HIGHLANDS AND ISLANDS MEDICAL SERVICE COMMITTEE

REPORT

To the Lords Commissioners of His Majesty's Treasury

Your Lordships having remitted to us to consider at an early date how far the provision of medical attendance in districts situated in the Highlands and Islands of Scotland is inadequate, and to advise as to the best method of securing a satisfactory medical service therein, regard being had to the duties and responsibilities of several public authorities operating in such districts, we at once took steps to carry out the remit.

PART I
SCOPE AND METHOD OF INVESTIGATION

1. The Area of Investigation

1. In the absence of definite indication in the remit as to the exact area to which the enquiry was to be confined, it was decided to take evidence from the counties of Argyll, Caithness, Inverness, Ross and Cromarty, Sutherland, Orkney and Shetland and from the Highlands of Perthshire, comprising the area in which isolation, topographical and climatic difficulties, and straitened financial circumstances are found most generally in combination, and, therefore, the area generally within which the question of adequate medical provision is most pressing.

2. Preliminary Enquiry

2. With a view to facilitating the enquiry and rendering the collection of information more systematic, two sets of Query Schedules with covering letter (App. 4) were forthwith prepared and issued to all medical men, with few exceptions, practising in those counties and to other persons known to be conversant with the problem to be investigated.
3. In all 260 Schedules were issued – 102 to doctors, and 158 to other persons – and of these there were returned, duly answered, 87 by the former and 144 by the latter.

3. Sources of Information

4. Further source of relevant information and suggestion available to the Committee were various published papers and reports issued in recent years, and more particularly the Report by the Poor Law Medical Relief Department Committee of the Local Government Board (1904), and the Report on Scotland by the Royal Commission on the Poor Laws and Relief of Distress (1909). The published Reports of the County Medical Officers of Health, including the Reports on School Medical Inspection, and the various Returns and Reports issued by the Registrar-General and the Local Government Board, were also found of great assistance.

4. Itinerary

5. It was decided that the Committee should visit the area of the remit in order not only to take oral evidence on the spot, but also to investigate so far as possible, and by actual observation, the various difficulties connected with medical provision in the localities where they were understood to be particularly urgent. Accordingly, meetings were held at Inverness, Thurso, Kirkwall, Fair Isle and Lerwick; at Lairg, Bettyhill, and Rhiconich in Sutherlandshire; at Stornoway and Garrynahine in the island of Lewis; at Tarbert, Harris; at Lochmaddy in North Uist; at Dunvegan and Portree in the isle of Skye; and at Kyle of Lochalsh, Perth and Oban.

6. At the outset, evidence was taken in Edinburgh from representatives of Central Authorities connected with the Highlands and Islands; and, finally, a meeting was held in Glasgow for a like purpose, and also with a view to obtaining direct evidence as to the working of the Dispensary System of medical provision, in Ireland from two representatives – Dr Coey Bigger if the Local Government Board, Ireland, and Dr Warnock, a medical practitioner from Donegal.

5. Witnesses

7. The total number of witnesses examined was 258, selected from all classes of the community and with due regard to the various interests involved. Of these, 170 underwent oral examination. A full list will be found in Appendix 5.
8. And we would bear testimony to the readiness with which witnesses, whether in a public or private capacity, responded to our appeal for assistance, and in many cases at considerable inconvenience. The care everywhere displayed in the preparation of the evidence submitted has been greatly appreciated by the Committee.

6. Previous Investigations

9. The question of medical service in the Highlands and Islands generally, has for a long time occupied the attention of both Local and Central Authorities, and accordingly statements as to its inadequacy are abundant in published reports, and more particularly in Reports issued by the County Medical Officers of Health and the Local Government Board. From these and other sources, the evidence is cumulative and decisive that there is a large amount of suffering in the more remote Highlands and Islands unrelieved by medical or nursing attendance. The Report of the Medical Relief Committee appointed by the Local Government Board (1904) demonstrated the existence of a genuine need for a more complete system of medical attendance in many Highland and Island parishes, and they quote from a Report by Dr MacKenzie, North Uist:-[1]

"As I have frequently pointed out already, the want of sufficient medical attend and nursing have a most prejudicial effect on the well-being of the district. The loss of life, hardship and misery which this implies cannot be calculated. To a certain extent the physical evil is evident, while it tends to produce a callousness to suffering and death that becomes only too apparent in the number of uncertified deaths, especially among the aged."

10. In the opinion of the Royal Commission (1909) on the Poor Laws also, the medical attendance in the Highlands and Islands is:-[2]

"Deplorably insufficient, and the affects not only the physical well-being of the paupers but also that of the whole population."

They hold indeed, that-

"The paupers themselves are better off in respect to medical attendance tan the classes immediately above them. The problem in these parishes is to secure a minimum of medical attendance for the inhabitants."

11. Many more references and quotations equally significant from these well-known public documents might be given, but it is unnecessary. The general trend goes fully to substantiate the conclusion to which the enquiry has led us, and that is-that in many parts of the Highlands and Islands the medical attendance on the bulk of the people is insufficient, even when measured by the wholly inadequate standard of medical treatment that long neglect and privation have established in the popular mind.

PART II.

THE HIGHLANDS AND ISLANDS AS A SPECIAL PROBLEM

1. Exceptional Treatment

12. In respect of medical provision, as in other respects, the Highlands and Islands present special features which demand special consideration.[3]

In the case of the land question and education, for example, the legislature long ago recognised this and took steps to ameliorate the conditions by exceptional treatment, but medical provision has not, so far, evoked special legislative recognition. That it should receive such recognition we have no doubt, and we would now mention a few facts which, in our opinion, justify exceptional treatment of the Highlands and Islands in respect of medical provision.

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[1] Page 71. [2] Page 152, para. 30.

[3] Fletcher, 15,723; Roger M'Neill, 19,348; Murray, 17,023, 17,046; Young, 22,131

2. *Difficulties of Travel*

13. The greater part of the area under review is sparsely[1] peopled. A considerable portion of the population is from twenty to thirty miles from the nearest doctor.[2]

The country is rugged,[3] roadless, and mountainous, and where not composed of islands is very largely peninsular on the seaboard, and inland is broken up by lakes and rivers.[4]

The weather conditions, too, and particularly in the winter-time, add enormously to the difficulties of travel.[5]

To quote from the evidence.

Mr Patten Macdougall, C.B., the Registrar-General, says:-[6]

"I happen to know of a case where a doctor was called from Oban to a shepherd's house which was about 12 miles off. This was at night-time in the winter. He went by road, but he could not get nearer than some two or three miles from the shepherd's house. He was caught in a snow storm, lost his way, had to return, and then be guided back to this place by a shepherd. He arrived there in the middle of the night… I know other instances where doctors have sometimes to go to an illness not very far from Oban, and there they have to cross a ferry, and then afterwards (there being no conveyance in the Island) they have to walk three or four miles before they get to the house which they have been called. There are cases which are very common all over the Highlands."

Rev. Father McNeill, Eriskay:-[7]

"We can never depend on getting a doctor when we want one. He has to go five miles by road and then three miles by sea, and in bad weather it is not possible to cross the Sound."

Mr Macrae, Knoydart:-[8]

"There are many days in the year that you cannot get a doctor owing to the weather."

Mr Macgregor, Bunessan:-[9]

"It is a bad ferry (to Iona)). It is shallow, and there is a heavy sea, and the current is very strong. There are many days in the winter-time when it cannot be crossed, and occasionally there are certain days in the summer-time when it cannot be crossed."

Dr Macdonald, Badenoch:-[10]

"The furthest homestead from your house is about twenty miles?—There is no road at all. I have nine miles of path.

"You have certain mountain trakcs that are very difficulty to negotiate?—I have to go on foot. I can go on horseback sometimes.

. . . . . .

"You are the Dr Macdonald are you not, who got the hero's medal for crossing a hill at the risk of your own life to attend a patient?—Yes."

14. Such physical conditions render medical service difficult and at times dangerous or impossible, with the result that not alone isolated homesteads but fairly populous districts may for lengthened periods be without any means to relieve suffering or stay otherwise preventable disaster.

As to this we would quote from the evidence of Mr Graham, fisherman, Rona:-[11]

"It is just the Portree doctor we have, and he must come in a boat, and in the winter-time he cannot come. We may possibly have to wait a fortnight for him, and the patient will be suffering pain all the time. It is quite possible that the patient may die without seeing a Doctor at all."

And of Dr Cochran, Shetland:-[12]

"I have known a case being without medical attendance there (Papa Stour) for eighteen days simply because they could not cross the Sound."

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[1] Maxwell, 558 ; Jeffrey, 683-85 ; Lovat, 2393 ; Macpherson, 4484-85 ; Ross, 11,292-93 ; Macleod 11,805 ; Graham, 17392-404 ; Roger M'Neill, 18,252.

[2] Mackenxie, 10-23 ; Jeffrey, 695 ; Macdonald 1229 ; Leach, 1646-51 ; Bremner, 8349 ; Macdonald, 16,084 ; Norris, 17,791 ; Macdougall, 20,424 ; Locheil, 23,417. 3 M'Neill, 20,697

4 Macphail, 352,456 ; Wallace 3142-43 ; Duffus, 4685 ; Park, 5943 ; Cochran, 6858, 6949 ; Fotheringham, 7779 ; Grant, 7809 ; Mackinnon 12,626-27 ; Macaulay 14,225-29 ; Roger M'Neill 18,297 ; M'Neill 20,690.

[5] Sinclair, 5465 ; Gibson 5692 ; Park, 6024 ; Mackenzie 13,691 ; M'Kechnie, 19,945-50 ; Reardon, 20,021 ; Macrae, 21,083.

[6] Patten Macdougall, 243. [7] M'Neill, 20,720. [8] Macrae, 21,083.

[9] Macgregor, 22,346. [10] Macdonald, 2702-03, 2751. [11] Graham, 16,416. [12] Cochran, 6842.

Dr Roger McNeill, Medical Officer of Health for the county of Argyll, also writes:-

"The population is so scattered that only a comparatively small number are within reasonable reach of a doctor in any one locality…. The difficulty of communication sometimes makes it impossible to get medical attendance in time to save life. I know myself of two such cases which occurred in the island of Colonsay, before a resident doctor was provided where two married women died before a doctor could be got from Islay – leaving two young families of seven and five, ranging in age from birth upwards, uncared for."

3. Circumstances of the People.

15. Under such conditions the cost of medical aid must obviously be high and, however reasonable, must in the great majority of cases be prohibitive.[1]
The bulk of the people are, over large sections of area, in very straitened circumstanes, especially at certain periods of the year, and are consequently unable to pay for medical attendance even when the fee, having regard to time and distance, is quite inadequate to compensate the doctor.[2] Ready cash is a rarity with the ordinary crofter; and the amount is at most so small that when he has provided for the necessaries of life and paid his rent and rates he has, as a rule, little or nothing left to pay the doctor.[3]

Mr Maxwell, Secretary to the Local Government Board, estimates that after allowing for the supplies of food and fire produced by the croft, and for rent and rates, the gross annual income of the average Lewis family—numerically the largest in the country—is £26, and there are other Hebridean districts where the figure is put as low as £10.[4]

16. The evidence as to the general inability to pay adequate fees is quite conclusive:--
Dr W. MacLean of the Seaforth Sanatorium, Ross-shire, replyig to the question whether the ordinary crofter is able to pay an adequate fee for medical attendance, says:--[5]

"No, he is able to pay nothing, because is payments are practically exchanging in kind. He rarely sees ten sovereigns altogether from one year's end to another."

Dr Charles Macpherson, Deputy Commissioner of the General Board of Lunacy, also says:--6

"I had the parish of Laird, and the parish of Kincardine in Ross, and I should say that a doctor might count on practically 20 per cent of his work being gratuitous work…. If you went to see a crofter fifteen or twenty miles away, he might pay for one visit. If you sent these people a bill for more than 40s. or 45s. you might as well strike them off your books. They could not pay it."

As regards, the crofter's income, Mr John Maclean, Coigach, says:--[7]

"I cannot give you an idea of the yearly income of a crofter in my district, but I can tell you this—that there are crofts in my district where the inome of the croft would not pay the herd boy."

Father Cameron, Barra, writes:--

"To pay anything like an adequate fee is beyond the means of nine out of ten of the population."

Dr Jamieson, Scourie:--

"The average ability to pay fees for medical attendance is very low indeed";

aslo Dr Mackay, Lochcarron:--

"There is a large section from whom I never expect a fee";

and Dr Roger McNeill, Oban:--

"Owing to the distance, the time taken up, and the expense of hiring conveyances by sea or land, the fees that must be charged for patients in such

1. MacGregor, 4438-40; MacKenzie, 10,935-36; MacCallum, 21,242-43.
2. Maxwell, 612; Jeffrey, 900-924; Bruce, 1544; Leach, 1771-76; Adam, 2887-89; MacAskill, 10,082; MacPherson, 15,055-56; Macrae, 16,552-62; Knox, 17,284; Graham, 17,429; Mackintosh, 21,829-33; Young, 22,137-39; Gilmour, 22,835.
3. Leach, 1769; Dick, 4175; Macpherson, 4510; Meade, 4565-67; Park, 5898-99; Anderson, 7433-34; Morrison, 12,813; Mackenzie, 12,906-07; Macdougall, 20,375-76; Macrae, 21,143.
4. Macdonald, 11,556-57; Nicolson, 16,321; Macdougall, 20,365-69; Cameron, 20,523; *Vide* Report by Mr Miller and Mr Maxwell on the Lews Parishes (1906), page xxxi.
5. Maclean, 3449. 6 Macpherson, 4510-11. 7 Maclean, 3674.

places are much beyond what people of the same means would have to pay elsewhere, with the result that in may necessitous cases no doctor is consulted, or if called in, it is often too late. What may appear to the patient or his friends to be an exorbitant charge often leaves the doctor but a very small margin when travelling expenses are deducted."

Some medical witnesses placed the number of unpaid visits as high as 75 per cent.

17. In these circumstances medical treatment becomes eleemosynary, and therefore uncertain. There is, indeed, conclusive evidence that it is not available for a large number of cases of illness, especially among poor non-pauper people. According to the testimony of witnesses such cases constitute a large percentage of the population; and the high percentage of uncertified deaths—a subject treated later—is further conclusive evidence in the same direction.

4. Insanitary Dwellings.

18. Any study of the problem of medical provision in the Highlands and Islands, and more particularly in the Hebrides, that did not take into account the vital factor of the housing of people would be essentially incomplete. In our opinion, based on actual observation, this lies close to the root of the whole matter. So long as dwellings in so many parts of the are continue in a grossly insanitary conditions,[1] so long will the local conception of medical requirements be crude, and the treatment of disease more or less ineffective.

19. In recent years the island of Lewis has, in this respect, attained an unbelievable notoriety, both in the public press and in official reports; and though there is evidence of improvement2 here and there, yet, judging by the accounts given to us on the spot and by our own observation, the old order at the present rate of progress must prevail far into the future.

By the way of further recent proof, we would refer Your Lordships to the last Report in Lewis by Dr Murray, the District Medical Officer of Health.3

The frequency of chest complaints in measles and whooping cough, and the heavy child mortality therefrom, the recurrent outbreaks of enteric and typhus fever, he attributes mainly or wholly to the grossly defective housing of the people.

Concerning consumption, he refers to "houses of practically only one room, with damp walls, damp clay floors, sunless interiors, a vitiated and smoky atmosphere, and the cattle under the same roof with the human inmates, the surroundings usually badly drained, and the site often damp. When a case if phthisis occurs in one of these houses, isolation is impossible. In too many cases the patient spits on the floor of churches and meeting-houses, scattering the tubercle bacilli all round. When one considers also the probability of the cattle being affected with tuberculosis, under the conditions prevailing what else could we expect than a wide prevalence of the disease."

And yet, in the parish in which these evils are most rampant, there is but one doctor to a population of 7000, spread over an exposed seaboard twenty-seven miles in length.

That such a condition of affairs as we found in Lewis should exist with twenty-four hours of Westminster is scarcely credible. Nor is it credible from a national standpoint.

20. In this connection it is worth recording that between the Regular Army, the Royal Navy Reserve, the Army Special Reserve, and the Territorial Force, over 4000 Lewis men are being trained in arms. In the words of Dr Mackenzie, Stornoway, "Every able bodied man in Lewis is a trained man."

5. Primitive Custom and Habits.

21. In some parts of the Highlands and Islands there still remains a belief in inherited skiill and traditional "cures".[5] And, as might be expected, we found that this obtains more firmly the more difficult it is to get proper medical attendance.

1Dick, 3990-93; Maclennan, 4261 4271; Sinclair, 5476; Bremner, 8507; Mackenzie, 10,939; Cameron, 12,016; 12,188; Ross, 14,481-82; Mackinnon, 12,641-42; Tolmie, 13,538-41, 13,574-76; Mackenzie, 13,931-33; Macmillan, 14,149; Fletcher, 15,844; Macdonald, 16,640; Roger M'Neill, 19,452; M'Neill, 20,759, 20,767 (A), and 20,765; Locheil, 23,427; Gilmour, 22,848-53; Hunter, 22,974.

2MacRae, 8812; Macmillan, 14,148; Anderson, 18,119; Cameron, 20,574; M'Neill, 20,737; Campbell 21,537.

3Annual Report on Public Health of the County of Ross and Cromarty (1911) pp. 26, 27, 34, 35.

4Mackenzie, 10,676

A witness from the remote island of Rona (Skye), which a doctor rarely visits, was particularly interesting in a description of Gaelic of some of the various "cures" which in default or disregard if medical advice are frequently resorted to. He told, for example, of a "cure" recently applied in the case of an epileptic. A black cock was buried alive beneath the spot where the patient had had the first attack of epilepsy. He also described the successful treatment of a woman suffering from tinneas on righ ("King's Evil" i.e. bone or gland tuberculosis) by a seventh son to whom she had gone all the way to the island of Scalpay, Harris.

Referring to the prevalence of this form of treatment, Dr Tolmie, South Harris says:-1

> "When they have bone disease they use the old remedies. There was a man suffering from keratitis and he was not getting well. It is a difficult disease to cure in an old person. He was not getting on, and I had to go over one very wild day to see him, and when I arrived he was away from home—it was a fearful day—and he had to drive nine miles and walk about another six to an old lady in Licisto. The old lady made up some rhyme and mixed some grasses with water and sand and sung. He came back and said he was a little better. The seventh son is supposed to be able to cure such disease. I know of one case of a person who had a curbuncle on the back of his neck, and it did not heal, and he got a seventh son to come to his house, and every night for a long time, he put cold water on it and a sixpence round his neck."

It is in such a field of ignorant faith that the "skilly" woman can practise all her arts at will, and with greatest danger where she is most in demand—and that is, in cases of maternity.

6. Inferior Diet

22. Another relative fact, and one of serious import in connection with our enquiry, is the character of the food consumed, especially by the children. For example, we were told that in South Uist it is rarely that any of the produce of the croft, with the exception of potatoes, is use for food. No meal is ground, the surplus sheep and cattle are sold for urgent cash, every egg is bartered for shop commodities, and the milk supply is insufficient, especially in winter. The excessive indulgence in over-brewed tea, especially by children, is deplored by several witnesses.2 Dr Murray writes:--3

> "The great feature in the decadence of the school child's menu is the abise of tea. The good old porridge pot has fallen from its high estate and the tea-pot has been exalted in its place. Probably over 50 per cent go to school on a breakfast of tea and loaf bread, the former usually long brewed…. A large proportion of children live so far from wschool that they cannot get home for a mid-day meal. The may walk from one to two and a half miles to and from school in all sorts of weather, and they work at their lessons all day upon this inadequate breakfast. In some places it is difficult to induce the children to even take a "piece" to school. All this works untold mischief, and it is impossible for the average child—say in the afternoon—to be in a fitly receptive condition for education. Going on from year to year in this way, the physical stamina of a child is bound to be undermined, and they are sent out into the world with their powers of resistance to diseased, such as consumption, greatly reduced."

