Patient and Staff Views

An Analysis of an Oral History Study with Patients and Staff in the Midlock Medical Centre, Ibrox, Glasgow conducted by Dr Hetty B Ockrim between 1991 and 1992.

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Abstract

The thesis consists of an analysis of an oral history project carried out with patients and staff members at the Midlock Medical Centre in Glasgow between October 1991 and February 1992. The interviews were conducted by the recently retired senior partner Dr Hetty Ockrim and her role and that of her predecessor, the practice founder, Dr Stevan George, are fondly but not uncritically recalled. The critical role of the interviewer is also discussed. The thesis shows the issues and challenges in the two parts of the study – the original interviews and their analysis more than two decades later. It considers the background of the clinical consultation, the encounter between patient and family doctor in general practice and shows how the extended format of an oral history interview with participants, former patients of the interviewer, and staff members provides a history from below, representing views not often seen in recounting medical history.

The thesis provides the context for the oral history study and its analysis. This is by extensively reviewing existing literature regarding important topics such as general practice, women in medicine, practice organisation and patient access to general practitioners. It describes Glasgow's troubled medical history and the deprived area in which the practice is based covering the period before and after the watershed of the National Health Service (NHS) in 1948.

Patients were chosen to represent a sample of ages and health experiences and to reflect the ethnic mix of the practice. Memories of many of the participants stretched back to the 1930s and indicated the source of many of the stigmas related to pre-NHS institutions, heavy handed and paternalistic handling of welfare and the illnesses associated with poverty and poor housing, such as tuberculosis and rickets. The use of the semi-structured questionnaire enabled the interviewer to follow a common track in conducting the interviews yet remaining flexible enough for, even lengthy, digressions Current issues relating to stigma and marginalisation are also considered relating to immigrant communities, substance misuse and mental health problems.

The oral history reflected also how care in the practice was delivered before the era of appointment systems, the heavy burden of house calls and the preference by many for babies to be delivered at home. By recording the testimony of patients and practice staff we can see the tensions between patient expectation and the reality of how clinical time was organised. The

thesis shows how the oral history was designed, participants enrolled, questionnaires formulated, and an extensive transcript produced. The transcripts provided the data on which the secondary analysis is based, and carefully selected excerpts reveal participant reflections on their care and the social aspects of health and welfare.

The thesis shows how patient needs and expectations were addressed. This involves testimony from both patients as well as receptionists, administrative staff and practice and district nurses. Topics include how patient and receptionists saw access to the doctor. This involved the patient/receptionist/doctor interfaces, office systems, the function of the waiting room, which doubled as a social hub, and the role of house visits.

In considering the critical issues relating to medicine, as experienced by the participants, a very wide and varied range of clinical topics were remembered. This shows how clinical topics inform our understanding of healthcare provision as well as how the community/hospital interface operated. The topic is laid out thematically dealing with issues which include patient/doctor communication, accuracy of recall, truth telling and coping with loss. Finally, these are considered through such headings as humaneness, recovering lost memories and closure.

The thesis illustrates, above all, the value of oral history in telling the health story from the patient's point of view, giving participants the time, not usually available in a consultation, to explain memories, feelings, and their interpretation of past events. Participants also showed what was important to them in terms of service provision. The study analysis identifies what was seen to be important to participants, indicating that there needs to be a sensitive understanding of what they felt were key issues. Finally, I will show how the close relationships between doctor and patients in the practice could improve both patient health and general wellbeing

Author's Declaration

I declare that, except where explicit reference is made to the contribution of others, this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Printed Name: Kenneth E Collins

Signature:

Maps/Illustrations

Figure 1: Glasgow

Figure 2: Ibrox

Figure 3: Cessnock Street

Fig.1 :The practice is situated in Ibrox with the bulk of patients in Govan, Cardonald, Bellahouston, Craigton/Mosspark and Pollok but some also as far as Darnley and Arden with a few in Castlemilk. The Southern General Hospital is in Greater Govan, the Victoria Infirmary in Battlefield with the Western Infirmary and the Royal Hospital for Sick Children in the Yorkhill area. © Vectorstock

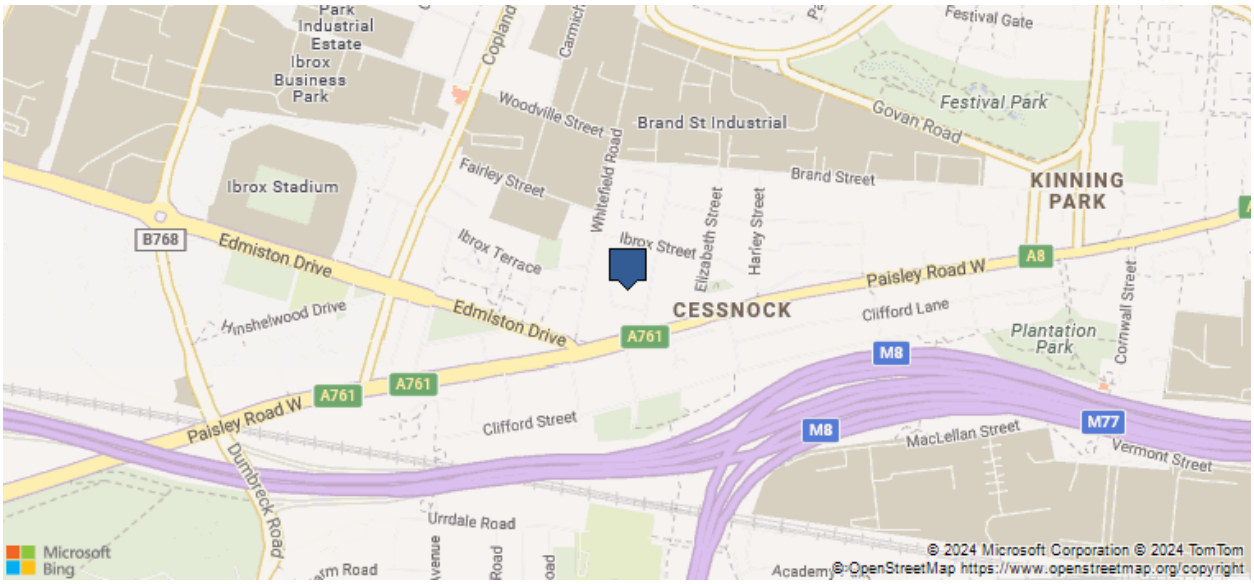

Fig.2: The location of the Midlock Medical Centre marked in navy blue. Cessnock Street is parallel to Harley Street, to its right, and runs from Paisley Road West to Brand Street. 'Wine Alley' was situated off Edmiston Drive just beyond Ibrox Stadium. (Google street maps - open access).

Fig.3: The former surgery at 2 Cessnock Street, Glasgow G51 1SL, is at ground level on the corner of the street (on right of photograph) where it joins Paisley Road West.

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Acknowledgements

My grateful thanks to all the patients and staff members of the Midlock Medical Centre who agreed to be interviewed by Dr Ockrim between 1989 and 1992 and to permit me to use material from their interviews in building the story of general practice in the Ibrox and Govan areas of Glasgow. Thanks are due to the Wellcome Foundation who provided the funding of £6,000 in 1990 for the purchase of Marantz recorder, an Amstrad word processor and secretarial help for transcribing of all the interviews. They also funded attendance at a training session in oral history in medicine (see Appendix F). Thanks also to Sandra Grant who transcribed the testimonies over many hundreds of hours catching so beautifully the idiom of the spoken words.

Thanks to Prof. Arthur McIvor of the Scottish Oral History Archives at the University of Strathclyde for agreeing to store the original interview tapes and for arranging their digitization. Under the terms of the original agreement with the interviewees access to the tapes is strictly limited and the copyright is held on behalf of the interviewees by me and the current doctors at the Midlock Medical Centre whose co-operation in the thirty years since the study began is much appreciated. The Scottish Oral History Centre (SOHC) was established in 1995 and is involved in a wide range of activities designed primarily to encourage the use of 'best practice' oral history methodology in Scotland.[1]

My especial thanks to Prof. Malcolm Nicolson for all his interest in this project during my long association with the Centre for the History of Medicine. Thanks also to Prof. Jude Robinson, Dr Hannah-Louise Clark for their wise counsel and guidance, endless patience and good humour in the supervision of the thesis.

My grateful thanks also to the Royal College of General Practitioners and the Master of the Worshipful Society of Apothecaries for the Award of the Rose Prize in May 2019 for an essay which outlined some of the content of the interviews. Short extracts of this study have been presented at conferences in London (British Medical Association), Edinburgh (British Society for the History of Medicine), Halkidiki, Greece (Physician Health), Jerusalem (UNESCO Bioethics) and Auckland, (Australia and New Zealand Society for the History of Medicine). These presentations followed themes of women in medicine, the beginnings of the National Health Service (NHS) and resilience as an essential character trait in medical practice.

Abbreviations

ARP	Air Raid Precautions
BMA	British Medical Association
BMJ	*British Medical Journal*
DSS	Department of Social Security
GPFC	General Practice Finance Corporation
HCP	Health Care Practitioner
MVLS	Medical, Veterinary and Life Sciences
NHI	National Health Insurance
NHS	National Health Service
RCGP	Royal College of General Practitioners
SAMH	Scottish Association of Mental Health
SIMD	Scottish Index of Multiple Deprivation
SOHC	Scottish Oral History Centre
TB	Tuberculosis
UNESCO	United Nations Scientific Educational and Cultural Organisation

Publications

Kenneth E Collins, *Patient and Staff Voices in Primary Care: Learning from Dr Ockrim and her Glasgow Medical Practice*, Taylor & Francis/CRC, Abingdon, 2023. **Though sharing a similar title to the thesis, and an overlap of text, the book has a different focus from the thesis, concentrating more on recording the participant testimonies.**

Kenneth Collins, Dr Hetty Brenda Ockrim (1919-2007) and her Medical Legacy, *Journal of Medical Biography, 22/4/2021,* **31 (1)**, 21-28.
Access at https://doi.org/10.1177/096777202111008404

Kenneth Collins, Patient Attitudes to Women Doctors, *BMJ Opinion*, 8/6/2015.
Access at https://blogs.bmj.com/bmj/2015/06/08/kenneth-collins-on-attitudes-to-women-doctors/

Ethical Approval

I first applied for ethical approval for the analysis of the oral history project in 2007.[1] On the 8th of August 2007, the Research Ethics R & D Directorate of NHS Greater Glasgow and Clyde gave a favourable opinion, RES reference number: 07/S0701/75, on "An Oral History of one urban General medical practice based on interviews with patients producing a narrative of the delivery of care measured against developments in the life story of the individual, their family and carers." Their only stipulation was that if any further interviews were contemplated the Consent Form should be amended to include specific consent to tape the interviews and for publication of the data. It was indicated that the favourable opinion was for the duration of the research. With legal requirements for patient anonymity, access to the recordings is restricted to researchers only with the approval of the partners at the Midlock Medical Centre.

When the current work began to base an MD thesis on the interviews it was agreed to revisit the ethical issues. The opinion of Professor Arthur McIvor of the Scottish Oral History Centre at the University of Strathclyde, where the interviews, now digitised, are held, ruled favourably on ethical approval, counselling only that care should be taken to preserve anonymity and to avoid quoting material which could prejudice individuals living or dead. His confirmation of this opinion was accepted by the College of Ethics of Glasgow University MVLS Faculty.[2] The interviewees have been anonymized using a simple code system for each participant. Two participants waived anonymity but are just designated in the thesis as DX and KNo, using the allocated code initials. Staff members were designated as Recep_1-3, PMan_1, Sister_1-2.

[1] Less formal arrangements, through the local Ethics Committee, were in place in 1991 when the first oral histories were conducted.

Chapter 1: Introduction

This thesis is based on my analysis of an oral history project carried out by Dr Hetty Ockrim, recently retired as the Senior Partner at the Midlock Centre in the Ibrox/Govan areas of Glasgow, places of significant economic and social deprivation, between October 1991 and March 1992. The choice of an oral history project was quite fortuitous. Dr Ockrim was looking for an active retirement study and I had recent contact with two historians who were conducting oral histories in Glasgow.[3] I saw the opportunity and potential and set the process in motion. Dr Ockrim interviewed more than seventy former patients as well as members of the practice's office staff and nursing teams. These oral history testimonies present a 'history from below' using voices that are not normally heard in the medical discourse. Their analysis enables the understanding of the historical context for the developments in health over several decades prior to the study. It will follow the increasing acceptance of women in medicine and show the various aspects of the doctor-patient interface.

When the NHS was set up there was to be a clear division between medicine in the community, that is in general practice, and hospital-based specialist care provided by junior doctors and consultants. Building on structures which existed before the NHS, dating back to the National Health Insurance Act of 1911, general practitioners were to be the 'gatekeepers' controlling the interface between community and hospital.[4] Patients registered with general practices and everyone on their lists received the exclusive care of that practice.

General practice is now recognised as a discipline within medicine.[5] The founding of the Royal College of General Practitioners in 1952 was followed the next year with the launch of the College's journal. In 1965 the first examinations for College Membership took place and while this endpoint of training was optional it is now recognised as an essential entry point into a medical practice.

The data obtained in the interviews will be shown to provide convincing evidence for the value of oral history in retelling the story of how patients understand their medical care, both

current and historic. The interaction of a family doctor and her former patients, now study participants, produced a vast complex of recollections. I claim that this study is unique in that it represents the recorded encounters between a general practitioner and her former patients covering events over many decades before and after the NHS.

Oral history methods have increasingly been used in medical history research and I explore the benefits of this approach. I will show how this study adds to the growing body of material on the history of general medical practice in Britain, through patient narratives as mediated by one of their own family doctors.[6] This account of the health care of patients in one urban practice and allows for their own understandings in the telling of the story. I will show that the choice of the retired doctor interviewing former patients gives a different perspective on oral medical history, compared even to Scottish studies recording the views of retired general practitioners.[7]

My analysis will be used to understand the management and delivery of health care in the past as well as indicating future needs. The watershed of the beginning of the NHS in 1948 will be seen as initiating many improvements in health care management. However, many issues still troubled the oral history participants often related to significant life events, including birth, death and serious or life-threatening illness. A further concern of participants was how stigma and marginalisation affected the health and welfare of patients and their families. Recollections also faithfully record cures and recovery, but memories also indicate where things went wrong.

Many oral history studies which show patient opinions are usually conducted by social scientists, and where they are conducted as part of a general practice-based study these are often in the form of focus groups looking at one aspect of their medical care. In this thesis I will use evidence from this study, which encompasses all the aspects of general practice, its personalities, its delivery and its content. This introduces the role of oral history in understanding medical practice, in particular what oral history can add to an understanding of the general practice as well as indicating what the analysis of the oral history in its wider social and welfare contexts can tell us. This will allow the analysis of questions related to practice history, women in medicine, critical health issues, practice organisation and medical and welfare stigmas.

These topics are important and extracts from the recordings will give key evidence about how former patients, study participants, recalled the history of the practice from at least two decades before the NHS began. I will also show the recollections of the prejudices that women faced in their practice of medicine.[8]

Practice organisation in the early years of the twentieth century, and indeed in the first years of the NHS, was quite rudimentary and yet I will describe how participants and practice staff felt that progress came at a price. Participants and staff clearly appreciated the new facilities at the Midlock Medical Centre which opened in February 1987. However, there remained a nostalgic feeling for the large but cramped tenement flat which had served the practice for sixty years.

Dr Ockrim as Interviewer: The role of the interviewer is also important. Dr Hetty Ockrim had been a partner in the practice from 1946 to 1989 and this lengthy period gave her the perspective to understanding the generations of patients who had passed through the practice. As former patients, study participants would have known Dr Ockrim well, and it was anticipated that this closeness would allow the presentation of medical and social issues of importance to participants and would include issues which might have troubled them for years, even for decades. We will also encounter the memories regarding Dr Stevan George, who had founded the practice in 1924, an era very different from that of the study period which concluded almost seventy years later.

The thesis will also show how Dr Ockrim saw the importance of her medical legacy in a series of letters found in her desk after her death in August 2007. After Dr Ockrim's death in 2007 my sister found a brown envelope in her desk with the words The Letters to No-one written on the outside. Inside were three 'letters.' Two of the letters were written during the period leading to her retirement in 1989 and related to her busy life as a general practitioner describing her hopes and fears for the future. A third was written a month after retirement. These shed light on the importance to her of the oral history study which formed part of a narrative illuminating not just the practice of medicine in one area of Glasgow but also the practitioner who conducted the interviews. These will be discussed later in the thesis.

A different oral history of local general practice was conducted in Paisley and the findings published in 2007. This will be discussed in the following chapter. This was through interviews conducted by a social scientist with retired and practising GPs, providing their account of the views of their patients.[9] It showed how the interaction between hospital and practice doctors was perceived as positive with 'local medical relationships in crossing the divide between primary and secondary medical practice.'

Thesis Analysis: A Personal (Positionality) Statement: Besides being the designer of the oral history study, the author of the thesis and the son of Dr Ockrim, I was a principal in the practice from 1977 till 2007. I knew most of the study participants as patients. While some of the stories recounted during the study were familiar to me, I also learned much of importance from the recordings and soon recognised that these memories formed a picture of medical practice which is both of historic interest but also reveals much which is of importance for the present and future of general practice. My own medical experience strongly influences my understanding of these testimonies and their value. While the views of the participants are carefully preserved my personal comments are often seen through the prism of their clinical meaning. However, my analysis and interpretation of the data reflects my role as dispassionate researcher.

From the outset the oral history was a joint project. I had continuous access to the recordings and sight of questionnaire forms and the participants frequently expressed their appreciation for our collaboration. They knew that Dr Ockrim's recording of their memories would be followed by an analysis which would tell their stories along with the context to which these stories related. Given the close relationship between us and the patient rapport in the practice, nurtured carefully for decades, many of the problems faced by more detached observers were avoided.

Thesis Outline: Following the information in this chapter on the background to the study, its questions and thesis aims, the Study Background will be outlined in Chapter 2 using an extensive literature review to cover the issues covered in the thesis: practice organisation; women in medicine; attitudes to consulting women doctors; social deprivation and its health consequences in Glasgow, sometimes known as the 'Glasgow Effect', fostering good general practice; stigma and marginalisation. The Background also includes the formative figures, firstly Dr Stevan George as well as Dr Ockrim. This includes memories of their early roles in the practice, Dr George's wartime heroism and Dr Hetty Ockrim and her medical practice.

Chapter 3 covers study methodology including participants recruitment, involving former patients, some practice staff, a sister midwife and a practice-based district nurse. The interviews followed semi-structured questionnaires and the recordings were transcribed. Chapter 4 covers practice organisation showing how patient needs and expectations were addressed. This involves testimony from both patients as well as receptionists, administrative staff and practice and

district nurses. Topics include the patient/receptionist/doctor interfaces, office systems, the function of the waiting room, which doubled as a social hub, and the role of house visits.

Chapter 5 addresses the topics of stigma and marginalisation. There was stigma related to old institutions, like Merryflatts (Southern General) and Hawkhead (Leverndale), which entered the NHS after 1948. Stigma was also related to illness: (e.g., tuberculosis, mental health, alcohol, and drug misuse), to poverty and heavy-handed welfare allocations and to housing in the Moorepark Estate (known as "Wine Alley" from its early association with alcoholism). Marginalisation affected ethnic communities with a significant Asian immigrant presence in the practice, which had grown substantially during the 1970s and 1980s and which brought its own health issues. Chapter 6 deals with critical issues in medicine, covering a very wide and varied range of how clinical topics were remembered. This shows how clinical topics inform our understanding of healthcare provision as well as how the community/hospital interface operated. The chapter is laid out thematically following topics which also include patient/doctor communication, accuracy of recall, truth telling and coping with loss.

In the concluding chapter, Chapter 7, I will consider the oral history, its interpretation and its analysis through headings including humaneness, recovering lost memories and closure. I will also discuss the important role of the interviewer. This chapter will illustrate the value of oral history in telling the health story from the patient's point of view. Participants also showed what was important to them in terms of service provision. It would not be possible to address all the wants that were identified in this study, but it was indicated that there needed to be a sensitive understanding of what participants felt were key issues.

The Clinical Consultation and Oral History: One of the challenges presented in this oral history study was the very close relationship that general practitioners form with their patients. As noted, the Wellcome Trust were concerned about how a recently retired general practitioner would interact with her former patients in conducting the oral history and insisted on some oral history in medicine training.[2] Listening is clearly important in both oral history and the consultation, but many doctors, used to short consultation times and expecting short answers to questions on symptoms, find active listening difficult.[10] Levenstein and colleagues observed that there are two agendas at play in the consultation – the doctor's questions being related to

[2] The issues of context, power and trust will be considered following page 61.

symptoms and disease and the patient's concern with fears and illness experience – and these have to be integrated.[11]

A regular feature of consultations in general practice is that doctors deal with somatic, psychological and social problems and their training focusses on the presenting medical problems and tends to underestimate the value of the patient's own perception of their health problems as a valid source of information.[12] Doctors ask questions and patients reply. It has been suggested that British doctors may be less able to become patient-orientated than their European counterparts because of the shorter time available for consultation and also because of class differences. This time difference often leads to less attention being paid to relevant psychosocial issues which in turn may increase the tendency to prescribe rather than listen.[13]

The interaction between family doctor and patient in the consultation may have different meanings for both though they both pursue the same goals of patient well-being, maintaining a therapeutic relationship and achieving a shared understanding of the current problem. All this needs to be done in a very short time, usually around ten minutes. The oral history study started from an established relationship and was intended to probe beyond the ideas, concerns and expectations seen at a consultation. Consultations are common – and the 'average GP' with a practice list of 2,000 patients would expect to have around 9,000 contacts with their patients in a year.[14]

The oral history should be seen as a meeting between experts. The interviewing doctor has the benefit of medical knowledge and usually some details of family and medical history. The participants know a great deal about themselves and their families and the personal values, experiences and lifestyle which colour their own stories. For the doctor a consultation places a responsibility on themselves to understand the patient's problem in a few minutes and take the necessary action to start to solve it. In the oral history interviews, there remained the same sense of expertise on both sides, but the interviewer had the task of acting as a neutral voice, able to elicit, with neutral prompts, the key elements of their health and welfare experiences from the participants.

Challenges, related to health and welfare inequalities, are an important part of this oral history study and their analysis will enable an understanding of what is important in primary care, which is one key component in welfare state provision. General practice care begins in the surgery but may reflect many issues related to the challenges mentioned in the National

Framework Report and had been part of the caseload of inner-city general practice for generations. This care begins with the general practitioner-patient encounter – the consultation. A study in Denmark indicated that patient priorities were focussed on such issues as a patient-centred approach, good communication skills, continuity, and appropriate clinical skills. They found that patients mentioned the importance of their GP being empathetic, patient-oriented, informative and coordinating and of course competent and skilled, enumerating the large range of tasks and strategies which they considered essential in improving outcomes for the patient.[15]

At the same time, they agreed with Levenstein and colleagues that integration of the two agendas referred to above was essential. The tasks and strategies were summarised as concerns for the whole patient and not just the disease, involving the patient in setting the consultation agenda and empowering the patient in making decisions. Pendleton and colleagues noted that 'taking a medical history is a method of controlling what the patient says though admitting that most patients would prefer a poor communicator who gets the diagnosis right to a good one who doesn't. It was Roger Neighbour who considered that the consultation should be powerful enough to give the practitioner a sense of purpose and direction, but at the same time simple enough to be unobtrusive.[16]

The Beginnings of Oral History in Medicine

As I will show, through an understanding of the importance of oral history and what it can tell us, this study begins with the traditional consultation format, doctor and patient, but recast as study interviewer and participant, without time constraints and with the interviewer as facilitator for the participant's story where relationship matters more than a formal clinical diagnosis.[17] There will be questions to be asked and lessons to be learned.

Paul Thompson,[3] regarded as a pioneer in social science research, particularly due to the development of life stories and oral history within sociology and social history, describes how one impetus for oral history in medicine began with reminiscence groups which were found to provide valuable historical evidence.[18] In his early work setting out the possibilities for medical history using oral techniques, Thompson pointed out that 'given that only the living can be interviewed, this neglect means that opportunities are being permanently lost' and

[3] Paul Thompson (b.1935), formerly Research Professor of Sociology at the University of Essex

commented that ‘a promising approach is through focused oral history research projects with thematic interviews on a specific issue in the history of medicine.’[19]

Thompson’s work has ensured that oral history has been increasingly recognized as a key factor in understanding the history of the recent past.[20] Despite his focus on the importance of institutional studies and autobiographies of leading medical figures he indicated that oral history:

> conveys ‘both empirical information and subjective interpretations from the past and that this has to be evaluated both for internal consistency and its relationship to other sources.

I will show how we followed Paul Thompson’s guidelines as laid out in his paper on ‘Oral History and the History of Medicine’ from the start [21] and we attended one of his courses on the subject. The role of oral history in understanding medical practice will be considered in the next chapter.

Research Questions and Thesis Aims

This thesis will show how oral history can provide a deeper dimension of understanding health care and its delivery in an inner-city practice, significantly affected by social and economic deprivation. The views of participants in the oral history study will be analysed to describe historic health care issues to find what this tells of the past as well as indicating future needs. The thesis relies heavily on the secondary analysis of the original oral history interviews. In this thesis show the importance of the insights recorded almost two decades earlier remain of considerable importance, recognising that memories of participants stretched back to even earlier decades.

The literature review on secondary analysis will show its benefits, which has been addressed by social scientists in many countries. Medjedović found that, though there have been concerns with this research strategy the experience of expert researchers suggests that the problems associated with secondary analysis, such as ethical issues, do not necessarily constitute unsolvable obstacles.[22] I will show that secondary analysis has potentially important implications for qualitative researchers who seek to investigate sensitive topics within health.[23]

These research questions are related to the original oral history interviews and their more recent analysis which forms the focus of the thesis:

1. How can oral history provide an understanding of health care and its delivery in a Glasgow inner-city practice, significantly affected by social and economic deprivation? Can participants' views subsequently be analysed to describe historic health care issues and how does patient respect for the doctor's authority impact on their health care?
2. How have attitudes to health and welfare changed with the creation of the NHS? What changes have taken place in the attitudes to the role of women in medicine and the way in which women practitioners are perceived?
3. Can this analysis, involving clinical issues, service provision, stigma and marginalisation be used to understand the management and delivery of health care in the past as well as indicating future needs?

Dr Ockrim's Study Notes

In preparation for the interviews Dr Ockrim formulated her own Study Notes which can be seen in Appendix C. These were to be the agreed framework which would set out the areas of testimony which she felt to be important. Foremost here were her 'favourite topics' which included all aspects of pregnancy care and child welfare. She worried about deficiencies in areas of National Health Service funding and wanted to know about participant experiences in the accessing of care. These Study Notes covered the topics, she would use especially for older patients to gain access to their memories of the pre-NHS days or her first years in the practice. She described herself as committed to an NHS where 'all patients could be treated equally and freely' and was always concerned that patients in need should receive the benefits to which they were entitled.

History from 'Below': The use of oral history will provide a historical context for the developments in health care and its delivery over several decades prior to the study. This oral history represents the patient perspective, rather than that of the healthcare professionals, and illustrates the doctor-patient interface and the experience of practice organisation, clinical topics, stigma and marginalisation.

To do this will require an understanding of how the practice was formed and operated prior to the NHS and how delivery of care within the practice was seen by the patients to change

after 1948. It will show the increasing acceptance of women in medicine, indicating how women doctors were viewed by patients within the practice. It will help to understand the role of the interviewer as the former GP and her encompassing practice presence.

I will show how oral history methods have increasingly been used in medical history research and will explore the benefits of this approach. This account of the health care of patients in one urban practice allows for their own understandings in the telling of the story. I will show that the choice of the retired doctor interviewing former patients gives a different perspective on oral medical history compared with previous studies where interviews of general practitioners or patients were conducted by social scientists.[24]

The study generated a large amount of qualitative data in the form of the extensive interview texts. In 2000 the *British Medical Journal* printed an article showing that qualitative research, such as in verbatim notes or transcribed recordings of interviews can produce 'vast amounts of data'.[25] I have followed the approach which indicates that the analytical process begins during data collection allowing the researcher to go back and refine questions, develop hypotheses, and pursue emerging avenues of inquiry in further depth. It also allows the use of paper systems, which may be considered old fashioned and laborious, but can help the researcher to develop an intimate knowledge of the data.[26] This approach, for example, led to the inclusion of staff interviews not considered in the original plans but were seen to be essential as the interviews progressed.

Interviewing Women: Ann Oakley has published extensively, over the past forty years, on interviewing women based on her own experience in a project interviewing of women becoming mothers for the first time. This was published as 'Interviewing women: A contradiction in terms?' in Helen Roberts (editor) *Doing Feminist Research* (Routledge, 1981) and was revisited in a fresh analysis in 2016 in her paper 'Interviewing Women Again."[27] Here she suggested that:

> some aspects of the researcher–researched relationship remain insufficiently acknowledged and explored, and that more attention should be given to the roles of time and memory in qualitative longitudinal studies and to the notion of the 'gift' as a framework for research participation.

The concept of the 'gift' was coined by Limerick and colleagues who suggested that: researchers need to accept as a gift 'of time, of text and of understanding' material provided by

the researched, because the product of the research is 'our story of their story.'[28] Considering that 'social science was emerging from a period of masculine domination' in the 1980s she drew on her experience of interviewing women to propose that such interviews incorporate elements of a 'transition to friendship', based on a shared sisterhood. Oakley noted that:

> In the conventional approach to interviewing, the person asking the questions dictates the framework of the dialogue and the form of its analysis. The person answering the questions is relatively powerless. It is not a reciprocal relationship: information passes one way only…. The textbook advice for interviewers at the time was that they must work at 'rapport'…. this was not my experience.

Oakley ended by noting that over 50-years in research she had interviewed many people whose values, lifestyles and backgrounds were unlike her own:

> the point about the professional practice of interviewing…. is that its starting point is interviewers' interest in other people's lives, responsiveness to their stories about these and a responsible attitude towards the data and the participants.

Dr Ockrim did not have to exert herself to establish rapport as the participants were enthusiastic at participating in the study and had long experience in sharing their information with her. Oakley also noted her naivete a generation earlier as, though the interviewer and interviewees shared a gender she had not taken into account issues such as age, class, ethnicity and sexual orientation, topics very familiar to Dr Ockrim and colleagues working in inner-city Glasgow.[29] Dr Ockrim was able to use her relationship with the participants, built up over more than four decades in some cases, to obtain their memories and accounts of their medical connections. I had been in the practice for almost fifteen years when the interviews were being conducted and had been a well-known figure to many.

Conclusion: In this thesis I will show what is important in the role of a general practitioner interviewing her former patients and providing their unmediated views. I will rely on methods of recording and interpretation developed during the development of oral history practices. I will show how this patient-centred oral history provides a window into how individuals interviewed in this study understood and interpreted their lives and health issues. The testimonies were very subjective, and I will show how the material recorded in oral history interviews sometimes carry

an importance providing a level of meaning which may allow for discrepancies in memory recall.

The oral history study was conducted when the NHS was already forty years old, but a substantial number of participants were old enough to remember their medical care or that of their parents from before the watershed year of 1948. Thus, as noted, my analysis of participant memories will illustrate health care in Glasgow before and after the NHS. It will show incidents and areas where provision met or exceeded expectations but also where it fell short.

Chapter 2: The Study Background[4]

In this chapter I will describe what is important in the study background. As the thesis is based on the analysis of an **oral history** study I will begin with the medical literature which describes how oral history can provide an understanding of health care and its delivery in an inner-city practice, significantly affected by social and economic deprivation, sometimes called the 'Glasgow Effect'.[30] The oral history study also provides the context of key figures in the practice, Dr Stevan George, the practice founder of the practice, and Dr Hetty Ockrim, who conducted the interviews.

The literature reviews will be considered under the following headings:

- **Oral history:** how oral history can speak to us about what is important to the consumers of health provision, the patients and their relationship with their doctors, the major impact of the creation of the NHS and how lessons from the past can inform future developments.
- **Women in medicine:** the growing role of women doctors and attitudes to consulting women doctors. and the beginning of the NHS; the changing provision for maternity services.
- **Demography: Changes, Challenges and the 'Glasgow Effect':** The history of deprivation in the practice area and attempts to implement remedial provisions.
- **Stigma and Marginalisation:** how welfare provision and a range of illnesses produced stigma and how different communities could be marginalised with an impact on health.

Oral History

Thompson noted that, in its first years, oral history was often challenged for presenting the selective memories of those interviewed.[31] He acknowledged that the passage of time and the way in which the story is heard, how it is to be recorded and who will eventually access it, are all

[4] My book based on the oral history interviews, *Patient and Staff Voices in Primary Care: Learning from Dr Ockrim and her Glasgow Medical Practice*, Taylor & Francis/CRC, Abingdon, 2023 draws heavily on this chapter.

factors which may affect the story. In addition, there is a tendency for participants to look at the past through the prism of their present experiences. However, I will show how this study has much to contribute to our understanding of the delivery of medical care before and after the establishment of the NHS.

People often can relate accurately distant memories whereas lesser important and much more recent happenings are forgotten. I will show some recollections where two people recall the same event slightly differently and others where some memories have changed with time. Budson and Price describe how age-related memory loss is a feature of normal ageing and is different from the severe memory deficits found in Alzheimer's disease.[32]

Abrams and Farrell review many studies related to language processing in the elderly and show that some researchers argue that the capacity of working memory decreases as we age, and so we hold less information.[33] They also note that others show that 'older adults are rated as better storytellers than younger adults' which may be, they suggest, because 'older adults have had more experience with telling stories throughout their life or possess different goals for communicating, particularly in autobiographical situations. However, Abrams and Farrell consider that they 'may come to give themselves a more central role than the original story might have warranted.'

A study in Paisley, conducted by Smith and Nicolson, relied for interpretation on the works of Schrager, Bakhtin and Portelli. Schrager attempted to identify elements in individual narratives that symbolise larger trends and social understandings, being particularly interested in the complexity of positions adopted within individual oral histories.[34] He sees many 'voices' in the diversity of individual accounts, which contributes to making oral history 'social'.[35] The works of the Russian philosopher Mikhail Bakhtin focus heavily on dialogue. As individual testimonies come together to create a 'form of dialogue' between the interviewees the social context is crucial to understanding.

Much of the theory and practice of oral history as it relates to memory and the accuracy of recall can be found in the writings the Italian oral historian Alessandro Portelli. He described the importance of oral history by saying that it:

> may not lie in its adherence to fact but rather in its departure from it, as imagination, symbolism and desire emerge…. memory is not a positive depository of facts but an active process of creation of meaning.[36]

He showed how recall of past events is held in our memory in a way which makes us feel 'good about ourselves.' This means that we can live our lives as we have been doing but it can also be part of a process 'that questions the certainties and beliefs on which we rest.'[37] Understanding that 'memory is neither good nor bad' he indicated that:

> We cannot control whether we remember or forget and have only partial control over the content and the functioning of memory…. The cliché of memory as weight and mere repetition is, ultimately, the result of an idea of memory as mere container, unchanging, forever frozen in a single, intangible, established meaning.[38]

In an interview in 2012 he commented on the accuracy of oral history saying that they were 'much more interesting when they are not' as they have become a 'work of imagination'. He said that he:

> realized a lot of the stories I was hearing were not actually accurate, which was sort of a Copernican revolution in oral history because for 25 years oral historians have been fighting to establish that oral sources were accurate…. Then you do the work of the oral historian, which is that you connect the facts to the subjectivity.[39]

He noted in the interview that when people repeated the same story the words were never identical considering that 'Change is inherent in a means of communication, which is totally immaterial, like a voice.' Therefore, the first thing that makes oral history different, therefore, is that it tells us less about *events* than about their *meaning*.[40]

Portelli wrote that 'the content of oral sources…. depends largely on what the interviewer puts into it in terms of questions, dialogue and personal relationship.'[41] Consequently, the role of the interviewer is crucial for recording oral history.

Besides the meaning that oral history provides, Portelli points out that what makes oral history different is 'the speaker's subjectivity' representing a cross-section of the subjectivity of a social group or class.[42] Patients might not be able to recount the precise year that major events in their lives occurred but as Portelli noted, oral history adds much more than such details. It contributes, he says, more than just events by adding meaning - 'an active process of creation of meanings.'[43] This holds irrespective of the accuracy of the recalled memory. Thus, he says that:

> 'The diversity of oral history consists in the fact that 'wrong' statements are still psychologically 'true', and that this truth may be equally as important as factually reliable accounts.'

Oral history provides a very subjective window into how individuals understand and interpret their lives. Thus, the recollections of the interviewees may often contain inaccuracies.

Mark Roseman commented that Holocaust survivors showed 'significant patterns of discrepancy' which could be related to the trauma of the event.[44] While the experience of patients in Glasgow is far from that of Holocaust survivors, we will see in the clinical stories of the trauma of family conflict and loss, addictive behaviours and paternalistic and stigmatising attitudes from health and welfare bodies. Lawrence Langer also confirmed that 'since testimonies are human documents rather than merely historical ones, the troubled interaction between past and present achieves a gravity that surpasses the concern with accuracy.'[45]

Thompson notes that interviews can give us 'information as valid as that obtainable from any other human source.'[46] He described the interpretation of the interviews as 'the heart of the matter' asking how we relate the evidence we have found to 'wider patterns and theories of history'.[47] He reminds us that 'the tension which the oral historian feels is that of the mainspring: between history and real life'[48] and considers that 'the oral evidence is treated as a quarry from which to construct an argument.' [49]

Thompson points to the paradox at the heart of oral history, saying that 'any historical work suffers the inevitable disadvantage of having to work from the real cases'[50] but also notes that interviews can give us 'information as valid as that obtainable from any other human source.'[51] Thompson also considers here that, in oral history, 'wrong' statements are still psychologically 'true.'

While one would not normally seek to use oral history, on its own, to build a standard history of past events, it is also true that as (Alistair) Thomson writes 'oral history is essential evidence for analysis of between past and present, and between memory and mythology.'[52] Thomson described how memories are composed to make sense of our past where often 'inherent traumas or tensions have never been resolved.'[53] One concern that Thomson had was that, in his interviews with ANZAC veterans, he took notes recording facial expressions and body language as the 'commentary' on emotive events. This, he felt, put him in a therapeutic position, which was great for the interviewer but could be damaging for the interviewee.[54]

Abrams reminds us that the oral history interview does not 'record the body-language in the interaction, the facial cues during the interview and the words exchanged when the recorder is switched off. [55] She notes that all we have is the interview, the recording, the written

transcript and the interpretation' and tells us that interpretation and meaning are important parts of the understanding of the interview and that the narrative, and its interpretation belong together. Abrams notes that oral history 'demands that we find ways of comprehending not just *what* is said, but also *how* it is said, *why* it is said and what it *means*… the process of interviewing cannot be disaggregated from outcome.'[56]

Borland points out that the researcher will take narrative chunks and embed them in a new setting, often in an academic journal or book, thus reshaping the original.[57] This poses great responsibility on the interpreter of oral history to ensure that the views of those interviewed are understood clearly in the context in which they were articulated. Oral history only works when the interviewee can understand the use of their memory and understands the context in which it is set. Thus, if the interviewer has a clear political agenda this should be disclosed at the earliest opportunity.

The strength of this study is to see the patient maintained at the centre of the story, while the narrative is expressed in a medical context of health care facilities and clinical outcomes. As the general practitioner also has intimate knowledge of the patient's circumstances, their medical history and family background it could be argued that narrative has long been the basis of doctor-patient relationship. In this study with interviews of participants representing a wide variety of backgrounds and experiences over a period of around two hours, all the aspects of their medical history are enriched by their attitudes to the doctor and their health. Launer, one of the leading figures in describing the medical narrative in Britain, points out that while doctors may believe in their explanation of symptoms of diagnosis as unshakable truths they can prove to be as transient or evolutionary as the stories the patients bring to their doctors about their own lives.[58] In this study, we encounter many different views of the patient understanding of 'medical diagnosis.'

While doctor's stories involve the interpretation of the illness to the patient, setting the context for diagnosis and treatment Launer has noted that doctors may still unwittingly ignore or disqualify people's realities by failing to catch many of the exact words, phrases, and metaphors with which they weave their stories.[59] Oral history studies can help our understanding of what doctor and patient tell each other in the consulting room.

I will show how trust is an important aspect of the relationship between patients and medical professionals. This can take years to build and can influence patients co-operating with treatment and accessing preventive services. Although evidence shows that the majority of

patients continue to trust physicians to act in their best interest, concern is growing that the rapid and far-reaching changes in the healthcare system have placed great pressure on that trust. [60] Mercer, Cawston and Bikker showed that patients from deprived areas in and around Glasgow want their GPs to understand the realities of their lives so that they can earn their trust displaying competence, concern, continuity, empathy while spending enough time to hear their patients' concerns.[61]

Empathy: Empathy with patients is an important skill for clinicians. While diagnosis and treatment require increasing technical scientific skills doctors still need to listen to, understand and comfort their patients.[62] The *Oxford Advanced Learners' Dictionary* defines *empathy* as 'the ability to understand another person's feelings, experience' whereas it defines *sympathy* as 'the feeling of being sorry for someone; showing that you understand and care about someone's problems - unlike empathy does not involve actively sharing in the emotional experience of the other person.'

Charon suggests that as the empathic physician listens to the patient, she or he 'follows the narrative thread of the story, imagines the situation of the teller (the biological, familial, cultural, and existential situation), recognizes the multiple and often contradictory meanings of the words used and the events described.'[63] With these skills the patient can build up trust in the doctor and enable the therapeutic encounter to proceed.

Angela Coulter asked what patients wanted from primary care.[64] She recognised that patients have diverse needs but that it was possible to discern themes such as fast access, effective treatment delivered by trusted professionals, emotional support, empathy and respect, and continuity of care. In the seminal work *Empathy and the Practice of Medicine* (1993), Spiro, the lead editor, commented:

> Of course, until a few decades ago, physicians could only *care* for their patients, now the chance to *cure* so many makes science and technology irresistible and essential…. Those who carry out procedures need no empathy. [65]

General Practice: I have described elsewhere the division in British medicine between the general practitioner, often with just a qualification from one of the Colleges of Surgery in London or Edinburgh, and the physician, usually with an MD degree from one of the Scottish universities.[66] This division goes back more than two hundred years. In Scotland, the position of

the general practitioner/ apothecary or surgeon/apothecary, licensed by the College of Surgeons in Edinburgh or the independent Faculty of Physicians and Surgeons of Glasgow, was already established by the time of the passage of the Apothecaries Act of 1815.[67] These early practitioners provided all the medical services that were available at the time. I also showed that what had been a chaotic licensing system with many unqualified practitioners able to pass themselves off as doctors was finally regulated by the Medical Act of 1858.[68] By the end of the nineteenth century the standard university degree for a British medical degree was the MB ChB[5] while the MD degree was a higher degree awarded later in the practitioner's career following submission of a thesis.

An understanding of the challenges of entering general practice in the inter-war years can be found in Digby, *The Evolution of British General Practice 1850-1948*. She notes the benefits of establishing a single-handed practice as many partnerships foundered because of different approaches to practice procedures, especially related to income, or attitudes to doctors from different backgrounds, whether religious or ethnic.[69] In his own practice a doctor could make his own decisions, be responsible for his patients and keep the practice profits for himself. However, the GP would also have to create a local following by creating a solid reputation, impressing potential patients with their skills and personality. The National Insurance Act had made the income of general practitioners more secure, and they were able to establish new and practices with the establishment of the doctor's 'panel'.[70] It created a system of health cover for industrial workers in Great Britain based on contributions from employers, the government, and the workers themselves. The alternative to solo practice would have been to join an existing practice as an assistant, who **might** have the opportunity for partnership at some unspecified time in the future or to become a junior partner, fully sharing the workload but receiving a far lower income than the senior partner.[71] Setting up in a solo practice, though, meant a period of uncertainty while recruiting patients through the National Health Insurance (NHI) Scheme of 1911 or through funding from members of trade unions or friendly societies.[72]

In the early years of the NHS general practice was held in low esteem, with poor facilities and out-of-date practices given as the cause.[73] Facilities were often rudimentary and with the beginning of the NHS family doctors were under increasing pressure, giving a minimal amount of time to each consultation. After 1948 the practice workload increased significantly as NHS

[5] MB ChB: Bachelor of Medicine and Bachelor of Surgery (Chirurgia).

provision extended the range of what was available.[74] Income was mainly derived from capitation fees so there was little incentive by many GPs to provide anything beyond basic services.

In a single-handed practice, notes could be also very rudimentary, if they existed at all.[75] The basic format for recording patient details was the so-called Lloyd George envelopes into which all medical information about the patient was placed. Lloyd George had been Chancellor of the Exchequer when National Health Insurance began in 1911 and the name for the envelopes stuck. These envelopes, which were only 5" by 7", were made of stiff paper and their small size gave little room for the accumulation of hospital correspondence and blood test results over the following years. In many cases the small amount of space available for note taking meant that even in larger practices notes were at a minimum.[76] Details might be summarised in just a word or two. As records became more detailed and hospital interventions more common the envelopes became overloaded, and the practice abandoned them in 1980 in favour of A4 folders.

Morrell noted that a British Medical Association (BMA) plebiscite in January 1948 showed that a large majority of general practitioners expressed themselves as opposed to the introduction of a NHS, although McCrae described attitudes in Scotland as being more favourable.[77] McCrae showed that general practitioners could see the benefits of the services for patients being free at the point of contact but many doctors had purchased the 'goodwill' of their practices and it took some time for the promised reimbursement to be paid.[78] He also noted that some of the old pre-NHS organisational structures remained; district midwifery and community nursing remained outside the framework of general practice; the substantial rise in house calls and surgery visits when financial constraints were removed and women, not previously covered by the National Health Insurance, were now able to access treatment without payment. [79]

The huge disparity in standards between practices became public on March 25, 1950, when *The Lancet* published a detailed article about the state of general practice in England by Dr J S Collings, a young Australian with an interest in health care systems.[80] He visited fifty-five practices, in a mix of industrial, residential, and rural areas, observing 'the doctor's method, his equipment, and, in a more general way, the doctor-patient relationship'. He felt satisfied that he had obtained a fair and representative sample of British general practice, saying that 'There are no real standards for general practice. What the doctor does and how he does it, depends almost wholly on his own conscience.'

Collings was scathingly critical of practice premises, overcrowded waiting rooms, grossly inadequate consulting rooms and cursory clinical examinations. He considered that the defects he had identified existed before the NHSs Act and were exacerbated by the increased workload on general practice when care was freely available to all. The article caused a storm with general practitioners who felt that they were providing a good service. Thus, Stephen Taylor's book *Good General Practice*, published in 1954, considered that Collings represented 'the worst as typical of general practice in Britain' though acknowledging that 'one twentieth are so bad it is hard to find excuses.' [81] Honigsbaum published a paper in the *Journal of the Royal College of General Practitioners* in 1972 where he counselled against using patient satisfaction as the marker for good care, considering them to be a poor guide. [82] He wrote that the 'general public lacks the knowledge for appraising the quality of his [doctor's] knowledge and called for 'another study on the Collings model.'

In the years following Honigsbaum's paper many more structured attempts have been made to assess patient views on the provision of care in general practice. Both Buetow and Jung and colleagues showed that views of patients and doctors as to what denotes quality of care often do not match and this can affect compliance and outcome.[83] Ramsay and colleagues, developed an instrument for assessing several important aspects of general practice, including the consultation, continuity of care and how GP care is perceived.[84] They found that interpersonal skills ranked higher than other factors such as those which relate to effectiveness. This may explain why patients often stay with practices with poorer facilities.

The NHS and Rising Expectations: General practitioners also had expectations from the new NHS.[85] They looked for clinical autonomy, diagnostic facilities, an adequate capitation fee and recognition of additional services by fees for specific activities.[86] There were concerns about the level of remuneration for general practitioners, many of which were not settled until the major changes of a new contract in 1965. To maintain the level of capitation fees it was not uncommon for patients to be retained on the doctors' list in the early years even if they moved to a distant part of the city.

