Proc. R. Coll. Physicians Edinb. 1998; **28**:207-217

FROM PHYSICIANS' ENQUIRY TO DEWAR REPORT: A SURVEY OF MEDICAL SERVICES IN THE WEST HIGHLANDS AND ISLANDS OF SCOTLAND, 1852-1912: PART II

Stephanie Blackden, Brodie Castle, Brodie, Forres, Morayshire*

DEVELOPMENTS IN HEALTH CARE IN THE POST-REPORT PERIOD 1850-1900

At the time of the Physicians' Report in the early 1850s, the balance between traditional and orthodox medicine was only beginning to be altered by the effects of the parochial medical service. In the ensuing 50 years, in order to cope with the growing popularity of orthodox medicine, communities wanting to retain a resident medical practitioner had to provide a reasonable financial inducement while also enabling poorer members of the non-pauper population to afford his services. In the 1850s attracting doctors had been relatively easy: the number of doctors graduating from the Scottish medical schools had created competition for a limited number of opportunities and forced many young graduates to seek employment where they could find it, including the less populated parts of the British Isles. Later in the century, as more avenues opened up for the ambitious doctor, this inevitably affected the crofting counties. The difficulties of retaining in post practitioners in remoter rural areas became acute as the demand for their services elsewhere increased.

An extensive district, such as Lismore and Appin, which included the area around Glencoe and the township of Ballachulish, because of a sufficiently varied population and its closeness to Oban, with its steamer and rail connections, could maintain several practitioners for the most part. It was far more difficult for a district such as Kilfinichan on Mull or Shieldaig in Wester Ross to provide conditions attractive enough for a doctor to stay. Remote districts experienced a rapid turnover of doctors, who remained a year or so and then moved on to further their career. Long delays were experienced before another doctor was appointed,[1] and as communities increasingly relied on orthodox medical treatment, their determination to retain their medical practitioner increased likewise, often regardless of whether they could support one.

The real problem lay in providing the doctor with earnings sufficient to enable him to settle permanently, yet ensuring that his fees lay within the reach of the bulk of the non-pauper population. The returns to the Physicians' Enquiry had shown how deeply doctors resented being placed in the position either of having to exact their fees 'by harsh measures' or of treating the sick and foregoing remuneration, 'more for humanity's sake than my own payment'. The charity of the local practitioner was not a reliable path to medical assistance for the working poor. Nor had the financial position of most of the population improved sufficiently to afford the doctor's fees, once travel and medical expenses had been included in the bill.

A number of methods for squaring the circle were attempted with varying degrees of success. Involvement of local landowners, the other way in which medical aid had been traditionally subsidised, had declined once the Poor Law was the ostensible authority to provide medical relief to the destitute; for example Colonel Gordon, landowner of South Uist, withdrew his financial support of the local surgeon on those grounds as early as 1850.[2] However, by the 1870s some return to landlord subsidies had occurred

*Wellcome Fellow in The History of Medicine at Edinburgh University.

in vulnerable areas. An interesting example of this, where the documents have survived, comes from the estates of William Fraser, in the parishes of Kilmuir and Snizort on Skye: Fraser drew up a legal agreement in February 1873 between himself and the local medical officer who was to attend free of charge all paupers, estate workers and those unable to pay fees, while all others living on the estate were to be charged one shilling for a professional visit and the usual chemists' prices for medicines.[3] The doctor had to keep a horse and be in readiness day and night for emergencies, and in return he was to be paid a salary of £140 *per annum*, less any salary he might be paid as medical officer for the parishes of Kilmuir and Snizort. This agreement covered Fraser's estates only and the expense seems to have been borne by him alone, whereas in the case of Arrochar at the head of Loch Long the principal heritor, Sir James Colquhoun of Luss, undertook to pay £20 towards the annual salary of a resident doctor for both Arrochar and Luss on condition that no less an amount was raised by the other ratepayers. This sum was then to be added to the medical practitioner's salary of £60 as parochial medical officer, making a total of £100, on condition that the local non-pauper population were also treated, according to a modest scale of fees.[4] The MacLeod proprietor of St Kilda sent a supply of medicines annually to the islanders, including castor oil, senna pods, various tonics and a supply of bandages and appliances for treating wounds and also paid for doctors to vaccinate the population from time to time.[5]