On this question the following evidence by Dr Reardon, South Uist, is not a little disconcerting:--4

> "Have you much tuberculosis?—Yes.
> "Both kinds?—Yes, pulmonary and non-pulmonary.
> "Is it increasing?—I am sorry to say it is.
> "What do you blame?—To begin with, there is no foundation for the children. The mothers don't nurse their chidren, and at the age of three months the are supposed to be able to take porridge and sops. The reason for that is that the milk of their cows is given to the calves, and there is no milk
> for the children. It is a case of survival of the fittest.
> "They are rearing calves instead of rearing children?—Yes.
> "Why do the women not nurse their children?—They are not able, they have not the strength."

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1. Tolmie, 13,587
2. The Mackintosh, 2176, 2221; Bremnner, 8622-29; Macleod, 9544-56; Mackenzie, 10,683-84; Provost Mackenzie, 10,939; Victor Ross, 11,405, 11,440; Cameron, 12,056; Burns, 12,737, 12.742; Mackenzie, 13,570; Fletcher, 15,790; Norris, 17,764, 17,844-47; Reardon, 20,302; Macdougall, 20,459-64, 20,468-72; Cameron, 20,544.
3. Ross and Cromarty Committee on Secondary Education, Report by Medical Inspectors (1911), p.40.
4. Reardon, 20,164-65, 20,167-69

Dr Mackenzie, North Uist, also attributed the prevalence of phthisis in the Hebrides to the inferior feeding in early years.

Dr Jamieson, Scourie, commenting on the defective nourishment of the people generally, says:--2

"I think the school children here are underfed."

On this subject Mr Ronald Macdonald, Portree remarks:--3

"The defective teetch is a disquieting element, as the children in these islands used to have first-class teeth until within the past thrity years. The change in the diet of the children is no dount responsible for the falling off in this respect—the abandonment of oatcake for softer substitutes and the giving up of porridge and milk in favour of tea."

23. Improvement of the medical, and even more of the nursing service, would go far to restore physical stamina, in respect not only of the treatment and prevention of disease, but of its wholesome educative influence on the physical and social conditions generally.

7. Rural Depopulation

24. In some districts of the Highlands and Islands where the problem of medical provision is most acute the tide of rural depopulation has not been quite so strong as elsewhere. In Lewis, indeed, the population has slightly increased in the last decade, and is now close to 30,000

Here and elsewhere, however, there has been steady emigration to the Colonies and to the cities of the South, and it might be thought that in consequence the need for medical service should decrease proportionally; but as to this it has been pointed out to us, and not without some force, that even if the medical service hitherto provided could be regarded as satisfactory, the decrease of population would not justify a corresponding decrease in medical provision.4 It had to be remembered that the emigrants have been mainly strong and fit, leaving behind a larger proportion of the weak and unfit, who at all times and everywhere claim the greater share of medical attention.5

To quote again from Dr Roger M'Neill:--6

"I think the strong health, and enterprising members of the population have been leaving the country so long that it is bound to have had an effect on the present population. leaving the weak and unhealthy and incapable behind."

25. The opportunities of better medical attendance offered by populous centres are alleged not only to be material inducement, especially to married people, to migrate from the remote districts, but also to discourage the return of town-people to the land.

In this connection important evidence was given by the Rev. M. M'Callum, Muckairn:--7

(Witness.) "Take, for instance, the forest of Inverleivor on Loch Awe side; I see they are advertising for married people without families."

(Chairman.) "And this is the Government?—Yes, I think it may be taken as token… O have a copy of the advertisement in the Oban Times, and I don't wonder at it when there is no provision. This is the advertisement—'Wanted, married couple, middle-aged, without family.' Then here is another—'Wanted, middle-aged widow or spinster for caretaker.' Of course there is no doubt it is a danger to have maternity cases occurring in these out-of-the-way places. I have no doubt that a great deal of the depopulation is caused by the fear of anything happening in cases of that kind so far away from doctors, and not even having a nurse. It is a terrible distress".

And by Mr Ronald Macdonald, Portree, who states:--8

"The crofter who resides at a distance of twelve or thirteen miles from a doctor—as a great many in Skye do—is very greatly handicapped when illness comes. In a city, people in his station life can get medical advice for a few

1 Mackenzie, 13,755 2Jamieson, 9985 3 Macdonald, 16,460
4 David Macdonald, 2022; Wallace, 3137; Maclean 3667-73; Meade, 4563; Durran, 4758; Johnston, 5581; Gibson, 5682; Tulloch, 5782; Saxby, 7136. 5The Mackintosh, 2225; Cameron, 12,194.
6Roger M'Neill, 19447. 7MacCallum, 21,185-87, 21,209.8Macdonald, 16,460

shillings, while here the cost of a trap alone would be 15s. The doctor would take four hours to pay a visit at this distance, and another 15s. would not be unreasonable in his case, so that, as matter at present stand, either the patient or the doctor has to go without any fee at all. If it is desired to encourage people to stay on the land, something must, I think, be done to make it easier for the sick and ailing in the country villages and townships to receive medical advice and attendance."

8. The Burden of Local Rates

26. As already indicated, the average ability of the patient to pat doctors' fees is at best so very low as to be almost a negligible factor in the provision of medical service. That any such service exists at all is due to the fact that the Parish Council, taking advantage of its statutory obligation to provide medical attendance for the outdoor sick poor, has appointed Parochial Medical Officers at a retaining salary which is out of all proportion to the number of paupers, and, in many cases, a heavy charge on an otherwise overburdened rate.[1] In several parishes the charge amounts to over £15 per pauper per annum, entailing a rage of from 9d. to 1s. per £. of gross rental is 15s., the rate for medical service along amounts to 1s. 3d.[2] It may be mentioned in passing that the total rate per £. Of gross rental is 19s. in the neighbouring parish of Uig, which has to give the doctor a retaining salary of £200 a year. Such a high total rate, however viewed, and even though depending to a certain extent on the low assessable rental precludes the expectation of further aid from the parish purse to better medical services.[3] And the adequacy of the service is ordinarily lowest where the rate is highest. In the parish referred to there is only one doctor for 4750 people living in townships that are scattered over an area of 180 square miles, still largely roadless, and very much cut up by inlets of the sea.

27. So far, then, the Parish Council is the only public body that has taken any steps towards the provision of general medical attendance on the inhabitants, but, as shown above, any further strain on its resources under existing conditions seems in most places out of the question.

28. It has also to be pointed out that, concurrently with increase of outlay in this direction, the income derived by the parish from the Grant in Aid of Medical Relief in Scotland has been yearly growing less. From a contribution of 10s. 9d. per £. Ten years ago it has fallen to 4s. 3d., and of the total grant of about £13,000 available for medical relief in Scotland less than £3000 went last year to the Highlands and Islands.

9. The Insurance Act only Partially Operative.

29. The industrial situation in the croftng districts renders the National Health Insurance Act much less operative in the Highlands and Islands than in other parts of Scotland. Except for casual employment and short periods of service at such occupations as ghillieing and occasional fishing, the crofting population is outwith the compulsory provisions of the Act.[4] That amount of voluntary Insurance is at present negligible, and there is reason to believe that in some cases the contributions made during the temporary employment referred to may not be supplemented by the number of contributions necessary to entitle such insured persons to the minimum benefit under the Act.

30. The general opinion of witnesses, and more particularly of those of them who are conversant with the frequent failure of medical clubs, even when the subscription for medical attendance on the whole family was much below the amount which would entitle an insured person to medical benefit under the Act, is that any system of insurance by voluntary contribution would in the economic conditions obtaining among the crofter population have but little chance of success.[5]

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1 Maxwell, 609; The Mackintosh, 2209, 2278; Lovat, 2347; Bruce, 7470, 7485; Mackenzie, 10,949-51, 11,014; Macdonald, 16,460; Murray, 10,018-20; Mackenzie, 17,125; Ross, 19,857; MacRae, 21,040, 21,094-99; Young, 22,125.

2 Maxwell, 551 (17). 3 Murray, 10,501; Anderson, 11,061 (A); Smith, 11,064-69

4 Lovat, 2247-53; Grant, 3220-28; Henderson, 3463-69; Garrioch, 6153-63; Macdonald, 8106-23; Mackay, 8245-69.

5 Macdonald, 1220-1340; Moir, 1391-1412; Brucce, 1529-33; Mackenzie, 1562-65; Leach, 1750-63; The Mackintosh, 2183-86, 2272-74; Lovat, 2375-77.

31. To summarise the foregoing conditions, which make medical provision in the Highlands and Island a special problem, we are of opinion:--

(a) That on account of the sparseness of the population in some districts, and its irregular distribution in others, the configuration of the country, and the climatic conditions, medical attendance is uncertain for the people, exceptionally onerous or even hazardous for the doctor, and generally inadequate.
(b) That the straitened circumstances of the people preclude adequate remuneration of medical attendance by fees alone.
(c) That the insanitory conditions of life prevailing in some parts render medical treatment difficult and largely ineffective.
(d) That in default or disregard of skilled medical advice and nursing, recourse is not infrequently had to primitive and ignorant methods of treating illness and disease. These methods are a source of danger, especially in maternity.
(e) That there is danger of physical deterioration from defective dieting, and more markedly in the infant and juvenile population.
(f) That rural depopulation is not a feature of the whole area of our remit, and that even where notable, the necessity for medical provision is not materially reduced.
(g) That the local rates, from which the doctos' income is mainly derived, are in many cases overburdened.
(h) That owing to the industrial conditions the Insurance Act is only very partially operative.
(i) That, in short, the combination of social, economic, and geographical difficulties in the Highlands and Island—not to be found elsewhere in Scotland—demands exceptional treatment.

PART III.

CONDITIONS AFFECTING THE ADEQUACY OF MEDICAL SERVICE.

1. Introductory.

32. Viewed in the light of foregoing conditions and requirements the existing medical provision can certainly not be regarded as adequate. Yet this, we believe, is due not so much to shortage in the total number of general practitioners requisite—though they are obviously too few in some localities[1]—as to defective means of locomotion and communication, and to a variety of conditions vitally affecting the welfare of the profession, which conditions in turn are calculated to discourage the average practitioner in the exercise of his profession, and to prevent him from rendering service commensurate with the real needs of the people.[2]

2. Motor Locomotion.

33. It is clear from the evidence that the use of motor locomotion by land and water would immensely increase, and we are inclined to believe, would, in some places at least, double the working capacoity of the existing medical service.[3] Ordinarily, however, the doctor cannot afford to purchase a motor care or motor boat; and in many instances he requires both. A few of the younger men have provided themselves with motor cycles, which, however, are far from suitable on Highland roads.

3. Telephones.

34. The advantage of providing a telephone service between the doctors' residence and certain well-chosen call offices was urged on the Committee, and it was suggested that the existing postal telegraph system, already in rural parts largely worked by telephone, might with comparatively little trouble be adapted for the purpose.

Expert evidence on this point was taken by the Committee from Dr Magnus Maclean, Professor of Electrical Engineering in the Technical College, Glasgow. He states:--[4]

1 Murray, 10,571; Anderson, 11,045; Macdonald, 11,635; M'Rae, 11,723; Ross, 12,279-81; Mackenzie, 12,919, 12,934-44; Roger M'Neill, 19,352-55.
2 Mackenzie, 13,818; Fletcher, 15,933-34; Mrs Stirling, 17,939; M'Nicol, 19,566-67; MacCallum, 21,268, 21,259-96.
3 Patten Macdougall, 320-22; Jeffrey, 860; Johnston, 2633; Wallace, 3047, 3117; Maclean, 3618; Heddle, 5012; Robertson, 6528, 6530; Saxby, 7141-51; Fotheringham, 7756; Sandieson, 7681-83; Bremner, 8457; Simpson, 8732; Mennie, 9285; Jamieson, 9817-26; Murray, 10,497, 10,500; Victor Ross, 11,378; Norris, 17,796.
4 MacLean, 23,485 and "Explanations".

"Telephones are already in use in some districts in the Highlands. For example, the whole of the west and north parts of Skye have telephone instruments for telegraphic work, with Dunvegan and Portree acting as exchanges with two instruments in each place.

"I see no reason why every one of these sub-post-offices should not be made into call offices for the public."

And he is satisfied that the expense entailed would be inconsiderable.

There is abundant evidence to show that liberal extension of telephone communication1 in connection with the medical service would be a great public boon, and preminently in the case of insular and remote centre where a trained nurse is stationed. She could discuss a case with the doctor and take his detailed instructions.2
At present efforts are often made to communicate by telegraph, which for purposes of medical inquiry and advice, is cumbersome and unsatisfactory.

The Committee were surprised to be told that the Post Office was contemplating the withdrawal of telegraph service from some of the remote Western Islands.3 We strongly deprecate any such action.

4. The Doctor's Income

35. That the average income of the medical profession was low those who know the Highlands and Islands intimately were well aware, but we were not prepared to hear that so many medical men were eking out a living, and some of them trying to rear and educate families, on incomes well below the limit of income tax. The facts elicited by Query 26 on Return of Information No. 1 show that of forty-seven doctors who gave the return requested, twenty-eight are earning an average gross income of £200, which yields, after rent and travelling expenses have been deducted, a net annual income of £120; and calculated on the same basis the average net income of the forty-seven is just over the income tax limit.* The lowest figure given in the returns is £100 gross income, which yields a net weekly wage of between a pound and thirty shillings. And there are cases worse than these. A prominent witness,4 after stating that in many parishes the doctor does not earn more than £50 to £70 per year, went on to say:--

"In one island that I know the doctor only gets £5 a year from the Parish Council, and I am sure he cannot make more than £40 a year. He lives alone, and when I called he had his coat off and his sleeves up, and was cooking his dinner."

36. Another obvious result of the low remuneration, is that the doctor is seldom able to provide against old age and infirmity—a serious disadvantage to him, which may also react prejudicially on the public welfare. In order to subsist he must continue in harness long after he is physically unfit to discharge his duties efficiently.5

Some form of superannuation scheme seems worthy of consideration.

5. Security of Tenure.

37. The importance which is, we think rightly, attached to security of tenure makes it a very prominent feature of evidence.

It has been a long standing grievance with Parochial Medical Officers that whereas the County Medical Officer of Health, the Poorhouse Medical Officer, the Sanitary Inspector, and the Inspector of Poor, can be dismissed only by or with the sanction of the Local Government Board, the Parish Council ha absolute power of dismissal over the Parochial Medical Officer, and cases were cited where the Council appear to have used the power harshly.6

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1 Patten Macdougall, 242, 319; Jeffrey, 847; Macdonald, 1364; Macdonald 1364; Bruce, 1484; Leach, 1704-09, 1782-85; The Mackintosh, 2163, 2205, 2236; Lovat, 2331-53; Ellice, 2496; Grant 3233-34, 3251; Maclennan 4273; Durran, 4775; Tulloch, 6013; Robertson, 6645; Yates, 7089; Bruce, 7508; Sandieson, 7685-96; Grant, 7987-88, 7994-98; Maclennan, 8909; Jamieson, 9854; Fotheringham, 17692-93; Norris, 17,731, 17,736; Drummong, 18,197; Madougall, 20,487; Locheil, 23,435.

2 Rumsey, 994; Maclean, 3444; Park, 6019; Murray, 10,462; Ross, 11,331, 11,333, 11,362; Cameron 11,997.

3 Macmillan, 14,132; Wilson, 14,500

* This calculation is based on the figures given in the Return, which show that on average the net income is six-tenths of the gross income.

4 Jeffrey, 118. 5 Mackenzie, 13,818, 13,826; Ross, 19,891; De Sylva, 22,074

5 Maxwell, 551 (11), 574, 589, 662-665; Jeffrey, 744, 829, 831; Murchison, 10,848; Campbell, 15,326-28; M'Rae, 16,620-23l.

But, briefly, the evidence amounts to this, that while cordial relationship between the Parochial Medical Officer and the Parish Council is the rule, and cases of unjustifiable dismissal the exception, there are occasional instances of harsh treatment of the doctor by the Parish Council, and this has created in the minds of the profession a feeling of district, which, in turn, has reacted detrimentally on the quality of the service in parts of the Highlands and Islands.1

38. We believe that this is the case, and that pending legislation in the matter of the readiest remedy is for both parties to stipulate that, in the even of disagreement or dissatisfaction, either side shall have the right of appeal to the Local Government Board for final settlement.2

In this connection we agree with the recommendation of the Departmental Committee of the Local Government Board (1904):--3

"That the tenure of the Parochial Medical Officers be placed on the same footing as that of Medical Officers of Health and Sanitary Inspectors under the Public Health (Scotland) Act, 1897. We are not favourable to the proposal of an *ad vitam aut culpam* tenure".

6. The Doctor's Dwelling House.

39. The provision of a dwelling-house for the doctor that would be satisfactory both as regards accommodation and situation is of extreme importance.4

Complaints were frequent that the house provided is ordinarily too small, is, in many cases either wind nor water-tight, is insanitary, and lacking in even the most elementary conveniences of civilised life.5

40. Moreover, instead of being centrally situated and so affording ready access to all parts of the practice, the doctor's residence is occasionally found in the remote corner of a large parish and distant some fifteen to twenty miles from half his patients. The main reason given for this anomaly, which seriously affects both the cost and readiness of medical attendance, is that the Parish Council, however willing in the matter, have not the requisite statutory powers to build or buy a suitable doctor's house.6

41. On this question, Mr Maxwell, Secretary of the Local Government Board, writes:--7

> "In some parishes it is difficult for the medical officer to find a suitable house. It has, unfortunately, been held that Parish Councils have no power to provide a house for the medical officer. I consider the provision* of a suitable house is second only to the provision of an adequate salary."

And there was evidence that the local proprietor or agent is occasionally responsible for this difficulty. Mr Tulloch, Eday, says8:--

"It is the trouble with the house that is the great difficulty… there were proposals made to build one. The first thing was to go to the proprietor's agent for a site. At first they were favourable, and then they refused and would not give a site".

And Dr Moir, Inverness:--9

"I know of a case where a doctor had the use of a house, and the relations between the doctor and the factor became strained and he was asked to move."

In marked contrast are a School Board's powers in regard to sites and buildings.

7. Holidays.

42. In view, of the inadequacy of his remineration it is not surprising to learn that the average doctor is but seldom able to take a holiday. The cost thereof, including the cost of a locum tenens, is beyond his means. This is regrettable in many respects. An

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1 Johnston, 2689; Macdonald, 2741.
2 Mackenzie, 1581; Meade, 4591; Cochran, 6898; Camerons, 12,026; Ross, 12,265-67; Chisholm, 20,895
3 Page 88.
4 Maxwell, 551 (10); Jeffrey, 703-07; Macleod, 3840-42; Tulloch, 5793-94; Grant Macdonald, 15,957
5 Gibson, 5665, Tuloch, 5794; Taylor, 6969; Saxby, 7152-53; Anderson, 7392; Jamieson, 9836-44, 9860; Victor Ross, 11,278-79; Tolmie, 13,626-28; Mackenzie, 17,088-89.
6 Jamieson, 9869-70; Macdonald, 11588-89; Mackenzie, 13,818; Mackenzie, 17,090; Macnicol, 19,498; Reardon, 20,058; Cameron, 20,605 7 Maxwell, 551 (10)
8 Tulloch, 5793-94. 9 Moir, 1381.

Annual holiday of , say, four weeks would go far to mitigate the disadvantages of isolation and to relieve the strain of medical practice.[1]

Every doctor ought to have an opportunity of attending one of the post-graduate courses not so well organised by the great medical schools.

43. Such conditions of medical service are not inspiring, and when consideration is given to the hardships of travel to be endured, the isolation, and consequent social and educational disability in rearing a family, and the unsatisfactory conditions, hygenic and other, under which, as a rule, a doctor has to conduct treatment of disease, it is a matter for wonder that so many men of high professional attainment as we met should choose to continue to practise their profession in the remote parts of the Highlands and Islands.[2]

Their reason for choosing such a sphere of labour are varied. Some are natives of, or have family connections with, the districts in which they practise, and on that account have been drawn thereto; others have gone to the Highlands for reasons of health, or have been attracted free, open-air life of the country. Many stay but a short time. Some, who delay their departure, in most cases married men, are induced by the uncertainties of change to settle down and make the best of it.