Major changes to the functioning of general practice had been set in motion by the new GP Contract, devised in 1965 and implemented in the following year. At the same time family medicine was emerging as an academic discipline. This was based on general practice

constituting a unique field of action, a defined body of knowledge, an active area of research and a training which is intellectually rigorous. [87] The GP Contract, usually called the Family Doctor Charter, provided financial incentives, improved social conditions, and improved the self-worth of GPs.[88] The pay structure for GPs was substantially improved and the balance of income moved from capitation fees to a broader system which included basic practice income and items of service as well as capitation.[89] Financial allowances were made for employing nursing and office staff with reimbursement of 70% of their salaries, though some worried that the establishment of a multi-disciplinary practice team threatened the old images of the doctor-patient relationship.[90] New schemes, cost-rent and notional rent, made it easier for the provision of new surgeries with better facilities and this was the basis on which the move to purpose-built premises was made in 1987, but planned for the year before that.

While the oral history interviews were being constructed there began to be increasing emphasis placed on the views of patients as consumers of health care. The Patient's Charter of 1991 encouraged health authorities to use questionnaires and surveys to assess current services and get suggestions for improvement. [91] Baker conducted a study in 1990 using a questionnaire to assess patient satisfaction in general practice and suggested how questionnaires could do this reliably.[92] Lewis described the benefits and drawbacks of various kinds of surveys which looked at the quality of consulting styles and medical skills in the context of stressing the interests of the patient as a consumer. [93]

Crawford and colleagues reviewed forty-two papers, mostly case studies, on involving patients in the planning and development of health care.[94] They found some positive responses from the patients who had taken party in the initiatives but concluded that 'an evidence based the effects on use of services, quality of care, satisfaction, or health of patients does not exist.' The British Medical Association produced a paper on areas of good practice in 2002 to help doctors deal with the changes of the 2001 contract. [95] Some of these areas had already been in place for more than a decade and influenced the way that care was delivered in our practice. They emphasised **c**linical quality standards, organisational standards and creating a positive patient experience.

Child Health: Weaver has shown how child health in western countries has seen the emergence of the baby as an individual out of the darkness of early death, uncertain survival, parental

resignation, and public indifference.[96] Glasgow's history of social deprivation and health inequalities was clearly visible in the field of paediatrics.[97] By the end of the nineteenth century high rates of infant mortality had become a subject of social and political concern. It would take some time from the inauguration of the NHS for the much-needed improvements to child health to take effect. Hutchison and colleagues' history of Glasgow's Royal Hospital for Sick Children gives ample evidence of the dirt, poor hygiene and unwashed clothing seen on admission even in the first years of the NHS. They described the aura of mystique, and autocratic practices, by specialist hospital paediatricians, confirmed by extensive interviews with former staff. [98] While parents were useful in obtaining the history of their children, consultants generally felt that families shouldn't have to worry about what was wrong. The days of understanding the psychology of young children and their parents remained firmly in the future.[99]

Improvements by the end of the Second World War which introduced statutory child welfare clinics led to a decline in infant mortality as did the greater reliability of health visitors attending new-borns following the Notification of Birth Act.[100] In 1967 the General Medical Council recommended, that 'the growing child should be studied in his family setting and in association with members of the domiciliary services.'[101] However, some of the complexities in providing adequate child care in general practice led to questions about whether paediatrics was safe in general practitioners' hands.[102] Few older doctors had qualifications and experience in paediatrics and the doctors studied differed widely in their management of hypothetical clinical problems, possibly owing to this lack of training.[103]

Interviewing: Grele considered that a key aspect of the oral history interview requires that the interviewee be allowed to develop their narrative without the constraint an interviewer with an agenda.[104] He emphasised that 'Interviews tell us not just what happened but what people thought happened and how they have internalised and interpreted what happened'[105] and so oral history can live up the promise of 'Everyman, his own historian.'[106] Kalitzkus and Matthieson found that the 'medical narrative is changing: a movement from the physician's [dominant, objective and scientific] narrative to the patient's narrative.'[107] They found that obtaining the patient's story often took comparatively little time as 'medical professionals are trained in medical history-taking with the goal of eliciting the relevant medical facts from patients.' Indeed, Kalitzkus and Matthieson quoted a study about spontaneous talking time of patients in general practice which

pointed out that two minutes of listening is enough for 80% of the patients to recount their concerns![108] Charon described the 'narrative competence' which is needed for speaking and listening which includes sensitivity to the context of the illness experience and the patient-centred perspective, establishing a diagnosis in an individual context instead of merely in the context of a systematic description of the disease and its aetiology.[109]

Portelli notes that the idea for the project usually comes from the researcher and that they may be told what the interviewee thinks they want to hear.[110] The documents of oral history always derive from the relationship of an interviewer and interviewee in a shared project. The interviewer must always be aware what the interviewee wants to tell and not what the interviewer wants to hear. Portelli indicates that it is impossible both to exhaust the entire memory of a single informant and to interview everyone who has shared the same experiences.[111]

Professor Thompson's Course

This course, at the University of Essex, was intended for historians in the field of the history of medicine and related areas who wish to use interviewing as a source for their work, and as noted was a condition of the Wellcome Trust's support. It gave Dr Ockrim and me the guidance we needed to conduct the oral history project and enabled Dr Ockrim, as interviewer, to find the balance between information gathering and therapeutic detachment and for me also to understand the underpinnings of oral history and the problems in its interpretation.[6] Dr Ockrim had experience of interviewing at the course and had received feedback from Thompson and other course leaders.

The course focussed on many of the themes that he had covered in *The Voice of the Past*. He emphasised that the interviewer must show respect for study participants and have an interest in them as individuals, an ability to show understanding and sympathy for their point of view and a willingness to sit quietly and listen.[112] The course included time for several encounters with interviewees with recordings to allow Professor Thompson time to listen to the recording and provide appropriate feedback. He emphasised the need to understand the area, its language and

[6] See Appendix for details of the Oral History in Medicine course. The course leaders besides Paul Thompson included Steve Humphries, a television producer and Alan Ward, Curator at the National Sound Archive

idioms and the importance of flexibility in the questioning thus avoiding a rigid check list of questions. The maxim was that the interview should be conducted with a light touch.

We received guidance on how to handle the responses from interviewees who could be excessively chatty to those who were much more concise. Thompson described when some more specific detail might be required, such as trying to 'establish specific facts' it might be introduced by words like 'Tell me about….' and ultimately moving from 'generalisations to detailed memories.[113] However, leading questions were to be avoided. For a general practitioner with several decades of experience the ability to elicit detailed information is based on an understanding of the patient's background, community, language and self-identification and was for Dr Ockrim a familiar way of working.

Thompson also insisted that an oral history interview was not a dialogue, and the course feedback was to ensure that the interviewer understood the importance of placing the participant in the foreground while keeping themselves in the background. He also recommended ending the interview on a positive note. Dr Ockrim always had an acute awareness of 'doing things properly' and following guidelines. She was energised by the course and keen to start interviewing in the way that the course demanded. Thus, study review meetings, and her own notes, never question the authenticity of participant memories, and she had no problems with the testimonies which often challenged her own role in the events.

Besides the oral recordings, Dr Ockrim's retirement Letters to No-one, only found after her death almost twenty years later, allow us to understand the importance of the study to her and how she interacted with her patients. In encountering these interviews, we can see the beauty of the recollections and the relationship between patients and doctors built up over many decades. As a former principal in the practice for thirty years, I knew most of these former patients well and have, for a long time, wanted to give voice to these records of health care. Both Dr Ockrim and those she interviewed expected that their testimonies would be published in a narrative form at some stage. This encouraged participants to express clearly what they felt was important in their past encounters with the medical profession and to give an accurate account of the social context where they lived – even to situations which had caused them considerable distress. This oral history study illustrates the story of a doctor and her medical partnership while giving meaning to attitudes to gender, ethnic minorities and the social history of Glasgow's Ibrox and

Govan. Thompson lays emphasis on the personality of the interviewer who is collecting the oral history: the ability to listen and their respect for the participants.[114]

History of Women in Medicine

Crucial to the oral history project was the personality of Dr Ockrim, who had seen her destiny in medicine from an early stage. In later life she would recount stories of her medical heroines who had entered the previously closed male medical world just a generation before her birth. She was well aware of the sentiments expressed sixty years earlier by Edith Pechey that 'We were to understand that no one would wish to consult us unless we were the best doctors to be had in our neighbourhood, so she said that we were to see that we were.'[115]

Women like Sophia Jex-Blake (1840-1912) and Elizabeth Garrett Anderson (1836-1917) had a lengthy struggle, with many setbacks, for acceptance in Britain.[116] Sophia Jex-Blake was in America in 1867 trying hard, but unsuccessfully, to enter Harvard University but only obtained some informal clinical experience at the Massachusetts General Hospital.[117] She returned first to medical studies in Edinburgh and then to London where she became the leader of the movement for women's medical studies founding the London Medical School for Women in 1874. Elizabeth Garrett Anderson finally obtained a licence in 1865 from the Society of Apothecaries to practise medicine, the first woman qualified in Britain to do so openly. She had been refused entry to more regular places of medical studies but obtained her qualifications through a loophole in the Society's regulations. Some of the first women doctors had started their medical training by enrolling in a nursing course.[118] However, it was the feeling of aspiring middle-class women doctors that nursing represented a type of work they did not wish to undertake. Sophia Jex-Blake had asked, in 1872, why women should be limited to nursing and the more detailed knowledge of disease be reserved for men.[119] Elizabeth Blackwell, a pioneer of medical education for women in Britain and America told the opening lecture of the London Medical School for Women in 1889 that there was no 'line of practical work outside domestic life' [so] eminently suited [for women] as the study and practice of medicine.[120]

In the United States women's entry into the medical profession after the initial, but often hesitant struggles, for acceptance was substantially achieved only after the Second World War.[121] Moberley Bell noted that in the UK women took longer to enter the profession, than did

American women, but once there, their presence in medicine increased through the twentieth century.[122] Another of Dr Ockrim's medical heroines was Elsie Inglis (1864-1917). She was active in the Scottish suffragettes and had begun medical studies in Edinburgh in 1887 and completed her training at the Royal Infirmary in Glasgow.[123] After obstetrics and gynaecology in London and Dublin she was in Edinburgh by 1894 where she opened a maternity hospital for poor women as well as a midwifery resource and training centre. This was the forerunner of the Elsie Inglis Memorial Hospital which operated as a maternity unit until closed by the NHS in 1988.[7] With the outbreak of the First World War Inglis offered the Royal Army Medical Corps a medical unit staffed by qualified women but when this was turned down the French Government took up her offer and she established her unit in Serbia.[124]

In the first decades of the twentieth century there was a continuing reluctance to employ women if qualified men were available and marriage was often seen as a bar to establish a medical career. While the first medical women had proved their worth in military hospitals during the First World War the post-war period still posed difficulties for women seeking a medical career.[125] Even before the First World War about a quarter of women graduates opted for a career in general practice which seemed to offer a better working option.[126]

Medical studies for women began in the University of Glasgow with the opening of the doors of Queen Margaret College in Glasgow in 1890. This gave women in the West of Scotland the opportunity to study and graduate in medicine through their own medical school. Glasgow was therefore in fourth place in Britain in providing facilities for women to study medicine. Within a few years, women were allowed to matriculate at the University of Glasgow though the separate lectures continued.[127] By the end of the First World War, there were around 1,500 women on the medical register in Britain. The entry of students of less affluent backgrounds was made easier in Scotland by undergraduate grants from the Carnegie Trust for the Universities of Scotland.[128]

As late as the 1930s medical women working for the Glasgow Corporation had to resign from their positions on marriage.[129] Even though more than thirty years had passed since the establishment of the women's medical school in Glasgow their presence was still regarded as being in 'the experimental stage' and the general feeling that bringing too much public attention to the question could be counterproductive.[130] While female doctors had to struggle to assert their

[7] Dr Ockrim worked there after leaving the Glasgow Royal Infirmary in 1944.

right to a university education, there was a common attitude in the community that shared the view that 'learning was for the men.' One participant who had worked and saved to give her daughter the education and career she had been denied, said 'I never had the chance of getting an education. You were always told that it was men that got educated, not women.' (CNk)

Gender Issues in Medicine and Medical Studies

There were problems of equality of opportunity for female medical graduates in Glasgow's main voluntary hospitals.[131] The Royal Infirmary had been open to women since 1899 while the Western Infirmary only began to employ women residents during the Second World War owing to the reduced availability of young male doctors, because of the number of call-ups to the Army. Women were also not admitted to residency posts at the Victoria Infirmary.

The medical undergraduate curriculum in the 1940s did not include any experience of general practice though any graduate would be aware of the opportunities it offered. Many of the women entering general practice had a medical family background which facilitated entry to otherwise male dominated practices. Women also had the advantage they were often seen as 'guides and wise counsellors in all that concerns the physical welfare of the family'.[132] Digby, writing in 1999 claimed that women GPs often had more of a closeness to their patients than to their male colleagues. [133] However, she noted that, when the NHS started, the caseload for female general practitioners was substantially made up of paediatrics with some obstetrics and other issues like birth-control advice, gynaecology and 'female neurosis.'[134]

In her historical study of gender issues in medicine and science in Scotland over the past three hundred years, Yeo noted that, in the usual historiography, with the exception of midwifery training – shared with male medical students in Edinburgh, Aberdeen and Glasgow, women have been pushed to the margins of modernity, as traditional healers in the countryside, in the private sphere of the family with a near-monopoly in nursing, health visiting and midwifery.[135] The health crisis, noted by the poor physical health of army recruits in the Boer War, which led to the *Report* of *the Interdepartmental Committee on Physical Deterioration*, put the health, especially of mothers and children, at the centre of the national agenda. As Yeo notes, the debate was

overlaid with concern for the welfare of the Empire and with eugenic issues affecting the British 'race'. The concern led inexorably to the gradual development of the Welfare State in subsequent decades.

With the increased presence of women in general practice following the Second World War a number of studies have examined the implications for general practice, with concerns that a female preference for part-time working, usually because of family commitments, would lead to a fall in the numbers of general practitioners available to treat patients.[136] McKinstry asked in 2008, 'Are there too many female medical graduates?'[137] The answer he gave was 'yes' pointing to the women doctors who chose to work part-time early in their careers for child-care opting to continue with part-time working when their children became independent. Though acknowledging that for years women have been unfairly discriminated against in medicine, McKinstry proclaimed the need for full equality of opportunity but maintained that there was a need to acknowledge the need for child-care in recruiting more female GPs.

An important component of general practice was the management of pregnancy and childbirth. However, the relationship between women doctors and midwives was complex. The development of midwifery as a professional discipline had led to anxiety within the male medical profession who recognised the need for better care of routine pregnancies, especially amongst the poor, but found it hard to cope with a better educated midwife.[138] In practice, midwifery remained confined to older, part-time, and often working-class women rather being seen as an alternative to a medical career in a subject like Obstetrics and Gynaecology which involved years of specialist training.

It was the Goodenough Report of 1944, implemented after the Second World War, which made Exchequer Grants to medical schools conditional on their being co-educational and recommended that hospital appointments should be open to men and women on equal terms.[139] While prejudice against women in medicine undoubtedly persisted well into the twentieth century Dingwall points out that those seeking professional careers for women in the pre-World War II era were a minority and certainly did not represent a mass movement.[140] In the case of medicine, she notes that women were seeking to enter a profession that was both intellectual and practical and that often it was the 'reticence and prescriptive code of middle class behaviour' to be found amongst women as well as men that caused the difficulties especially at examinations.[141]

In 1943 when Dr Ockrim graduated from the University of Glasgow, the female graduates were still a clear minority and had only recently been included in the graduation booklet, produced annually by the graduates themselves with photographs and quotes about staff and students. That this was a concession was illustrated by the placement of the new women doctors in a group at the back of the booklet! Graduating during wartime it might have been expected that, with so many male doctors being called up for military service that openings would be available for underemployed women doctors. However, many of these doctors were replaced by recent retirees.[142] When Dr Ockrim entered a predominantly working-class practice in 1946 there was an understanding that having a woman doctor as an equal partner in the practice would take some time for acceptance. At this time less than a third of female medical graduates were working full-time due to family commitments.[143] Even as late as 1987 it was still being said that equality of access to medical schools had not led to equality of access to senior hospital appointments, leaving women behind in more junior positions.[144]

In the three decades before the oral history study more women were entering the labour market, and the proportion of women doctors also increased. Medical school admission became more merit based and this favoured female students who were higher achievers than their male counterparts. Jefferson and colleagues found that 1988 to 2013, the number of male GPs remained relatively stable, whereas the number of female GPs rose threefold.[145]

Choosing a Doctor

There have been many studies looking at the preferences that patients have when choosing their doctor. In 1967, Hopkin and colleagues had felt that the issue was ‘probably marginal’ as they ‘seldom encounter any overt difficulty as to whether a man or a woman attends a patient.’[146] However, questions **are** often asked about age, ethnic background, place of qualification as well as gender. One such study looked at just these questions both for hospital doctors and general practitioners.[147] Results showed that people were more specific about selecting GPs than hospital consultants and they also showed a preference for UK-trained doctors.

Sally Nichols conducted a postal survey of 512 women in 1987, looking at women’s preferences for the sex of a doctor.[148] Less than one in ten said they would prefer to see a female general practitioner for general health problems, compared with nearly six out of ten for women's

health problems. Similarly, almost 60% would prefer to see a female health professional for cervical screening and for breast screening by physical examination and instruction in self-examination. She concluded that more women general practitioners might increase compliance rates for cervical screening among high-risk groups.

Studies have also shown that women doctors saw considerably more women with women's health problems than did their male colleagues.[149] Women were more likely to consult a woman general practitioner if she was more available, and younger women were more likely than older women to choose women general practitioners. Many studies also show that women general practitioners had longer consultations than their male colleagues for a variety of reasons based on the style of practice but mainly because more health problems were presented per consultation.[150] Women doctors often engaged more in preventive services and were felt to have a more supportive manner.

Patient choice where sexual issues or intimate examinations were concerned usually involved women seeking a female doctor and male patients favouring a male doctor.[151] Weisman and Teitelbaum considered that physician gender might impact mainly on the relationship through patients' different expectations of male and female physicians pointing out that patients may seek a doctor of the same gender as a key factor promoting a better communication of information, establishing a climate of rapport and facilitating negotiation.[152]

Waller found that women are important users of the health care service, attending their general practitioner more frequently than men and receiving more prescribed drugs.[153] She showed that women patients believe women doctors to have the good qualities of both male and female physicians, like assertiveness and initiative, but also tenderness and nurturance and pointed to evidence that women doctors give their female patients more surgery time than is allocated to them by male doctors. In practices where there were no women doctors about half of women attending stated that they wanted to see a female GP in at least some circumstances.[154] Plunkett and colleagues found that, of those women who expressed a preference, most favoured female doctors but when asked to consider this preference in relation to experience, bedside manner and competency, gender became a much less salient consideration.[155] For practices with a significant presence of Asian patients the issues of difficulty in communication and female reluctance, especially for Pakistani women, to be examined by a male doctor arise.[156] In brief, the

studies showed that patients prefer to see doctors similar to them in terms of ethnicity and gender, especially when dealing with more intimate health problems.

Patient Access to General Practitioners

Personal continuity of care is much prized while factors like out of hours services, the growth of larger group practices and the establishment of multi-disciplinary practice teams have threatened the old images.[157] Patients began to differentiate between an acute consultation for a new self-limiting illness and the need to consult their regular doctor for an ongoing and more chronic problems, which often had remissions and relapses.

In practices in areas of high deprivation, such as Govan and Ibrox, the concentration of health and social problems result in levels of need and demand which place substantial and continuous pressures on primary health care teams.[158] In such areas, primary care is often characterised by higher consultation rates, shorter consultation times and a larger list of problems to address within the consultation while GPs report limiting influences of time and stress.[159] Heaney and colleagues, at the Department of General Practice, University of Edinburgh, noted, in 1991, that just as primary health care is free for patients it is also 'free' for doctors, since their clinical decisions are largely independent of their remuneration, and they can decide how to allocate their time.[160]

The question of appointments against open access can be framed in terms of utility, that is the efficiency of organisation and the need to reduce the time in the waiting room. However, I will show how the arguments in favour of appointments, more time for the patients and consistency of arrangements for the doctor, could also be buttressed by offering better patient outcomes. Many doctors were convinced by the arguments of fixed-time surgeries and better working practices in the office to set up appointment systems. In the current atmosphere of evidence-based medicine such benefits, if proven, should be easy to justify using evidence-based medical guidelines from the Scottish Intercollegiate Guidelines Network (SIGN) and its English equivalent the National Institute for Health and Care Excellence (NICE) following peer-reviewed articles and opinion columns in leading medical journals.

When Loudon, Horder and Webster edited *General Practice under the NHS 1948-1997*, which was published in 1998, the book devoted just over one page of text to appointment

systems.[161] Bosanquet and Salisbury who authored the chapter on 'The Practice' noted that larger partnerships with additional reception staff enabled patient demand to be 'channelled and structured' by using appointments.[162] They described clear benefits to having fixed appointments: waiting times in the surgery were reduced and less waiting room space was needed.[163] Doctors were less hurried and appointment times could be adjusted to accommodate local needs. Reception staff could retrieve patient records before the surgery session commenced, but, inevitably, the receptionists came to be seen as the 'obstructive, person who came between doctor and patient.' These early systems relied on what today might be considered as simple technology, such as patients making appointments using land-line phones which discriminated against poorer families without phones.

In 1964 only 15% of a sample of practices had an appointment system but thirteen years later follow-up with the same practices showed that this figure had risen to 75%.[164] Writing in 1966, when appointment systems could be said to be in their infancy, a key paper by Stevenson asked the question 'Do patients like them, and how do they affect workload?' [165] Stevenson's practice had gone over to full appointments in 1962 and it took some years before he concluded that 'there were indeed benefits to their practice, that appointment systems in time would become universal and that practices without them would struggle to obtain new patients.' In another paper from the same practice an overwhelming majority of patients expressed satisfaction with the new system.[166] However, this early work on appointment systems, seen by some as pioneering, came at a considerable cost in terms of practice staff and organisation. Some practices reported that in areas of high deprivation a mixture of open access and appointments might work better.[167]

Once instituted appointment systems carry the authority of the practice offering calmer and longer appointments but regulated and controlled by practice management. Thus, for the doctors, organisational utility could be matched to justice and fairness, sometimes described as 'moral economy'.[168] There was a sense that rushed open-access consultations might lead doctors to miss important clues and lead to the need for repeat visits thus causing possible delays in dealing with potentially serious conditions.

There was criticism of appointment systems in the Merrison *Report of the Royal Commission on the Nation Health Service* and additional studies, such as Cartwright's, seemed to indicate that patients were averse to change, preferring the system, open access or appointments,

that they were used to.[169] This was reinforced in a study which showed that the proportion of those, in practices with open access systems, who preferred this was much higher than the respective proportion of satisfied appointment users. [170] While Allen, Leavey and Marks found that patients with appointment systems waited in the surgery only half as long as patients using open access systems, paradoxically, both groups appeared equally satisfied with the length of time they waited. They noted also that a study in Manchester, had found that people using open access systems were more than twice as likely to put off seeing their doctor because of the anticipated wait than were users of appointment systems because of difficulty getting appointments.[171]

The many conflicting views on the topic of access to the doctor, continue to generate a considerable amount of research, much of it published in the *Journal of the Royal College of General Practitioners*. The dilemma is in achieving the balance between open access which makes it easy for patients to consult with minor complaints, and appointment systems which make it difficult for patients with urgent problems to be seen. Much has been made of the need to see a particular preferred doctor though many of those interviewed also felt that any practice doctor, part of the medical framework they trusted, had the authority and the background information to meet their needs. During the time that these debates were taking place, mostly in the 1970s and 1980s, there was no clear understanding which produced a better outcome for the patient.[172] Where appointment systems are used for rationing demand rather than adjusting or spreading the time available for seeing patients, life becomes difficult for receptionists who are seen to be 'policing' the system.[173]

One large study looking at patients' expectation of speed of access indicated that important factors were seeing a doctor of their choice, being seen at a convenient time of day, and seeing any available doctor.[174] It was found that, depending on the level of anxiety, patients traded off speed of access for more convenient appointment times, but they were also willing to trade off speed of access for continuity of care.

Missed Appointments: Another organisational problem for practices related to missed appointments. Such patient defaults caused problems for the patients who had been turned away and could have filled the vacant slots and for the receptionists who would have treated some of those seeking appointments differently if they had known who would not show up.[175] This study also indicated that practices in areas of socio-economic deprivation were associated with a

threefold increase in the likelihood of missing an appointment, while younger patients defaulted more often. [176] One practice decided to look at the reasons for defaulting and found that some patients had felt too ill to attend, others had recovered while a third group had just forgotten that they had made the appointment.[177] It was said that too easy contacts with the doctor could come at a price on the practitioner's health with the stress of a heavy workload and dealing with the NHS bureaucracy.[178] Historically, the consultation and the doctor's caring attitude produced an undeniable placebo effect, and every consultation was expected to conclude with a prescription.[179]

House Calls: A valued part of general practice has been house calls. When the NHS began it was estimated that around 25-33% of consultations took place in the patient's home though the proportion began to fall with time.[180] Patients were reluctant to move sick family members, especially with an acute illness, from home to the surgery especially if they lived at the far end of the catchment area and needed to take two buses to reach the surgery. Mothers expected that fevered children would be seen at home as would patients with chronic disabling illnesses. A few even worried that the doctor might have other, and sicker, patients to attend to elsewhere and some were concerned that the busy waiting room would be the breeding ground for infection.

The GP contract states that the decision to make a house call belongs to the GP.[181] Mitchell et al have recently pointed, in a post-Covid world, to a lack of a robust evidence-base regarding GP home visits and relatively little research to understand the circumstances in which patients request GP home visits, when and why GPs undertake home visits, and how outcomes can be optimised within a resource-constrained health service.[182] Beale, reporting in Wiltshire in 1991, and Fry, based in Beckenham in 1972, showed that the proportion of house calls in their practice was decreasing and was now substantially related to elderly patients with chronic illness.[183]

Bosanquet and Salisbury pointed to a drop in the proportion of house calls to the total consultations dropping from 22% in 1971 to 10% in 1990.[184] Studies from many different parts of Europe and North America have confirmed this trend. In general, British general practitioners have shown themselves to be aware of the role of house calls and their advantage in enabling comprehensive patient care. However, problems of the time involved and scarcity of facilities in the patient's home often militated against the concept.[185] Consequently, there have been calls recently for home visits in primary care to be delegated to an alternative health care

professional.[186]

Data from consultation and house visit lists between 1989 and 1992 show that house calls in the practice were a little less than 10% of patient contacts, thus still forming an important part of doctor time. Though this was much lower than the contacts made a generation earlier it was still much higher than Beale and Fry's figures. Some of the testimony confirmed that house calls could be done for social as well as medical reasons and the practice had a permissive attitude to accepting them, though, as time went by, there was more of an attempt to triage requests. In 1973 a study was carried out at the Woodside Health Centre and the Glasgow University Department of General Practice which showed that only about one third of the requested house calls were considered by the doctor to justify a visit that day.[187] Of the remainder, most could have been either brought to the surgery that morning or advised to attend the evening surgery. The remaining quarter could have been treated by reassurance.

Consultant Domiciliary Visits: In the early days of the NHS, general practitioners were accustomed to request consultants to carry out domiciliary visits to their patient's home.[188] The practice attracted a fee for the consultants and GPs were expected to be present when the specialist called. This was sometimes seen as part of the GPs' education and the visit of the consultant could occasionally result in outpatient management rather than an immediate hospital admission. Frank Honigsbaum's paper on Quality in General Practice has a section on domiciliary consultations.[189] Honigsbaum noted that in Scotland, GPs attended almost all of the consultations while in South-east England the proportion falls below one third which negated the educational value of the consultation. Honigsbaum felt that the service should be seen as a chance to improve skills, to bypass waiting lists and secure beds for elderly patients.

In a study conducted in 2000 Crome et al found that most of the domiciliary visits were in geriatric medicine and old-age psychiatry sometimes as a prelude to hospital admission as home circumstances could be an important indicator of the need for hospitalisation.[190] An Editorial in the *BMJ* in 1991 noted that their number had been falling in the previous decade though clearly still much enjoyed by some GPs and Consultants who often seemed to be paired together frequently.[191] The Editorial noted that good reasons for requesting a domiciliary visit might include advising on the home management of palliative care of a terminally ill patient or where a consultant's opinion might reassure the patient, relatives, and primary care team.

Demography: Changes, Challenges and the 'Glasgow Effect'

Glasgow is no longer an industrial city having suffered job losses in the 1980s through a decline in heavy industry and manufacturing leading to health services, business administration, finance and retail as the largest employment sectors. The city's population in recent years has fallen to around 600,000 compared to levels of over a million inhabitants in the first half of the twentieth century. The increased birthrate following the Second World War (the 'baby boomers') and a further 'boom' during the 1960s made no difference to Glasgow's population fall as slum clearances, population movement to new towns like Cumbernauld and East Kilbride and hiving off the prosperous suburbs to form their own local authorities accelerated the decline.

In acknowledging Glasgow as the 'sick man of Europe' because of its excess mortality McCartney and colleagues pointed out that Scottish mortality, and particularly that of Glasgow, only began to improve more slowly than elsewhere in Europe after 1950.[192] They noted that for the first half of the twentieth century, Scottish mortality rates were broadly comparable with those of other Western European countries. They described the immediate causes of more recent excess deaths as high rates of alcohol and drug-related deaths, suicide, violence, cardiovascular disease, stroke and cancer.

The 'Glasgow Effect': Possibly no other city has been assessed for its adverse health outcomes as much as Glasgow. That these outcomes had only worsened in recent decades before the oral history study was a serious case of concern and needed understanding. Many of the problems with morbidity and early mortality were blamed on post-war economic change and the challenge for health care policies has been to try to ameliorate what has become known as the 'Glasgow Effect.'[193] Liverpool and Manchester have similar levels of deprivation, but Glasgow continues to experience levels of poor health 'over and above that explained by socio-economic circumstances.'[194] Walsh et al considered that Glasgow was more vulnerable than Liverpool and Manchester, because of historic deprivation, loss of heavy industries, overcrowding and adverse social policies.[195] They found that Glasgow has a profoundly different mortality profile: premature deaths are more than 30% higher, and all deaths around 15% higher as compared to Manchester and Liverpool. Walsh and colleagues here suggested that causes were related to deindustrialisation and detrimental economic and social policies which resulted in worse outcomes. Historical factors, such as poor housing, the selective relocation of an economically active population to new towns outside the city

and more detrimental processes of urban change which impacted on living conditions. Local government policy in the 1980s which impacted in negative terms in Glasgow but conferred protective effects on Manchester and Liverpool was also blamed. Importantly, these higher levels of mortality are seen across virtually the whole population: all ages (except the very young), both males and females, in deprived and non-deprived neighbourhoods - with around a half of all 'excess' deaths directly related to alcohol and drugs in the young male population.

It is hard to explain these differences. In their detailed statistical analysis of Scotland's health parameters, produced in 1991 Carstairs and Morris painted a depressing picture of Scotland's health inequalities.[196] They used population information obtained from Census returns, to lay bare the close link between socio-economic factors and health. They concluded that the adverse effects for those living in deprived areas began at birth and they continued to have the highest mortality levels in older age.[197] Glasgow had by far the highest number in the most socially and economically deprived categories at 50% - no other area in Scotland even came close.[198] The core area of the practice studied, G51, was divided into four sub-areas by Carstairs and Morris. Two were in category seven, the most deprived, and two in category six. G51 1, which is where the practice surgery is situated was in category six, and some of the areas where slum clearance households were resettled, such as G53, showed a similar level of deprivation to G51. They showed that there was a substantial excess of multimorbidity in young and middle-aged adults living in the most deprived areas. These adults had the same prevalence of multiple morbidities as people aged about 10–15 years older living in the most affluent areas. Further it showed that women had higher rates of multimorbidity than did men, and consistently higher rates of mental health disorders.[199]

The Inverse Care Law

One of the leading figures in understanding general practice and developing its research-based underpinning was Julian Tudor Hart (1927-2018), who described what he called the Inverse Care Law, which applied to areas of socio-economic deprivation. [200] He noted that 'the availability of good medical care tends to vary inversely with the need for it in the population served'. Thus, in areas with the greatest health needs general practitioners may have more work, larger lists, less hospital support, and inherit more clinically ineffective traditions of consultation.

He also warned that the ‘inverse care law operates more completely where medical care is most exposed to market forces’ calling them primitive and outdated which ‘could further exaggerate the maldistribution of medical resources.’

Tudor Hart’s perceptive analysis of health care in deprived areas applied especially in cities like Glasgow.[201] It was said that experts would come to Glasgow to study its notoriety in the field of health and health care - they were ‘prepared to be shocked [and] they have been rarely disappointed.’[202] The classic medical undergraduate teaching was that the cause of the symptoms of younger patients would likely be a single pathology while in older patients, multiple illnesses could co-exist. However, Cooper and colleagues indicated that, especially in Scottish practices with a high level of deprivation, multiple pathologies, including problems with mental health, could exist in younger patients too, causing both an increase in general practitioner workload and emphasising the importance of good continuing care.[203]

Poverty and Deprivation

McCartney and colleagues found that many of the health problems found in Glasgow matched the Bradford-Hill criteria,[8] which have been widely used in public health research and can help in finding epidemiological evidence of a relationship between a presumed cause and an observed effect.[204] It seemed clear to them that poverty and deprivation continued to play an important role in explaining Scotland’s (and Glasgow’s) higher mortality, but that there were also additional causal health behaviours and political factors at play.[205] Walsh and colleagues had also argued that political factors, such as the way urban clearance moved former city dwellers to new towns and what they considered to be the more detrimental processes of urban change and the differences in local government responses to UK economic policy in the 1980s.[206] Walsh and

[8] The criteria are climate, alienation, substance misuse, deprivation, health behaviours, lower social capital and political factors.

colleagues also cited protective factors which related to less emphasis on social capital than, for example the experience in Liverpool.

Norman and colleagues found no significant rise in mortality elsewhere in the UK and that the rise among men in Scotland was driven by results for Glasgow where mortality rates rose by over 15% during the last decade of the twentieth century.[207] These results justify even more of a public health focus on Glasgow and further work is needed to understand the social and demographic factors which may contribute to these findings. Further evidence for Walsh and colleagues' conclusion that 'politics matters for population health' was produced recently in a paper from Schofield, Walsh and colleagues.[208] This paper emphasised their belief that what is called the 'Glasgow Effect' is rather a political effect which needs a political response. As they still found pronounced levels of excess mortality in Glasgow, they considered that previously published policy recommendations to address poverty, inequality and vulnerability in the city remained highly relevant, requiring additional Government measures to protect the poorest in society.

Collins and Levitt considered that policymakers had been aware from the mid-1960s that plans to modernise the Scottish economy were having a seriously deleterious effect which were a cause of excess mortality in the years ahead.[209] These years were also the years of increased migration into the city, especially from Pakistan and India, and the newcomers from the Indian subcontinent were found to be more prone to diabetes and heart disease.[210]

Going beyond the usual causes blamed for the 'Glasgow Effect' Cowley and colleagues suggested that the compounding effect of a unique blend of accumulating life stressors, social, environmental, attitudinal and cultural, may predispose Scots, and particularly socially disadvantaged Glaswegians, to a wide range of health disorders. In short, a confluence of factors combines to negatively influence biological health.[211]

Whyte and Ajetunmobi showed that mortality among Scottish men and women has deteriorated relative to trends in Western Europe even though there had been reductions in mortality rates across all age groups in the last sixty years.[212] They found that this was particularly noticeable for infants, children and the younger working age population of both sexes, and for elderly women and concluded that mortality rates among younger working age adults in Scotland were of particular concern. They noted, however, that improvements had occurred, for example for colorectal cancer, female breast cancer, male lung cancer, male

ischaemic heart disease and cerebrovascular disease. However, their data showed that suicides and chronic obstructive pulmonary disease (COPD) were increasing, and liver disease was at high levels.

Measuring Deprivation

The Scottish Index of Multiple Deprivation is a relative measure of deprivation across 6,976 small areas (called data zones). If an area is identified as 'deprived', this can relate to people having a low income, but it can also mean fewer resources or opportunities. SIMD looks at the extent to which an area is deprived across seven domains: income, employment, education, health, access to services, crime and housing. It can allow effective targeting of policies and funding where the aim is to wholly or partly tackle or take account of area concentrations of multiple deprivation. The western end of the practice area, Govan/Linthouse was in the top 1% of deprived neighbourhoods while to the east, Ibrox East/Cessnock less deprived but still in the top 10% of deprived neighbourhoods. Little had changed in the years between 2012 and 2020; if anything, crime and housing were worse.

From the late 1960s, a series of national social studies and area-based policy initiatives spotlighted Glasgow's problems and aimed to put resources into the neediest areas. While the National Child Development Survey (NCDS) highlighted the effects of deprivation on childhood development, the central government began to use census data (Census Indicators of Urban Deprivation) to quantify and qualify measures of multiple deprivation for the urban population more broadly. [213]

Given Glasgow's health record the West Central Scotland Study (WCSS) was commissioned in 1971 to guide a new plan for the regeneration of the region.[214] Glasgow's large-scale post-war slum clearance and house building programme was seen to have directly contributed to the concentration of multiple deprivation. While living standards had improved with better opportunities the report acknowledged 'another side to the coin' with the persistence of inner urban slums and many residents 'trapped at a halfway stage' in council estates towards the city's outskirts.

Reducing Health Inequalities

Public Health Scotland, which monitors Scotland's health care data, has committed itself to reduce health inequalities, prevent disease and promote health and wellbeing with a focus on reducing drug, alcohol and tobacco use and encouraging better management of cancer. Fully operational from April 2020, Public Health Scotland aimed to reduce child poverty and improve mental wellbeing while encouraging the promotion of population by working with local and national agencies.[215]

The Scottish Government's National Framework Report for Quality and GP clusters in Scotland, published in 2017, was aimed to support GPs to care for their patients and address the health needs of their local communities better.[216] It acknowledged that caring for an increasing population, which is living longer, and more often with multiple conditions; together with addressing the underlying social determinants of ill health and the health inequalities that are experienced by some communities has been a challenge.

Challenges in Primary Care

The pre-existing models of primary health care provision have come under increasing pressure in recent years as remote primary care consultations have become more prevalent. GP workload pressures were identified before the impact of the Covid-19 pandemic by Atherton et al.[217] However, with the arrival of the pandemic there was a rapid move to remote consulting (telephone, video, and online) in general practice which had major implications both for doctors and patients. In a paper published in 2021, Murphy et al showed that managing high levels of remote consulting carries greater GP-perceived clinical risk and, they expected that, post-pandemic, the proportion of face-to-face consultations should increase.[218] They noted that clinicians recognised that certain problems are suitable for telephone, others for video, some for photo-plus-telephone, and some always require face-to-face. One of the practitioners interviewed in Murphy's paper hoped that 'we'll never go back to just whole mornings of patients booking by themselves, quite often when they don't need to see a doctor, when it could have been dealt with in another way or by another person.'

The Deep End

The oral history project ended in 1992. In subsequent years promising initiatives appeared which offered the opportunity of dealing with Glasgow's endemic health problems. In 2009 a large group of general practitioners working in the most deprived areas of Scotland, which included the Govan area, described as 'the Deep End' came together to share experiences and views on providing best quality health care to their vulnerable populations.[219] This has established a voice and group approach for these GPs. This was described in an Occasional Paper of the Royal College of General Practitioners indicating areas for improvement, such as in anticipatory care, prescribing and looking after young adults and vulnerable children and families. The stated aim of the project was to 'make a difference' through learning and listening.

The Deep End operates from examples of GP experience to face and deal with challenges by providing the extra time and care that their vulnerable patients, with their social problems and multiple pathologies, need. The project has influenced practitioners at all stages from undergraduate learning through career pathways with educational input at every stage. As patient contacts are primarily in general practice, where GPs struggle with the problems of health inequalities, this is where resources are most required. No fewer than twelve articles were published in the *British Journal of General Practice* (*BJGP*) in 2011 and along with the RCGP Occasional Paper an editorial appeared in the BJGP in 2012.[220]

Housing

Pacione referred to how Glasgow has been described by previous writers: John Betjeman saw it as the most impressive Victorian city in the world, C A Oakley regarded it was the workshop of the world; Sean Damer saw its socialism and Rudolph Kenna its post-industrial success.[221] He noted that, of all British cities, Glasgow suffered most from severe urban deprivation high rates of unemployment due to the decline of heavy industry and the large number of 'sub-tolerable houses' both in the older inner city tenement areas and in some of the post-war peripheral council estates. Welfare provision had to be shared between the two areas.[222] Collins and Levitt showed that Governments had accepted from the early 1970s that compared to other UK cities, Glasgow suffered the highest rate of gross overcrowding and infant mortality as well as

population loss due to movement of more the economically active to the surrounding new towns.[223] Maver pointed out that by the 1970s the city planners recognised that their policies were creating new problems and shifted their priorities from high rise buildings and overspill which had taken away much needed investment along with many of the more economically active population. These developments had the effect of fracturing community identity.[224] Kearns and colleagues showed that while people adapted to the new areas they still nostalgically looked back to when 'everyone looked after each other'.[225]

Andrews noted that there had always been, quoting Ortolano, a 'spatial dimension' to the welfare state, developments in the 1970s led to a fundamental shift in what we might loosely term its spatial practice. This spatial practice reshaped social policy in Britain, contributing to the erosion of foundational Universalist principles as outlined by William Beveridge. Thus, whereas behaviour remained a key part of the emerging concept of multiple deprivation, it was increasingly seen as the result of structural and spatialized inequality, rather than individual psychology.

Jephcott and Robinson pointed to 'solid arguments' regarding social issues against the 'high flats' leading them to recommend that their provision be discontinued.[226] While initial impressions were often positive, two decades later conditions and attitudes had changed.[227] Abrams and colleagues agreed with Jephcott's conclusions adding that:

> in the context of the post war welfare system which constructed women as dependants and an employment market that was still segregated by gender, they served to create the conditions in which women were denied the dignity that comes with independence.[228]

One of the areas in Govan mentioned by participants exemplified this: the Moorpark (Moorepark) estate, known locally as 'Wine Alley', where alcohol and drug misuse became rife, and the social conditions that it represented, produced both stigma and marginalisation of the residents.[9] Situated just a mile west from Midlock and Cessnock Streets, it was often considered to be Britain's most notorious h**o**using scheme.[10] Drug-related crime was common, and police would only enter in pairs with another car on standby. A damning indictment of officialdom was contained in a report by Damer, a social scientist who spent six months living there in 1975.[229] With no communication between planners and residents, fundamental errors in managing the

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[9] Participant references to Wine Alley can be found on p.141.

[10] Moorepark was named by *The Independent* newspaper in April 1994 as one of the worst areas in the United Kingdom

properties were constantly perpetuated.[230] Eventually, the placement of social misfits, who could not be housed elsewhere, destroyed the estate and it was demolished in the late 1990s. Today the area houses some small business workshops.

Damer's social history of Glasgow Council housing illustrated the prejudices that existed at a bureaucratic level with residents of 'Wine Alley' who were deemed to be unsuitable for 'respectable schemes' and the social stigma this represented. The following memory, from 1954, from tenants whose income level entitled them to a move is typical:

> the [West Drumoyne housing factor] looked at me. 'Do you belong to the "Wine Alley"?' He says, 'We don't want "Wine Alley" people up here.' [231]

Damer also recorded the 'battery of measures on the public health front, of which the nocturnal raiding of the small 'ticketed houses' in the slums was the most draconian.'[11] Houses could be searched without warning in the middle of the night by Public Health Inspectors and such actions occurred from mid-Victorian times until the start of the Second World War.[232]

Besides the substantial migration away from the city, the West Central Scotland Study contended that slum clearance had seen many residents 'trapped at a halfway stage' in council estates towards the city's outskirts, with still more people left in inner urban 'slums.'[233]

Changing Glasgow's Image

Around the time of the planning of the oral history study new initiatives in the city helped to change Glasgow's image. The reliance of the city on heavy engineering was ending and Glasgow had to reinvent itself to remain relevant. The surgery was close to the Clyde and many patients had depended on the employment opportunities in the local shipbuilding industries and docks. With the end of the traditional industries the successful promotion campaign, Glasgow's Miles Better, with its use of the cartoon character Mr Happy, was launched in 1983 and created the groundwork for the Glasgow Garden Festival in 1988 and the city's year as European City of Culture in 1990.

The Glasgow Garden Festival followed previous major city exhibitions. One hundred years earlier, in 1888, International Exhibition of Science, Art and Industry had been held in

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[11] Remembered by Dr Ockrim: see Appendix C, p.200. Ticketing limited the number of tenants in properties smaller than 2,000 cu. feet and living in such properties carried a stigma.

Kelvingrove Park which attracted almost six million visitors and the profit made was used in the building of the Kelvingrove Art Gallery and Museum. A further Exhibition was held in Kelvingrove Park in 1901. In 1938 the Empire Exhibition, was held in Bellahouston Park, in the practice catchment area, and illustrated the strides Glasgow was making to recover from the Depression of the previous decade. Dr Ockrim had been 19 years old during the Exhibition, remembered it well and was certain that the Garden Festival would be both an event to cherish and that it would do much for the city's image.

The Garden Festival Site on the south bank of the Clyde was near our new premises in Midlock Street and at its closest point was just a few hundred yards away. Funds had been set aside to improve the visual appearance of the area and this proved to be to our advantage. As work on the Festival site was proceeding, we became aware that though the funding obtained through the General Practice Finance Corporation would ensure the completion of the building it would not cover the cost of providing a road level finish to the car park.[12] As a new building close to the Garden Festival, it turned out that we were eligible for an improvement grant from the Festival organisers and were awarded £25,000 for the carpark and external landscaping.[13] More than four million people visited the Festival during its four months of operation, enjoyed the magical garden experience and its related activities.

Although the Garden Festival and Year of Culture did not feature in the oral history testimonies there is no doubt that the two events provided a new sense of positivity for Glasgow's citizens. While no figures are available for the number of neighbourhood residents who visited the Garden Festival site there are indications that it was well attended by the local community. With good planning, effective marketing and reasonable weather, Glasgow had a significantly larger attendance than Liverpool Garden Festival, which ran for a longer period and benefitted from a larger catchment population.[234]

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[12] The General Practice Finance Corporation (GPFC) provided the capital for the new surgery building and income from the Health Board covered the cost of the loan.

[13] Worth almost £80,000 at 2024 prices.

The Glasgow Garden Festival site: in the heart of the practice area.