Such arrangements depended on the benevolence of local landowners and were modified or abandoned according to the inclination of the heritor involved. Often parochial boards, largely composed of the men of substance in a community, became active in attempts to extend medical assistance to the non-pauper population in their area. Loch Carron drew up a scheme in 1872 whereby the parochial medical officer had to make at least four free visits annually to local ratepayers, if required, and thereafter could charge according to a scale which included a maximum of £1 for home visits and midwifery cases, with half this sum being charged to those with a rental of £20 or under.[6] The involvement of ratepayers in raising money to maintain a doctor, largely through the Poor Law, became more pronounced after 1894 once wholly-elective parish councils replaced the old Parochial Boards with their landowning element. These ways of using the poor relief to benefit the non-pauper section of the community were of questionable legality.

Other community-based efforts centred on the Medical Associations, a number of which were founded towards the end of the century. The membership fee entitled the member and his family to medical attendance, including midwifery, at a reduced rate. Some Associations in prosperous areas, for example the Shapinsay Medical Association in Orkney, survived for a number of years and played a modest part in raising the funds necessary to maintain a resident doctor.[7] However, those established in villages and townships along the west coast were often faced with greater survival difficulties. An Association would be formed, the initial membership fees would be paid and a doctor appointed, but within a short period poverty or apathy reduced the membership and the Association would no longer exist, for lack of support. These attempts to extend medical aid to the working population affected no more than a small proportion of potential patients, but they illustrate the efforts made to retain the services of a resident doctor.

Highland doctors had to be versatile and ready to treat conditions that elsewhere would warrant hospital admission; inevitably, however, patients occasionally needed an operation or specialist advice. From the 1850s (if not earlier), the Lowlands and the central industrial belt of Scotland had been well supplied with charitable dispensaries,

voluntary general and specialist hospitals for treating the sick poor above the level of the destitute, an advantage the crofting counties lacked. At the time of the Poor Law report in 1845 few hospitals existed in the west Highlands, the Northern Counties Hospital in Inverness being the only large one, serving northern Inverness-shire, Ross-shire and Sutherlandshire. Small charity institutions had also been founded, notably the Balfour Hospital in Kirkwall on Orkney.

This dearth of dispensary and in-patient care was not necessarily felt as a disadvantage by the working population: few Highlanders were happy to leave their familiar surroundings for the unknown ordeal of hospital treatment. As late as 1907, a Clyne fisherman in urgent need of a hernia operation flatly refused to go to hospital in Inverness, and wanted the operation to be performed in his dirty, ill-lit cottage.[8]

Nevertheless, hospitals were potentially another dimension of orthodox medicine available to those willing to take advantage of it. For the patients, this involved submitting themselves to a steamer journey south for admission to the Greenock or Glasgow Royal Infirmaries if they lived in the Western Isles or on the west coast, to the Aberdeen or Edinburgh Royal Infirmaries if they came from Orkney or Shetland. Although this must have been a daunting prospect, every year patients unable to get relief from their illnesses at home made the journey. Shetlanders had a strong preference for Edinburgh Royal Infirmary as it was the hospital attached to what they regarded as Scotland's foremost medical school. One hundred and sixty three patients were admitted to its wards from Shetland for the five years to July 1885.[9]

However, for hospitals to be of any real assistance to the Highland population, let alone be accepted as a place of healing, they had to be brought within closer physical reach of patients and their families. As the century progressed, the cottage hospital movement affected the west Highlands and Islands; small hospitals were founded in centres of population such as Stornoway on Lewis, Lerwick in Shetland and Fort William in Inverness-shire. As well as providing in-patient treatment, these hospitals increased job opportunities for doctors. Under the threat of infectious diseases, small isolation hospitals were also established or wards were added to existing hospitals. In the early years of the twentieth century, tuberculosis was on the increase in the west Highlands and Islands, particularly on Lewis, and a few sanatoria were established.

