**Reflections on a lifetime’s experience of (including a career in) the National Health Service in the UK**

*[write about something that you experienced in the NHS while working there as a health professional that convinced you that such a public system was more humane and needed not just in the UK but all over the world, particularly in the developing world. An experiential narrative works very well in sensitising people to ethics, to the idea of universal access as justice. You may connect your experience with the current Covid-19 crisis, the crisis of the NHS brought about by the govt policies and yet, it is the only system in the UK that stood by the suffering people].*

My experience of our National Health Service starts in1949. I was 7 years old, the National Health Service just one year old. My acute urgent admission to the children’s ward of Sedgefield hospital (with osteomyelitis of the neck of the right femur…I was considered deserving of the ‘last rites’) for weeks of treatment with the recently available penicillin, resulted in full recovery with no sequelae. Otherwise I probably wouldn’t be here to write this 70 years later.

Despite this, I have to confess I unthinkingly took the NHS for granted for the next more than half a century. It is only in retrospect that I can see so many global even existential issues being relevant to the message intended from this article; Individual health cannot be usefully considered detached from the global health of the entire planet and all that lives on it.

Leaping forward a decade, I met Hazel my wife-to-be in 1961 when we both started at the University of Leeds Medical School. For us it was six years of a crammed curriculum. I remember all of us after two years of 2nd MB starting clinical work for the first time and wondering about the relevance of the previous two years.

My belief now is that much of that was…but how much better would it have been spent widening our horizons to see the place of health and disease in the broadest possible context in order to firmly and forever fix the concept that ‘Health’ must be a ‘Human Right’ and is dependent on the health of all life on this, our only common home, our only common planet.

Over the next many decades change would be experienced, but its significance missed. That the NHS would ever be threatened would never have entered our heads…till it was almost too late. Only now in my latter years, do I start to understand that nothing can be taken for granted.

We were medical students when a paternalistic medical profession was still comfortable using euphemism to impart bad news and options with respect to treatment were not considered as a matter for the patient. ‘Sir Lancelot’ was still around; <https://www.youtube.com/watch?v=oVWjAeAa52o>.

Not having taken a great interest in the history of the NHS, it came as something of a shock that the majority of doctors needed “their mouths stuffed with gold” to accept that ‘Jewel in the Crown’ of the new Welfare State; the National Health Service. It dawned on me; doctors are only human.

General Practitioners are to this day technically outside the NHS but contracted almost in their entirety to the NHS. Using this aberration as an argument for ‘Privatisation’ of healthcare is entirely spurious.

Given that patients and all of our best interest is global health, it is not difficult to see that financial profit has no role in pursuing these aims. This insight comes not from years of medical education, but more from the influence of ‘leaders’ like Greta Thunberg.

 Despite such negative retrospectives, we students did not question but that everyone, without exception regardless of background, status or wealth, received the best most appropriate treatment available. Yes, the private wing of the hospital was there, and we serviced that too. There might have been single rooms and carpets, but the treatment and respect for the patient was the same.

Career advice (if any was given) was more likely oriented to career as an end in itself rather than giving consideration to how it might fit into the wider context.

Ensuring global health (remembering all that entails; social determinants to care for the elderly and palliative care) in a truly civilised world would leave no room for any degree of unemployment. So relevant to mention here is the growing awareness of the concept of democratisation of work, inherent in which it is the responsibility of governments to ensure full employment. Encouragingly, during this month of May, an initiative by three academics has gained thousands of signatures from academics around the world;

*This initiative is the result of a collective endeavour launched in May 2020 by three scholars:* [*Isabelle Ferreras*](https://isabelleferreras.net/%22%20%5Ct%20%22_blank)*,* [*Dominique Méda*](http://www.fmsh.fr/en/college-etudesmondiales/234%22%20%5Ct%20%22_blank)*, and* [*Julie Battilana*](https://www.hbs.edu/faculty/Pages/profile.aspx?facId=382192%22%20%5Ct%20%22_blank)*. The three share an abiding interest in democratic and sustainable ways of working and organizing that diverge from the model of shareholder value maximization. The initiative came from a hope to help in the unfolding crisis – in health, climate, the economy, and political life – that* we *are facing in the midst of the COVID-19 pandemic. Cooperating distantly, as is the new norm, the three scholars sat down to draft an op-ed together about what we are learning from this pandemic around the specific issue of work. Their goal was to name – clearly and urgently – the core lesson they saw emerging:* ***it is time to democratize firms, decommodify work, and remediate the environment.***

