picture in the years 1939 to 1948 was of hospitals of all sizes in the big cities, for example in Edinburgh, where there were both voluntary and municipal hospitals. The voluntary hospitals were lead by the Royal Infirmary as the university and teaching hospital, and then the Deaconess and the Chalmers Hospitals linked with the Church of Scotland, the Sick Children's and the Princess Margaret Rose. Leith had its own Hospital. The non-voluntary hospitals had evolved from the Poor Law system and as Municipal Hospitals were funded by Town Council of Edinburgh. These were named by the points of the compass. The Northern housed medicine in particular rheumatology, the Southern housed medicine and geriatrics, the Eastern housed surgery in particular thoracic surgery and the Western was a major hospital with all departments including cardiology, gastroenterology and urology.

In these hospitals the pattern of medical staffing was Senior Staff, consisting of Consultants, Chiefs and Sub-Chiefs, then Clinical Tutors, then Residents. The consultants were unpaid and a typical day was spent as 8am to 10am operating in a private nursing home, 10am to 2pm operating, doing ward rounds and teaching in hospital, 2pm to 7pm doing domiciliary visits, consulting in private consulting rooms, covering special interests in clinics or in research.

Some days might be spent in hospital operating all day. There were ward rounds every day, including Saturday and Sunday. In some units Sunday was the Grand Round, with the Chief, the Sub Chief, the Ward Sister, the Houseman, the Junior, who was a student, and proverbially the ward cat.

The provincial hospitals outside the teaching centres were staffed by "Honoraries", GP Surgeons and GP Physicians, with considerable experience and higher qualifications, but part time and in General Practice. There would be a Resident Surgical Officer and a Resident Medical Officer, supported by junior staff.

The family doctors were in single or group practices, which were bought and sold, usually with the practice premises. Many patients were members of contributory schemes, from sixpence a week upwards, through mutual organisations or subscribed by their employers (the value of money was different and using the retail price index for 1944 as a measure of inflation, the equivalent today would be 60p). The collectors usually came house to house fortnightly. The monies were collated by firms of accountants and paid to the practitioners who had contracted to supply the service. To be on one of these lists was to be "on the panel". The doctor would greet each patient "Panel or Private?" A small charge such as half a crown was made (equivalent £3.03), but this might rise to seven and sixpence (equivalent £9.08) and rather more for a home visit. The great Rutherford Morison gave this advice to his younger brother, setting up in practice, "The patient will be more grateful and will better heed your advice if he is charged a fee, however small". These family doctors, the general practitioners, were responsible for their own patients

throughout 24/7 hours of the week and would arrange cover by mutual arrangements. Locum services had yet to come. The municipal hospitals would charge patients their keep, perhaps three pounds a week (equivalent to £78.66). The voluntary hospitals would suggest a charge, but would accept a donation. The Free Hospital in London, later the Royal Free was an exception, as it did not charge at all.

From the generality of the medical profession, let us turn to the house surgeon, and I was one of the three at the Western General; I was HS for six months, 1944/45. The hospital was familiar as I had been a resident student during the summer vacation and had been at school across the road. A typical day started at 9am and continued with meal breaks until 9.30 or 10pm. The work was ward work, assisting in clinics, assisting in theatre and being available for casualty and any emergency. There was the Wednesday fracture clinic for applying and taking off POP (plaster of Paris) casts, and a Tuesday morning of rag and bottle anaesthesia for the tonsillectomy list. The evening was spent in the basement doing the urines, the blood counts and the blood ureas of patients in the 24 bedded ward. Na and K estimations were less frequent and required opening the main laboratory and using the flame photometer, leaving it all spotless for the biochemist in the morning. After this, came the writing up of case notes, often a back log, and so to bed. We worked one in three, except for the six weeks when one was on leave. Saturdays and Sundays were morning only; usually the Sunday Grand Round finished by 2pm or 2.30pm.

Our salary for the six months was £73,14s,0p, under three pounds a week (equivalent to £1932.40 as pay, but we had our keep; meals, lodging and laundry provided, so we might double this to make it £3865, which would bring the salary to £7,370 per annum). I received 15 guineas for assisting in private and four guineas for medical reports (Guinea equivalent to £27.50). It was great fun and we got to the odd picture house or rugger match and there were good mess parties. My dues to the Royal Medical Society were one shilling and three pence for the Society's key, two guineas twice for annual membership and four guineas for life membership. There had been little change in the actual figure since 1796 when the fee for the first two years was five guineas. In 1944 the annual subscription to the Drumsheugh Baths was only three guineas.

The general picture before the appointed day was of service, with the privilege of service and in return security and an established place in society. Most of us stayed on the tramlines, leading to becoming consultants in hospitals or principals in general practice. The administration of a hospital was simple with a Chief Administrator and his staff and a very powerful Matron with an Assistant Matron. The municipal hospitals benefited enormously by having an administrator who was medically qualified, who was known as the Medical Superintendent, and he fully understood the problems and could communicate with the medical staff at all levels.