Despite this, some critics felt that the Year of Culture had more to do with selling Glasgow as a place for inward investment than as a celebration of Glasgow culture and Glaswegian life – at least the culture of working-class Glasgow. Mooney and Danson described this point of view succinctly:

> Flagship cultural events can do little but gloss over and divert attention away from the major structural problems which characterise many ex-industrial cities… But hidden behind the logoed smiles of the Glasgow's Miles Better campaign is another Glasgow, a city in deep economic crisis, and a city haunted by the reality of growing poverty.[235]

However, cultural policy has played an important role in the vision of a rejuvenated Glasgow economy and is recognised as a 'creative impulse' for economic growth feeding into the perception of success and improving morale.[236]

Narrative Medicine

When the oral history interviews began, following Dr Ockrim's retirement in September 1989, the interest on narrative in medicine was fairly new. In their Introduction to their book *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*, Greenhalgh and Hurwitz indicate

that, in the diagnostic encounter, narratives are not just where patients experience illness but they set a patient-centred agenda.[237] They considered that the search for meaning, which was at the heart of narrative in medicine, could be challenging for doctors, based as it is in literature rather than science.[238] Consequently, they say, 'doctors and patients often assign very different meanings to the same sequence of events.' However, Heath notes that narrative occupies a special place in general practice as it is the long-term relationship between doctor and patient which underpins primary care.[239] She also considers that narrative takes time and requires the listener to acknowledge the longitudinal nature of the patient's experiences. Hurwitz has pointed out that the view of the consultation as just an attempt to formulate a case history means that this account then becomes 'progressively abstracted from the patient's control, and the context of its original telling may end in case conferences, and the medical literature.'[240]

The patient stories that create the medical narrative thus provide a wider context for understanding the patient's illness, by setting episodes of illness in the framework of their life experiences and beliefs. The consultation with the doctor may reflect just one passing incident in the long-term narrative of health care and the narrative will need interpretation, as well requiring medical investigation. This may lead to empathy and thus improve the communication during the consultation. In a study of patients with rheumatoid arthritis in the north-west of England, Williams asked 'how and why people come to see their illness as originating in a certain way'. He reckoned that 'Causality needs to be understood in terms of narrative reconstruction' and indicated that his work on this showed that it could alert doctors to reasons for the apparent resistance of some patients to clinical explanations.[241]

Doctor-Patient Relationship

This thesis follows the relationship between one general practitioner and a representative sample of her former patients. The doctor-patient relationship derives from the short and outcome-focussed surgery consultation and the study of this relationship has received much attention. It would be impossible to understand the dynamic between doctor and participant without reference to the work of Michael Balint (1896-1970). Balint was the pioneer of understanding the patient's story in the context of, as the title of his seminal book described it, *The Doctor, His Patient and the Illness,* (Churchill Livingstone, London, 1957).[242] Balint had emphasised the importance of

the doctors need to 'learn to listen', getting the physician to view and experience empathically the patient's world and his or her situation within it.[243] Balint believed that the result of persistent hard work on both sides to gain the other's confidence formed part of an important domain for research 'which medical science has neglected.' He noted that little or no attention had been given to the patient's subjective experience of improvement or sense of resolution of his or her illness and the doctor's sense of satisfaction with having effectively understood and addressed the patient's illness describing 'every illness is also the 'vehicle' of a plea for love and attention.'[244]

Marshall Marinker (1930-2019), Professor of General Practice at the University of Leicester, was a participant in Balint's groups and his work on the analysis of that relationship set the agenda for generations of general practitioners.[245] He pointed out that science alone could not encompass the whole story as 'the belief that the clinical task is to distinguish the clear message of the disease from the interfering noise of the patient as a person – constitutes a threat to medical humanism.'[246]

Marinker taught GPs to think about the care they provide and the relationship with their patients in new and challenging ways.[247] He pointed to the changing way in which the patient's problem, or illness, came to be understood by the doctor because general practitioners had developed the self-confidence to challenge the biomedical model taught at university which did not always help with the problems posed by their patients.[248] Marinker urged practitioners to be aware 'of the power not only for good but also for evil, in the clinical transaction.' Doctors see people at their most vulnerable. They offer an account of their symptoms to their physician and accept a loss of personal autonomy as they trust that the therapeutic process, in whatever form it follows, will be to their benefit. Marinker described how the patient presents his disorganised story which the doctor sorts and shapes to make a diagnosis for the patient. Limerick and colleagues considered that in oral history the point at which the researcher's power is unrivalled by those being researched is in the analysis phase when their words are interpreted, and a narrative is created.[249]

Marinker saw Balint as the leading figure in establishing an understanding of the doctor-patient relationship and understanding how the physician's persona becomes part of the therapeutic process.[250] From this starting point Marinker divided ill-health into three categories: disease (diagnosis), sickness (what other people see) and illness (what the patient feels)

indicating that becoming a patient involves forming a healing relationship with doctor, or another health-care professional. Marinker conducted a study with Balint and other colleagues in 1970, looking at patients who were receiving a repeat prescription for medication often over a period of many years.[251] They found that before the repeat prescription started the patient had reported illness which despite investigation had not yielded a diagnosis. Once the repeat prescription began "the doctor-patient relationship became peaceful, and the patient seemed to function more or less effectively in his own environment.' Marinker concluded that 'the patient had no demonstrable disease, he no longer complained of an illness, and he rarely seemed to occupy the role and status of a sick person. The act of consulting, the giving and receiving of the prescription, seemed to constitute its own reason.' He quoted Franz Kafka: 'To write prescriptions is easy, but to come to an understanding of people is hard.'[252]

Marinker claimed that 'there is a paradox at the root of modern medicine.'[253] He indicated that 'clinical method is concerned to compare the reality of the unique individual with the model of the ideal disease.' The benefits of this approach have led to major advances in modern medicine and behavioural science. At the same time doctors must understand the patient, with his or her experiences, beliefs and background. Attention has also drawn to the abuse of power that can occur when experts operate in areas such as family, culture and gender. Richard McKay has pointed out that:

> We use medicine and healing as lenses for exploring different experiences of health and disease, which are affected by class, race, ethnicity, gender and sexuality.[254]

By 1990 with further NHS reorganisation, Marinker noted that 'the tasks of the intimate consultation between doctor and patient were being disaggregated and shared with others.'[255] Iona Heath has argued for a rebalancing of the two sides in every clinical consultation acknowledging that there are situations 'for which evidence-based medicine has no answers' and that trying 'to describe people in terms of data from biomedical science… are not, and will never be, enough.'[256] She acknowledges that evidence-based medicine provides doctors with 'an alphabet—but, as clinicians, we remain unsure of the language.'

Meyerscough describes the short clinical interviews as requiring a balance between involvement and detachment, with doctors tending to tip the balance towards detachment.[257] He suggests that involvement can seem burdensome and threatening and that its risks of greater intensity could lead to burnout. He showed how the clinic consultation can also give a lively

sense of ease and comfort where difficult issues, including often considered taboo subjects as death and sexuality, can be considered in an atmosphere of mutual respect.

Mishler called the disconnect between 'humane care' and 'social justice' the 'unjust world problem.'[258] This American version of Tudor Hart's 'inverse care law' would be of benefit if doctors, and other health care practitioners, could bring humane care and social justice into their medical practice. He noted that major changes had occurred from the 1980s with 'a phenomenal growth of interest in patients' stories in the health care field'. This, he said, was a consequence societal unease with a 'highly technological form of clinical practice' which had led doctors to spend less time in talking to or listening to their patients.[259]

Mishler found that there was very little reference in studies of patients' stories in clinical encounters to their daily experiences of living under conditions of poverty, oppression or social exclusion.[260] This could be, he felt, the result of collusion between doctor and patient and he declared that 'We need exemplars accounts of efforts that not only include patients' stories in transcripts of clinical encounters… but that engage them critically as socially positioned persons with alternative understandings of what has been happening to them.[261]

Mishler acknowledged that as patients usually came to research studies as 'patients rather than as persons' he recommended expanding the focus of theories and research 'to include a fuller and more comprehensive trajectory of patient illness and treatment experiences.' This would, he felt, 'expand the scope of our studies… by including multiple types of health care providers and sites of practice.[262]

Truth Telling: By the time that the interviews were conducted patients were expecting more information about their illnesses. This was evidenced especially in the changing attitudes to information about cancer and was highlighted in a study carried out in the West of Scotland and published a couple of years after the project finished. [263] This indicated that almost all cancer patients interviewed wanted information about their illness, the diagnosis, their chance of cure and the possible side effects of treatment. But it also found that a substantial minority of British doctors were still avoiding telling patients that they have cancer, through a sense of unease about discussing serious illness and dying, feeling that knowledge of the diagnosis will depress and alarm patients and will impair their quality of life. While attitudes in Britain have changed, Shahidi observed that 'While autonomy has gradually become a key concept in the doctor–patient relationship, truth-telling is far from being the norm in many countries.'[264] A

recent paper by Hart suggests that 'honesty and deception are both central to determining clinical outcomes.'[265]

There are studies which show that 'protecting [cancer] patients from the truth' may be counterproductive - while emotional distress is transiently greater when patients are informed of the diagnosis, there are positive effects concerning coping, compliance, tolerance of treatment, planning for future occasion and communication with physicians.[266] While patients did not receive the diagnosis family members were often told the truth creating a barrier between patient and relatives. Others, however, have indicated that the anxiety and depression generated by a cancer diagnosis should not be underestimated. One study carried out in Glasgow and published in the *Journal of Epidemiology and Community Health* indicated that severe depressive illness is significantly associated with a lung cancer diagnosis.[267] Consequently, they recommended that proper patient understanding was essential to allow measures of psychological adjustment before and after treatment, so that appropriate supportive care can be provided.

The Scottish Cancer Therapy Network (SCTN), which documents clinical practice, and the use of evidence-based clinical guidelines, also found that patient lung cancer, from deprived communities, are at a disadvantage when it comes to treatment and survival.[268] Records show that postcode sectors in Scotland that were categorised as deprived in 1981 were relatively more deprived at the time of the 1991 census - while death rates from lung cancer were falling, the reduction was greater in more affluent areas.[269] SCTN has strongly recommended that such patients should be managed by a lung cancer specialist. While general practices strive to provide for their cancer patients and for their terminal care when required, Margaret Kindlen has pointed to such issues for specialist nurses as 'role identity, role conflict and ambiguity, and resistant attitudes' pointing to for example information sharing between patients, families and professionals.[270] Pugsley and Pardoe noted that their hospice movement in London began with an attempt to meet the need for adequate pain control in cancer patients but gradually extended into providing hospices for a holistic approach to terminal care as well as supporting patients at home.[271]

When focussing on the doctor-patient relationship, oral history study has a special contribution to make to narrative medicine.[272] A story usually has a narrator and a listener, and the doctor-patient relationship can form one example of the narrative. In the analysis of the participants' testimonies, I show how these extended memories give a detailed exposition of their health life-stories. Thus, the analysis of these memories leans also on what we learn from the

newly emergent discipline of narrative medicine. We will understand what separates the oral history interview from the surgery or home-based consultation and reflect on what each can teach the other in the retelling of these stories.

Stigma and Marginalisation: Stigma calls into question a person's moral character and choices, and his or her right to full membership in society. Feelings of stigma can influence behaviour, create anxiety, reduce interaction with other people and compromise recovery prospects. Many social stigmas are embedded in popular culture and may relate to gender and race as well as health. Despite the Scottish sense of openness and joint belonging, represented by the saying 'we are all Jock Tamson's bairns' there is a long history of incoming groups feeling isolated from the mainstream, being different due to religion, race or language.[273] The problems of stigma can be described as follows: [274]

- **Health problems**: diseases such as tuberculosis, psychiatric illnesses and physical deformities.
- **Behaviours:** which fall outside society 'norms' in addiction and sexual orientation. This may include poverty and its associated housing, welfare and institutional provision.[275]
- **Different**: being a member of a nationality, religion or race or any minority group, which is seen as 'different.'[276]

Feelings of stigma can influence behaviour, create anxiety, reduce interaction with other people and compromise recovery prospects. Therefore, Link and colleagues note, difficulties faced by stigmatized individuals can be partly attributed to the stigma attached to it, and compound the problems being experienced. They clearly define stigma as a society rather than an individual problem though it is experienced by individuals.[277]

In an article on Stigma and Social Identity in 1963 Goffman described stigma as an interactive social process whereby an individual is deeply discredited by society because of a perceived personal attribute or behaviour, creating a 'spoiled identity' imbued with social failing.[278] Labelling certain illnesses and behaviours as shameful or stigmatising affects the self-perception of patients and even their behaviour. This created a new field of study which was still growing rapidly at the time that the oral history interviews were being conducted. In 2001, Link and Phelan noted the dramatic growth in social science research on stigma in previous decades

before their extensive research on the topic was published.[279] In this article *Conceptualising Stigma* they defined stigma as 'the co-occurrence of its components–labelling, stereotyping, separation, status loss, and discrimination–and further indicate that for stigmatization to occur, power must be exercised.'

Link and Phelan described the phenomenon of stigma power saying that 'Once people are labelled and stigmatised, they lack the ability to make meaningful changes to their situation…. [stigma power allows stigmatisers] to keep people down, in and/or away by using stigma-related processes.' [280] These measures can be quite obvious but may also be more subtly hidden 'in processes that are just as potent, but less obviously linked to the interests of stigmatisers.' As stigma can be used to control, exploit or exclude others, people may have an interest in using stigma power to put people down or away. Link and Phelan claim that stigma is frequently the power mechanism of choice and may even be used covertly. They show that because there are so many stigmatized circumstances stigmatization can have a dramatic bearing on all the aspects of life chances, both social and health.

Link and Phelan developed a modified labelling theory that recognized the overlap in meaning among concepts like stigma, labelling, stereotyping, and discrimination and did not claim that labelling directly caused the mental illness but 'merely' adversely affected patients with consequences for employment, socialising and self-esteem. [281] They felt that the extent to which a stigmatised person is denied the good things in life and suffers more of the bad things has been posited as a source of chronic stress, with consequent negative effects on mental and physical health.[282]

Angermeyer and Matschinger used Link and Phelan's concept of the stigma process to examine public attitudes towards people with schizophrenia.[283] They found that labelling as mental illness increased the likelihood that someone suffering from schizophrenia would be considered as 'being unpredictable and dangerous.' Scheid and Brown point out that society has given psychiatrists and other mental health practitioners the authority to cast diagnostic labels on their patients and to provide treatment for them.[284] This leads, they say, to changes in how others perceive them and even how they perceive themselves. However, Schied and Brown considered that 'social science research on labelling and stigma might help to address some of their negative consequences' concluding that 'stigma erodes confidence that mental disorders are valid, treatable conditions.'

As stigma places people at a substantial social disadvantage with respect to available resources, it increases their exposure to risks and limits access to protective factors, potentially adding to their burden of disease or disability. Stigma is, for example, part of the explanation for the non-take-up of benefits by those who are in need and eligible, perpetuating hardships that the system was designed to avoid.[285] A study of English foodbank users during the austerity of the last decade indicated that most users experienced stigma but if could be overcome once people recognised that 'other people like us' were receiving a food parcel.[286]

Scheff, claimed in 1984 that 'mental illness is manifested solely as a result of societal influence which often places the label of mental illness on those who exhibit them.'[287] In turn, these individuals change their behaviour to meet what is expected of them. Gove disagreed, believing that society has no influence at all on mental illness and its perceptions are related to patient behaviours.[288] Scheff considered that this definition confounds stigma itself with stigmatization, the process that leads to stigma. Most research on labelling and mental illness takes a position between those of Gove and Scheff. [289]

Bruce Link and colleagues conducted several studies which point to the influence that labelling can have on mental health patients which led them to advance a "modified labelling theory." This could lead patients to withdraw from society and affect their self-image.[290] At the same time Scrambler has shown that while doctors may wish to adopt a holistic approach which will deal with the labelling as well as the stigma, constraints within the health care delivery system may limit what can be offered.[291]

By looking at historic stigma attached to welfare policies, societies can use these stories to mobilise opinion against failed and discriminatory practices and devise more appropriate solutions for those in need.[292] Indeed, many studies show that is the stories of those with mental health problems which open up the possibility of solutions. Sheff labelled shame as the 'premier social emotion' indicating that experiences and circumstances that are deemed shameful 'may be the glue that holds relationships and societies together, just as unacknowledged shame is the force that blows them apart'.[293]

One encounters resilience by many people in precarious financial and social settings who respond in positive ways. However, Donoghue and Edmiston show how resilience cannot be understood as a progressive logic within current discourses and formations of welfare

governance as it can entrench and legitimise regressive policy by relying on a public determined to cope while living through what seems like a perpetual crisis.[294]

Over time some areas of stigma were ameliorated only for others to emerge. Gradually, the NHS's building programme created an infrastructure which eventually ended the relationship between certain hospitals and the old poor law institutions, but the sense of shame associated with stigma could still be felt many decades later. While one might expect that families and friends might rally round the stigmatised individual, they might also be the very people who have borne the brunt of the negative behaviours associated with stigmatising institutions, illnesses or behaviours.

Institutional Stigma: Williamson noted that it took some time before the sense of stigma disappeared from the Glasgow hospitals which had been involved with Poor Law health care.[295] Scottish poor were not required to be housed in poorhouses, as in England, but could be given relief in cash or kind.[296] Many poorhouses were built, however, and in the cities, parishes often joined together to build one. The poorhouses were intended for the sick and destitute poor and catered extensively to those suffering from mental illness.[297] They were segregated into male and female areas with children usually accommodated with their mothers. They were further segregated into differentiating between the 'deserving and non-deserving poor,' with the latter receiving much less attention. In the practice area the Govan Combination Poorhouse historically served the parishes of both Govan and Gorbals. Their buildings catered extensively to those suffering from mental illness and provided very basic accommodation though with asylum and infirmary beds.[298]

Poverty Stigma: We have noted how individuals living in Scotland's most deprived communities experience a higher burden of morbidity and early mortality than those living in more affluent areas. Aspects of poverty stigma which are relevant to health inequality operate at various public and individual levels including access to welfare systems.[299] Inglis and colleagues noted that poverty affects mental health and well-being through a range of mechanisms, one of which may be experiences of stigma associated with living in poverty or accessing services designed to assist individuals on low incomes (including social security).[300] Many aspects of poverty in Britain have been described as deeply stigmatizing yet the concept of being shamed

by poverty stigma has often been neglected in the literature and studies often use alternative terms.[301] As Scheff described in 2014, shame refers to the 'internalisation of stigmatising social labels that force an individual to view themselves 'negatively through the eyes of others.'[302] Indeed, Baumberg, Bell and Gaffney found that benefits stigma is mainly about self-esteem and what we think others might think of us.[303] Participants described how the use of Means Tests by governments to target welfare resources where they are needed by assessing the financial resources of an individual or family was often felt by welfare recipients to be implemented in a way which was felt by recipients to be demeaning and stigmatising. Study participants often referred to the shame, such as experienced by the public wearing of welfare clothes and they recounted how some areas were also stigmatised like the 'Wine Alley' scheme near the practice.

The struggles to improve the health of the Scottish population, and especially in Glasgow, go as far back as the first decades of the twentieth century.[304] The emphasis then had been on extending health care provision, such as free access to GPs, to those who did not qualify for Poor Law relief or were not covered by national insurance. Many of the city's inhabitants had serious health problems: infant mortality remained high, as did the levels of infectious diseases, including tuberculosis, which necessitated a large provision of medical resources in the pre-immunisation and pre-antibiotics era.

Women and Health Inequality

Bartley and colleagues asked if the rapid changes in women's lives seen over the decade after 1984 had been reflected in changes in the pattern of health inequality. Their evidence showed how employment issues were important in predicting ill health.[305] More recently a *Lancet Commission* report in 2015 concluded that 'Girls' and women's health is in transition and, although some aspects of it have improved substantially in the past few decades, there are still important unmet needs.' [306]

Adenu and colleagues showed how priorities in women's health have been changing from concentrating on maternal and child health to meeting all the health needs of women in their

lifetimes. Meeting these needs can be difficult for many women, especially migrants, members of ethnic minorities and women in vulnerable communities, with poor housing and other poverty related issues.[307] Tinner and colleagues showed how discrimination can affect health outcomes and increase health inequalities in Scotland. In research developed to support evidence needs of the Scottish Government's Women's Health Plan they pointed to the growing evidence that suggests that discrimination disproportionately affects women's health focussing on how young women in Scotland experience discrimination and the extent to which that impacts on their mental and physical health.[308]

Much recent research on women's health has considered social factors. Duffy and colleagues looked at the management of symptoms in menopausal women in the north-east of Scotland and pointed to the benefit of social support interventions. As a topic this was not often mentioned in the interviews and usually considered in terms of GP contact (which was considered to be important), medication and hospital management.[309] Consequently, measures to improve women's health need to be seen in a wider context. Craig and Robinson emphasised the importance of preventive measures in reducing health inequalities and the need to harness

> the political will to move towards a more preventative approach with the determination and skills required to use the complex available evidence in a complex policy environment shaped by competing interests.[310]

There may be conflicts, for example, between doctors and family members which will need to be to inform women's decision-making. However, there was a significant change in physicians' and patients' attitudes toward HRT after publication of the Women's Health Initiative study.[311] Studies indicate a change in the political profile of equality issues in Scotland, with its higher mortality rates and larger health inequalities than elsewhere in the UK, since devolution, however translating principle into policy has still some way to go.[312]

Illness Stigma

Tuberculosis: Jenkinson devoted a lengthy chapter on tuberculosis, its management and consequences, in her *Scotland's Health 1919-1948*, (Peter Lang (Bern) 2002). She notes that it took the reform of National Insurance in 1946 to provide disability benefits for all TB patients and that in 1948 9.5% of all deaths in Glasgow were due to tuberculosis.[313] As patients feared the

disease and its consequences participants recalled how the diagnosis was often concealed from them.

Tuberculosis was the illness most frequently cited in the oral histories as the classic stigmatic disease. As Jenkinson showed, the disease was rife in Glasgow during the first half of the twentieth century and the sense of stigma was its association with overcrowding in tenement homes. In the pre-chemotherapy era, participant memories were of morbidity and mortality in sufferers. The decades before the NHS had seen disappointing figures for the prevalence of tuberculosis in Glasgow, though mortality levels had been falling, but there were better results for the other infectious diseases, such as measles and whooping cough.[314] Tuberculosis was the commonest cause of death in young adults and was rightly feared in Glasgow.

By 1951 more than half of all cases of TB in Scotland could be found in Glasgow and surrounding burghs. Neil McFarlane has argued that it was not poor nutrition which was the major factor behind Glasgow's resurgent TB in the 1930s and 1940s but rather 'the small, crowded tenement houses.'[315] Lilli Stein convincingly showed, in 1952, that respiratory TB incidence and mortality rates were highly correlated with both overcrowded homes but less so with poverty and unemployment.[316]

It was believed that rest and fresh air which were provided in Glasgow at suburban hospitals Ruchill, Mearnskirk and Philipshill Hospitals could assist the healing process. McFarlane noted that, with the opening of the facilities at Mearnskirk in 1932, Glasgow had the best level of TB bed provision in the country and yet was unable to improve treatment outcomes. In patients with a positive finding of the TB bacillus in the spit, for the years 1935-1938, almost three-quarters were dead within five years.[317] McFarlane concluded that it was cheaper to hospitalise patients than deal with the underlying social problems![318]

In the pre-antibiotic era, treatment for TB could mean years in an institution, often with lengthy and painful treatment for its complications. There was a high mortality from the condition and the sequelae of these complications could last a lifetime. As the 1950s progressed TB became a treatable condition managed at the outpatient Chest Clinic. The first drugs for TB were frequently described as 'wonder drugs': streptomycin and PAS (*para*-Aminosalicylic acid), were available from 1946. When PAS was combined with streptomycin it greatly reduced the occurrence of drug resistance. In 1952 isoniazid (INH) became available and the three drugs were often prescribed together.

The family and personal experience of tuberculosis had a pervasive effect on many of the interviewees and the length of time confined to sanatorium or hospital had major effects on subsequent lives, and the stigma of the disease could not be ignored. The stigma operated at two levels. Firstly, there was the association of TB with inferior and overcrowded housing with conditions which increased the risks of transmission and reinforced societal attitudes against patients. Secondly, there was the self-image of patients with the disease who had allowed the diagnosis to affect their sense of worth, producing shame and fear.[319] Consequently, healthcare organisations have developed strategies for supporting clients who feel that their views or their worth are not being properly respected.[320]

Rickets: Rickets was a common scourge of children in the Glasgow tenements in the first half of the twentieth century where sunlight was extremely limited.[321] Because of the association of rickets with poor diets and slum dwellers, rickets carried a social stigma. In 1973 it was finally accepted that proper exposure to sunlight was required to produce the Vitamin D that was necessary to prevent rickets as its absorption orally is limited, though Vitamin D supplements are usually provided.[322] The condition began to be diagnosed more recently with significant numbers of patients from the Indian subcontinent settling in the area, unused to the Scottish weather, but by this time the poverty stigma associated with it had gone.

The Unmarried Mother: One significant carrier of stigma until the last decades of the twentieth century was the unmarried mother - having a child out of wedlock was deeply stigmatising for the whole family.[323] Society has now come to acknowledge the mental trauma caused to unmarried mothers. The families' options were to have the baby born out of Glasgow, to arrange adoption or, if the baby was to remain within the family, it would be brought up as the youngest child of the baby's grandmother. Though there was often some sympathy for single mothers they were stigmatised as 'wronged women' or just as 'sinners.'

Mental Health

In this section I will show how mental illness became associated with stigma and outline some of the extensive literature on the topic.[324]

Schizophrenia: Dickerson and colleagues showed how many schizophrenics are devalued and discriminated against because of their mental illness.[325] They reported that patients may have heard offensive statements and media accounts about their condition with socioeconomic

variables related to the extent of stigma and discrimination experiences. Ertugrul and Ulug linked society stigma to those with more severe symptoms, such as depression and active social avoidance, and thus were more disabled. They found that this relationship between the perception of stigma and symptoms of mental illness is a vicious circle in which the elements reinforce each other and hampers recovery.[326]

Depression: Depression is also seen as stigmatising, mostly in relation to employment and access to health services but additionally within the family circle.[327] The impact of the economic cost of depression and its impact on society has prompted studies on how stigma can be reduced.[328]

Dementia: Dementia has been declared a national policy priority and that 'reducing the high levels of stigma' associated with the condition is one of the key objectives of the *National Dementia Strategy for England.*[329] The psychiatric stigmas now include dementia showing how stigma is associated with certain behaviours in patients with dementia.[330] These behaviours included unpredictability, a sense that dementia suffers were somehow different, that treatments produced a poor response and that patients never recover. Milne, who has written extensively on wellbeing in mental health, described it in 2009 as 'one of the most serious challenges facing the older population, their families and health and social care services in the developed world.'[331] She called for 'a review of the impact of stigma and discrimination on the lives and wellbeing of people with dementia and explore ways to address them.'

Swaffer notes that dementia care is of a lower standard due to stigma within the health care profession.[332] She quotes studies which show how stigma increases the feelings of shame, both towards the patient and by the patients themselves while 'it is the carer's voice which remains dominant in dementia and stigma literature.' Iliffe and colleagues show how early diagnosis can reduce uncertainty, exclude rare but treatable causes, provide patient and family support and help to avoid crises. At the same time, they note that early diagnosis can also create anxiety and depression and for some this carries a stigma.

Substance misuse and Addiction

NHS internet guidance defines addiction[14] as 'not having control over doing or using something

[14] https://www.nhs.uk/live-well/addiction-support/addiction-what-is-it/

to the point where it could be harmful to you' and is 'most commonly associated with gambling, drugs, alcohol and smoking.' I will show that addictions, illicit and prescribed drugs, alcohol, cigarettes and gambling, are an important element of general practice care, and stigma is a major factor in its various forms. Given the ubiquity of the problem it seems strange that Loudon, Horder and Webster's book on *General Practice under the NHS 1948-1997* makes no reference to drug addiction, alcoholism or cigarette smoking.

Addictions are commonly accompanied by a sense of shame or self-stigmatisation which results from public attitudes which lead the addict to internalise the negative stereotype that society associates with substance misuse.[333] Thus, public opinion stigmatises and marginalises the addict, and reduces their sense of self-worth. Hay and colleagues at the Glasgow Centre for Drug Misuse Research noted that labelling people as 'problems' meant that they were seen as separate from mainstream society.[334]

'Alcoholism': The World Health Organisation defines alcoholics as 'those excessive drinkers whose dependence on alcohol has attained such a degree that they show a noticeable mental disturbance or an interference with their bodily and mental health, their personal relations and their smooth social and economic functioning, or who show the prodromal signs of such a development. They therefore need treatment.'[335]

Acceptance by the patient of the label 'alcoholic' has been viewed by many practitioners as a prerequisite to alcohol abuse recovery. However, the label is seen as a highly stigmatised term associated with people who have lost homes, livelihoods and family due to alcohol. A *British Journal of Addiction* editorial in 1987 considered that '**t**he term 'alcoholism' … has now been largely discarded' as a word 'synonymous with the disease of alcoholism'.[336] The word 'alcoholic' has become a term of abuse symbolising the problem drinker, while most people in Britain accept that drinking alcohol has an important social function. The Royal College of Psychiatrists removed the term 'alcoholism' from the second edition of their policy on alcohol in 1986, preferring the term alcohol dependency.[337] There are good reasons for calling into question the continued usefulness of a word which is all things to all men, laden with mythology, and sometimes cruelly unkind to the person [through] stigmatisation.

'Drug Addiction' (Substance misuse): Substance misuse is commonly accompanied by a sense of shame or self-stigmatisation. This results from public attitudes which lead the addict to

internalise the negative stereotype that society associates with substance misuse.[338] The abuse of illicit heroin in the Govan area increased substantially during the 1970s and 1980s.[339] Some addicts died young because of complications with intravenous injections or from overdoses of the abused drugs. Suddenly, doctors were assailed by young patients looking for addictive prescription drugs, such as benzodiazepines and dihydrocodeine, which had a street value and could be abused or sold to fuel the habit of illicit drugs. Studies confirmed the extent of drug abuse in Glasgow noting both that deaths occurred in a younger age group compared to other cities and that mortality rates among drug abusers were higher.[340] By late teens or early twenties, problems of drug abuse and criminality will be well established and difficult to rectify.

There was an awareness that abuse of prescribed medication called for drastic solutions. Andrea Williamson, in a Glasgow based PhD thesis, found that those dependent on street bought opiates or on prescribed medication, described as "revolving door"[15] patients, had unreasonable expectations of what the NHS had to offer, displaying inappropriate behaviour yet with unmet health needs.[341] The response in Glasgow was the formation of the Glasgow Drug Problem Service (GDPS) in 1994.[342] The Service organised the use of oral methadone to enable many opiate-dependent drug injectors to reduce or cease injecting, with consequent improvements in health and social stability. The scheme was widely adopted but there was also scepticism about its efficacy and reservations about its benefit remain.[343] Drug related deaths in Scotland have been increasing sharply, numbering 1,332 in 2020, having increased more than five-fold since 1996 and around a third of these had lived in the Greater Glasgow and Clyde Health Board area.[16]

Cigarette Smoking: Cigarette smoking is recognised as the single most important contributor to ill-health in Scotland, with economic costs to the smoker and society and increased demands on health care resources.[344] Primary health care team professionals in Scotland actively promoted smoking cessation especially through opportunistic health promotion though constraints of time and lack of training proved barriers to success.

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[15] Revolving door describes their frequent removal from GP lists sometimes just days after their allocation to a new practice.

[16] The figure for 2022 showed a significant drop to 1,022 but increased again in 2023 to 1,197. These were by far the worst in Europe and still three times the level for England and Wales.
https://www.gov.scot/publications/suspected-drug-deaths-scotland-october-december-2023/pages/3/

In a major publication, Proctor described the cigarette as the 'deadliest artifact in the history of human civilisation.'[345] He observed that no other industry had shown such disregard for the welfare of its customers. By 1950 papers began to appear in the British and American medical journals warning about smoking and lung cancer.[346] Doll et al followed up a large cohort of doctors from 1951 to 1991 looking at the excess mortality in cigarette smokers and found that it was chiefly from diseases related to smoking.[347] They found that about half of all regular cigarette smokers would eventually be killed by the habit.[17] Stopping smoking before middle age could eliminate almost all the risks and even some reduction could confer partial benefit.

Because the health risks of cigarette smoking and increasing social pressures against the habit there has been a significant decline in the number of smokers. Hilary Graham attributed the decline in cigarette smoking in high-income countries, to 'the increasing social unacceptability of smoking, a cultural shift in which tobacco control policies are identified as playing a major part'.[348] However, cigarette control strategies have led to a situation where the smoking has become stigmatised, especially among the disadvantaged groups where the habit mainly persists.[349] Studies have also shown that smoking stigma may prevent smokers from consulting a physician.[350] Public health authorities have stressed the need to counteract stigma in order to promote better public health. Bell and colleagues felt that stigmatising smokers would not reduce smoking prevalence in the disadvantaged groups who represent the majority of smokers and considered that it might actually limit access to healthcare efforts in primary care.[351] At the same time stigma is being employed as part of society's attempts to push cigarette smoking beyond the barrier of normal behaviour.[352]

Immigration and Health Issues

Large immigration from the Indian subcontinent from the 1950s produced an increasingly ethnically diverse population in the practice, which required cultural sensitivity.[353] The practice learned how to meet the challenges of dealing with immigrant health issues, often related to conditions such as heart disease, diabetes, tuberculosis and rickets. Glasgow had attracted other immigrant groups in the past, such as the Irish, Italians and Jews from Eastern Europe who had

[17] Positive associations with cigarette smoking are found for many cancers, as well as chronic lung diseases, vascular diseases and peptic ulcer. Smokers who were also alcohol abusers, had an increased risk of cirrhosis and suicide.

also experienced discrimination, stigmatisation and marginalisation.[354] Before the passage of the Aliens Act of 1905 Jewish migrants were falsely accused of bringing trachoma to Britain which highlighted the 'need' for immigration control.[355] It was easier to hide discrimination behind the quest for public health safety.

As some of the patterns of illness in the South Asian population differed from that found in the general population attempts were made to try and tackle health inequalities, concentrating on such illnesses as cardiovascular disease, hypertension and diabetes mellitus.[356] Some arrived with symptoms of tuberculosis and these patients were quickly referred for treatment. It had also been known that Asians who immigrate to northern Europe have lower serum Vitamin D than Caucasians, and they are thus prone to develop vitamin D deficiency, rickets, and osteomalacia. Studies established the extent of the problem in Glasgow. [357] The addition of Vitamin D supplements eliminated the prevalence of florid rickets in the Asian children. Asian women were also given vitamin D to prevent osteomalacia. Thus, a preventable condition, associated with stigma in the Glasgow population a generation or two earlier, had become the opportunity to reduce health inequality.

Conclusion: This chapter illustrates how the many themes covered in the analysis of the oral history interviews have been dealt with in the literature, both in academic medical and social science journals. It provides the context for understanding the importance of participant memories, looking at oral history, women in medicine, Glasgow's health challenges and stigma and marginalisation. These issues will be described in detail in later chapters

Chapter 3: Study Methodology

'Memory and history confront each other across the tape recorder.'[358]

In this chapter I ~~will~~ describe the methods used in conducting the oral history study, how the excerpts were identified for inclusion and what they tell us about the functioning of a general practice in Glasgow, how its patients saw it and described their health experiences a generation and more ago.[18] It will understand how general practitioners interact in the consultation and

together with the patient to produce what is important in a medical narrative which encompasses more than just the illness.

Consequently, this chapter will also examine issues related to oral history, such as truth and memory, language processing and creating the medical narrative and producing an authentic history of one general medical practice. It elicits the health care account of patients in one urban practice and allows for the reconstruction of history in the telling of the story of how patients understand health, its management and illness impacts on them and their family. Through the interviews, and their analysis, it plans to follow such issues as the doctor-patient relationship and the full range of clinical encounters that a general practitioner will follow in their lifetime. This study's concept is pioneering, as the product of the interview encounter by a general practitioner with her former patients in an extended dialogue.

Oral History Analysis: Though the oral history interviews were completed by May 1992, their analysis only began in 2009, two years after the death of the interviewer. Bornat has described how the exploration of archived oral history interviews presents interesting dilemmas and indeed controversies as the passage of time changes contexts for analysis and interpretation where new ethical considerations may emerge. Bornat addressed some of the questions generated or processes involved in the secondary analysis of archived oral history in a paper at the University of Essex in 2008.[359] These questions concern the effect of the passing of time, changed contexts for analysis and interpretation and new ethical considerations. At the same time, she pointed out that secondary analysis brings rewards for the researcher, allowing new understandings and interpretations thus producing new knowledge. Clearly, historians deal with interpretation of old, even ancient, texts and in effect create a kind of dialogue with the historical material. Consequently, Bornat concludes 'for historians, the re-use of another's data is normal practice and uncontroversial.'[360]

Bornat quotes Louise Corti who also explains that the historian is used to the study of material that is unfamiliar to them.[361] She points out that re-using archived qualitative data enables further exploration of the data from a new perspective and allows comparative research to be carried out over time.[362] In this analysis of the original oral history interviews I have aimed

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[18] This chapter closely follows the text of the Introduction in my *Patient and Staff Voices in Primary Care: Learning from Dr Ockrim and her Glasgow Medical Practice*, (CPC Press, Abingdon, 2023), pp.1-14.

to be sympathetic to the original data and the context in which it is set while at the same time providing fresh interpretations which can provide guidance into how these issues can be seen today. As a designer of the original study and partner in the medical practice, though not involved in the interviews, I believe that my analysis will indeed form a dialogue with the original material.

Ann Oakley, who has published extensively over the past forty years on interviewing women revisited an early study carried out in 1981 entitled 'Interviewing women: A Contradiction in Terms?' This paper[19] was based on interviewing women becoming mothers for the first time. Returning to the study more than thirty years later in her paper 'Interviewing Women Again.' she could see how secondary analysis enabled her to see changes in the way her previous research should be understood, through insights she had gained over the years.[363] For the later paper she managed to re-interview 36 of the original participants coming to understand that her original observations in 'Interviewing women' were naïve on certain features of the researcher–researched relationship, particularly with respect to the complex conditions that shape familiarity, friendship and power.[364]

She pointed out that in 'the conventional approach to interviewing, the person asking the questions dictates the framework of the dialogue and the form of its analysis.' This means that the person answering the questions is relatively powerless and she argued that:

> The basic lack of congruence between the mission of constructing meaningful, trustworthy and authoritative stories about people's lives and the task of living those lives and developing consistent narratives about them is akin to the dilemma at the heart of experimental research.

Our oral history project depended on my analysis of the original interviews. Dr Ockrim did not have to exert herself to establish rapport as the participants were enthusiastic at participating in the study and had long experience in sharing their information with her. Oakley also noted her naivete a generation earlier as, though the interviewer and interviewees shared a gender, she had not taken into account issues such as age, class, ethnicity and sexual orientation. These were topics very familiar to Dr Ockrim and her colleagues working in inner-city Glasgow.[365] She was able to use her relationship with the participants, built up over more than four decades in some cases, to obtain their memories and accounts of their medical connections.

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[19] *Doing Feminist Research* was edited by Helen Roberts and published by Routledge in 2016.

At the same time, as someone deeply involved with the oral histories, I was able to come to the secondary analysis as an integral part of the study.

Oral History, Collective Memories and Intersubjectivity

In using the medium of oral history, relying on methods of recording and interpretation which have developed in recent years, this oral history project has enabled the study of many aspects of life and experience not found in the standard history books. In this study we feature an example of the doctor and patients combining to lay out a display of health and social history. Writing in 1997 Yow examined the effect of the testimonies on the interviewer, producing a view that there can be no objective history as there are always biases, that are brought to the encounter.[366]

Around the time of this study's interviews there was increased interest in the interaction between interviewer and participants. As Yow says oral historians have themselves made substantial contributions to the theory, method and politics of qualitative research through their interdisciplinary reflections on interview relationships and about the interpretation and use of recorded memories.

This, says Valerie Yow, may extend to the interviewer focusing on the issues that he or she feels are the most important but where, as in this case, the interviewer has had a personal relationship with those being interviewed over many years, or even decades, this can have a significantly positive effect.

Thompson showed how the content of oral history depends to a large extent on the way the interviewer asks the questions and how any previous relationship affects the answers.[367] In this study we were encouraged to see how the encounter with the doctor is recalled, sometimes many years later, confirming the importance of the patient's narrative.[368] For the most part the voice of the interviewer has been omitted except in situations where the responses would have seemed stilted without it. In many cases, the responses reflect that the voice of the interviewee is replying to a question. Oral history represents a dialogue and while the voices of the interviewees is the primary focus of the study, we cannot ignore the presence of the questioning, retired general practitioner, Dr Ockrim. However, her role in these interviews has been to guide the discussion without confronting patient memories. In rare instances her own opinions were

carefully noted, for example where she defended the ethos of the NHS where a participant suggested the superiority of private medicine in America or where racist comments were expressed about Asian patients. Everyone has their own way of looking at events and telling their story. Here the voices of the interviewees are presented with as little interference as possible. Where interviewees record known facts imprecisely this will be recorded in a footnote.

Portelli comments on the risk of researcher bias in analysing the interviews but comments that the clash of historian and 'sources' is what makes oral history interesting.[369] Trevor Lummis argued that social interpretation, as Samuel Schrager had done, became possible with the aggregation of individual testimonies, asking whether the group of interviews might be representative of a wider social group.[370] He concluded that 'Oral accounts from those who experienced the specific situation provide unsurpassed and irreplaceable evidence for actual behaviour.'

Identification of Oral History Themes

In preparation for the interviews Dr Ockrim formulated her own Study Notes which can be seen in Appendix C. These were to be the agreed framework which would set out the areas of testimony which she felt to be important. Foremost here were her 'favourite topics' which included all aspects of pregnancy care and child welfare. She worried about deficiencies in areas of National Health Service funding and wanted to know about participant experiences in the accessing of care. These Study Notes covered the topics, she would use especially for older patients to gain access to their memories of the pre-NHS days or her first years in the practice. She described herself as committed to an NHS where 'all patients could be treated equally and freely' and was always concerned that patients in need should receive the benefits to which they were entitled.

From the start we followed Paul Thompson's guidelines laid out in his paper on 'Oral History and the History of Medicine.'[371] He described how oral memory conveys 'both empirical information and subjective interpretations from the past and that this has to be evaluated both for internal consistency and its relationship to other sources.' Despite his focus on the importance of institutional studies and autobiographies of leading medical figures he indicated that oral history:

> provides important opportunities both for original research and for new forms of the public dissemination of medical history. I believe that the encouragement of oral history initiatives in the field can now bring substantial returns.

Dr Ockrim and I worked closely on the clinical themes which were seen to be of greatest importance. These placed obstetrics and gynaecology and paediatrics in the foreground along with stigma and marginalisation as well as the development of the practice over the decades. In addition, memories were to include the full gamut of general medical and surgical conditions, cancer, infectious diseases in children and adults and mental health. The purpose always was to allow the participant to express in their own words how they were affected by their illnesses, or those of close family members, the care they received and any wider impact. This might include experiences of health care, and its cost, from before the NHS and the interface with the hospital and its doctors.

Systematic Analysis and Thematic Organization: At the time the oral histories were collected, and the first transcripts were produced I understood the importance of a thorough and systematic analysis. Today many researchers use a variety of coding packages which enables collected data to be organised thematically. Gibbs describes how coding is how one defines what the data being analysed are about. This involves identifying and recording one or more passages of text or other data items that may exemplify the same theoretical or descriptive idea. These can be linked by the code.[372] When the transcripts were transferred to a Word format, I could organise material thematically using a long list of searchable key words involving all the medical and social scenarios encountered in the text. This was the analytic methodology I followed; an approach still used by many oral historians. Others refer to the 'old-fashioned pencil and paper approach' and indeed the latest edition of Robert Perks and Alistair Thomson's *The Oral History Reader* in 2016 does not take coding into account.[373] When the transcripts were transferred to a Word format, I could organise material thematically using a long list of searchable key words involving all the medical and social scenarios I encountered in a careful reading of the text.

The interviews cover a wide range of patient experiences, and I found that many important medical and social topics formed part of the collective memories of those interviewed. Accounts about tuberculosis, alcohol dependence and cancer dominated the memory of disease and pre-NHS problems, particularly related to the cost of care and forbidding Victorian-era institutions were important for older interviewees. A commonly expressed memory in the interviews was the thought that it was the timely intervention of Dr Ockrim, or one of her

colleagues that saved the lives of themselves or their children.

However, the semi-structured questionnaire format gave scope for the interviewees to expound on a wide range of themes not all of which were anticipated when the project was being designed. The interviewees were linked only in the sense that they were patients in one general practice and mostly lived within a defined geographical area. Even though attachment to one group of doctors was their only shared characteristic their memories illustrate many common themes.

One such theme concerned the tenement experience. Another reflected the need to find money to pay for services before the NHS

Qualitative Data

The data produced by the study, the collection of oral history interviews, forms a complex account of memories, beliefs, experiences and opinions. Such outputs are often described as qualitative data, as opposed to quantitative data where research focusses on analysing measurable numbers to produce conclusions. As Ritchie and Spencer note, the last two decades have seen a notable growth in the use of qualitative methods for applied social policy research.[374] Qualitative research seeks to understand the views and perspectives of the people being studied and through careful analysis it can provide a detailed understanding of complex social interactions which can have greater meaning than the numbers-oriented qualitative approaches.[375]

The extended text of qualitative research can be cumbersome to display and difficult to assess as it cannot be easily seen as a whole. It can be ‘flexible’ and ‘exploratory’ and can produce texts which foster the development and communication of ideas generating conclusions in previously unexplored fields.[376] Studies have considered the question of researcher bias as the qualitative researcher becomes part of the research process because he or she is interacting within the study.[377] This highlights the importance that the qualitative researcher be well educated and experienced in the research methodology. The background and personality of the researcher is also important. Dr Ockrim and I reflected on the risks of interviewer bias as we planned the study, attended Thompson’s course together, and carefully followed his guidelines.

I show how Dr Ockrim’s had aimed to bring a more humane approach into the care of her patients. This empathetic ethos had benefits beyond the consultation. From many of these

encounters, participants showed how the care and understanding they had received over many generations of family experience in the practice had led not just to favourable clinical outcomes but had provided a better sense of wellbeing in physical and mental health terms. Of course, not all medical consultations can result in a complete cure, but I have shown how the ongoing involvement with patients, for example in terminal care at home or with a bereaved mother following a cot death, has clear benefits and remains a core value in general practice.

Safeguarding Participants

In providing a grant for the oral history interviews the Wellcome Foundation was aware of the complexity involved in a family doctor interviewing former patients as participants in the study. One aspect was the problem related to the interviewer being able to share in the lived experience of another person, a concept described as intersubjectivity.[378] Benjamin considers a core element of intersubjectivity to be mutual recognition.[379] Gillespie and Cornish show how the concept is used widely, but with varying meanings.[380] They take intersubjectivity to refer to the variety of possible relations between people's perspectives considering that it should be a core concept for the social sciences in general and understanding social behaviour in particular. They outline some definitions related to how people might understand each other and how different perspectives might affect relationships. This can help to see the participants in the study as representing the practice and seeing the practice through the experience of individual patients.

I have described how Marshall Marinker, on page 60, urged practitioners to be aware 'of the power not only for good but also for evil, in the clinical transaction.' In offering an account of their symptoms to their physician and accept a loss of personal autonomy as they trust that the therapeutic process, initiated by the doctor will be to their benefit.[381] Mishler felt that there was a lack of attention by health care practitioners and researchers concerned primarily with patient–practitioner communication, often based on issues of power and hierarchy, and how the relationship impacted on indices of morbidity and mortality, and access to care and its possible impact of this relationship to health care inequalities.[382]

In the American setting McCullough has shown how physicians, using evidence-based medicine, guidelines and the status accorded them by their professional qualifications 'makes the

ethics of power – the legitimation of physicians' power – a core concept of clinical ethics.'[383] With Whitney he emphasised how:

> Physicians' power in the clinical setting is comprehensive in its scope and consequences for the patient's interests, rights, and well-being.[384]

Consequently, to balance the clinical relationship doctors need to show how they are acting in the patient's best interests by following appropriate therapeutic pathways, promoting autonomy and thereby gaining patient trust. In a *BMJ* leader, Saxena and colleagues pointed to the benefits of physician power in acting as stewards of high value, cost-effective while accepting its implications for patient care.[385] Simply expressed, patients need to be able to trust doctors while accepting that the relationship, in terms of medical knowledge, will be one-sided.

The testimonies recorded show how these issues of context, trust and power were handled and indicate how the interviewer was able, as noted elsewhere, to act as the neutral facilitator.

The Phases of the Oral History Project

Preparation: This began with the proposal for an oral history project with the retired general practitioner in conversation with former patients. In encountering these interviews, we can see the beauty of the recollections and the relationship between patients and doctors built up over many decades. As a former principal in the practice from 1977 until 2007, I knew most of these former patients well and have for a long time wanted to give voice to these records of health care. Both Dr Ockrim and those she interviewed expected that their testimonies would be published in a narrative form at some stage. This encouraged participants to express clearly what they felt was important in their past encounters with the medical profession and to give an accurate account of the social context where they lived – even to situations which had caused them considerable distress. This oral history study illustrates the story of a doctor and her medical partnership while giving meaning to attitudes to gender, ethnic minorities and the social history of Glasgow's Ibrox and Govan.

The oral history testimonies were to be recorded and transcribed and a publication was to be generated. The Wellcome Trust wanted to be sure about the value of interviews carried out by the patients' former doctor, worried that the doctor-patient relationship might affect the way memories were conveyed. Their grant to fund the recording of the interviews and their

transcriptions was conditional on Dr Ockrim and me attending an oral medical history course organised by Professor Paul Thompson, at the University of Essex at the end of September 1991.[20] The Wellcome Trust paid for the purchase of high-quality Marantz recording equipment, an Amstrad PCW8512 word processor, then a new but very significant improvement on the standard typewriter, and for the secretarial help to transcribe all the interviews.

Literature reviews accompanied each stage of the project. Ethical approval was obtained from the Greater Glasgow Health Board Research Ethical Committee. The preparation period was thus quite lengthy, taking more than a year from Dr Ockrim's retiral.