Poor Law administration also contributed towards in-patient care for the pauper population to a limited extent. From the 1860s onwards, under pressure from the Board of Supervision, poorhouses were built in various parts of the Highlands, and though only a few were substantial enough to have separate sick wards staffed by trained nurses, all had beds for the elderly infirm and chronic sick. The resistance of the Highland population to incarceration in a poorhouse, however, meant consistent underusage of the beds available. In an attempt to make poorhouses pay their way, the Local Government Board for Scotland in the early twentieth century encouraged poorhouse boards to provide isolation beds for tuberculosis sufferers and wards for the harmless insane.

Another development was the introduction of trained district nurses and midwives. Involvement in local committees of Nursing Associations was a favourite charitable enterprise of the wives of landowners and, under their direction, nurses were recruited and their salaries subsidised. The work of Nursing Associations received a welcome boost after 1897 from Queen Victoria's Jubilee Fund. Such nurses were particularly valuable when based in townships and island communities where a doctor rarely visited; a good example is Fair Isle, where the resident nurse in the early twentieth century also had a dental qualification.[10] As well as being on hand to carry out the doctor's instructions,

nurses could perform a whole range of educational and practical functions, teaching basic sanitation, nutrition and even cooking, and improving the standard of care of sick or injured members of a family within the home. They were accepted on a level the doctor could not stoop to, and thus had a more direct impact on the daily lives of their community.

Resident nurses also improved standards of midwifery and, being cheaper than the doctor, were much in demand for help and advice with small medical problems. Though they might be regarded by the population as second best - Papa Westray in its struggle to attract and maintain a doctor, repeatedly turned down the suggestion that a nurse would be sufficient - many small islands and remote communities had only a resident nurse for many years and no doctor. The people of Gigha, who obtained a Queen's Nurse in 1911, said of her that 'since Nurse — came to the island there is a feeling of great security in the minds of the inhabitants'.[11] The ubiquitous parochial boards, or parish councils as they became after 1894, were sometimes involved in the recruitment and deployment of nurses, and would pay a small annual sum to the nursing association for the free treatment of paupers. Stornoway parish council had an arrangement with the local hospital for the training of locally recruited women as Queen's Nurses, who were then contracted to work in outlying areas of the parish for a period of five years;[12] in this instance half the nurse's salary was provided by the Ladies' Highland Association of Edinburgh. As well as being subsidised by local philanthropy and the Poor Law authorities, nurses were also paid small fees for their services directly by patients or through Medical Associations.

Even cheaper than the nurse as a source of medical advice was the local chemist. As town populations expanded pharmacists were encouraged to set up shop, so widening still further the range of semi-professional advice and treatment available. To the medical profession, the spread of such commercial dispensaries proved a mixed blessing; although they eased the burden of dispensing, obtaining and storing drugs, they diverted profits from the sale of medicines which had added significantly to the doctor's income, and the chemists' over-the-counter advice drew patients away from his consulting rooms.[13]

Positive gains in orthodox medical care had been made by both doctors and patients in the half century between the Physicians' Enquiry and the start of the twentieth century. Most rural doctors had at least one official appointment, as parochial medical officer, vaccinator, poorhouse medical officer or under the lunacy and public health legislation, and some held several positions contemporaneously. These provided an assured basic salary which in a few instances, for example county medical officers of health, was sufficient to make the doctor independent of private patients.[14] The opportunities in many rural areas for building up a private practice had improved with the development of sporting estates, tourism and rural industries. Doctors who practised in towns, particularly those with hospital facilities and a direct rail link to the main cities of the Lowlands, had a professional life not very different from their counterparts in lowland towns of similar size. They also had the advantage of being able to get in touch with other local general practitioners to discuss cases and obtain assistance, and there were more opportunities for attracting private patients. In general the extension of railways into all parts of the west and north in the 1890s and the improvement of roads and ferry services, as well as drawing the west Highlands and Islands into closer contact with the rest of Scotland, made easier movement around their districts for Highland doctors. The introduction of the telegraph, and later of the telephone, made instant communication over long distances a reality for the town physician and promised to be of future benefit to the rural physician once extensions into the countryside had been made.

