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THE NHS REVOLUTION: BEFORE AND AFTER. A PERSONAL VIEW

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This article is based on a talk I was asked to give at Lothian Health's celebration of 50 years of the NHS.

My main qualification for commenting is that I am a survivor, having qualified in 1937. I will give strictly personal impressions of medicine as practised before the NHS, mostly based on experience in London before I came to Edinburgh. I will then go on to say what I think have been its main achievements. Finally, I will put forward my own views about its future. This will be even more personal and idiosyncratic.

HEALTH SERVICES PRE-NHS

General practice

Before the NHS was established general practitioners bought their 'practice' and sold it when they retired: their main income was in fees from patients. I gathered from friends that one of the major chores, often undertaken largely by the doctor's wife, was sending out the monthly bills. Perhaps a quarter or a third were never paid. Of course a number of general practitioners treated very poor people without seeking payment.

From the 1911 Act doctors also treated 'panel' patients for a small annual fee from the state. But these were only patients who had employment and there was no provision for treating the members of their families. In some areas there were local 'clubs' where people with low incomes paid a few pence a week into the club in exchange for some GP services. 'Poor Law' patients were seen by a doctor under the control of the Medical Officer of Health. They were referred to him by the 'Relieving Officer' of the Poor Law, often as preliminary to admission to hospital.

In a number of parts of the country local cottage hospitals were looked after by GPs and were concerned mainly with treating comparatively minor illnesses.

One of my contemporaries went into a pioneer Group Practice in North Devon. Each of the GPs in this practice had a specialty: obstetrics, surgery etc; they worked from a health centre, employed secretaries and nurses, and had beds in a cottage hospital. But this was one of the first of such practices, very few of which were started in the 1930s. They formed a model for later developments in the NHS.

Teaching hospitals

Some of these, such at St Bartholomew's and St Thomas' in London, were the descendants of monastic hospitals influential enough to escape the depredations of Henry VIII. Others were charitable hospitals founded in the eighteenth or nineteenth century by public and private subscription. They all had major problems with continuing finance. Usually some sort of endowment had been made for these hospitals but a great deal of time had to be spent fund-raising through flag days, collecting tins and other such activities. Patients had to pay if they could.

At St Thomas' where I trained, we had 'Lady Almoners': their title was also a monastic relic. Their official job was to make sure that patients who were able to pay,

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did so; in practice they were wonderful women who spent most of their time organising various forms of social help for patients.

Municipal/local authority hospitals

Many of these were general hospitals. In 1930 the old Poor Law hospitals, previously mainly occupied by the aged sick and poor, were handed over to the local authorities. Many were eventually converted into general hospitals.

From early in the century local authorities were also responsible for 'fever hospitals' for infectious diseases. From the 1911 Act, mainly inspired by the work of Sir Robert Philip in Edinburgh, local authorities also became responsible for caring for patients with tuberculosis, including hospitals and sanatoria specifically designated for this common disease.

The Medical Officer of Health, funded by the local authority, was a very powerful person. Legislation ensured him a large amount of independence; he was responsible for environmental and public health and he produced what was often a very authoritative and influential Annual Report which was taken heed of by those in power. The role of the MOH gradually became eroded after the NHS started and the post sadly became defunct in the 1974 reorganisation when its functions were taken over by Health Boards/Health Authorities. Happily this very valuable annual review of local health has been revived in the NHS in the last few years.

In Edinburgh, the Western General Hospital was originally a municipal hospital. The City Hospital was the 'fever hospital' (including beds for advanced tuberculosis). The Royal Victoria Hospital was the tuberculosis hospital for milder cases.

Peripheral voluntary hospitals

These were established in many provincial towns. They had the same sort of financial problems as the teaching hospitals, depending on major local voluntary effort. Many of them were staffed part-time by local general practitioners.

SOME PERSONAL AND ANECDOTAL IMPRESSIONS: PRE-NHS

General practice

A much older cousin of mine was an assistant in a general practice in a mining valley in South Wales. Both the mining company and the miners paid so much a week into a fund which went to the 'owner' of the practice. He spent much of his time going shooting with the local landowners. He employed four assistants at £250 a year. The general practice served both the miners and their families. The facilities were truly basic: the patients queued in a corridor without any chairs, there was a single room with one or two beds for patient examination. I am not sure whether the patient had a seat here. In actual fact some of the young assistants were very good and conscientious, though of course treatment was very limited at that time. My cousin wrote a fascinating account,[1] a copy of which I gave to a former President of the Royal College of General Practitioners.