Selection of Patient and Staff Participants: The initial aim was to interview sixty patients chosen on the basis of a wide range of medical, surgical and psychiatric conditions. Given Dr Ockrim's clinical interest it was important to include experience of pregnancy and childbirth. Finally, it was felt important to represent the ethnic and social mix of the practice. In 1990, the practice population had around 12% of its patients from ethnic minority communities, particularly from Pakistan, and, as noted, high levels of social deprivation as measured by health indicators.[386]

By the summer of 1991 planning had been completed and letters were sent to just over one hundred patients, reflecting the above criteria. Because of the aim to give priority to the examination of the experience of women's health and especially maternity care provided in the practice, it was agreed that 60% of the letters would be sent to female patients and 40% to males. The letter gave an outline of the study proposal explaining that the interviews would be carried out by Dr Ockrim, who had recently retired as the Senior Partner in the practice.[387] These would be used by me to produce a history of the practice, creating an account of family medicine over the previous decades.

There was a very good response to the mailing, and it was decided to interview all those who had responded positively. Some seventy-seven former patients provided oral histories between October 1991 and May 1992. When oral histories obtained from practice staff members are included, Dr Ockrim conducted about two or three interviews a week. Given the relatively long lead time between invitation and interview, regular contact was kept with participants to ensure ongoing interest. The age range of the research participants was 31 years to 85 years

[20] See the course programme at the University of Essex on pages 208-209.

(average 57.5 years) and most patients above the mean age had good recollections of conditions in practice before the establishment of the NHS and its operation during its first years. Fifty-five women (72%) and twenty-two men (28%) were interviewed indicating a much higher acceptance of the invitation by women registered at the practice. In many ways this study reflects the 1980's which saw the increasing development of the voice of women in oral history.[388] Two of the interviewees were born in Pakistan, and two more came from families who had immigrated to Scotland from Pakistan and India.

Conducting the Oral History Interviews: Participants could choose where the interviews would take place, to cause them the least inconvenience. Limerick and colleagues were conscious of the power associated with their role as researchers and therefore aimed in their oral histories to empower the interviewees by encouraging them to choose the location. [389] Their concern about the researcher's power led each interviewer to reassure the potential participant about such matters as confidentiality and anonymity, to clarify agendas was also followed. Most interviews took place in the surgery, which was perceived as a neutral place after Dr Ockrim had retired and no longer had a consulting room there. Like the participants she was now a visitor there. A few were conducted in the participant's home, often reflecting a desire to extend hospitality in a way that would not have been appropriate before. Interviewing people at home meant that different interviews might have different contexts but Dr Ockrim or her colleagues had visited many of these homes and consequently this could be seen as familiar territory.

The aim from the start was to hear the authentic voice of the former patient, through the recording of their testimonies, as they related their memories of personal and family ill-health and how all these myriad experiences had affected them. Dr Ockrim and I worked closely on the clinical themes which were seen to be of greatest importance. These placed obstetrics and gynaecology and paediatrics in the foreground along with stigma and marginalisation as well as the development of the practice over the decades. In addition, memories were to include the full gamut of general medical and surgical conditions, cancer, infectious diseases in children and adults and mental health. The purpose always was to allow the participant to express in their own words how they were affected by the illness, the care they received and any wider impact.

The interviews were planned around a Semi-structured Questionnaire which provided a basic framework with the questions directed by the interviewer.[390] There is an extensive

literature on the use of Semi-structured Questionnaires especially when dealing with health and illness.[391]

However, the flexible nature of the questionnaire allowed the patients considerable latitude in the topics covered. The aim of the questionnaire was to produce a free-flowing conversation between doctor and participants, and I have used the terms oral histories, interviews and conversations interchangeably. I designed the Semi-Structured Questionnaire, shown in the Appendix, to give the interviewer a basic framework while allowing the interviewee to recall key moments of the past, for themselves and their families, and to cover topics felt to be of importance to them. This was done following the interview guide outlined by Thompson.[392] The Questionnaire was not to be conceived so rigidly that patients would not be able to digress where there were important issues that affected their health or well-being. The interviews usually lasted for up to two and a half hours, but a few lasted longer as important recollections could take longer. No interview was curtailed through lack of time.

The 'questionnaire' had four main sections:

a) Opening Discussion: these included the first memories of the practice, how it worked, the premises, personalities and events; pre- and post-NHS, hospital referrals, relative status of GPs and hospital doctors
b) Personal Health Issues: main medical problems, how dealt with; attitudes to illness and how it was handled; impact of the illness on the patient and family; lesson learned from the illness.
c) Family Health Issues: illness in the family, how dealt with; support from medical and other agencies; experiences, lessons and impact.
d) Health care Changes: attitudes to developments in modern medicine; GP teamwork and greater clinical responsibility by GPs for monitoring patient health.

The use of the questionnaire enabled Dr Ockrim to follow a common track in conducting the interviews yet remaining flexible enough for, even lengthy focus on topics of special interest to the participants. Commonly these topics reflected memories held for decades which were brought to mind during the course of following the structure of the questionnaire. The discussions, as shown below, begin with recollections of the practice, the premises and its workings, before dealing with personal, and then family, health issues. This allowed a gentle transition to the key individual memories. To conclude, participants were able to comment on

changes in the delivery in medicine they had noticed over the years. Sometimes these also brought other personal questions into focus. Attitudes to access to the doctor were frequently expressed and the growing importance of the concept of autonomy and a reduction in physician paternalism could be discussed with less of the emotion that the clinical topics sometimes engendered.

The Questionnaire form had space for brief notes by Dr Ockrim to comment on the main elements of the session. The Oral History in Medicine Course attended by Dr Ockrim and me had emphasised the importance of allowing the voice of the participant to be heard and the person conducting the oral history to ask and direct the questions but otherwise to be a silent presence.

Practice Staff and Nurse Interviews: As the interviews proceeded, we realised that much of the patients' memories were centred around the provision of care and how it had changed over the four decades since the founding of the NHS. Accordingly, Dr Ockrim and I decided to supplement the patient histories with those of the practice manager, reception staff and practice and district nurses. The dynamics of the oral history also marked a major difference from a medical consultation. Dr Ockrim would have seen each of her patients about the local average of about four to five encounters a year, but additional contacts could have occurred with the consultations with their children, partners or elderly parents. Consultations in the open-access era averaged around six minutes while some of the oral history interviews lasted around two and a half hours, longer than the Oral History Association guidelines which suggest between one and two hours.[393] No history was curtailed through time pressure. There was time to understand not just the issue of the day but to have a full sense of everything that the participant represented, beliefs, opinions, illness and extended family connections, stories and legends.

Oral History Notes: Dr Ockrim kept records of her conversations with former patients in two forms. The limited space for notes on the Semi-Structured Questionnaire attracted few comments. It was originally anticipated that the interviewer's notes would be kept on the questionnaire forms, but it became quickly apparent that this would be inadequate. Therefore, most of the feedback she recorded can be found on the cards in a small box file. This has ensured that we do have detailed interviewer notes following the encounters and pointers to what seemed to be the most important elements of that interview.

The card contains some key details which can be a helpful introduction to the contents of the lengthy recordings and transcripts. They indicate aspects of how the session went and something of the interaction between the participants. This was of much value given the need for interviewer and me, to communicate effectively in the evaluation of the interview.

Thompson describes the value of the careful evaluation of the interview once recorded and transcribed.[394] He also exhorts the interviewer to stay behind and chat after the session is completed, going forward 'with tact and caution'.[395] One note records that an interviewee requested that any mention of his anxiety recorded in a quoted text should be done with anonymity. In two cases the interview ended with a request for Dr Ockrim to return for a further discussion. Another describes her arriving at the home of an interviewee to be met by the former patient's son. While waiting for his mother to appear, he confided that he was 'previously a drug addict but that his mother did not know.' A few anonymised examples are given in the Appendices.

Significant remarks on the card files sometimes include throwaway remarks after the recording had been completed. Thus, some family conflicts were mentioned only 'off the record'. One concerned a patient whose child had been fostered. Two referred to concerns about hospital experiences of relatives. In one case there was a note about a relative who, it was alleged, had an accidental overdose of medication in hospital. In another post-interview remark, there was a belief expressed that a relative's death in hospital was euthanasia. One mentioned as he was going out the door that in his Alcoholics Anonymous group he had once asked Dr David to come as a guest speaker and that he had done so.

The interviews with members of the practice and district nursing staff utilised a different Questionnaire (see Appendix). Greater freedom was given to outline what they felt was important in their practice role and how their encounter with the patients played out. Their Questionnaire was considered to be an aide-memoire rather than a prescriptive list. It included memories of the old surgery in Cessnock Street, its working conditions and the relationship with the patients and how they coped with the variety of situations which occurred. There was a feeling of nostalgia for Cessnock Street as the move from the 'cottage industry' to the modern medical centre took place.

The reflective time during the interviews allowed for an exchange of views on changes in practice and what patients look for in the encounter with their doctor. One patient (ZT) reflected,

missing the 'old days' when 'the doctor knew the whole family, he knew all about the family. He knew what the illnesses had been and what the granny had died of.'

As the interviews were completed these were passed for transcription and monitoring. Transcription is a very tedious process, ensuring that the dialogue is recorded faithfully with due account of how the testimony was delivered and any dialect expressions carefully included.[396] The transcribing was fully funded by the Wellcome Trust, and the transcriber was particularly skilled to address the needs of the project.

Editing and Analysis: During the recruitment and recording process Dr Ockrim and I continuously reviewed the progress of the study and continued to monitor the recordings and the feedback from participants. More recently has come analysis of material, the organising of texts in a thematic form, creating the thesis' structure and its text. The study generated around 200 hours of recordings and the transcription took over 500 hours. This produced more than 2,000 pages of transcripts, comprising more than half a million words, laboriously printed out at the time on the Amstrad word processor. The Amstrad used an early computer programme called Locoscript and this was converted to Microsoft Word format in 2008 which facilitated my study of the transcribed interviews.

The choice of material from the transcripts, representing less than a tenth of the total word count, was also a complex task. The main themes of the interview were:

1. **Historical**, covering material included in the previous chapter.
2. **Organisational**, dealing with all aspects of practice management arrangements, including access to the doctor and house calls, covered in Chapter Four.
3. **Clinical** medicine in all its aspects - related to obstetrics, gynaecology, paediatrics, infectious diseases, general medical and surgical conditions, including cancer, respiratory and cardiovascular diseases. These aspects and how they were handled are covered in Chapter Five.
4. **Stigma and marginalisation** relating to health, welfare, behaviours and ethnicity. These topics are covered in Chapter Six.

The first step in organising the material was to separate the material related to the four categories just mentioned. This involved careful study of each of the interviews and including all of the questions and responses related to the topics. From there, the quotations were edited,

retaining the essential meaning of the testimony in as concise a form as possible. Finally, the material was further refined, ensuring its flow. There was careful attention to retaining the language of the interviewees and less common dialect words have been explained. The texts were also edited with a view to making it extremely difficult, if not impossible, to identify the interviewees who described sensitive material.

The quotes from the transcripts cover the full range of the experience of general practice, its organisation, and its medical practices. Clinical topics, for example, were scattered through all the interviews. These topics, viewpoints and memories had to be arranged into common themes. Within these themes, such as practice arrangements, there were further subdivisions which were identified. This included attitudes to open access and appointment systems, home visits and childbirth. The process was very time consuming and had to be completed before organised study of the material could begin.

Many of the testimonies said much the same things on a variety of topics. Not all the material that was fascinating, from a social or even a medical point of view, could be used. At the same time, I was mindful of Thompson's words that oral history can give a central place to the people who made and experienced history, through their own words.[397] The interviewer took great care to remain the silent facilitator in the interactions between former doctor and patient. The recordings show great respect of one for the other and there is much to say about the role of women in medicine as well as the aspiration by one female practitioner who saw herself as part of the movement of women into Scottish professional life.

Though the interviews were not intended to have a therapeutic component I will show that there is much to learn from the oral histories in the way in which clinical interviews are constructed. Though surgery consultations may be constrained by time there are options for extended patient time and many of the interviews where troubling memories are revealed point to the need for closure. Many studies have pointed to the potential for therapeutic outcomes in oral history through its revisiting of troublesome past events.[398] Dr Ockrim was used to asking questions about health in all its aspects in a clinical context and recent studies have shown how these are framed.

As the study moves from the recordings to an analysis of their content, I have benefitted from some handwritten notes by the interviewer describing her reaction to the interview and which indicate some of the atmosphere in which the encounter took place. The Questionnaire

forms only gave a small amount of space for notes, so the interviewer's comments were mostly recorded in a small record card file. Here she noted how she felt the interview went, what were the key aspects of the interview and sometimes, some throwaway lines after the interview had terminated. These were helpful in the evaluation session after the interview but were not included in the transcripts and form no part of the historical record.

In his Foreword to *Patient and Staff Voices in Primary Care: Learning from Dr Ockrim and Her Glasgow Medical Practice,*[399] Malcolm Nicolson wrote that:

> Dr Ockrim shows herself to be an empathetic, non-judgemental and, to an extent, self-effacing interviewer, with an unrivalled knowledge of the practice area, its issues of socioeconomic deprivation as well as its strong sense of community. A great strength of the interview material is that it is obvious that she has the confidence of her interviewees, having been, in many cases, their family doctor, often for more than one generation. She understands how social and personal factors interact with issues of health and welfare. There is an enjoyable irony in the fact that such an effective demonstration of the value of a departure from the physician-centred approach should be accomplished by a physician.

In a few places I have added some explanations and clarifications from insights made during my own experiences of over thirty years as a partner in the practice for, nearly half of which, from 1976 to 1989, were as a colleague of Dr Ockrim. We will see how her approach, as illuminated in these interviews, shows how she viewed each participant as unique individuals while never losing the focus on the clinical elements. In 2014, as noted the digitised oral history recordings, and the transcripts, were deposited at the Scottish Oral History Centre (SOHC) at the University of Strathclyde, Glasgow but remain accessible only with the approval of the Midlock Medical Centre.

Since the interviews were carried out more than one third of participants have died and a further fifth have moved away but attempts have been made to contact patients still within the practice to show how their testimonies will be used. All the staff members agreed to waive anonymity as did two of the other participants. I have given careful thought to how the original names of interviewees should be used. Some researchers feel that it is appropriate to use the real names of those interviewed as it gives an additional degree of authenticity. Bornat describes the issues related to confidentiality, which matters more in a healthcare setting.[400] She notes that the British Copyright Act of 1988 gives copyright of the words to the participants and of the recordings to the responsible person or organisation conducting the study. SOHC advice was to

anonymise the names and the two options were using a code, with numbers and letters, which I followed, or providing substitute names.

Producing a flowing narrative for this oral history is complicated by the way the way people speak – sometimes sentences are truncated, and stories interrupted when the telling leads the narrator on to something else which has just been recalled and is also of importance. Bartlett has said that 'in a world of constantly changing environment, literal recall is extra-ordinarily unimportant…Every time we make it, it has its own characteristics.'[401]

Researchers have come to accept that there is more to the testimonies than established fact. Perks and Thomson counsel us to remember that oral history is not 'a collection of empirical data transmitted by some mechanical process.'[402] Accepting minor inaccuracies does not detract from how the past was understood.[403] There were subtle differences in recalling of the same events by different observers, such as the heroism of Dr George, the founder of the practice, during the Clydeside Blitz and the question of an award for his wartime work. We see how individual memories function in corroborating the main events while we note some minor details of difference which add nuance to the story.

In some instances, the memories of patients interviewed in this study were challenged. There were two occasions where a central character in the recollection, namely the Practice Manager, was said to have made the diagnosis personally, which she vigorously denied, both at the time and in a later evaluation session. We might conclude that the stories might indicate how the Practice Manager was seen to have been a significant and authoritative person in the practice.

Two of the small number of comments about the abilities of local hospital consultants concerned just one orthopaedist. He had been described by one patient as one of the most kind and caring doctors she had ever encountered while another considered that he was the rudest person 'on the face of the earth'. Two interviewees recalled the occasion around 1950, with some differing details, when Dr Ockrim had no patients waiting for her while the Waiting Room was full of patients waiting for Dr Collins. Producing an understanding of the material involved a review of the various aspects of how handling oral history is dealt with.

Practice History – Dr George and his times

The medical background requires an understanding of the role of the practice founder, Dr Stevan George and of the interviewer Dr Hetty B Ockrim. These interviews were carried out more than forty years after Dr George had left Glasgow. Nevertheless, these recollections indicate a great deal of affection and acceptance for the abilities and personality of the young man who had come to Scotland in 1916 as a refugee during the First World War. Stevan George (1900-1967), was born Slavoljub[21] (Slavko) Djordjević in Serbia.[404] He finished his school studies at Hillhead High School and studied medicine at the University of Glasgow, where he won a rugby 'blue' and graduated in 1924, setting up his own practice in Blackburn Street in the Kinning Park area of Glasgow as a general practitioner. Around 1929 he moved to more spacious accommodation a few hundred yards along Paisley Road West at 2 Cessnock Street, directly across the road from the subway station, which allowed him, and his growing family to live 'on the job'.[405] He later moved from Cessnock Street to a house in nearby Dumbreck and brought in a resident caretaker to look after the premises. The surgery area had two good-sized consulting rooms, with running water and examination couches which could be screened off and there was a very small reception area that housed the patients' notes.[406]

Stevan George had made up his mind to leave Glasgow before the start of the NHS, when he would still be able to sell his practice goodwill. As the premises in Cessnock Street were rented from the Glasgow Corporation there was no property to sell. After he left Glasgow, he settled in the Bahamas where the Queen personally appointed him Officer of the Order of the British Empire (OBE) in 1966 at Government House in Nassau.

Dr Hetty Ockrim: a Brief Biography

As the conduct of the oral history is very much a project of Dr Ockrim's retirement and one that she pursued with her usual commitment and determination some biographical details are appropriate here. She was born in Govan, on the 23rd of August 1919 to a family of Jewish immigrants who had arrived in Scotland from Poland in the 1890s. She attended Abbotsford Primary School before going on to Hutchesons' Grammar School for Girls. As a teenager, Dr Ockrim had already decided that she wanted a career in medicine. The major movement of Jews

[21] Slavoljub means Glorious in Serbian.

into medicine in Scotland especially with the rise of the first generation to be born in Scotland was essentially a male phenomenon.[407] Even by 1938 the number of Jewish women in medicine in Scotland was just a bare handful and her father felt that the medical profession was not one for his daughter. Under pressure, she chose a science course which shared the same first year studies with medicine and was accepted into the medical course the following year. Her parents were quickly reconciled to her choice and were proud of her care and compassion, and the remarkable energy which informed all that she did.

The experience of being thwarted in her first year at university from embarking on the course of her choice and the action she took to put her career on track gave her a rare understanding of people trying to follow their dreams, and her ability to counsel people at the cross-roads of life became legendary. Her medical studies continued during the war years, and she graduated in January 1943, followed by first house jobs at the Glasgow Royal Infirmary. Her plans were to go into obstetrics and gynaecology, but she was sympathetic to the plight of local doctors, unable to arrange locum cover for holiday breaks during the war as so many doctors were with the British Army in different locations around the globe.

She spent some months working in Blantyre, then a small mining town not far from Glasgow. It was a rapid introduction to life in the community. There were mining accidents and the full range of medical conditions to treat in wartime conditions. She coped well with the work and a reference from the practice doctor, Dr Arthur Gordon, related that:

> Dr Ockrim had the difficulty of being the first lady doctor in the practice and the way in which she not only overcame certain prejudices but won over these people, is in itself a testament to her abilities…. She was a good clinician, sound in her diagnosis and treatment, and always anxious to learn and improve where possible.[408]

She began training in obstetrics and gynaecology in Edinburgh and Glasgow but her plans to continue specialisation changed after meeting an ex-army doctor who was to become her husband. Dr David Collins had been born in London in February 1912 to a Jewish immigrant family from Ukraine, which had moved to Glasgow just a few weeks after his birth. After graduation he worked first at Blawarthill Hospital in Clydebank and he was there during the devastating Clydebank Blitz, when two massive air-raids by the Luftwaffe took place on successive nights in March 1941. Clydebank and its heavy industries suffered extensive death and destruction and it was the only British town that had to be evacuated due to enemy action.

He joined the British 8th Army invasion of North Africa at the end of 1942, as a field general-practitioner based near the Algerian town of Bône (now Annaba) and was in an army unit which followed the invasion of Italy before returning to Glasgow after being demobbed at the end of 1945.

Dr Ockrim was then working at Glasgow's Royal Samaritan Hospital for Women where the distinguished consultant gynaecologist, Dr Albert (Bert) Sharman was based.[409] Sharman was friendly with Stevan George, and he arranged for him to meet with Drs Ockrim and Collins and by February 1946 they had bought the practice. Dr David started work in the February was joined in June by Dr Ockrim. They took over the large ground-floor flat at the corner of Cessnock Street and Paisley Road West and kept the resident caretaker. Gradually, as practice conditions demanded, additional space for office staff, and for extra doctors was needed and the practice gradually filled the whole space. After the NHS began the practice population regularly numbered around 9,500. This size practice was normally served by four doctors and consequently a third partner, Dr Ian Russell joined the practice in 1949, in addition to the regular appointment of a practice assistant. The practice continued with four doctors until the 1980s.[410] I joined the practice as an assistant in November 1976 and became a partner in the following April. Further doctors joined the practice; Dr Barry Adams-Strump in 1978 and additional partners were appointed in the following years.

Dr Ockrim's Retirement and the Letters to No-one: Dr Ockrim faced the prospect of retirement with some trepidation, and we discussed some options which would ease the transition from the active and bustling life of an inner-city general practitioner into more traditional retirement pursuits. It had become the norm for many general practitioners, facing an increasingly intrusive NHS management bureaucracy to retire around the age of 60 years. Dr Ockrim was not ready to leave her work at that stage, although she did stop her obstetrics work, then based in the General Practitioner Unit at the Southern General Hospital

The first letter was dated April 1989 and a final one in October 1989 just a few weeks after retiring. In April she described her busy life in practice as 'rushing and running' and wondered what was to be when this stopped. She worried about the patients she had cared for over the past four decades whose personal problems, even more than their strictly medical ones, affected her deeply. She saw little value in celebrating retirement but contented herself that she

had established a thriving medical practice, living the life of an urban Glasgow general practitioner touching the lives of many people, overwhelmed by their affection and involved in all aspects of their care.

> Is it a celebration? I have prepared myself that at the age of three score and ten I should retire. It seems now the right decision but when shall I know? All my life I have rushed and run and when the running and rushing stops, what then? This is what worries me. I am not used to sitting about but neither am I trained for anything else and physically I do not feel up to starting something new. And what of my temperament – intolerant in a word. However, my decision is resolute.

Her description of herself as 'intolerant' is interesting. She was certainly intolerant of bureaucracy and health service delays, of alcoholism and malingering but tolerant of all she met and her ability to care was legendary. Her strong sense of right and justice compelled her to support those who needed help but to take issue with patients who tried to abuse the system. It was clear that her care was not just a matter of paying attention to cases in a clinic but a concern for each patient's wellbeing that persisted all through her working life. This concern was as strong at her retiral as it had been throughout her working life, as she wrote in the first letter:

The final concern in the first letter was about keeping up to date with medical developments and the frequent re-organisations of NHS primary care.

> The pressures of medicine today are too great. The new and complex drugs with their interactions and side-effects, one must be alert and quickly reactive. I do not think I could continue to be up to my own expected standard and target and give of my best. Although, I do think, at the moment, I am no worse than anyone else – am I being complacent?

If the first letter represented her thoughts about retiring some month before her resignation had been tendered there is a change by the time of the second letter, in July 1989. Here she faces the reality that retirement will bring.:

> The die is cast. My resignation has been tendered and a notice of my retiral has been posted. The sad part of me is that I am going and will lose contact with all those who have been part of my life for 43 years. The glad part is the emotional sentiments of my patients and friends, because that is what these people have become. I am overwhelmed that most think that I am taking early retiral although many know that I have been working in Ibrox for 43 years…. The over 70s are sad and some are tearful as they speak of their memories of their parents, children and grandchildren…. The children will miss me - perhaps my successors will be happy to display

> their school photographs, which they love to bring, their paintings and enjoy a little sweet which they know I keep for them in the top drawer.

In some ways, the final letter, written on the 5th of October 1989, just after finishing work and clearing her desk on the last day of September, is quite surprising given the detailed introspection which preceded it. The date of retiral was timed to lead into the preparation time for a pre-arranged holiday so that the new life would follow an overseas trip. On her last day at work there was a retirement party which she described in the October letter as 'probably one of the outstanding days of my life: a party arranged in the surgery by the staff.' More than anything else the emotions generated by the retirement party and the cards, messages and small gifts from many dozens of patients produced an awareness that the oral history study that I had proposed was a fitting way to perpetuate her legacy and indicate the relationships which develop over the generations of caring.

The 'letters' formed part of a presentation I made at the International Conference on Physician Health, sponsored by the Medical Associations of Britain, Canada and the United States of America in September 2014, in a session entitled Planning Well for Senior Choices and Related to the Milestone of Retirement. A medical academic from Vanderbilt University in Nashville, Tennessee commented that if someone is asked to write about their feelings about retirement, and share them, the results might be very different from someone describing their hopes and fears and putting them in an envelope which might never be discovered.

Consequently, such a private introspection on a career in general practice, of importance in understanding the outlook and motivation of the interviewer, is rarely available to medical historians. Practitioners might tell family and colleagues of their feelings at such a time, but these are also rarely recorded. We cannot know precisely why Dr Ockrim decided to write these letters but there are some clues within the letters themselves as the extracts show. There is a sense of satisfaction in the direction her career had taken her but a sense of unease at the uncertainty which retirement represented. Writing the Letters to No-one gave her the opportunity to express her private feelings, declare that her 'decision [to retire] is resolute,' put the letters in an envelope and give herself a sense of closure. She justified her decision by writing that she had prepared herself for retirement, expressing concern that:

> I do not think I could continue to be up to my expected standard and give of my best.

These private musings reveal the emotions of a caring doctor approaching a milestone in life. By committing these thoughts to paper, she gave a permanent account of the conflicting emotions that retirement engendered.

Practice Relationships

In encountering these interviews, we can see the beauty of the recollections and the relationship between patients and doctors built up over many decades. As a former principal in the practice from 1977 until 2007, I knew most of these former patients well and have for a long time wanted to give voice to these records of health care. Both Dr Ockrim and those she interviewed expected that their testimonies would be published in a narrative form at some stage. This encouraged participants to express clearly what they felt was important in their past encounters with the medical profession and to give an accurate account of the social context where they lived – even to situations which had caused them considerable distress. This oral history study illustrates the story of a doctor and her medical partnership while giving meaning to attitudes to gender, ethnic minorities and the social history of Glasgow's Ibrox and Govan.

Dr Ockrim herself remained a silent witness in these interviews. She allowed the participants to express their memories in their own way and her own feelings were very rarely expressed. Recalled with affection by many of her former patients and credited by some with the intervention that saved them or their children from certain death. Her dominant personality enabled female patients to have an enhanced sense of themselves and gave many the support and encouragement to follow what they saw as their destiny.

Through the words of her former patients, we will discover how these aims worked out in practice with her acceptance as a practitioner with rare skills of empathy, judgement and resilience. As a partner in a large medical practice from the summer of 1946 she had to establish herself as a trusted listener, confidant, diagnostician and practitioner. Forty-three years in one medical practice did not dim her enthusiasm for her work or for the ethos of the NHS which sought from the outset to give quality medicine to the entire population, free of charge at the point of contact. Her marriage, and formation of a GP partnership drew together all these strands in a positive way:

In the first days in the practice, when the attention of the doctor counted for as much as the prescribed medication, there was a sense of appreciation which always remained with the patient. Mercer et al noted that GP Principals in Scotland showed continuing wide-spread support for holistic primary care, and frustration at a system which appears to discourage such a priority.[411] Their study shows that the quality agenda in general practice has focussed more on access and bio-medical aspects of care than on relationship between patient and doctor. These oral history interviews show the vital importance of this relationship and gives an insight into how various factors, such as implicit trust, played out in one inner-city Glasgow practice.

Oral history allows for more than just the recovery of undocumented historical events. The narrative, created from the hundreds of hours of recordings and the thousands of pages of transcript, has also given expression to otherwise unheard voices and their concerns. We hear the opinions of those who wanted their babies born at home and access to the surgery to be open on a 'first come' basis. We hear the anguish of lives blighted by alcohol and illicit substances, cancer and tuberculosis. Above all we find the voices of those who place their trust in their family doctor. We hear those who recognised in their doctor someone who would argue for their rights, enable the disadvantaged to find their way and help the curious to follow their dreams.

Conclusion: In this chapter I have considered the various issues involved in conducting an oral history study, I have examined how the testimonies have been used – analysed and interpreted – looking at validity of the evidence, how participants were chosen, and their recollections recorded. In addition, I have given brief accounts of Dr George, the founder of the practice in 1924, and of Dr Hetty Ockrim, the interviewer, who joined the practice in 1946 and retired in 1989. Memories can be flawed but recollections form part of identity, and the past has lessons for the present and future. I will now consider this extensive collection of medical and social narratives through the prism of practice organisation, stigma and marginalisation and clinical issues.

Chapter Four: Practice Organisation, Appointments and House Calls

In this thesis I show how oral history can provide an understanding of health care and its delivery in an inner-city practice, significantly affected by social and economic deprivation. In this chapter I will look at practice organisation and the way that access to the doctor in the surgery and at home was handled. I will analyse the views of participants who had been staff members as well as former patients as they describe how practice organisation impacted on historic health care issues. This will enable an understanding of what both staff members and participants found to be important. I will show how progress was made in identifying health needs, meeting expectations and planning for the future. This indicates how patients accessed health care in the surgery and at home and allows for consideration of patient-doctor access in terms of surgery arrangements.

Although the original plan for the oral history study was based exclusively on patient contacts, we soon agreed on the need to record further interviews with members of the practice team: the office staff, the first practice-based nurse and one of the attached district nurses. These staff members and nurses, all females, represented a mix of newcomers and more experienced individuals.[22] The interviews help to give their views on the organisational arrangements for the practice and describe the context in which the patient contacts took place. Together they provide a window into conditions in general practice and the developing role of receptionists and practice manager. This is the story of a medium sized practice which grew from just two partners in 1946 to five by the time of Dr Ockrim's retiral in 1989 as experienced, remembered and related by its patients.

First, I consider, through the oral history testimonies, how the practice operated, both in Cessnock Street and at the purpose-built Midlock Medical Centre, with its staff – at first just clerical and administrative and later with clinical support. The receptionists had a key role in delivering many of the changes that came to be accepted as good practice. These included

[22] By the time of the interviews there were around six office members, including a practice manager, receptions and clerks. There was a practice nurse and the two district nurses and two health visitors who served the practice population were also based at the Midlock Medical Centre.

forming the interface with patients and providing access to the doctors, the organisation of the office paperwork, which ensured NHS funding and facilitating the work practices of the doctors. At the time of the study there were around 9,000 patients in the practice, or 2,250 patients per full-time doctor which was higher than the Scottish average.[23] Gradually, the recruitment of additional doctors on part-time contracts and the increased demands of new NHS contracts led to this number dropping close to the national average.

Social Conditions in the Practice before 1948

The interviews yielded much interesting social data, and this gives an indication of the lives of the local population and helps to explain their historic and current problems with their health. The Govan and Ibrox of the 1930s and 1940s were, in many ways, examples of local self-help and communal adhesiveness that has, to a great extent, been lost in recent decades. It may have been difficult for children to do homework in crowded flat but with grandparents nearby there could be room to escape. Sanitary facilities were often primitive. At the same time there remained considerable nostalgia for the cramped tenement buildings. One study participant remembered:

> In the old tenements, you all had the same key to open every door and if you came home from school and your parents weren't in, you went into the neighbours. and they gave you a sandwich or a cup of tea or something till they came in. When you went into the big scheme, it was a lot different because you didn't go into each other's houses. Everyone seemed to keep themselves to themselves. In the tenements it was marvellous. (HNi)

There was a period of slum clearance and intensive house building through the 1950s and 1960s. While some of the local tenement buildings near the surgery survived, large swathes of decaying tenements, which could have been saved, were demolished in the 1960s. This destroyed for many the sense of community, which had been such a feature of local life, and which mitigated to some extent the hardships they experienced. Worsdall commented that the tower blocks 'dehumanised and magnified social problems' producing a city 'devoid of the community

[23] In 1990 the average GP list size was around 1,800. Figures are produced annual by Public Health Scotland: Current and historic figures can be found at https://publichealthscotland.scot/publications/general-practice-gp-workforce-and-practice-list-sizes/general-practice-gp-workforce-and-practice-list-sizes-2011-2021/

spirit which used to be so strong.'[412] They missed the neighbours who would club together to help pay for a doctor's visit or who would provide food for children from the close when they returned from school. There was a feeling that something of importance had been lost. The replacement buildings were often sub-standard and belatedly it was realised that many of the solid sandstone structures which were being demolished could have been restored and adapted to produce a better quality of life. Some patients moved nearby to high-rise flats in the area. Others were rehoused further afield, and this led to depopulation of the area around the surgery. Patients who were now in peripheral areas of South-West Glasgow like Pollok, Darnley, Nitshill and Arden tended to stay with the practice, places that were, for the most part, considered to be part of the practice area.

> A lot of families are scattered now. They go into these big sprawling schemes. There's no community spirit or life. Of course, maybe the poverty in thae days - poverty drove people together. When I look back now…. it's sad. I wouldnae like to see thae days coming back again, no way. (ID)
>
> Oh, we were very happy, and you never needed to lock your door. (RC)

Many of the recollections of those interviewed were memories of the difficult social conditions of the past, poor housing with no indoor baths or toilets and with medical access for many conducted by schemes which related to old Poor Law provision, or which came at a level of expense that caused hardship. Sanitary facilities were often shared, and conditions were poor. This could be a factor in having patients admitted to hospital.

> Just a room and kitchen. An outside toilet. I shudder to think …. There were four families on the landing. You just had to use the baths in Plantation St or Scotland St in Govan. I used them twice a week. I think it was about sixpence. We had the usual wash facilities - just the big sink. I often wonder how anyone managed in thae days. (DS)

> We had a [toilet on the] landing and [it was shared by] three neighbours. Oh, they would tin bath every Friday night. It was in front of the fire. When we were still at school, it was the big zinc bath and you got your hair washed and bone combed every Friday night… (MMf)

The memories of the struggles to pay for the services of a doctor before the NHS were vividly recalled by many, recalling that 'In those days you had to be pretty bad before you saw the doctor.' Charging a fee to attend a child who had died in the interval between the call for help being made and the doctor's arrival was recalled with distress more than forty years later. It

would be many years before the pain of these events faded and they remained part of the collective memory.

While the amounts recalled varied there was no doubt that finding the money for the doctor was a constant fear.

> I can recall my mother talking to another woman and there was fear in their voices because they couldn't afford a doctor. Under the panel scheme, only the patient that was insured was treated on the insurance. Any dependent had to be paid for. The charge was six pence. (CN)

> I remember my mother had to pay 4/6 for the doctor and if you couldnae afford that, that was too bad. You couldnae get a doctor, so maybe you just applied to the, what they called, Parish. (DD)

Patients somehow managed to cope with the financial consequences of illness knowing that if there was no money there was no doctor. Others managed with medical self-help like 'the aunt or somebody like that who was good with poultices.' (ZI)

> That was the time you had to have the money on the mantelpiece, for the doctor coming. Yes, half a crown…. I remember a [doctor who] used to come in and if the money wasn't on the mantelpiece, he just walked out again. (FS)

Memories of the Dr George's first surgery indicated that the waiting area was quite basic as was the consulting room. As he had no receptionist to meet the patients when they arrived he had no access to notes and had to accept that his patients knew who had arrived earlier and were to be seen first.

> I think it was a small room at the top of Blackburn Street. Wooden forms to sit on. Very small. [The consulting room was] even smaller. Just the leather couch. Then it went to Cessnock. (HT)

> He was just there on his own, most of the time, and it was like one big waiting room where you all sat in a circle and kept moving on as it was your turn. He would shout 'Next!' for you to go in. The man was too busy to go in and out when he was alone. (IL)

Meeting and Raising Standards and Expectations in GP Practice

To understand the dynamic of the doctor-patient consultation and how it was viewed, and valued, in by the participants it is important to analyse what is often considered to be a 'core value' in general practice.[413] At the same time, it is also necessary to consider the factors in practice organisation which are tasked with facilitating the encounter between doctor and patient.

Howie and colleagues describe two of these core values as ‘patient-centredness’ and ‘holism’.[414] The term ‘patient-centred’ first appeared in *The Future General Practitioner*, presented as an approach which encompasses ‘the patient's total experience of illnesses,’ and it has come to represent the defining philosophy of general practice, emphasizing the importance of taking patient beliefs and characteristics into consideration when making clinical decisions.[415] This contrasts with the disease-centred method in which only the doctor's agenda is addressed.[416] Consequently, this study, which focusses on patient responses to their family doctors enables us to see the two characteristics of this approach: patient-centred consulting and patient participation in decision making. This requires that the doctor facilitates the patient's expressing herself and that, for her part, the patient speaks openly and asks questions and any conflict between doctor and patient be settled by negotiation.[417]

While I will show that the last decades before the interviews showed many improvements in health care delivery, Horder pointed to studies which showed that patients were becoming more knowledgeable and more likely to criticise their doctors, a trend which has only accelerated after 1990 as access to the internet and social media increased.[418]

For patients, easy access to doctors at the surgery and at home carried a high level of priority. This was one of the main topics which troubled patients and the participants interviewed were almost solidly against the introduction of appointments. The practice was one of the last in the area to adopt an appointment system and many patients accepted the wait for a particular doctor as an indication of the doctor’s abilities, as understood by their patients. The three partners who had joined the practice in the 1940s were also solidly against the idea of appointments as they felt that their patients prized open access as much as they did. As I will show there were good arguments on both sides and the medical literature shows benefits and drawbacks for the two methods.

However, change did come to the practice at the time that the interviews were being conducted. Most of the interviews were conducted before the full impact of the new appointment system, which began with appointments in the evening only, could be assessed. Patients were understanding that having open doors until 6pm meant that surgery sessions could extend well into the evening, causing inconvenience for doctors, staff and patients. Introduction of morning appointments came later.

The process of creating a relationship with a GP is an active, dynamic process. Patients want their doctor to take their symptoms seriously, to listen and/or ask questions about their symptoms, to treat them as a real person and not only a patient, and to ask questions about other things than the disease such as family or work issues. Access to the general practitioner and the problems related to appointment systems frequently came up in the interviews. Personal continuity of care was much prized by those interviewed while factors like out of hours services, the growth of the practice with increasing numbers of doctors and the establishment of a multi-disciplinary practice team threatened the old images.[419] Patients began to differentiate between an acute consultation for a new self-limiting illness and the need to consult their regular doctor for an ongoing and more chronic problems, which often had remissions and relapses.

Patient Access

For most of the period studied, that is before the interviews began, the practice retained an open-access system in the surgery. Patients simply turned up at the designated times, usually between 9am and 11am and again between 4pm and 6pm from Monday to Friday, but with a half day on Wednesdays. The surgery times had been inherited from pre-NHS days and allowed the doctors to catch up with house calls or practice administration or just to have a 'breather' between the heavy toll of morning and afternoon consultations. Dr Ockrim had early afternoon surgeries on Tuesdays and Thursday aimed at children and pregnant women. There was also a surgery on Saturday mornings, officially for 'emergencies', open between 9am and 11am. Before 1948 there was a surgery on Sunday mornings which was dropped before the NHS began.[420] The practice had inherited from Dr George, the holding of a surgery at 5pm on Saturday afternoons. It was, supposedly, just for emergency consultations, but was popular with patients who had been at the Saturday afternoon football match at the nearby Ibrox Stadium. It was only discontinued around 1958. The Saturday morning surgery continued until the deputising services, the Glasgow Emergency Medical Service (GEMS), provided full weekend-cover. Recep_02, one of the receptionists, described the reception process at Cessnock Street:

> When the patients came in, they queued up at the window on the left-hand side. They gave their names and went in [to the waiting room} and waited for the doctor. They joined whatever queue and they just moved along the seats. As one went came out, the next one went in. We took their

> [record] cards out and we just slipped them into the doctor as a patient came out the room. We waited until there was a few and handed them in.

Patients understood that if they were prepared to wait to see their doctor that their doctor would wait to see them:

> I prefer seeing the doctor when I am ill. I think it is the height of nonsense that you should phone up a doctor and they say you can only have an appointment in two days-time. Two days can be an awfully long time if you are in pain or anxiety about something. (IS)

Waiting time could be just a few minutes or be more than an hour but a same session consultation was guaranteed. A receptionist, Recep_01, recalled that at peak times 'quite a lot of them were actually standing outside. The waiting rooms were actually full, and they had to stand in a corridor and out into the street because sometimes it was so busy.'

With open access the practice was never in a situation of seeing patients being turned away or being offered fit-in slots by duty doctors, or even locums. However, the experience at the Midlock Medical Centre reception staff was that it was usually difficult for them to persuade patients to see locum or trainee doctors, as other than for minor complaints patients preferred to consult their regular doctor. We have seen that in the early days many patients were wary of seeing a woman doctor. Just a few years later, that had changed significantly. As Dr Gordon had mentioned in his reference about her GP locum work in Blantyre it was Dr Ockrim's skills – her knowledge, decisiveness and empathy – which very quickly made the difference. In addition, within a few years there would have been few patients who had not had a child, or a grandchild delivered under her direction. Many participants described how Dr Ockrim had become the tried and trusted doctor, indeed a friend too, but with a reputation for intolerance of alcohol excess, spouse abuse and malingering.

I have already shown how the work of Michael Balint explores the dynamics of the relationship between doctors and patients. Digby, writing in 1999, observed that 'discussion of the dynamics of the patient-doctor encounter is a feature of the recent past' indicating that studies of the encounter in earlier times had to be derived from a variety of other sources, including the few doctor obituaries in the *BMJ* which mention patients.[421] This underlines the importance of this oral history which explores this relationship with memories stretching back in some cases to the 1930s. These recollections augment much of what we know from such sources as the Women's Health Enquiry of 1933, featuring over a thousand working-class women.[422] The

Enquiry showed, as seen here, that the women had a variety of options for managing their symptoms, besides a medical consultation, but that medical advice was sought more often by the more affluent of respondents.

Study participants saw the issues of most concern to them – ability to see the doctor of their choice at a time of their choosing without the interface of office staff. Not surprisingly, the office staff saw the conditions, where patient records could not be located until the patient showed up at the reception window, to be somewhat anarchic. However, they were aware that as the conduit to a consultation their role became increasingly stressful. They had accepted, in earlier times when telephone access was far from ubiquitous in the practice population, that there were serious constraints on organising an effective appointment system.

The Working Group on Inequalities in Health,[24] published in 1980, indicated that a broader understanding of the extent of health inequalities would come from a focus on economic and social constraints rather than service provision in the NHS.[423] Though the Black Report did not receive the attention it merited at the time, numerous studies since then have taken up its themes. One paper, published ten years after the report, commented that while lifestyles have been recognised as being important the reality is much more complex. The authors pointed to evidence of widening material inequality and social class difference in mortality.[424] With regard to patient access the Report noted that the population in the greater need for primary health care, may find that appointment systems may act more as a barrier, with the receptionist placed between them and the doctor.[425] In other words, appointment systems facilitate the use of general practitioners by the more articulate while discouraging use among the socially deprived.

Given the situation of the practice in an area clearly recognised as showing high levels of deprivation, the practice partners saw the absence of an appointments system as facilitating access by the neediest parts of the community. As noted, the practice had taken the first steps towards an appointment system, at the time of the interviews and thus it was too new for a proper evaluation. The senior partners, those who had joined the practice in the 1940s, had been loath to abandon open access. However, patients were able to see some of its problems. The rule was that the doors were open till 6pm in the evening and someone arriving at 6.01pm was liable to be disappointed. However, hard decisions and flexibility could cause their own problems and even what seemed like a simple request at the reception window could upset patients.

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[24] Better known as the Black Report, as it was chaired by Sir Douglas Black.

> I phoned for my heart pills and was told I would have to come along to the surgery. I said, 'I don't know if I can make it [in time]'. I got ready and when I got ready, I thought I could make it, so I came out and I got in here at about five to six. I got my turn to wait, and I sat outside for a wee while because sometimes there's a musty smell in there.[25] Anyway, I went back to tell the girl that any doctor would do me - it was only a prescription I was in for…. the next thing the door goes, so the girl came round, and said, 'I'm sorry we're closed'. The man said, 'Oh, but darlin'' - She lets him in full of drink. I thought, well that's a good one. I broke my neck to get along here for five to six and she lets two in who are worse for drink. (DD)

For many housewives the crowded Waiting Room was a welcome place to meet and share, as DX described:

> It was a good way of meeting your family. We all went down to the surgery, and we all met there. We all knew where one another was. It was a family practice. I think it was nice. It was very close knit. I liked it anyway. Oh, I talk to a lot of people [in the Waiting Room]. I don't go in and just sit and look about me. Before you know it, you're busy blethering and talking away. I think it's nice. Before we know it, we see one another again. That's how you get to meet people. Aye it's nice and friendly.

The move to the new premises in Midlock Street led to a re-opening of the debate about appointments and it was eventually decided, as a first move, to start with evening appointments while leaving the morning for open surgeries. It was clear, by the end of the 1980's, as Dr Ockrim was planning to retire, that the open-access system was no longer functioning for good practice in the evenings. The view from the office, as well as from the doctors, was quite clear. Doctors and staff had other commitments, families, child-care and working for the evening deputising services which had evening shifts which began at 6pm. Open access in the evening had become untenable. One of the receptionists, Recep_02, said that she welcomed the idea of evening appointments:

> I think it is a good idea because the evening surgeries are becoming really long. Sometimes we weren't getting out until 8 o'clock at night…. With having open access in the morning, you are still giving a good service to people. They know they are going to be seen on the day that they want to be seen. It will take a bit of getting used to for the patients and for us, but I think it will work.

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[25] In the last days of the surgery in Cessnock Street in the winter of 1986/7 water leakage from the vandalised roof caused patches of fungal growth on some of the ceilings and walls.

This was the feedback to the doctors from most of the patients though the issue was not mentioned by participants who focussed on their appreciation of historic open access.[26] Another receptionist, Recep_01, agreed:

> I actually think the patients have accepted it not too badly…. I think if they don't get the doctor that they want that day, I think they'll come to the morning surgery.

The introduction of evening appointments while maintaining open access in the mornings led to greater acceptance, or at least greater understanding, when morning appointments were eventually introduced after Dr Ockrim retired. She had been happy with the 'first come, first served' approach and was personally sorry to see it go. It has been pointed out that if urgent consultations were allocated to the duty doctor, instead of the personal doctor, which is likely to be the least irritating system for the doctors, there would be a certain further loss of personal medical care.[426]

Personal Medical Care: Ridd and colleagues showed that the concept of personal medical care was a cherished value of almost all the general practitioners surveyed in their study. However, they were unable to form an opinion on whether the same benefits could be achieved within the growing trend to form 'practice teams'.[427] At the same time, they indicated that too close a relationship with one doctor could have risks, such as collusion in management, and counselled better understanding of how to deliver continuity before policy changes made its loss inevitable. Schers and colleagues wrote, based on patient surveys in the Netherlands, that in a changing society with apparent emphasis on turbulence and short-lived interpersonal contacts, most patients within general practice continue to value a personal doctor for serious and emotional problems, regardless of age, sex, place of residence, and present circumstances.[428] They also said that patients appear to value personal continuity because they think that this will be beneficial to their health. However, Guthrie pointed to the difficulties in maintaining personal relationships in practices with over about 6,000 patients.[429]

While the personal physician is, as described by Jones and colleagues, the 'gold standard' for consultations, patients understood that there were, of necessity (illness, holidays, study leave) limits to availability.[430] Still, fifteen years after the interviews began it was noted that there remained a dearth of evidence of improved clinical outcome related to open access as against

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[26] Some interviews were done even before morning booked appointments began.

appointments.[431] In 2013 The Patients Association reported that poor access to GPs was of real concern with too many unable to get through to their surgery on the phone or book an appointment.[432] As recently as June 2024, when the last words of this thesis were being typed, the BMJ Editor's Choice of 20th June refers to John Launer's warning on the damage to continuity of care, describing it as 'collateral damage.'[433] He indicated that:

> Human attachments, continuity, and trust are basic needs for everyone. We need to restore and protect these for our own wellbeing, just as much as for our patients.

