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FROM DISILLUSION TO DELIGHT:
REFLECTIONS OF A PRIVATE DOCTOR

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I assume that most doctors would want to see that patients who had the greatest need and least capacity to help themselves, would be the ones who are most likely to receive help through a State system. Sadly, the experience of my professional lifetime is the opposite. The NHS is largely a system run by the middle class for the benefit of the middle class and with emphasis on the clinical conditions most likely to be suffered by the middle class. Services are poorest, and the doctors least well qualified and equipped, in the areas where the demand is greatest. Most people live in cities and they have the worst services. There is something fundamentally wrong in the State healthcare system.

As an undergraduate, as an active member of the North Kensington Labour Party, I was fiercely in favour of the NHS. This enthusiasm persisted into my early professional life. After a year of general practice training in Caterham (in those days one was not allowed to work in one's definitive practice in an area in which one had trained and I therefore chose to train somewhere that I had absolutely no intention of ever seeing again), I worked as an assistant first in Shepherds Bush and then as a partner in a practice that spread between High Street Kensington and the Harrow Road. As the junior partner, I was mostly stationed in the Harrow Road end of the practice. For two years I worked in an office where there was no washbasin. This was common in that part of London and had also been a feature of the Shepherds Bush practice. It seemed odd that my colleagues would have such little professional regard for clinical examination of patients but I learnt very quickly that General Practice was primarily a social service and that the perceived greatest need was merely for prescriptions and certificates rather than for early diagnosis and appropriate initial treatment. I am not the greatest clinician in the world but at least I believe that medical practice should involve something more than a paternalistic smile.

Another feature of central London practice at that time was that it was relatively impoverished. Doctors were paid the same wherever we worked in the UK but our expenses were inevitably higher in central London. Therefore we had less to take home. In my second year in the Kensington partnership I took a locum appointment in an east coast town so that I could earn some money during my summer holiday. I saw a different level of clinical practice and a more personal relationship with patients. I had always enjoyed the human side of general practice, as opposed to the mechanistic aspects of hospital work, but it now occurred to me that one could get the best of both worlds. I therefore resigned my partnership, converted our home living room into a waiting room and the dining room into a consulting room and put a plate on the front door that announced to the world that my home was now a doctor's surgery.

On the first morning of my first day in independent practice (still under the NHS) I saw one patient: a friend, Margaret Humphrey-Clarke. She came to see me quite deliberately just so that I would be able to

say that I had seen one patient on my first day. None came to see me that first evening so she was indeed the only person I saw that day. I covered other doctors' practices at lunchtimes and in the evenings but by the end of the first year I had built up a list of a thousand patients of my own. I survived, even though my own practice did little more than cover its expenses in that first year because, as with all doctors, I was paid retrospectively at the end of each quarter and based upon the number of patients at the beginning of the quarter.

I then drove a coach and horses through the NHS restricted area system (in which some areas were deemed to be over-doctored and others under-doctored) by forming a partnership between my own practice in North Kensington – an open area – and two doctors in South Kensington – a closed area. The NHS Authorities said that we couldn't do that but our argument was that the formation of a partnership was entirely up to us. The arrangement suited the South Kensington partners because I provided much of the night work and weekend cover and also covered their practices for holidays. It suited me because it gave me a toehold in South Kensington where I had spent part of my childhood and where I had always wanted to work.

The clinical standards in this particular practice were no better in South Kensington than they had been in my previous partnership. There was a secretary but no nurse and, again, no facilities for clinical examination. However, first one and then the other partner left medical practice and I found myself promoted to being the senior partner of a group practice at the age of thirty-four.

I jumped at the opportunity of getting new premises, designing them to my own specification, bringing in two new enthusiastic junior partners, getting a range of staff – and proper clinical facilities so that for the first time in my professional life as a GP I could wash my hands after examining a patient.

Between the three of us we built up the practice to thirteen thousand five hundred patients on our regular list and we also saw sixty temporary patients each week. It must have been one of the busiest medical practices in the whole country. However, our income did not represent that fact because our expenses must also have been among the highest in the country. We employed six staff but, as was the general rule, the Government contributed only 70% of the salaries. The 30% that we had to provide in South Kensington would have covered 100% of a staff salary in many other parts of the country. Secondly, the Government contributed to the cost of premises but only if they corresponded to strict specifications, for example on the size of the waiting room. I pointed out that there are no "green-field" sites in South Kensington and that one has no choice but to convert existing property – if one can find it at all. In any case, I argued that the size of a waiting room was not an important factor if one had long consultation hours and an effective appointment system – which we had. This argument was not persuasive and we were therefore reimbursed with only two thirds of the actual cost of our premises even though we worked full time for the NHS. We had plenty of opportunities for private practice but rejected them.

