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Why the NHS is Worth Saving

GAVIN FRANCIS

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for my colleagues,
whose many unnoticed acts of
kindness and professionalism
sustain the NHS

CONTENTS

THE NEW

NATIONAL HEALTH SERVICE

★

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

This book has been inspired by hundreds of conversations with dozens of fellow clinicians who work across the NHS. Many of them have preferred to remain anonymous. Names and identifying features of the patient stories that follow have all been changed, but I'd like to reassure the reader that everything described in this book *has happened*, though not to the patient described. Just as physicians must honour the privileged access they have to our bodies, they must honour the trust with which we share our stories. As a doctor who is also a writer, I've spent a great deal of time deliberating over what can and cannot be said without betraying the confidence of my patients. Protecting confidences is an essential part of what I do: 'confidence' means 'with faith' – we are all patients sooner or later; we all want faith that we'll be heard, and that our privacy will be respected.

1

A DAY IN THE LIFE OF (POTENTIALLY) THE BEST JOB IN THE WORLD

An ordinary Tuesday morning and I'm arriving at my GP practice for a day's work. It's 8.30 a.m., and the receptionist on duty is Nicola. 'Any dramas?' I ask her as I approach the desk; 'Not yet, but it's early,' she says with a wry laugh. From the moment the phones begin to ring in the morning until they hand over to the evening service at 6 p.m., practice receptionists are at the front line of the health service, bearing the brunt of patients' anger, disappointment and frustrations with the NHS. A couple of years ago I stopped saying 'good

morning' and began to experiment with alternative, more optimistic greetings. 'It's going to be a Tuesday of Happiness,' I say as I stop at the desk. 'Let's hope so!' she replies.

I leave a cup of tea cooling as I switch on the computer, which runs on an old operating system and usually takes a few minutes to get going. The GP computer systems don't talk to the hospital systems, and it often feels for clinicians as if they're drowning in passwords and glitches. Some parts of the NHS still use pagers and, until very recently, fax machines. Most of us are trying to provide medical care fit for the 2020s with computer systems better suited to the 1990s.

There are two letters with handwritten sticky notes laid over my computer keyboard – urgent messages left by colleagues for me to action today. Modern healthcare is so complicated that no one case or story could illustrate the problems of today's NHS, but these two letters, left out for my urgent attention, illustrate some of the pressures on the health service today.

One is a discharge letter about Helen R., a former schoolteacher and a formidable bridge player, a widow and a Londoner, now in her early eighties, who I'd admitted to hospital three weeks earlier for treatment of a kidney infection. The infection had made her confused and unsteady, and she waited most of the day for an ambulance, getting progressively unwell. In the first hours of her admission she'd fallen out of bed onto the hard hospital floor and broken her hip. I know from speaking to hospital colleagues that at the time she fell the ward had been very short of nurses. I feel a flash of guilt, as if I'd broken her hip, though I'd had no choice other than to send her in – the acute medical unit had been the only option open to me to keep her 'safe'. But because of understaffing the hospital ward had proven anything but safe.

The other letter was about William S., a man in his late forties who had been referred for colonoscopy after coming to see one of my colleagues several months ago and complaining of persistent diarrhoea and blood loss, with

a discomfort in his lower belly. He had been anxious that his new symptoms were a sign of bowel cancer, and my colleague had referred him urgently for specialist assessment. But because of his relative youth (under fifty-five), and the huge pressures on the service caused in part by pandemic backlog and in part by lack of staff, that referral had been downgraded from 'urgent' to 'routine', and he had waited many months for the test. Now the colonoscopy confirmed what William had most feared: cancer. It had most likely spread to the liver, and a hospital appointment had been scheduled for the following week to discuss what treatment options remained to him. I groaned inwardly and made a note to call William later, to see how he was taking the news. Pressures on the service are now so extreme that urgent referrals are often downgraded, and life-threatening diagnoses are being missed.

The computer seems to be working reasonably well, so I open the four different applications I need to access the different elements of my patients' notes. There are thirty-five

pieces of correspondence to read – specialist letters, scans, X-ray reports – and two screenfuls of blood tests to review. When there's adequate time in the day I enjoy going through these letters, reports and results: they tell me whether the working diagnoses I've made have been correct, and where a test or scan result is unexpected they offer learning points. Specialist letters help me to plan my next encounters with each patient, and unanticipated results feel like puzzles to be solved, not unwelcome irritations. But on pressured days those anomalous results feel like obstacles, slowing me down when there's already insufficient time to get through the workload. Hurry creeps in; the chance of things being missed begins to rise. Many of the letters will need to wait until lunchtime to be read properly, but before clinic starts I cherry-pick some easy issues that can be dealt with swiftly.