The open access system allowed for varying times for consultations – the simple signing of a form might take just a couple of minutes, while a complex medical problem would take much longer. Morrell and colleagues saw no evidence for patients who attended for a five-minute appointment receiving more prescriptions, more hospital referrals or even repeat consultations within the next month.[434] While Howie and colleagues had found that there was more to patient outcomes, they also reported that more long-term health problems were recognised and that there was more time for health promotion leading to greater patient satisfaction.[435]

The number of consultations at Cessnock Street was generally high, with doctors having to see thirty or more patients at some morning surgeries, allowing the patients just around five or six minutes with the doctor. Crowded surgeries and time constraints had a marked effect on the doctors in Cessnock Street. In the early days, consulting time had to include procedures, such as ear syringing, changing dressings and blood tests which were later undertaken by practice nurses.

Patients were therefore appreciative that they could be seen when they wished to initiate contact with the doctor and the receptionists only had to pass the case notes to the doctor. They knew that the practice was one of the last in the area to adopt appointments and that their doctor would be aware of their past history and all the other issues which could have an influence on the consultation.

Patient Views on Surgery Appointments: The problems that most patients found, as shown in the following extracts, with appointments related to the perceived difficulty in accessing a quick medical assessment for an acute illness though not all felt the same way.

> I think it was your words years ago – 'If you want to see me, well I've other patients. If you want to see me, you'll wait for me'. You just cannae rush a doctor tae see you. (LN)

> I prefer seeing the doctor when I am ill. I think it is the height of nonsense that you should phone up a doctor and they say you can only have an appointment in two days-time. Two days can be an awfully long time if you are in pain or anxiety about something. (IS)

> You always had a long wait in the surgery before you were taken. We don't mind, we would rather have it that way than have an appointment. I never felt rushed. You didn't dally because you knew the doctors were busy. (LNd)

> I don't see the point in it. Is it to get more patients or what? I know there is quite a lot of them but that's what I like about our own surgery. If I don't feel really well one day I can go down and maybe see the doctor the next day. My neighbour upstairs - I had to phone for her wee boy on Monday and she wasn't getting taken until yesterday morning. I think that's terrible for a boy of ten. As I said to her, 'You should just call him out and tell him that you need to see him'. (BE)

> Personally, I would prefer an appointment system. I don't like sitting in a big waiting room with a lot of people and kids screaming around me. I don't like that very much…. Well, I don't have to wait too long generally. I time it so that if I'm going to go there, I go in just before 11. I have always. (ZT)

Others had their own take on the possible wait and their sense that despite the sometimes-congested waiting room they would be dealt appropriately at their own consultation.:

> Because you could just go doon there at 8 o' clock in the morning and sit and wait for you coming in. It's not the same as it used tae be. I'll go doon when I need my pills, and that's it. I sometimes don't even go doon. I used to love going doon tae the surgery and it was homely…I used tae come oot after I had spoke to you for an hour and I felt brilliant all day. (LD)

> They [the doctors] are very helpful. They're no' there to get you in and push you out quick. They'll let you sit and tell them everything you want to tell them and they're very understanding. Great support. It doesnae matter if it takes you two minutes or twenty-two minutes, they'll sit and listen. I have been in twenty minutes before. (DX)

QD, a former senior porter at the Southern General Hospital, who was well aware of how GP surgeries functioned commented:

> What I remember of the practice at Cessnock Street - I used to always think it was like Argyle Street when you went in, because there was no appointment system, which I admire. I don't agree with appointment systems, because I think at the end of the day appointment systems don't

always work. I believe in the first come first serve.

As the doctor knew the patient, their life story and extensive family connections many surgery visits could be very brief. Other consultations took whatever time was required and there was an understanding that these longer encounters, sometimes planned after regular surgery hours, were an essential part of the doctor-patient relationship. However, there was a sense that this relationship was beginning to change:

> I actually preferred the old doctors. The new ones, I suppose, will be ok but it takes a bit of getting used to. You got to know the doctors and they were friends as well as being your doctor and if you had any problems, you knew you could go to them. I think you felt closer to the doctors before …. when you are getting on in years it maybe you feel you would like a doctor to be a wee bit older. (IT)

The Waiting Room: The crowded waiting room in the open access era functioned as a social centre and was highly valued by many for that reason. For some patients who had been relocated to the peripheral housing schemes it also offered an opportunity to visit the 'old' areas and perhaps meet up with former neighbours, friends and family. Thus, the therapeutic process involved more than just the consultation.

> I thought it was very good. It always did and yet people'll say - I'll say I was doon at the doctors at Ibrox. 'Whit dae ye go away tae Ibrox for when there's doctors roon' here?' I say, 'It's just like a family, you're used to it, so you don't want to change.' If the doctors had said change, we would change but they were quite willin' tae take us. It's just noo, we're usin' the doctors more than ever. I think it's very good. (JN)

DX recalled:

> It was a good way of meeting your family. We all went down to the surgery, and we all met there. We all knew where one another was. It was a family practice. I think it was nice. It was very close knit. I liked it anyway. Oh, I talk to a lot of people [in the Waiting Room]. I don't go in and just sit and look about me. Before you know it, you're busy blethering and talking away. I think it's nice. Before we know it, we see one another again. That's how you get to meet people. Aye it's nice and friendly. You go down there for a day out. By the time I go there and get back it takes me about three or four hours. I miss the atmosphere down there.
>
> Oh aye [I talk to people in the waiting room]. They'll talk about the doctors. They'll say, 'He's awful good or he's awful nice or I don't like her - Him, I wouldnae send my dog to him.' This is

> the sort of thing they say. Only because they probably didnae get the prescription they really wanted the time before. They'll maybe give you their life history, you know - from the day they were born till they came to this particular appointment…. A blether and a wee bit of company. (RNk)

Not everyone agreed with the rosy view of conditions at Cessnock Street:

> I think your [entrance] hall is too small because on a cold, wet, windy day it's full of people. I have stood outside on an occasion when it was cold and wet. I know you can't make it like Hampden Park [but]…. [27] (FC)

Some patients, who had chronic health problems themselves, were often surprised to be given the details of their neighbours' medical issues in the Waiting Room.

> Yes, you talk [in the Waiting Room]. People who are there waiting tell you their problems and then you wonder why you're there. (DT)

KNo noted that receptionists were often trying to quieten bored children in the Waiting Room, which at busy times could be very noisy. The staff were concerned that some children might leave toys on the floor and that could be a hazard for elderly patients. She commented:

> They used to be terribly hard on children [in the Waiting Room] - I noticed that. There was nothing for children to do, no area where they could sit and play with toys or look at books or draw, and yet the staff seemed to think they should sit quietly. I always went provided with books for the children, but not everyone thinks of that.

Another patient remarked:

> I've never really had any thoughts at all to put in the suggestion box, but [my son] has, but we didn't put it in. He wants something to play with while he's waiting.
>
> [I have seen] a couple of children maybe squabbling about something or running around making a loud noise but nothing other than that. (KNk)

Dr Ockrim was aware of this and thought that she might give a gift to the practice on her retirement of some child friendly toys. Smaller toys provided in the past quickly disappeared, so she recalled:

> When I left, I suggested giving them a trampoline or a chute or something and the office staff just about went mad when I suggested it.

However, a children's play table soon appeared:

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[27] Hamden Park – the Scottish National Football Stadium. The record attendance there was 149,115 in 1937.

> I like the way they've got that wee table for the kids now. The other week I was there, there was two wee ones and did they enjoy it! It was nice watching them. (IS)

The experience of these interviews is that, on the whole, patients did not feel hurried, and that due attention was paid to all their concerns and individual needs. When appointments were introduced at Midlock, patients were allocated ten minutes, almost double the average time of an open access consultation, and this alone may have helped anchor the new system. However, it was not possible for the new system at Midlock to offer the same number of consultations as had been available under open access. Offering repeat prescriptions at longer intervals helped save appointment slots but patients who expected to meet family and friends in the waiting room followed by a supportive chat with the doctor, without any fresh medical issues to discuss, were likely to be disappointed.

While open access guaranteed a visit to the doctor when the patient wanted it was the office staff who had to deal with problems before they presented to the doctors. Recep_01, described what could occur in the reception area at the time.

> I think you just get a bit tired talking the whole day to patients and you always get your arguments and things that they didn't agree with. The first person they see is you, so you get the brunt of anything that goes wrong. We don't take prescriptions over the phone, and we would tell a patient that and they would say it was a lot of rubbish because the doctor had told them to phone and things like that. They thought we were being obstructive some of the time and I think wires get crossed sometimes.

While drunks were a frequent occurrence, violent incidents were fortunately rare, but seemed to increase in the new premises. The Practice Manager, PMan_01, described one event at Midlock Street as 'That was the first encounter of anything going wrong. Here it's an every-day occurrence.' However, she recalled an incident at Cessnock Street:

> When I started, I think I came across one drunk man that was really abusive. He came out - he went into Dr Collins, and he just wouldn't take no for an answer. We tried to be diplomatic with him, but he just came out and slammed the doctor's door and came into the reception area and it was a glass door, and he slammed the door and the door just shattered.

In another, more frightening event in Midlock Street, the Practice Manager described the events when a female patient, under the influence of drink or drugs, was described as 'rather abusive' and when challenged she:

> produced the shaft of a hammer from her sleeve …. started wielding this and she hit the brand-

> new pillars, which annoyed me and hit the brand-new seats and then fortunately the trainee came to my assistance. By this time, the receptionist had phoned the police, and she was apprehended. (PMan_01)

Practice Staff

The growth in the employed practice staff in Cessnock Street and subsequently in Midlock Street mirrored developments nationally.[436] In the early years of the NHS, the concept of employing a practice manager or even office staff was not a common one. Some practices would have paid an accountant to manage their personal accounts and tax payments and of course dispensing practices would have needed a dispenser. However, such book-keeping records as existed were often seen as being within the remit of the doctor's wife though receptionists began to appear in a few practices from the beginning of the twentieth century and were expected to receive patients, answer the phone and type letters.[437]

Bosanquet and Salisbury trace the development of general practice under the NHS from 1948 to 1990.[438] They describe the introduction of partial reimbursement of staff salaries, from the landmark 1965 GP contract. This helped provide the resources to recruit the receptionists and others needed to manage the practice and to forge a relationship with the central administration of general practitioners in Glasgow. This administration was done, firstly through the local Executive Council and later with the Primary Care Services of the Greater Glasgow Health Board. The areas served by Executive Councils were designed to serve a particular area but did not necessarily have the same boundaries as the medical services retained by local authorities.[439] With payments based on capitation and item-of-service there was a constant flow of forms from practices to the Executive Council.

The first receptionists appeared in Cessnock Street almost from the start of the arrival of Drs David Collins and Hetty Ockrim. Someone was needed to welcome patients, take their details, make necessary telephone calls and provide the doctor with record envelopes. PMan_01, later practice manager, started working at Cessnock Street on 28th August 1966 when the medical staff consisted of three full-time doctors and a part-time assistant. Despite the size of the practice, which stabilised around 9,000 patients from the 1950s, the practice functioned with just one office worker until 1976. Gradually, the role of the office workers expanded, and the concept of a practice manager emerged.[440] In 1978 Recep_01, joined the office staff and by the time Recep_02

arrived in 1981 PMan_01 had been appointed Practice Manager and three others were working as receptionists or general office staff.

When Recep_03 joined the reception staff in 1989 there were six whole-time equivalent (WTE) doctors, three practice nurses in addition to the two attached District Nurses and two health visitors. There was also a part-time dietician and a nurse working on a specific research project related to incontinence in the community. The increase in the size of the staff and the need to form good working relationships led to regular joint social and training events:

> Over the years we have developed some nights out and this includes the doctors, and we go to [training exercises and] bowling nights. We are all on first name terms which is very good. It is more of a complete team rather than having bosses and staff. We also have a Christmas dinner evening which has been very successful, and they can all let their hair down. I think the working conditions are very good. (PMan_01)

From the beginning the office staff had clearly delineated tasks to perform. While the procedures were relatively straightforward the atmosphere was often quite frenetic. Without an appointment system, the patient's records could not be located in advance which might have freed staff time to deal with paperwork, sorting out forms and making and receiving phone-calls. Consequently, the busy consulting times were a period of intense activity for the office staff.

The new Contract in 1965/6 brought about many changes in the office. With access by GPs to hospital laboratory services there were the results of blood and urine tests to be filed. Copies of referral letters to the hospital, replies from outpatients and the hospital discharge letters also had to be filed and extra office shelving was needed as case folders expanded. Increased Health Service bureaucracy required extra form filling which in turn led to the need for more staff to process them. Before computerisation, which simplified the system, there were **forms** for ordering **forms** for ordering **forms**!

> I think the paperwork [now] takes up all of the time. I'm doing more paperwork [related to practice accounts and item of service claim forms] now than I have ever done. (Recep_01)

Surgery Premises

In the first years of the NHS little changed in the layout of the surgery premises. The introduction of the Family Doctor Charter, with its encouragement of improvements in GP surgeries, opened the way for major changes. The development of the surgery premises in can be

seen in the context of wider provision for improved primary care facilities. Until 1966 the Cessnock Street Surgery consisted of two proper consulting rooms and one interview room, that is without an examination couch. The interview room was just used, as we have noted, on a Monday night when all the partners consulted at the same time. Reducing the size of the main waiting room enabled the interview room to be converted into a full-sized consulting room. Space was taken from the caretaker's accommodation to provide an extra consulting room and some extra waiting space.

In 1980 with the death of the caretaker two extra rooms were added to the surgery. These both became additional consulting rooms.[28] Dr Ockrim's former room became a full-sized office space which could accommodate additional clerical staff and the extra shelving needed for A4 sized-record folders. The small space, formerly used by the practice receptionist became a base for attached staff, nurses and health visitors. Until December 1978, when Dr David Collins retired after a stroke, only two doctors consulted in the surgery in the morning while the two most junior doctors were out of the surgery dealing with the heavy load of house calls. This involved them covering a practice area which stretched from Ibrox in all directions, reaching Pollok, Nitshill, Croftfoot, Castlemilk and even Newton Mearns. Gradually the load of house calls diminished and from early 1979, three doctors consulted at the surgery in the morning and only one doctor was out on house calls.

At Cessnock Street, there was no space for a Treatment Room as all the rooms were needed for the doctors or were waiting rooms or office space. Blood and urine tests, injections and treatments like bandaging and dressings were all done by the doctor which obviously imposed constraints on consulting time.

> There was no accommodation [for the practice staff] at all. It was just the reception area which was actually a glorified long corridor…. We had the files on one side and a window and a typewriter at the other. (Recep_01)

The Practice Manager, PMan_01, recalled that she worked alone for her first ten years in the practice, expected to do all the tasks required:

> [I did] everything. When I first started the patients would come in and I wouldn't be able to find records for them because we didn't have records for some of the patients.

She described her activities as the sole receptionist as follows:

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[28] One for Dr Ockrim and one Dr Barry Adams-Strump, who had arrived as a new partner in January 1979, replacing Dr David Collins.

> the patients would come in and give their name at the window and I would look out the cards for them and I would put them in to the doctors. I would file the cards at the end, answer the phone, take dictation, type letters, make coffee, go for the biscuits and any other odd job that would occur…. When I first started, I had contact with the patients from when they came through the door until they left.

By 1986 it was clear that the surgery would have to leave Cessnock Street. The City Council who owned the building planned to refurbish it, and it was made clear that there would be no room for 'commercial property' which is what the authorities considered a medical practice to be. The search then began to find alternative premises and fortunately a site, just three streets away in Midlock Street, belonging to the City of Glasgow, was identified. Along with consulting rooms for all the doctors, including trainee practitioners, there would be improved office space, patient areas and bases for district nurses, health visitors, treatment rooms. In addition, there was space for practice meetings, a small practice library and rooms for occasional sessions for a dietician and social worker. Soon additional space was needed for the practice nurses. A substantial extension took care of all these requirements, funded by a mixture of NHS grants and practice loans.

The new practice building, the Midlock Medical Centre, opened in February 1987. Inevitably comparisons were made with Cessnock Street. Everyone understood that the facilities were much superior and more comfortable for the patients, but the new developments came at a price as a break from the past often does. Cessnock was seen by patients and staff to be 'warm and homely,' even as conditions deteriorated in its last months, while Midlock was 'clean and clinical'. Recep_01 explained her fondness for what had been left behind:

> When I started at Cessnock Street I used to think, 'What have I got here?' but looking back now, I would go back to Cessnock Street tomorrow, no hesitation at all.

There was also a feeling that working relationships had been affected:

> I feel there was more companionship. I felt there was more friendliness. It's too big an area now and you just don't get to know the people…. I don't know the health visitors or the nurses…. I even feel as if I don't know half the people that work here…. (Recep_01)

She also commented that in the past, with a much smaller staff, 'We coped really well. The filing at night was done before we went away. We were never really very late.'

The surgery was the last tenant to leave before the building work began and the last winter in Cessnock Street was particularly uncomfortable, as Recep_01 recalled:

> I can remember during the [last] winter at Cessnock Street when we used to have to come in with our wellies and keep our raincoats on, because the water was pouring through the ceiling, and we had to put [a] tarpaulin down in Dr Ockrim's room.

She explained how the difficult conditions in these last few months really stretched the office staff and illustrated their commitment to the practice, with 'fungus growing out the toilets' and with stolen slates from the roof 'there was something like two tons of water above us and it was slowly making its way down to us.'

The move to Midlock Street was delayed for a week by a major snowstorm but took place in February 1987. Again, the staff worked energetically to complete the move quickly as PMan_01 explained:

> We had to do [the move from Cessnock to Midlock] it over a weekend. We finished [at Cessnock] on the Saturday morning and immediately started to move which meant that we had to have the patients' records taken from Cessnock and installed in Midlock Street, in the right order. We are talking about 9,000 plus, patient records. We had the equipment which was being moved - all in a matter of a day and a half…. The doctors, receptionists, sons, husbands, boyfriends - everybody mucked in.
>
> Well, we have a very much enlarged office area, and our record system is expanding…. The most important one that I found was the A4 folders. That was the thing. When we came along here, and we had them all out it really looked very impressive…. Space was a thing we saw the biggest difference in. (Recep_01)

This last comment is somewhat ironic. When the surgery was being planned in late 1985 it was reckoned that there might need to be space for one office computer and that practice record folders would require increasing amounts of room. By 2020 there were computer terminals everywhere, patient records were accessed electronically, and the folders were stored out of the office.

It was not long before there were examples of petty vandalism around the new surgery. The low roof encouraged children to climb around the roof tiles, but the main problems were inside the building and the car park.

> We used to have soap dispensers on the wall [of the toilets] and they actually set that on fire, and it set the alarm off. They smoke in the toilets. They are beginning to write on the walls outside. They burn the bells off the door. It's just wanton vandalism. They stick chewing gum on the carpets. (Recep_01)

> Initially there was a lot of vandalism.… Really from the word go, we've had broken windows and we've had the instance where they put super glue in the locks…. We had to get the locksmith out to renew the locks. (PMan_01)

Practice Records

In 1980 work began on changing the patient record system from the outdated Lloyd George envelopes, always referred to as 'cards', to the more familiar A4 folder, as used in hospitals. While practices in England had to pay for the better record format, the Scottish NHS covered the costs of the materials and it was just left to the individual practices to make the arrangements for the change-over.[441] The new A4 records were to be eventually replaced by computerised records but at the time of the move to Midlock Street in 1987, ample space was given to the A4 records which needed much more shelving than the small envelopes they replaced. The task of moving the notes from the record envelopes to the new folders was complex and time-consuming.

> Yes. I had just started in the Practice at that time, and I got the job of sticking on all the sticky labels on to the cards. I remember that well. I remember us coming along with all the boxes of cards - it was a big job, and it took a long time for the complete change-over of the card system. The system that we have today is great.
>
> It [the new GP Contract] has certainly made more paperwork but as for the standard of health care, I have my doubts about that. There is so much paperwork to do now and so many other things. Instead of just concentrating on getting a patient better now, you've got to go through all these papers and find out if you are doing the right thing. Everything you do now, there's a paper attached to it. Your mind is taken up with that more than actually getting patients well or getting them to attend. (Recep_02)

The Consultation

It was said that making contacts with the doctor too easy could cause stress to the practitioner with the burden of a heavy workload and dealing with the NHS bureaucracy.[442] The consultation and the doctor's caring attitude produced an undeniable placebo effect, and every consultation was expected to conclude with a prescription.[443] Doctors could feel rushed, and patients could feel frustrated by lengthy waits. In later years, given the open access in the

evening surgeries, the numbers entering before the doors closed at 6pm could take an hour or more to clear.

> There's no' been a time when I needed a doctor or needed to go to the surgery or anything like that - there was always somebody there – and there's always an ear to listen to you. You always have somebody there that's interested in your welfare. I think so. I could always discuss it with you…when I was young and I came to you and I had any problems, If I didnae tell you, my auntie did. I never was embarrassed, because in my opinion, you were the person that could help. If anything was wrong and it could be put right, you could help to do that. (INa)

> I was always concerned [at the surgery] that I didn't catch anything that would keep me off my work and everyone spluttering around me. (AH)

> Some doctors, even in thae days, had ideas of grandeur - They were doctors you know, *bow doon* or *salaam me* or whatever. That was their idea of being a doctor but as I say, they were above what they were able to perform because it was a' in their mind. If you went into your surgery and explained 'what was the matter?' – 'Nothing's too much bother. I'll try and get something to fix that.' (INa)

We have already noted how the relationship between GP and patient should function and the importance for the patient of achieving easy access to the general practitioner. We have also seen how areas of high deprivation have a concentration of health and social problems, and this affects the encounter with the patient. There are higher consultation rates, shorter consultation times and a larger list of problems to address within the consultation, often with difficult or sensitive information and GPs report limiting influences of time and stress.[444]

> I consider myself to be very friendly with Dr David and he was a kind of father figure to me, and I had no closeness between me and my [own] father. When there were difficulties in my life, adolescence or whatever, I found David Collins was a great listener. I would take up half an hour of his time. I'm sure many others as well did. If I was having a low - I would make up some kind of physical condition and go along and see about it. I didn't go along and say I wanted a chat, but I got a chat out of it. So, he was very special in my life. (ZT)

> Oh aye. I found that the doctor always spends the time with the patient that would satisfy himself and his diagnosis. I've never found anything else in our surgery. That's always been the pattern in our surgery. If you needed a certain examination to diagnose, you got it and there was always a very thorough - Dr Collins Senior was tremendous. Many a time when I've gone in with my skin

> in such a state, he would take the time to look at it. He wouldnae just say, oh here's tablets - He would take the time and look at it and say, we'll try this and that.… Many a time I was all bandaged up and he would take the time to help me off with it and look at it and put a fresh bandage on. (QD)

> I've heard them saying, 'You go in there and you're oot before you're in and I don't know how they know whit's rang wi' me. They're writing lines out before you get sitting down.' I've never found that. Even when I was working, if I went down because I had the flu or something, I was wanting something for it, there was never a case of you sitting writing a line out before I even got in. I don't know where they get it from. Some people just find something to complain about. If they wernae complainin' they wouldnae be happy. (IMi)

QD was not shy in warning me if he knew that a patient was malingering, 'swinging the boot' as he put it:

> I remember once in the hospital I had one of my staff who was a patient of the practice, and I knew he was swinging the boot a wee bit, so I phoned and one time I was in seeing Dr Kenneth. I said, 'I think this fellow is swinging the boot a wee bit and I told him some of the things this fellow was up to outside.' Then, I had that relationship with the doctor that I could do that. He was obviously conning the doctor a wee bit.

DU, who had been a local chemist, was aware of changes in consultation outcomes as doctors were increasingly prescribing pre-packaged items:

> When we started first of all there was a lot of the British National Formula. We made up more actual prescriptions and there was less sophistication in the drugs of course. Gradually it became that you were just counting out tablets and filling up bottles and putting on labels.

However, patients arriving at the reception window often wanted something different than a consultation with the doctor. It could be information on any of the other practice services and the following shows that patients could be frustrated by the rule that receptionists were not allowed to disclose medical information about family members without written permission:

> I never found the clerical staff very friendly or co-operative. I think they are dreadful. I think their attitude - there was a wee lassie on yesterday and I gave my name clear and gave my [practice] number. My wife had asked if I would get her cholesterol result and it was as if I was asking for a fish supper…. I think that if they are there and you are paying them good money, they should have some kind of rapport. They are not there for pleasure…. I know they've all got jobs to do but I would think that when the surgery opens you want to get as many people looking

> after the patients and get them into the waiting room as quickly as possible. (FC)

The position of the practice receptionist in the busy office, standing at the window and receiving dozens of patients in an incredibly short time inevitably led to tensions, not all of which were capable of easy resolution. With the absence of appointments and patients being seen on a first come, first seen basis there could often be exceptionally busy periods and other times which were much quieter. Most patients seemed happy to accept the possibility of a long wait when they knew that they could be seen at a time of their choosing.

Changes in patient registration requirements made it easier for patients to change doctors. Recep_03 recalled:

> Oh yes. We are getting a lot more, new patients now that it's easier for them to change their doctor. You find that you get a lot more coming in and going. Moving into the area and staying in flats and then moving on…. Yes, [there is a big turn over] especially with the young ones…. By the time we process them and get their old records in, that's only a couple of weeks and they are going elsewhere, and their records are going back [to the Health Board] again.

The practice responded to the new challenges offered by revised contracts for general practitioners in the decade before the oral history study. It had previously benefitted from the Family Doctor Charter of 1965 which had provided significant reimbursement for employed staff. By the time of the interviews the scope had expanded considerably:

> [The nurses do the] smears, blood pressure. The nurses actually do a lot of asthma clinics, hypertension clinics. There's a lot of [health promotion] clinics now that never was in Cessnock Street. It tends to be the nurses that are doing these. (PMan_01)

Consulting a Woman Doctor:

I have noted the history of women in medicine and their increasing presence in general practice. However, ‘entrenched’ attitudes, as one participant put it, took some time to change.[29] Becoming a full-time partner in general practice in 1946 did not mean that the prejudices against women doctors in the past were over. Dr Ockrim had to encounter many challenges within the practice until the patients were used to her and the role of a woman doctor. The following shows a range of views on the role of women doctors as they saw it in their own practice.

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[29] FC recalled ‘The entrenched thought of people those days, nobody wanted to go to the lady doctor.’ DS confirmed: ‘I think in the old days very few people went to see you because you were a lady doctor.’

> ‘I feel I cannae talk to a man. I missed you terrible when you went. Tae me you’re no a doctor, tae me you’re my friend as well as a doctor.’ (LD)

This patient refused to change her doctor when she moved outside the practice area indicating her discomfort at the idea of starting to build a new relationship in a different practice:

> I’ve known you since I was a wee lassie. It’s a’ right for him to say you’ve flitted; you’ll need to change your doctors. I could come and talk to you and tell you all my problems. (LT)
>
> ‘I was with [a male doctor] and he told me I was pregnant, so I came over to your practice because I preferred a lady doctor’. (IT)

However, this was not a universal attitude and certainly in the late 1940s and early 1950s there remained serious prejudice against women in medicine. This had already existed during Dr Steven George’s time, but these attitudes clearly persisted after the practice changeover in 1946:

> ‘I think in the old days very few people went to see you because you were a lady doctor. My son-in-law always used to go to you, and they would say, ‘Look at that jessie sittin’ there to go to Dr Ockrim’. (ET)

One patient described how her husband, complaining of chest pain, preferred to go home without seeing a female doctor, with disastrous consequences. While it would be impossible to apportion blame for a fatal outcome in an illness where sudden death occurs the story resonates with the grief and anger of the bereaved wife.

> When I came out the hospital, I came down to see you and my husband was with me and I said to you that - and the receptionist took me in without waiting and I went in to you and I said to you and you said, ‘Oh, you're fine’ and I said ‘Yes.’ I said, ‘My husband's outside, he's been complaining of chest pain.’ You said, ‘Tell him to wait and see one of the other doctors.’ So, when I came out, I said to him, ‘Come and we'll see one of the other doctors.’
>
> He wouldn't come in with me because you were a woman doctor. I said, ‘Why don't we wait and see? He said, ‘No, no we'll just go home.’ After he died - he was actually dead - he just dropped dead. When they phoned [the surgery] and told the [male] doctor, he came out to the house and he was chalk white and I stood, and I bawled and shouted at him. (BC)

In fact, in the early days it was not unusual for the large majority of patients to choose to see the male doctor. A couple of patients recalled the following incident, which occurred in the early 1950s, some decades before the practice introduced an appointments system, and waiting times were often long:

> I was sitting with the children in the big waiting room and there was a big queue. So, they were all waiting for Dr Collins at this side, and the next thing Dr Ockrim flares out of her room, stands

> with her hands on her hips, and says, 'I'm a doctor too, you know – NEXT!' Everyone just sat with their mouths open and there was a few laughs. She was quite right. (39JG)

The other recollection of the same incident, though possibly just a similar episode, indicates Dr Ockrim's intolerance of malingerers. Someone wanting some time off work for a medical condition which could not be proved objectively, such as backache, would hardly be likely to consult her.

> I remember just one time. You were to blame. They were all waitin' to get in for Dr. Collins and you were in that wee side room and you says, 'Next, please!' I was waitin' on someone movin' and naebody moved and you came out and you said, 'Right,' to this man. You said, 'Oh aye, just wait for him, he gives the sick lines out' - and you shouted and bawled at him. I said to myself, 'Oh.' You didn't give the sick lines.[445] Aye, you knew a' their faces. I'll never forget that day. This man says, 'Look at the size o' her tae.' (IO)

During the 1970s there was a significant influx into the area of patients from Pakistan and India who had a more conservative attitude to gender issues and who actively sought out a practice with a woman doctor. If no female doctor was available a family member always accompanied the female patient.:

> …my mum went to Dr Ockrim, because she was a female. It is in our religion. We always went to a female rather than a male doctor. A male always went to a male. (FC)
>
> I used to always have to talk to a man doctor. I don't know. I think I was more dominated by a male. I reckon that's the answer. Mostly, because it's been a male that's dominated you all your life. I don't know why that happens. I think it goes back to your mother. She didnae help so you didnae feel she was interested. You felt that women were just a waste of time. (DM)

This patient did however come to consult with Dr Ockrim, able to see in a woman of authority a sense of the ability to control that had been lacking in her own life:

> When I was a kid, you gave me the impression that you didnae like ma da' and I liked that. I felt you had more power over him, but at the same time I couldn't talk to you about it.
>
> Aye, I felt kind of close, but no' close enough to tell you [about the abuse]. There was something powerful about you that I liked. There was a lot of people didnae like you. I used to say to people, 'She's straight forward and she'll tell you to your face what she thinks.' There was just something aboot you. My da' was always with me. You used to say to my da' – 'Are you still drinking? Do you not think it's about time you stopped drinking?' You were saying this, and I thought, that's great. My ma couldnae dae that and I used tae see you stronger than my da'. (DM)

Some complex testimony from this participant, who had suffered physical and sexual abuse from her father will be discussed in the next chapter.

House Calls

The 'good old days' when the doctor had a much smaller array of medications and care was represented by the time spent at the bedside in the patient's home was recalled. Participants had fond memories of the responsiveness of the doctors to visiting at home in the early years of the NHS, but they were often, in retrospect, aware of the placebo effect of the doctor's visit.

> Although, medication in those days, there was a lot of psychology about it. Doctors – their strong point was their bedside manner. I remember as a small boy, when one of the doctors would come to me if I had the flu. We were very impressed if they would sit there and talk to you and then you ended up with a bottle of some kind, which had great properties, according to the doctor, and it made you better. (ZI)

> I think at the beginning she would be [kept in bed]. I wasn't born [yet]…. but I do recall [hearing] that Dr Collins gave her every attention because what I remember is during the night even, no matter what time of the night or early morning, Dr Collins would come out. I can't remember if it would be an injection or tablets or whatever but whatever he would give her, he would come through to the kitchen and he said he wanted to wait and see what the reaction was. He would sit and have a cup of coffee and after a certain time he would leave. Now, that happened not just once or twice but over the years. (LM)

> Q. Why didn't you call the doctor if you felt so bad?
> A. I don't like to annoy the doctor coming to my house.
> Q. Do you think the doctor would mind?
> A. No, but I think he might be needed somewhere else. (DT)

> This night I had went out with my husband. On the way home, I was quite sick. I said, 'I'll no' bother wi' the doctor' and I went into my bed. I was in my bed, and I was getting worse. I said, 'I think you better go and get the doctor'. He ran away down the street and phoned. Dr Collins came to the door… He came in and he said I had pleurisy. He told my husband to - every four hours to waken me and give me these tablets during the night. By the morning my temperature had gone down. I said to Dr Collins, 'I'm awful sorry to get you out of bed'. He was there with

> his pyjamas under his jacket…. He said to my husband, 'I knew when [you] phoned it was something serious. He was so good. He had a lovely bed-side manner. (BD)
>
> I remember, years ago, when [my daughter] was a baby she suffered from severe earache, and I remember having seen a child with mastoid …. It was coming up to midnight when there was a knock at the door, and who was standing on the doorstep but Dr [David] Collins. Dr Collins came in and said that he was just passing. He said that I sounded quite worried about the baby's ear, and he thought that he would come in and have a wee look. You don't forget these things. (DK)

The practice was also sensitive to the needs of the housebound and often scheduled regular visits to patients unable, for whatever reason, to come to the surgery.

> I always remember Dr Russell - he would come, and we would say - we never sent for you. He said, I know but your mother was bad, this morning so I thought I would come up and see her. You don't get doctors doing that now. (QD)

Some patient recollections covered especially memorable house-calls. Being able to deal with illness with a house-bound patient enabled the development of a particularly close bond between patient and doctor. I remember that on one occasion a patient with cancer was refusing the hospital admission that Dr Ockrim had said was essential and she asked the patient what it would take for her to agree to the admission. The patient immediately said that she would like the dress the doctor was wearing, when she had finished with it. Dr Ockrim had the dress cleaned and it was waiting for the patient when she returned home. An important aspect of the doctor visiting the patient's home has been for supervising terminal care, considered in a later chapter, but in other cases it was assessing the situation regarding the need for home treatment or admission to hospital.

Occasionally it happened that a practice doctor was called when the patient's own doctor could not be contacted in an emergency:

> I remember my next-door neighbour and she came running into me one day and she said, 'Oh my god, Ina, oor James has just took a heart attack and we phoned the doctor and the doctor'll no' come oot.' I said, 'Wait and I'll give you the number o' oor surgery and phone them and explain what's happened and maybe some o' them'll come oot.' That's what happened - Dr Russell went oot. The man had came in from his work, took a heart attack sitting in the chair and died. He was only 46 and he had never been ill, never had an illness, it just came out of the blue and they couldnae get their own doctor to come. (INa)

The practice was a long-time user of deputising services, though covering its own patients on the weekday evenings until midnight. It was only after this project was completed that in 1996 the service was reformed as the Glasgow Emergency Medical Service (GEMS). Some eight years later GEMS was taken over by the NHS. By this time there were risks in visiting some of the areas in the practice after surgery hours especially as many of the requests for house-calls were being made by addicts hoping that an unknown out of hours doctor might be more receptive to their request for opiates. They might even to try to steal the doctor's medical bag. Ronald Campbell related the following, based on his experience as a driver for the deputising service. It should be remembered that when the practice covered its evening calls there was no driver to call for help in an emergency. Furthermore, the daily workload made the idea of a night on call an unwelcome prospect.

> I had three arrested in Castlemilk one night….They were waiting for the doctor coming up. What they do is they phone for a doctor for such and such but it's actually not a genuine call. It's a hoax call, so that they can see the doctor coming and get the drugs. How is the controller to know it's a hoax call until you get there? The doctors' deputising service meets a need, but I still think a doctor from the practice is more important - if it's got sufficient doctors to do one night a week. Oh aye, in your young day as a doctor, you wouldnae have given it a thought… but if it was now, you would have second thoughts about going into certain areas. Even to your own people in your own practice.
>
> The doctor comes to the house for him - he's usually that bad he can't get out. [This] is the best surgery to put a call in without having them nagging at you. I know other people in other surgeries and their doctor is always moaning and groaning over them coming out to the house. (FC)
>
> I think that was the first time you had ever came up to the house 'cause I always went tae the surgery. I only called out the doctor when I really needed it. Aye, I was used tae you and I didnae like phonin' somebody oot 'cause I knew it was somebody else that was gonnae come. (LD)

For many years the practice had a flexible attitude to a catchment area. Many patients from the Ibrox and Govan areas had been rehoused in Castlemilk and they were given the option of remaining with the practice. Gradually, the time involved in house calls to Castlemilk and other outlying areas, such as Newton Mearns and Ralston, became hard to justify as visits to

these areas could involve a round trip of about an hour. A policy was established of requiring patients to move to a local practice if they changed address, even a change as minor as moving a few doors down the road and closer to the practice than other family members who had not moved. This proved to be extremely unpopular and patients who remembered how Drs David and Ockrim put patient loyalty above such considerations were deeply offended.

> I phoned the doctor, and it was [because] my daughter was in another hoose. He turned roon' and said, 'Oh, you'll have to get off the surgery'. He never even gave her a prescription or a line for her work or nothing and away he went ..… (LD)

Glasgow GP and regular *BMJ* columnist Spence put the case for house calls very cogently and succinctly.[446] He argued that doctors were seeing patients only on 'our own consulting room turf, sanitised and controlled' and missing all the healthcare clues which came with a home assessment. In considering that 'the house visit is at the heart of medicine' Spence concluded that it forms an important and undervalued part of medical care.

Two participants recalled the visit of a consultant surgeon on a domiciliary visit who had recommended that they should be admitted for further investigations and treatment.

> Dr Collins, senior, came out to the house and said that he would like a surgeon from the hospital to come out and see me. Mr Tankel [the surgeon] came out to the house to see me. He said he would like me to come into the hospital so that he could examine me properly and do X-rays. (FC)

> Anyway, Dr [David] Collins came and he … I may be wrong, but I think he had a friend who was a surgeon from the Victoria Infirmary. Dr Collins got him to come to check [her] over, at the house. (LM)

As noted, domiciliary visits by hospital consultants have declined markedly in number except in specific instances, usually related to geriatric medicine where consultant sight of the patient's home could be relevant to the rehabilitation process.

Conclusion: In this chapter we have seen how oral history testimonies showed the shape and content of general practice as seen by its consumers, the patients. The tensions over appointment systems and open access were finally resolved in the practice in favour of appointments, but at a much later date than virtually all other local practices. Patients valued their doctor's time and respected their opinions while looking on the surgery visit as a complete experience, which might include discussions in the waiting and a nostalgic trip from a suburb back to the core of the

practice area. We have also seen how it took many years for the role of a woman doctor in general practice to be routinely accepted. House calls have been and remain an essential component of family medicine, though the proportion of visits at home compared to consultations in the surgery continue to fall, with the now ubiquity of mobile phones and better patient mobility.

At the beginning of the Chapter, I showed that these topics, open-access, appointments, organisational systems all combined to contribute to the doctor-patient relationship and that consequently they require an integrated approach to its understanding. Many studies have focussed on the different aspects of the ‘general practice experience’. Bringing them together I have placed the attitudes of patients and reception staff in a single context. This chapter provides a unique window into the functioning one large urban medical practice in Glasgow illustrating the various components of surgery organisation. Patients prized personal contacts with their doctor and while eventually accepting of appointment systems remained loyal to open access for as long as it could be sustained.

Chapter Five: Stigma, Shame, Discrimination and Marginalisation

In this Chapter I will show how the topics of stigma and shame as well as discrimination and marginalisation emerged as major themes in many of the interviews. Participants reported the shame they felt in the way they were treated by uncaring systems, whether in health, welfare or education, which labelled them with stigmatising conditions. I will also show that this labelling continues to the present day with terms such as alcoholism now coming to represent stigma and shame. I will show how these topics – institutions, diseases and addictions - impacted on people's lives and altered their perception of the society around them. Participants also reported discriminatory attitudes and racist language about Asian patients in the practice which seemed as shocking to the interviewer as they will to the reader.

Institutions and Stigma

The voices of the participants tell of grim pre-1948 buildings which were still used by the NHS, the heavy-handed distribution of welfare and society's reaction to them as they suffered from tuberculosis, schizophrenia and addictive behaviours with accompanying stigma. In many cases participants recalled events which evoked shame and guilt in settings clearly related to stigma though often the word was not mentioned. Sometimes the word 'taboo' was used and frequently the images created clearly evoked stigma and marginalisation.

Participants described what life was like for individuals living in institutions they described as 'fearsome' that the NHS would inherit.[447] They often reported that the stigma that they, or their families, felt about mental illness was not necessarily associated with its symptoms but related to what was experienced in prison-like conditions, often far from home. Many of these places, the Victorian asylums, had extensive grounds which claimed to offer a quiet and peaceful environment for the mentally ill, and a self-supportive community lifestyle, to aid recovery. Climie described the way that, even today, property developers who are trying to sell houses on the land of former mental institutions around Glasgow, such as Gartnavel, Woodilee

and Hawkhead, are coy about mentioning the real history of these sites.[448] Marketing skilfully projects the positive advantages of the new homes, set in extensive landscaped gardens.

The local hospital, the Southern General, had begun as a poorhouse while the Victoria Infirmary, to the east of the practice area had been a private hospital, supported by patient charges as well as charitable donations. Participants were quite clear that there was a stigma to being a patient at the Southern General Hospital which was not associated with the Victoria Infirmary.

> It was always the Victoria he recommended. You see my father was very much against the Southern General. He said to my mother, 'Don't put me in the poorhouse.' It had this sort of stigma to it. It all changed, but the older people thought that this was still a place that wasn't supposed to be spoken about. (QN)

> The only thing I remember is, my father talking about the Southern General - a Parish Hospital and he wisnae keen on going in. (ID)

There was also a hierarchy of clinics for outpatient treatment in the pre-NHS days. The Victoria Infirmary had a dispensary in the practice area – 'at the bowling green in Bellahouston Park' - while nearby in Summerton Road was the 'parish clinic' which was associated with the poorhouse, marginalisation and stigma. As FN recalled 'The very bottom used to be the poorhouse [clinic]'.

One participant BC recalled the effect on her family of being placed in the Foresthall Home and Hospital in the early 1950s, due to temporary homelessness caused by a storm damage to their home. Foresthall[30] had a reputation, while it operated as a poorhouse, for the harsh conditions in which the inmates were forced to live and work.[449] …. BC described the conditions she experienced which explained why it was associated with stigma.

> that was an eye opener. It was old people, and they just sat all day on the chairs. We were actually going into the bathroom that the old people were in, plus one night my sister came along and said, don't let the boys into the bathroom just now. One of the old people started to wash herself and by the time she had finished, she was standing in the nude. (BC)

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[30] The grim buildings of the Foresthall Home and Hospital in Springburn stood in extensive grounds. It opened as a parish Poorhouse in 1853 and at one time was the only one in Glasgow and the largest in Scotland with 2,000 residents. When the NHS was set up in, Foresthall remained under the control of Glasgow Corporation and catered mainly for the homeless and elderly. The buildings were demolished in 1988 and a housing estate was built on the site.

Several participants described how they had felt stigmatised by the way in which they were treated by the authorities because of family poverty and in consequence by how they saw themselves regarded in their local society. One woman, FS, brought up in a single-parent home, following the death of her father just weeks before her birth recalled the extreme poverty of the 1930s. At the same time, her testimony shows how the welfare provided was also stigmatising. She explained how her mother relied on the 'Parish' and 'had to sell all her furniture' and use orange boxes instead. While there was food poverty at home it was the clothing that was felt to be stigmatising, the public aspect of their poverty. FS recalled the embarrassment and shame of welfare clothes because 'Everyone knew that was the sign of parish clothes - poverty, and I mean poverty.'

The assessment of entitlement to benefit by the Means Test was also felt to demeaning. Rules were applied strictly and often in an unfeeling way. IS struggled to help her brother-in-law financially, but the means test inspector's response was 'if you can't keep him on that we can put him into Foresthall'.

Illness Stigma

Here I will show how stigma operated in a variety of clinical conditions, associated by many with poverty, poor housing and inadequate diet., exemplified by the association with tuberculosis, but also operating in other conditions.

Tuberculosis: In this testimony, ZI remembered that his mother refused accommodation to a young family member with TB through fear of transmission. He recalled that 'nobody spoke about it' and that it was 'a taboo subject'. He added:

> TB was the stigmatic thing. Nobody spoke about it. I knew plenty people who had TB, thankfully nobody in my family. TB was a taboo subject because a family who had a person with TB, and sometimes there's more than one, they didn't want to know because then they would be known as an unhealthy family and another family wouldn't want to be married into, which was quite ridiculous. Oh, there **was** a member of my family who had it - a cousin from Edinburgh. Again, this was something I found quite hurtful at the time. Nobody would have him…. he died because nobody really cared enough'.

BE recalled that 'if you heard that somebody had TB, you used to think that was terrible' while HC acknowledged that 'there was always fear of infection in the house' and 'there was an

unclean sort of feeling about it. It was a terrible disease, and they had no answer to it at that time.' IS said that she was so concerned about the stigma of TB that when she went on the tram car to the clinic 'I went past the stop because I didnae want him [the driver] to see where I was going. Just because it was TB.'

RNr remembered that when she 'was a young girl, tuberculosis was a bad word. Consumption they called it. That was a bad word.' She was not given the diagnosis. IT had all the investigations and treatment associated with TB without the stigmatising word tuberculosis being mentioned, although by this time the name streptomycin was synonymous with the disease. Even when TB could be cured by medication the stigma persisted and she was only told that 'they discovered it… just like two tiny pieces of thread just over the top of both lungs.' LNd said she was told that she had 'hip-joint disease because 'I don't think anyone mentioned the word tuberculosis in those days.' EL admitted that she had hardly known any close family with TB because 'I'm going back to pre-war, and you weren't told about things.'

LNd, who suffered from tuberculous bone-disease, felt marginalised by the city's Education Department who refused her admission to Bellahouston Academy, where the science class wasn't in the same building. Despite pleading that she was fit enough to walk from one building to the next the head teacher suggested that her father 'Just put her into some domestic thing where she can learn to sew and cook.' Attitudes gradually changed with the introduction of chemotherapy and HS was made to feel privileged that she could be treated with treatment at her local hospital rather than be transferred to the sanatorium environment at Mearnskirk.

Patients who were diagnosed with tuberculosis by the 1960s were often picked up by a programme of X-ray screening in which some of participants had been examined. In 1957 an intensive five-week campaign was launched in Glasgow to identify TB carriers in the city.[450] Thirty-seven mobile radiography units, manned by volunteers, visited housing schemes, offices and factories with the initial aim of X-raying 250,000 people. However, intense media coverage, support of community activists and a weekly prize draw from the names of those who came forward helped raise the number of screenings in the city to over 600,000. Confirming this HS said that her TB was 'brought to light by the mass x-rays. It was done at work.' TB lost its stigmatising labelling when chemotherapy meant that a course of medication could be curative.

I have described another condition, rickets, which was associated in Glasgow with poor diet and housing. One mother came to Dr Ockrim, worried about the stigma associated with

rickets:

> [My son] had legs like barrels. The Green Lady told me it was rickets, and I went along to you, and I said, 'The Green Lady said he had rickets.' …. You said, 'Let him walk'. I told him to walk. You said, 'Rickets! what is she talkin' aboot? She doesnae know what she's talkin' aboot. He's no' got rickets. He's bow-legged, but he doesn't have rickets.' (JB)

The Unmarried Mother: Fear of stigma could lead to a concealed pregnancy where a woman who knows that she is pregnant does not tell any health professional. AS described herself as a 'gullible' youngster, unaware that she could be pregnant as she said that 'I had never had intercourse.' Her father had to be told not to chastise her and she 'was put into the Tor [Christian] Nursing Home in Edinburgh,' which cared for these young mothers. She recalled:

> That was six months pregnant right up until the baby was born and it got adopted.'

Other families could be more pragmatic. IK was determined to stand by her pregnant unmarried daughter and had resigned herself to the baby being adopted out of the family. However, at the last minute the daughter decided not to go through with the adoption and the baby was brought up in IK's home: 'He gets the attention and love that all kids need. (IK)

The more open society around the time of the interviews relegated this stigma to history but it did not stop one participant, DX, reflecting on her own generation and its lack of knowledge about contraception and pregnancy, and the next generation with its '…free for all world':

> They are doing things all different. They're having their weans then getting engaged and then getting married. They do everything all stupid.
>
> Well, my son is staying up with his girlfriend just now and he has been for five years. I keep suggesting they get married. He said: That's just a piece of paper.