We enjoyed our work and certainly made an impact on the healthcare system in our local area. All went well until the General

Election of February 1974 after which Harold Wilson brought in his Social Contract between the Government and all "useful" people. He and his unspeakable Health Minister, Barbara Castle, put up the income of general practitioners by 6% but the staff salaries by 30%. As our expenses already comprised 40% of our gross income, the practice clearly could not survive in its current form and with its current philosophy.

The three partners sat down together to discuss what we should do and our split decision was based, ultimately, on the ages of our children. Mine were already at school age and therefore I could afford to spend longer hours away from home whereas those of my younger partners would benefit more from having greater parental contact. The partnership therefore dissolved, with the other two doctors staying in the existing premises and cutting services in an exclusively NHS practice while I returned to single-handed practice and began to take private patients.

With the disillusion brought about by my experience of a Labour Government, I visited the USA with a view to emigration. My eyes were opened when I saw the clinical standards of my American counterparts. It had never occurred to me that doctors could have not only washbasins but also simple laboratories and even x-ray units. Nor did it occur to me that doctors might go to a postgraduate lecture at half past seven in the morning because they actually wanted to improve their clinical skills.

On returning to the UK I realised that, much as I loved America, I loved London more. I therefore resolved to try to recreate in London what I had seen in America. I was fortunate in being able to buy the flat next door to the existing medical practice and I was even more fortunate in being able to get planning permission to establish my independent practice there. I did indeed design a small laboratory and an x-ray unit (into which subsequently we also installed ultrasound examination equipment) and the nursing room had an ECG machine (a rare commodity in general practice in those days) and also a sterilizer and equipment for eye tests, ear tests and lung function tests. To all intents and purposes I created a one-stop shop.

It took almost two years to create that new practice. During that time, I worked out of two rooms at the back of the former group practice. One of them had a washbasin so at least that was something. As it happens I have never in my entire life had such a high income (taking account of inflation) as I did in those two years. I had a full list of NHS patients and minimal expenses on premises and staff. I was providing very poor quality service for my patients but getting very well rewarded financially for doing so.

At that time I did two surveys of general practice clinical care in the South Kensington area. The first was through examining the use of hospital diagnostic facilities by GPs. I found that the average GP, with a practice of two thousand four hundred patients, arranged for one pathology test (blood test, urine test etc) a day, one x-ray of any kind a week, and one ECG a month. This represents clinical neglect on a simply vast scale. Furthermore, with GPs doing work that could have been done by nurses, it meant that hospital consultants had to do work that could have been done by GPs. The financial costs of that misapplication of human resources are immense. So much for the NHS being the envy of

the world! The second survey showed that there was one full time member of staff to every five doctors in the area and one part time member of staff to every three. As most general practitioners in those days were single-handed it demonstrated that a significant number of doctors had no staff whatever. I remember one colleague telling me proudly that she had a good income because the first patient had to turn on the light.

I opened the new premises on 4th July 1976 as a deliberate homage to American Independence Day. I was determined to bring to London the quality of care that I had seen in America. For four years I tried to persuade the NHS to adopt the model of the PROMIS Unit (as I called my new practice in deference to the Problem Oriented Medical Information System of Professor Lawrence Weed and the University of Vermont) as an alternative model to the standard Health Centre in which there may be district nurses, health visitors, chiropodists and heaven knows who else but no diagnostic facilities. The Department of Health were totally unimpressed and suggested that I should try to persuade my professional colleagues to support the idea. The British Medical Association were also supremely unimpressed.

All I was asking was that the Government would pay for the cost of the x-ray films and the cost of the laboratory re-agents. I already owned the equipment and employed the staff. Predictably, the Department of Health refused my requests. They knew perfectly well that this would be the thin end of a political wedge and that general practice would become a clinical rather than social service.

I had taken private patients in order to pay for the comprehensive facilities and staff. The NHS has a built-in system to discourage private practice in NHS practices and I believe it is right to do so. Whatever proportion of the doctor's income is received from private practice is deducted in that same proportion from the allowances paid towards the costs of premises and staff. I refused to provide a two-tier service to my NHS and private patients and therefore gave my NHS patients full free access to my x-ray and laboratory facilities and I paid the full costs from the income that I gained from private practice.

