Part 1:

I'm setting up the recording equipment and we are chatting. I ask him about his early influences.

… a useful life in the labour movement, because that was what I wanted to do. I mean we are talking about 1943 or 4 about [then] that I am taking these decisions. When the Russians were winning the war and if they hadn't been winning the war we would have been losing the war and all the people who sympathised with Hitler would have been in charge, everywhere. And eh…

So were you a member of the party at point?

No I was in Canada, in a school in Canada, in a boarding school in Canada.

Right.

But I decided, I spent 3 months as a Social Democrat then, I think it was in 1944. Quite in love with the Labour Party and all its compromises, of which I'm now a member of course. But I went through that pretty quickly. My father had sent me out the two volume Lawrence and Wishart sort of *Essentials of Marx and Engels* thing which I used at school. Marvellous stuff, wonderful if you are doing history. And I knew all the sort of really basic stuff, *Manifesto* and *Wage, Labour and Capital*, and *Value, Price and Profit*, and all that kind of thing - as sort of catechism. And on the whole, that stuff, the part of it that is not useful, is obviously not useful, you can drop it out quite easily and the stuff that you don't drop out is actually, that's the basic stuff that we need for analysis now. More now than then I think, so anyway, I decided that the only job I could do that would make me an acceptable person to that tribe I wanted to join was being a doctor and being a GP. A sort of people's doctor.

And I thought just like Lenin said that people should not be afraid of being Members of Parliament, but even though Parliaments were, were talking shops and fraudulent that you could have honest people who would be tribunes of the people. Well I thought that was actually rather like General Practice which was also largely hokum, but the people really did value having a good GP, eh that actually was committed to them as an advocate. And that's true and that's worked.

I did find that attempts to invent a socialist medical science - I had a go at a few daft things like that. And that coincided with the Lysenko[1] time and it was pretty obvious that, saying well, if we are going into a new, if there is going to be a paradigm shift in society then there is also going to be a paradigm shift in science and culture and so on, which is true. Eh therefore we must create it, because that shift has already occurred, therefore, you know, it has got to be different. Now I can see now that the real

[1] Trofim Denisovich Lysenko, born 1898, Karlovka, Ukraine, Russian Empire, died November 20, 1976, Kiev, Ukrainian S.S.R., Soviet biologist and agronomist, the controversial 'dictator' of Soviet biology during Stalin's regime. He rejected orthodox genetics in favour of "Michurinism" (named for the Russian horticulturist I.V. Michurin). As the president of the Agricultural Academy of the USSR, he was the principal opponent of genetics. In 1948 Lysenko denounced non-Michurin geneticists in USSR, which lead to purges of the scientific committees.

reason that it didn't happen was because the paradigm shift [in the Soviet Union] had not in fact occurred.

Hmm, hmm.

But you can't make it other than out of real, you have, got to have real data, it's not speculative, it's not just a question of how you handle the data in your mind, it's also a question of the data itself and we didn't have it. So for a while I got a rather wrong message that essentially you just took everything, eh you took the body of medical science as it was and any modification is going to come later. Now, that was both the good and the bad thing to do. And while I was at medical school I could, I was beginning to see then that epidemiology and social medicine, obviously, that that was where, if we were going to have some innovation, that's where it was going to happen.

So then, by the time I had finished at medical school I had a planned life ahead of me, that I was going to be a GP, I was going to be a colliery GP. It was mixed up with very romantic ideas about coal miners and mining villages and how they related to their GPs.

Where did that come from?

Well obviously for everybody it came from that, from Cronin, because he had provided the model.[2]

Right.

But I wasn't that stupid, I mean anyone could see that that was actually a very superficial actually not very good novel,[3] and the reason it's been so enormously successful and is still print, people still read the damn thing, is obviously that it must contain some truth in it. And really quite a big truth which I think was the idea of the GP as the people's advocate in a, in that kind of community.

Right, you don't think that's a mythical figure then? You don't think [interrupted].

