

Fortunate men or penny collectivists? General practice in Lancashire and Westmorland during the “classic” NHS

Dr Michael Lambert, Fellow in Social Inequalities BA (Hons) MA PhD

ABSTRACT

The enduring image of general practice during the “classic” NHS, from its creation in 1948 until its first major reform in 1974, is that provided by John Berger’s poetic prose and Jean Mohr’s captivating photographs in their 1967 study *A fortunate man*. It paints a picture of a country doctor equipped with almost universal medical expertise singularly devoted to his patients and his rural Gloucestershire community to the exclusion of everything else. Whilst such an image of general practice as a slow, idyllic cottage industry is alluring given the modern experience of industrialised primary care, it fails to capture the pressures and constraints of working under the NHS. Pressures were different but similarly inexorable, and noticeable by their absence from Berger and Mohr. Instead, it is far more accurate to see general practitioners (GPs) as “penny collectivists” within a burgeoning socialised medical economy which favoured the extension of hospital services. Within this health economy GPs were effectively impoverished entrepreneurs being squeezed from below by rising patient demand, expectations, and professional rivalries, and from above through a complex corporate bureaucracy. This paper captures this dynamic through the oral histories of GPs who practised in Lancashire and Westmorland combined with archival records of local primary care bureaucracy from 1948 to 1974.

INTRODUCTION

The enduring image of general practice during the classic NHS, from its creation in 1948 until its first major reform in 1974, is that provided by John Berger’s poetic prose and Jean Mohr’s captivating photographs in their 1967 study *A fortunate man*.¹ It paints a picture of a country doctor equipped with almost universal medical expertise singularly devoted to his patients and his rural Gloucestershire community to the exclusion of everything else. From the opening scenes where he dramatically drives through a farm gate to attend to an injured woodsman trapped beneath a tree, to patient consultations where he listens empathetically, the general practitioner (GP) at the heart of the book – Dr John Sassall, a pseudonym for Dr John Eskell² – is lauded as the embodiment of the medicine as a vocational calling.³

Given the modern experience of general practice as a form of industrialised primary care – as GP Stephen Iliffe argues – for doctors and patients alike, the nostalgic portrait Berger offers of Sassall is alluring, capturing a time when the family doctor practiced with considerable autonomy in a ‘cottage industry’, as an influential 1963 report on GPs noted.^{4, 5} However, such an imaginative portrait fails to capture the pressures and constraints of working under the National Health Service (NHS) even during such a purported “golden age”. Pressures then were different but similarly inexorable as now, and swathes of the experience of being a GP are noticeable by their absence from the book. Drawing on John Benson’s work exploring the ingenuity of impoverished working-class entrepreneurs in the informal Victorian economy, termed “penny capitalists”,⁶ it is far more accurate to see GPs as “penny collectivists” within a burgeoning socialised medical

economy under the NHS which favoured the extension of hospital services. Within this health economy GPs were being squeezed from below by rising patient demand, expectations, and professional rivalries, and from above through a complex corporate bureaucracy.

This paper captures this dynamic of being a “penny collector” during the classic NHS in Lancashire and Westmorland from 1948 to 1974 through a framework which examines policies, the practitioners, and the life of the practice. Such a view challenges the romantic ideal of Berger’s fortunate man. It is based upon the oral histories of GPs who practised in urban and rural communities across the area taken from both the North West Sound Archive and the Wellcome Collection. These oral testimonies are complemented with archival records of local primary care bureaucratic bodies during the period including those of Executive Councils, Local Medical Committees, the Central Health Services Council Subcommittee on General Practice and, where they survive, administrative records from individual practices.