It is clear, however, that this attitude of toleration is not a wholesome one, and that a primary step in the direction of rendering medical service adequate should be to place a doctor in such a position of financial competence and professional security as would enable him to carry out the highly responsible duties of his post with the fullest efficiency, zeal and contentment.[3]

8. Conclusions

We are therefore of opinion that the general efficacy of the existing medical service is impaired:-

(a) By inadequate remuneration.
(b) By inability to provide for old age and infirmity.
(c) By difficulties of locomotion and communication.
(d) By insecurity of tenure under the parochial system of appointments.
(e) By the difficulty of obtaining suitable house accommodation.
(f) By lack of facilities for holidays or post-graduate instruction.

Our general recommendations as regards medical service will be found in Part IX.

PART IV.

EVIDENCE OF INADEQUACY OF MEDICAL ATTENDANCE

1. Uncertified deaths

44. The general trend of the evidence as set forth in the foregoing portion of this Report demonstrated, in our opinion, that the existing medical attendance in the Highlands and Islands is inadequate.

45. But the most conclusive evidence on this point is to be found in the statistics of uncertified deaths.

46. To take the figures furnished by Dr Macdonald, Medical Officer of Health for the county of Inverness, the percentage of uncertified deaths to the total number of deaths in the county during the past ten yeas was 29; and in the case of 10 parishes it ranges from 41 in the parish of Snizort to 59 in the parish of the Small Isles,--an average percentage of 48 for the 10 parishes. That is, out of a total of 3825 persons who died, 1821 had not had medical attendance for some time prior to their death.

47. Dr Crawford Dunlop, Superintendant of Statistics, Register House, Edinburgh, discussing the number of uncertified deaths in the county of Ross during 1908-10, states:--[4]

"In the insular rural districts there were 326 uncertified deaths, amounting to 47.5 per cent. of the total. The insular registration districts of the county show the following results--

1 Jeffrey, 861-65l; Moir, 1400; Leach, 1723-25; Johnston, 2622-23; Park, 5936, 5950-53; Cochran, 6824-25; Taylor, 7022-23; Saxby, 7216-19; Macdonald, 11,667-70; Cameron, 12,027; Mackenzie, 13,818.
2 Park, 5937-38; Saxby, 7227; Felix Maclennan, 8939-41; Ross, 12,313; Grant, 19,719.
3 Dunlop, 545-47; Macpherson, 4518; Murray, 10,502, 10,572; Victor Ross, 11,469; Macdonald, 11,592; Ross, 12,356-57; Campbell, 15,315; Macdougall, 20,491-92.
4 Dunlop, 504, 505.

Uig,	76 uncertified deaths,		69 per cent.	
Carloway,	77	"	61	"
Lochs,	81	"	42	"
Barvas,	92	"	36	"
Stornoway,	106	"	17	"

"Among the mainland registration districts there are the following:--

Sheildaig (Applecross),	25 uncertified deaths,		78.1 per cent.	
Coigach (Lochbroom),	38	"	80.9	"
North Gairloch,	19	"	46.3	"
Lochbroom,	38	"	40.4	"
Lochcarron,	21	"	33.9	"
Kincardine,	14	"	33.3	"
South Gairloch,	43	"	32.8	"

By way of contrast it may be state that the average of uncertified deaths for the whole of Scotland during the past five years is about 2 per cent.

48. Mr Jeffrey, Secretary to the Scottish Insurance Commission, states that there are quite a number of parishes in which the medical service is inadequate, and in proof of this he gives the following striking figures:--1

	Years	Total Deaths	Certified	Uncertified
Farr,	1904-08	240	140	100
Lochbroom-				
Coigach	1901-10	148	9	139
Ullapool	1901-10	126	90	36
	Coigach paupers	12	1	11
Ardnamurchan—				
Kilchoan	1907-9	33	3	30

Another striking fact disclosed in evidence is that in the Waternish portion of the local parish of Duirinish, Skye, there were of the 9 deaths in 1909, and of the 12 in 1911, none certified, even though there was a doctor at Dunvegan and another in Edinbane, about seven and eight miles respectively on either side of the district.2

49. While it may not in every instance be true that non-certification connotes want of medical attendance, it is undoubtedly the case that where there is insufficient medical provision the number of uncertified deaths is greatest.3 Nor are these confined to old age, when nature having run her course medical intervention is apt to be deemed of no avail. They occur at all ages.

To quote again from Dr Crawford Dunlop's statement as to the number of uncertified deaths in Ross-shire during 1908-10:--4

"Of the total number, 504 were of children under 5 years of age, 306 were of persons between 5 and 25, 411 were of persons between 25 and 45, 602 were of persons bet 45 and 65, and 1633 were of persons aged 65 and over."

50. Many witnesses were disposed to attribute the failure to call a doctor and the consequent non-certification to a fatalistic attitude to death in the case of the aged.5

Dr Macdonald, Inverness, on the other hand, while admitting that "fatalism" may at times be partially operative, says:--6

"A great many of them are very young people, children, or very old people. My own opinion, from the information supplied and from my observations, is that it is due to a very large extent to poverty, and also to inaccessibility."

Several witnesses discount fatalism altogether, holding that the predominating causes are distance and the cost of medical attendance.7 One witness, Mr Henderson, Registrar, and Chairman od the School Board of Lochbroom, closes his remarks on the subject in the following words:--8

"After the person is dead they may say the person had to go and all that sort of thing, but notwithstanding that, if there be hope at all, if the doctor can be got he will be got."

After consideration of the evidence, particularly the figures submitted by Dr Crawford Dunlop, the Committee cannot regard the theory of fatalism as accountting for the facts, and they consider the evidence as quite conclusive that the high percentage of

1 Jeffrey, 709. 2 Patten Macdougall, 263-64. 3 Dunlop, 512, 526
4 Dunlop, 506. 5 Reardon, 20,335-36; Macdougall 20,403-04 6 Macdonald, 1315.
7 Dick, 4093; Macpherson, 4513; Mackay, 15,369, 15,388-89. 8 Henderson, 3555.

uncertified deaths is mainly due to the lack of medical attendance, and that no medical service can be regarded as adequate where such neglect as is indicated by the figures herein stated still obtains.

2. Evidence as to Illness not Medically Attended

51. The evidence is cumulative that there is a vast amount of illness among poor non-pauper people not medically attended.1 The witnesses very considerable in their estimate. Some put such cases as high as 50 and even 75 per cent. This figure can, of course, be at best only roughly approximate; but in such circumstances as are described in the following quotation much illness without medical attendance is to be expected--

Mr Angus Pirie, Rogart says:--2

"There is no resident doctor in our district being a wide and scattered one where the people live widely apart, only when relatives think the illness is of a serious nature do they send for a doctor. There is no free circulation of money, and owing to the doctor residing from seven to seventeen miles away his fees are necessarily high. If there is the prospect of a recovery from the illness without calling the doctor, the people hesitate to call him, and in some cases the delay has proved unfortunate and fatal. I know this from experience."

The following quotation from the evidence of Dr Roger McNeill is also highly instructive:--

"People in out-of-the-way localities sometimes resort to various devices to bring the services of a medical practitioner within their reach. While relieving a parish doctor in the island of Skye, I received an urgent message to visit a pauper in a populous crofter township distant about sixteen miles. On arriving, I found nothing alarming the matter with the pauper, but I was consulted by over twenty persons bordering on pauperism regarding their health, mostly on the roadside, and I had there and then to give them advice, such as it was gratis."3

And Dr Bremner, says:--4

"When I go to the west (of Sutherland) the people flock round me. It is difficult to get away."

Dr Leach, Beauly, having expressed his opinion that in respect of medical attendance country people are neglected, adds:--5

"Honest people, if they cannot pay for his services, wont send for a doctor until it is too late."

Dr Gilmour, Islay:--6

"There is considerable amount (of illness) where you are called in after the mischief is all done, and when there is far more to do than you can do properly."

Dr Maclennan, Thurso:--7

"I might mention that one finds generally that a large proportion of non-attendance exists among children."

Dr Jamieson, Scourie:--8

"Though the fee is small, it deters many from calling the doctor until the case becomes extremely urgent. After the first visit, to save expense the doctor is hardly every requested to make return calls. In most cases, if the doctor gives a second visit without being asked, he gets many thanks but no fee. Some die without medical attendance—I cannot say how many—but the number is not inconsiderable. . . Poverty is the cause of non-attendance."

52. The frequent reference in the evidence to the habitual delay9 in calling in the doctor, even when there is no fear of a fee, I attributed not alone to apathy or ignorance,

1 Lovat, 2311; Ellice, 2474-75; Stewart-Mackenzie, 3309-10; Mackenzie, 3718-19; Macleod, 3889-90; Dick, 3969; Maclennan, 4244-45; Kennedy, 4372-73; Park, 6030-31; Anderson, 7360; Mackay, 8255; Fraser, 9324; Gunn, 10,196-210; Macaskill, 10,079; Cowie, 10,286; Macdonald, 11,641-43; Mackinnon, 12,608, 12,618-22; Mackenzie, 12,872-919; Macdonald, 15,517; Stirling, 17,945.

2 Pirie, 9693.

3 Mackay, 15,391; Roger M'Neill, 18,247, 18,250.

4 Brember, 8527.

5 Leach, 1670

6 Gilnour, 22,842

7 Maclennan, 4244.

8 Jamieson, 9944.

9 Rumsey, 978; Macleod, 3890; Heddle, 5101; Sinclair, 5260; Murray, 10,473; Macdonald, 11,574-76; Tolmie, 13,492-95; Macleod, 14,747; Macdonald, 16,008; Robertson, 17,872; Drummond, 18,185; Grant, 19,918; Ross, 19,863; Young, 22,097.

or poverty, but not to an attitude of patience in suffering, which has evolved from the lack of medical advice and assistance in the past.

3. Inadequacy as disclosed by School Medical Inspection.

53. School medical inspection as now established throughout the country is so far the only systematic means for determining the amount of medical defect in any section of the general public, and if the disclosures made thereby be—and we think they ought to be—taken as a measure of the real need of medical diagnosis and treatment in all sections of the people, there is no doubt as to the insufficiency of the existing medical service.

54. There is abundant evidence as to the existence of disease and physical defects in school children which, were it not for this system of medical examination, would have remained unsuspected and untreated, to develop into chronic ill-health in later life.[1]

To select but one of the many defects urgently demanding medical treatment, namely, caries of the teeth.

Dr Macdonald, Chief School Medical Officer for the county of Inverness states:--[2]

"In many cases the teeth are beautiful, but the results shown by school medical inspection are appalling."

Dr Dick, Medical Officer of Health and School Medical Officer for the county of Caithness:--[3]

"I should say that a school child of about thirteen years of age, has on an average six decayed teeth. On the whole, I should say that the teeth are very bad in Caithness, with the exception of one or two districts."

Dr Fletcher, School Medical Officer for the Inverness-shire portion of the Hebrides, states in his Report (1910-11):--

"The condition of teeth, generally speaking, was found to be bad. . . . In one large village school the exception was to find a complete set of teeth in the village children. . . . Parents do not realise the importance of tending the teeth, and but few will believe that disease about the lower jaw and neck, enlarged tonsils, and even tubercular mischief in its gravest form may have originated in the cavity of a decayed tooth."

Dr Bremner, School Medical Officer for Sutherland, asked as to whether the teeth of school children were particularly bad, replied:--[4]

"Yes, very bad, I don't know how we are going to overcome that unless a dentist comes round the schools twice a year. It is all a question of money."

55. The mass of ailments in the school population revealed in the reports issued by the officers of this service has already had a profound effect on the public mind.

In short, no scheme of medical service hitherto devised has gone so far as schoold medical attendance which should be regarded as adequate to the needs of the people generally.

Further reference to this important subject will be made later in the Report.

4. Substitutes for Medical Attendance.

56. An interesting and not unimportant type of evidence, indicating inadequacy of medical attendance, is the brisk trade in patent medicines which has developed in recent years, and more particularly in the case of quack medicine of American manufacture. This is explained by one witness as due to the fact that the Americans are more expert advertisers than the British. We are told that the quantity of such medicine is sold is much more than that supplied on a doctor's prescription.[5]

Mr Cairnie, chemist, Thurso, who puts the proportion as high as five to one, on being asked as to whether the want of doctors in the various districts induced the people to doctor themselves by the use of patent medicines, replied—"Yes, far too much. It is much cheaper to buy patent medicine than to send for a doctor. In many cases the distances are so great that they must hesitate before they send.

This practice of self-doctoring is increasing and will so continue so long as the need

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1 The Mackintosh, 2176; Stewart Mackenzie, 3376; Macleod, 3870; Saxby, 7290; Macdonald, 11,621-22,, 11,626.
2 Macdonald, 1273. 3 Dick,, 4000.
4 Bremner, 8557.
5 Dick, 3972; Cairnie, 4960-69; Park, 6037; Mennie, 9299; Smith, 12,949.

to which it owes its origin is not more adequately met by the provision of skilled medical attendance.

57. The persistence of the traditional "cures" and superstitious practices in remote districts referred to in paragraph 21 is undoubtedly due largely to the want of medical attendance.1

58. To the same cause may also be assigned the fact disclosed by the evidence that some nurses and more particularly nurses with little or no training, assume the role of medical practitioners. Voluntary assumption of such a role is, however, not common.2 It is more often the case that the nurse is drive thereto because the patient cannot readily procure the services of a doctor, and in isolated communities that must frequently happen.

To quote but one witness, Mr Macrae,3 Uig, L4ewis, in reply to the question as to whether there is considerable proportion of illness among the people which is not seen by the doctor, says:--

"Yes. It occurs in this way; in cases where they are far away from the doctor they put themselves in the hands of the local nurse, and when the thing becomes serious they send for the doctor, and the doctor has no change then. There are a number of cases that are not attended to as early as they should be on account of the poverty of the people. They are afraid of the fee."

59. In short, we are fully satisfied from our own observation, from the evidence of witnesses, and from the large body of facts otherwise at our disposal, that the existing medical attendance in the greater part of the Highlands and Islands is quite inadequate, and we would accordingly recommend that steps be taken forthwith to amend conditions that have so prejudicial an effect on the welfare of the people.

PART V

PROVISION OF NURSES

1. General Urgency

60. Testimony is unanimous, both on the medical and lay side of the evidence, that no matter affecting the welfare of the people of the Highlands and Islands is more urgent that the provision of an adequate supply of trained nursing.

Accordingly, we have endeavoured to give the subject as full consideration as the brief period of the enquiry permitted, and we would not lay before your Lordships the following short statement on the main aspects thereof.

2. The Existing Provision.

61. In thet Highlands and Islands, as generally elsewhere, any provision hitherto made to meet the urgent need of skilled nursing in the case of poor people has almost wholly been used on the voluntary effort of individual benefactors and philanthropic agencies.4 In course of time such agencies have in certain localities developed into nursing associations, with varying degrees of efficiency and completeness as to organisation.

62. To maintain the existing nursing provision under these associations three main sources of revenue are available:--

(a) Occasional contributions from the Parish Council or the District Committees—usually a few pounds.
(b) Subscriptions ranging from 2s. to 10s. from members of the association, in return for which the subscribers are entitled to the service of a nurse free or at a reduced fee.
(c) Fees for services rendered (usually very low).
(d) Contributions and donations from the general public. This is the main source.

In the case of the Victoria Jubilee Nursing Institute, the nurse's services are given gratuitously to the poor. This is the case as to some other nurses privately supported.

63. At this point, we desire to acknowledge the public spirit and generosity displayed.

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1 Graham, 16,442. 2 Cameron, 12,147-55; Ross, 12,526; MacNaughton, 21,685-7; Gilmour, 22,885-90.
3 MacRae, 11,703. 4 Macphail, 329 et seq.; George, 9273-74.

By many proprietors, shooting tenants, and others, in providing nursing attendance for poor people resident in the Highlands and Islands.1

64. At the same time, the fact that nursing provision has in the main been instituted and maintained by private effort has resulted in an extremely unequal distribution of nurses over the area of our investigations and in an occasional, and in an occasional tendency to restrict the services of a nurse too exclusively to a give locality, with the result that, even when she is unemployed in that area, her services, however much required, are not available in the immediately adjoining district.2

In reference to the tendency to such restriction, Lord Lovat remarks:--

"As a rule there are about half a dozen people who subscribe half the expenses. One of the difficulties in the way of reform is, that big subscribers do like their own people looked after, and therefore like control over nursing arrangements."

His Lordship further stated that he could cite cases of illness, including confinements, proving fatal through the lack of nursing, when a nurse in a neighbouring district was meantime unemployed.3

65. The need of immediate action to supplement and co-ordinate the existing provision of nurses was strongly insisted on, and it was suggested by several witnesses that with a view to this, and generally to improve existing conditions, it is most advisable that steps be taken forthwith to amalgamate public and private effort by establishing a system of nursing organised on a larger, say, a County basis, with an executive representing all the interests involved.4

It need hardly be added that we regard such a step as eminently desirable.

The only Nursing Associations within the area at present organised on a County or District basis are to be found in Argyllshire and Sutherlandshire.

3. Qualifications of Nurses

66. As regards qualification, the nursing service provided by the benefactors or agencies referred to may be classified in several ways. For convenience we adopt the following classification:--

I. *Maternity Nurses*, properly so called. These are women—generally widows—who have attended a course of lectures and have conducted a certain number of confinements under the supervision of a medical man or midwife attached to a teaching institution in a large centre. The duration of the coures, both theoretical and practical, is three months. At the end the candidate is furnished with a certificate of efficiency after examination to the satisfaction of the granting body.

II. *Cottage Nurses*.—(a) Nurses trained in connection with a nursing institution in maternity and general medical and surgical nursing, for a period varying from six to twelve months, and holding a certificate of proficiency in the maternity or midwifery work.

(b) Nurses trained similarly, but for a period of from nine to twelve months, and holding either the certificate of the Central Midwives Board or of one of the recognised maternity hospitals.

Sub-Classes (a) and (b) posses qualifications generally corresponding to those of the nurses furnished by the well-known "Govan Home for Cottage Nurses."

III. *Fully Trained Nurses*.—These have had three years' hospital training in a recognised hospital of not less than 100 beds and, in addition, usually possess midwifery training and certificate.

The nurses supplied to the Highlands by Queen Victoria Jubilee Institute are thus qualified, and in addition undergo a course of six months' training in "district work" under supervision. As far as may be judged, this class possesses the highest qualifications obtainable for district nursing.

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1 Mackenzie, 35; Macphail, 382; Leach, 1702; The Mackintosh, 2240-41; Kennedy, 4342-45; Park, 5914; Roger M'Neill, 18.295, 19.349 (A); Macnaughton, 21,686, 21,743.

2 Kennedy, 4348; Chisholm, 20,847, 20,878; Stirling, 17,966; De Sylva, 22,061.

3 Lovat, 2339, 2342. 4 Mackenzie, 1604-05.

67. Though there was general recognition of the advantage from a medical point of view of employing fully-trained nurses, and evidence was led to show that those less fully qualified were sometimes less amenable to direction by the doctor and more ready to encroach on his proper sphere, several witnesses expressed the opinion that there was scope both for the fully-trained nurse and for the nurse qualified in midwifery only.[1] Emphasis was laid on the importance of a nurse in attendance on a maternity case in an isolated district being ready to stay in the house when conditions of living permit, and, in the absence of help from a neighbour, to undertake some of the more urgent household duties and evidence was generally to the effect that such a service was more readily to be expected from the less qualified woman.[2]

68. Further, Sir Donald MacAlister, Principal of the University of Glasgow and President of the General Medical Council, laid stress on the difficulty of finding fully-trained nurses (even if of Highland birth) who would be ready to continue long at work in isolated and difficult areas, and, thoug strongly of opinion that only those women who had passed through a three years' training should be regarded as having a full right to the title of "Nurse", considered that in view of the existing difficulties a nurse with, say, a years' training in midwifery and general medical and surgical work was a more attainable ideal.