The website to this initiative is here; <https://democratizingwork.org/background>

The overall content of the medical curriculum and subsequent career structure is not conducive to the future of ethical medical practice. If the young medical student and young doctor are not ‘armed’ with  knowledge of; the ‘Social Determinants of Health’ as being by far (especially on a global level) the major determinant, and the ‘traps’ that lie ahead that are likely to wittingly or unwittingly lead to betrayal of the patient’s interest in favour of the doctor’s or some other agency (I have Big Pharma in mind), then the future of medical practice is not safe in the hands of the medical profession.

This in no way detracts or is intended to detract from the unimaginable achievement of the creation of our National Health Service, rather it reminds how this creation will always be a work in progress and therefore, I do not apologise for highlighting the serious shortcomings as I see them.

Nothing less than total rethink of medical education is needed. All sections of society must be engaged in its redesign.

There exists a problematic tendency to encourage and recognise achievement of success by teachers and their students in terms of specialisation and super-specialisation above the skills of the generalist. Figuring how to wed these two as has been achieved by the team at Jan Swasthya Sahyog (JSS) in Ganiyari Chhattisgarh should be a major objective.

Participation professionals and all sections of society is necessary to redesign a curriculum that will sensitise young students and young doctors to their wider role as custodians of the system for health care delivery as well as being responsible competent ethical practitioners for their individual patients. Complete rethink of how medicine and allied professions relate to each other with a preparedness to break down unnecessary boundaries in the interest of improving patient access to high quality care.

For the young doctor, engaging in the evolution of the very concept as well as practice of medicine and the promotion of health will be a great privilege as well as a great responsibility.

Recognition that this is a dynamic ongoing evolving process rather than a once and for all time event is essential by all involved.

Turning to a couple of examples of the experience of working in a still rapidly developing specialty during the latter 1980s and 90s; I did not feel I had the power or influence to demand extra staff for this or that development I wished to pursue, and yet I was  engaging in for the time, cutting edge and labour intensive treatments. That meant that the best that each member of existing staff could potentially contribute must be recognised, developed and utilised to the full. I will illustrate with three examples;

Shift from the unmanageably large doctor (me) led anticoagulant (warfarin) ‘clinic’ to ‘dispersed phlebotomy led patient attendance by smart and safe use of proforma-aided data assembly allied to the computer based algorithm, transformed management of wafarin. This new pivotal role was embraced by the phlebotomist who now was the only person directly interacting with the patient who no longer had to wait in a crowded clinic. I was released to spend time in other developments.

Such willingness for evolving roles and responsibilities was not always my experience; there was a crying need for the ward nurse to start the pre-agreed antibiotic regimen in the severely neutropenic patient when the almost inevitable fever developed, thus avoiding delay that could make the difference between life and death. Although I am confident the ward nurses would have been more than willing to take this on (as the phlebotomists had done), unfortunately, the new breed of nurse managers would not allow it. Undoubtedly that resulted in avoidable deaths.

Biomedical scientists were another example of huge enthusiasm and realising of newfound skills in the harvesting procedure of both bone marrow and peripheral stem cells for autologous transplantation and rescue. This represented a huge step up in responsibility as well as job satisfaction. We were lucky that our blood stem cell harvester took to the role with such zeal that her green fingers resulted in referrals from our tertiary centre when their harvest failed.

Encouraging evolution of roles of all team members, remembering all staff are team members, speeds and enhances development and increases job satisfaction and level and quality of service. I fear this would be difficult or impossible to achieve today in a District General Hospital through the initiatives of front line clinical staff.

Hospital provision in the the UK was expanded by the the creation in most towns of District General Hospitals in the 1960s. These were in addition to the large Teaching hospitals in major cities. This development was steered by the then Minister of State for Health Enoch Powell (infamous for his ‘Rivers of Blood’ speech). The future of the DGH has been threatened for many years, there being powerful forces for centralising more complex work in the tertiary centres, and devolving less complex to the community and primary care.