GP POLICY ARCHITECTURE

The nationalisation of hospital services that was ushered in by the NHS in 1948 had little substantive impact for GPs. Nationalisation ossified a tripartite division within an existing mixed economy of health between GPs, public and private hospitals, and community services run by local authorities. Each was organisationally and professionally discrete, and this was cemented in the policy architecture which administered the classic NHS. Aside intense political disputes over remuneration, for GPs 1911 was far more significant than 1948.⁷ Then, the Liberal Government under Lloyd George introduced a scheme of National Health Insurance (NHI) which allowed working men – as women were excluded – access to a limited range of health services provided by GPs in return for regular payments from both workers and employers. Despite being lauded as a watershed moment, the 1911 reforms in fact served to provide some standardisation and regulation to existing practice provided through savings clubs and workmen’s friendly societies, as well as more financial and professional security for the medical profession.^{8, 9, 10} The creation of the NHS in 1948 did not encroach upon this settlement.

Since 1911 at the local level GP services were financed, administered, and audited by Insurance Committees which also served as representative panels for employers, workers, doctors, pharmacists, dentists, and insurance companies. Insurance Committees should not be imagined as precursors to modern purchasers or commissioners as they possessed limited influence to shape what individual GP did or where they worked. Their main function was to pay receipts, handle patient complaints – which were scarce despite the often massified and dismal quality of care encouraged by a capitation payment system¹¹ – and ensure access. Moreover, the territorial footprint of Insurance Committees was based on Victorian local government boundaries. This meant for notionally rural counties, historic Lancashire stretched from the outskirts of Manchester in the south to Windermere in the north whilst Westmorland centred on Kendal, extending from Grasmere to Kirkby Stephen. Urban areas were administered

according to the limits of county boroughs which, like Barrow, Blackpool, Burnley, Blackburn, Bury, and Preston were often compact and covering a small population. This left large discrepancies between the numbers of GPs, termed ‘panel doctors’ because of these arrangements, in neighbouring localities.

In 1948 the NHS introduced Executive Councils to provide oversight in place of Insurance Committees although, as official historian of the NHS Charles Webster argues, these ‘were little more than reincarnations’.¹² For Lancashire, Westmorland and the towns within them, there was near perfect continuity of their territorial footprints, the administrators who ran them, as well as appointed representatives.

The only remotely meaningful change was the establishment of the Medical Practices Committee (MPC) at a national level which was created owing to the unequal distribution of GPs across Britain, with enormous concentrations in the South of England compared with the North. Executive Councils served as *de facto* deputies for the MPC, arguably based on close local knowledge of practice sizes, un- and under-served populations, and existing competition. However, as Webster notes, Executive Councils as bureaucratic bodies possessed little traction and exercised limited intervention in the process whereby GPs, as fiercely independent entrepreneurs, remained suspicious of the state health bureaucracy and wished to control professional practice. Senior GPs determined appointments and practice succession themselves, often in their own parallel bureaucracy: the Local Medical Committee (LMC), also created in 1911 to mirror Insurance Committees.¹³

Here, the place of individual GPs as independent contractors, despite being monopoly providers within a largely closed health economy, is significant in exposing the limits of state intervention into their organisation and work even after nationalisation in 1948.¹⁴ Along with occupying a marginal economic position within the NHS policy architecture, general practice exercised precious little political influence. Indeed, as Webster notes, general practice was treated as a ‘receding backwater’ by the Ministry of Health, which was reluctant to intervene given the series of bruising encounters it experienced with the profession as far back as 1911. Indicative of this was the fact that out of 2320 staff employed by the Ministry during the 1960s, only 14 were solely dedicated to general practice, although there was some overlap with other divisions such as on prescribing and local authority health centres.¹² The state was content to leave GPs largely to their own devices which both curtailed change and constrained resources.

Crucially, at both regional and local levels a lack of national muscle from the MPC combined with the professional corporatism embedded in the policy architecture of Executive Councils and LMCs sustained inequalities for both the quantity and quality of GPs across the region. Indeed, although the territorial footprint of the policy architecture was transformed with local government reorganisation in 1974 – rebalancing the urban and rural demarcation of Victorian design – little else changed. From 1974 newly minted Family Practitioner Committees (FPCs) which replaced Executive Councils continued to remain separate from the otherwise increasingly integrated NHS.¹⁵ It was not until the cumulative reforms of limited lists, practice mergers, performance management and medical audit realised through a new contract and fundholding during the 1980s and 1990s that general practice lost its feel as a cottage industry worked by “penny collectivists”.^{16, 17}