69. Sir Donald was also of opinion that in order to be better able to "follow up" cases requiring treatment as disclosed by school medical inspection nurses of the type mentioned above should receive some special additional training. All witnesses were agreed that, for the Gaelic-speaking districts, nurses with a good knowledge of Gaelic was preferrable.[3]

70. Both lay and medical witnesses are equally insistent that on no account should the nurse be a substitute for the doctor,[4] but at the same time they all agree that there are at present many calls on the doctors' service for slight ailments and accidents which might quite well be dealt with by a nurse; while, as already stated, were telephone communication available between doctor and nurse in remote and insular parts, she might, under his direction, take preliminary measures in serious emergencies pending his arrival, and subsequently conduct the treatment and keep him duly informed of the progress of the case. With such assistance, and with motor locomotion by land and sea, the efficiency of the existing medical service would be immensely augmented.

In the case of the smaller insular communities, such, for example as those on the islands of Foula, Papa Stour, Fetlar, Eriskay, St. Kilda, and on Fair Isle, were for special reasons it is impossible to have a doctor, nursing service should be regarded as essential.[5]

4. Insufficiency of the existing Supply of Nurses.

71. In the evidence before us there is abundant proof of the inadequacy of the existing provision. Notwithstanding the laudable attempts made by the philanthropic agencies referred to meet outstanding cases, the sum total of effort has left a wide field of clamant need untouched.[6] The dearth of nursing attendance in birth and infancy came from frequently before us in the Hebridean section of the enquiry; but in many other parts of the area it is evident that it is only from the "skilly" woman or untrained neighbour that such help be obtained.[7]

72. To give some examples—in the island of South Uist, with a population (including that of the adjacent island of Eriskay) of close on 4000, there is no qualified nurse, and attendance is given in Eriskay by a woman of over 80 years of age. Dr Reardon of South Uist informed us that two women had died as a result of this deplorable deficiency in trained skill, and stated that in every case in which he had been called in to give advice he had found the patients suffering from results of mismanagement in their confinements.

Dr Cameron of Lochs, Lewis, spoke of the cases of puerperal fever and infantile

1 Dick, 4032, 4188; Maclennan, 4350; Meade, 4574; Asher, 4906; Sinclair, 5338; Robertson, 6499; Simpson, 8751-58; Macrae, 8821; Ross, 12,522-23; Tolmie, 13,633; Chisholm, 14,322; M'Rae, 16,614-15; Macnicol, 19,613; Reardon, 20,210-11; Chisholm, 20,848; Mackintosh, 21,815-17; Gilmour, 22,886-90; Locheil, 23,450-51.

2 Asher, 4910; Sandieson, 7663; Mackenzie, 13,904-06; Norris, 17,808-12; MacKay, 19,827-28; McKechnie, 20,002-3; Cameron, 20,633-35; Macalister, 23,095-99; Locheil, 23,441.

3 Mackenzie, 6330; Campbell, 15,277; Mackay, 15,483; Macdonald, 16,421; Macalister, 23,216.

4 Jeffrey, 851; Walker, 1100; Lovat, 2348; Mackenzie, 10,762.

5 Heddle, 5097; Park, 5970-; Robertson, 6653; Cochran, 6720-21, 6858, 6907; Taylor, 7012; Mackenzie, 10,947.

6 Murray, 10,533-57, Mackenzie, 10,712; Macmillan, 14,113; Stewart, 14,862; Macpherson, 15,035; Knox, 17,238; Macdougall, 20,318; Cmaeron, 20,620-23; M'Neill, 20,766; Macrae, 21,202-03.

7 Dick, 3981; Sinclair, 5261; Robertson, 6465; Tolmie, 13,521; Mackenzie, 13,772; Macaulay, 14,243; M'Rae, 16,593-94; Drummond, 18,186-87; Reardon, 20,309; M'Neill, 20,772.

Tetanus resulting from the absence of a trained midwife. Dr Ross, Barvas, described the attendance of crofter wives on each other as "a social danger."1 In North Harris, Dr Macleod informed us that not only a neighbour but occasionally even the husband was the only attendant in confinements, and that in the absence of any trained nursing only a small proportion of these cases received any skilled attendance.2 He mentioned that he had known of deaths of as many as three mothers in twelve days. Another doctor told us of a case (not, however, recorded in Minutes of Evidence) where a woman at the crisis of her confinement, read out to her husband from a medical treatise directions to enable him to afford her the necessary assistance. In South Harris, Dr Tolmie informed us that he was only called to about six out of eighty confinements annually, and stated that he knew of two mothers and one infant who had died from improper or insufficient attention.

Evidence was forthcoming from witnesses representing several other parts of the area as to serious, sometimes fatal, results from the lack of skilled nursing. Father M'Neill of Eriskay, after stating that the infant mortality there was abnormally high, informed the Committee that no doctor had attended a maternity case on the island for the last seven years, and that on one occasion when no other help was available he "had to bring out the medical dictionary and to take it to the schoolmaster and to get him to attend." He further stated that last year out of eleven deaths on the island no less than five had been of infants under twelve months, and that he attributed this to the lack of competent person to advise the mother.3

73. Nor is the deficiency confined to cases of birth and infancy.4 Mr Bruce of Symbister told of a man in Whalsay who had died of pneumonia for want of skilled nursing, and Father MacDougall of South Uist informed the Committee that he had known several persons who had died rather from lack of nursing than from the lack of medical attendance.

Evidence was also given as to the insufficiency of nursing in infectious diseases. Dr MacLeod, North Harris, after stating that such cases were usually nursed at home by the mother of the family, went on to say: "They don't get any nursing, they simply lie there till they are better. They get no nourishment beyond milk and water." And Lieut.-Col. Macdonald of Skye stated that "Sometimes a poor patient is left in a very perilous condition with nobody to look after him."

74. Conversely, there is ample evidence of the great boon that trained nursing is to such communities as have been fortunate enough to possess it.

Mr Patten Macdougall quotes the following from a letter from the Secretary of the Argyll Nursing Association:--6

"A long-felt want was met by a Queen's nurse being sent to the island (Gigha) in May 1911. As so often happens when medical aid is required, stormy weather makes it well-nigh impossible, on many occasions, for a doctor to cross over, but since Nurse -- -- came to the island there is a feeling of quiet security in the minds of inhabitants, which is welcomed as well as greatly appreciated by them."

This is further borne out by the following extract from the evidence of Mrs Burns, Lochs, Lewis:--7

"Last year I received an object lesson on how much a nurse was valued. A lady missionary sent here from Edinburgh conducted a class in the neighbourhood. It became known that she knew something about nursing, and every night of her class I saw people waiting for her to get attention or to urge her to visit houses were there was sickness. With one doctor for the whole parish and one nurse, and that only a maternity nurse, the medical and nursing provision in the district is quite inadequate for the north side of Lochs, looking to its extent and population."

From the visit paid by the Committee to the Fair Isle, they realise the great value the services of a trained nurse must be to a lonely island community. In the present case the nurse had, with a view to he work on the island, received in addition to her general qualifications as a Queen's Nurse some special training in dentistry.

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1 Macleod, 3,051; Cameron, 12,011, 12,066; Ross, 12,349-50; Mackay, 19.819.
2 Cochran, 6720; Macleod, 13,048-49; Macaulay, 14,243; MacCallum, 21,183.
3 Lovat, 2339; Cochran, 6860, 6731; Macleod, 13,052; Tolmie, 13,504-09; Macdonald, 13,535-39; Fletcher, 15,701-02, 15,871; Mackay, 16,593; Macnicol, 19,533-4; M'Neil, 20,744-53, 20,768; Brander, 21,938.
4 Park, 5921; Cochran, 6731; Bruce, 7506, 7576; Murray, 10,592; Macleod, 13,099, 13,100; Tolmie, 13,532; Fletcher, 15,820; Macnicol, 19,602.
5 Macdonald, 15,651. 6 Patten Macdougall, 251. 7 Burns, 12,725.

75. It is unnecessary to elaborate the evidence in this direction further than to mention one very important respect in which the inadequacy of the nursing service is revealing itself, and that is in connection with the system of school medical inspection created under the Education Act 1908. Treatment of defects in school children disclosed by such inspection has hitherto been all too rare, due partly to poverty or carelessness, but very largely also because a capable nurse is not available to "follow up" a case and see that the parents carry through the treatment prescribed.[1]

76. Emphasis was also laid on the necessity for training the people in hygiene, invalid cookery, first aid and the feeding of their children; and the greatest importance was attached by both lay and medical witnesses to the value of a nurse's influence in these respects.[2]

Dr Ross of Uig, Lewis, considered that nurses had more educative influence than doctors, and Dr Reardon of South Uist gave it as his opinion that education by the nurses was an urgent matter, and informed us that he had to give his patients lessions in cookery, poultice-making, and even bed-making. "A nurse, in many cases, is far more essential than a doctor."[3]

In the opinion of Father M'Neill, the influence of nurses "in regard to the necessity of proper sanitary conditoins would be more effective than any legislation that could possibly be devised";[4] and Lord Lovat goes so far as to sat that "medical salvation of the Highlands lies in organised nursing".[5]

77. Nor should another aspect of the preventative value of a nurse's services be forgotten. Reference has already been made to the frequent delay in sending for a doctor, a delay which, although mainly due to poverty and distance, has also by several witnesses been partly, at east, ascribed to ignorance.6 An intelligent and tactful nurse who is on friendly terms with the people in her locality should often be able to ensure that medical advise is called in before it is too late for it to be effectual.

78. The physical conditions that affect adversely the provision of adequate medical service in the Highlands and Islands are applicable also to the nursing service. While, indeed, the disadvantages of isolation, and the frequently insanitary and otherwise unattractive field of labour are probably more keenly felt by the nurse, it is also the case that unsatisfactory as the class of house provided for the doctor often is, the arrangements for the housing of the nurse are much less satisfactory. In some of the remote and insular localities she cannot get even tolerable lodging accommodation. Accordingly, a strong inducement to a trained nurse to live and work in these locations would unquestionably be a comfortable home.7

5. Conclusions

79. We are satisfied:--

(1) That the total number of nurses is quite inadequate.

(2) That in a great part of the area of the enquiry the efficiency of the existing supply of nurses suffers from lack of organisation.

(3) That while tending generally to alleviate suffering and remove danger in sickness and disease efficient nursing is at present urgently required in connection with—

   (a) The birth and infancy of children.
   (b) The "following up" and treatment of diseases and defects in children as disclosed by school medical inspection.
   (c) Promoting among the people a knowledge of personal and household hygiene, dietary, etc.
   (d) The earlier detection of illness.

6. Recommendations

80. We accordingly recommend:--

(1) That all existing voluntary nursing agencies, where practicable, be organised under a country or district scheme, but that in order to retain local interest and support, the system of local nursing committees to be continued and encouraged. Such nurses

1 Dick, 3998; Macdonald, 8219; Kirkpatrick, 15,150; Macdougall, 20, 454.

2 Bruce, 1619; Lovat, 2345; Ross, 11,333; MacRae, 11,078; Burns, 12,728; Macleod, 13,048; Macmillan, 14, 206; Macleod of Macleod, 14, 668; Stewart, 14, 918; Nicolson, 16, 361; Cameron, 20, 587.

3 Reardon, 20, 177-78. 4 M'Neill, 207,67 (B) 5 Lovat, 2312.

6 M'Leod, 3890; Mackay, 8255.7 Macphail, 350; Lovat, 2343; Mackenzie, 13, 818.

could by arrangement be utilised by public bodies under such a scheme, and the public bodies in question could have representation on the management committee.

(2) That the total number of nurses be largely increased, and that the claim of island communities receive special consideration.

(3) That nursing be regarded as an integral part of the medical service and that in the discharge of her duties the nurse, through organisation, be directly responsible to the medical attendant.

(4) That a suitable lodging or residence by provided for the nurse.

(5) That the telegraph-telephone system now in use in many parts of the Highlands and Islands be made available for telephonic communication in connection with the nursing service.

PART VI

PROVISION OF HOSPITALS

1. General Hospitals

81. The facilities for hospital treatment in the area of our remit have been carefully investigated, not only in the examination of witnesses but by personal observation of local requirements and by visits paid to representative hospitals in the course of our itinerary.

We have, therefore, at our disposal a large amount of valuable information on this important question—a question, which, for special reasons, must be regarded as particularly vital to the adequacy of medical provision in the Highlands and Islands.[1]

82. One prominent condition, which has already been referred to as adversely affecting medical service in several districts, is the difficulty of carrying out effectively domiciliary treatment of ordinary illness or disease in an average rural dwelling-house, and more especially in the Hebrides. The insanitary surroundings and the absence of nursing care and discipline in all their bearing on the welfare of the patient render medical practice under such conditions, as one doctor put it, "quite disheartening."

And Dr Hunter, Lochgilphead,[2] replying to the question as to hospital supply, said:-

"That is one great want: it would be a great advantage to our district to have a cottage hospital, even a small one. It need not be a fully equipped one, if it was only a place where you could get the patients to, because in some of these wretched houses you can do nothing.

83. It is also obvious that in a sparsely peopled or insular practice it must frequently be impossible for the doctor to give the requisite attendance in a case of serious illness, requiring, say, a daily visit, and there may be several such cases at the same time and at various distant points throughout his practice.

84. To meet these difficulties of remoteness and insanitary conditions in the case of serious illness, both lay and medical witnesses strongly urge the necessity of providing cottage hospitals erected near or within easy reach of a doctor's residence and in charge of a competent nurse.[3] This would not only insure more efficient treatment for the patient, but it would effect a saving of the doctor's time and energy for other urgent medical service. Special reference was made to the boon that such a hospital would be in the case of expectant mothers living in remote glens and islands, more particularly when a difficult confinement is anticipated.[4] And in this connection it is interesting to note one of the three main purposes, as stated in the deed of mortification, for which the Belford Hospital, Lochaber, was founded, viz: For "the wives of poor shepherds in one of other of the said parishes living at a distance and about to be confined for the purposes of confinement and other treatment."

Dr Mackenzie, North Uist, thinks there should be a small cottage hospital in every parish where urgent surgical and other cases could be taken for operation and adds:--5

"I have had to operate in a hut on a case of strangulated hernia, where a clerk gave chloroform and light was obtained from a tallow candle held by the neighbouring crofter who fainted during the proceedings! This was before the

1 Jeffrey, 848-49; Walker, 1159-63, 1167; Macdonald, 11242; Bruce, 1477, 1507-08; Leach, 1686-90; Lovat, 2386-87; Wallace, 3134-35; Maclennand, 4270-72; Park, 5934; Victor Ross, 11,496; Ross, 12,469; Hunter, 22, 974. 2 Hunter, 22, 974

3 Jeffrey, 848; Mackay, 8252-54; Macaskill, 10,105; Murray, 10,622; Ross, 12, 384-86, 12,478; Burns, 12,781-88; Stewart, 12, 989; Fletcher, 15, 838; MacRae, 16, 653; Knox, 17, 244-45, 17, 288-90; Cameron, 20, 569.

4 MacRae, 20, 990. 5 Mackenzie, 13, 818.

advent of the nurses who can give more efficient assistance, but the huts are there still."

In this connection, the following statement from the evidence of Mrs Burns deserves special notice:--[1]

"I think that rooms like than (in a nurse's house) are absolutely necessary for the doctor for some of the cases he had. It is impossible for a doctor to perform anything like even a small surgical operation in the room of a black house. Now, that is done. I can give a case of a little girl who is not better yet—a little girl of eight—and I think she has necrosis of the bone in her leg. Her leg was opened up . She had no anaesthetic. A small bit of bone was taken out and tubes were put in. This was all done in a black house while the smoke was going round. She had nothing at all, hand the nurse as present with the doctor, and the girl's uncle was holding her on the table. That occurred almost a year ago. Now, the little girl's leg is still very bad."

86. Many witnesses hold that where such hospitals have been provided they have proved of the highest value in educating the people in sanitation and the treatment of disease.[2]

On this point Principal Sir Donald MacAlister says:--"They would form centres of what one might call model treatment, and would be useful not only for the patient in the hospital, but as good examples of proper treatment to the neighourhood."[3]

87. It has also to be noted that almost all the hospitals at present in the area of our remit are located in the more populous centres and, consequently, are not readily available for a distant patient even when a bed is vacant. For it has to be borne in mind that the cost and danger of travel by sea and land, particularly in winter time, and when probably the only ambulance available[4] is an open boat or a jolting cart, are enough to deter a patient in a weak condition of health from undertaking the journey.

88. Another plea put forward in favour of the provision of cottage hospitals is that they would meet the not uncommon difficulty of finding suitable residence for a district nurse, and the lack of accommodation in many of the doctor's houses for consulting and dispensing purposes. In many cases the doctor's kitchen is the consulting-room or waiting-room, and sometimes it is both.

89. The existing hospital provision for general sickness is set forth in a list detailed in Appendix 3 in this Report.

With hardly an exception the witnesses are unanimous as to the inadequacy of this provision, not only in respect of accommodation but also in respect of accessibility.5

90. It may be here remarked that both the evidence of witnesses and our own investigation on the post have led us to the conclusion that for financial and other reasons, including at least in one instance, difficulties of control and management, some of these institutions have not been serving the needs of their area to the full extent of their capacity.

For example, the only hospital in the island of Lewis, with its population of 30, 000, has 12 beds, and yet on the occasion of our visit it contained but two patients, not, we were told, because there were no cases of illness awaiting treatment there, but on account of disagreement between the committee of management and the doctor, who since its inception has been the principal medical attendant.[6]

It was also stated in evidence that the management of Gesto Hospital, Edinbane, Isle of Skye, was such as largely to defeat the intentions of the founder; and opinion was strongly expressed at our meeting in Thurso that the Dunbar Hospital there should be made available as a general hospital for the town and district, a purpose for which it is eminently suited.7

91. It has been suggested that a contribution from public funds, with a corresponding measure of public representation, would be a two-fold benefit to all hospitals.

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1 Burns, 12,781
2 Lovat, 2345-46; Macdonald, 11, 584; Mrs Stirling, 18, 009.
3 Macalister, 23, 122
4 Durran, 4764l; Heddle, 5121; Macaulay, 14,254; Stewart, 14, 881; Fletcher, 15, 826-27
5 Maclennan, 4267; Park, 5934; Low, 6231; Robertson, 6533; Taylor, 7009; Saxby, 7264.
6 Murray, 10, 599; Mackenzie, 10, 956; Anderson, 11, 026-27; Ross, 11,194 et seq; Macdonald, 11,580.
7 Durran, 4779; Asher, 4892-95.

92. It is obvious that at least in the larger islands Tuberculosis Hospitals are necessary. Frequently, there is considerable danger in conveying tuberculosis patients by sea. But apart from this, there are numerous cases where treatment nearer home is, on social grounds, desirable and where removal to the mainland would itself be a detrimental factor in the case. Occasionally, of course, early cases of tuberculosis may be transferred with perfect safety; but the high death-rate from tuberculosis in some of the islands, points to the desirability of establishing some form of tuberculosis hospital.1

That is particularly desirable in the island of Lewis, where the death-rate from pulmonary tuberculosis is exceptionally high and where the hospital accommodation for the disease is practically non-existent. A case almost equally strong could be made out for several other island, and for remote and inaccessible parts of the mainland. But the point is so obvious that statistical proof is really unnecessary.

93. Under the Insurance Act, sanctorium benefit goes a certain length to solve the problem for insured persons and their dependants. Where sanatorium benefit is not adequate for the purpose, it is open to the local authorities to accept responsibility for half the deficiency, the Treasury accepting the responsibility for the other half. Where the resources of the local authority are sufficient and the rates are not over-burdened, where, in particular, the public health rate of 1s. in the £ still retains a considerable margin, the problem may be difficult, but it need not be insoluble. Where, however, there is no margin to the public health rate, the problem must either remain unsolved or be solved through charitable agencies of the accidental generosity of individual philanthropists. A third possibility is a subsidy from an additional Imperial grant.