From the patient's point of view, the expansion in the numbers of medical practitioners from under 100 in 1852 to 170 by 1912, the establishment of hospitals, the coming of the district nurse and the chemist, had increased the choice of options available for advice and care when sick. The doctor and nurse were now regarded as indispensable to communities which, 50 years earlier, would have gone first to the minister or quack for advice in illness. To the thousands of infirm and elderly poor who depended on the Poor Law for maintenance, the parochial medical service provided free treatment, medicines and medical appliances, improved diet and nursing care. The gains for both doctor and patient were therefore substantial, but were they sufficient to ensure that the population was provided with a medical service of the standard similar to the rest of Scotland?

HOW ADEQUATE WERE MEDICAL SERVICES IN THE LATER NINETEENTH CENTURY?

The realities of highland medical practice in the early twentieth century comes to us through two important sources. An enquiry set up in 1901 by the Local Government Board for Scotland enquiring into the state of the Poor Law medical service took evidence from doctors and Poor Law administrators; the resulting Report gives information on Poor Law medical relief, throughout Scotland including the crofting counties.[15] This was a precursor of a much more detailed investigation undertaken by Parliament specifically into the state of medicine and health care in the west Highlands and Islands, the Dewar Commission, which reported in 1912. These Reports, and to a lesser extent evidence from the Poor Law Commission of 1909 and other sources, give a more accurate picture of the situation for both doctor and patient. They show that medical services in the crofting counties continued to lag behind the rest of Scotland, and indeed the Local Government Board for Scotland tacitly accepted that the parochial medical service could not be expected to be on the same level in the Highlands as it was in the Lowlands.[16]

The problem was not so much attracting doctors to highland communities as persuading them to stay. Papa Westray, possibly the most extreme example, had 13 medical officers between October 1895 and June 1914 when the islanders temporarily abandoned the struggle.[17] One of the reasons for this was lack of suitable accommodation: some communities provided their doctor with a house, which was frequently 'not fit for a labouring man', and was nevertheless the subject to an exorbitant rent.[18] The doctor might have to consult his patients in the kitchen, which occasionally doubled as the waiting room as well. Dr Taylor, who practised on the remote Shetland island of Yell in the first years of the twentieth century, was provided with a house that lacked surgery, a waiting room, bathroom and even a water supply: a well and water butt having to suffice, and he added these essential amenities at his own expense.[19] Travel was still a difficulty. Although in most areas the roads were now well surfaced, many townships or houses were inaccessible to vehicles. Dr Taylor, who introduced a motor cycle and then the first car into the island to help him on his rounds, frequently had to leave it and tramp miles over rough moorland.[20]

To reach the remotest cottage, doctors had to take dangerous routes. One doctor giving evidence to the Dewar Commission had received an award for risking his life in crossing a mountain to get to his patient. Any doctor whose practice included island or peninsular communities, probably the majority, had to be prepared for sea-crossings in open boats, which often meant spending hours in wet clothing and staying a night away from home in inadequate accommodation. Taylor provided himself with a motor boat, an expense beyond the financial capabilities of many Highland practitioners. The

enterprising islanders of Papa Westray owned their own boat to fetch the doctor from neighbouring Westray, but all too often elsewhere time had to be wasted while a boat and crew were found.[21] Those doctors recounting their travelling experiences to the Dewar Commission used language similar to that of their counterparts writing to the Royal College 60 years earlier.

Having eventually reached the patient, the doctor often had to examine and treat him in very adverse surroundings. Although houses were improving slowly and many were clean and well-kept, cottages were frequently small, extremely dirty and without basic sanitation. In parts of the Hebrides, 'black' houses were still inhabited with their earth floors, in many cases without chimneys, and with a single door giving access for humans and the livestock which shared one half of the building. Surgery had to be performed under such conditions, with or without anaesthetics. One doctor told the Dewar Commission of having to perform a hernia operation with the local clerk giving the anaesthetic and with light given by a candle held by a neighbour who fainted during the proceedings.[22] The difficulty of obtaining trained assistance was not easily overcome, although the advent of the qualified nurse eased the problem where she was based.