As seen from a London teaching hospital, 'The Panel' was not very impressive. Many of the GPs seemed to use the local hospital's casualty department to do their work. It was quite common for the panel patient to come up with the doctor's card and written on the back was 'Please see and treat'. I remember when I was helping with an outpatients' clinic at what is now the Royal Postgraduate Medical School, a patient came up with a note: 'Pain in shoulder. Please see.' When the patient took his clothes off there was an enormous tumour protruding from the shoulder. On another occasion I asked the patient to undress to examine his chest. He said with surprise,

'Do you want me to take my clothes off? My doctor always examines me through my coat.'

At that time, as medical students we were also taught how to remove teeth. Of course there was no public service for dentistry. Sometimes patients with agonising toothache arrived in the evening at casualty. Out of pity one might remove the offending tooth. Within an hour there would usually be 20 other sufferers sitting on the benches as the word got round. Where did one draw the line?

In summary, general practice as seen from a London teaching hospital was very unimpressive. I used to reckon that 60% of the patients I saw as outpatients need not have come if the doctor was prepared to get out of his chair and examine them properly. When I came to Edinburgh, admittedly after the NHS started, I found a totally different picture and almost never saw an unnecessary patient in my clinics; however I imagine that, also before the NHS, general practice in Edinburgh was probably much better than in London.

Teaching hospitals

The consultants in teaching hospitals were unpaid. They were primarily there to look after the sick poor but there was an important cryptic recompense. My own two chiefs each did two rounds a week on their own patients but these were almost entirely teaching rounds. Although the patient might well receive some incidental benefit, there was a major incentive for the consultant to be a good teacher. His students would be going into general practice and would hopefully later refer patients to the consultant's private practice, which he had to depend on for his living. I should add that my own senior consultant when I was a house physician did an additional round on Sunday mornings which was entirely for the benefit of patients (and me!). One of the disadvantages of the system was that the consultant had to appear to his students to know everything. When this had gone on for some years, he often may have persuaded himself that he did. This was very different from the probing questioning and critical discussions to which consultants were exposed during the staff rounds which I later experienced at the Royal Postgraduate Medical School. In my day, these sessions were 'red in tooth and claw', painful for the presenter, but we all learnt a lot. There was no such round in my own undergraduate teaching hospital, and I think only in a few others.

As house physicians and house surgeons we received no pay; we even had to pay for our own laundry. There was only one HP to each 'firm' and we looked after 50-70 beds and had to work extremely hard. It was a very monastic existence. At that time we were expected to do a good deal of our own laboratory work. We had a laboratory in the basement and one often spent two hours after dinner in the evening doing the laboratory work. Very difficult tests, and some other necessary checks, could be done in the hospital laboratory. We officially had a weekend off every fortnight. But my own weekends usually started at six o'clock on Saturdays and I was back the next evening on the job. Our main professional help was from the resident assistant physician or the resident assistant surgeon. Each of these was usually a very experienced and skilled person, who was responsible for the whole medical or whole surgical side, deciding which patients were to be admitted or discharged. They both seemed to be on duty day and night for seven days a week: they were up most nights either operating or seeing difficult admissions. They were splendid people who usually went on to get on the staff but to say that they were grossly overworked is an equally gross understatement. One tried, therefore, not to bother them too much.

I had a registrar on my own unit but he spent most of his time in the outpatients clinic and only did teaching rounds in the ward. In practice, I learnt most from a wonderful Sister on one of my wards. She managed to teach me a vast amount but did so with infinite tact. My admiration for her was even greater when I realised that she was doing this for new housemen every six months.

At St Thomas' we then had a ridiculous system of emergency admissions. Each 'firm' was on emergency admissions for a whole week at a time. One might be out of one's bed for much of every night during the entire week 'on take'.

As students we had a great deal of responsibility. In fact, I was one of the first generation of housemen who had to keep their own notes; previously all the notes had been kept by the students. We worked in pairs, usually had responsibility for about six patients apiece and were expected to know each other's patients. On the ward round, it was the student who presented the case. Of course, one thus learnt a lot of clinical medicine.

In teaching hospitals the nursing standards were usually extremely good. St Thomas' had been Florence Nightingale's hospital and the nursing there was superb. There was much competition to train in nursing there, and a fair amount of background snobbery. It was said that you needed to have a bishop supporting your application for it to be accepted! But the nurses were ruled with iron discipline: the matron was always a formidable figure. Even consultants quailed when the cold front, represented by the matron, then Dame Ethel Still, and her entourage, was seen advancing down the main corridor.

The 'lady almoners' (equivalent to present hospital social workers) were equally superb. It was their splendid work in looking after patients' social problems which stimulated my lifelong interest in the social side of medicine. It is astonishing that, I think up to the 1950s, all hospital social workers were trained in London, most of them at St Thomas'. In the 1950s I was on the committee in Edinburgh University to plan the initiation of such training in Scotland.