94. In certain parts of the area, the case for such an additional subsidy is over-whelming. Whatever be the number of insured persons, the number of uninsured in the Highlands and Islands is relatively very great. All the factors that make for a high death-rate from pulmonary tuberculosis equally involve a high public health rate. In Lewis, the public health rate for some ten years has stood practically at its maximum. In other places the public health rate is high, and, even if raised to a higher point, would probably not even at its maximum bear the burden necessary to provide accommodation for pulmonary tuberculosis. Whatever be the precise truth as to the cause of the high rates, whether they be due to permanent or transitory conditions, is of little account; for, even if the rateable subjects were considerably increased, the outlays for adequate treatment of pulmonary tuberculosis would still be too high for many localities.

Where, therefore, the local authority is able to provide nothing at all or at best a very small amount, the subsidy of 50 per cent. from the Treasury would be nugatory. Fifty per cent. of nothing is still nothing, and 50 per cent. of a hopelessly inadequate sum is still hopelessly inadequate. It follows that, if pulmonary tuberculosis in large areas of the Highlands and Islands is to be put on the same plane as pulmonary tuberculosis in other parts of Scotland, a special Imperial subsidy will be necessary.

95. The amount of pulmonary tuberculosis is large; the number of insured persons is likely to be smaller in proportion that in the other areas of Scotland; and the need for hospital accommodation will certainly be considerable. For large parts of the year, many insured persons in the Highlands and Islands are out of employment. Consequently, unless they are deposit contributors they will, in a considerable percentage, fall into arrears. This, though it need not diminish the amount of sanatorium benefit, will tend to diminish the financial sufficiency of the families and to increase the need for public relief.

On every ground, therefore, the case for a special subsidy beyond what is provided for under the Insurance Act or the conditional grants subsequently announced is abundantly demonstrated.

96. After what has been said in other paragraphs of this Report, it is almost unnecessary to emphasis the defects in housing, the deficiencies in the quality of the food supply, the long periods of industrial unemployment, the hard struggle to maintain economic independence through the desolate winters, or any of the many other factors that tend to increase the death-rate from pulmonary tuberculosis.2

1 Patten Macdougall, 289-95, 323-28; Murray, 10, 419-20, 10, 623-31; Mackenzie, 10,725; Smith, 11,124; Victor, Ross, 11,338-42; Mackenzie, 12, 865-67; Mackenzie, 13,990-91; Stewart, 14,985; Grant Macdonald, 16, 098-102.

2 Murray, 10,419-22; Tolmie, 13,516-19; Mackenzie, 13,775; Norris, 17,761; Macdougall, 20,474.

97. On non-pulmonary tuberculosis, the same propositions are true, but probably to a less degree. As, however, non-pulmonary tuberculosis affects predominantly the younger general, its relative importance is not to be estimated by the relative numbers. If the tuberculosis of early life is not to be properly investigated and treated, the tuberculosis of later life will continue to takes its toll on victims. If there is one proposition in the whole of pathology better established than another it is that the success in the anti-tuberculosis campaign rests primarily on the wholesome up-bringing of children and the protection of them from tuberculosis infection. This proposition is so completely admitted in every country of the world that no special argument should be needed to enforce the truth of it for the Highlands and Islands. Yet, so far as the Committee were able to discover, nothing substantial was done anywhere, either in the country or in the town, for the special treatment of tuberculosis of children. It is important to say "nothing substantial". It is, of course, true that in several places cases of non-pulmonary tuberculosis were under treatment; but what is meant is that the number under treatment is a mere fraction of those requiring treatment. It is within the facts to say that no adequate arrangements for the treatment of non-pulmonary tuberculosis are, at the present moment, possible in the Highlands and Islands.[1] How far the conditions may be improved when sanatorium benefit is in full operation it is not yet possible to say. That some improvement should take place is, of course, certain; but, in the families of the uninsured, the large number of children needing treatment for non-pulmonary tuberculosis will remain almost as great a problem as the total number of pulmonary cases.

3. Conclusions.

98. To put it briefly,--the evidence makes it quite clear:--

(1) That the existing general hospital provision is quite inadequate, even if available in every case to the full extent of its capacity.

(2) That there is urgent need of further provision; that such provision should be mainly in the form of cottage hospitals, and for the following special purposes:--

(a) To bring near to the doctor a distant case of illness requiring frequent visits.
(b) To provide for the removal of patients from conditions which render medical treatment largely futile.
(c) To reduce the cost and danger of travel entailed in removal from outlying parts to most of the existing hospitals.
(d) To provide a home for the district nurse and a local dispensary for the doctor.

(3) That in any scheme proposed for improvement of hospital service the expediency of subsidising existing hospitals on definite conditions should be favourably considered.

(4) That the provision of tuberculosis hospitals is quite inadequate.

4. Recommendations.

99. We according recommend:--

That cottage hospitals should be erected at various convenient centres, and of such a size as to accommodate from two to four patients, with a nurse and necessary assistance, and to provide a local dispensary for the doctor; and that the provision of tuberculosis hospitals, more particularly in the larger islands, should receive special consideration.

100. In Appendix 2 will be found plans with specifications of a type of hospital suited to the requirements of the remote parts of the Highlands and Islands. These plans have been prepared by Mr John Wilson, Architect to the Local Government Board for Scotland.

It is suggested that for such an institution, a suitable staff would be—a trained nurse, who would also act as district nurse, and a ward-maid, or an assistant trained or in preliminary training.

101. The question as to the authority in whose name the buildings should be vested as a matter for the Treasury to determine.

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1 Young, 22,169-71.

PART VII

PROVISION OF MEDICINES AND MEDICAL APPLIANCES.

102. The conveyance of medicines and medical appliances to the registered poor is dealt with in the Report of the Local Government Board Departmental Committee (1904). The difficulties there pointed out affect not only the registered poor but the general public as well.[1] The distances between patient and doctor as such that drugs have to be sent either by messenger or by post. In many localities there is no regular druggist, and consequently the doctor must himself maintain a supply of drugs and medical appliances. In the evidence placed before the Committee, it was held by doctors, and admitted by druggists, that no arrangement was possible. Such an arrangement however, occasionally leads to difficulties. Many drugs are of perishable nature, and the expense of maintaining a supply to meet the demands is relatively very great. There is frequent reference to this in the evidence of medical witnesses. For example, Dr Victor Ross, Lewis, says:--

"It (medicine) is one of the biggest expenses to me in this island. It is an awful drain on my purse."

The result is that, with the inadequate remuneration available in many districts, a doctor may find difficulty in keeping himself provided with a sufficient stock.[2]

103. In the more populous localities, the drugs are usually provided by a local druggist. But even here the doctors occasionally dispense their own prescriptions, leaving only a proportion of them to the chemists.[3] The latter usually undertake to have the medicine conveyed to the patient.

104. There is some evidence by druggists to indicate that the dispensing of drugs by doctors is regarded as more or less an encroachment on the druggists' proper sphere; but, on the other hand, it was admitted that so-called "counter prescribing" and advice by druggists were not uncommon.

Most of the medical witnesses expressed their preference for having their prescriptions dispensed by a properly qualified druggist.[4]

105. In various parishes, in order to save delay in the conveyance of drugs, small depots of suitable drugs has been established. In one locality, though for a time successful, the arrangement had been given up largely for reasons personal to the doctor. Several witnesses suggested that local depots for drugs were very desirable; but it was admitted that they were suitable only for those less perishable and less expensive drugs. In other localities, the doctor maintained a small dispensary, which he visited periodically, and where the patients came for advice and medicines. From the patients' point of view the arrangement seemed as a rule to work satisfactory, but it did not find much favour with the majority of doctors. They seemed to consider that the trouble and expense of maintaining a room and supply of drugs were out of proportion to the convenience and remuneration. Some of them, however, were of opinion that it would be desirable to utilise the schoolhouse or similar institution as a centre for keeping drugs and for meeting patients on occasion.

Several witnesses referred to the delay in the delivery of medicine.[5] On this point Mr Gunn, Farr, Sutherlandshire, says:--

"The supply of medicines is a very difficult matter in this parish. Take the medical officer that comes to Strathhalladale. He has no medicines with him, and when he prescribes the quickest way to get the medicine is—he goes home and sends the medicine by car the next day. It is three days before the medicine gets to its destination."

106. The provision of cottage hospitals at convenient centres would, however, largely meet the difficulties as to prompt delivery of medicine, and there seems no reason whey the doctor might not have a chest containing a small stock of the more important medicines conveyed on his motor car.

107. It is clear that the difficulties in the provision and conveyance of drugs and in the disproportionate use of proprietary medicines (referred to elsewhere) impair the efficiency of the medical service in many sparsely populated localities.

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1 Gunn, 8021; Mennie, 9298; Burns, 12,722; Brander, 21,917.
2 Johnston, 2624; Ross, 11,521; Macdonald, 11,674; Norris, 17,726
3 Walker, 1146; Ross, 19,865-66.
3 Smith, 12,949; Dewar, 16,479.
5 MacGregor, 4455; Dewart, 16,489-90.

108. In administering the Government Grant suggested in this Report it would be proper for the authorities concerned to exercise such supervision and control as would be open to them over the standard and quality of the medicines and appliances supplied, as is done under the Irish Dispensary System.[1]

PART VIII.

EXISTING MEDICAL PROVISION

1. Introductory.

109. The circumstances represented in the foregoing statements already clearly indicate that the existing provision of medical attendance in the Highlands and Islands s inadequate; but, before proceeding to give definite advice as to the most feasible means of effecting an improvement, it is necessary to consider the existing organisation with a view to developing upon it, or from it, a scheme of medical service which may give promise of attaining the end desired, due regard being had to the duties and responsibilities of the several public authorities operating in such districts.

2. Existing Medical Services.

110. The existing medical services are:--

A. Public health medical service
B. School medical inspection.
C. Health insurance medical service.
D. Medical service in the Poor Law.
E. General medical practice.
F. Specialised medical service.

111. The correlation of these services with a view to their administrative consolidation and the provision of a more satisfactory financial basis for private practice is ore fully expounded by Dr Leslie MacKenzie, a member of the Committee, in a Memorandum appended to this report.

A. PUBLIC HEALTH MEDICAL SERVICE.

112. Public Health Authorities are under obligation to appoint medical officers of health to deal with all conditions affecting the health of the people, and especially with the isolation and treatment of cases of infectious disease, though the medical officer of health, as such, does not treat infectious disease. They must also, when required, provide hospitals for these purposes and the necessary medical and nursing service for persons suffering from such disease. In the area of our remit the hospitals so far provided under the Public Health Act are only capable of accommodating a proportion of even the most serious cases. Moreover, reception houses for convalescents and contact cases have not hitherto been provided, the reason being that were the requirements as to such provision rigidly enforced, the resultant cost would be more than local resources could possible endure.

113. In some parts of the Highlands and the Public Health Authority have exercise their powers as to the domiciliary treatment of infectious diseases, and in one or two cases the have appointed nurses for the purpose; but the extent to which this nursing treatment is carried out is inconsiderable.[2] So also is the extent to which arrangements have been made with medical practitioners for attendance on infectious patients at their own homes.

114. In some cases, however, the Public Health Authority nominates the parish medical officer in consideration of a small retaining fee—in many cases as low as £2—to act as local medical officer of health under the county or chief district medical officer of health.[3] Several of the medical witnesses remark favourably on the arrangement, holding that the local medical officer should be a statutory official for the purposes of public health and should receive a reasonable salary.4 The evidence, goes to show that in most cases the present rate of remuneration of the ordinary medical practitioner

1 Macdonald, 15,595; Coey Bigger, 22,423-24.

2 Murray, 10,592; Tolmie, 13,531-32; Mackay, 15,471; Fletcher, 15,850. 3 Jeffrey, 843-44; Maacdonald, 1283-90.

3 Leach, 1831-44; Dick, 4191-92; Murray, 10,494, 10,525, 10,589; Graham, 17,568-70; Roger M'Neill, 19,412.

for his service to public health is so low as to be of little value as a stimulus to special effort in this most important branch of public medical service.[1]

Now that tuberculosis is regarded as an infectious disease, the demands on the resources of the public health medical service, which, as regards other infectious diseases, are already unusually heavy, especially in the Western Highlands and Islands, will be greatly increased.[2]

115. In the evidence placed before the Committee, several cases were mentioned where the local medical practitioner had to attend a large number of infectious cases of such epidemic disease as diphtheria and typhoid fever; but we found that, as a rule, such attendance is regarded merely as an ordinary part of the duty of the general practitioner.[3]

One illustration, which has been extracted from the evidence of Dr M'Naughton, Salen, Ardnamurchan, will suffice:--[4]

> "In your wide district you have had tremendous exposure during your time?—Yes.
> And you have had to attend frequent epidemics of diphtheria?—Yes.
> You attended them very much alone?—Yes.
> To what extent did the Local Authority assist you in these matters?—They did not assist me at all.
> You broke down in consequence and contracted diphtheria yourself on one occasion?—Yes.
> Did the Local Authority come to your assistance in the way of providing a substitute?—No.

116. Reference has already been made in this Report to the exceptional amount of pulmonary tuberculosis, especially in the Hebrides. If, therefore, the Public Health Authority is to grapple successfully with cases brought to their knowledge under the Order for the compulsory notification of pulmonary tuberculosis recently issued by the Local Government Board, local finances must be very substantially aided.

B. SCHOOL MEDICAL INSPECTION.

117. In all counties within the area of our remit, excepting Orkney and Shetland, school medical officers have been appointed by the County Education Committees and the Scotch Education Department as the central authority. This service has already done excellent work in the way of detecting physical defects and diseases of school children, and in directing not only the attention of parents and guardians thereto, but also of public authorities. As the result of their reports a certain amount of treatment has been carried out, but unfortunately in some districts, owing apathy or carelessness, or to poverty, no action has followed on the disclosures made by the school medical officer.[5] The difficulty of procuring specialist treatment in certain forms of physical defects, such as defective teeth and eyes, is, in the remote parts, particularly acute.[6]
This feature of the service should be kept very prominently in view of developing a better system of medical attendance for the population as a whole.

118. It may be remarked in this connection that while provision for general and specialist medical treatment is made in respect of pauper children boarded-out in highland families by Parish Councils of the great industrial centres,--including more particularly the Glasgow Parish Council, which has at present 2146 such children boarded-out in various districts of the Highlands and Islands,[7]—there was no evidence that such treatment is available in the case of the poor non-pauper native chidren.

119. Recently the Treasury, through the Scotch Education Department, has made a grant of £7,500 for the treatment of necessitous school children in Scotland, and though the share falling to the Highlands and Islands is insignificant it is welcomed as a step in a direction which is of vast importance to the well-being of the community.

120. Extension and organisation of the nursing service would, as explained elsewhere,

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1 Cameron, 12,082; Ross, 12,437; Campbell, 15,323-24; Mackenzie, 17,098; Graham, 17,412.
2 Fotheringham, 7783-92; Murray, 10,510; Mackenzie, 11,014; Smith, 11,154-55, 11,167; Victor Ross, 11,450-52; Cameron, 12,014-16; Macdonald, 16,460; Roger M'Neill, 19,345; Gilmour, 22,861.
3 Saxby, 7245, 7297; Ross, 12,329-31, 12,435-36; Mackenzie, 13,979; Macaulay, 14,256-71; Campbell, 14,945-48.
4 Macnaughton, 21,729-34.
5 Ross, 11,425-30, 11,511-13; Fletcher, 15,761, 15,926; Macdonald, 16,460; MacRae, 16,678-79; Knox, 17,273-76; Graham, 17,486; Norris, 17,829; Cameron, 20,603(C).
6 Saxby, 7290-93; Tolmie, 13,622-24; Kirkpatrick, 15,175; Fletcher, 15,780-83. 7 Motion, 23,300.

go far to ensure the effectiveness of this important branch of medical service, and to stimulate parental interest and sense of responsibility.1

121. It is to be remembered that under the Children Act neglect to provide a medical aid is a ground for prosecuting parents.

122. The development of physical education in schools on a scientific basis may also be noted in this connection as a feature in the growing attention given to the physical condition of school children.

C. INSURANCE MEDICAL SERVICE.

123. Though this branch of medical service has not yet come into operation, it has to be reckoned with in any scheme of amelioration under our remit. The number of insured persons is not at present ascertainable. In their case it is the duty of the County Insurance Committee to make arrangements for administration of medical benefit in terms of the Act. In so doing account must be taken of the question of distance, and of those geographical and climatic difficulties that have been referred to as prominent factors in the adequacy of the existing medical provision in the Highlands and Islands.

124. Enquiry was made from time to time as to whether the average crofter would be ready to pay contributions in respect of at least twenty-six weeks, that is, an annual average of 3 ½ d. a week. The invariable answers was that in those impoverished and districts contribution without compulsion is unreliable, and that even if legislative power to compel were forthcoming the system would still lack the main guarantee of success, namely, an employer responsible for employed contribution.2

125. We are, therefore, convinced that the industrial conditions of the Highlands and Islands are such as to make the provisions of the Insurance Act less operative than in other parts of Scotland, and we foresee considerable trouble in providing medical benefit for fully insured persons far removed from a medical centre, more particularly when it is borne in mind that so large a proportion of them are thus situated.3

Special subvention even in their case would, indeed, appear to be necessary, and the provision of medical attendance for their dependants is also a matter requiring urgen consideration.

D. MEDICAL SERVICE UNDER THE POOR LAW.

126. This service includes:--

(a) Medical attendance on registered poor, outdoor and indoor (i.e. in poorhouses).
(b) Medical attendance on old age pensioners.
(c) Medical attendance on pauper lunatics.
(d) Vaccination of defaulters.

(a) Medical Attendance on Registered Poor, etc.

127. In almost every parish in the Poor Law Authority has appointed a medical officer to attend to the registered sick poor. This has been done largely at the instance of the Scottish Office, who make such appointment a condition of participation in the Medical Relief Grant, which, however, amounts to only £20,000 for the whole of Scotland.

It may, however, be pointed out that whereas the salaries of the parochial medical officers have steadily increased in recent years the proportion of the grant has steadily decreased. It has, as already stated, fallen in ten years from 10s. 9d. to 4s. 3d. per £ of the parochial medical officers' approved salaries, the result being a general tendency to increase the parish rate.

In the area of enquiry the total sum paid to the Parish Councils in aid of the medical officers' salaries is less than £3000.

128. The cause of decrease in this subsidy is the growth in the first charge on the total grant of £20,000, viz. the grant paid to the Parish Councils in respect of trained nurses in poorhouses, which now amounts to over £7000. But it has to be noted that of this

1 Graham, 17,469; Chisholm, 20,857. 2 Jamieson, 9904-13; Mackenzie, 10,665; Mackenzie, 11,000-01.
3 Jeffrey, 882-90, 922; Walker, 1132; Lovat, 2306, 2314; Macdonald, 16,460; Graham, 17,425, 17,430-31; Drummond, 18,213-13; Locheil, 23,422-23, 23,458.

only £272 went last year to the Highlands and Islands, the bulk of the grant being absorbed by the large poorhouses in the industrial centres of the South.[1]

129. No part of the grant is available for the nursing of outdoor paupers and attendance on paupers, or pauper lunatics.

130. As already explained, the Parish Councils have, in order to secure the services of a medical officer, been obliged to offer salaries which, compared with the salaries offered elsewhere by Parish Councils in Scotland, are frequently out of all proportion to the number of paupers to be attended.

Reference to this important fact was made in paragraph 26, but by way of further illustration the following examples selected from returns supplied by the Local Government Board may be given here.

In each of the parishes in Eday, Coll and Strachur, the number of outdoor paupers is four and the medical officer's salary is £70, an average of £17, 10s. per pauper. In the parishes of Colonsay, Lochgoilhead, Kilmorich, each with eight paupers, and Southend with six paupers, the average is £12, 10s. and in respect of each of the ten paupers in the parish of Kilean-Kilkenzie the parish officer is paid £11, 10s.