Of course it's a mythical figure. Well I mean quite apart from anything else he didn't base it on real people. There were real people that he could have based it on, but he didn't do that. The people who, of

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[2] Archibald Joseph Cronin, born July 19, 1896, Cardross, Dunbartonshire, Scotland, died January 6, 1981, Montreux, Switzerland. Scottish novelist and physician whose works combining realism with social criticism won a large Anglo-American readership. Educated at the University of Glasgow and served as a surgeon in the Royal Navy during World War I. He practised in south Wales (1921-24) and then, as medical inspector of mines, investigated occupational diseases in the coal industry. He opened medical practice in London in 1926 but quit because of ill health, using his leisure to write his first novel, *Hatter's Castle* (1931; filmed 1941). Other novels include, *The Stars Look Down* (1935; filmed 1939), *The Citadel* (1937; filmed 1938), and *The Keys of the Kingdom* (1942; filmed 1944).

[3] *The Citadel* (1937, filmed 1938), that showed how private physicians' greed can distort good medical practice. This greed is contrasted with an idealistic young doctor whose first practice was in Welsh valleys. See also Hart, JT. Storming the Citadel: from romantic fiction to effective reality. In: Michael PF, Webster C (eds). *Health and Society in Twentieth Century Wales. University of Wales* Press; 2006. p. 208-15.

that generation who did those sort of things, Alfred Salter in London did it in Bermondsey, there were several other people.[4] Some Labour people did it, some Communists did it. What they all had in common was extreme paternalism and authoritarianism and which was only matching expectations, that's what people mostly wanted. I mean it was a very paternalist, because medicine at that time was still 95 per cent illusion and five per cent reality. The illusion was sustained by doctors pretending they knew everything when they knew hardly anything and patients pretending that they believed that the doctors knew everything. So there was a big element of collusive illusion which was all about sustaining people's hope in otherwise hopeless situations which people rightly believed might just make that one per cent difference that got you through some illness rather than having a completely cold dispassionate attitude that didn't help people. So it wasn't completely wrong, but that the social relationship was like that, where they, they, were very undemocratic people and so was I.

Hmm, hmm. When you first began you mean?

Oh yes, yes. It didn't really occur to me to be anything other than, 'I'm the person that knows it all and you've come to me, because you don't know anything, and I'll help you'. As opposed to the people who didn't help you who either didn't actually know it, or if they did know it they weren't using it. I mean the difference in good doctors and bad doctors was doctors who examined you and doctors who didn't examine you. Doctors who came out in the night when you sent for them and people who didn't. Doctors who ran through their whole list once a year, saw this happening, striking off everybody over 80 years old or everybody who lived more than three flights of stairs that you had to climb, they would just cross them off. It was general working class, industrial general practice was industrialised and it was, I've described it all in a *New Kind of Doctor*.[5]

Sure.

And it was very important to wear a white coat to emphasise that you actually were scientifically educated and so on. It was hem, the theatre at that time was about not being a doctor who drank too much, a lot of, a tremendous lot of those; a doctor who examined people; a doctor who listened to people. Although we were very authoritarian we were good history takers and that meant a long period of silence.

Right.

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[4] Albert Salter (1873-1945) radical general medical practitioner who along with his wife Ada established a practice in Bermondsey at the beginning of the twentieth century. Supporter of women's rights, temperance, republicanism and pacifism, he was elected to Parliament in 1922, 1924, 1929 and 1931. Founding member of the Socialist Medical Association.

[5] Hart, J. T. (1988) *A new kind of doctor: the general practitioner's part in the health of the community*, London: Merlin Press.

Really letting people go on and tell you about their illness, so there was in fact quite a big democratic input but it was very clinical, very much into the personal illness story.

Hmm, hmm.