Nurses may have been seen as the salvation for isolated communities out of reach of rapid medical assistance, but in practice they were required not only to be skilled in patient care but prepared to roll up their sleeves and scrub floors, wash clothes and cook food, if they were to be of real assistance. Few trained nurses were willing to do this, or to accept the dismal accommodation offered to them in many instances, and their length of stay was frequently as short as that of the doctors.[23] Marriage, then a bar to continuing at work for a woman, also frequently terminated a nurse's career. A language barrier also often arose, and parish councils made real efforts to recruit Gaelic-speaking doctors and nurses. Finally, in spite of the improvement in their financial status, many doctors still found themselves unable to collect fees from private practice and either treated their non-pauper patients free or had to accept payment in kind. Savings were difficult to accumulate, and it was not uncommon for doctors to continue to practise into their seventies, largely, on their own admission, because they were unable to provide for their old age in any other way. This was the case throughout this 60-year period.

The many difficulties experienced by doctors throughout the period of this study beg the question as to why they chose to practice in the crofting counties when other openings were presumably available. In the case of young graduates wishing to gain experience, the post of parochial medical officer, in a district otherwise bereft of medical assistance, provided an assured salary until a better career prospect presented itself. To women graduates in the early twentieth century, the crofting population's need was often their opportunity, particularly as jobs for female doctors were hard to come by. More than half of Papa Westray's doctors were women, but they stayed no longer than their male counterparts owing to lack of anywhere to live.[24]

Many Highland doctors, however, settled permanently. Dr Wishart of Dingwall had been 56 years in his practice in 1851. Though this was exceptionally long it is possible to find examples of even longer-serving doctors: Dr MacCrae of Stornoway who finally retired in 1906 at the age of 84 had been parochial medical officer for 57 years. He had been in his practice even longer and, as a young doctor, had filled in the Physicians' questionnaire. His career at Stornoway thus spanned more than 60 years and virtually formed a bridge between the Physicians' Enquiry and the Dewar Report. Even if Dr Wishart and Dr McCrae can be considered exceptional, no fewer than

seven of the 56 doctors returning the Physicians' questionnaire had been 30 or more years in their practices, and 18 had been 20 or more.

Probably the most important factor in bringing doctors to the west Highlands and Islands was family connections. In Unst, for example, the second largest island in the Shetland group, three doctors were in practice in the early 1850s when only two others, both based in Lerwick, were working in the Islands. This apparent imbalance was partly due to the land fertility of Unst which supported a large and prosperous population, but chiefly was the result of a strong medical tradition among landowning families, notably the Edmonstone and Spence families.[25] At the same period Dr Kennedy of Plockton in Wester Ross had one son in partnership and another a medical student, the latter helping out during his vacations. The Dewar Commission, which attempted to address the question of why doctors were drawn to Highland practices, also stressed the importance of Highland origins.

Connection with the land had other attractions for doctors. At the time of the Physicians' Enquiry, practitioners frequently augmented their earnings by doubling as farmers. This might be nothing more energetic than letting out glebe lands for grazing at one extreme to working substantial farms at the other. At least one doctor in 1851 abandoned his practice on South Uist altogether to become a tenant farmer on Barra. Dr Robertson of Poolewe at the same date divided his time between his practice and a little sheep farm at Gairloch. This connection between farming and medical practice has more in common with frontier areas such as western Ontario, Canada, at the same period than elsewhere in Britain. From his surviving Account Book we know that Dr Harmaunus Smith who practised at Ancaster at the end of Lake Ontario in the mid-nineteenth century frequently failed to collect fees from his patients or had to accept payment in kind. His wealth came from managing his large concessions of land.[26]