Mental Health, Alcohol Dependency and Substance misuse (Addictions) and Stigma: Physical conditions such as rickets and tuberculosis were seen as stigmatising, by representing poverty, while mental health problems carried a fear of the unknown. The whole field of mental illness occupied a somewhat peripheral place in medicine in the first decades of the twentieth century. Significant psychotic episodes had to be treated with custodial care and psychiatric hospitals, formerly known as lunatic asylums, had a fearsome reputation. This could be due to harsh discipline, inadequate diet, and restricted movement.[451] Memories of mental illness in the

family could cast a long shadow.

> There's a few tragedies. Granny had a young son who had a nervous breakdown…. and Granny was trying to cover up. It was Leverndale and she didnae want anybody to know. I think he was only a young boy when that happened. It was months and months. I think it was a stigma on some people. That must have been part of Granny's generation. Anything else can be wrong with them as long as it's no' a mental illness. (IK)

One of the participants, DS, had been a male nurse in the Hawkhead Asylum in the 1930s when the extensive hospital grounds contained a farm with over a hundred cattle. In the days before the State Hospital at Carstairs opened to cater for the criminally insane, Hawkhead dealt with inmates on murder charges. His testimony illustrates just how such institutions operated and why stigma was associated with them. He recalled patients coming from Barlinnie in straightjackets. At this point, Dr Ockrim recalled that during her undergraduate psychiatric training she was at Hawkhead, and she thought the practice of displaying the patients to see them perform foolish actions was degrading and very cruel. She remembered that 'some of them used to do silly things and the nurses or doctors would ask them to do things and they would do things, and everybody laughed as if it was a joke.' DS agreed saying that in the lecture room 'they would maybe have the epileptics in, and they would maybe have ten of them in and he would have them all doing this and that with their ear. One fellow could flap his ear, and this caused a laugh of course.'

Depression: One participant, ET, played down the mental health aspects of her illness, concerned about stigma and worried that people might have thought she had been 'in the loony bin.' Two patients described the unsympathetic attitude of their employers, and one the unfeeling attitude of a hospital nurse while the final memory showed the limits of sympathy to a real mental health illness within the family.

> I went back to work [after about] nine months and… I had to get my courage back to face my workers and my neighbours. I thought at that time, 'It's silly, I know – [but they might be thinking] Oh she's been in the loony bin'. I thought that people wouldnae understand that there was nothing wrong and I was just exhausted. (ET)

The next memories describe the sense of shame associated with depression and the stigmatising and unfeeling attitudes of those in authority which compounds the problem. Depressed patient found it impossible to admit to a stigmatising illness which was affecting the standard of their work. GD admitted that:

> Everything seemed to be getting on top of me…. Maintenance which I believed should have been done was being pushed aside and I used my own men[31] and trained them to do the necessary preventative maintenance and I was stopped doing that.'

RN described how she had experienced 'a terrible depression' while working as a home help and was stigmatised by her illness. Her supervisor:

> wasn't terribly sympathetic and she would say, 'You'll just have to cope, it's as simple as that'…. I got to the stage I couldn't cope.' What I would have to do in two hours, I was trying to fit into an hour.

ZR described the details of his wife's depression and its effects on the couple's interactions with friends and acquaintances. He said that:

> If she had died in her sleep, I would have been relieved. I knew she couldnae go on the way she was going.….. When this started, I went to drink and then she died. I was drinking a bottle of whisky a day.'

The idea of stigma was very much in these participants' minds.

Schizophrenia: The following is the voice of a parent, ZL, who feels he has to navigate a Kafkaesque world in understanding his son's schizophrenia and providing a safe home environment for him. The patient's father recalls the history of his son's illness, and its associated stigma, and relates how he involved himself with family support groups, specifically the Schizophrenia Fellowship, and also read widely in detailed psychiatric texts. It is an important account of the development of a complex mental illness with its frequent relapses into unpredictable behaviour with all the aspects which engender stigmatisation. It also shows the patient's struggles with his parents, and especially his father, to come to terms with it and the encounters with both general practitioner and hospital services.

> We went in to see the psychiatrist and his attitude was hostile to me - not with me… Well, there's hardly a panel in our house which wasn't fractured. … His obsession was the media, which is not uncommon. The television interfered with his thoughts. All forms of media was a threat to him. His concentration went away as far as reading was concerned. Televisions got smashed. I think we had three smashed. He was tremendously guilty afterwards.
>
> All my collection [of books] which never done me much good, was all gathered one night, quietly and all burned. The psychology books, psychiatry books. They were all taken out and burnt. That didn't bother me too much.

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[31] Thus, crossing demarcation lines.

> My view now of schizophrenia is that I'm a part of my son's illness, my wife's a part of my son's illness, his friends and relatives are part of it, his GP's a part of it and his psychiatrist is a part of it and it's the way we respond to his illness for good or better. (ZI)

The insightful commentary of the father and his sometimes-cynical views of the professionals engaging with his son, both in the practice and in the hospital, give the narrative a feeling for how paranoid illness affects the wider family. Yet the family never give up on their disturbed son who is marginalised by his illness and lives in a solitary state that few can understand. However, in families less able to cope with the severe stress associated with the care of a seriously disturbed family member statutory services lagged behind what sufferers expected.

The following memories show the feelings of guilt experienced by carers, the difficulties in providing an acceptable level of care at home and even making sure that the patient remains safe as her memory deteriorates. We see the struggle of daughters to provide care at home and the feelings of guilt and shame as they realise that their mother has to enter a care home. Then there is the son who works out of town has difficulties in helping his mother cope with declining mental function.

> I remember one night she started. By this time, she was in a bed with the sides drawn Up. Oh yes, she was becoming demented…. It wasn't her…. The doctor called one day and took a look at me and said, 'We've got to do something.' I still feel terribly guilty. (LG)

> She [my mother] had taken a slight stroke on the Monday and on the Tuesday, she took a massive one and she was put into the Southern General…. From there, they tried to rehabilitate her back home again, but she was too badly disabled. Because of my circumstances, she actually died in Crookston Home… [It was] awful. I couldn't visit her. I would go in and I would run out the door, because I was so guilty… But it's just when I get talking about it I think, 'How could I have done that?' (EX)

Home care for dementia sufferers might be ideal but often is not practical as reflected in these recollections. The stigmatisation of patients with dementia left significant guilt feelings on these families as admission to residential care was perceived as a family failure.

Substance Use Disorders:[32] Addiction can be defined as a chronic, relapsing disorder characterized by compulsive behaviour despite its adverse consequences. The addictive behaviours mentioned in the interviews related to the use of illicit drugs, alcohol, prescribed

[32] This is now the preferred description for addiction to illicit substances.

drugs, cigarettes and gambling. In some cases, patients found relief with self-help groups, such as Alcoholics Anonymous, while sometimes residential programmes could be helpful. However, it was often the resulting damage to families, from violence, separation and financial loss which were the predominant memories.

Alcoholism (Alcohol Dependency): There were many examples of the behaviour of alcohol-dependent patients which demonstrate how the habit came to be associated with stigma in families, at work and in society leading to conflict and exclusion. Only a small number are quoted here. These memories describe the problems related to excess alcohol consumption and explain why the associated behaviours are stigmatising. ZF said that he was drinking 'every waking moment.' He did not want to:

> get taken into hospital, so I pooh poohed it until such times as a bed **had** to be found for me… I woke up in Leverndale one morning. I was pretty bad. It was an institution - a psychiatric pit. There was a reception area of all the nervous disorder people, court cases, alcoholics and general inadequates of society.'

ZF found that he could turn his life round and move forward free of the stigma that his excessive drinking had provoked by attendance at Alcoholics Anonymous (AA) and at the time of the interview he had been sober for 31 years. He remarked 'I'm not confident, just vigilant against the first drink.'

ZT admitted that she never sees her brother:

> because he turned out to be a complete rogue. He's never out the jail and I just don't want that type of person. My father put him out when he was seventeen. He was stealing [from] my father. And he was breaking into houses. I kept him for a year and then put him out. He was stealing and lying.'

HN mentioned a father who recovered through working with down-and -outs at the Salvation Army and LD described the problems related to her marriage to a binge drinker:

> It was maybe every three months; he would take a drink and when he went out with his friends, he would take a drink maybe every three months or even six months. He wouldnae hit you but he would throw things about, and I just gave him an ultimatum. I said, the next time you dae that, I'm no' goin' oot the house, you can please yourself. You either stop going oot wi' your pals and stop drinkin' or I don't come back wi' the kids. Ever since that he's never touched a drink.

Drug Addiction (Substance Use Disorder): The abused substances included prescribed medication, such as the benzodiazepines (such as diazepam, temazepam and nitrazepam) and

strong painkillers (including dihydrocodeine – branded as DF118). At the same time there was an epidemic of heroin abuse in the area. The hostel for the homeless in the practice area gradually found that their elderly alcohol-dependent clientele was replaced by heroin addicts, many of them receiving methadone in attempt to wean them off the dangerous injecting practices associated with heroin.[33] The practice had many patients in 'Wine Alley' and for the most part they differed little from the patients in the neighbouring areas. However, as increasing numbers of people with social problems were given housing there, older patients were very aware of the addicts in their midst.

> You hear of some of the young ones in the scheme. You hear about them mostly up at Wine Alley. I think that's where a lot of it goes on. … I suppose there's a lot of decent folk up there too. It's just the same everywhere. (BE)

> There's a drug addict [in the building]. She doesnae affect me. I'll talk to them. They don't bother with me. I don't bother. She's been there for about eleven years. She was in with the jags[34] and that. You know when she's high. There's quite a few of them. That's the Wine Alley over there. Well, they're emptying half of that I hear…. It's Moorpark now. There are nice people over there. I've met quite a lot and I think they are nice. (IT)

It took some time for the practice to create coping mechanisms for dealing with substance users and their self-stigmatising and marginalising behaviours. Policies had to be established for finding out who was entitled to be seen as a patient. Because of the abuses of the system, including lying and forging prescriptions, such patients were frequently removed from GP lists. As substance misusers found major problems in registering with a different practice they would be allocated to a named practice, usually for a period of three months. Unfortunately, it often took three months for case notes to reach the new practice and the receptionists had to obtain the necessary accurate information before the doctor could see the patient. Sometimes false information was given which would lead to a fruitless search for accurate information.

> Well, we have quite a lot of problems with prescriptions from addicts - whether they are taking the drugs themselves or selling the drugs on the street, we're not terribly sure. The policy of the Practice now is that when a new patient or a temporary resident patient comes and the girls are suspicious of them, we have a typed note to say that as a Practice we do not prescribe certain drugs. These drugs are named, and these are the drugs that the drug addicts want. This in a way

[33] The practice provided medical service for the hostel at Kingston Halls.
[34] Syringe and needles

> helps but if it's our own patients, we find that all the drug addicts around here know each other and if the surgery doesn't have a strong policy as regards withholding certain drugs, then they would all actually come to this surgery or come to whatever surgery they found easiest to get drugs. We have had patients apprehended from the surgery, but this has been known patients to the surgery who have come in and we knew that they were actually wanted by the police. (PMan-01)

> You are very aware of the problem [of drug addiction] here. You see so many - we get at least three or four a week. It's quite frightening sometimes because you don't know how they are going to react to you. If they are told they have not to join the list for some reason, they can become quite violent. They refuse to leave the surgery and on a lot of occasions we've had to call the police in. You've got to learn to deal with it. Drunks are different, you can sort of humour them, and they tend to just go away. (Recep_02)

Receptionists would check with Health Board records to confirm the addict's story only to find that the name of the doctor given was fictitious or that, commonly, there was no record of registration with a practice. The addict would then be informed that they would need to contact the Health Board themselves and that they would then be allocated to a practice.

> We've got about a dozen [drug addicts] or thereabouts…. The doctors tend to keep them under control. The doctor gives us the prescription, we take it round to the chemist, the chemist them gives the patient the tablets. It is in case they are actually altering the prescription itself.
>
> One patient was issued a prescription and went to the local chemist and before she had time to get it dispensed, when she was still in the shop, we realised that she shouldn't have had the prescription because of her history…. So, I rushed round to the local chemist and took the prescription out her hand, and she was left standing without it. (PMan_01)

Patients began to report that their children, other close family members or neighbours had become addicts. Their constant need for money to buy illicit drugs led to petty criminality, often shoplifting but frequently too, selling off prized possessions within the home.

> If my daughter was in the house…. we were so silly taking her back. Learn to be harder hearted. Having to lift your purse when you go to the toilet. It's horrible when you can't trust who's living in the house with you. I can't describe it to you. It makes a cloud in the house and the atmosphere. You're listening to her saying something and you think to yourself, "Is that the truth or is it a lie?' You can't believe anything they say and you've to watch what they're going to do.
>
> I couldn't talk about it at all. It was horrible. You felt ashamed. I was blaming myself that she went to the drugs and all that and yet I know in my heart..… When I used to go up [to the

> surgery], I'd be sitting there and I'd say, 'Oh God, there's one of my daughter's pals'. You could spot a junkie a mile off. I just hated being in the same room as them. It was a horrible feeling, you know. (LB)

> Yes, I've came across it because one of my sons was on it and ended up getting septicaemia[35] and had to get new valves in his heart …. the doctor [said] 'It's septicaemia he's got and he hasnae got very long…. It was a Prof, and he came and spoke to me in the hospital. He said, 'You know, this treatment costs an awful lot of money, and do you think that he'll have learned his lesson, if we put all this work and effort in to making him better? I said, 'I think he looks as if he's learned his lesson.' (IN)

> The boy above me died through one of them. He injected himself. He used to come to my door. In fact, he set his room on fire the night he came here. He used to come here - Well you know the drugs my husband was on …This boy used to say, 'I'll gi' ye' a pound for a tablet.'…. I wouldn't give them a tablet. I gave him [a] cigarette and he went away up and went to sleep on his drugs and set the bed on fire. … The place was in flames. I was lucky I never got injured. (LI)

> Quite a few in the street have died wi' drugs. You see them coming up in the cars and there's a boy who used to be…. selling them out the windae. The police didn't seem to be interested. They would come but they seemed to know when the police were coming…. There was a shooting a fortnight ago, through drugs…. You've no idea what it's like there. (LI)

Substance misusers using intravenous heroin also came into contact with the medical services through faulty injection technique which resulted in abscesses and other complications. Often, these had to be dealt with by the district nurse:

> The drug people - abscesses on their arms, legs, thighs. We wear gloves for all dressings now. We are told we must use gloves for all dressings. We would also wear an apron and have the special disposal bags for contaminated waste to make sure that it is properly disposed of…. One boy I remember - he seemed very pleasant to talk to, but he had a massive, big abscess and he was living with his girlfriend and two young children in the house. The house was - there was nothing in it. (Sister_01)

When asked if she would report such things to the Social Work Department, Sister_01 replied:

> No. The problem is if we were going about doing these things, we would probably not get back into the home again. You have got to be careful. It's difficult. Unless they actually ask for some

[35] Transmission of pathogens often occurs due to improper and unhygienic handling or sharing of needles and can lead to life threatening complications including septicaemia.

help - then you would refer them to a social worker.

The final recollections come from patients who had seen drug dealers and users in their neighbourhoods. These include comments about their perception of inadequate police responses.

> Well, there is a problem. There is drugs gettin' sold aboot here. You see the needles everywhere. You see them gathering in wee groups and the fancy cars coming. We don't know who they are. They're all strangers. [The police come] occasionally, but they're no' around a great deal. It's all stopped recently in this area. I don't know what's happened. It's all calmed doon in this particular bit. I seen them [the addicts] stoatin' aboot and I seen the needles lyin' aboot, but I've never had any bother wi' them.
>
> I phoned the police once because there was a really bad fight at the corner… The next morning, I went oot all the boys were shoutin', 'Oh there's a grass in that close.' It's no' right…. The only time the police bother is if there's a murder getting done…. It's a waste of time. (LD)

> If you are in the pub, you hear all kinds of things. Thae shopping centres and different places - there's certain ones [drug pushers] hanging about there all the time. I often wonder [why the police can't spot them] …. The pubs in Nitshill - it was a well-known fact that every pub had them. The police must know that. At times I think they do [turn a blind eye]. That's my opinion. (ID)

These memories of the problems of drug addiction mostly refer to the behaviours which stigmatise the abusers of illegal substances. Solutions proved to be beyond the scope of individual practices who sometimes were overwhelmed by the demands posed by addicts. At the same time, regular users of the medical services including close relatives of addicts clearly saw all these behaviours as stigmatising and shaming for their relatives.

Tranquillisers and Sleeping Tablets: Benzodiazepines are a group of drugs which can be prescribed in the short-term for anxiety because of their ability to slow brain activity making them useful for spells of anxiety or insomnia. Used in the short-term, they may be beneficial in helping patients over a difficult period, but long-term use carries risks of addiction and tolerance. They were popular with substance misusers in large doses and had a significant street value.

Patients liked them and once a prescription was started it could be difficult to stop, even though prescribing guidance was that these drugs should not be used for more than a few weeks. Most patients in the practice who were habituated to taking these drugs were monitored carefully and usually managed to negotiate long-term benzodiazepine therapy without having to increase the dosage. Dr Ockrim asked one participant if she had ever used tranquillisers and sleeping

tablets.

QM answered that she did ‘have a sedative that I take occasionally’ saying that ‘It wasn't given to me as a sleeping pill’ but was prescribed when her husband had a major heart attack. She explained:

> I wouldn't take tranquillisers - valium or anything like that, I don't think I would take, but I think that a mild thing that makes you sleep is much better than tossing around all night, being an absolute wreck in the morning.

However, she was actually being prescribed limbritol,[36] which contained a benzodiazepine just like valium, which was eventually removed from the list of NHS drugs though it could still be obtained on a private prescription. She would not accept the explanation that her medication might have been appropriate after her husband’s heart attack but a combination of an anti-depressant with a benzodiazepine was not suitable for long-term use. Claiming that it gave her ‘a restful night’s sleep’ with ‘no side effects at all’ she insisted on getting a private prescription. When limbritol were withdrawn she was given a simple sleeping tablet, but she felt quite ill with it, seeing it as a problem with the new drug rather than withdrawal of the original prescription.

Cigarette Smoking: Smoking cigarettes is a major cause of morbidity and mortality. While the practice was seeing less cigarette smokers the habit became increasingly associated with stigma. Some participants recalled their struggles with stopping the habit while others expressed their antagonism to smokers.

> I said, I'm not going to smoke any more but after four weeks of boredom and missing my cigarettes, I lit up and my husband was absolutely flaming mad…. I had plenty of warning and I didn't listen… How you did this for years and not think you would do any damage. (DT)

> What I didn't like [in the hospital] was … everyone from all around about came into that ward and smoked. You could cut the atmosphere with a knife in it…. I kept opening the window and arguing with people in the ward. They were shouting to shut the window…. But they smoked - all day. They spoke to this man next to me about smoking in bed. I was concerned because there was oxygen there…. In fact, him and I had words about it. Slightly more than words. I had him round the throat. I was gonnae throw him out the window… and then I calmed down. (HT)

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[36] Limbritol contains both chlordiazepoxide and amitriptyline, thus a combination of a benzodiazepine and a tricyclic antidepressant.

Discrimination and Marginalisation

The interviews showed how the theme of marginalisation was felt by patients whose ethnic or religious background placed them outside, what they perceived to be the mainstream. One of the Jewish interviewees felt marginalised because of his background which had a very different attitude to social drinking.

> When I worked with the Scottish Radio Orchestra, at lunch time we would go out and have six pints and then come back and play and play well. They are heavy drinkers. When I first went into television drama, the head of television drama invited me for lunch and a drink. I said, 'I don't drink at lunch time.' He said, 'I don't trust people who don't drink.' There is that attitude in our society that drinking is part and parcel of our social life - especially in areas where it is very attention filled. In the acting, writing, music world - it's so fraught with uncertainty that people do drink and do drugs. (ZT)

In the next memory we see how Dr Ockrim's own religious identity was questioned by a patient's priest. However, she was fully supported by the patient who would not allow the priest to question the views of her doctor.

> I remember this time that the priest had come in and he was talking to me about the children. Me having had four sections, I was worried about children, and I happened to say to the priest about having children. I said to him that my doctor was worried, and I was not to have any more children. He said to me, 'What religion is your doctor?' I said, 'The doctor is a Jew.' He said, 'Oh, you should get yourself a Catholic doctor.' I said, 'What difference does that make?' He said, 'Oh, the Catholic doctors will understand you better.' I said, 'I wouldn't swap my Jewish doctor for anything.' He said, 'He doesnae understand.' I said, 'Well my Jewish doctor is better than any of your Catholic doctors.' (BC)

From a medical point of view in the practice, the majority Protestant population and the minority Catholic community had similar views and outlooks although we will note some issues relating to Protestants having births at the St. Francis Nursing Home. However, the increasing numbers of mainly Pakistani Muslims in the Govan area with their different skin colour, language, religion, dress and customs created a big impact on the neighbourhood.[452] By the time the interviews were being conducted, patients of South Asian origin made up around 12% of the practice numbers, reflecting almost exactly their proportion in the local population. Though serious racial incidents were reported to be few, or mainly of a minor nature, violent episodes did

occur. Qualitative data collected specifically in Edinburgh suggest that Muslims visibility has triggered some ethno-religious discrimination.[453]

A local pharmacist, who was interviewed as a patient in the practice, noted that:

> There was a definite ethnic change. There was a lot of Asians came into the area. It brought us in a lot more prescriptions. I think they made good use of the health service. I am not saying they didn't need it, but they certainly used it. (IU)

A few patients mentioned the presence of Asian patients in the Waiting Room talking in their native languages. Dr Ockrim was sensitive to the question of racial prejudice and took issue with the interviewees when memories were recalled in racist terminology.

> The only incidents I see is when the Paki's are in, and they are talking in their own language. I did see one of the receptionists telling them to keep to English when they're in there. That was the only time.
>
> *Dr: But the thing is, some of them can't speak English.*
>
> I never thought of that.
>
> Dr *Do you think they may be saying something against you?*
>
> I think it gives you an inferiority complex, as if they're speaking about you.
>
> Dr *So how would you feel now about listening to them speaking their own language?*
>
> I don't suppose it would bother me now that it's been pointed out to me.
>
> *Dr So, do you think a lot of the racial feeling is that people don't understand and don't know and there should be a lot more understanding?*
>
> Yes, I do.
>
> *Dr Have you ever heard some of the girls [in the office] speaking Gaelic in the surgery?*
>
> No.
>
> *Dr Well they do. So how would you feel about that - Do you think you would feel the same way about that?*

> The only fault (in the surgery) is, when you are sitting in there, these Asian patients – When they are all speaking it's like a constant drone. I mean they're pleasant. I would never ignore them. I speak to them and that **if** they've spoken to me. (RNr)

> The only thing I didn't like was in the old surgery - The Asians used to come in and there used to be two in front of you and another two would come in and another two - six or eight of them would walk into the room at once…. The Asians you couldnae talk to. They just wernae interested in having a conversation. (LG)

LB a Pakistan born participant, and local shopkeeper, felt that he ‘got on OK’ with the locals. However, he admitted that:

> Here and there they will call me black B's and this and that, but that's only to make me angry more than anything else - to get their anger out of them and trying to make me angry. Jealous - yes. People are jealous for a lot of different reasons. They maybe think - right I'm standing in the shop and the till is going ding ding, ding-ding - I'm making a lot of money and the person in the street is unemployed. He can't make any money – He can't get any job. I'm to blame for that. Well, I'm not to blame for that. He doesn't know that I'm there from six o'clock in the morning till six o'clock at night. I know that all I'm getting at the end of the day is wages.
>
> No, I don't think (there’s a racial problem) in Glasgow. Definately[37] not. I've had my problems - I've been mugged in my shop. They steal from me. I wouldn't say that was due to racial. (LB)

> I was working the buses and I never seen anything. If they did, I don't mind because in Pakistan, there is good and bad people all over the place, so I don't notice. (LC)

> One time a boy in another class hit him [my son] with a bottle on the head. I went to the headmaster. The headmaster was very good. They told me not to worry about it. He knows all the family. He called the police, and the police took action. (LC)

A younger patient, (FC) who had experience of working as a social worker had her own view on the racial prejudices she had encountered as a Muslim. This included people saying, ‘You should go back to your own country’. She and her husband made the decision to send their children to private schools where she felt that though there was still an element of racial prejudice ‘if we've left our own country, we want our kids to be brought up with good manners.’ Alcohol was seen as a problem, she said that she had ‘been to functions where they are drunk.’

> When we do visit them, alcohol is involved in it. We feel that we are left out at a function and it's not the right place for us to be, but we do go up with a gift and come back very early.’

Abstention from alcohol was so ingrained in the local Muslim community that when a patient of the practice developed alcohol-related cirrhosis of the liver there was some disbelief at first and, while the family provided exemplary care as their relative died from complications of liver failure, it was obvious that the family felt a stigma. Some of the men might have a drink if they were travelling around Scotland on business but an illness related to prolonged heavy, and necessarily secret, drinking was hard to cope with.

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[37] West of Scotland pronunciation.

The story of a sixteen-year-old exemplified a lot of these issues and her father was keen to portray his opinion on the matter, as her behaviour related to stigma within his family and community and reflected the interaction of immigrant parents and the next generation. The practice, as the story unfolds, tried to maintain close touch with parents and daughter, providing valuable support and understanding for father and daughter.

> They were sent to the mosque when they were young. They read the *Koran* - they all have their own books. I request of them that once or twice a week they should read their books. They done it in their own time. I didn't say, 'Look sit down and read.' It was put into their mind that if they read it is good for them. [She] was always quite a nice girl, and she had a very good report from the school. Always happy, and the teacher was always very pleased with her.
>
> Very helpful at home. Good at school. Never said no to her mother, never said no to anybody in the class. Apparently, there was a girl in that school who we had heard from people that she was not good to be friendly with… We never had any problem with [her], but slowly and slowly that girl got working on [her] and she was sort of misleading [her]. Then all of a sudden, one morning [her younger brother] came from the school and told me she was not in the class. (LB)

When her parents disciplined her, the situation spiralled out of control. Her father admitted that his wife had 'hit her a couple of times' and that, if truanting did not stop, he would 'break every bone in [her] body.' The school nurse, the head teacher and social workers were all involved though following a review by the Police, the Court Reporter and the Social Worker no further Police action was taken but with his daughter's agreement the social worker arranged admission to a children's home. The family was much more accepting of the situation when she continued to show her attachment to her faith. The home gave her a self-catering room and allowed her weekly access to the mosque.

> I spoke to her about her marriage, and I told her - In fact I went back and told my mother and father as well. Nearly all my relations know now. My mother and father know, and they said, 'Look when the time comes for her marriage - If she can get married to a Muslim child, she will get together again.' That is their judgement. I would agree with that, and I think that is the only hope…. if she would get married to someone non-Muslim then I'm afraid I don't want to see [her] at all. (LB)

All the patients quoted in this section saw themselves as part of the mix that makes up Scottish society, sometimes described as 'Threads in the Tartan.' As first-generation immigrants, the participants of Pakistani and Indian origin saw many things in their background and beliefs

that they wished to maintain. In this, they saw themselves as marginal to the mainstream of Scottish society with which they wished to integrate. At the same time, they had to acknowledge that pressures from the society outside would mean the making of some compromises while struggling to keep red lines in place. Stefano Bonino argues that it is hard to gauge the extent of anti-Muslim sentiment in Scotland and that the goal should be the reduction of discrimination where it occurs while maintaining Muslim distinctiveness within Scottish society. [454]

Conclusion

Stigma continues to exist as a society response to a range of diseases and behaviours. I have shown how stigma was often experienced as shame, particularly where welfare payments and tuberculosis were concerned. Some historic stigmas have disappeared while others have taken their place. Other stigmatising behaviours such as alcoholism, substance misuse and cigarette smoking have become associated with marginalisation. Marginalisation and discrimination have also affected different minority communities as they try to find their place in their local communities. Various strategies have been suggested to deal with this. These include improving knowledge about the issues through the media, campaigns like See Me, training programmes and removing barriers, legal and employment, which reinforce stigma. These testimonies show how stigma and marginalisation impacted on the lives of the study participants. It will require work with stigmatised individuals to engender a feeling of self-worth and personal responsibility and a greater awareness in society about reducing stigmatising and discriminatory attitudes.

Chapter Six: Critical Issues in Medicine

In this chapter I will show how the oral history data, which records patient interpretation of how their health issues were understood, informs our understanding of healthcare provision and points to areas where needs are not addressed. This will be done by looking at some of the important issues raised by the interviews with former patients: communication with the doctor, the accuracy of memory, changing attitudes and coping with loss. Communication with the doctor required access to the consulting room or the doctor's visit to the patient's home as I showed in Chapter Four. The experience of childbirth formed an important part of the interviews and general practitioner involvement, including intra-partum care was an important memory for many mothers, reflecting its increasing medicalisation and the disappearance of the GP from the delivery room. These issues draw memories from medicine and surgery, obstetrics and gynaecology, paediatrics and infectious diseases. Some patient encounters with doctors had not received any form of closure, whether related to diagnosis or treatment, and concerning themselves or close family members, despite the passage of years of even of decades.

By its nature any consultation in general practice could potentially take the practitioner down many different clinical pathways.[455] Thus, the patients attending a morning or afternoon surgery could display a bewildering variety of symptoms representing a myriad of diseases. While detailed knowledge of rare conditions would not be expected the GP has to be able to recognize important symptoms and, where management is beyond the scope of general practice, refer the patient to the appropriate hospital department. These patient voices will provide an insight into patient needs and wishes. The former must be met while the latter need to be respected.

In this chapter I show memories of general clinical topics, childbirth and child health. This includes a wide range of clinical topics, especially relating to cardiovascular disease, kidney disease, lung conditions (especially asthma), arthritis and the full range of infectious illnesses. Participants recalled encounters with general practitioners and the referral by GPs to hospital doctors. For most patients their accounts of healthcare provide a satisfactory outcome or at least

an understanding that all that could have been done was done. While medical staff usually know what the patient describes in health terms, in many of these stories, things go wrong because symptoms are not believed, and when the facts emerge, as DR recalled 'the surgeon just shrugged.'

Memories were long enough to include diseases such as diphtheria and smallpox, no longer seen today. AH remembered a young family member with diphtheria and two others who died with mastoid disease and commented that 'you had to be very hardy to survive in these days.' Other participants recalled medical interventions that reflected the superstitious nature of folk medicine now more often referred to as 'traditional medicine.' This had a long and persistent reach. DD recalled what she was told of a serious childhood illness she had experienced. Conventional medical treatment available at the time seemed to be ineffective but she described the only options available - prayer and, in the way, of traditional folk medicine, providing a way for the illness to exit the body:

> Well, when I was a year old [in 1927] - I was told [later] I had meningitis. [I was] in Ruchill [Hospital] for a long, long time. The report line was out for me, and my father got the minister in Admiral Street Church to call to the hospital. He said a prayer. One of the people in the hospital suggested to my mother there was a chance, but she would need to sign some document and they explained to her what they were going to do…. They said they were thinking if they cut part of the toe that the disease would [pass] … She suggested my ear [instead] because the hair would cover it…. It is [an 'old wives' tale'], but… there's something to it. (DD)

Accuracy of Recall: I have already noted that testimonies can contain minor inaccuracies. One participant claimed that it was the practice manager (PMan_01) who diagnosed her diabetes.[38] She explained that she felt she might be diabetic, and she sought out the practice manager after her contact with the doctor, who seemed to underplay her symptoms. She remembers telling the practice manager about her symptoms and giving her a urine sample. The practice manager strongly denied the account, commenting that she would never have acted in this way, and it was much more likely that the doctor had requested the urine test after the consultation.

> She (PMan_01) said to me, 'Whatever is wrong with you? I don't like to say but you're looking

[38] In 1992 diabetes affected around 4% of the adult population, with a significant proportion undiagnosed. Most patients have Type 2 diabetes, which is associated with insulin resistance and excess body weight. This can usually be treated with weight loss and oral medication unlike the less common Type 1 diabetes where insulin injections are required.

> dreadful today.' She said, 'See me when you come out after seeing the doctor'. So, I did… I went out and told her. She said to me, 'Let me see what doctor has given you'. She said, 'Did you take a sample of your urine?' I said, 'No, I didn't think about that'. She said, 'Well give me one now and I'll test it for you, and I'll take it in and see doctor.'

In another story the participant's recollection is that the diagnosis of pregnancy was given to the patient by the practice manager. She again explained that she would never give such patient medical information. DD recalled:

> Then it dawned on me that I hadnae seen an illness[39]…. you sent a specimen away. Well, when I went back for the result of the specimen it was [the practice manager] and quite laughingly, she said, 'Well would you like to be pregnant, or would you like to be feeling the way you are?' I said, 'What!' She said, 'I'm telling you you're pregnant'. I said, 'You are joking'. Well, I cried the whole way home.

Patient Trust: I have shown how patient trust is a fundamentally important aspect of medical treatment relationships. This can take years to build and can influence patients co-operating with treatment and accessing preventive services, such as immunisations and cervical cytology. One participant BNg recalled that she thought that her daughter was dying during an asthma attack[40] but that she was reassured by the doctor's assessment:

> I thought she was gonna die. It was Dr Collins that told me, 'She can bring it on herself. See if she's in bother - which she is quite a lot - she's a bad, bad manager…. Dr Collins said, 'It is a nervous asthma' - She was fighting fit the next day. (BNg)

Where trust breaks down participants recalled the need to complain. LI felt that her the seriousness of her husband's chest infection, an exacerbation of chronic bronchitis, was missed by an out of hours doctor. LI came to see Dr Ockrim telling her:

> He was very ill, and I came down [to the surgery] and spoke to your son and he said, '…. I'll speak to my mother'. I said, 'I don't like to cause trouble, but I'm no' lettin' him away wi' it.' –

When trust breaks down it might never be restored. LI observed that her brother had an operation and was 'ripped open without giving him anything'. The illness is described in graphic terms though it seems hard to understand as a purely medical account.

> Well, my mother wasn't in favour of hospitals because I had a brother who had taken peritonitis

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[39] Period.

[40] Asthma is a common general practice respiratory problem, sometimes triggered by emotional or allergic factors. However, many patients die each year in acute flare ups.

> and took a cerebral haemorrhage in the brain, and they took him back to the hospital… They ripped him open without giving him anything. I can always remember that. She never had any faith in the Royal…. he ended up in the Western with spinal fever. He was blind, he was speechless, and he was paralysed. It was so heart breaking to see him.… They operated but the haemorrhage went over the brain, and he died.

Trust depends on patient understanding that the doctor will deal with any illnesses with competent efficiency.[456] One of the illnesses which participants recalled as challenging that trust was meningitis, as its effects in young children can be devastating.[41] Communication between parents who understood the behaviour of their children and hospital doctors who were unfamiliar with the child could be fraught as the following interviews described. Such acute and serious illnesses are challenging for doctors and parents.

> I was shattered, I couldn't believe it. We kept insisting that there was something wrong. Because it was our first baby, they just seemed to think they knew better, and it wasn't till the third time that they actually saw him taking a fit. Then they started to believe that there was something seriously wrong with him. (AK)

> Just a couple of years ago I had [fostered] a wee boy and when he got up on the Saturday morning he got up and his neck was sore, and his throat was sore, and I thought - that's meningitis. I phoned the surgery right away and the doctor came out and he said, 'Oh there's nothing wrong with him. He's kidding you on, tell him to get up and play.' All that morning I kept watching the wee fella and he was staggering, as though he was drunk…. So, I phoned stand-by and… they said, 'Right… We'll send you a taxi and take him right over to Yorkhill.' So, I took him over there, and he got a lumbar puncture done and it was meningitis.
>
> So of course, the next time I saw the doctor I told him what I thought of him. He said, 'I'm really sorry but I really did think he was kidding on.' I said, 'You should have listened to me when you came into my house.' (HNi)

In this next memory we have a child who had a history of febrile convulsions who has had frequent encounters with paediatric hospital staff. When he develops meningitis there is a reluctance of the hospital staff to make the diagnosis. The father recalled:

> The second time we saw the child doctor, yes and it was ok….. but they always say – 'a

[41] Meningitis can be difficult to diagnose in its early stages and the condition can be life-threatening because of the inflammation's proximity to the brain and spinal cord. Immediate hospitalization is, thus, essential. Because of the difficulty with diagnosis, there could be communication problems between doctor and parents who understood the seriousness of the situation.

> mother's instinct'. The next day, I came home from work, and I saw [him] taking one of the fits…. I took him straight to the Southern and this time they took us up to the children's ward. The doctor saw him taking a fit and the next thing he was called for a lumbar puncture. It was meningitis he had, and he was transferred to Yorkhill. (AK)

In contrast Dr Ockrim was credited with an early diagnosis of meningitis:

> They took her [my daughter] away. I think it was Ruchill…. I saw the doctor in the hospital, and I said, 'It couldn't have been meningitis then'. He said, 'Yes, I'm afraid it was. Only for your doctor's quick thinking - only very few doctors can diagnose that.' I had to thank Dr Ockrim for that. (JG)

Patient Communication: The last decades have seen significant improvements in communication between doctors and patients.[457] Yet, still many memories in the oral history, even of incidents which occurred during the 1980s tell a different story. MMf contracted the rare infection known as Legionnaires' Disease while on holiday in Spain. The diagnosis was never mentioned during the several weeks spent in Ruchill Hospital in Glasgow, having been admitted directly from Glasgow Airport, and it was only an overheard remark made when the consultant, accompanied by some medical students, passed by her bed that gave her the diagnosis. She heard him say:

> Now Mrs M went to Majorca a healthy woman and came back with Legionnaires' Disease. That was the first I heard it. I nearly took a heart attack because I never knew that. (MMf)

Chronic illnesses were often recalled by participants who felt that their symptoms were being misunderstood or, worse, mismanaged by hospital specialists. One participant, DR, with a duodenal ulcer, described how she had had 'stomach spams for two years and that she:

> kept telling the medical profession that there was something the matter with me and they kept telling me there was nothing the matter with me…. I felt I was going off my head …. because I am telling them that I was ill - and they are keeping telling me, there's nothing wrong with you.

Eventually, she came to surgery after an emergency admission and a duodenal ulcer was discovered. She said to the surgeon:

> You told me there was nothing the matter with me.' He just smiled and shrugged his shoulders.

Another participant, ZI, who had experienced an ulcer some decades ago recalled how after a major operation, removing most of his stomach, he still was unsure, actually 'frightened,' about how to tell the surgeon at a follow-up outpatient clinic how he felt:

> I was frightened to tell him [how I felt] in case there was something wrong. He said, '…away you go home and have a fish supper and a pint of beer'…. So that was me. (ZI)

One powerful memory elated to an episode of arterial occlusion that was missed on more than one occasion by a Casualty doctor who never expressed remorse over the incident which nearly cost the patient her leg. EX had initially been referred by Dr Ockrim to the Southern General with leg pains and the doctor there told her that:

> it was all my imagination, there was absolutely nothing wrong with me…. However, - the pain! I didn't know where to put my legs and the pain was still in both my legs.

After a second referral she was seen by the same doctor and was told that the pain was muscular and that it would pass. She was again told that 'it was all in my mind.' When symptoms worsened, she self-referred and again it was the same doctor, who said this time:

> 'Well, we'll admit you to Ward 15 since you're going to be so dramatic.'…. By this time, I was really in tears, because the pain was horrendous….

When the night sister saw the leg during the night, the vascular surgeon was alerted, and he warned her that there was a risk of amputation. However, the surgery was successful in removing an extensive blood clot.

When Dr Ockrim asked about the doctor who had refused to recognise her symptoms at the beginning and whether he had apologised, she said:

> …. the young fellow couldn't look at me. No [apology]. I think he was so embarrassed.[42] … He just slithered at the back. It was a bit embarrassing, but then I thought, I hadn't done anything. I only wanted help.

LNf recalled the problems faced after her mother's admission to Shieldhall Hospital, which by the 1950s served as the geriatric unit of the Southern General Hospital. Geriatric wards usually had a mixture of patients with disabilities of old age, including dementia as well as physical problems, often following a stroke. Patients who were mentally alert often resented being in the same ward as those who had advanced dementia.

> I was quite angry, because they sent her to Shieldhall Hospital. She shouldn't have been sent there really, because she was alright in her mind…. She was only there a day, and she was going right down so I went to see about it and one doctor said he had nothing to do with her going there… So, I went to see the Matron of the Southern General and she said to me that she should not be

[42] It is doubtful that the most junior doctor would have turned away a patient more than once without conferring with someone more senior. Perhaps there were others who should have been embarrassed too.

> there and for me to write a letter to the Medical Board about this. Then I seen the other man, the Superintendent and he wasn't all that nice about it at first… I eventually had a row down there…. I demanded to take my mother home…. and she came on after that

AK described, with great clarity his gradual onset of chronic renal failure, his lengthy struggles with haemodialysis, eventually leading to a transplant. The process in such an illness can be long in time and arduous for patient and family.[43] If things had been difficult for the patient, they had often been fraught for the wife, and extended family and the anxiety and tension lasted beyond the dialysis to the aftermath of the transplant. The arrangements for his discharge caused further upset. She explained:

> …. the hospital just put him out after a week [following the transplant] - it was dreadful. The service in the hospital - it wasn't their fault. There was lack of money, lack of funds. Two, three days after having his transplant, I went up to visit and he was sitting in a day ward and was still connected to tubes and catheters and different things and he was in that day ward the whole day, because they never had a bed for him…. He got bed rest here and better service here, but I was dead apprehensive when he came home.

One participant felt distressed with the advice given by her hospital registrar obstetrician, and she left the hospital ante-natal clinic and made straight to Cessnock Street to be reassured by Dr Ockrim. However, the registrar wasn't finished with her as the second part of the memory shows:

> I think it [the pregnancy] really was the way I expected it to be, other than one doctor, I think she was a registrar and I had heard stories about her. Well, not very good ones…. She had measured me with an inch tape and hummed and hawed and hadn't appeared happy, but she hadn't said anything, and she just said, 'Come back in a month'…. She obviously was thinking there was something not right, but she hadn't said anything.
>
> When this particular doctor came round the ward when [my daughter] was born, she said something about 'Well it's definitely a very small baby, I'm just going to underline this'. I thought this was really childish. She was just trying to show me that she was right. [She] was fine and she's not exactly a small child now. (KNk)

Two participants recalled being told that their babies had died only to discover subsequently that they had survived. One recalled that:

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[43] Successful haemodialysis, which removes waste products such as creatinine and urea developed only around 1960 beginning as a hospital procedure. The first kidney transplant in Glasgow was performed at the Royal Infirmary in 1968 but subsequent transplants were carried out at the Western Infirmary and from 1972 at Stobhill Hospital which focused on supporting home haemodialysis patients and their carers.

> '[then the baby] was born and there was nobody there. No nurse, no doctor. They discovered that he was still alive.'

Another (EX) was told by the doctor that:

> 'the baby was dead and unfortunately: they would have to section me'…. that was the only sad part about it, nobody had come [after I awoke from the section] and told me that the baby had lived.'

The relief at the survival of their babies seems to have outweighed any need for an apology for such misleading information.

Communication with Cancer Patients and their Families: The diagnosis of cancer appeared to be the most feared by participants in the oral history study; consequently, it was one of hardest topics to discuss. Else-Quest and Jackson note that until recently cancer was synonymous with death.[458] They note that stigma may be associated with cancer for being a lethal disease and some cancers may be stigmatized for other reasons, such the connection between lung cancer and cigarette smoking. Its treatment may be identified with alopecia and its manifestations may produce marginalisation due to shame and negative self-image leading to mental health issues.

If accepting the truth was difficult for patients, telling the truth was often just as difficult for the doctors, educated in an era where patients were not to be told a cancer diagnosis. [459] As students and young doctors we were told that a diagnosis of cancer would deprive patients of hope.

The idea of an incurable disease was hard for many clinicians, displaying traditional paternalism, to accept and consequently the burden of disclosure was passed to the GP.[460] Euphemisms were used instead if in the patient's hearing.[44] Even when doctors began to divulge the presence of cancer to patients it was not being done in an empathic way.[461] Although the average general practitioner will only look after two such patients to the end of life in a year, home care will be provided for four more patients before the final event in hospice or hospital. I will show, through the memories of cancer within the family, how these recollections shed light on the relationships with doctors and other health care workers and how these relationships changed over time as society became more open about the diagnosis.

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[44] Expressions like neoplasm and mitosis were often used.

The concept of terminal care was virtually unknown before the 1960s.[462] It was left to pioneers like Dame Cecily Saunders, who created the hospice movement and began to focus on a patient-centred approach with a better approach to pain relief.

> I think she [my mother] really knew all along [that she had cancer.] I think she knew she would never come out of hospital. Probably she knew before we were ready to accept it…. (KNk)

This reluctance to tell the truth to patients persisted into more recent times. Patients, or their families, would return from the local Chest Clinic saying that they did not have cancer while the letter from the clinician indicated otherwise. Interpreting the exact words that had been used at the hospital it was clear that the consultant had been using language as a subterfuge to avoid telling the patient the truth.[463] ZNg remembered that it was the family that received the diagnosis after bronchoscopy:

> …. we were told [the diagnosis] - I didnae want to know and they told us then - eight weeks, which was - It was the most horrible thing, and I wouldn't accept the fact.

In fact, the patient survived for more than two years, staying at home to the end, having refused treatment other than pain relief and relying on practice and family support. The key sentence in the recollection is that 'Dr O'Neill was great, and he explained what was going to happen.':

> If we needed - no matter what we needed, we were to phone the surgery at any time - day or night. We couldnae have asked for a better doctor than Dr O'Neill and the care that he gave my mother.... She looked forward to dying and she looked forward to that boy coming. I mean, she would make an effort to wash her face, comb her hair, spray her deodorant. (AMg)

VF recollected that his wife was diagnosed with lung cancer in 1963 but she was given the impression, which was never corrected, that she had TB. Non-smokers can develop lung cancer through passive inhalation of tobacco smoke or other pollutants.

> She was sent down for x-ray and they instilled in her the idea that it could be TB…. She died thinking that.

HN also remembered that his wife didn't know what she had:

> It was pains in her back as far as she knew and when you've got pains in your back, in those days, it was pains in your back. You never for a minute suspected that you had cancer in your womb, in these days. (HNa)

> I had a feeling that she knew [she had cancer]. Only once, she said, 'I don't like my colour, I think there's something deeper than what they're telling me.'(LNl)

> She knew she was going to die. She refused to accept the fact. No-one was to mention the word

> cancer - no one, not even Dr O'Neill, not even the priest and no one was to mention cancer…. but she wanted - if she was going to die, she wanted to die in her own home, with her own family and we gave her her wish - I felt, my mother kept her dignity. (ZNg)

In recent years there has been a greater readiness to inform cancer patients of the diagnosis. This has, of course, to be tempered with an understanding of each patient, their psychological make-up and their response to hard news. Properly handled, home care can provide the patient and the family with the support that they need through the hard times that are consequent with a final illness. However, some participants found that the great openness could also be stressful and sometimes, the condition progressed so rapidly that patients and their families struggled to cope with its emotional impact.

> She knew she was going to die. She refused to accept the fact. No-one was to mention the word cancer - no one, not even Dr O'Neill, not even the priest and no one was to mention cancer…. but she wanted - if she was going to die, she wanted to die in her own home, with her own family and we gave her her wish - I felt, my mother kept her dignity. (ZNg)
>
> My aunt was told, in the Western that she had cancer. She didn't want to believe it. She never told us she had cancer. I seen my aunt bottling this up. In one particular ward in the Beatson [cancer hospital] most of the women in the ward had lost their hair and she turned round and said to me one night, this is the wrong ward for me…. She said, this is for people who are terminally ill. Then she was advised to go to a home in Duntocher - a hospice. She was in the hospital the time, and I told a wee white lie. I went down myself one night and she broke. She said, 'I don't want to go in there'. I said, 'There's nothing wrong with it'. I said, 'You only go in there to try and get yourself better'. She said, 'Do you really believe that?' I said, 'Of course, I believe it'. (ZG)

> I had a feeling that she knew [she had cancer]. Only once, she said, 'I don't like my colour, I think there's something deeper than what they're telling me.'(LNl)

The concern about cancer could lead patients just to accept treatment without questioning. As LNa indicated 'I didn't ask [what had been wrong]. Not being in that frame of mind, I didn't worry, as long as it wasn't cancer.' Sometimes, it can be hard to pinpoint the primary cancer lesion early on. The following daughter's account is of a patient whose first symptoms suggested a lung lesion, and then possibly bladder disease before a spinal tumour was diagnosed after a body scan.