Looking back, the attitude to patients was interesting. There was no doubt that the care of patients in the hospital was splendid. They had the best medical care available at that time, with as good nursing and social care. But there was a slight background attitude, particularly among consultants and senior medical staff, that the 'sick poor' were a slightly different species. It might be implied that 'they don't feel pain like us', though it was never so crudely stated, this presumably being the result of the domination of private practice. The Harley Street consultant was considered to have reached the peak of the profession. Academics mainly lived in departments in the basement and they carried far less prestige.

Local authority hospitals

In most local authority hospitals the medical superintendent, as well as being the chief administrator, was officially in clinical charge of all the patients. He usually had a number of not very well paid assistants who did most of the routine work. At any rate this was the set-up in a London county council hospital, St James', where I spent a month as a student as part of my obstetrical training. I was horrified at what I saw: the patients were treated like cows. Every patient coming in to A&E was stripped naked. As students we tried to see as much medicine at possible. I remember going down with the doctor to see an old lady who had just been brought in. The nurse just whisked off the sheet and there was the poor embarrassed old lady stark naked. It was

immediately obvious that she had fractured her hip. An easy diagnosis but with no consideration of the patient's dignity and rights.

When I attended the antenatal clinic, the grossly overworked medical superintendent (MS) was rushing round doing vaginal examinations. The poor nurses were vainly trying to keep up with him and to get the few available screens round the embarrassed women. Mostly the MS beat the nurses to it!

I was there for a month over April and May. The bureaucratic law was that summer started on 1 May. All the hospital heating was switched off in the middle of a particularly cold spell. I found one of my patients shivering in her bed, I asked the nurse if she could have extra blankets. I got the most tremendous rocket from the ward sister for daring to interfere in nursing matters which should not be any concern of mine.

The gossip at that time about local authority hospitals was that the Middlesex county hospitals were very good. Lancashire was said to be pretty good. Surrey not too bad. Others were thought to be pretty poor though I have since heard that at least one hospital in Birmingham was exceptionally good.

In Edinburgh I had a medical patient in her nineties who told me something about her experiences, admittedly before the First World War. When she qualified in Edinburgh it was extremely difficult for a woman to get a job. The only one she could get at first was in a home for alcoholics run by nuns in Northern Ireland. When she came back to Edinburgh, she applied for a job at the Western General Hospital, then of course a Poor Law hospital. This was officially under the clinical care of the Medical Officer of Health. He made it quite clear to her before accepting the post that he would have no time to visit the hospital. She became the hospital's only doctor, on duty seven days a week and 24 hours a day. I am not clear whether she ever had a holiday.

The City Hospital, under Sir Robert Philip's scheme, took the more advanced cases of tuberculosis but I believe that until the arrival of the NHS it had no X-ray facilities. The City Treasurer at that time boasted that the rates had not been increased for ten years and hospitals simply had to improvise as best they could. It is these experiences and gossip which always made me bitterly oppose any suggestion of handing over administration of hospitals to local authorities.

The patients

I was a clinical medical student in the early Thirties in the depth of the Great Economic Depression. There was gross malnutrition in children and rickets was rife. After sitting in at paediatric outpatients, it made one ashamed to go home and eat one's dinner. When we did our obstetrics 'on the district' with the midwife, we visited the real slums often with bugs climbing up the walls. In those pre-chemotherapy days the horrors of sepsis were very obvious. In St Thomas' there was a special ward for these advanced cases. After surgeons had done their best by letting out any 'laudable' pus there was little further that anyone could do and the mortality was high.

As an illustration of what things must have been like in Edinburgh at that time a patient in Craigmillar told me of a friend of his in the early 1930s whose little daughter became extremely ill. He was far too poor to be able to call in a doctor or even to pay for a journey by bus. The only thing he could do was take his daughter in his arms and walk the five or six miles up to the Royal Infirmary. When he arrived there he found his daughter was dead.

The lack of imagination of what illness might mean to the sick poor is illustrated by a story told me by the splendid sister who was still working in the Royal Victoria

Dispensary (the main tuberculosis clinic in Edinburgh) when we took it over in 1954. I suppose she had come to work there somewhere about the mid-Thirties. My predecessor, the famous Sir Robert Philip, did a good deal of teaching. He had a teaching room in the Royal Victoria Dispensary with a number of pathological specimens in bottles. The show-piece was a glass case containing a dead boy split down the middle to show the tuberculous lesions. This was the room in which stretcher patients were put to wait to see the doctor! The Sister decided her first duty was to fashion curtains to cover this dreadful vision.