PENNY PRACTITIONERS UNDER SOCIALISED MEDICINE

A central part of the reason behind the financial marginalisation and lack of change in general practice in both 1911 and 1948 stemmed from the division in British medical practice between GPs and hospital doctors, primarily consultants and specialists. As Frank Honigsbaum has convincingly demonstrated, unpaid honorary consultants working in private voluntary hospitals could only obtain their high status and private practice through reliance on other means until they secured an appointment.⁸ GPs could not afford the same luxury and so were compelled to earn a living through managing their own practice. In short, the division in British medicine was as much about class as it was about advancing medical technology and expertise associated with specialisation.^{8, 18} If GPs became “penny collectivists” under the NHS, it was because they had previously been “penny capitalists” in the mixed economy of care. It is with good reason that Lord Moran, Winston Churchill’s private doctor and President of the Royal College of Physicians, infamously likened moving into general practice as ‘falling off the ladder’ in evidence to the Pilkington Commission on doctors’ pay.¹⁹ As with policy architecture, this only began to change at a glacial pace under the NHS.

Beyond the class distinction between GPs and hospital consultants were issues of gender and race. Despite both constituting only a small proportion of the medical profession during the classic NHS, there were clear concentrations in general practice, among junior doctors and – where they eventually did attain the rank of consultant – in unpopular specialisms such as geriatrics and psychiatry.^{20, 21}

The oral recollections of Dr Dilys Davies exemplify this trend, showing that GPs were as much unfortunate women as fortunate men. After following in her fathers’ footsteps to Middlesex Hospital Medical School in 1948 she returned to Preston and worked in a series of junior hospital posts across different specialisms – which she likened to ‘galley slave class’ in comparison to modern facilities and ample staffing in London – on the expectation of becoming a consultant. However, after marrying a fellow doctor and then with children, she was increasingly unable to work the required long shifts needed to obtain consultant rank, instead reluctantly moving into general practice in 1956.²²

Equally, as Julian Simpson’s oral history of South Asian doctors working in general practice in Northern England shows, such a concentration could transform the contours of the profession at local, regional, and national levels.²³ Despite the prevalence of South Asian doctors in Westmorland and Lancashire in particular, their voices are absent from the oral histories available. However, it is abundantly clear from the administrative records of Executive Councils and LMCs that persistently unpopular areas or practices which struggled to find doctors – often designated by the MPC – were disproportionately filled by doctors either of South Asian heritage or qualifications.^{24, 25, 26} As Dr Davies notes, where white doctors from the Dominions – Canada, South Africa, Australia and New Zealand – were appointed, it was mainly into hospital specialisms with a view to building a portfolio of experience and expertise in order to obtain senior roles in their home countries.²² Colonial assumptions ran through the everyday medical experience of the metropole even in the peripheral North West.²⁷

Socialised medical practice was, therefore, shaped by gender and ethnicity as much as class. This is also apparent in another crucial point of entry into the profession: obtaining a locum, assistant or junior partnership position within a practice. For Dr Matthews who qualified from St Andrews University Medical School in 1955 this was made easier as he became a junior partner in 1956 then principal at his father's practice in Kirkby Stephen when he retired a few years later.²⁸ Equally, Dr Richard Oddy moved into a Kendal practice in 1948 owing to the worries of two existing GPs on the cusp of retirement, anxious about the changes being introduced by the NHS and looking to ease the burdens of a large practice list of 4,500 patients.²⁹ A similar experience can be found in the testimony of Dr John Carne, who like Dr Oddy also qualified from St Andrews in 1955, who moved into general practice for security following marriage and children, taking on the local practice of Dr Wilkin in 1963 as a junior shortly before Wilkin's retirement in 1966.³⁰ Again, the records of the Executive Council and LMC policy architecture points to the careful management of such appointments in order to prevent competition from established doctors and maintain stability.^{25, 31}