As an extreme case of the salary paid to the parochial medical officer—ostensibly in respect of outdoor paupers—it may be mentioned that in the island of Papa Westray, Orkney, the Parish Council have appointed a doctor and they pay him a salary of about £70 for attending one pauper.[2]

The general result is that the poor rate, supplemented by the Medical Relief Grant, bears to a large extent the burden of medical attendance on the general public in the Highlands and Islands.

(b) Medical Attendance on Old Age Pensioners.

131. In virtue of his appointment the parochial medical officer is bound at the request of the Parish Council to give free medical attendance to such old age pensioners as are unable to pay for it.[3]

(c) Medical Attendance on Pauper Lunatics.

132. The medical officer must give attendance to pauper lunatics at a fee which may be included in his salary, and for which he must pay four statutory visits per annum to every resident lunatic, whether well or ill. In some cases, however, the attendance on pauper lunatics is at a fixed rate, usually 5s. per visit.

The amount paid to the doctor in respect of the four statutory visits on pauper lunatics is regarded by the medial witnesses as insufficient.[4] Dr Wallace, Ullapool, in answer to the question, "Does the Parish Council pay you for visiting resident boarded-out lunatics?—Yes, I get £5 a year for them. . . I think I have over a dozen (lunatics), but there is one living on the very extreme edge of the parish that costs me about 30s. to visit.

The payments to the doctor for attendance on lunatics do not rank for any part of the Medical Relief Grant, nor does the amount (£13,314) paid to the Highlands and Islands from the Pauper Lunacy Grant of £150,000 bear an equitable proportion to the burden which this service entails on local resources.[5]

The decrease in this grant is thus stated by Mr Ronald Macdonald, Portree:--[6]"The Lunacy Grant also used to be one half of the amount expended, but it has also dwindled, until, last year, the Portree Council received only £187 out of an expenditure of £697, or a little more than the fourth of the amount expended."

133. It has frequently been suggested in the evidence that the cost of lunacy, including pauper lunacy, should be transferred wholly to central administration. As is well known, the Highlands and Islands furnish a larger proportion of lunacy than the other parts of Scotland.[7] The maintenance of pauper lunatics, therefore, constitutes a serious burden upon rates, and especially in the poorest localities, where mental disease most prevails. There is evidence that generally remuneration for medical service to

1 Maxwell, 615-47. 2 Jeffrey, 738. 3 Cochran, 6775-79.
4 Maxwell, 673; Wallace, 3168; Murchison, 10,908-13; Tolmie, 13,596-602; Reardon, 20,274-75; Morrison, 22,323.
5 Maxwell, 551 (8); Anderson, 7411; Bruce, 7469-74, 7587; Macleod, 14,779-81; Macdougall, 20,478-80.
6 Macdonald, 16,460.
7 Reardon, 2074; Tolmie, 13,596, 13,651-52; Morrison, 22,321; Gilmour, 22, 862; *Vide* Report by Sheriff Fleming, K.C., on the Parishes of Barra, N. Uist, S.Uist, and Harris (1906), pp. xv. And xix.

pauper lunatics boarded out among the population, is not commensurate with the responsible character of the work.1

(d) Vaccination of Defaulters.

134. It is also the duty of the Poor Law Authority to provide for vaccination of defaulters, and, as in many parts of the Highlands and Islands the majority of parents become defaulters, this duty entails a considerable charge on the parish rate.2 There is no grant in aid for this service.

Lately there has been an increasing tendency in certain districts to take advantage of the conscientious objector's clause in the recent amending Act,3 and so to escape the trouble and expense of vaccination. As to this, Mrs Burns states:--"At present it (the charge for vaccination) is 2s. 6d. This means that a patient has to carry her chid to a centre which may be two miles away on a day fixed by the doctor. She has also, of course, to make a second journey a week after for certification."

135. In our opinion, there ought to be no hesitation in offering, under normal conditions, free vaccination to infants and re-vaccination to adults, and the administration of the Acts ought to be transferred to the Public Health Authorities, who are the bodies most intimately concerned.4 But in many parts of the area of financial resources are so slender that such additional charges would hardly be justifiable without substantial assistance from Imperial funds.

(e) The Parish as a Medical Administrative Area.

136. As already stated, the medical officer's salary from the Parish Council, as a rule, the bulk of his income, and the appointment of *de facto* controls his interest in the general practice of that particular area. This has given rise to certain disabilities which have been repeatedly referred to in the course of evidence.

For exampled, it was pointed out that it not uncommonly prevents the full utilisation of the existing supply of medical men in the area of our inquiry, and for the following reason:--the medical officer appointed by the Parish Council tends, as a rule, to regard himself as the doctor for the parish, and therefore he resents any encroachment on his practice by a practitioner from a neighbouring parish. One illustration may be cited.

The parish of Lochbroom, one of the largest in Scotland, has an area of over 400 square miles and one doctor. The most populous district of the parish, viz., Coigach, is 25 miles distant from his residence in Ullapool, but it is much nearer Lochinver, where the doctor of the adjacent parish of Assynt resides. The doctor of Lochbroom told his neighbour that as he was nearest he was free to practise in Coigach, and he continued to do so till that parish doctor left and his successor wrote the Assynt doctor accusing him of breach of professional etiquette.5

137. Another aspect of the difficulty is lucidly described by Mr Jeffrey, Secretary to the Scottish Insurance Commission, and for some time General Superintendent of Poor under the Local Government Board:--6

"The Parish Council in appointing a medical officer frequently fix the fees to be charged in respect of private patients, and these are usually much lower than the ordinary doctor's charges. The arrangement, or contract, however, applied only to persons resident in the parish, and the doctor may charge any fee he likes in respect of attendance on patients outside the parish, so that by force of circumstances the people are compelled to call in the doctor for the parish, although he may be much further from them than a doctor of a neighbouring parish. A very good illustration of this came under my notice in connection with an inquiry I held in Bettyhill, in the parish of Farr. The parish doctor, who at that time resided in Thurso, thirty-five miles away, had been snowed up and unable to reach a patient who was seriously ill. A complaint was lodged against the doctor, and it was contended that he was much too far away. I admitted the contention, but suggested to the complainer that the position was not so serious as he made out, inasmuch as he might have called in the doctor resident in Tongue—only twelve miles away.

1 Cochran, 6755; Murchison, 10,907-12.
2 Maxwell, 655; Kennedy, 4696-97; Heddle, 5092-93; Sinclair, 5221-26; Low, 6195-96; Saxby, 7158-60; Victor Ross, 11,285-87; Ross, 12,271; Tolmie, 13,476-77; MacRae, 16,529; Norris, 17,718.
3 MacLennan, 4395; Mackenzie, 6312; Robertson, 6343; Mrs Burns, 12,726-27.
4 Mackenzie, 6312-14; Robertson, 6609#. 5 Maclennan, 8876, 8993. 6 Jeffrey, 698.

To this he replied somewhat as follows:--1"Yes, but he would have charged twto guineas a visit, whereas the Thurso doctor is bound to come for 5s. a visit."

138. Altogether, the general tenor of the evidence as to this aspect of the problem would incline us strongly to the belief that a scheme of medical provision should include such a rearrangement of medical districts as would locate the doctors at centres from which the respective districts can be most easily worked—somewhat on the lines of the medical areas under the system of Dispensary Medical Service in use now for many years in Ireland.1

139. The claims of the area corresponding to the County District Committee area as a suitable medical administrative unit were strongly advanced by several witnesses on the ground:--

(1) That it would prevent, or greatly reduce, the anomalies referred to above.

(2) That at present it is the statutory unit for health administration in the county.

(3) The interchange of services would be more easily arranged.

E. GENERAL MEDICAL PRACTICE.

1. Scope of General Practice.

140. General medical practice in a rural district embraces the whole range of professional training and experience, and forms with vastly preponderating portion of a doctor's duties even when these are combined with functions of an official or semi-official character. When it is remembered that a doctor practising in a rural district has to be ready to perform the widely dissimilar specialised duties pertaining to the surgeon, obstetrician, and physician in city practice, it will be recognised on the one hand how much responsibility and strain lie upon him; and, oin the other, how much of varied skill is expected of him unaided.2

The daily routine of a doctor's work away, and indeed generally does, include patients belonging to this different categories—medical, surgical and obstetric—and the fact that the doctor has to face the possibility at any moment of having to conduct the most serious and critical operation in surgery or midwifery implies the desirability of establishing a system of medical service of even a higher degree of competence than ordinarily obtains amongst practitioners within reach of specialised skill and consultation.

141. We have before us medical men who notwithstanding the disabilities to which attention has been drawn, including insufficient remuneration, realise the type above described, yet it has to be admitted that the personnel and professional standing of the medical service in the Highlands and Islands suffers from these disabilities.3

In this connection the following forcible statement from the evidence of Dr Mackenzie, North Uist, is well worthy of quotation:--4

"The remuneration should be adequate to attract capable men who would elect to stay. At present, owing to the general poverty of the class that chiefly demands their services, this is not so, with the result of positions are very frequently occupied by two classes—(a) Young men recently out of college who make the appointment merely a stepping stone to something better, who remain only a year or two—not long enough to become sufficiently acquainted with the idiosyncrasies of the people, or the diseases that families inherit or are liable to. (b) Older men, who after perhaps a chequered career, fall back on such places as a last resort of harbour of refuge. While to the capable man, who, from inclination or perhaps the force of circumstances, elects to spend his life in these regions, the most hopeful outlook before him is to die in harness, in case he dies of starvation when old age and decrepitude render him unable to continue work."

2. Frequent change of Doctor.

142. In consequence of these unfavourable conditions there is in some districts a constant change of doctors. Certain parishes have, indeed attained unenviable notoriety

1 Patten Macdougall, 312-18; Maxwell, 666-72; Jeffrey, 693-97, 788-94; Moir, 1401, 1431-33; Bruce, 1513-17; Macdonald, 2068-70; Lovat, 2359; Ellice, 2555-57; Wallace, 3153; Henderson, 3562-65; Maclennan, 4293-94; Mowat, 9059-60; Murray, 10,472; Anderson, 11,050-51; Macdonald, 11,597, 11,600; Chisholm, 20,867; Macrae, 21,085-86.

2 Dick, 4141; Cochran, 6954; Saxby, 7234.

3 Fotheringham, 7746; MacRae, 21,032-33; Macrae, 21,074.

4 Mackenzie, 13,818.

in this respect. To give a few instances: In one parish there have been ten doctors and as many locum tenentes in twenty-two years, and in another two parishes there have been in ten years seven and five doctors respectively and several locum tenentes.[1] Such frequent changes cannot but affect adversely the efficiency of the medical service in these localities.

3. Forms of Remuneration.

(a) Fees and Subsidies.

143. The question of remuneration from general medical practice has already been referred to in some detail in the discussion as to the doctor's income, and earlier in the paragraph dealing with the economic circumstances of the people. It is unnecessary here to re-tell the facts. Suffice it to repeat the general conclusion, which is borne out by all parts of the evidence, that private practice, more particularly among the cottar and crofter population, is far from being remunerative,[2] In some of the poorer districts it is of little consequence as a supplement to the doctor's income. The general effect is very much as put by Dr Bremner, Medical Officer for Health for Sutherland:--[3]

"The sum paid to the doctor by the parish is hardly sufficient to live on and pay his ordinary expenses, and in many cases he has few or no private patients from which to supplement his income. Consequently, the question of expense is uppermost in his mind, and at whatever cost to himself he must reach his patient in the cheapest way possible and as seldom as he conscientiously can."

144. There are, indeed, a few exceptional cases where by reason of continued successful fishing,[4] or of the liberality of proprietors and shooting tenants, or of a special industry peculiar to a locality (as for instance, quarrying, afforestation, electric works, etc) the regularity of people's income is such as to enable them to defray medical services on the very moderate scale of fees calculated on the basis of mileage,, of time, and of the degree of professional attention required. It has, however, to be recognised that those who have to pay for distance and time are placed at a great disadvantage[5] as compared with their fellows to whom such additional heavy outlay does not apply.

145. To redress this marked and unavoidable disability should be one of the chief aims of the betterment of medical service in the Highlands and Islands.

(b) Voluntary Medical Clubs

146. In default of remuneration from fees, various means have from time to time been adopted to supplement the parochial salary of provide a doctor independently thereof. For this purpose voluntary medical clubs or associations have been set up in a number of parishes and more commonly in the insular area, where the difficulty of attracting a medical man is greatest.[6]

A common annual subscription per family is 5s., but in many cases the amount is graded to the circumstances of the various classes of the community. In some places there is an addition of a small fixed fee per visit. The advisability of having such a "check" fee in order to prevent trivial calls was urged by the majority of medical witnesses, and more especially by those who had experience of the club system.[7]

147. The general trend of the evidence demonstrates that, however small the contribution, it is difficult to get it paid where, as is the case over large parts of the area, little ready money is regularly in circulation.8

An average type of such club has been in operation in the island of Barra for a

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1 Heddle, 4986; Bell, 5203; Johnston, 5613, 5619; Gibson, 5714; Tulloch, 5791; Garrioch, 6133; Fraser, 9337-45; Mackenzie, 17,087; Macdougall, 20,391-943; MacGregor, 22,358-59.

2 Park, 5989; Yates, 7079; Saxby, 7175; Anderson, 7372; Maclennan, 8913; Ross, 12,285; Macdonald, 16,255; Graham, 17,447, 17,543; Ross, 19,869.

3 Bremner, 8457. 4 Bruce, 7476-82; Macleod, 11,774-79; Cameron, 20,518-20; M'Neill, 20,712.

5 Maccallum, 21,233.

6 Mackenzie, 13,730; Stewart, 14,817; Drummon, 18,209; Reardon, 20,081-2.

7 Macdonald, 1257-58; Kennedy, 4393; Mowat, 9105; Tolmie, 13,555; Mackenzie, 13,719, 13,854, 13,959; Stewart, 14,837; Maclean, 15,247-48; Fletcher, 15,677; Macdonald, 16,046-51; Macleod, 16,757-61, 16,822-27; Mackenzie, 17,146-50; Anderson, 18,169-70; Reardon, 20,204; Mackintosh, 21,800, 21,812, 21834.

8 Sinclair, 5238; Fletcher, 15,862-64; Macdonald, 16,228-32; Reardon, 20,091-105, 20,207; Macdougall, 20,503; Mackintosh, 21,850.

number of years, and commenting on its insufficiency as a m means of securing an adequate salary for the doctor, one witness, the Rev. Father Cameron, says:--[1]

"About a third of the people, from various causes, do not pay even the small club fee. In the case of these, when medical attendance is required, it is generally impossible to extract a special fee per visit, with the result that the doctor has either to refuse attendance or to give his services gratis. If he elects the latter, as he is frequently compelled out of humanity to do, his "club practice" goes to the winds, as others will take a lesson from his forebearance."

And he concludes by remarking that "the club systems is a degrading farce."

Another interesting feature of the club system is thus described by Mr Jeffrey, Secretary to the Scottish Insurance Commission:--[2]

"There are medical clubs in many parts of the Highlands, but my experience is that they are not a success. A new doctor comes to the parish and everybody is enthusiastic about him. A canvass takes place and members are enrolled. The second year a number of members drop out, and probably by the third year, the doctor himself clears out. It is not altogether the fault of the people that they don't join the club. They are quite willing to contribute something, but what frequently happens is this: they pay their four shillings a year towards the doctor's club, he gets the four shillings and clears out at the end of six months, and they are left in the lurch."

148. The only cases where we found the club system succeeding to any reasonable extent were in one or two parishes where the economic[3] conditions are above average, as in the case of Strath, Skye and in a few others where the club is more or less directly under the control of the estate, in which case the estate officials usually collect the subscription with the rent.[4] Here, however, the proprietor is almost always a generous subscriber, and in this connection also we would place on record the public-spirited generosity displayed by many proprietors in endeavouring to make medical aid available to remote and isolated communities on their estates.

149. An instructive sidelight on the whole financial problem is that while the medical witnesses generally condemn the system of medical clubs they go on to sat that, precarious and meagre as the resultant income is—and the facts at our disposal show the average to be about £50 a year—it is more than they can hope to get from fees.[5]

150. Our conclusion, therefore, is that as a general means of guaranteeing a substantial addition to the doctor's income such a system of voluntary payment, however desirable on theoretical grounds as a form of mutual aid or insurance, as in this area unreliable. The evidence was conclusive that in order to be successful it must be compulsory.[6] It would, however, be an obvious advantage that a contributory fee fund on a voluntary basis should be established in a district by means of a small annual payment per household. In order to encourage this it has been suggested that on the analogy of the National Health Insurance scheme a contribution from any Imperial Grant made to the improvement of medical service in the Highlands and Islands might be legitimately applied to the encouragement of any such voluntary effect.[7]

(c) Subsidies from Imperial Grants.

151. The extent to which ordinary medical practice is subsidised by the Pauper Lunacy Grant, the grant in respect of Medical Officers of Health and of School Medical Treatment, is, as indicated, of little moment; and as regards the grant in aid of Medical Relief, which, though never adequate, has been the mainstay of local resources in the provision of medical attendance for the inhabitants, it is shown to have fallen less than half the rate per £ which ten years ago encouraged Parish Councils to offer salaries sufficiently high to attract medical men to these remote parts. The steady reduction in this grant has two obvious effects, especially in the poorer districts: it has entailed corresponding increase of the parish rates and has tended to discourage increase of the medical officer'' salary.

1 Cameron, 20,601-03 (1). 2 Jeffrey, 891.

3 Gibson, 5462-67; Macdonald, 16,460; Macleod, 16,739, 16,849-50, 16,886-87; Macrae, 21,124-25.

4 Lovat, 2299-302; Campbell-Orde, 2769-80, 2814-40; Macleod, of Macleod, 14,615.

5 Duffus, 4655-57; Mowat, 9103-04; Stewart, 14,972; Macpherson, 15,039; Fletcher, 15,676; M'Iver, 16,909-10.

6 Macleod, 3851-53; Kennedy, 4365-69; Sinclair, 5394; Macpherson, 15,051-54, 15,079-82; Maclean, 15,233-37; Mackay, 15,407-10; Murray, 17,038; Knox, 17,212; Robertson, 17,898; Roger M'Neill, 19,358; Reardon, 20,242-46; Macdougall, 20,386, 20,428-34; Cameron, 20,579, 20,672; M'Neill, 20,776; Chisholm, 20,885; MacRae, 20,994; Mackintosh, 21,783-85; Young, 22,182, 22,186; Locheil, 23,415-17.

7 Macdonald, 15,984-85.

case. Mere extraction of teeth is totally insufficient even as the beginning of a general dental service. Preventative and conservative treatment is absolutely necessary. Apart from the overwhelming facts revealed at the recruiting stations, the masses of evidence adduced in the School Medical Officer's Reports can leave no doubt anywhere as to the need for special dental treatment. Personal care of teeth may do much to prevent dental disease, but real conservative treatment cannot be provided except by skilled dentists. In no part of the area can medical service become adequate unless it includes skilled dental service. The best method of providing such a service is open to discussion. The localities are not all alike. In one place, a peripatetic dentist might be able to overtake the work; in another place, a whole-time dentist might be essential. In some cases, probably it would be most convenient to subsidise the Country Education Committees that they could not only undertake the treatment of defective teeth among school children, but also make the services of the school dentist available for the general public. Both for children and the general public it should be possible to arrange suitable tariffs or fees. But whatever arrangements are finally made, there can be no question of the national importance of providing a dental service. This position is now accepted and supported by every person concerned with the inspection of school children, ad with every service where the teeth come under examination.