But when it came to treatment and the options I don't think I presented options to people much. And I was very didactic and very prescriptive and the patients went along with that. I mean on the whole that relationship went on being viable, particularly in industrial working class populations, not so much in middle class populations, and accounted for a lot of the popularity of working class patients with doctors. When the GPs overwhelmingly said (unless they were absolutely at the top end of money making and leafy practice), but on the whole in more average kinds of class mixes, GPs preferred working class patients, but I think mainly, partly for good reasons but you know they were more mutually supportive and, but mainly because they were much less critical.

Hmm, hmm and deferent.

Much more grateful, deferential yes that's right. And their manipulations, naturally they were manipulative but they were manipulative in a different way.

You also hint where there was one way of listening as well by GPs. You know you speak of good history taking but the material that is taken out of that history tends to be of a type and that tends to be a [interrupted]

I don't think there was one way, I think there were two ways. I think there was a cross-examination technique for getting histories, which is really terrible and still exists. A very powerful thread, because people deceive themselves that this is more scientific, or in some way more admirable where the patient nominally telling the truth, the whole truth and nothing but the truth, is in fact like in court. You just try and start telling the whole truth and you are cut off right away.

There is actually data about this, an American did a study about how long patients had before they were interrupted to get the, by the doctor to get them onto his agenda and it was 18 seconds and that's with generally longer consultations.[6] So here, with this John Howie consultations, somewhere between 5-10 minutes if you are lucky.[7] I don't know of any similar studies here, although they need to be done.

But that was a very important division between GPs. The ones that understood that you must let patients talk about what they want to talk about, because if you don't do that you are going to have too many

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[6] Beckman, H. B. and Frankel, R. M. (1984) The effect of physician behaviour on the collection of data, *Ann Intern Med*. **101**: 692-6.

[7] See for example Howie, J. G. R., Porter, A. M. D., Heaney D. J., and Hopton_J. L. (1991) Long to short consultation ratio - a proxy measure of quality of care for general-practice, *British Journal of General Practice*, **41, 343**: 48-54.

consultations where you end up thinking, 'What the hell was going on here?' So there was a thing about sensitivity to patients.

The other thing that you could see happening very much was that GPs learnt as they went along. They tended, you were given, I mean for people who qualified like I did in the early 50s and for a long time after that, almost nothing that you had been taught in hospital was of value in practice for 95 per cent of the cases. There was five per cent of the cases who had got the kinds of major organic disease that you have been taught about in hospital and it was very important to deliver hospital quality care to those people. I mean people with pernicious anaemia needed to be found, people with malignant hypertension needed to be found. People with early bowel cancers needed to be found by examining them, by doing routine tests and son on and doing them consciously and that was not being done by lots of GPs and that was very important. But the other 95 per cent, it just made you angry with patients for not having the diseases that you wanted them to have, because they weren't hospital patients and people either learned to accept that - to accept that patients have to set the agenda for doctors, if you are a specialist you can afford to say, 'I only see people with cancer of the rectum or suspected cancer of the rectum'. But nobody else, generalists can't do that. They have got to accept what comes round the door.

And you either swim with that tide or you break your heart and getting heartbroken that way you know would lead to people going into alcoholism, getting out of general practice, and going into becoming a specialist or becoming patient haters. Patient hatred was very common in the 50s and the first half of the 60s, and the great thing about the College and the Balint orientated GPs and so on,[8] who on the whole that was what they were was good listeners, was that they had a humane response to this mismatch between what they had been taught and what actually existed.

I get, curiously I get the idea though that there was people already in place before Balint.

Oh yes. Yes there were, but Balint was enormously important, because he gave the GPs self-respect. He told the GPs. He was delighted to discover GPs, he really was pissed off with doctors in general, and then he finds this bunch of people who came much closer to what he thought doctors ought to be like and I think that's right. Particularly psychiatrists, he found that psychiatrists were, well, he felt they were giving almost nothing to patients, except drugs. Now of course, effective drugs had just arrived so that in a way made them worse. I mean it reinforced them in their old attitudes, because they appeared to work. Hem, so he praised up the GPs and gave them self-esteem, which they very badly needed in the early 60s, and he gave it to them in a form that was politically acceptable to them. I mean it still left them completely ruling the roost. They could be completely still doctor-centred in fact, but with an illusion of being patient-centred.