Indeed, across Lancashire, Westmorland and the towns of the region it is also clear that stability was maintained through continuity in medical education. Although common to swathes of northern England,¹¹ without a medical school of its own and lacking – at that time – close medical educational ties to its provincial capital Manchester,³² a large proportion of GPs and hospital doctors appointed did so with qualifications from Scottish medical schools, especially St Andrews.^{24, 25, 33, 34} This slowly changed over time with increasing orientation towards Manchester and a growing recognition of the need to embed postgraduate medical education for GPs. In the region this is exemplified in the life and work of Dr Patrick Byrne, a GP practicing in Milnthorpe who would become the Chair of General Practice in the University of Manchester Medical School and the first Professor of the specialism in England in 1972 before becoming President of the Royal College of General Practitioners (RCGP) from 1973 to 1976.³⁵

Such a shift in orientation from historic appointments of graduates from Scotland to the provincial centre of Manchester was discernible but slow. Moreover, these informal associational links proved instrumental in opening doors to the type of precarious or junior GP opportunities which led to principalship or single-handed practice as noted above. Fortunate men did not become so by accident, but by design.

PRACTICING GENERAL MEDICINE IN THE NHS

If both the policy architecture and profile of GPs themselves were marked by virtually seamless continuities under the NHS, it was in the experience of *being* a GP and *practising* general medicine that there was the most visible change. This was exponential rather than incremental throughout the classic NHS and can be best framed through the changing dynamics of the practice and the delivery of patient care.

PRACTICE

Practices remained the unit of organisation for the delivery of services under the NHS, and for the majority of the 25 years from 1948 to 1974 GPs practiced in splendid isolation from

one another. As the published annual reports of Lancashire LMC and Westmorland Executive Council show, single-handed practice declined over the period but remained prevalent. Although only 28% of the 1788 GP respondents to a survey issued to all 2005 members by Lancashire LMC in 1964 were emphatically single-handed, this masked a trend of GPs who were single-handed for all intents and purposes but practiced from the same premises with others, or shared outreach clinics in peripheral premises.³⁶ They maintained separate lists. The annual report of Westmorland Executive Council for the same year shows that 20 of the 71 GPs registered to provide services on behalf of the NHS were single-handed.³¹ The figure was the same as Lancashire – 28% – but also had the same uncertainty around definition.

The move from single-handed to double-handed or partnerships lacked any direction from the Executive Council and instead reflected incremental compromise from the LMC and senior local GPs about admitting new appointments. Whilst competition for patients was reduced under the NHS, it remained. For instance, Dr John Hopkinson who qualified from the London Hospital Medical College in 1946, initially obtained a single-handed practice in Ulverston, where there were five other GPs, leaving him with around 900 patients on his list. However, with the advent of the NHS and with the help of interim financial support from the British Medical Association (BMA), the doctors' union, he built this to 3,000 within three years as well as generating a significant private practice. The work was onerous leaving little time either off or away, and only slowly did he build reciprocal relationships with local doctors to provide mutual – or 'knock-for-knock' – out of hours coverage to patients.³⁷ Where possible, few of the fortunate men wished to dedicate their entire personal lives to the practice as well as their professional one, although many were compelled to do this for a portion of their early career.

More frequently GPs without an obvious successor, resulting in the Executive Council advertising them externally, introduced younger blood into areas often leading to mergers or partnerships between practices. This happened in 1963 when Dr F. Smith, who qualified from Manchester in 1951, took over a practice in Morecambe with premises on both Lancaster Road and his new home address of Heysham Road. Within three months he had gone into partnership with Dr E. M. Goodall who ran one of the many practices dotted along Marine Road who was looking to increase his list size.²⁴ The records of Executive Councils are replete with similar instances of new appointments prompting mergers.