3. Eye, ear, etc.

155. It goes without saying that diseases of the eye and ear are among the most prominent and most urgent. The School Medical Officer's Reports have revealed in the Highlands, as elsewhere, large masses of eye and ear diseases needing special treatment. The economic importance of corrective defective eyesight in the earlier stages is admitted everywhere. No less can be said of the danger of chronic ear disease. But the correction of eyesight demands the services of a skilled oculist; the treatment of ear disease is frequently more a matter of persistent attendance and nursing. But in both cases, there is need for some special service. In some localities, the general practitioner is skilled in eye work and in ear work; but it must be admitted that this is exceptional. In eye and ear diseases, the remote areas of the Highlands and Islands are at a peculiar disadvantage. The difficulty has been felt in many other rural areas; but it is particularly acute in the Highlands and Islands. The result is that eyesight is impaired in large numbers of cases and ear disease become chronic. The economic disadvantages in after life are subtle and widespread.

4. Special Pathological Service.

156. For the ordinary infectious diseases, certain arrangements are in force in almost every public health area. In doubtful cases of diphtheria, it is possible for any medical practitioner, at the public expense, to have material from the throat examined by a skilled bacteriologist. The same is true in cases of typhoid, he may have the blood examined; and in cases of tuberculosis, he may have the sputum examined. He may also have, at the public expense, antitoxin for the treatment of diphtheria and tuberculin for the treatment of tuberculosis. Where a local authority has not already made arrangements for these tests or curative agents it may at any time make them. Frequently, Local Government Board, out of its vote, is able to assist local authorities by special investigations of carrier cases of typhoid or special outbreaks of diphtheria or of other infections; but this service by central department mist, in the nature of things, be only occasional. Briefly, it may be said that complete machinery exists, and, in places, is utilised (a) for the testing of those infectious diseases where such testing is an aid to diagnosis, and (b) for the provision of the two curative agents, antitoxin and tuberculin.

157. But this pathological service might very well be extended. The same laboratories as carry through the tests spoken of might, with very little expense, carry through other tests such as the examination of the blood in particular diseases, the investigation of the resistance to, or the presence of, specific toxins, preparation of vaccines, etc. But these examinations are highly technical; they cannot be conducted efficiently except in a well-equipped laboratory by a highly skilled pathologist. They are not in themselves expensive; but the number of persons qualified to undertake them is very limited. Besides, the consume a great deal of time, and, unless the expert is employed daily in making the examinations, he cannot either maintain the necessary technical equipment for performing the examinations of safely offer a skilled opinion. These examinations are among the most delicate of the modern methods for the diagnosis of disease and for the guidance of treatment. With a relatively small outlay, it would be perfectly possible to bring the whole area of the Highlands into touch with well-equipped laboratories at the great medical schools.

Further, it would be possible to arrange with the Medical Schools for the advice of medical pathologists skilled in the most recent technicalities. This would be an advantage both for the national study of disease and for the local diagnosis and treatment. The medical services of all the principal towns and the greater part of the counties are already in intimate touch with the pathological laboratories of the Schools, and, occasionally, individual men in the provinces maintain small pathological laboratories and provide vaccines of various kinds. But this pathological service should not be left to the accident of locality or to the intellectual service to be placed on an organised footing and to become part and parcel of the system of medical service.

5. Ambulance Service.

158. From the geographical conditions indicated earlier in the Report, it mau nbe inferred that, in the Highlands and Islands, there is a particular need for an ambulance services. For the infectious diseases, the local public health authorities are under obligation to provide ambulances, and, as a rule, such ambulances have to be provided. But for the removal of cases of general sickness to hospital, there is no ambulance service except what is provided by the charitable organisations. There seems to be no sound reason for not providing a sickness ambulance out of public funds. To every class of the community sickness comes sooner or later; for many cases of sickness, removal to hospital offers the only chance of remedy; but safe removal of very often beyond the means of the individual. Whatever view be taken of the best method of providing hospitals for sickness, there is a strong case for providing ambulance service out of public funds. The ambulance provided by many local authorities for infectious diseases have rendered the use of distant hospitals easier and more satisfactory. In one county of the area a motor ambulance for infectious diseases has been provided, with the same result as elsewhere, viz. The partial elimination of the distance-factor. The same might become true for general sickness. Indeed, there is no physical reason why the ambulance used for infectious cases could not, with proper precautions, be used for non-infectious cases. As, however, the danger of infection could not always be eliminated, the general use of one ambulance for infectious and non-infectious cases cannot be recommended. But it seems desirable that each county should have some form of ambulance service for cases of general sickness and accident. A motor ambulance would not equally suit every district of the area; but it would suit sufficiently large parts of the area to justify the installation of a public ambulance service. Such a service would be a legitimate subject for an Imperial subsidy, For insured persons on sanatorium benefit and their dependants an ambulance service is made possible under section 16 (4) of the National Health Insurance Act.

6. Medical Consultation.

159. Thus from several standpoints it has been made apparent that the inadequacy of the medical service in the Highlands and Islands cannot be removed merely by increasing the number of general practitioners. But apart from specialisms like dentistry, or ophthalmology, or pathological bacteriology, there ought to be much more provision for medical and surgical consultations between local doctors. There should be provision for assistance at operations, or in difficult confinements, or in the administration of anaesthetics, or in the many classes of unforeseen emergency where professional discussion and assistance are desirable. At present, the expense of such assistance or consultation is, in many localities, prohibitive. So long as this remains true, no medical service can be considered satisfactory.

PART IX.

GENERAL RECOMMENDATION.

160. It is clear that, having regard to the economic conditions prevailing in the Highlands and Islands, the extent to which the foregoing services are at present subsidised from Imperial funds is quite inadequate, and that as local resources are in many parishes already well-nigh, if not wholly, exhausted, any general amelioration of the existing medical service cannot be achieved without a further and more substantial subsidy.

161. It has been shown that, in the Highlands and Islands, general medical practice rests very largely on the subsidy from Poor Law authority and to a much less extent on subsidies from other public authorities. But it must be pointed out that the remuneration from these various authorities bears no proper relation to the work done or to the degree of responsibility involved. Consequently, the individual practitioners are discouraged and medical service as a whole suffers.

162. But the Committee are of opinion that, by proper administration of an additional Imperial Grant, all these public services could be so developed and correlated administratively aas to provide a more satisfactory financial basis for general medical practices.

163. For the administration of any subsidy granted by the Treasury for the carrying out of the policy indicated in this Report, the Committee suggest that a central authority an a local authority be constituted.

164. The Committee, after carefully considering the administrative conditions, are of opinion that a special central authority and a special local authority would be required.

165. The Committee suggest that the central authority should contain a representative of each of the four principal central departments concerned with administration and control of medical services, namely:--The Local Government Board for Scotland, the National Health Insurance Commission, the Scotch Education Department, and the General Board of Lunacy; a representative nominated by the General Council of Medical Education and Registration of the United Kingdom; a chairman nominated by the Secretary for Scotland and approved by the Treasury.

166. In making this recommendation, the Committee have had regard to all the medical interests involved, the duties and responsibilities of the public authorities operating in the Highlands and Islands, and the desirability of bringing about, as far as is practicable, a consolidation of the various services. The central authority thus constituted would act under regulations made by the Treasury.

167. To enable central authority to administer the suggested Grant with due regard to the conditions of each locality, a local authority would also be required. It is not desirable to multiply authorities without necessity, and, in the Highlands and Islands, on account of the difficulties and expense of attending meetings, this principle deserves special consideration. As it is of primary importance to retain the administrative interest of the parishes, and as all the Parish Councils are already represented on the District Committee, which is the local authority for public health, the Committee recommend that the local authority for the administration of this special grant should be the District Committee along with representatives from the Insurance Committee of the county or District Insurance Committee, a representative from any county or district nursing association, or, in default of such association, a representative nominated by the District Committee; a representative from the local branch of the British Medical Association; and an officer from one of the central departments concerned—this officer to act as assessor. The Medical Officer of Health of the County or Chief Medical Officer of Health for the District might attend meetings of the Committee for the purpose of giving advice and assistance.

It would be the duty of this Local Medical Service Committee to prepare a scheme of improved medical and nursing service for submission to the central authority with a view to an Imperial Grant.

168. The Local Committee in preparing such a scheme, and the Central Authority in considering the scheme should have regard to the following points:--The financial position of the public medical services in the district; the possibility of administrative correlation and consolidation of such services; the geographical difficulties of the district; the local distribution of population; the sufficiency of general and special hospital service; the adequacy of general and special nursing services; the economic difficulties of private medical practice; the desirability of securing to every person below a certain income within the area medical attendance on terms adapted to his economic condition, whether by low uniform fee, graduated fees, system of club payments, or otherwise; the local need for specialised medical service, such as special local consultations, local assistance at operations, dental treatment, eye treatment, etc.; the need for special travelling allowances for doctors and nurses; the possibility of securing an adequate minimum salary for the local medical practitioners from public sources, local or Imperial; the need for additional medical practitioners; the need for subsidising authorities or individuals in order to secure adequate service; the need for safeguards against trivial and vexatious calls for medical attendance; the ambulance service available in the district for sick or disabled persons; any other matter or circumstance that would enable the central authority so to apportion their grant as to secure satisfactory medical and nursing service for all classes of the community.

169. After considering the evidence and statements submitted by the medical witnesses, the Committee express their opinion in a general way that for public and private medical service (in single practice areas) a minimum income of £300 per annum, with travelling allowance, should be secured to every medical practitioner recognised by the central authority.

170. In the case of several doctors living in common centre (multiple practice area) where it would be in the public interest to arrange that outlying patients be attended at small fees, the doctors should receive an annual subsidy to enable this to be done.

171. As suggested by Sir Donald MacAlister, on the analogy of India, a tariff of fees suited to local circumstances should be prepared by the doctor for inclusion in any scheme submitted by the local authority for approval of the central authority.

172. The relations of the Local Medical Service Committee to all the other authorities and interests would be adjusted by regulations issued by the Central Authority, who should be authorised to make grants conditional on the establishment and maintenance of a satisfactory medical service—the conditions to include any special qualifications necessary for medical officers, nurses, and others; questions of tenure of office; submission of tariff charges for private practice, and the like. The central authority would act in concert and consultation with the central departments represented on it.

173. These are our recommendations as to what might be the best way to administer the proposed grant; but the Committee recognise the possible objections to the creation of a new central authority, and that the Government may consider it more expedient too administer a grant through the existing central and local authorities acting in concert.

In conclusion we desire to place on record our appreciation of the able services rendered to the Committee by our secretary, Mr Beaton. His intimate knowledge of the Highlands and Islands was of the greatest importance, and from the beginning to the end of the enquiry he devoted himself to the work of the Committee in a way which is beyond all praise.

(Signed) JOHN A. DEWAR, *Chairman*.
KATHARINE TULLIBARDINE.
J. C. GRIERSON
ANDREW LINDSAY.
W. LESLIE MACKENZIE.
JOHN C. M'VAIL.
A. C. MILLER.
CHARLES ORROCK.
J. L. ROBERTSON.

M. BEATON, *Secretary*.

24th December 1912.

APPENDICES.

APPENDIX No 1.

SUGGESTED SCHEME FOR THE ADMINISTRATIVE CONSOLIDATION OF MEDICAL SERVICES.

By W. LESLIE MACKENZIE, M.D., LL.D., Medical Member of the Local Government Board for Scotland.

INTRODUCTION

1. The Committee's remit contains the words:--"To advise as to the best method of securing a satisfactory medical service therein, regard being had to the duties and responsibilities of the public authorities operating in such districts".

2. In the scheme here sketched out, it is assumed that an additional grant from Imperial sources will be made available.

3. If such a grant is to result in the establishing of a "satisfactory medical service", it is essential that the existing medical services shall be consolidated. Legislative consolidation could not be accomplished without serious amendment and readjustment of a large number of statutes affecting the health of the country as a whole. As the Committee is concerned only with the Highlands and Islands, the present seems a favourable occasion for the framing of a scheme to show how far, through the instrumentality of a grant, it is possible to bring about an administrative consolidation of existing services. Such an administrative consolidation would result in increasing the efficiency and developing the resources of the present services, in demonstrating what additional service is necessary and in preparing the way for any legislation afterwards found to be expedient.

4. There are several factors in the problem:--the smallness of the unit area of administration of parish medical service, the economic deficiencies of particular districts, the geographical difficulties of transit, the conflicting interests of local administrative authorities, the insufficiency of general and special hospital service, the inadequacy and imperfect organisation of general and special nursing services, the economic difficulties of private practice, the comparative absence of specialised medical practice. To show how some of these difficulties and defects may be overcome it is necessary to enter with some detail into the statutory constitution and obligations of the existing medical services, to indicate some statutory resources that are still underdeveloped, and to show how the public services, once properly correlated, may become the basis for a more adequate system of private medical practice. A primary point to consider is the relation of the public medical services to private medical service; for it may here be said at once that, over larger areas of the Highlands and Islands, private medical practice on the ordinary lines is a demonstrated failure. Large numbers of sick people go untreated; yet the doctors cannot make a living.

THE MEDICAL SERVICES.

5. The medical services here to be discussed may be classified as follows:--

I. Poor Law Medical Service
II. Old Age Pension Medical Service
III. Local Lunacy Medical Service
IV. Vaccination Medical Service
V. Public Health Medical Service
VI. School Medical Service
VII. Maternity Medical Service
VIII. National Health Insurance Medical Service
IX. Factory Medical Service
X. Post Office Medical Service
XI. Nursing Service

Private Medical Practice; including the club system, fee-paying practice, etc.

Included in his salary. But the amount paid in respect of lunacy does not rank for any grant. The cost of pauper lunatics, however, is partly

Of these services, two—the Factory Medical Service and the Post Office Medical Service—are State medical services, the officers being appointed by the central departments concerned—the Home Office in the one case, the Post Office in the other. With the exception of Private Medical Practice, the others are, in one degree or another, supported by the local rates or Imperial subventions, or both. The details are given below.

Although, for the purposes of exposition, each service is separately named, all the named services are not on the same plane of importance. Thus, the "Old Age Pension Medical Service" is a small matter relatively; so is the Vaccination Medical Service. But each service named is based on a separate Act of Parliament, and may, therefore, properly be considered as a separate service. But frequently in the sparsely populated places duties under several distinct statutes are performed by one body, the Parish Council, and these duties are indicated under "Poor Law Medical Service". As, however, it is necessary to show the legal inter-relation of services, each service is discussed under a separate hand. The cross-classification is justified by the purpose of the argument.

I. POOR LAW MEDICAL SERVICE

6. At present, the following medical services, though not all under the Poor Law Acts, and, therefore, not all affecting the registered poor as such, are, nevertheless, carried out by the Poor Law Authority, viz. The Parish Council:--

A. Medical attendance on the registered poor in poorhouses or outdoor.
B. Medical attendance on old age pensioners
C. Medical attendance on pauper lunatics.
D. Vaccination of defaulters.
E. Attendance, nursing or other, on paupers in poorhouses, and also on outdoor paupers and pauper lunatics.

To fulfil these functions the Parish Council appoints a parish medical officer. This officer is not a statutory officer; but, as a result of the conditions laid down by the Scottish Office for the distribution of a grant of £20,000 for medical relief and nursing in poorhouses, the great majority of the parishes have assented to the appointment of a parish medical officer. He attends on paupers and on old age pensioners; he visits periodically the pauper lunatics in the parish; he vaccinates paupers and vaccination defaulters. As parish medical officer he must, in all these capacities, act at the instance of the Inspector of Poor, who is responsible, under the Parish Council, for seeing that the directions of the medical officer are carried out.

The salary of the parish medical officer must be approved by the Local Government Board, who determine what proportion of salary shall rank for the medical relief grant. This grant amounts to £20,000 for the whole of Scotland. A first charge on it is made for trained sick nursing in poorhouses; the remainder is distributed as a subvention in aid of the medical officer's salary. This subvention at present amounts to about 4s. 3d. per £. No part of the grant is available for the nursing of outdoor paupers, or for lay attendance on paupers or pauper lunatics. The fact that trained sick nursing *in poorhouses* is a first charge on the grant affects unfavourably the Highlands and Islands districts; for, in those districts, the vast majority of the registered poor are on the outdoor roll; only a small minority are in the poorhouses. It follows, that, although the proportion of poor is large, the proportion of medical relief grant is small. In the memorandum prepared by Mr Maxwell, Secretary to the Local Government Board, full details are given as to the inequitable incidence and operation of this grant.

7. For his visits to pauper lunatics, the parish medical officer is paid by separate fee, which may, however, be

refunded to the Parish Council from the pauper lunacy grant of £150,000, which is distributed by the Scottish Office on the certificate of the Local Government Board.

8. For his services in the vaccination of defaulters the parish medical officer is paid out of the poor rate alone; no grant being available for this purpose.

9. In order to obtain medical officers to discharge these functions the Parish Councils have been obliged to offer salaries sufficient to induce men to reside in localities not otherwise likely to attract a private medical practitioner. Consequently, the salaries, compared with the salaries given elsewhere in Scotland, are, in the Highlands and Islands, very frequently out of proportion to the number of pauper lunatics that have to be medically attended. The incidental result is that the poor rate, supplemented by the Medical Relief Grant, bears to a considerable extent the burden of "free" medical service; for it is a common understanding that the medical practitioner appointed as parish medical officer shall attend non-paupers at reduced fees. Frequently, indeed, the parish medical officer attends poor but non-pauper residents without any prospect of obtaining a fee. In the Highlands and Islands that is an extremely common practice. The general grounds for this are fully explained.

10. It may be added that where medical attendance alone is given by the Parish Council (that is, medical attendance without maintenance, the person attended is not disqualified for voting for a member of parliament, or at a municipal election, or as a burgess or for certain officers; but he *is* disqualified from voting for the election of a parish councillor. As, however, medical relief dissociated from maintenance is practically never given by the Parish Council, this question of non-disqualification is of minor importance in the Highlands and Islands. (But see under II.—Old Age Pension Medical Service.) The principle, however, is important; for it implies that a resident may receive for himself or his family full medical attendance without the sacrifice of any civil right except the capacity to vote for a parish councillor. The parochial medical service, therefore, is, to this extent, a public "free" medical service paid chiefly out of the poor rate.

11. In the proposed scheme it is assumed that the salary thus provided out of rates, supplemented by grant, would remain as at present. In some cases the salaries may even have to be increased in order to render the parochial medical service more efficient. The salary cannot be reduced without the sanction of the Local Government Board. (A full account of the whole Poor Law Medical Service is given in the Departmental Committee's Report, 1904, and in the Scottish Report of the Royal Commission, 1909. In both of these many suggestions are made for improvement of the medical service generally.)

II. OLD AGE PENSION MEDICAL SERVICE.

12. As indicated above the parish medical officer attends on old age pensioners. This is because the majority of old age pensioners in the Highlands and Islands districts cannot afford the expense of a private medical attendant, and they are not disqualified by receipt of medical relief, even when administered under the Poor Law. In a circular issued by the Local Government Board on 30th May 1911, occur the following words:--

"Medical Relief to Old Age Pensioners.—If the relief given is of the nature of "medical or surgical assistance (including food or comforts) supplied by or on the recommendation of a medical officer" (Old Age Pensions Act 1908, section 3 (1, (a) (i)), disqualification for a pension will not follow. Accordingly, every pensioner who is in need of such assistance and is unable to pay for it is entitled to obtain it from the Parish Council without forfeiture of pension. It will be observed that the medical relief which may be given without disqualification covers more than mere medical visitation. In the opinion of the Board it includes. Besides medicines, medical and surgical appliances, nutritious diet, etc., such as nursing or attendance as may be ordered by the medical officer as part of the medical or surgical treatment of the case.

It must, however, be pointed out that while medical relief does not itself disqualify for receipt of pension, the value of such relief must be reckoned as part of the income of the recipient. There may, accordingly, be cases where the amount of the relief is such as to prevent the recipient, in respect of means, from being eligible for a pension."