BACKGROUND TO THE NHS

The Emergency Medical Service was initiated at the beginning of the Second World War to deal with the vast number of air-raid casualties which were expected. In fact they proved much fewer than expected. Very sensibly the Service went on to carry out a great deal of routine hospital medicine, producing somewhat of a model for the future NHS. The war resulted in what was probably the greatest social cohesion in the history of the UK. Because so many doctors had been in the Services or in the Emergency Medical Service, it greatly decreased the power of medical vested interests. My impression was that, like myself, most of the younger doctors were all in favour of the proposed NHS; but there was plenty of savage objection from the more senior members of our profession. As a young academic consultant at the Royal Postgraduate Medical School, I went to a meeting at BMA (British Medical Association) House in London which might have disgraced a political meeting in the East End, the shouts and boos and yells were in such abundance. The BMA itself was all against it. Its Secretary, Dr Charles Hill, was the famous 'Radio Doctor' and he was violently against it.

But Lord Moran, the President of the Royal College of Physicians of London, was shrewd enough to realise that the NHS was inevitable. He was determined to get both the service and the consultants as good a deal as possible. As Churchill's doctor he carried a lot of clout. With his help, Aneurin Bevan, as you will know, 'stuffed their mouths with gold', and it all went through and the NHS came to pass. The GPs suddenly realised that colleagues who signed up for the NHS would attract patients away from those who were still charging fees. The opposition and objections quietly collapsed.

THE MAJOR ACHIEVEMENTS OF THE NHS REVOLUTION

From the patient's point of view the great achievement of the NHS was the removal of financial barriers to seeking medical help. For poorer people illness had always been a perpetual anxiety. At what stage was the problem so threatening and severe that they had to spend their meagre money on calling a doctor? Removal of this perpetual background anxiety was one of the major achievements. From the GPs' point of view they now had an assured income without having to send out a lot of, often unpaid, bills. Gradually the development of group practice made life much more tolerable and rewarding. Particularly since the initiation of the Royal College of General Practitioners and the so-called GPs' charter (1965), standards and interest in general practice have steadily risen. The academic standards for getting into medical schools have also steadily improved. Previously, many medical schools would take sons or daughters of old students without too much enquiry. The intellectual deadwood at the bottom of the class in Medical Schools later tended to drift into becoming poor general practitioners or poor public health officers. Fortunately most of these have now retired.

The public health aspect was a slightly less happy story: when this aspect of medicine was taken over by the NHS in one of the later reforms, public health doctors came to be employed more as administrators of the hospital service. In the last ten years a pendulum has swung and there has been an appreciable, and very happy return to public health standards cognisant of a growing realisation that public health has a much broader social base than mere prevention of disease. After a long interval, yearly reports on the local public health are now obligatory. These can still have major influence.

Non-teaching hospitals

The great achievement on the hospital side is that first class consultants now work in peripheral hospitals all over the country. Formerly many of them were staffed by part-time GPs, with much less specialist training and experience. These consultants have demanded higher standards and enormously raised the quality of service to patients.

THE FUTURE

Acute services

I have now retired for more than 20 years from clinical work so I can only comment on this from gossiping with younger friends. The system of having admission wards with intensive care and quicker turnover both through the admission wards, and through the general wards to which the patients move, has undoubtedly increased efficiency and turnover. The disadvantage is the lack of continuity of care between patients and staff, both nurses and doctors. It tends also to give the staff and medical students much less continuity as they often do not see the patient right through from admission to discharge. This has disadvantages for professional education as well as posing difficulties in establishing continuing rapport between staff and patients.

The social aspects of illness, often neglected in the past, now come into the foreground because of the need to ensure that patients can be discharged from hospital as quickly as possible. Since I became a consultant in the late 1940s, we did a social round in my own unit once a week on all the patients there. This was attended by all the doctors in the unit, senior nursing staff and social workers, together with a health visitor whose role was to liaise with her colleagues in primary care. This enabled us to plan home care after discharge well in advance of the date of discharge. But it also enabled us to cope with any major social problems the patient might have. In my experience, at any one time for about a third of the patients in the ward the social problem was more important than the medical. For a number of patients the best thing that happened to them was that they became ill, because this led to a solution to some of their even more important social problems.

Achieving a rapid turnover of patients in hospital implies good organisation of follow-up medical care and social support. This puts an enormous additional strain both on primary care and on the social services. Social services, funded by 'capped' local authorities, receive greatly reduced resources to face steadily expanding lists of statutory duties. The immense pressure gives them very little time to sit back and look at broad problems or to liaise personally with their colleagues in health and social services. The greatly expanded responsibilities of primary care, taking up much work formerly done by hospitals, an expanding preventive role, and now their proposed increasing responsibility for the disposal of local health service budgets, imply an immense need for expanded support.