While the word tumour did not immediately alert to the diagnosis of cancer, GH did recall that she 'had a funny idea that it was a cancerous tumour.'

> They took him to neurosurgical and did all these tests on him and then they discovered he had a tumour in the spine…. They said it was a tumour, but they didn't know what kind of tumour it was. I had a funny idea that it was a cancerous tumour…. the doctor spoke to me. He said, 'I'm sorry to give you the bad news, but it's not very good. I think your dad is going to eventually just pass away.'

In another memory ZR describes how his wife had breast cancer alongside episodes of anxiety and depression during and after the treatment despite being reassured that the cancer therapy had been successful.

> Other than that, she enjoyed good health until this depression set in…. Of course, she had to get one of her breasts off for cancer. … Sir Robert Wright[45] said it was malignant and the breast would have to come off…. He said, 'She is taking it very good and she's happy and accepting it'…. [When she came home] She wouldnae let me go in when she was undressed, but the wound was leaking, and she was having to dress it herself in the morning…. She got the all-clear [but] if I tried to get on that subject [of the cancer] she would say, 'Oh, don't talk about that.

LN struggled with her sister's cancer of the tongue:

> They took out all her teeth and cut her tongue and then they took away the glands. Then they took away the muscle. I used to feel so vexed. I just thought to myself, what they're putting her through and the time she's got…. They put radium in her tongue. When I went up, they warned me before I went in…. [They] said 'don't show any emotion because she really isn't pleasant to look at.' She had radium needles right the way down and she couldn't speak, but she could hear, and she would write down, 'The birds sound beautiful today, I've been listening all morning to them.' I used to think, 'How can you think like that? - the state you're in.'

The fear of cancer and the reluctance by many clinicians to be open with their patients led to suspicions by families that a cancer diagnosis was being withheld.

Of course, not every illness can be resolved easily. The following is an account of a persistent problem which, despite many visits to the hospital for investigations, and treatment, including surgical procedures, never seems to be resolved satisfactorily. The patient was worried that information was being withheld and that she might have had cancer. In the end she just remarked:

> I get aboot wi' it. There's nae use in complainin' aboot it, is there? I couldnae sleep and I

[45] Sir Robert Wright DSO OBE (1915 –1981) was President of the General Medical Council of Great Britain, former President of the Royal College of Physiciqans and Surgeons of Glasgow and Surgeon-in-Charge at the Southern General Hospital from 1953.

> was up during the night screaming wi' it. I couldnae walk and I couldnae get up and doon stairs. I was demented wi' it by this time. It was worse than it ever wis…. When I went back out to see the Orthopaedic Surgeon, he said to be truthful he didnae know what it was. … Well, I thought I had cancer. This was the second time he was saying he would discuss it with his colleagues and I definately thought I had cancer. He kept saying to me it was nothing nasty and I kept saying to myself, well if it's nothing nasty what' all this they've got to discuss. (LD)

Communicating the Diagnosis: Some participants described the uncertainty of not knowing a diagnosis, even of significant illness. With multiple sclerosis there was a reluctance to tell patients the diagnosis until the condition was definitely established.[46] IT recalled:

> [My daughter] said she knew what was wrong with her before she went in. She said to Dr Grieve, 'I know what's wrong with me'. She told her she had multiple sclerosis…. When she came out, she says, 'I'm crying with happiness, because I know what's wrong with me…. They don't have a cure for it, but I'm quite reconciled to the fact that I've got it.
>
> After that I heard no more about it.

QM described the story of how her husband, a successful businessman used to private hospital care, had a heart attack diagnosed around 1975:

> … [A friend] took him to the Royal, and they told him that they only did Health [Service]. He said, 'Well take me to the Victoria.' They said, 'You are going nowhere, but into Intensive Care.'

The hospital care following the diagnosis changed his views on the NHS and he gave up his subscription for BUPA which had covered him for private hospital treatment.[47]

LNf described her development of thyrotoxicosis [an over-active thyroid]. Listening to her account the symptoms of thyrotoxicosis seem so obvious that one wonders why it took so long for the penny to drop.

> [Dr Russell] sent me to the Southern General and I was there a number of times before they discovered. There was three doctors and they all took me and gave me the same examination and then when they were finished with that, they went away and had a consultation about it. Dr Kirkwood…. said to me, 'Well, we have all decided that you've got an over-active thyroid.
>
> One recollection concerned the return to Scotland from America of a patient who had emigrated

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[46] Multiple sclerosis is a disease of relapses and remissions where the coverings of nerve cells in the brain and spinal cord are damaged. This damage disrupts the ability of parts of the nervous system to transmit signals, resulting in a range of signs and symptoms, including physical, neurological and sometimes psychiatric problems

[47] He lived outside the practice area, but he and his wife joined the list when his wife, in her 40s, was looking for a GP who would deliver her at home.

many years earlier but, dissatisfied with her diagnosis and treatment in America, decided to return to her sisters in Glasgow, following a colostomy operation in the States. LM described how the treatment in Scotland proved to be curative, confirming the family belief in the superiority of Scottish medicine, and the surgeon from the Victoria Infirmary did not mince words with the surgeon in America.

> She had about three or four different operations in and out…. [over] about 6 weeks. It was truly amazing the difference in her eventually. After a spell she went back to America. When she went back everybody - they couldn't believe it…. However, she went to her own doctor…. and she said, 'Don't you see a difference, doctor?' He said, 'Oh yes, I remember you, your doctor in Scotland wrote and called me a butcher.' (LM)

IK described how her daughter was admitted to hospital with profuse rectal bleeding. Again, the precise diagnosis and management eluded the surgeon in Glasgow, and this led to a sequence of events ending with a specialist in London who was performing a new procedure called an Ivalon sponge rectopexy.[48]

> Eventually Mr Tankel [the surgeon] [49] sent for us himself and he admitted that she was having substantial bleeding, but he couldn't find the source. He was bringing in a second opinion…. His words were, 'I'm a consultant [general] surgeon, I'm not a specialist. I feel she should be put into the hands of specialists.' He said, 'I'm afraid it'll have to be London.' (IK)

The final recollection here describes the following of a patient LH with such chronic constipation that eventually major surgery had to be carried out. After many investigations the first surgeon said that he thought that 'it was a psychological problem' and that she should be referred to a psychiatrist. She disagreed with the suggestion that the condition was psychological, and I recalled making a referral which led to an operation which gave her many years of respite as she recalled below. She recalled that the surgeon indicated that this would be his first time carrying out the procedure, in around 1982, though he was able to publish a study of his experience with the operation in 1987.[464]

> …. from there I went back to Dr Collins and Dr Collins agreed with myself that I didnae need a psychiatrist and he asked me if I was willing to give it one more go, and he sent me to the

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[48] Normally carried out for complete rectal prolapse. Harold Ellis, (1926-) Professor of Surgery in the University of London, described as one of the most outstanding surgeons of his generation, started using the technique in 1961. All costs for the patient and her mother were covered by the NHS.

[49] Henry Tankel (1926-2010) consultant general surgeon at the Southern General Hospital in an era where the Surgical Department performed operations, such as prostate and thyroid surgery, now normally carried out by specialist surgeons. He had a distinguished role in medical politics and was a leading figure in Scotland's Jewish community.

> Western. [They referred] me to Peebles-Brown at Gartnavel General and he took me in for a week and he x-rayed me and done all sorts of tests and things. He said that I would need this operation, but this would be the first time that he was actually performing the operation.

Communication with Children and Parents: Care of children is an important part of general practice, and the testimonies show how their children's illnesses were seen, as well as the interaction of parents with the healthcare professionals. Hutchison notes that it was not until the 1986 edition of Sacharin's *Principles of Paediatric Nursing* that nurses were recommended to obtain a rapport with the parents and to understand the psychology of their young charges.[465] Parents and children were kept apart. One patient remembered:

> I was in hospital for scarlet fever. I remember when you go to Belvedere, [with an infectious disease] your parents weren't tae get in then. When you went in there was a waiting room [for parents to see their children] and a long wall with windows along the top. The nurses, whoever came to these windows, and you gave them your whatever, for your child, and the parents spoke to whoever was above. (LI)

Study participants recalled the difficulty of parent and hospital staff communication in the early days. Others were more concerned by the memories of hospital visiting which restricted access of children to their parents. In this memory, the parents eventually made the decision to take the child home where fortunately, the symptoms just disappeared.

> I think he was a year and four months. He had just started to toddle - This morning I got him up and he couldn't stand. His legs just kept going away from him… He got an ambulance and took him to the Southern and they kept him in there for ten days and they didnae discover what had brought that on. This day I'd been down - the wee soul - he was tied to the end of the cot. (INa)

Given the mother's anxiety, the father brought the child home where he made a rapid recovery. Another parent recalled that he and his wife 'weren't all that pleased with the hospital there.' The staff were described as 'too domineering' and 'they weren't nice to the kids at all. He said that he didn't take the matter up with the staff as that would have 'upset us more'. (VK) A mother, with experience of a handicapped child described the attitude of the obstetrician as:

> all wrong - he would examine you - no conversation and look doon on you and back oot the door again.' She finished 'Maybe it was just me, I don't know.' (LH)

For Dr Ockrim, the relationship with parents and their children was important from the start. She was determined to help parents see their offspring develop their full potential. The wall of her consulting room was filled with the pictures that her child patients, or their parents, had

given her over the more than forty years of her practice. The presence of a familiar face could also provide reassurance for a sick child facing a clinical examination. She recalled:

> Children used to bring in the photographs that they got taken at school and of course, when they came in, they liked to see their pictures on the wall.

There were several accounts where doctor-patient communication was difficult. One condition was what today would be called Attention Deficit Hyperactivity Disorder (ADHD) but when the following diagnosis was made such children were labelled as 'hyperkinetic,' or even just called maladjusted. Consequently, there was a limited understanding of the disease process and what could be done to help child and family. One mother looks back when the son has reached the age of twenty-one clearly only managed within the practice without the use of Ritalin (methylphenidate), now the current drug of choice.[466]

> He was hyper-active as a child. I just felt I wasn't getting through to him. He was only eighteen months old or something and I felt I was smacking him a bit too much…. Eventually I got to a pitch, and I came down to yourself…. I remember saying, 'Dr Ockrim, is he all right mentally?' That's when you said to me, '… he's hyper-kinetic.' (HK)

Her father had been concerned with the child's behaviour and his daughter's response to it but was reassured by the GP's opinion: "Well that's alright if Dr Ockrim said it. If I thought it was anything you had done.…"

Another memory was of two years spent in hospital after an unspecified event. She did recall that neither she or her parents had any knowledge of a diagnosis, or that she received any treatment before eventually being discharged.

> I got a fright, during the black out in 1939…. I was in Yorkhill Hospital for a year and Stobhill Hospital and then a year in Drumchapel.[50] [No treatment], just complete rest. I enjoyed it, believe it or not, I really enjoyed it. (RNr)

In an emergency situation it can be difficult to make the right decision and sometimes the advice from professionals can be challenging even if later they seem to have made sense. LH, the mother of a profoundly mentally and physically disabled baby, recalled:

> It just happened one day…. when I walked into the ward, I could see doctors and nurses running everywhere, I never thought for a minute that they were at my son. He [the doctor] came in and said, 'I don't think your son is gonnae make it, he's just taken another attack and he's in a coma'…. He said, 'My advice to you is, I don't want you to go in'. I thought no. I didnae like it.

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[50] Drumchapel Hospital: then regarded as a hospital annexe for convalescence.

> Looking back, he was obviously right…. but you don't really think at that point.

One participant ZI described how his mother managed to convince the surgeon to remove his tonsils, a procedure widely acknowledged to be of doubtful benefit.[467] He mentioned how 'Tonsil cutting was a fashion then. You never hear much of it now….'[51] As he had no sore throat or other symptoms, he reckoned that the surgeon decided to operate 'for a quiet life.' He also described the experience as being 'quite traumatic'.

> There was a whole lot of little children, and we were all herded along to the operating theatre, and I had one of the babies to carry and we sat outside the door of the operating theatre and the children went in one by one and the terrible thing was that they came out facing us…. there was blood all over their face and running down their fronts and this had a terrible effect on us.

Of course, in more recent years facilities are provided for parents to be in hospital with their children. A mother whose son was undergoing cardiac surgery recalled how she welcomed the opportunity to be able to stay in hospital with her children:

> Oh yes … I don't think I could have got through it otherwise…. because before his operation, obviously the medical students want to learn all about the different heart complaints, and he was being taken away all the time and I was pleased that I could be with him when there was all these strangers examining him. (KNk)

Patient Support Groups: Sometimes the ongoing support and counselling of patients falls beyond the scope of general practice – and patients may turn to widely available support groups.[468] I have described participants contact with support groups such as Alcoholics Anonymous and the Schizophrenic Fellowship in a previous chapter but there are many other groups dealing with everything from Bereavement Counselling and Coeliac Disease to Leukaemia. Two mothers described their relationship with support groups, while acknowledging the positive response within the medical practice. Different parents have different expectations of such groups, but they are widely acknowledged to be helpful in providing information and emotional support. The first mother benefitted both from the counselling and information provided and was prepared to speak to other parents; the second acknowledged the support she had received from counsellors but was much more ambivalent in speaking to other parents and

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[51] This memory relates to a period before World War II, but tonsillectomy remained a popular procedure until the 1970s. Indeed, tonsillectomy had been such a widespread procedure that the stories of the operation being carried out on the kitchen table were part of the legend of general practice.

getting involved in group discussions. These thoughtful testimonies describe the benefits and some drawbacks of patient groups, and the comment that a doctor might not warn of the risks of a procedure would not belong today.

> I've been attending an Association for Children with Heart Disorders, and a lot of people don't always want to know things that I wanted to know…. I asked a lot of questions…. I would have liked to have had literature to read.[52] I don't know that I was ready for the Association before [the] operation. I think I was too nervous about what the future would hold… I don't think a doctor will say, this might happen or that might happen. You have to ask questions.
>
> There was a social worker in the hospital and before [the] operation I went along to a meeting…. Two of the other mothers that were there, their children had had their operations the week before. Those mothers were quite relaxed and ready to ask questions, but I wasn't…. So, I think maybe the time is after the surgery, when you're more prepared. (KNk)

KNo described her experience having a cot death at home and how it affected the life of the whole family. She changed practices because of a lack of understanding of her emotional needs.[469] She explained how the practice were able to support her at a vulnerable time and makes it clear that patient support is more than just the prescription of Valium.

> It was a cot death. I just felt the [previous] GP's attitude was very rigid. I always felt he made all the moves, and he dictated the terms on which our relationship was going to be based and it was very much a doctor-patient relationship, in the old-fashioned sense, rather than being a person-to-person relationship…. He came up and left a lot of Valium and didn't come back again.

On moving to the practice, she recalled that 'as a practice, the doctors I go to are very supportive and you form a relationship with them which I never really did [before].

She recalled the support provided at the Royal Hospital for Sick Children:

> Well, the Cot Death Trust at Yorkhill[53]: we went to see them, but that was completely of our own suggestion. They were wonderful. I can't praise them enough; they were just wonderful. Just the way they talked to you, the way they treated you. They sent a health visitor to come and see us and kept in touch. To know that it happened to other people.
>
> No, there weren't very many people locally who had [a similar experience] and I didn't really want to [speak to other parents] at the time. I can't really remember why now. I think I felt my own experience was so intensely personal that no-one else could possibly understand what it

[52] None was available at the time.

[53] The Scottish Cot Death Trust was founded in 1985 to provide support for bereaved families and educate the public and professionals about sudden unexpected death in infants (SUDI). It is based in Glasgow but offers its services throughout Scotland.

> was…. Now I think I'm wrong, I think they probably could have, but at the time I didn't. [Self-help groups are good] for people who prefer a communal experience rather than getting over things by an effort of your will, then they provide a great deal of support.

Different parents have different expectations of such groups, but they are widely acknowledged to be helpful in providing information and emotional support. The first mother benefitted both from the counselling and information provided and was prepared to speak to other parents; the second acknowledged the support she had received from counsellors but was much more ambivalent in speaking to other parents and getting involved in group discussions. These thoughtful testimonies describe the benefits and some drawbacks of patient groups, and the comment that a doctor might not warn of the risks of a procedure would not belong today.

> Any time I've been in, I feel that I could stay there as long as I liked and I'm the one who decides to stand up and go, which is a great feeling.

Fostering: Fostering children was a topic mentioned a few times by different participants. General practitioners are involved during the fostering process as medical assessments have to be carried out regularly and they provide the care for the fostered child while they are with the family looking after the child. I recall examining a young child, in the presence of the social worker, who had been abused by a foster parent and I remember well the anguish of the social worker who had believed that the child had been placed in a safe environment. Social workers assess the family and help to engage them with support and clinical services but does not contain a mental health treatment component.

The provision of foster care has been a difficult area for local authorities to monitor, as they try to ensure that foster parents provide the 'nurture and unconditional love (that) are fundamental to caring for damaged and vulnerable children'. [470] Intervening with the most vulnerable children in their very early months and years of life can reap large rewards for that child, the family and the whole of society. At risk children have major health and lifespan risks and those with an early persistent conduct disorder go on, as adults, to commit half of all crime. There were problems noted in securing safe, nurturing permanent placements for abused and neglected children, many of whom moved to and fro between maltreating birth families and temporary foster placements.

One of those interviewed became a highly skilled foster mother, caring in the short term with children who had social and health issues while bringing up her own family. Some fostering was carried out within the framework of the Social Work Department but historically

arrangements could be more informal

> The children that we get in are actually on a place of safety order, with it being a crisis situation they're coming in, in and the parents know that if they keep that child then they will get into trouble with the police.… I've got to say to them, 'Well look, I know you've told me this, but I've got to tell the social worker, or I will get into bother'. They'll say, 'That's ok, but do you mind if I try and tell her before you'. The fostering situation could be a lot better. You could put a lot more support from the social workers than you do get…. (HNi)

> Yes, my brother-in-law was left with the three kids and then he couldn't cope and that's when he started to drink… So, the social worker came up and seen me. They came up to see me and I told them I had been helping with the kids…. He says, 'If you want, I can put you on to fostering if your brother's agreeable and you'll get money to help you out tae keep them.' So, it all sort of stemmed from that and I'm their foster parent right up tae [they] left school there and started work. (BE)

> This big Irish priest kept saying to my mother, 'You know, if you take that child and bring it up, you're not losing out because you've just lost a child and God will put all the graces upon you and I can assure you that your husband will come back safe and sound [from World War I]'. (LM)

Coping with Loss: Many participants talked movingly about the death of family members, many as noted, were related to terminal care of patients with cancer but also following other diseases. ZT made no reference to religion during the interview but his mother's terminal nursing care, in which I was closely involved, had an unexpected and almost spiritual quality

> Strangely enough but those last few weeks for me were quite special, I got very close to my mother then and also, I found it quite, in a sense, exhilarating, because I had never seen a death before like that - She seemed to have a lot of peace at the end. It was a great understanding of what death was about, I suppose, and I'm quite content about it. (ZT).

The loss of a baby could have a profound effect on the family. One participant (CM) recalled 'Yes, it was [a terrible tragedy]. She never got over them, my mother' and the family maintained a weekly visit to the cemetery for many years. Other participants remembered their own experience of stillbirth. One mother (DD) had experienced a fall and she recalled 'I had 'I had twin girls and lost them. That was a fall I had. I was full time.' Another mentioned the loss of a grandchild with spina bifida, who was 'dead on delivery'.

Changing Attitudes: Participants recalled changes in society which affected their relationship

with their doctors, nurses and paramedical staff. I have already described the greater openness to a diagnosis of cancer which has come along with better treatments and public awareness. Changes were obvious in other areas to. Authority was more likely to be challenged when good reasons could not be given for maintaining outdated practices:

> Well, I'm older and I know a lot more and I think nowadays - then you kept your mouth shut - you did as you were told…. Now, I think with experience, you do question things, and you say, 'Well is that right?' (BC)

Various changes were remembered. One theme that emerges with many of the older patients is the prevalent level of sexual naivete. 'I knew what you had to do I suppose, but I can assure you that I was a virgin when I got married… Even when I'm talking to you, I can feel my heart going.' (EL). Some female patients were reticent to talk about intimate and sexual matters even with a woman doctor. There were examples of adolescents being terrified by the appearance of a first period and the colloquial term for menstruation was often described as an 'illness.' One participant (ZR) said:

> You didnae discuss these things. I was quite ignorant. It was mainly my grandparents that brought me up and her mother was very straightlaced and she wouldn't discuss anything like that.

The embarrassment about sexual matters extended to gynaecology investigations.

> Well, if you really want to know [why I've never attended the Well Woman Clinic] it's because I get the smear - I've never even had an internal. I've never…. and I think I'm actually frightened. (BE)

In the previous chapter we encountered a patient who had accompanied her father to the surgery and had seen how Dr Ockrim had been able to confront her father about his drinking problem. However, there was a deeper and far more serious problem, unacknowledged at home and which was only communicated to her doctors decades later after a television programme brought the whole issue into the public domain. She had been experiencing physical and sexual abuse at the hands of her father, possibly even with the knowledge of her mother. She felt unable to confide in family members, but she did open up to a school friend. This was far from producing any resolution.

> Aye, I had a pal and her da' was da'en the same thing to her…. I told my pal that my da' took me to bed and she said, so does ma da'. We were all quite young. (DM)

The abuse continued into the next generation with her brothers abusing her daughters. It was only at this stage that she and her daughters finally decided to challenge their abusers. She

explained what had changed. In the early days she felt that she could not approach a doctor:

> I felt you had more power over him [my father],[54] but at the same time I couldn't talk to you about it…. Aye, I felt kind of close [to you], but no' close enough to tell you.
>
> I think it's fear from the person who's dominating you. I think that person that's dominating you had got more power over you than what a doctor would have.

She recalled eventually visiting me and my spending a considerable amount of time with her and one of the daughters. I remember counselling her of the risks in taking their story to the police and, in the end, DM had her day in court, but one abuser was found not guilty, and the other verdict was not proven.

Change seemed to be moving very slowly and she explained how it happened:

> I've learned to like myself. I learned to see that the things that was done to me was bad and wrong. That it should have never happened. I learned to dae withoot being hurt. It took me years to get over not being physically hurt. I had depression because I wisnae gettin' battered. I needed to be hurt. That was part of my life and I needed that.

She finally made the point that social workers and others are still learning to how to handle these cases, saying:

> I reckon that they could learn better fae a person that has been abused. The person that's already had to deal wi' it.

Adopting parents are now much more open in telling children that they had been adopted. One participant only discovered that she had been adopted when she received her pension book at the age of sixty:

> The reason I found out I didn't belong to them was when the pension book came through and they sent me a pension book …. I thought I had somebody else's pension book, so I ran up to the welfare place and asked to see somebody to hand the book back and apparently, I hadn't noticed [my name] at the end of it…. They said that it was the proper book - I got a fright. (CNk)

Changes in society led to the beginnings of a male role in supporting their partners during the birth process.

Special classes were organized for fathers so that they would have some familiarity with the delivery room procedures. KNo recalled mixed emotions over her husband's presence at the delivery:

> He [my husband] was quite happy to be there. I think he found the first one - he wasn't actually

[54] She had witnessed Dr Ockrim remonstrating with her over his drinking.

> in the room for the first one and he was in the room for the rest. I think I was quite glad…. I don't think he was any support at all, no. I think the pain is so excruciating you haven't really much time for anybody…. he was so upset at seeing me in pain that I had to pretend I wasn't in pain so that he would feel better.

Major changes also occurred from the old Glasgow system of health visitors in pre-NHS days. They were known as the 'Green Ladies', because of the colour of their uniform, who were employed by Glasgow Corporation. They offered advice on feeding, advocating breast-feeding, hygienic food preparation and domestic cleanliness. However, Green Ladies were not always well received in homes. Some mothers resented what they considered to be an invasion of privacy and people believed that health visitors were quick to criticise. Sister_02 recalled that the Green Ladies were 'held in awe' often because of their critical approach saying that:

> She was the person who told them who kept their house and who didn't keep their house.

One of the participants was aware that Dr Ockrim understood the tensions between the Green Ladies and their clients.

> …. the Queen's Nurses wouldn't come to Abercrombie Street, so I had to get the Green Ladies and you didn't like them very much… so, when I went into labour - she was that intent on me gettin' an enema, that you came to the door before she had me ready and…you weren't very happy. (HNa)

In more recent years the role of Health Visitors has changed from its paternalistic origins to be able to engage with new mothers and parents of young children in a supportive manner.

Dr Ockrim and Obstetrics Dr Ockrim entered general practice following hospital training in obstetrics and gynaecology and she had undertaken a brief course of anaesthesia using an open breathing system with gauze and ether or chloroform.[471] She was prepared to deliver at home, patients that many GPs were happy to refer for hospital delivery. These might include forceps and breech deliveries, twins and elderly primipara. Dr Ockrim was determined to work in a co-operative fashion with the community midwives. She had been concerned about standards in some of the private nursing homes in the area and campaigned for them to improve or face closure. Study participants had good memories of their home deliveries as the following representative sample shows.

> The home would win all the time. I don't think that a hospital is the place to be when you need sympathy and understanding…. What I felt was – it was my decision to do what I was going to do at home. (HNa)

> I booked my first baby at home, but complications arose… The second baby was born at home. Dr Ockrim, herself, delivered him in the house. I preferred the home delivery. It was a different experience entirely. There was no comparison. The doctor was there the whole time and attended to you. In the hospital you were left quite a lot yourself to get on with it, but at home you had a student, a midwife and the doctor in attendance and everyone couldn't be nicer. (GT)

> Well, they say I'm old-fashioned, but I still preferred a house birth to a hospital birth. I believe in that. I think there is a closeness to the baby, plus if you have got any other family, you are there, and to me it is a happier feeling. My mother had six of us all in a room and kitchen [without an inside toilet]. (RNc)

Not all home deliveries proved to be straightforward. Two participants remembered Dr Ockrim performing a forceps delivery one time with the mother improvising the use of an anaesthetic and on the other occasion with the help of the patient's sister.

> The nurse hadn't arrived, and I was having difficulty…. and you said to my mother, 'You put that on - that mask and I'll leave my hands free for a minute' and you …. got forceps and that was how you delivered her. (HOa)

> You told me to go straight home [from the surgery] – yes, I was in labour. It [the anaesthetic] was a thing you put over your face. My sister stood at the top of the bed and held this thing – it was tiny drops. (GT)

Obstetrics in General Practice: Fitting in the time for home or nursing home deliveries while having a practice with fixed consulting times meant a constant juggling of commitments. Patients were very appreciative of the input of the practice doctor and midwife for home deliveries and especially when the delivery involved a considerable amount of time. In the early days of the NHS Dr Ockrim might have attended a difficult forceps birth during the night after a busy day in the practice with another busy day to follow.

The oral history study covers memories of childbirth for over forty years. The era begins with most births taking place at home, continues with the increasing medicalisation of childbirth so that it is now uncommon for any births at all to take place outside hospital. During these years the involvement of general practitioners in intra-partum care declined. Some GPs, like Dr

Ockrim, continued their obstetric work in nursing homes or hospital GP units but even this gradually declined. The case against GP or midwife led deliveries follows studies which show that there is a high rate of transfer to specialist services which canno0t be predicted in advance.[472] Though local budgetary issues severely curtailed choice, the National Childbirth Trust briefing included the statement in 2011:

> All pregnant women should be able to make choices about their planned place of birth. There should be sufficient provision of midwifery-led services, based on a social model of care, to meet the demand in all areas.[473]

In this section we will examine the patient attitudes to GP pregnancy care, follow the changes that occurred and understand what was important to mothers. Many patients remembered the early years of NHS hospital provision and concluded that home was the better option and greater acceptance of hospital deliveries only came with the provision of upgraded facilities or even new buildings for maternity care.

> Better [with a home delivery]. Well, I can only go back to the conditions of the Southern General at that time. They had two wards, and two toilets. You didn't get the attention that you get now. That was the most wonderful thing that ever happened in Govan! It's sheer luxury. They would rather go in there now, as have them at home. They get peace…. But in the Southern years ago, I wouldnae wish that on anybody. (FS)

> Stobhill, I think is very run down…Even my maternity treatment – it was OK having the baby, but things like the ward – You were going for a bath, and you had to make sure that you had thoroughly scrubbed the bath before going into it. You were finding yourself wiping things down before using them. (FK)

Nursing staff did not tolerate difficult behaviour. One participant remembered that the woman in the next bed was smacked because she had been screaming. The Sister said:

> 'You're upsetting everybody else. You've already had three kids and thae other lassies have no' had babies and you're frightening them - behave yourself!' So, she got scudded[55]… (HNa)

In recent years paternalistic attitudes in the wards changed. Even patients who had babies a few years apart noticed significant change. For older patients, who had always accepted authority with simple obedience, there was the beginning of understanding that some procedures were optional, and maybe even questionable. KNo recalled:

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[55] Scudded: slapped or smacked (Scots)

> I think when my oldest was born there was a kind of rigid routine in the hospital. You had to do this, you had to do that. You weren't allowed to pick up the baby. It never occurred to me after she was born that I could pick her up any time I wanted. I felt she still belonged to the hospital. I picked her up to feed her and change her and I put her back down and that was it…. By the time the youngest was born [nine years later] it was a far more relaxed atmosphere, and the nurses would sit on the bed and chat to you, and you would call them by their first name instead of Sister Starched Apron giving you a row because you weren't eating your sprouts.

One participant KNk felt distressed with the advice given by her hospital registrar obstetrician, and she left the hospital ante-natal clinic and made straight to Cessnock Street to be reassured by Dr Ockrim. However, the registrar wasn't finished with her as the second part of the memory shows:

> I think it really was the way I expected it to be, other than one doctor, I think she was a registrar and I had heard stories about her. Well, not very good ones…. She had measured me with an inch tape and hummed and hawed and hadn't appeared happy, but she hadn't said anything, and she just said, 'Come back in a month'…. She obviously was thinking there was something not right, but she hadn't said anything.
>
> When this particular doctor came round the ward when [my daughter] was born, she said something about 'Well it's definitely a very small baby, I'm just going to underline this'. I thought this was really childish. She was just trying to show me that she was right. [She] was fine and she's not exactly a small child now.

Deliveries: Hospital vs Home: In his book *The Division in British Medicine: A History of the Separation of General Practice from Hospital Care, 1911-1968* Frank Honigsbaum described the British separation of hospital, and consultants, from GPs and the community.[474] With the establishment of the NHS, GPs were excluded from the hospital and given the role of gatekeepers to the specialist services in the hospitals. This was to have major implications for the provision of obstetric care in general practice. Training doctors to manage increasingly more medicalized intrapartum care gradually required more training time than could be provided for GP trainee programmes. In addition, the increasing time constraints at GP surgeries reduced the ability for GPs to conduct deliveries.

When the NHS began general practitioners were responsible most of their patients' deliveries. Around half were conducted at home and others in the private nursing homes around

Glasgow but by 1975 virtually every birth took place in hospital. Major changes in the delivery of maternity care followed Sir John Peel's Report of 1970 which stated that every woman should have access to hospital care when giving birth.[56] The Report's aim was to reduce maternal and infant mortality, but the move had a profound effect on domiciliary midwifery. It was becoming difficult for general practitioners to get enough of a caseload to maintain their expertise as participation during labour was limited by other commitments. The Royal College of Obstetricians and Gynaecologists reported in 1982 that 'it is not possible to predict with accuracy which labours will be uncomplicated' and they hoped 'few, if any, pregnant women will be delivered at home.'[475] Bull considered in the 1980s that the general practitioner accoucheur will still have a role but heroics in his or her field will no longer be appropriate.[476] The primary lesson seems to be the need to balance patient safety with the level of care that patients expect.

An *Occasional Paper* of the Royal College of General Practitioners (RCGP) in 1995 pointed out that the basic structure on which health care in Britain rests, is on primary care services. The RCGP noted that in maternity care the decisions about specialist care have come from the hospital sector and the views of general practitioners have been marginalised.[477] The *Occasional Paper* made the case for the GP role in care before and after birth but indicated that the intrapartum role of the GP was only in support of the residual element of domiciliary midwives.

These views were widely accepted though other voices, such as Campbell and MacFarlane, questioned the safety claims and said that many women felt that the hospital was an alien environment and that they were more comfortable at home.[478] Patients had seen many advantages in having a home delivery with a family support network around them and attendance by the now familiar figure of the family doctor. While general practitioners were expected to be available to patients even during the delivery most doctors were happy to leave things to the local midwives and be guided by them if there were complications necessitating hospital admission. The Central Board for Midwives in Scotland (CBMS) was dominated by general practitioners and obstetricians until 1983 reflecting the difficult relationship between GPs and midwives. [479]

One of the interviewees was Sister_02, who had first been a community midwife before working at the St. Francis Nursing Home and then at the Southern General Hospital. She said

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[56] Sir John Peel (1904-2005) was a President of both the Royal College of Obstetricians and Gynaecologists and the British Medical Association.

that ‘when the doctor delivers patients, there's a kind of bond… they feel very secure with their own doctor’ but also acknowledged many GPs were happy to leave things to the midwives. Midwives would often spend many hours with their patients while general practitioners, who had to juggle other commitments, would often need to confine their time to a short period of assessment and then return in time for the delivery.

An oral history exploration of the experiences of Scottish midwives was conducted by Lindsay Reid and published in 2008. The traditional unqualified birth assistant, the ‘howdie’, commonly found in rural areas, was still operating in Glasgow as late as the 1940s.[480] The recollections of more than twenty midwives covers much of the same period of time as the women in this study were undergoing their pregnancies and childbirth.[481] Grievances included the need for a general practitioner to authorise the call for the emergency flying squad.[482]

Though there were maternity services available at the local Southern General Hospital some mothers were encouraged, or even forced, to take the option of having their babies at ‘overflow facilities’ at Lennox Castle Hospital at Lennoxtown[57] at the foot of the Campsie Fells, and around 12 miles from the practice area.[483] Transport arrangements were difficult, family visits were few if any and it just seemed to tick a box without reference to patient preferences.

> I was washing the floor and I took no’ well and [my husband] ran and phoned the doctor and it was an ambulance that was sent, and the ambulance man took me first to the Southern General, but there was no vacancies, so he was told to go to Lennox Castle. (LD)

> The boys were delivered in Lennox Castle. I've no idea [why]. It was a terrible place to get to. (ZR)

> My husband and my sister-in-law came with me to Montrose St. That was the health centre place, and we got a van that took us to Lennox Castle. The families weren't allowed to go - just the patients in this van. (HNa)

For many years, as the number of genuine home deliveries decreased, Dr Ockrim did the bulk of her maternity work at the St. Francis Nursing Home, which had been opened in 1945 to uphold Catholic values related to termination of pregnancy and sterilisation. The Home supported mothers to have multiple Caesarean sections and young unmarried mothers were given support to go through with their pregnancies. While Dr Ockrim was greatly appreciative of the skills and

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[57] The hospital also housed a large facility for patients with learning disabilities and the use of the maternity facilities, started on an emergency basis during World War II, lasted until the 1960s.

care of the nuns at St. Francis, not all the patients had the same attitude to childbirth in a nursing home with a strong Catholic ethos.

> I don't think she was very happy there. I think - alright with [our first], it was - the second one. She was left, if I remember right. They were left on their own and they seemed to attend the Roman Catholics more. That was the impression I got. She didn't go back there. (HT)

> St Francis was very good, apart from all their ringing bells and that. Waking you up at all times in the morning. They didn't twist it, you know, [her] not being Catholic which was very good. (VK)

> I had gone to St Frances and was interviewed there, and they more or less booked my place to go and have the baby and when I went home and told my father - he didn't approve. He said, there is no grandchild of mine being born in a Catholic home. It was dreadful. My father was Highland, and I suppose that's [the reason]. (DR)

> [Dr Ockrim] said, 'You can go to St Frances.' I said, 'I'm not a Catholic.' She said, 'That doesn't make any difference.' [It was] marvellous. They made no difference. (IN)

The facilities at St. Francis could not compare with the Southern General Hospital's new Maternity Unit and the opening of a GP unit within the new building meant that those general practitioners who wished to continue to offer full intra-partum care could still do so. At the same time, St Francis seemed to be struggling as midwife recruitment had been falling and the costs of new equipment had become prohibitive. The Southern's GP Unit was equipped to deal with any emergencies so patients could have every level of care available in one place. The Unit eventually closed because the GPs were becoming increasingly committed to core practice activities and few younger doctors had the necessary experience.

> The amenities were different. They were far superior, but I think the big, long ward was - you had more company. (IK)

> I think it was yourself that delivered my second baby in the GP Unit at the Southern General. I preferred my own doctor to do the delivery because it was more personal. They were with you all through the pregnancy and I think it was nice to have them at the end of it. You felt comfortable. (DX)

After an initial period of enthusiasm, Dr Ockrim eventually found the time required at the hospital's GP unit too much of a conflict with practice requirements and she withdrew from the service around 1980. She made it clear that this was because of time restraints rather than more complex changes in intrapartum management.

> I know myself; I stopped going because if I went in and to have a drip or something put up, there was never any staff, they were all too busy with the hospital side…. That was the reason I stopped.

Medicalisation of Childbirth

Reid considers that the remorseless drive to medicalise childbirth has marginalised midwives and has led to the belief that only hospital deliveries can be considered 'safe'.[484] Major developments in the conduct of labour had also made a substantial difference to the perceived benefits of hospital delivery until the need for district midwives all but disappeared. Questions were then raised: has medicalisation gone too far? [485] Johanson and colleagues, in an article in the *British Medical Journal* in 2002, tried to answer this question. They describe how many mothers report that:

> they have inadequate information about the risks and benefits of procedures and therefore the extent to which they can exercise informed choice must be questioned.

and noting that some consider the increases in caesarean rates as 'an appropriate clinical response to women's preferences about their care' argue that:

> the predominant and growing philosophy of care in the United Kingdom during the past decade has been "value-free" choice rather than a philosophy of birth as primarily a physiological process Women prioritise their baby's and their own safety very highly and worry about losing control, so services offering high rates of straightforward birth with guaranteed midwifery support throughout labour, low need to admit babies to special care baby units, and good postnatal and breastfeeding support are popular.[486]

Homer and colleagues found that the highest rates of normal birth, with a lower rate of caesarean sections, seemed to be associated with successful community focused approaches.[487]

Cheyne, the Royal College of Midwives Professor of Midwifery based at Stirling University explained how:

> Midwives and in general, our medical colleagues are committed to normal birth …. There is growing evidence of the long-term health consequences for mothers and babies associated with unnecessary labour interventions, although we have not as yet understood the full extent of these.[488]

She noted that while the rate of induced labour had halved between 1976 and 2011 the caesarean section rate had risen from 8.7% to 27.8% in the same period at a time when the Scottish stillbirth rate had hardly changed.[489] She worried that:

> 'diagnosing' risk, and acting on that diagnosis, has the potential to precipitate the outcome for which the woman was considered to be at risk…. stimulating that powerful ability of experienced midwives to synthesise complex information and exercise clinical judgement offers a way forward yet to be maximised.

Henderson and Redshaw found that while women were, in general happy with their intra-partum care there were many complaints too:

> Women reported that midwives were very busy, unable to help with even the basics, taking time to respond to calls and just interested in "strapping on a monitor". Women felt neglected, not a priority and fitted in to suit the convenience of the staff or the unit.
>
> Once induction was started the issues raised were the same, associated with delivery ward being full and staff shortages, but other issues also emerged. Pain was a major concern, arising from contractions, vaginal examinations and insertion of the gel or pessary. And a lack of pain relief generally.[490]

The evidence from this study suggests that, as with other aspects of maternity care, good communication, choice, kindness and respect are essential and should be standard practice. Written evidence from the Parliamentary Select Committee on Health in 2003 contained a memorandum from the Association for Improvements in the Maternity Services (MS19) which indicated that medicalisation remained a problem:

> the quality of maternity care currently provided has not improved since then and has in fact deteriorated further…. Birth has become increasingly medicalised, with devastating effects on maternal health and well-being. It has also led to a need for "obstetric nurses" rather than skilled midwives…. who can facilitate physiological birth, and support and nurture women.[491]

The debate on the medicalisation of pregnancy and childbirth still continues sometimes focussing on the ethics of its impact on the relationship between doctors and pregnant women and the way in which doctors treat foetuses.[492]

Patient Support in Challenging Cases

While it is not possible for every patient's problem to be solved in primary care, I have shown how participants relied on the support of their doctors being guided, if necessary, to agencies which, hopefully, would provide the appropriate and sensitive care. Participants who described serious mental health issues or substance misuse in their families clearly saw their GP as having a good understanding of their own feelings. In supporting ZL who, as mentioned, had the complex task of caring for a son with schizophrenia with frequent relapses into destructive paranoia. He acknowledged that Dr David Collins:

> was very helpful…. but the impression I got from Dr [David] Collins was that he was very defeatist about schizophrenia, [but] he helped me in every way he could.

In looking after his son myself I was aware of the large sacrifice made by his parents in keeping him at home as they aged and became frail themselves. Coping with the necessary monitoring by psychiatric community nurses and psychiatrists and what the parents were experiencing was a complex task. In particular, the father with his own insight was a frequent visitor to me during crises.

The interview with DM was one of the longest and at the end she said that there was still more that could be said. The feeling that there was never enough time to meet all her needs seemed to be true for all her interventions by the doctors in the practice as well as her regular contacts with social workers and psychiatrists. Confronting endemic sexual abuse in the family and with no help from her mother, the medical practice and social workers were her pillars of support. Psychiatry referral usually followed prolonged episodes of anxiety but provided little relief. When her daughters were abused by her brother and 'molested' by her husband she went to a lawyer and then consulted me. She recalled:

> I went to Dr Collins, and I told him. He brought LM in but LM wouldnae tell Dr Collins until I left the room. LM was in for about 15 or 20 minutes…. Aye he tried to help. I don't think he could have helped in that way. He probably didnae have the time to help me. I think it was somebody you would need to be long enough.
>
> . Society is changing now. There should be more help and there should be better ways of dealing wi' it. Everybody's learning. Social workers are still learning. You've got to learn from your mistakes, so they're still learning. I reckon that they could learn better fae a person that has been abused. The person that's already had to deal wi' it.
>
> I'd been seeing Dr O'Neill on a Monday night…. I cannae cope wi' it and I've got tae talk tae Dr O'Neill aboot it. I talk to him aboot how I'm feeling and many times he's asked [my daughter] tae

come doon and [she'll] no' go doon.

It all seemed to be related to time and understanding. Not all problems can be solved but the practice did try to provide understanding, sympathy and a commitment to listening.

Conclusion: In this chapter I showed how past illnesses and traumas have become rationalised in the minds of the participants and yet many still indicate that even many decades later questions remain. In the three decades since these interviews took place there has been a more open attitude to patient concerns. Many issues arise from these clinical memories, and these will be explored in the concluding chapter indicating how these stories, views, opinions and impressions contribute to an understanding of the issues which will address the aims, themes and message of the thesis.

In considering the role of obstetrics in general practice this chapter illustrates many memories which feature much of what Dr Ockrim frequently expressed as being important in her medical career. While a product of its time, general practice intra-partum care following close involvement at every stage of the pregnancy proved to be a powerful force in the link between doctor and patient. The variety of the issues covered in the interviews has given a window into the past as experienced in one urban Glasgow practice.

Chapter Seven: Discussion and Conclusion[58]

At the outset of the thesis, I posed some research questions based on the original history project and the analysis of the data obtained from it. The oral history project was designed to capture the memories of patients of a Glasgow inner-city practice through interviews conducted by their former general practitioner, between October 1991 and May 1992. In this concluding section I evaluate the oral history project and assess the lessons to be drawn from it.

The thesis provides a view of health care in an area of Glasgow affected by social and welfare deprivation by analysing the testimonies obtained from participants who had been patients of the interviewer. The oral history testimonies provide an opportunity to understand how patients in one practice saw their health care experiences and how it was delivered. I have shown how stigma and marginalisation affected the health and welfare of participants, their families and neighbours. I have also shown patients, marginalised by ethnic origin, behaviour patterns or mental health problems, have also been shown to have difficulty in accessing the care they need and how help was organised within the practice studied. The patient views were enhanced by the testimonies of clinical and administrative staff, giving a rounded impression of the functioning of one primary care practice

The oral history study produced a huge amount of data in the original interviews and transcribed texts. I have analysed participant's views employing the familiar skills I have worked with, both as a general medical practitioner and as a PhD graduate in medical history, to describe historic health care issues and to find what this tells us. This has been done within a historical context for the developments in health over several decades prior to the study. This has allowed me to encounter this complex mass of material to analyse what participants said, and how they expressed it, allowing me to ask the questions that the interviews demanded and to study what the texts mean and what they imply. I have shown how this approach has yielded issues which may be unlikely to arise in the clinical encounter.

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[58] *Patient and Staff Voices in Primary Care: Learning from Dr Ockrim and her Glasgow Medical Practice.* (2023) also draws heavily on this chapter - pp.153-166. While the book ends by focussing on 'telling the stories' and understanding their meaning this concluding chapter of the thesis also has the objective of answering the research questions set at the beginning.

I have shown how the practice was formed and operated prior to the NHS and how delivery of care within the practice was seen by the patients to change after the major watershed of 1948. as indicating future needs. I have also shown how attitudes within the practice changed to women practitioners, given the key role played within the major health care areas of pregnancy, childbirth, childcare and women's health. The study shows a high level of doctor loyalty, accepting the authority earned by years of dedicated closeness to their patients. At the same time, doctor errors, whether caused by hospital doctors or locum practitioner still caused distress when recalled decades later. Such events ideally require timely reflection, I show that the study indicates that closure may possibly come years or decades later, or even not at all.

Oral history methods have increasingly been used in medical history research. I believe that this study shows some of the benefits of this approach and adds to the growing body of material on the history of general medical practice in Britain. This oral history study, using participants' narratives as mediated by one of their own family doctors claims to be unique.[493] It allows for their own understandings in the telling of the story, and I have shown that the choice of the retired doctor interviewing former patients gives a focussed perspective on oral medical history related to general practice.

One of the study aims was to assess what the oral history interviews can tell us about future needs suggests that what participants valued most was communication skills, the ongoing relationship with the general practitioner, someone they liked and respected, who had good medical skills and would provide care over many decades.[494] These factors may represent the 'gold standard' in primary care which have been severely challenged as the NHSs has had to deal with an ageing population, insufficient resources, a shortage of doctors and the after-effects of the COVID-19 pandemic. Nevertheless, given these restraints, the study confirms recent calls for the need for a public discussion on patient needs, wants and demands for care.[495]

I have shown how these testimonies inform the questions about the establishment of the practice and its development over many decades. The view from the oral history interviews confirms the work of many researchers quoted in the literature review that timely access to their doctor was important. I have reviewed the considerable suspicion of appointment systems which many feared would create a barrier between them and their GP and remove the instant access they had come to rely on. The study indicates that patients and staff considered the gold-standard of care to be the face-to-face meeting with the general practitioner. While telemedicine has

resolved many questions for short-term medical problems in a technically savvier population, I have shown how the interviews indicate that change needs to be managed sympathetically.

The study brought many aspects of social history to the fore. The tenement slums had engendered a sense of 'togetherness' which had now been lost. Today's waiting room at Midlock Medical Centre has a calm appointment-based clientele far removed from the frenetic atmosphere of Dr Ockrim's years. I have also shown how some nostalgia and the more 'homely' working environment' in the cramped tenement flat which preceded the purpose-built medical centre. Patients were shown to cherish a family medicine practice that stayed close to its origins.

Dr Ockrim repeated regularly at practice meetings that her obstetric work was a key component of general practice. The evidence from the interviews is that most mothers agreed, while understanding that the medicalisation of childbirth could not be reversed. I have shown how general practitioner involvement in maternity care, including the delivery period, was an important early factor in anchoring patients to the practice. I have also shown how the attitude to women in the practice changed with the arrival of Dr Ockrim and her authoritative presence.