13. The medical attendance on old age pensioners does not amount to a separate service, but it illustrates very pointedly the power of the Poor Law to administer medical relief without involving the recipient in any disqualification either as to his pension or as to certain rights of voting. What applies to old age pensioners applies equally to all others in need of medical relief alone. Thus, under the Children Act, 1908, section 12 (1), the failure to provide medical aid may be regarded as neglect, and the parent or other person legally liable to maintain a child or young person may be deemed guilty if he fails to take steps to procure the medical aid "provided under Acts relating to the relief of the poor".

14. But it must be said that the medical attendance on old age pensioners does not constitute a serious item at present in the work of the parish medical officers. In some cases the medical officer had never been called to an old age pensioner, although there were many in the parish. Probably the failure to call the doctor is in many cases due to ignorance of the legal right. But, apart from the Poor Law, there is no provision for medical attendance on old age pensioners, and, as they are presumably unable to afford ordinary medical fees, they may in may instances go without medical attendance even when they require it. The medical officer of the parish is not specially paid for his attendance on old age pensioners, and in one case brought before the notice of the Committee the medical officer himself has had to provide any drugs prescribed for such pensioners. This he had to do in every case where application for medical relief had not been made through the Inspector of Poor in the regular way. This is not a satisfactory state of matters. The attendance on old age pensioners, and no medical officer should have to pay out of his own pocket for the drugs prescribed.

III. LOCAL LUNACY MEDICAL SERVICE.

15. Although the pauper lunatics are attended by the parish medical officer, the Lunacy Medical Service is distinct from the Poor Law Medical Service. The treatment of lunatics, both in poorhouse lunacy wards and in private houses, is supervised by the General Board of Lunacy, who control both parish and other asylums. The Local Lunacy Boards are distinct from the Parish Councils. It is, therefore, important to note that the Lunacy Medical Service, is a distinct medical service. In the Highlands and Islands the proportion of lunatics is larger than in many other parts of Scotland, and, consequently, the cost of the treatment of lunacy is a very heavy burden on local rates. It has, on more than one occasion, been suggested that the treatment of lunacy should be entirely met from Imperial funds. If this were done, one serious on the Highlands and Islands would be removed. In any claim for an Imperial grant to increase the inadequacy of the medical service in the Highlands and Islands, the cost of lunacy may legitimately be emphasised. In several localities it was pointed out to the Committee that lunacy was the most expensive item in the whole medical service. To a certain extent this burden has been relieved in the western islands by the use of the two poorhouses (Stornoway and Lochmaddy) for the accommodation of suitable cases of lunacy. The Local Lunacy Medical Service should be paid for on a more adequate scale than at present.

IV. VACCINATION MEDICAL SERVICE

16. Under the Vaccination Acts the Parish Council is charged with the duty of vaccinating defaulters, and taking all legal proceedings necessary for the purpose. There is no system of public vaccination as in England. In Scotland, vaccination is normally a private medical service rendered by a practitioner to his patient, and paid for by the patient. Only when a child's guardian becomes a defaulter is the child vaccinated at the public expense. In many of the Highland and Island parishes practically all the guardians of infants become defaulters, and thus have their children vaccinated at the expense of the poor

rate. There is no grant to assist the parishes in the execution of the Vaccination Acts. It may be added that the fee for vaccination acts as a deterrent.

17. A Vaccination Medical Service is also provided for under the Public Health (Scotland) Act, 1897, which authorises the Local Authority for Public Health to defray the cost of vaccination and re-vaccination. This power, however, is permissive. In the Highlands and Islands vaccination is entirely carried through by the Parish Councils, except occasionally, when there is a smallpox outbreak or a smallpox "scare". Vaccination is then offered freely by the Public Health Authorities.

18. It has been suggested that the whole work of vaccination should be a statutory obligation on the Local Authority for Public Health, which is the authority directly interested in the prevention of smallpox. This authority may at any time defray the cost of vaccination and re-vaccination; but it cannot be placed under obligation to carry out the Vaccination Acts until those Acts are amended. Possibly, however, if the Public Health Authorities in the necessitous districts were assisted from Imperial funds, they might be induced to relieve the Parish Councils of this particular service, for the execution of which the Parish Councils are not in any way specially fitted. It may be added that in many localities the Committee found evidence of the rapidly increasing number of conscientious objectors. As, however, the registrars may be required to transmit to the Public Health Authority any declarations of conscientious objections, it is normally to be expected that the amount of vaccination and re-vaccination done by the Local Authorities for Public Health in these localities will steadily increase, and the consequently increased outlay may properly form an item in any claim for an additional Imperial grant. The operation of the Vaccination (Scotland) Act 1907, has largely converted compulsory vaccination into voluntary vaccination. An, as voluntary vaccination is provided for under the Public Health Act, it is from the Public Health Authority that any future improvement in the Vaccination Medical Service is to be expected.

V. PUBLIC HEALTH MEDICAL SERVICE.

(a) Hospitals, Convalescent Homes and Reception Houses.

19. The Public Health Medical Service is concerned with all conditions affecting the health of the community, and, in particular, with the isolation of treatment of all infectious diseases. For these purposes the Public Health Authorities are under obligation to appoint medical officers of health and sanitory inspectors. They may also be required by the Board, and in practically all cases have been required, to provide HOSPITALS, temporary or permanent or portable, for persons suffering from infectious diseases; but, though in many cases eminently desirable, these Reception Houses have nowhere been provided in the Highlands and Islands. Further, they may be required to provide Reception Houses for persons that may have been exposed to infectious disease. Such houses, however, have nowhere been provided in the Highlands and Islands. Hitherto, the hospital accommodation provided has tended to the minimum necessary for the isolation and treatment of proportion of the persons affected by the most serious infections. (These obligations are contained in section 66 of the Public Health (Scotland) Act 1897.)

20. In many localities, however, the provision even of hospitals has been found so difficulty on account of the poverty or the geographical conditions of the area that, even for the major infections, no hospital is at all available. These localities are undoubtedly the exception; but the economic conditions are frequently such that the rates would be grossly overburdened if adequate provision of Hospitals, Convalescent Homes, and Reception Houses were rigidly enforced. This is an item that may legitimately be pressed in the claim for additional Imperial grant.

(b) Domiciliary Medical and Nursing Service.

21. Under the same section (66) the Public Health Authority, with the consent of Local Government Board, may also, either instead of providing such hospitals or houses, or, in addition to such provision, employ nurses to attend persons suffering from infectious disease in their own houses, and may also supply medicines and medical attendance for such sick. In several localities in the Highlands this power has been employed. On or two Public Health Authorities in the Highlands have appointed nurses to attend patients in their homes; but the comprehensive powers of domiciliary treatment conferred by the Act have not been developed to any considerable extent. This, no doubt, is largely due to the expense involved both in the provision and in the housing of trained nurses. All over the Highlands the Committee have been confronted with the difficulty of housing nurses and doctors. In some cases, too, the public health rate has approached or reached its statutory maximum, viz 1s. per £. In those cases no adequate provision, either of hospitals or of nursing, is possible without Imperial assistance. At the same time, probably the failure to provide nursing may fairly be assigned in part to the inadequate appreciation for the need of nursing. Frequently, epidemic diseases—such as measles, typhoid and even typhus fever—are allowed to run riot until the number of immediately susceptible persons is exhausted. In many localities the nursing provided is quite inadequate for epidemic work; but there is evidence that the need for domiciliary nursing is being better appreciated.

22. It may here be added that in a great many localities the houses are quite unsuited for the isolation and treatment of any infectious disease (including tuberculosis). It follows that any system of home-nursing for infectious diseases must remain more or less abortive. Yet, in the large epidemics that must occasionally occur, particularly among children, nursing at home is an essential adjunct of any Public Health Medical Service.

23. Hitherto only one or two Local Authorities have made any fixed arrangements with medical practitioners for attendance on infectious patients at their own homes. This, however, is clearly a competent arrangement under the section, and, as the Public Health Authorities are responsible for the management of all infectious diseases, they may legitimately be urged to develop the domiciliary medical treatment of infectious cases, where no other arrangement is, for the time being, practicable. In the evidence places before the Committee, several cases were mentioned where the local medical practitioner had to attend, on behalf of the Local Authority, a large number of infectious cases—such as persons suffering from diphtheria and typhoid fever; but in most localities, such attendance was regarded merely a an ordinary part of the duty of the general practitioner to his patients, and was not paid for by the Local Authority.

24. The term "infectious disease" in this section includes tuberculosis, whether the disease be compulsorily notifiable or not. The Local Government Board in reports and circulars have indicated their view that the Public Health Act is applicable to tuberculosis as to other forms of infectious disease. In particular, they have issued an order requiring the notification of pulmonary forms of tuberculosis. It is, therefore, open to the Local Authority for Public Health to provide for domiciliary treatment of tuberculosis, and this has been indicated in a circular recently issued by the Board (P.H. XVII., 1912).

25. The powers conferred by this section (66) of the Public Health (Scotland) Act, 1897, are, therefore, of the greatest practical importance in the Highlands and Islands, where hospital accommodation is, for geographical reasons, frequently difficult to establish; where, as in some of the islands, the housing is particularly defective and insanitary; where too, the population is frequently very much congested. No doubt the occurrence of tuberculosis is largely a problem of housing; but, pending the improvement of housing, there is abundant need for an extension of the domiciliary medical and nursing systems. Illustrations could be taken from almost any part of the Highlands and Islands.

26. Generally, it may be said that in the Highlands and Islands the powers of hospital provision, convalescent home provision and provision for patients that have been exposed to infection, have not been developed to anything like their full extent, nor has adequate attention been

concentrated on the possibilities of medical attendance and nursing at home. Probably, if additional assistance from Imperial Grants were available, medical and nursing service for infectious disease, including tuberculosis, could be made immensely more adequate. A nursing service developed under these powers would also cover a large part of the cases emerging from the medical inspection of school children, who, as is well known, suffer in considerable numbers from diseases such as ringworm, impetigo, and other infectious skin diseases, not to speak of infectious eye diseases, septic catarrh of the ear, and septic conditions of the throat. The amount of money available from the Public Health Rate and the Imperial funds might thus become a substantial basis for a nursing system that could be readily extended to non-infectious cases. There seems to be no sound reason why a nursing system established by a District Committee (that is, the Local Authority for Public Health) should not be consolidated with any nursing system established under a Parish Council. If the various monies available were funded there is no reason why the nursing work of a whole district should not be so arranged as to suit the purposes of every parish within the district. Such a system would be at once more economical and more efficient than the scattered and sporadic efforts at present made to deal with individual cases.

27. In this no account is taken of the excellent work done by voluntary nursing associations; but there is no reason why a public nursing system should not be developed in harmony with the local systems here and there established. At present the absence of systematic organisation over a sufficiently large area results in waste of money and energy. (See below, XI.)

(c) Control of non-infectious Endemic or Epidemic Diseases.

28. It is right to direct attention to another section of the Public Health (Scotland) Act, 1897. B section 78 of that Act: "The Board may from time to time make, alter, and revoke such regulations as to the said Board may seem fit, with a view to the treatment of persons affected with any epidemic, endemic, or infectious disease,…and may declare by what authority or authorities such as regulations shall be enforced and executed."
It is under this section that the recent order for the compulsory notification of pulmonary tuberculosis was issued. If it be held that the terms "epidemic" and "endemic" are to be read as alternatives to the term "infectious disease", it will at once be clear that the powers of this section may cover a number of serious and wide-spread diseases, infectious and non-infectious. Among the diseases which might be dealt with in such an order are hyatid disease, which is common in Shetland; croupous pneumonia, which is common everywhere; and the malignant diseases (including cancer), which at present cannot receive in the Highlands and Islands the same medical attention they receive even in small towns. It need hardly be said, however, that any serious extension of the present obligations of the Public Health Authorities along those lines could not be contemplated without additional assistance from Imperial funds.

(d) Cleansing and Disinfection of Houses and Clothing.

29. Under the Public Health Act, also, there are abundant powers for the cleansing and disinfection of houses, for the transport of patients to and from hospital. In the direction and execution of such work an adequate service of nursing might be developed, with the greatest social profit. Over and over again the Committee have had impressed upon them the value of trained nurses in educating the inhabitants in the maintenance of cleanliness, both of house and person. Amongst the many incidental benefits from a public nursing system this is undoubtedly one of the greatest. Such educative direction subserves in no small degree the primary purposes of the Public Health Act.

(c) Ambulance Service.

Further, if it be legitimate to take the larger view of the terms "epidemic" and "endemic" disease, the development of the public health ambulance system might readily dovetail into any ambulance system that was found to be necessary for the removal of cases of general sickness. This would bring the transit of patients either to large distant hospitals or small local hospitals into relation of the Public Health Service of the area. At present patients are removed to hospitals in carts or other conveyance, without any consideration for the nature of the illness or the danger to the patient. The damage to patients must from time to time be considerable. At any rate it is eminently desirable that some regular system of ambulance should be established, and one ambulance could serve for a very large area. The ambulance associations in the thickly-populated centres of Scotland do an enormous amount of good work in this connection, and if there were proper organisation of nursing and medical service, those associations might find for their ambulances a fairly continuous use in the Highlands and Islands. It does seem unsatisfactory that every Public Health Authority should have to provide for the removal to hospital of cases of infectious fever, while a case of pneumonia or acute rheumatism, or Bright's disease, or heart disease, should have to rely on any chance vehicle that the individual himself may find available in the locality. For insured persons and dependants, cost of removal to or from sanatoria or other institutions may be defrayed out of the sums available for sanatorium treatment.
This, however, is offered only as one of many possible illustrations of the uses that might be made of the powers of the Public Health Service to provide the mechanism to assist the organisation of general treatment and the management of hospitals or every variety.

(f) Pathological Service, including Bacteriological Examinations, etc.

30. As a Pathological Service is an essential part of any adequate medical service, it is important to consider how far such a special service can be provided. Already all Local Authorities for Public Health have the power to provide for the bacteriological examination of cases of infectious disease—tuberculosis in all its forms, diphtheria, enteric fever, etc. These powers include the full pathological investigation of all such diseases. Most of the Scottish Local Authorities have already made arrangements for the most urgent parts of this work, and some Local Authorities have special laboratories of their own. Such arrangements might, without any difficulty, include such work as the diagnosis of tuberculosis cases by tuberculin, the technical direction of tuberculin treatment or other similar treatment, the preparation of special vaccines, and the like. With very little additional outlay a full system of pathological assistance and consultation could be instituted. This would be eminently suitable subject for as subsidy from any additional grants contemplated.

31. As the intention here is rather to indicate lines of organisation than to elaborate details of administration, other powers available under the Public Health Acts (including Housing Acts) may meanwhile be passed over. Attention may, however, be directed to the comprehensive powers conferred by the National Insurance Act, secs. 16 (1) and 17, under which the Local Government Board, in the case of insured persons and dependants, may authorise Local Authorities to undertake the treatment of tuberculosis or such other diseases as the Local Government Board with the approval of the Treasury may appoint. (See also financial powers conferred by sec. 15 (7) and (8) on County Councils and Town Councils as to medical benefit, which covers every form of disease and treatment).

VI. SCHOOL MEDICAL SERVICE.

32. This medical service has been organised under the powers of the Education (Scotland) Act, 1908. The central authority is the Scotch Education Department, which has the duty of approving schemes prepared by the County Education Committees and large School Boards. The details of the organisation need not here be specified. Briefly, it may be said that everywhere the system of school medical inspection is effectively correlated with the system of the Public Health Medical Service.

33. The School Medical Service will soon be, where it is not already, supported by a system of school nurses, whose first duty will be the "following up" of the cases discovered at the medical inspection. The nurse will

thus come to act as a most important intermediary between the school medical officer, the parent, and the parent's family attendant. In the evidence placed before the Committee it was made abundantly clear that hitherto the number of children brought by the parent to the medical practitioner is very small relatively to the numbers needing treatment and notifies to the parents by the school medical officer. There is here an important gap to be filled if the School Medical Service is to be made efficient. This gap can be filled by the school nurse, who, at the instance of the school medical officer, would "follow up" the case in the home, and, under the direction of the medical practitioner, would carry out the treatment prescribed.

34. Recently a grant has been given by the Scotch Education Department to such School Boards as have asked for it to enable them to ensure that medical treatment is provided for "necessitous" children. A certain portion of this money might well be spent in securing the assistance of the local medical practitioners for the treatment of such ailments as they might properly undertake to treat or do habitually treat. The school nurse would normally superintend or carry out the treatment prescribed by the medical man in charge. But such a nurse would in many localities have time to do nursing work for the Parish , or the Public Health Authority, or the Insurance Committee. There is here, therefore, opened another line of possible organisation of nursing and medical service. Where the districts are sparsely populated, and where a concentration of nursing and treatment work is readily accomplished, it would be a waste of money and energy for each ad hoc authority to provide its own nurses. The "following up" of school cases might easily be fitted into the treatment of such cases and adapted to the other nursing work of a district.

VII. MATERNITY MEDICAL SERVICE

35. In the course of he Committee's investigations nothing has been more striking that the casual nature of medical service in regard to birth and infancy. The medical practitioners in their returns indicate that they are summoned in a considerable percentage of confinements, but the greater percentage of confinements, almost everywhere, is left to the charge or trained nurses, partially trained midwives, or totally untrained women. In some localities that are difficulty to access, or far from a doctor, births take place either without any assistance whatever or with such assistance as the husband or other person can render on emergency. The evidence shows that only a small number of cases are attended even by trained nurses; the majority are attended by the partially trained midwives or by unskilled persons. In almost no locality, however, is there any definite understanding between trained nurses, midwives, unskilled persons, and local doctor. The doctor, no doubt, is often summoned in difficulties; but that is accidental. There is no obligation of any kind on any midwife, trained or untrained, to summon a doctor; there is no notification of births; there is no registration of midwives; there is, in a word, no systematic relation between doctor and maternity nurses. This is true with very few exceptions.

36. From no standpoint can this chaos of casual practice be regarded as adequate medical service. Apart, however, from the obvious want of system or mutual understanding, the damage done by the unskilled management of confinements is known to be considerable. Where practice is so casual precise information is naturally very difficult to obtain; but the Committee have had abundant indications of the injury done to individual mothers by the unsuperintended and undirected practice of partially skilled or unskilled women.

37. The Midwives Registration Act does not apply to Scotland. Consequently, midwives of any grade of qualification may practice absolutely without supervision by any medical man or by any other external authority. In none of the county districts visited has the Notification of Births Act been applied by the Local Authority. The result is that the attendant at a birth is not brought into official connection with the Health Authority. (The Act has been adopted in the town of Inverness).

38. As a first step towards the remedy of this entirely indefensible condition of practice, two things may be suggested:--(1) that the Bill recently before Parliament for the registration of Scottish midwives should be passed into law at as early a date as possible; (2) that the Local Authorities should be requested to apply the Notification of Births Act over their whole areas.

39. As the passing of the Midwives Registration Bill involves legislation, it need not further be discussed here; but the local adoption of the Notification of Births Act would be a real beginning in the promotion of an organised Maternity Service. The Local Government Board had, on more than one occasion, suggested to the Local Authorities the desirability of applying the Notification of Births Act; but hitherto the Act has been adopted only in a small number of places, mainly towns. But, under the Act, the Local Government Board has itself power, by order, to enforce the Act in the area of any Local Authority. Probably, when the Local Authorities are made fully aware of the kinds of evidence brought before the Committee, whey will readily take this first step in the promotion of a more adequate medical service for the management of birth and infancy. In several towns and some county districts in the South the adoption of the Act has been followed by the appointment of a Health Visitor acting under the direction of the Medical Officer of Health, and sometimes assisted by voluntary workers. The primary duty of such a visitor is to assist the mothers in the management of infants, and generally to foster the knowledge of infant life. But, short of the appointment of health visitors, the Local Authorities, through the information conveyed under the Act, might do a great deal to bring expectant and actual mothers into relation with the local medical practitioners, and, in this way, to develop a much more adequate medical and nursing service. In the case of insured persons such a service would facilitate the administration of the maternity benefit clauses of the National Insurance Act, and is, indeed, essential to the proper working of those clauses. Conversely, the service required under those clauses might readily be extended to the uninsured.

40.