The challenge of all the reorganisation, which may result in much greater efficiency in administration of services, is to reconcile this with the humane aspects of the emotional needs of sick patients, particularly in their relation to professionals. We still have to work out ways of getting the ideal mix of these sometimes contradictory aspects of care.

Public health and prevention

In the last 15 years or so I have been particularly concerned with poverty and health, following my responsibility in the production of the Scottish Office publication *Health Education in Areas of Multiple Deprivation*.[2,3] Arising from that, we experimented with starting a community development health project in Pilton, Edinburgh. Thanks to splendid development workers, this has proved an outstanding success and is now widely copied. I am extremely impressed how such projects, run by local people in deprived areas, can give these people and their communities increasing self-confidence to address what they see as their major health problems. Many are now jointly funded by the NHS and local authorities, but financially-restricted local authorities find great difficulty in maintaining their support. Both for these projects and for voluntary bodies they are only given a year's grant at a time with no security for future funding. This makes it very difficult to plan or to employ personnel. I am glad to see that in the recent Scottish Office Green Paper longer term funding is strongly advocated but, if so, local authorities will also have to know what their long-term funding is going to be. Three-year rolling funding should be the ideal.

I have also been extremely impressed by 'family centres'. I have visited a number in Tayside. Again they give tremendous self-confidence to local communities and can cover social, educational and health aspects. Unfortunately, there are very few of these centres in Lothian.

Voluntary bodies of various kinds have an enormous part to play in developing new projects and producing services. Once again they have serious difficulties if they are only supported by year-to-year funding by statutory bodies, health service or local authority.

Finally I would like to draw attention to two very major public health problems which have slipped away down the political agenda. These are alcohol abuse and fluoridation of drinking water.

Alcohol abuse[4-6]

Alcohol abuse causes immense physical, mental and social problems;[4] all the evidence is that things are getting worse. Ten years ago, Action on Alcohol Abuse (AAA) was founded by a number of the medical Royal Colleges as a lobbying organisation. While it lasted, it was extremely effective with an influential cross-party parliamentary group. This led to an inter-Ministerial official committee, chaired by the Leader of the House. Unfortunately, after AAA's initial grant from the Rowntree Trust ran out, no further funding was made available: AAA closed and the alcohol problem evaporated in the political agenda.

Officially, instead of having the authority of a parliamentary committee the work was moved to a Cabinet committee and we never heard of it again. In recent years the previous Government has obviously been heavily influenced by the alcohol industry, even making alcohol cheaper in successive Budgets. The recent Green Paper from the present Government has promised the evolution of an alcohol strategy. But there has been considerable evidence of a continuing cosy relationship between the Government

and the alcohol industry. My own personal experience has shown that the industry will resist any measures which threaten to reduce consumption and hence profits; as a result I fear that any strategy so evolved may be cosmetic rather than effective.

Fluoridation of water supplies[7]

This is one of the most classical examples of man as an irrational animal. A small fanatical group with a magical concept of 'pure' water has terrified politicians, local and national, into failing to fluoridate any water in Scotland at the present time. Governments pay lip service to their desire for fluoridation, but leave it to local authorities to decide for themselves individually, and take no steps to educate public opinion (although in point of fact surveys of public opinion reveal a large majority in favour of fluoridation). Scotland's children have the poorest dental health in Europe and there has been no improvement over recent years. Dental health is very much worse in the more deprived areas. Yet experience in the West Midlands of England, where water has been fluoridated for more than ten years, shows that with fluoridation the poor achieve as good dental health as the rich. Innumerable scientific enquiries have shown that the recurrent panics about ill-effects put forward by the anti-fluoridation lobby are without foundation. Governments must have the courage to change the law so that water authorities must fluoridate when requested by health boards after appropriate local consultation.

CONCLUSIONS

For me it has been an immensely rewarding privilege to have worked with the NHS, in one way or another, during the last 50 years. With all its difficulties it is probably the most cost-effective health service in the world.

Of course such an immense and complex organisation has many incidental problems and frustrations. I sometimes say to exasperated friends 'If your job isn't frustrating, it's not worth doing. Anyone could do it.' But do not let politicians and administrators take this as an invitation to make NHS jobs as frustrating as possible!

I am sure that the next 50 years of the NHS will see even greater achievements both for patients and for enhancement of the population's health. Future work in the NHS should be even more exciting and rewarding. I salute those who will make it so.

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