A love of remote places and a desire to bring their families up far from the pressures of towns are also mentioned by the Dewar Commission as important reasons in bringing doctors to the crofting counties. It is also possible that doctors were trapped by their own character traits. Those who found it difficult to fit in with the suffocating society of lowland towns and villages, or who had idiosyncrasies which blocked their advancement, could well find in a Highland practice a refuge where patients were willing to overlook their faults in order to preserve their services. There are hints in the Physicians' Report of friction between doctors and ministers, and suggestions of lack of respectability indicating a lifestyle not without blemish.[27] The minister of Morven, in his long and authoritative letter to the Royal College, pointed out that alcoholism was a problem among isolated medical men, a point they conveniently left out when quoting the relevant passage in their Report. Sixty years later the Dewar Commission also indicates that standards were not as high as they might be.[28] Highland practice may well have provided a professional outlet for those whose eccentricities or lack of individual skill would prove a barrier to a livelihood elsewhere in Britain.

To turn to the patients, their problems were a mirror image of those of the doctor. If he had a long and tiring journey to reach them, they and their relatives often had to wait anxiously for help which might take days to arrive. Dr Cochrane of Shetland told the Dewar Commission of instances when patients on the island of Papa Stour had to wait nearly three weeks for the crossing of the Sound to become possible, and this was not an isolated incident. Again, if the doctor found it difficult to exact payment from his patients, they found his fees beyond their financial capabilities. A crofter on Lewis might have a disposable income of £26 a year, after paying rent, rates, food and fuel, and in other parts of the Highlands the amount was even lower. To the doctor who had

to hire a conveyance and perhaps stay overnight, a charge of three guineas, would leave only £1 as his profit. The crofter might well be plunged into poverty by attempting to pay this. Serious illness could impoverish crofter families and the doctor was often sent for once but seldom twice.[29]

Midwifery was one area where traditional practices remained strong. The knee-woman, or med-woman in the Northern Isles, would be called to assist at a confinement and the need for a doctor to be present would only be considered if complications occurred. The importance of midwifery had been recognised by several of the ministers responding to the Physicians' Enquiry, who suggested providing unqualified midwives with some basic training. However, midwifery was a potentially valuable area for private practice and inevitably the medical profession began to move in on the preserves of the traditional midwives. It was not difficult to discredit their methods when these were linked to birth rituals which seemed to have more in common with magic than medicine. A surgeon from Walls in Shetland reported to the Dewar Commission with some satisfaction that the death from post-partum haemorrhage of a woman in the parish, who had been attended by a med-woman, 'put an end to the services of the handywoman', although his assumption that he would have saved the patient was perhaps unduly optimistic.[30]

As evidence of the increased popularity of orthodox medicine even in this last bastion of traditional medical practices, Medical Associations generally included attendance at confinements as part of the medical services available to the subscribers. Such associations were necessarily confined to communities with a large and relatively prosperous population. Elsewhere in the crofting counties unqualified midwives continued to practice into the twentieth century. In the absence of trained nurses they even worked in co-operation with the medical profession. Dr Taylor of North Yell admitted that some of the med-women he worked with were not unskilled and had incorporated ideas on cleanliness and basic sanitation into their work.[31] However, on the darker side it is very likely that some birth rituals, particularly those connected with the anointing of the umbilical cord, were the cause of disease in the new-born.

Although smallpox, through vaccination, had ceased to be a problem by the end of the century, tuberculosis, often introduced by workers returning from the Lowlands, ran like wildfire through a relatively unprotected population and was a matter of concern to local communities.[32] Furthermore, by the end of the nineteenth century emigration was reducing the population of the crofting counties, leaving behind an ageing population which needed considerable medical care. Most of the elderly and infirm were attended in their own homes by neighbours or relatives, not always with much skill, but those without relations or friends might have found themselves in the sick wards of a poorhouse, occasionally many miles from their community. The medical officer of Lorne combination poorhouse in southern Argyll said of his elderly patients 'nothing is more depressing than to see elderly inmates sitting still staring into vacancy day after day'.[33] Lorne was large enough to employ a trained sick nurse, but smaller poorhouses might have no such facility and pauper nurses were still to be found in Highland poorhouses until the First World War. Thurso combination poorhouse had only the matron to look after the inmates, a woman with no nursing training of any sort although on occasions the medical officer performed small operations and took care of cases of cancer and other serious illness. He himself had to bring medicines and any equipment he might require with him when visiting the inmates.[34]

Poorhouses, of course, touched the lives of a very small proportion of the sick and ageing population. More important to general health care were the voluntary hospitals.