After four years of this crusade I had totally failed to persuade anybody in political circles to support the ideas. By that time my expenditure on my NHS patients exactly matched my income from the State. I saw no point whatever in pursuing that hopeless quest. Crusades may be magnificent but ultimately one has to be realistic.

At the same time, I had read Ayn Rand's *Atlas Shrugged* and realised that I had been fundamentally wrong in my altruistic beliefs. People do not benefit from the State system. I had seen in practice that this was true but now I understand from Ayn Rand *why* it was true. I recognised that the Communist GP Dr Julian Tudor-Hart's *Inverse Care Law* – that those who need the most help are least likely to get it – was actually caused by the State medical system. I resigned altogether from the NHS in 1980 – and received a lot of abuse from patients (lawyers, accountants, politicians and civil servants among others) for "abandoning" them. One lawyer wrote me a six page hand-written tirade of abuse. Very few of these NHS patients, despite their professional standing, became private patients of mine. The two populations are different philosophically. Those patients who could

afford private practice but stay "loyal" to the NHS do so because they believe they have rights. Those who become private patients do so because they acknowledge their responsibilities – and because they appreciate what it takes to provide good quality services in any area of human activity.

Interestingly, quite a number of former NHS patients who did come to see me privately were those whom I would not have anticipated could possibly afford to do so. The local milkman said "you stuck by me: I'll stick by you" – and he did. Private general medical practice is not phenomenally expensive, when one puts it alongside what people spend on alcohol, cigarettes and gambling.

My private practice gradually built up and I took on a full partner. We worked together happily for ten years but eventually this partnership dissolved amicably on a difference of clinical interest. I became particularly interested in patients who suffer from alcoholism, drug addiction, eating disorders and other compulsive behaviours, whereas my colleague retained a primary interest in asthma, heart disease, diabetes, cancer and all the other bedrock clinical conditions. I share his interest in those clinical subjects but I felt that provision for them was already generally well covered whereas the patients I was interested in tended to be clinical rejects. Furthermore, I felt that the work that I was doing was really preventive medicine at its most important level. If I could get patients to give up smoking, reduce their alcohol consumption and stop doing all sorts of things that were damaging to themselves and other people, then some would never need the care of doctors who specialised in cancer, heart disease and the other major clinical conditions that fill up our hospitals – until they did so simply through age and decay – and there would be less domestic and social trauma.

However, I accepted that each doctor has his or her own clinical interests and therefore it was perfectly reasonable that we should part company. On that same basis, I would not criticise doctors for choosing to work in the relatively privileged conditions of the NHS rather than give their services to the truly destitute in the Third World. My former partner and I still work next door to each other in our separate general medical practices and we remain good friends, as indeed I do with my former NHS colleagues. Incidentally, both of those doctors – five and ten years younger than me – have now retired from the NHS in disillusion.

In 1986 my wife and I re-mortgaged our home and our medical practice and built the PROMIS Recovery Centre, a residential treatment centre in Nonington, near Canterbury in Kent – and close to our weekend cottage. We built it in that part of the world so that we could run it ourselves at the weekends and because the cost of property is so much cheaper than in central London. We had attempted to fund it through charitable sources by establishing the PROMIS Trust, with the Archbishop of Canterbury as the President, a noble Lord as the Chairman, and various other members of the nobility and clergy and the Great and the Good as the members. After one year we had raised not a penny. Addiction isn't sexy.

My wife, Meg, and I therefore funded the Treatment Centre ourselves. In the first year we tried to give help to those who most needed it and who had least capacity to pay for it. I reckoned that everyone could afford £10.00 a week out of Social

Security benefits and therefore I offered fifty consecutive patients free treatment provided they paid me back £10.00 a week during the subsequent two years. I was once paid one £10.00 note. By the end of that first year I had lost £1,000 a day. It was only because property values had increased dramatically during that particular year that I was able to re-mortgage and survive. My wife and I had to move down to the basement of our home and we took patients into the ground and upper floor as an extended care facility or halfway house. In due course that came to grief when the Social Services Department decided that room sizes had to correspond with those of nursing homes. I pointed out that our patients were generally young and fit and that if we caught them in bed in the afternoons we would discharge them from treatment. This argument was not persuasive and the bureaucrats had their way: the only halfway house in the borough had to close. The regulations were met – by the simple process of having no-one left to regulate.