These increased following the implementation of recommendations from the 1963 Gillie Report, establishing the Family Doctor's Charter in 1966 which provided payments for group practice and other expenses previously borne by the “penny collectivist”, particularly ancillary staff.^{5, 12, 30, 38} Although, as Dr Matthews notes, this depended on local medical politics with many public health doctors, the Medical Officer of Health (MOH), continuing to jealously guard the attachment of midwives, district nurses and health visitors which remained the responsibility of local authorities until 1974.^{28, 39} Such professional antipathies also limited the move into modern, purpose-built health centres which were the responsibility of MOsH with GPs renting them from the local

authority. Despite the prospect of unfettered access to large patient populations and list payments, there were few willing volunteers. Unlike new towns which modelled GP services through health centres, overspill estates for slums – such as Ormsgill in Barrow – provided the main source in the region.³³ It was not until after 1974 and the removal of public health from local authorities that health centre expansion and GP concentration in the region increased apace.

Part of the explanation behind slow practice amalgamation, partnership and health centres was the persistence of large patient lists. In the whole of the North West – including Liverpool, Manchester and Cumberland – the average list size in 1952 was 2,654, shrinking to 2,427 by 1963. Both figures being higher than the national English average of 2,548 and 2,343 respectively.¹¹ Such a crude average masked a considerable spectrum of sizes. In Westmorland in 1963 four lists were below 500 and twelve under 1000, managed primarily by part-time doctors, juniors or assistants to other principal GPs.³¹ Most of these lower status GPs were left with ‘humdrum activities’ and largely exploited by principals in the interests of economies of scale within the closed socialised health economy.^{11, 40} At the same time, several single-handed GPs in the county were managing lists larger than 2,500 in largely rural conditions and the largest partnerships nearly 4,000.³¹ Such spectrums of difference in list sizes were linked to income and ultimately propelled by incentives.

The place of incentives in the activities of practitioners is visible in the range of other services they rendered. As the account book of Dr Dorothy Potts, working out of two premises in Bloomfield Road and Central Drive adjacent to Blackpool promenade, shows, GPs continued to earn additional income by conducting occupational medical inspections and undertaking clinical work on behalf of local authorities. For women, such as Dr Potts, this typically meant maternity and child welfare clinics.⁴¹ The period of the classic NHS also saw the emergence of modern vaccination and immunisation programmes which were often managed by local authorities although delivered by GPs on a sessional or payment basis.⁴² Beyond this, despite the division in British medicine between generalism and specialism, many GPs continued to perform specialist services for hospitals, usually in the periphery where consultant appointments were sparse, or where doctors were on more friendly terms with local hospital specialists.^{30, 43} Indeed, in evidence to the 1954 Cohen Committee on General Practice,⁴⁴ the only other major inquiry prior to Gillie in 1963, Dr B. Spencer who ran a practice in central Burnley noted that prior to the NHS all specialist work had been done by GPs with some claim to experience or proficiency and this was slowly changing with the appointment of consultants and the hosting of clinical sessions by Manchester specialists.⁴⁵

Such enterprising activities of “penny collectivists” waned during the period of the classic NHS, as noted in Gordon Forsyth and Bob Logan’s study of hospital referrals by GPs in Barrow during the 1960s,⁴⁶ but they did not cease entirely.

PATIENTS

Whilst the experience of patient care was conditioned by policy architecture, the professional position of GPs and

the circumstances of practice under the NHS, it possessed its own distinctive characteristics which underwent exponential rather than incremental change: propelled by technology, modernisation, and social change.

The type of mobile encounter between doctor and patients in the fields, homes and workplaces of rural Gloucestershire depicted by Berger reflect a crucial difference in general practice during the period: most patients were not seen in the surgery but elsewhere, typically in their own home. This represented a combination of a lack of mobility on the part of patients, particularly the elderly, infirm, or those with chronic conditions, as well as an expectation for doctors to be accessible by the Executive Council and to provide services as they had done since 1911.¹¹ However, as Dr Oddy notes, many rural patients remained hesitant to call for the doctor.²⁹ Still others recall either driving or employing a chauffeur to make visits as swiftly as possible, often leaving the engine running, or drive between surgeries.^{30, 41} Given the lack of motoring infrastructure, especially motorways but also adequate lighting and signs, such complaints by LMCs to local authorities were regular.^{26, 47} The additional costs incurred by rural practices, which moved from a mileage to single practice payment system in 1963, were evident in comparative assessments by Westmorland Executive Council which remained one of the highest per visit in the country.³¹