Then came the the Appointed Day, 5<sup>th</sup> July 1948. The National Health Service, like Caesar's Gaul, in *tres pars divisa est*; in as much as it was divided into (1) the hospitals (2) the family doctors, the dentists, the pharmacists and opticians and (3) the Local Authority Health Services. It was a massive structure to come into being. The hospitals came under some 14 to 16 Regional Hospital Boards and hospitals are the part of the health service upon which I feel able to comment. The transfer appeared to be smooth, although there were frequent Committees and Commissions required to adjust and adjudicate and to litigate and legislate. There was

a chronic shortage of money. The country was impoverished after the 39-45 War and was committed to a further drain in the Korean War; *parri passu* there were considerable and rapid clinical advances. Aneurin Bevan, the founder of the NHS had said that the Service would always be in deficit because of medical advances in treatment and care.

Pre-1948, medical and surgical practice was mostly involved in the exanthemata, pneumonia, sepsis, osteomyelitis, poliomyelitis and tuberculosis of lung and bone. Post-1948, antibiotics, anti-tuberculosis drugs and immunisations changed the picture; beds were saved but treatments were costly; fever hospitals and sanatoria were closed, but drug bills increased, both in hospital and in general practice. As an aside, I remember when simple hemiorrhaphies were kept flat in bed for three weeks, and they are now day cases. The first penicillin was given in 1945 as 100 units given by the Eudrip (Edinburgh University drip), which was a perforated intramuscular needle gravity fed from a 12oz flat medical bottle containing a greeny yellowy liquid too impure to dispense in mgm. Limbs and lives were lost from septic fingers and tetanus was not unknown. There was an appreciable infant mortality.

Now let us move on a score of years, having served overseas in the RNVR, I was trained as a general surgeon at the WGH including nine years as a senior registrar. 1963 saw me as a consultant surgeon in the small town of West Hartlepool with a population of 100,000. Here the same professional relationships applied. The administration was simple with the Secretary, the Matron and a chosen member of the Medical Staff running the hospital with a minimal supporting staff. There was further good support from the Regional Hospital Board with their teams of engineers, architects, statisticians and others. Money was short. In most Districts funding followed the past. The large institutions in the cities fared well but the one time poorhouses in small towns fared badly. There was still a voluntary element: the management committee and the medical staff committee met in the evenings and did not close until the business was completed. The theatre lists might be long and delayed by emergencies but operations were never cancelled. Not only was money short in the hospital service, it was also short outside the hospitals and charges for prescriptions, for dental services and later for optometric services were introduced.

Private patients were allowed as outpatient in the hospital, with no different medical care, but in a single room with a different coloured bed cover and a special tea set. They were a useful source of funding, because the money which came in was free money and could be used as the local management thought best. As a side benefit it kept the consultant at work in his own hospital. However, it became anathema to Barbara Castle and thus politically unacceptable.

Criticism has been raised about the remuneration of consultants by the merit award system: it always seemed to me that those involved bent over backwards to be fair and even minded. There was considerable professional freedom; patients could be referred by the family doctor or by the consultant to any specialist unit wheresoever. There was never

any direction from an administrative or financial authority. Many patients were seen in their homes, either by the GP's on their rounds or by consultants on domiciliary visits. These consultations were good both for the patient, who might be disabled, and for the doctor, who would see the patient in his own surroundings.

In the two decades, 1945 to 1965, money was short and for doctors there were not many job opportunities; pay did not move with inflation. There was medical emigration and many Scottish doctors moved abroad, especially to Canada. Many of the teaching staff, lecturers and junior lecturers moved to the United States. Sadly many did not return and we are still suffering from this transatlantic brain drain. In the nineteen seventies for a few years the coffers were opened, pay was comparable to the other professions and many of the long-planned building schemes came to fruition. This was a slow process and some of the schemes were truncated and delayed; many were only completed in the eighties.

In the years 1950 to 1980 power was predominately in the hands of the professions of medicine and nursing, at first the doctors and then the nurses. This was healthy for the patient. It seems to me, on the sidelines, that power then passed to the administrators who are directed as puppets by the ideological fancies of the politicians. There is far too much paperwork, paperwork which has been increased rather than diminished by the coming of information technology. No piece of paper is less than foolscap and on these sheets it is so easy to print boxes to be ticked for every single activity. Before the health service and in its early years the doctors were supported in the care of their patients by superb nursing. However busy, nurses knew their patients and talked to them; today they appear to have moved from the head of the bed to the case notes and to the proforma at the foot of the bed and at the nurses' station. Their smartness and their uniforms in hospital have been lost and their drab working clothes are seen in supermarkets and on the streets.

Both before and for some years after the introduction of the NHS the hospitals were active and busy, they were scrupulously clean and all levels of staff pulled together and collaborated. The immediate effects of the change were good. In all three divisions of the health service there were improvements and these were made available to everybody. There were big tasks awaiting the new Health Service; the country was making good after the privations of total warfare and there were now available new and miraculous remedies. The changes in the Health Service have been very much greater during its life than at its birth. There has been a considerable increase in management, in executive and in administrative growth. I am of the opinion that management should be made smaller and decentralised and I take the view that financial resources should be directed to the training and provision of more nurses and more doctors.

Now is the time for reappraisal. We should assist this reappraisal by making comparison with what is provided in other countries in Europe and in the English speaking world. It is important for everybody that we get this on track before our own National Health Service attains its Golden Jubilee in 2008.



*The Four Presidents: Gordon McNaught (second from the left) as Junior President*