Although most of the larger towns by the early twentieth century had at least a cottage hospital, these lacked specialist, laboratory and X-ray facilities, and were not large enough to accommodate more than a small number of patients. For any illness requiring specialist treatment or major operations, the journey to the lowland infirmaries still had to be made.

What the Dewar Commission regarded as the most damning indication of a failure of orthodox medicine to meet the needs of the population was the large number of uncertified deaths in the west Highlands and Islands. According to the medical officer of health for Inverness-shire these averaged 29% over the whole county in 1911, but this figure obscured a range which went as high as 59% in the parish of Small Isles. This figure was exceeded by the Ross-shire parish of Shieldaig where it was 78%, at a time when the average for Scotland as a whole was around 2%. Although fatalism in the case of elderly patients was regarded as a factor contributing to these deaths, the Dewar Commission concluded that poverty and remoteness and inaccessability of care were more important.[35] The Commissioners were naturally concerned by these figures, but the absence of a regular medical practitioner to attend the last illness of a patient did not, of course, necessarily mean that help of some sort had not been sought and given.

By the early twentieth century, communities were struggling to hold on to those medical services they had. That backbone of Highland medical aid, the Poor Law, was becoming less able to support them owing to dwindling resources available for the outdoor medical service. In 1885, in an effort to improve nursing services in the large city poorhouses, the Board of Supervision had introduced a nursing grant which was a priority on the general medical grant, which had been raised to £20,000 in 1882. This had almost no relevance in the Highlands where the few poorhouses had one or at most two trained nurses, sometimes none, and catered for a minute proportion of sick paupers. Its effect was to diminish the amount of grant left over for the outdoor medical service upon which so many Highland communities depended to pay their doctor. Medical salaries did not stand still, and sums out of all proportion to the numbers of paupers had to be raised through the rates for the medical officer's salary. The most absurd and thus frequently quoted is the case of Westray in Orkney, where the medical officer was paid £70 per annum to care for one pauper on the roll. Rates were often so high that they could not be increased any more and the larger ratepayers were beginning to complain that the rates no longer related to the actual requirements of paupers. Their concern was with what appeared to be endless financial demands from parochial authorities dominated by smaller ratepayers who were less affected by spiralling rates, in order to ensure a doctor was available for the non-pauper population.[36] This brought a contentious political dimension to a largely social problem, but it had the advantage of encouraging the larger landowners to support the idea of a state-funded medical service which in other circumstances would be ideologically unacceptable.

On appointment the Dewar Commission found that all sections of Highland society were united in wanting reform, particularly as the National Insurance Act of 1911 was virtually a dead letter in the crofting counties as it catered only for employees and the crofters were self-employed. Much of the evidence was taken while the Commissioners journeyed round the Highlands and Islands seeing the situation at first hand, and the subsequent Report made clear that the area would have to be treated separately from the rest of the United Kingdom if the health gap was to close. It was accepted by Parliament with almost no opposition and legislation setting up the Highlands and

Islands Medical Grant Scheme followed eight months later.[37] Under the scheme, money was to be made available to subsidise doctors' salaries and expenses, particularly for travel, to improve laboratory, consultant and X-ray facilities in Highland hospitals, and to extend telephone and telegraph services. Although held up by the outbreak of the First World War, in the 1920s and 30s the Highlands and Islands Medical Service was gradually implemented to form the first major state-funded medical system in Britain available to all sections of the population, albeit in a geographically limited area.[38]