[8] Michael and Enid Balint were psychoanalysts who started seminars for GPs in London in the 1950s, which resulted in the publication Balint, M. (1957) *The doctor, his patient and the illness*, London: Pitman. This then led to the setting up of 'Balint groups' throughout Britain and then later internationally.

And then David Tuckett, have you read that stuff?[9] I mean really, I think that is an enormously important piece of research, even though the numbers are small. He takes 30 Balint trained GPs who are convinced that they are totally patient centred and then 30 randomly sampled matched controls who haven't had Balintry. And finds that there is absolutely no difference at all in the space that they give patients actually to express their own ideas, not to answer questions, and to have ideas about treatment and so on. I think it is a piece of nicely quantified research with really extraordinary clear, qualitative results, and I don't think, although it is cited quite often, it is very rarely cited with an acknowledgement of what a big thing that is. Because I think it is being interpreted just still in terms of a provider/consumer transaction.

Right.

And they think, I don't think David Tuckett's ever spelt this out all that well himself actually, but it's sort of latent in everything he has written, but I'm not sure if he's ever drawn this conclusion. Ehem, I mean to me what it shows is that patients are potentially co-producers and that's what we ought to be talking about is are we allowing them, are we helping them to work with us in production. Whereas the general interpretation has been you are not allowing the consumers enough consumer choice, you are not respecting them as customers.

No, no, this is a theme that runs through your work.

Well, I mean I think this is what gets back to Marx - is that what I think is so wonderful about Marx and Marxism, and the reason that we should go on talking about it, is that it gives you the key to explaining any [pause] well not the key to explaining, but the initial entry point for explaining any human situation is to look at production and the social relations of production. See who owns things. Who defines what the product actually is? What is the main product and what is the by-product? That the difference between having profit as a product and useful work as a by-product and having useful work as the product and forget profit. That is absolutely fundamental, if you haven't got that right, it's like trying to use round bricks to make a rectangular building, you can't do it.

And I think that the idea that the doctors, GPs particularly are a primitive economic formation who have been side-lined by the development of production in general because medicine was not, had a illusory product. It was mainly about giving people feelings, giving them hope and so on. And the five per cent or ten per cent or whatever it was of effective care interventions that actually changed the course of illness were just a vehicle for supporting this much larger body of illusion which had to have something to sustain it. Now you don't need much to sustain it, I mean religion kept going, although it had absolutely nothing at all to sustain it.

But it's still a process of co-production though, isn't it?

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[9] Tuckett, D., Boulton, M., Olson, C., et al. (1985) *Meetings between experts: an approach to sharing ideas in medical consultations*, London: Tavistock.

Yes it is, both of them are.

Which leads to the point [interrupted]

Yes, yes absolutely, oh yes. I don't think the role of being co-producer is not new.

Hmm.

The patients have always been co-producers but that is not their theatrical role, their social role, well actually nobody spelt it out, in America they did. In America a transactional view of care is culturally acceptable. The idea that patients are all customers and doctors are purveyors.

Sure.

That was okay, but that was not acceptable in this country. In this country we had a paternalistic view of medical care as essentially a social service. There was always a sub-set of people who could afford to have more than sort of workhouse care, eh basic minimum care, but they were always seen as a fortunate sub-set and that didn't provide a living for a sufficient proportion of doctors for them to be [interrupted]

No. It's a different history from the United States.

Absolutely. That is very, very important for us.[10]

[10] For international comparisons in the recent period see Horder, J. (1998) Developments in other countries, in Loudon, I., Horder, J., Webster, C. (1998) *General Practice under the National Health Service 1948-1997*, London: Clarendon Press, 247-277.