The reverse portrait of the sweeping landscapes of the Lake District driven by such fortunate men was the often small, dingy, and lifeless waiting rooms found in surgeries. Appointment systems were only slowly spreading through practices, and they were not intended to accommodate large numbers of patients. Given investment came from surplus practice funds until 1966, few except the most progressive “penny collectivists” or those working from health centres gave the issue much credence.⁴⁰ Without the voice of the patient, such criticisms of practice condition are sparse in oral testimonies. However, speaking in 1993, Dr Hopkinson commented on the ample size of his own amended premises in relation to the dismal condition of his colleagues in Ulverston.³⁷

The 1966 GP contract was dubbed the Family Doctor’s Charter in recognition of the type of services provided. Yet as Nick Bosanquet and Chris Salisbury recognise, it also had another truth in that general practice was a family business reliant on the work of wives and children to subsist.⁴⁰ All of the oral testimonies mention this experience in one form or another: either as a child in their father’s practice or as a GP themselves using the labour of their family.^{22, 28, 29, 30, 37, 38} Such recollections were also linked to sense of being and belonging to the community which was associated with both status and deference from patients, with Dr Hopkinson likened to being a Parson, and Dr Matthews a Vicar, which quietly dissipated on retirement.^{28, 37}

Despite this sense of gratitude captured in the oral testimonies of doctors, medical practice changed substantially during the period, particularly in the 1960s and the white heat of the medical technological revolution encapsulated in the growth of therapeutics and proprietary medicines. Dr Matthews remembers the impact on the practice and his patients of employing a nurse for several sessions a week able to deliver cytokine injections in place of his previous prescriptions for iron-rich liver.²⁸ Equally, by the time of her retirement, Dr

Davies reflected on the ‘absolutely overwhelming’ impact of therapeutics with which it became increasingly hard to keep pace through the professional literature. This, despite her own recollections of her father – the Chair of Preston LMC into the 1960s – continuing to employ a qualified family member as a pharmacist on the premises during the early NHS to prepare prescriptions in a period before blister packs and pre-packed mass-produced medicine.²² Changing regulations coupled to the commercialisation of pharmaceuticals on an increasingly industrial scale meant high street retailers like Boots and Lloyds became an integral part of the GP’s landscape.^{30, 41}

Beyond the creeping therapeutic revolution, an abiding memory of GPs was working with elderly patients in their own homes, who, lacking institutional care relied on doctors to ease discomforts, illness, and chronic conditions. Dr Carne routinely visited all elderly patients on his list, and Dr Matthews noted the role of neighbourliness in bringing issues of the elderly to his attention in a community with limited mobility.^{28, 30} This often led to blurred boundaries of care, particularly around conditions with emerging knowledge such as diabetes, or where hospital-GP disputes spilled across into local authority social services and the voluntary sector.^{48, 49} Such problems only worsened into the 1980s.⁵⁰

Blurred boundaries were also to be found in maternity care and obstetrics, where many GPs continued to provide services – particularly in the more rural communities of the region – in both a routine and emergency capacity. Indeed, a review of access to maternity beds in both district and cottage hospitals by GPs conducted by Manchester Regional Hospital Board (RHB) which provided hospital services for Lancashire and Westmorland in 1961 – in anticipation of the significant Hospital Plan initiated in 1962 to modernise ageing stock – caused outrage due to limitations. Preston, and Lancashire – among others – petitioned the RHB for planned access to beds in order to maintain services for patients as well as professional accreditation.^{26, 36} However, Dr McQuay recognised the high maternal mortality rate for visits as a profession and Dr Matthews opaquely referred to a lack of concern with ‘awful blunders’ at the time.^{28, 38} The resulting refusal had a substantial impact for Lancaster, Kendal and Morecambe. None of the hospitals in these towns were identified for development as part of the Hospital Plan,⁵¹ yet alongside losing the emergency maternity services of GPs, also suffered the closure of maternity homes and hospitals into the 1970s. Crucially, the “penny collectivists” had limited political and economic influence beyond the immediate organisation of their contractual obligations.