Vivid memories of illnesses showed how these events came to be understood in terms that could be easily understood. In the section on addictions, I have shown the struggle with alcohol and latterly with drugs, which destroyed the lives of addicts and split families apart. Like the 'ghost of times past' I have used the testimonies to record the memory of the pre-NHS days where patients struggled to pay for a consultation or a house call or had to accept humiliation from the parish system and the poorhouse.

Recovering Lost Memories: I have shown how the memories of patients and staff have enabled the telling of a story which began with a Serbian teenage refugee arriving in Glasgow, having escaped from his native land during the First World War. These memories, buttressed by information from Dr George's daughter, have produced the only written account of the first years of the practice. The story continued with the arrival of the newly married Drs David Collins and Hetty Brenda Ockrim in the last years before the NHS began, at which time the ideal of a comprehensive health-care system which would be open to all, and free without regard to the ability to pay, shaped new prospects for general practice.

Oral history allows for more than just the recovery of undocumented historical events. The narrative, created from the hundreds of hours of recordings and the thousands of pages of

transcript, has also given expression to otherwise unheard voices and their concerns. I show the opinions of those who wanted their babies born at home and access to the surgery to be open on a 'first come' basis. We hear the anguish of lives blighted by alcohol and illicit substances, cancer and tuberculosis. Above all, we find the voices of those who place their trust in their family doctor. We hear those who recognised in Dr Ockrim someone who would argue for their rights, enable the disadvantaged to find their way and help the curious to follow their dreams.

Accuracy: I have shown how researchers have come to accept that there is more to the testimonies than established facts. As Mark Roseman noted, above, though oral histories may show 'patterns of discrepancy,' we come to see these recordings as memories and understandings that can transcend the worry about accuracy. Accepting minor inaccuracies does not detract from how the past was understood. The recalling of the same events by different observers, such as Dr George's heroism during the Clydeside Blitz, shows how individual memories function in corroborating the main events while we note some minor details of difference which add nuance to the story.

In some instances, the memories of patients interviewed in this study were challenged. There were two occasions where a central character in the recollection, namely the practice manager, was said to have made the diagnosis personally. In one case the diagnosis was of a pregnancy and the other was of diabetes, which the patient indicated had been missed by the doctor. The practice manager vigorously denied that she would ever have given a patient the results of a test or suggested a diagnosis and a closer reading of the testimony supports her personal recollection. However, the patient's recollection of what happened many years later might just indicate how the practice manager was seen to have been a significant and authoritative person in the practice.

Sometimes memories might stray into 'gossiping', a behaviour that one patient, who was a local pharmacist would not be drawn into. In this case she expressed the care she had taken to avoid getting drawn into conversation about the merits of the local doctors and the merits of their prescribing. She recalled:

> I didn't approve of gossiping in the shop. I felt it wasn't the right thing to do. You got one or two coming in complaining and then the next person would come in and talk about the same doctor, and say they were marvellous. (JT)

I recall that one new doctor in the practice was seen twice by one patient in a short period of time. When she returned a third time, she requested the doctor she had seen last as she had no confidence in the one she had seen first. The receptionist discreetly avoided mentioning that the 'two doctors' were one and the same!

More than one interviewee recalled the occasion when Dr Ockrim had no patients waiting for her while the Waiting Room was full of patients waiting for her husband. The story was broadly similar with only minor embellishments to each account. One patient understood Dr Ockrim to be indicating that a woman could also be a doctor. Another recollection was that Dr Ockrim had suggested that people who were waiting to see her husband were motivated by his acceptance of malingerers at face value and the fact that he would be more likely to issue a 'sick line.'

Dr Ockrim was happy to accept the verdict of the patients that she interviewed, even that of a patient who told her that were many patients who didn't like her:

> There was something powerful about you that I liked. There was a lot of people didnae like you. I used to say to people, she's straight forward and she'll tell you to your face what she thinks. There was just something aboot you. (EL)

If malingerers, wife or child abusers didn't like her, she would have accepted that quite easily.

One patient memory concerned the morning that Dr David had his heart attack. The patient had expressed surprise that Dr Ockrim had been able to carry on with her busy surgery to the end, showing her customary conscientiousness. Dr Ockrim noted in the box file that 'I thought I had followed [the ambulance] in the car with [the Practice Manager]. PMan_01 confirmed that they had followed the ambulance.

Humaneness

It was the warning in Professor Sir Henry Cohen's Presidential Address, at the Annual Meeting of the BMA in Liverpool in 1950 which placed an emphasis on humanity along with the achievements of medical science.[496] He felt that all the great advances in his field of surgery 'will avail but little if they obscure the need to foster sympathy and kindness' believing that his medical contemporaries were motivated by the satisfying reward 'to help our fellow man' but

still worried that 'the torrent of scientific discovery… [had] all but engulfed the humanism of medicine.'

I have shown how Dr Ockrim had aimed to bring a more humane approach into the care of her patients. This empathetic ethos had benefits beyond the consultation. From many of these encounters, participants showed how the care and understanding they had received over many generations of family experience in the practice had led not just to favourable clinical outcomes but had provided a better sense of wellbeing in physical and mental health terms. Of course, not all medical consultations can result in a complete cure but I have shown how the ongoing involvement with patients, for example in terminal care at home or with a bereaved mother following a cot death, has clear benefits and remains a core value in general practice.

We have seen many examples of her approach to perceived injustices. In his great novel of the history of the first forty years of the NHS, *Sickness and Health*, published in 1992, Colin Douglas, the pseudonym for the geriatrician Colin Currie, described the scenario of a child admitted to hospital in Edinburgh during World War 2 for the treatment of tuberculosis. The child's parents were told that because of wartime travel restrictions and the blackout, they would not be able to visit their child but should consult an Edinburgh newspaper each day and only visit the hospital if their son's code number was listed. The parents eventually were called to the hospital for the last days of their son's illness and his death. I was appalled by the story and felt that even something written in a novel did not have to be fiction. Dr Ockrim told me that she believed the truth of the story and that, qualifying during the era that the story had been set, she had been committed to a more caring practice of medicine. The author later confirmed to me that the story was true and was the story of his brother and was a reason which drew him to medicine.

I have also shown how Dr Ockrim expressed this humaneness. She was especially focussed on children and aimed to provide the care that would enable them to fulfil their personal and professional dreams. This approach can be identified throughout the interviews but is also part of the 'Letters to No-one'. In the first letter (30th April 1989) she wrote:

> At work I am upset by the distressing stories of hardship among young and old. I have compiled several lists of names of people with problems – each one could fill a book.

She was also concerned with maintaining professional standards as she approached her 70th birthday, aware of the latest medical developments and worried that her work might eventually fall below her 'own expected standard' and concerned that she might be complacent in thinking

that she was ‘no worse than anyone else.’

In the second letter, dated just July, she wrote that she was sad about losing contact with her former patients but was comforted by the emotional response she received on retirement:

> I do not think that any branch of medicine could give the same set of satisfaction or relationship. … I am on my 5th generation (of patients).

The final letter was written on the 5th of October, just a few days after her retiral. She described the retirement party in some detail, calling it ‘probably, one of the outstanding days of my life’ referring to some reminiscences and the presentation of unexpected gifts.

In addition to the recordings, as noted she kept a box file for notes of the interview, focussing chiefly on the medical conditions and social problems described. A few notes illuminate her sense of the interviewees worth. One patient whose parents died young and was then brought up by ‘a cruel grandmother’ was described as a ‘very kind thoughtful person – could have [had a] better life given chances.’ One note concerned a Muslim patient who was insistent in telling her, after the recording was completed, that he was taking the family to Mecca and that ‘they would pray there that they would return safely to see me when they returned.’ Another note records that one interviewee requested that any mention of his anxiety recorded in a quoted text should be done with anonymity. In two cases the interview ended with a request for Dr Ockrim to return for a further discussion.

Arriving at the home of one interviewee she noted that the door was answered by the former patient’s son. While waiting for his mother to appear, he confided that he was previously a drug addict but that she did not know. Dr Ockrim expressed her dissatisfaction about three of the interviews blaming poor memory recall by the interviewees, all in their late 70s. One patient had wanted only to talk about one phase of his life working in Leverndale and she expressed frustration that she couldn’t get his own health experience in the detail she wanted. She went as far as removing a mother from a substandard nursing home, around the early 1950s, and taking her in her own car to a place with appropriate facilities for proper professional care. This indicated a commitment to a humane holistic medicine which went beyond providing a minimum standard of medical care.

Looking after the health of the children of the practice as well as the provision of the full range of maternity care were the most rewarding parts of Dr Ockrim’s medical life. Her institution of a Child Health clinic, held every Thursday afternoon, allowed her to build a rapport

with children as well as their mothers. This was forty years before the 1986 edition of Sacharin's *Principles of Paediatric Nursing*, suggested that nurses were recommended to obtain a rapport with the parents and to understand the psychology of their young charges.[497] One participant recalled that the nurses 'were too domineering as far as the children were concerned… they weren't nice to the kids at all.' (VK). He had not challenged the staff as 'It would have upset us more, I think.' It is only in recent times that children's wards had facilities for parents to be with their children, and it took some time for children to be allowed to describe their symptoms rather than have to rely for their parents to speak for them.

Marginalisation and Stigma: I have shown how the oral histories testify to many different examples of marginalisation and stigma. Poverty was a major cause, and the testimonies include many fraught memories related to social deprivation. This was the cause of many of Glasgow's struggles with health issues which have continued to the present day. In the pre-NHS days, many vividly recalled the stigma attached to the workhouse or the inferior 'parish' services and the fear of not being able to afford the cost of a consultation or a house visit.

The memories of addiction to illicit substances, principally heroin, and its concentration around 'Wine Alley' describe another group of stigmatised and marginalised patients for whom health services struggled to provide appropriate care. Communities were scarred by the loss of their children to addiction along with its associated thievery and petty criminality. Authority action often seemed cosmetic rather than restorative and thirty years after the interviews Scotland had clearly not found ways to provide for its addicts who were still dying at a far higher rate than anywhere else in Europe.[498]

One mother remembered:

> It's horrible when you can't trust who's living in the house with you. I can't describe it to you. It makes a cloud in the house and the atmosphere. You're listening to her saying something and you think to yourself, "Is that the truth or is it a lie?" (LB)

Alcoholics too faced an uncertain present and future. While we have seen some who successfully turned their lives round, others destroyed themselves and their families fuelled by the desire for alcohol. Patients with chronic psychiatric problems such as schizophrenia and bipolar depression often found themselves cut adrift from family and did not always receive the specialist care that their conditions required. One parent ZI recalled:

> We went in to see the psychiatrist and his attitude was hostile to me - not with me.

Ethnic minorities appear in the oral histories as a final marginalised group. The three patients of Pakistani origin felt that they had been well received in Glasgow but expressed their struggle to maintain religious traditions and community practices in a secular society. While there were problems in assimilating into the local ways, they felt that they had integrated as citizens of Scotland which was promoting cultural diversity within the banner of 'One Scotland – Many Cultures.' The young Sikh woman felt marginalised within the home of her extended family and expressed her hope for a home just for the nuclear family. The experiences of a German woman (DT) indicate that acceptance within the Scottish family did not come easily:

> I wasn't made very welcome by my in-laws. My mother-in-law wasn't a person I could confide in. She was not very well mentally. I didn't realise that in the beginning, I thought it was just bad temper. She just about tolerated me because I was married to her son.

I showed the negative reaction by a Protestant family member to the possibility that his grandchildren might be born in a Catholic nursing home reflecting Glasgow's history of sectarian strife and indicating that the process of acceptance can be a lengthy one. I have also shown the instances where the interviewer herself was seen as a marginalised individual such as when a Catholic priest suggested that a Catholic doctor would understand the patient better. The participant did not agree. The interviewer had indeed seen herself initially as a medical outsider in a man's world with few Jewish women as role models. I have shown how this was a formative aspect of her developing medical career.

Closure

While the interviews were not planned as therapeutic encounters, I have shown how I identified a sense that they contributed to producing a sense of closure or finality for many of the patients and offered the interviewees the opportunity to see their story in a wider context. Studies have shown that emotional coping improves with time and telling, and fading memory may also be a factor.[499] This sense of closure or finality may have been enhanced by the fact that their family physician had featured in many of these memories but was now approaching them in a different capacity following her retirement – as many were interviewed two or three years after she had retired. An example concerns a participant who had deliberately misled a relative with terminal

cancer with what he described as a 'white lie' persuading her to go to a hospice 'to try and get yourself better.' (ZG)

Family traumas were sometimes relived and the opportunity to revisit the past in the presence of their family doctor could bring a sense of closure. LI's dramatic memory of a sibling whose operation was described as 'They ripped him open without giving him anything. I can always remember that' gave the participant a welcome moment to grieve.

I have shown that for Dr Ockrim too there was a sense of closure following her retirement. The GP obstetrician had almost disappeared by the time she retired but she could sense that the importance of her obstetric work in the practice had contributed to its success. She had come to terms with her role in general practice for forty-three years as she wrote in one of the Letters to No-one:

> If my late husband had not been discharged from the army at that particular time, I should not have been in general practice and would have missed all this. I do not think that any branch of medicine could give the same sort of satisfaction or relationship.

Or as the wrote in the final Letter on 5th October 1989 just a month after retiring. She was deeply appreciative of the warmth expressed by her former patients:

> It gives me a good deal of satisfaction in feeling that my life has been of some use to others.

Strengths and Limitations

One of the key strengths of the study lay in the partnership between interviewer, Dr Ockrim, and me as the creator of the analysis. Consequently, this oral history project was a product of its time. Dr Ockrim had an especially close relationship with her patients and the eagerness of participants to have their stories recorded is a tribute to her skills, both medical and personal. Her well-known empathy helped the ease of recollections from the participants. The outlines for the interviews provided the framework for the testimonies, flexible enough to cope with important digressions but organised enough to capture what was important to both participant and interviewer. Much of the shared intimacy between Dr Ockrim and the participants would have been lost with a more detached interviewer, even had I still been the interpreter of the recordings. Participation would have been less, and openness reduced. Thus, I doubt that with hindsight we would have organised things any differently.

Hammersley has described how using archived material could expose researchers to damaging forms of assessment which would limit its contribution.[500] This study had the unusual advantage of having both the interviewer and oral historian working in partnership as they had done for many years in the medical practice, and this was fully understood in advance by all the participants. The breadth and depth of recall has given this study an enduring quality.

Lessons for the Future

The final question, which alluded to lessons for the future, has proved to be the most complex. An oral history conducted in 1991-1992 cannot be expected to predict future health care needs. However, some important strands can be identified which may still illuminate present and future discussions on health and social welfare. In summary the following strands stand out:

1. **Meeting Expectations:** Participants also showed what was important to them in terms of service provision. When open access and GP home deliveries were available these were important elements in primary care. As times changed, though these desires could no longer be met the focus changed to timely access and attending a doctor who understood their cares and anxieties, their personalities and life struggles. Williams and colleagues found that the most frequently stated requests were for 'explanation of the problem' items followed by 'support' items and not for 'tests and diagnostic related information.' [501] This aspect of primary care remains of crucial importance and has major implication for the education of medical students and doctors in training posts regarding effective communication. Webb and Lloyd found that the individual general practitioner consulted was not an important factor in influencing patients' expectations but rather what general practitioners will do when presented with that problem.[502] Some of these issues emerged during the interviews.
2. **Where General Practice Works Best**: Besides illustrating the importance of effective communication, participants reflected the move from medical paternalism as patients now expect to be able to express their treatment preferences and for the doctor to respect their views.[503] Brody and colleagues noted that patient satisfaction with their physician is an important component of the quality of health services and is more related to the physician’s efforts to provide the patient with information, give support and advice.[504] This theme emerged strongly in the interviews. Armstrong described how patients need

protection from the dangers inherent in much medical investigation, diagnosis, and treatment and for the foreseeable future must continue to rely on medical pre-eminence in these areas. General Practice works best when these various strands are observed.[505]

3. **Dealing with Stigma and Marginalisation**: Stigma and marginalisation still remain as issues in healthcare, whether related to mental health, alcohol and substance misuse and marginalised groups. Though many of the positive initiatives of recent years are making a difference, and supported in the Midlock practice, there is still much to be aware of and much more to do. The most intractable problems have been related to those patients who are dependent on illicit substances and their challenging behaviours in their search for prescribed drugs with a street value or had severe long-term mental health disorders. Solutions for some of these patients lies beyond the scope of general practice on its own to solve.

   Mental health problems encountered in the study, especially schizophrenia, illustrated both the place and limitations of general practice and the frustration with a condition that might be controlled but never cured. ZL saw the benefit of medication for his deeply troubled son but felt that ‘They do much more good for families and hospitals than they do for the person that's taking them.’ Fortunately, his son found a psychiatrist around 1980, many years into the illness, who was:

   what a psychiatrist should be. He has no answers any more than anybody else, but he has a sympathetic approach and that's the difference between a good psychiatrist.

   While ZL expressed the view that ‘The average GP just doesn't know how to deal with that’ he and his son had consulted one practice doctor who, they felt, showed the required level of sympathy

4. **A Paradigm for Oral History in General Practice:** I have shown how this study, by focussing on patients and staff in one Glasgow inner-city practice, delivers a story which deserves to be heard and understood. This allows for the views of the users of primary care, the patients, to have a voice. In the past oral history in medicine has concentrated on leading personalities and their involvement in medical and research organisations. This study includes memories from general practice covering around sixty years, from about 1930 to 1990. Given the immense changes in medicine and society since the oral history

was completed, further studies in general practice will be able to show comparisons with study and indicate how these changes have been viewed by patients.

Discussion and Conclusion

I have confirmed Thompson's view that oral history is 'Unique, often disarmingly simple, epigrammatic, yet at the same time representative, the voice can, as no other means, bring the past into the present.'[506] Patients value on-going relationships in primary care and wish to maintain and even strengthen them.[507] The creation of the NHS undoubtedly made a major change in the delivery of health care, while removing worries about health care costs. Older participants, and also the interviewer, who had experience of pre-NHS times, were protective of the new system and appreciated its benefits.

I have shown how the participants recalled their care in a wide range of settings, described its delivery while still providing evidence of the socio-economic milieu in which they lived. A few memories recall a time before smallpox, diphtheria and even tuberculosis have become maladies of the past. The thesis also confirms the importance of narrative in medicine and Tudor Hart's assertion that such cooperative decision-making can produce better and more appropriate outcomes for all involved.[508]

The creation of the NHS undoubtedly made a major change in the delivery of health care as perceived by the participants. The worry about health care costs was removed with consultation and treatment now free at the point of contact. Older participants, like the interviewer, who had experience of pre-NHS times, were protective of the new system and appreciated its benefits. The years since the interviews were conducted have seen an NHS stretched by the growing health needs of the infirm elderly, the costs of treatment of chronic disease and the experience of austerity and a global pandemic.

Dr Ockrim's Place in the Medical World

The analysis of the oral history interviews has confirmed the path Dr Hetty Ockrim had set out to establish herself as a doctor in what was very much, and in many ways remained, a man's world. For most of her career her partners in the practice were all male as were most of her hospital colleagues. It was her energy, charm and ability that won people over and her experience of having to oppose her parents to study medicine enabled her to understand the need for people to follow their dreams, helping them succeed, often beyond all expectation. She distrusted the hype of drug companies, and she made frequent use of the yellow forms to report previously unreported side effects of new medicines. Thus, she never prescribed thalidomide[59], which was being pushed for morning sickness in pregnancy, about which she was frequently consulted.

The oral history project remains her medical legacy. The data she collected informs key questions in medical practice. It identified what was seen to be important to participants, indicating that there needs to be a sensitive understanding of what they felt were key issues. By analysis of participant testimonies, I have shown how the practice could contribute to the delivery of high-quality personal and continuing medical care in a deprived area by indicating how participants valued the continuing presence of trusted practitioners, who, if not available for every consultation, could be there for them when really needed.

The testimonies reflected the trend for paternalism in medical practice to be on the retreat as patients now expect to be able to express their treatment preferences and for the doctor to respect their views.[509] Participants also showed what was important to them in terms of service provision. Some of the 'wants' of some patients might no longer be met: many participants expressed approval of open access, home deliveries and the homely atmosphere of the old Cessnock Street surgery but these could not meet the requirements of modern health care provisions. However, all agreed on the need for empathic practitioners who could listen, guide and treat.

[59] Licensed in the UK in 1958 as a sedative and for use in morning sickness it was withdrawn from the market in 1961. Some 2,000 pregnancies were blighted in the UK – many babies died or survived with major limb abnormities.

Appendices

Appendix A: Practice Timeline

1900 Birth of Stevan George as Slavoljub (Slavko) Djordjević in Serbia. After taking part in the Retreat, an escape from the war-torn country over the mountains he arrived in Scotland in **1916** where he completed his schooling and qualified in medicine at the University of Glasgow in **1924**.

1912 Birth of David Collins. Attended the High School of Glasgow and studied medicine at the University of Glasgow. After qualifying and wartime army medical service he returned to medical practice in Glasgow.

1919 Birth of Hetty Brenda Ockrim in Govan, Glasgow. After schooling at Abbotsford Primary in Gorbals, Glasgow and Hutchesons' Girls Grammar School, she entered the University of Glasgow in **1938** and graduated in medicine in **1943**.

1926 Stevan George begins his solo medical practice in Glasgow with premises in Blackburn Street, Kinning Park. With increasing patient numbers, he moved to larger premises nearby in **1929** at 2 Cessnock Street directly across the road from the Cessnock Underground Station.

1942 The Beveridge Report (Social Insurance and Allied Services), was influential in establishing the post-war welfare state.

1944 The Goodenough Report led to a complete overhaul of medical education, with teaching restricted to universities and providing equality of entrance to women.

1946 Stevan George decides against working for the proposed NHS and through his friend, the gynaecologist Albert Sharman, he agrees to sell the practice to David Collins and Hetty Ockrim, who start work as medical partners in June **1946** and marry in November that year.

1948 The NHS (NHS) begins in July 1948, one year after the passage of the NHS (Scotland) Act. The NHS offers comprehensive health care, free at the point of use.

1949 With the increasing workload following the beginning of the NHS Dr William Ian Russell joins the practice as third partner.

1952 The Royal College of General Practitioners is established.

1965 The Family Doctor's Charter provides a series of measures to improve standards in general practice through funding initiatives for doctors, practice staff and premises.

1976 Dr Kenneth Collins joins the practice in November 1976 and becomes a partner the following April. David Collins has a stroke in April **1978** and his locum Dr Barry Adams-Strump becomes a partner in January **1979**. Practice reorganization includes surgery-based district nurses and health visitors and a change of practice records to A4 folders. The practice is accepted as a training practice.

1982 With the death of the caretaker the extra space released at 2 Cessnock Street is incorporated into the surgery with additional consulting rooms, office facilities and a better base for attached staff.

1986 All the residential property at 2 Cessnock Street is emptied and the Glasgow City Council, the building landlords, indicate that when the building is refurbished there will be no room for the surgery. At the same time, they make available a 1200 square metre site in nearby Midlock Street on a 99-year lease with permission to erect a purpose-built medical centre for the practice. The Midlock Medical Centre opened in February **1987.**

1989 Dr Ockrim retires on 1st September 1989 and is replaced by Dr Alison Thomson.

1990 Lengthy period of extensive NHS reforms begins.

Appendix B: Project Timeline

1989 Planning for **t**he oral history project begins after Dr Ockrim retired on the 30th of September 1989. The project was designed by Dr Kenneth Collins and received funding from the Wellcome Foundation for recording equipment, word processor and secretarial expenses for transcribing the interviews. Questionnaires were devised and patient selection begun. Interviewing only begins after Drs Ockrim and Collins attended a course on Oral History and Medicine run by Professor Paul Thompson at the University of Essex at the end of September 1991.

1992 The interviews were completed in March 1992. Regular feedback by Dr Ockrim was made during the interviews but the only change in the study was to interview employed and attached practice staff as it was agreed that many of the participant's views on access to doctors and the functioning of the practice reception needer a broader context than patient views alone. A local pharmacist and a former midwife colleague were also interviewed. Transcription of the recordings was completed, and initial evaluation carried out.

2007 With the death of Dr Hetty Ockrim in August 2007 an envelope marked 'Letters to No-one' is discovered in her desk describing her reflections on her medical practice and her hopes and fears as she approached retirement. Dr Kenneth Collins retired as partner in the practice in August 2007 just a week before Dr Ockrim's death, but he continued working as a part-time Glasgow general practitioner until July 2009. Following retirement as a practice partner he became a Senior Research Fellow at the Centre for the History of Medicine at the University of Glasgow. As a first step to working on the material the project received ethical approval from the Research Ethics R & D Directorate of NHS Greater Glasgow and Clyde in August 2007.

2009 Progress begins in the study of the oral history. The transcripts are transferred from the Amstrad Locoscript format to Microsoft Word and the lengthy work of reading the texts and bringing the material into workable themes begins. This was not completed until 2014. An initial assessment of the oral history study was that the material was of great historic significance which had only increased in the past two decades and that a detailed analysis of the organised text was essential.

2014 The oral history audiotapes and transcripts are deposited at the Scottish Oral History Archives, at Strathclyde University, with careful regulations limiting access to Dr Kenneth Collins, failing whom permission to be granted only with agreement of the partners at the Midlock Medical Centre. The audiotapes, now 25 years old, are digitised. Dr Kenneth Collins begins discussions with Professor Malcolm Nicolson at the Centre for the History of Medicine at the University of Glasgow and Professor Ivor McIvor at the Scottish Oral History Archives Centre about how best to write up the oral history, studying and analysing it in its widest context.

2018 Dr Kenneth Collins applies to the School of Medicine, Dentistry and Nursing to carry out research on the oral history project for the degree of MD.

2019-2020 The analysis begins, initially with Prof Malcolm Nicolson as sole supervisor, and complying with the MD regulations as previously followed at the Centre for the History of Medicine.

2020-2021 The work now follows the latest MD guidelines and is supervised by Dr Hannah-Louise Clark of Economic and Social History, with a strong interest in the history of medicine, and Professor in Health and Wellbeing Jude Robinson.

2023 Thesis submitted.

Appendix C: Dr Ockrim's Study Notes

The following is the transcription of the handwritten photocopies of the Study Notes which were written by Dr Ockrim prior to the start of the interviews.-

It was not surprising to find that these notes were carefully written in capital letters. Her handwriting always looked very tidy even if it was often quite hard to decipher. There had once been an incident when a chemist was ready to dispense the wrong item because he thought the script looked more legible when he held the prescription upside down! Fortunately, he returned the prescription to the surgery so that the item could be checked against the doctor's notes.

The following are the various issues covered, **in her own words**, in eight pages. No attempt has been made to make additions, deletions or corrections though some clarifications have been added.

The Costs of Care

'Sick pay was 10/- a week and medical service was free from their panel doctor. This was the state of affairs when I entered practice in Ibrox 44 years ago. A visit to the surgery was 2/6 – house call 5/- if the patient could afford it. There were private schemes administered by trade unions and friendly societies.'[60]

The Glasgow Water Supply

'The Loch Katrine scheme was one of the great enterprises in Glasgow. It brought fresh clean water to the city. Unfortunately, our present reservoir systems are not adequate for our expanding suburbs. Prior to this, water was drawn from the heavily polluted Clyde. The single water-tap and the outside toilet continued until quite recently'.

Housing Supply

'As the city grew rapidly with the expansion of shipyards, engines, railways, warehouses and new industries many immigrants came looking for work – Irish, East Europeans and of course from the Highlands. Housing, poor as it was and in short supply, became scarcer. Overcrowding was the order of the day. 'Ticketing of houses' was introduced. Tickets denoted the square area of the house and the number of people to live in the house.

Inspectors came frequently to enforce the law. People could be ejected, and the proprietor fined up to £500. Often the man of the house was unemployed, and a lodger was taken in to help pay the rent.

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60 Five shillings in 1946 is worth around £5 today. The average industrial wage then was around £10 a week.

Many a child was delivered in this type of accommodation. Concealed beds: families have to move to neighbours. Most confinements took place at home. Abnormalities – breech, forceps, twins – we had to be ready for these. Maternity beds were in short supply and abnormalities only were sure of a bed.

At the end of the last (nineteenth) century provision was made for public baths, washhouses and swimming pools. Many enjoyed seeing *The Steamie* depicting a part of life for those unfortunates without (adequate) home facilities.'[61]

Nursing Homes

'There were some nursing homes. I remember one in the Woodside area not long after I entered general practice. I was called to the patient to find a dirty room with dirty bed linen – and it had a certificate of worth from the Health Board. I put the patient into my car and took her to the maternity hospital and soon that home was closed.'

Medical Care for the Poor (before the NHS)

'Often the sick could not afford to call the doctor and dispensaries were set up. Patients were given advice and simple treatments although it is only in the last fifty years that treatment has improved – remember that at this time there was no penicillin'.

Rickets: 'Many will remember the bowlegs, due to lack of Vitamin D causing stunted growth and great difficulties in childbirth, often resulting in the death of the child and rupture of the uterus if a Caesarean Section was not undertaken.'

The Hospitals: There were three types of hospital before the NHS:

1. Voluntary: maintained by (public) subscriptions and legacies. They were stark and clean, and the public were admitted by obtaining a line from a subscriber. Consultants gave their services free.
2. Poor Law: such as Merryflats at the Southern General and Forresthall on the north of the river. These admitted unmarried mothers, destitutes and 'incurables'. Standard of care was poor and chances of survival less.
3. Infectious disease hospitals: for measles, polio, smallpox, mumps and whooping cough. Sanatoria were set up for tuberculosis and asylums for the mentally ill. Conditions were dire due to overcrowding, poor nutrition and insanitary conditions. Tuberculosis did not just affect lungs – bones, (lymph) glands and abscesses – and took a very long time to heal - all these

61 *The Steamie* is a comedy-drama stage play, written by Tony Roper, first performed in 1987, following the lives of a group of 1950s Glasgow women washing their clothes in a public washhouse (steamie).

> conditions spread rapidly. Rheumatic fever was also prevalent. This led to valvular heart disease – the first heart operations were heart valve replacements.62

Treatments: 'Fortunately, because of the introduction of vaccines, smallpox has been eradicated world-wide and if everyone would have their children inoculated other diseases could also be wiped out. Tuberculosis can now be successfully treated – hospitalisation is not necessary. As for mental illness drugs and counselling are available for treatment and great many (of former hospital inpatients) are now in the community. Often young people and young adults were admitted [to mental hospitals] because there was no-one to care for them'.

Social Services: 'At the beginning of the [twentieth] century the School Medical Service was started, and the National Health Insurance scheme started in 1911. Until this time there was no social security, no unemployment relief and no pensions. Money was short and working hours long. The fortunate worked until they died. When National Health Insurance (NHI) was introduced, it was only for workers, not their wives or children.63'

Notification of Births: 'It was as recent as 1907 that notification of births64 within 36 hours became compulsory and 'Green Ladies' delivered milk to new-born babies.'

The Tragedy of Today's Ills: 'Today's ills – smoking and alcoholism, always with us. Wife beating, child abuse, although always present has become more prevalent. AIDS, drug abuse, as well as affecting whole families, leads to stealing, mugging and even murder to fuel the drug abuse. AIDS is another disease often innocently infected'.

Appendix D: Questionnaires

62 In fact, the first heart operations were valvotomies, where constricted valves could be stretched in minimally invasive procedures.
63 While the families of male workers were not covered by NHI working women were entitled to its benefits.
64 **Notification** by the medical services which took place before the parents' **registration** of the birth.

The questionnaires used by Dr Ockrim follow on the next two pages. First is the Semi-Structured Questionnaire (Topic Guide) used with former patients followed by the Outline Questionnaire for GP History Study: Questions to Ancillary staff.

SEMI-STRUCTURED QUESTIONNAIRE

Name…… Occupation……

Address……

……..…….. Registered with Practice from…….

INTRODUCTION: explanation of the history project……NOTES OF INTERVIEWER

SECTION ONE: opening questions

first memories of the practice: e.g. how it worked…….

premises, personalities, events: pre- and post NHS……..

hospital referrals, relative status of GPs and…….

hospital doctors……..

SECTION TWO: Personal Health Issues……..

main medical problems, how dealt with, attitudes……..

to illness & how it was handled; impact of …….

illness on the patient & family; lessons ……

learned from the illness …….

SECTION THREE: Family Health Issues

illness in the family, how dealt with, support ……

from medical and other agencies: experiences ……

lessons & impact ……

SECTION FOUR: Health Care Changes

attitudes to developments in modern medicine ……

GP teamwork and greater clinical responsibility ……

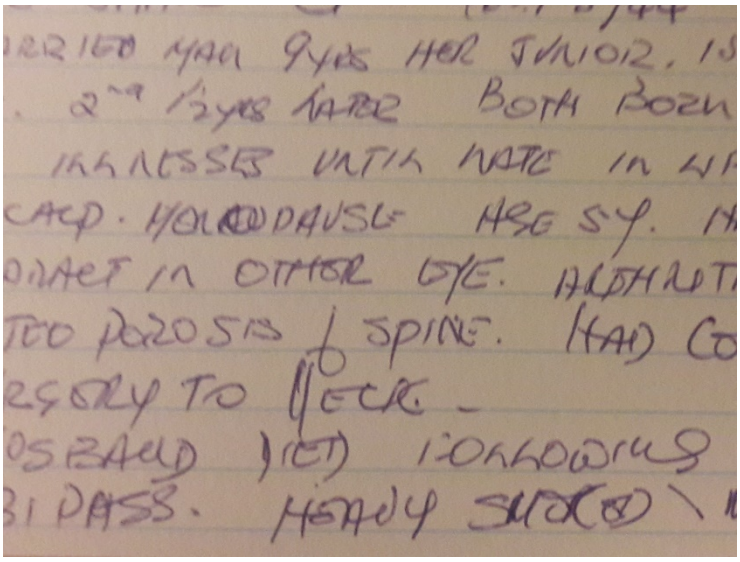
CONCLUSION: closing discussion

OUTLINE QUESTIONNAIRE FOR GP HISTORY STUDY: QUESTIONS TO ANCILLARY STAFF

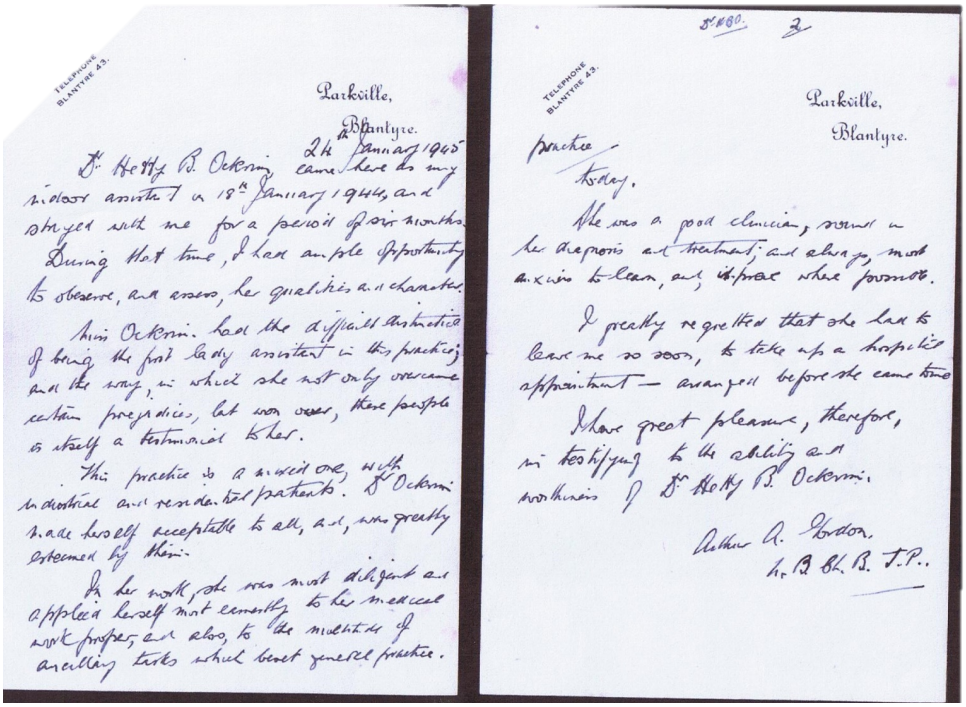
Flexibility will be needed to allow each interview to develop depending on the detailed reminiscences of the interviewee but one or more of the following would serve as a guideline.

1. Memories of the old surgery in Cessnock and recollections of the patients' attitudes to it. This might include:
   a) Working with a smaller staff – less paperwork?
   b) The movement of patients round the chairs in the waiting room
   c) No treatment room (doctors doing all the tests, dressings etc).
2. Many patients have expressed a warm and nostalgic attitude to Cessnock Street despite the clear lack of facilities compared to Midlock Street.
3. Incidents remembered from either Cessnock Street or Midlock Street.
4. Doctors are now dealing with greater numbers of patients with severe social problems, especially to drug addiction. Has there been a change at the reception window over the years? Have the staff had problems in dealing with drug addicts, drunks, false registrations?
5. The practice has held out longer against an appointment system, but it now plans to introduce one for evenings only in February 1993. What reactions have the staff had to the proposed change?
6. Have changes to the GP Contract in recent years posed extra work for the office staff? Do they feel that the changes have led to better standards of health care?
7. The practice functioned at one time with four doctors and one person in the office. How has the change from 'cottage industry' to the present set-up been managed?

Appendix E: Card File Text/Reference/Abstract of Letter to No-one



1. Section of text from a card file – cropped to remove personal identifying features.



Parkville,
Blantyre.
2th January 1945

Dr Hetty B. Ockrim came here as my indoor assistant on 18th January 1944, and stayed with me for a period of six months.

During that time, I had ample opportunity to observe, and assess, her qualities and character.

Miss Ockrim had the difficult distinction of being the first lady assistant in this practice; and the way in which she not only overcame certain prejudices, but won over these people is itself a testimonial to her.

This practice is a mixed one, with industrial and residential patients. Dr Ockrim made herself acceptable to all, and was greatly esteemed by them.

In her work, she was most diligent and applied herself most earnestly to her medical work proper, and also to the multitude of ancillary tasks which beset general practice.

5th Feb. 2

Parkville,
Blantyre.

practice today.

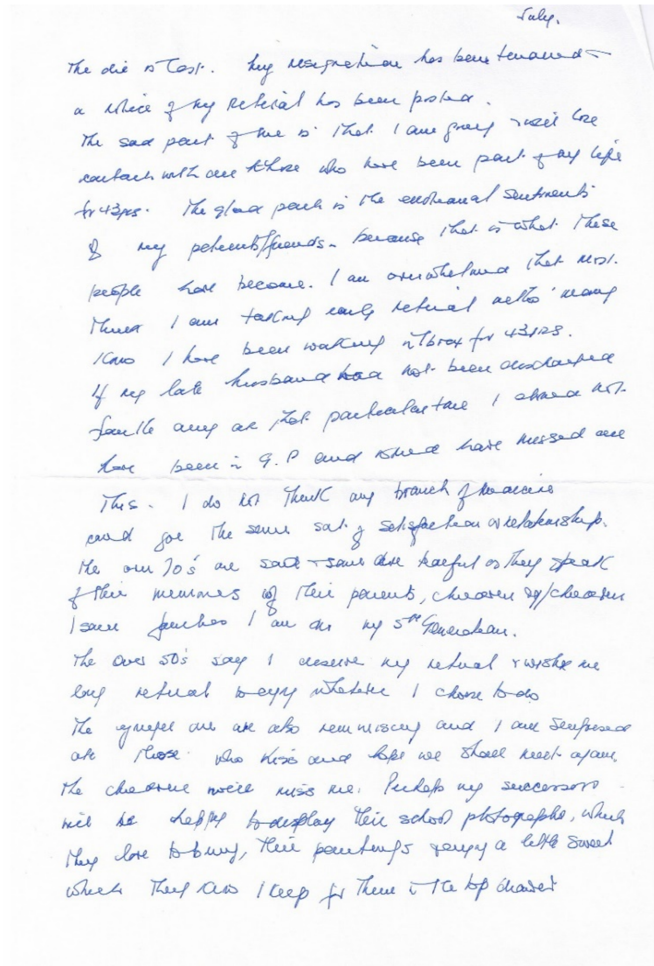
She was a good clinician, correct in her diagnosis and treatment; and always most anxious to learn, and improve where possible.

I greatly regretted that she had to leave me so soon, to take up a hospital appointment — arranged before she came here.

I have great pleasure, therefore, in testifying to the ability and worthiness of Dr Hetty B. Ockrim.

Arthur A. Gordon,
M.B.Ch.B. J.P..

2. Reference from Dr Arthur Gordon, GP Blantyre, January 1945



July.

The die is cast. My resignation has been tendered & a notice of my retiral has been posted.
The sad part of me is that I am going to lose contact with all those who have been part of my life for 43yrs. The glad part is the emotional sentiments of my patients/friends – because that is what these people have become. I am overwhelmed that most think I am taking early retiral after 'many' years I have been working in Ibrox for 43yrs.
If my late husband had not been discharged at that particular time I should not have been in G.P and should have missed all this. I do not think any branch of medicine could give the same sort of satisfaction & relationship.
The over 70's are sad & some are tearful as they speak of their memories of their parents, children &/children's same families I am on my 5th Generation.
The over 50's say I deserve my retiral & wish me long retiral to enjoy whatever I chose to do
The younger ones are also reminiscing and I am surprised at those who kiss and hope we shall meet again.
The children will miss me. Perhaps my successors will be happy to display their school photographs, which they love to bring, their paintings & enjoy a little sweet which they also I keep for them in the top drawer

3. Beginning of the second 'Letter to No-one' July 1989

APPENDIX F: ORAL HISTORY IN MEDICINE COURSE

The details of the Oral History in Medicine course, which was attended by both interviewer and author follow on the next page. Thompson's course was of great benefit in guiding both in conducting the interviews and the care required in interpreting the material once it had been recorded. After the course details is the Certificate of Introduction for Dr Ockrim signed by Professor Paul Thompson, which gave her authority to carry out practice interviews, including topics of a sensitive medical nature, during the course.

Besides Thompson the leading lecturer at the course was Ludmilla Jordanova, now Professor of Visual Culture in the Department of History at Durham University. She has been Director of the *Centre for Research in the Arts, Social Sciences and Humanities*, University of Cambridge and was Professor of Visual Arts at the University of East Anglia. She is the author of many texts regarding the history of science, thinking, gender and art. She was the first female President of the British Society for the History of Science, and her publications include *History In Practice* and *The Look of the Past: Visual and Material Evidence in Historical Practice.*

A major course participant, who made a great impression on all present, was Professor Elizabeth (Tilli) Tansey, a former neuro-chemist, now Professor Emerita of the History of Modern Medical Sciences, best known for her role in the Wellcome Trust's Witness seminars. Her interest in oral history, already active in 1991, led her, between 2012 and 2017, when she was head of the History of Modern Biomedicine Research Group, on a five-year research project, funded by the Wellcome Trust, titled *The Makers of Modern Biomedicine: Testimonies and Legacy*, to record oral testimonies from those who have contributed significantly to modern medical sciences. Her Witness Seminar series, held at the Wellcome Trust Centre, had the aim of bringing together medical professionals, scientists and technicians in group discussions, with the purpose of learning about significant periods in the history recent medicine. Topics covered have included oral contraceptives, genetic testing and post-penicillin antibiotics.

ORAL HISTORY IN THE HISTORY OF MEDICINE

5 Day Course to be held at the Wivenhoe Park Conference Centre

(Sponsored by the Wellcome Trust)

University of Essex 30th September – 4th October 1991

The course is intended for historians in the field of the history of medicine and related areas who wish to use interviewing as a source for their work or who are already working in this way.

It will provide both practical training in sound recording and interviewing techniques and also a discussion of the philosophy of oral history and the problems in its interpretation.

The course will be led by **Paul Thompson**, the leading figure in the development of oral history in this country. He is Research Professor of Social History at the University of Essex, co-founder and Director of the National Life Story Collections, founder of *Oral History* and author of the definitive work on the subject, *The Voice of the Past*. His other books include: *The Work of William Morris* and other biographies, *Living the Fishing* and *The Edwardians*. Most recently he has published *I Don't Feel Old* and *The Myths We Live By.*

Other staff associated with the course are:

Ludmilla Jordanova is Professor of History at the University of Essex. Her publications include *Lamarck and Sexual Visions* and she has edited and contributed to *Images of the Earth* and *Languages of Nature*. Teaching interests: history of nineteenth century science and medicine, history of the family, concepts and methods in social history. Current research projects: studies of the eighteenth-century European family, the relationship between science, medicine and the visual arts in the eighteenth and nineteenth centuries.

Steve Humphries is a television producer and author of *Hooligans and Rebels* and *The Secret World of Sex.* **Max Blythe** is Principal Lecturer in Epidemiology and Health Studies at Oxford Polytechnic. **Alan Ward** is Curator at the National Sound Archive. He is the author of *A Manual of Sound Archive Administration*.

APPENDIX G: FINAL TRIBUTE

A final tribute to Dr Ockrim for her community obstetrics appeared in a letter to the Editor of the *(Glasgow) Herald* on the 19th of September 2007, just one day after they had printed an obituary about her and her career. Headed 'Wonderful Woman,' it read:

> *Dear Sir,*
> *Thank you for the tribute to Dr Ockrim Collins (September 19th). Dr Ockrim, as she was known, is a legend in our family, following my successful delivery in June 1962 in the family home in Drumoyne. My mother was a patient of Dr Ockrim's husband, Dr Collins, who was sensitive to the difficult labour and trauma of a sick baby my mother had suffered at the Southern General some years earlier and recommended his wife for a home delivery. Mum still recalls with affection the care she received from this wonderful lady. Ever outspoken, Dr Ockrim's only complaint about mum's preparation for, and co-operation during the birth was to voice dissatisfaction about the choice of my name as she had already delivered more than one Karen that week. Mum is now in her 77th year and shed more than just a few tears on reading the obituary.*
> *Jim and Karen McQueen, 22 Nethercliffe Avenue, Netherlee, Glasgow*

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[73] Anne Digby, *The Evolution of British General Practice: 1850-1948,* pp.141, 289; Anne Hardy, *Health and Medicine in Britain Since 1860*, (Palgrave, Basingstoke, 2001), p.142. See also, Irvine Loudon, John Horder and Charles Webster, editors, *General Practice under the National Health Service 1948-1997*, p.3 where inner-city practices in Glasgow and Birmingham were described as having 'intensive patient demand, a fast patient throughput and standardized medicines.'

[74] Anne Hardy, *Health and Medicine in Britain since 1860*, (Palgrave, Basingstoke, 2001), p.81

[75] One patient VK recalled: It seems that Steven George's records were unbelievable – they just didn't exist.

[76] A personal recollection is that sometimes a single word sufficed to explain a consultation. An example is of a consultation represented by a single word – a prescribable anti-spasmodic. This indicated a negative abdominal examination, following the history taking and the diagnosis of possible irritable bowel syndrome.

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[81] S Taylor, *Good General Practice*, Oxford University Press, 1954

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The criteria are effect size, reproducibility, specificity, timing, does-response relationship, plausibility, coherence, experiment and analogy.

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[447] Paul Climie, *Asylums in Glasgow: The buildings where madness was managed*, accessed on 31/5/2021, at https://sourcenews.scot/asylums-in-glasgow-the-buildings-where-madness-was-managed/; https://canmore.org.uk/site/44226/glasgow-1345-govan-road-southern-general-hospital (accessed 23/1/2019). This describes clearly why people feared these institutions.
[448] Paul Climie, ibid.
[449] *The Workhouse in Barony, Glasgow*: accessed at http://www.workhouses.org.uk/Barony/ 14/2/2021
[450] https://www.nhsggc.org.uk/about-us/history-of-the-nhs-in-greater-glasgow-and-clyde/70th-anniversary-of-the-nhs/70-years-of-the-nhs-in-greater-glasgow-and-clyde/1948-1950s/1948-1950s/1957-chest-x-ray-campaign-helps-to-eliminate-tb-in-glasgow/# Accessed 22/3/2021, Between March 11 and April 12, 1957, a total of 714,915 people were screened in Scotland - 622,349 of them in Glasgow. More than 30,000 were called back for further investigations and 2,369 were identified as having TB, while a further 4,124 people were urged to return for check-ups. *Evening Times* (Glasgow) 14/4/2007.
[451] David Hamilton, *The Healers*, p.230-232.
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Tell all the truth but tell it slant —
The Truth must dazzle gradually
Or every man be blind —
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