We sold our former home and moved down to South Kensington, near our medical practice. In due course we established an outpatient facility in separate premises in South Kensington and that has now expanded to cover two substantial mews houses. A third house (in a row) has now been made into a thirteen-bed eating disorder unit and we hope to establish these entire premises as an independent hospital.

Enter the National Care Standards Commission (NCSC). The Government, through the Care Standards Act 2000, established a set of principles for all medical care, State or private. The Department of Health bureaucrats then converted these principles into a set of core standards and further sets of specialist standards for particular institutions, such as mental hospitals. Altogether there are sixty-two such standards that apply to PROMIS. For each of these standards we have to establish a set of procedures to show how we will implement the Government standards. Then, for each of those policies, we have to establish a set of training programmes for the staff. Then, for each of those training programmes, we have to establish monitoring systems to ensure that the training was implemented. Specifically, in the mental health standards, it is acknowledged that the intention is "to reverse the balance of power". Further, there is the requirement that we should be "*pro-active* in addressing the needs of individual patients with due regard to race, ethnicity, religion, gender, age and sexuality *and so forth*". How on earth one could do that absolutely beggars belief. Political correctness is one thing but absolute craziness is altogether another.

I believe that we are currently in the "White Russian" phase of this revolution. The members of the National Care Standards Commission whom I have met – as with the members of the National Institute for Clinical Excellence – are highly motivated in a positive way and have been appreciative of the work that we try to do at PROMIS. However, we live in a culture of complaint, accountability and blame. This will inevitably lead to the "Red Russians" taking over in due course from the "White Russians". The notes that I made last Christmas on the requirements of the Care Standards Act 2000 amounted to fifty-three pages – and these were simply the jottings that I made in instructing my senior staff on how we needed to prepare the various policies and procedures. I believe that the completed document of policies, procedures, training programmes and monitor-

ing systems will run to over one thousand pages. This will be a legal document. I shall be accountable for it. Lawyers – who, along with governments, can be guaranteed to destroy anything creative when they put their minds to it – will in due course argue that PROMIS has failed their clients on particular subsections of particular policies and therefore that we should be deemed to be irresponsible and not worthy of our licence. They will then argue that their clients should be reimbursed with the cost of their fees for treatment at PROMIS.

Doubtless they will play the same games with the PROMIS Unit, my general medical practice, which has also been ensnared into supervision by the State through the NCSC. One particularly bizarre feature of this State supervision is that private GPs now have to send copies of their consultation notes to the patient's NHS GP or to the patient to take to his or her NHS GP. The idea that a patient might not want to have an NHS GP – I myself have none – does not occur to statists. Or perhaps it does occur and they want to make life as difficult as possible for private doctors. In my single-handed private general practice I have taken on an additional full time secretary purely in order to do the paperwork now required by the State.

Periodically during the last seventeen years of operation of the PROMIS Recovery Centre, we have had lawyers argue that when their clients had relapsed after receiving treatment from us, this meant that our clinical services were inadequate and not worth paying for. Further, they argued that our patients were not in a fit state to make appropriate judgements at the time that we accepted them for treatment and therefore they should not be deemed to be responsible for the costs. Lawyers will indeed destroy anything if they possibly can.

At present everything in the garden is lovely. We passed our first inspection by the National Care Standards Commission with flying colours – and so we should. Incidentally, we have provided reams of paperwork for the NCSC but they very rarely reply to my letters at all when I have asked for advice or interpretation. I suppose the same is true for these bureaucrats as for any others – they don't want to get caught holding the parcel when the music stops. I can understand that general principle in an under-valued branch of the Civil Service or independent sector (as the NCSC term themselves) but it doesn't help those of us who have the creative urge. I sympathise with the probability that they are understaffed and under-funded – but that now cramps me. By taking the private sector under the wing of supervision by the State, there may be a few third rate practices that can be stopped – but I fear that there will be a large number of first rate practices that will be hindered. The absence of negatives does not necessarily produce the presence of positives.

I was talking to my friend Tim Bell, Lady Thatcher's PR guru, recently and I mentioned my concerns for the future. His response was that creativity will always find a way. I hope he is right. I fear, however, that the story of my professional life shows that Ayn Rand is right when she says that the difference between a welfare state and a totalitarian state is merely a matter of time.