By providing government funding to pay doctors' salaries and expenses, particularly for travel, the Medical Grant Scheme went a long way towards eliminating those stumbling blocks to efficient medical practice which had been so convincingly portrayed in the Physicians' Enquiry 60 years earlier and had remained unresolved ever since. The Highland ministers responding to the questionnaire had made the point that only funding from outside the area could improve medical services. The Physicians' Enquiry itself had been a clear statement by the leaders of the profession not only that medical aid should be made available to everyone in remote areas, whatever their social and financial circumstances, but also that something should be done to improve the working lives of Highland doctors. The Dewar Report restated these ideals and laid the foundation for the legislation that would make them a reality.

REFERENCES AND NOTES

1 Resolis Parochial Board Minutes, 22 September 1884; 10 December 1884.
2 RCPE Report; Return of the surgeon of South Uist.
3 Document lodged in Inverness Archives Office.
4 Arrochar Parochial Board Minutes, 23 November 1878.
5 Steel T. *The life and death of St Kilda* Glasgow: HarperCollins, 1975: 147.
6 Loch Carron Parochial Board Minutes, 9 May 1872.
7 A copy of the *Constitution and rules of the Shapinsay Medical Association* is in Orkney Islands Archives, Kirkwall.
8 Clyne Parish Council Minutes, 30 April 1907.
9 Letter to the *Shetland Times*, 27 June 1855.
10 *Dewar Report:* 12, 24.
11 *Dewar Report:* 24.
12 Stornoway Parish Council Minutes, 28 July, 25 August 1897.
13 *Dewar Report:* 19,29.
14 *Departmental Committee:* 161 para. 4852.
15 *Report of the Departmental Committee appointed by the Local Government Board for Scotland to enquire into the system of Poor Law medical relief* pp.XXXIII 1904.
16 *Departmental Committee:* 70, para. 145.

[17] This long saga is detailed in the *Minute Book of Papa Westray Parish Council* in the Orkney Islands Archives.
[18] *Departmental Committee*: 70.
[19] Taylor HP. *A Shetland parish doctor* Lerwick 1948: 19.
[20] Taylor HP. *A Shetland parish doctor* Lerwick 1948: 59.
[21] *Dewar Report:* 738; Papa Westray Parish Council Minutes.
[22] *Dewar Report:* 25.
[23] *Dewar Report:* 21-2.
[24] Papa Westray Parish Council Minutes.
[25] Information supplied by Brian Smith, archivist, Shetland Islands Council.
[26] Roland C, Rubashewsky B. The economic status and practice of Dr Harmaunus Smith in Wentworth County, Ontario, 1826-67. In: Canadian Bulletin of Medical History 1988; 5:29-49.
[27] RCPE Report; see returns of the ministers of Poolewe, Kildalton and Westray.
[28] *Dewar Report*: 20, para. 992.
[29] *Departmental Committee:* 177, paras 5307-12; *Dewar Report*: 9.
[30] *Dewar Report:* Evidence of Dr Cochran, para. 6860.
[31] Taylor HP. *A Shetland parish doctor* CITY?, Lerwick 1948: 91.
[32] *Dewar Report:* 26-7. See also Stornoway Parish Council Minutes, 30 April 1902; 26 October 1904.
[33] Lorne Poorhouse Minutes.
[34] *Departmental Committee*: 161; Evidence of Dr Duncan, medical officer to Thurso Combination Poorhouse.
[35] *Dewar Report*: 17; *Departmental Committee*: 70-1.
[36] This question is discussed with regard to Orkney in Rex Taylor, 'Doctors, Paupers and Landowners', *Northern Scotland* 4:113-120.
[37] *Highlands and Islands (Medical Services) Grant Act* 1913, 3 and 4 George V cap. 26.
[38] David Hamilton. The Highlands and Islands Medical Services. In: Gordon McLachlan, ed. *Improving the Common Weal; Aspects of Scottish Health Services 1900-1984* Edinburgh 1987: 483-90.

A cottage in Islay (from Ordnance Gazatteer of Scotland, 1885).