CONCLUSION

In an era of virtual appointments, patient anger, performance management and diminishing resources underpinning the industrialisation of family medicine, it is easy for GPs to imagine their forerunners as fortunate men in a simpler era of idyllic cottage industry and professional status. Berger and Mohr’s intimate poetic depiction lends weight to this image. However, what this paper demonstrates is that romantic nostalgia is to be cautioned against. Even during an era of the classic welfare state and widespread consensus, GPs were underpaid, overworked and overlooked by prestigious hospital consultants who had benefited from the Bevan’s nationalisation

settlement. With disinterest from the political centre until the 1980s, GPs were effectively reluctant “penny collectivists” rather than fortunate men: deploying entrepreneurial resourcefulness of their own making to navigate the new socialised health economy.

The contours of these conditions have changed over time, however. Reduced patient lists have not eased workloads but placed different demands on GP’s time beyond patient care. Doctors driving around country roads have been replaced by patients compelled to travel to centralised health centres. Dinky practices have been modernised but the doctor-patient relationship at the heart of the professional ethic has been diluted through creeping economies and rationalisation. Practice management has been extended beyond wives and children but has eroded cherished professional autonomy and increased marketisation. Taken at face value from oral testimonies, this paper could easily be interpreted as legitimating the view of GPs of the classic NHS as fortunate men: indeed, many concluded their interviews reflecting on how difficult it is for the current generation of GPs. Many, unsurprisingly, have sons or daughters in the profession. Yet with proper historical contextualisation in time and place, this paper shows the subjective dynamics of being a GP, or a “penny collector”, and what this means for policy, practitioners and patients.

Correspondence to:
m.lambert3@lancaster.ac.uk

REFERENCES

(a full list available on request)

1. Berger J, Mohr J. A fortunate man: the story of a country doctor. London: Allen Lane; 1967.
2. British Medical Journal. Obituary: J Eskill. British Medical Journal. 1982;285(6347):1052-1053. Available from: <https://doi.org/10.1136/bmj.285.6347.1052>
3. Jeffrey D. The process of empathy: insights from John Berger’s A Fortunate Man. British Journal of General Practice. 2016;66(650):476-477. Available from: <https://doi.org/10.3399/bjgp16X686869>
4. Iliffe S. From general practice to primary care: the industrialisation of family medicine. Oxford: Oxford University Press; 2008.
5. Gillie A. The field work of the family doctor. London: HMSO; 1963.
6. Benson J. The Penny Capitalists: a study of nineteenth-century working-class entrepreneurs. Dublin: Gill and Macmillan; 1983.
7. Honigsbaum F. Health, happiness and security: the creation of the National Health Service. London: Routledge; 1989.
8. Honigsbaum F. The division in British medicine: a history of the separation of general practice from hospital care, 1911-1968. London: Kogan Page; 1979.
9. Eder NR. National health insurance and the medical profession in Britain, 1913-1939. New York, NY: Garland; 1982.
10. Digby A. Making a medical living: doctors and patients in the English market for medicine, 1720-1911. Cambridge: Cambridge University Press; 1994.
11. Digby A. The evolution of British general practice, 1850-1948. Oxford: Oxford University Press; 1999.
12. Webster C. The politics of general practice. In: Loudon I, Harder J, Webster C. (eds.) General practice under the National Health Service, 1948-1997. Oxford: Clarendon Press; 1998: 20-44.
13. Webster C. The Health Services since the War, Volume I: Problems of health care. The National Health Service before 1957. London: HMSO; 1988.
14. Webster C. Doctors, public service and profit: general practitioners and the National Health Service. Transactions of the Royal Historical Society. 1990;40:197-216. Available from: <https://doi.org/10.2307/3679168>