The overall trajectory of our NHS is a long and tortuous one. Numerous campaigning groups to protect our NHS have long recognised chronic progressive underfunding, increasing privatisation and fragmentation, increasing ‘control’ by large financial corporations and alignment towards a US system of health care. If it had not been for the relentless efforts of these campaigners across the length and breadth of the country, in exposing secretive government plans, there would now be little left of our NHS.

Progressive contraction of the hospital bed base over many years, declining staff numbers, increasing workload under a system no longer trusted by huge sections of the NHS staff, with consequent falling morale, has now been exposed by the catastrophe of Covid-19. Yet the drive for increasing privatisation (Nightingale Hospitals, centralised laboratories and much more) continues unabated.

The need for highly broadly educated medics with wide vision and eyes wide open, who will work at the ‘coalface’ and be motivated to evolve the system of health care inspired by a belief in conditions and services to promote ‘Health’ as a ‘Human Right’, is urgent in the UK. We still have something worth saving to build on. We need solidarity with colleagues in all countries who recognise these imperatives. Global Health as we all know now is indivisible.

During my visit to JSS in February one doctor who must surely be of the foremost and empathetic in all of India and is a founder member of Jan Swasthya Sahyog, Yogesh Jain, explained why; the much older than she looked lady whose blood film I examined (the diagnosis of Chronic Myeloid Leukaemia already having been made by the bio-medical scientist in the laboratory), with a spleen filling her distended abdomen, **would be unlikely to ever receive the one tablet a day simple treatment** that would to all intents and purposes be curative (abolishing as it would all signs of disease, restoring her to normal health and life expectancy), thus condemning her to uneccesary avoidable early death. The whole edifice of ‘Structural Violence’ (a concept I heard for the first time at the Medico-Friend Circle annual meet I had just attended in Sevagram) unfolded in all its stark horror in that unfortunate ladies presence and in her coming fate. The JSS ‘Atlas of Rural Health’ is an encyclopaedia of such ‘Structural Violence’. I hope to provide a copy for the library of my Alma Mater the University of Leeds Medical School.

Likewise during my stay with Jan Chetna Manch Bokaro, in my extended discussions with the founders Lindsay Barnes and Ranjan Ghosh, it was clear to me that despite the wonderful support from individual doctors from around India and beyond, the ‘system’ as a whole worked against their efforts. ‘Structural Violence’ again at work.

In the words of our immediate past president of the Royal College of Paediatrics and Child Health Nina Modi;

***C19 exemplifies why it’s time the world rejected the notion of healthcare as a commodity to be bought and sold, and recognised it as the foundation of strong societies and economies, and hence universal provision a cardinal duty of governments to their citizens.***

How to hold our ‘leaders’ to this account will not be not through the vagaries of short term governments hijacked by big corporations.

The radical change necessary for a better healthier world can only be achieved by a global effort of like-minded at once trusted by the people they serve, coming together with them and supported by relevant international agencies including the WHO and UN.

Michael Galvin (retired haematologist)

The article needs to have some structure. For instance, starting with the event at the age of 7, you may use a couple of paras explaining the NHS - established in 1948 following the acceptance of the Beveridge committee report. It established national healthcare services where the secondary and tertiary hospitals were nationalised while the primary care, delivered by private practicing GPs, was contracted-in, thus making them a part of the NHS with a proviso to negotiate the contract from time to time. Over 40% of doctors are GPs and they are empaneled - i.e. they are responsible for the primary care of individuals registered with them.

Private healthcare was marginalised, constituting only say 10-15% of the care, and is expensive and used only by the rich from the UK and the abroad.

The system worked well in providing universal access but at the same time it faced criticism from women for not being sensitive on gender aspects, from black people for discrimination and so on.

In the 1980s, Margaret Thatcher started campaign to dismantle it. There was push-back from medical profession and people, but different governments kept eroding it, a brick at a time.

After providing something like this, he may talk about his experiences. Unfortunately he provides three four sentences of his experience and then starts philosophising. His reflective points must come from the narrative of experiences. What he has written reads very disjointed - I couldn't keep pace with it and lost interest in reading.