Only when I've scanned the correspondence do I open my NHS email. A motley collection: one message tells me that the hospice is closed to new admissions, and the community palliative

care nurses are struggling to cope. They ask that I avoid referring all but the most complex cases their way, and handle the rest on my own. If any dying patients are in crisis they'll need to be admitted through A&E. There's an email too from the clinical leader of primary care to let me know that the front door of the local hospital is experiencing 'extreme pressure', urging me to explore all possible alternatives before considering an admission for any of my patients – as if I didn't do that already. The tone of the letter is apologetic; this particular clinical leader still works as a GP, and knows how frustrating and patronising these letters seem. The community psychiatry team has rebuffed one of my urgent referrals, and asked me to follow up a suicidal patient myself as they have no capacity to see her. I forward the email to the receptionists, and ask them to find out if the patient can come in today and be added on to the end of my already full clinic.

The local hospital for children has put out a message to say that if any GPs would like to order blood tests for a child, there's a three-month

wait for an appointment at the local dedicated paediatric clinic – a service so slow that it might as well not exist. I don't make the decision to send children for blood tests lightly, and I can't think of a situation where I'd be happy to wait three months for a result. The children's phlebotomy clinic was set up with good intentions: its staff are highly skilled, and children are less likely to develop a needle phobia if the blood is taken there, rather than by a rushed GP. But it's another example of an underfunded service that has failed to keep up with demand.

There's a letter from Scotland's Chief Medical Officer reminding me that the NHS should not be providing any pre- or post-operative care for people seeking private surgery abroad. The diminution and degradation of the NHS means that health tourism is booming – but so is the cost of fixing foreign hospitals' mistakes. The NHS is still trying to figure out a reliable mechanism to bill overseas private providers for the follow-up required when British people fly abroad for procedures that go wrong.

Only then do I examine the list of the morning's patients. I've been a GP for eighteen years, a partner in this practice for thirteen of those, and about half of the fourteen names are familiar to me. It's the enormous diversity that I love about the work – from the names on the screen, I know I'll be dipping into training in psychiatry, paediatrics, orthopaedics, gynaecology, dermatology, geriatrics, and that the morning will bring problems that, at one end of the spectrum seem fleeting and trivial (though they may not seem so to the patient), and at the other, life-threatening and desperate. Both extremes can be satisfying to treat: in its essence, the practice of medicine is about using medical knowledge to ease suffering, and its best manifestations are a strange alchemy of science and kindness. Even the most seemingly trivial encounter will require me to sift through the patient's story and symptoms for worrying features, excluding scores of potential diagnoses before arriving at the most likely and then formulating a plan that acknowledges the limits of the service and the patient's own preferences.

The architect of the NHS, Aneurin Bevan, wrote of general practice: 'What is not so obvious is that the average doctor is equipped by his general education and by temperament to make an assessment of so many imponderables. He requires for this delicate task imaginative sympathy, sensitivity, and a liberal education.' Doctors and nurse practitioners are obliged to train for a great many years because as a society we expect them to hold a wealth of knowledge about the body and mind, and to exercise wisdom, kindness and professionalism in how they apply it. The enormity of twenty-first century medicine, with its increasingly unwieldy power to diagnose and treat but also to complicate and *over*treat, looms over every encounter. Sometimes it seems absurd to me that so many expectations, or 'imponderables' as Bevan put it, have to be attended to in less than ten minutes. But though my days are always pressured for time, it still feels as if the job is worthwhile, and usually that it's possible to do a great deal of good.

The clinic begins with someone suffering

stomach pains that won't respond to treatment; her ultrasound scan was normal but her pains persist; she has been told that it's more than a year until she'll be seen in the outpatient clinic and can be considered for an endoscopy. She's lucky; for some specialties the waiting list to be seen is now more than two years. Another patient is just out of hospital after a chaotic four-day stay; she has two contradictory discharge letters about the plan for treatment now that she's home, and no hospital follow-up booked. We spend much of the appointment time on the phone trying to get through to the responsible consultant's secretary. One man has had surgery overseas, and brings a list of expectations for follow-up, as well as further tests, all drafted by a doctor whose first language isn't English, and who works in a health system geared entirely towards profit. I have to explain that the procedure he paid for wouldn't have been recommended here in the UK, and that the follow-up specified by the foreign clinician won't be possible on the NHS – he'll have to fly back to the country where he got his

surgery if he wants it. He blusters out of the room in anger, and I take a few deep breaths to calm myself before calling the next patient.

One man who speaks no English has missed his long-awaited specialist review because the appointment letter arrived at his home the day after he was due to be seen. I get back on the phone to the secretaries, trying to rearrange the appointment and make sure that the new one will have an interpreter available. Scattered among these complex, difficult conversations are far easier encounters where brief advice, or a simple prescription, have a good chance of curing someone's problem, or at least improving their quality of life: an ear infection, a steroid injection to an arthritic knee, a new cream for scarring acne, HRT for debilitating hot flushes. At the end of the surgery I call William S., and listen for a few minutes to his justified fury at the delayed diagnosis of cancer that now threatens his life. I tell him we'll do everything we can as a practice to support him through the surgery and chemotherapy he now needs.

Among the home visits to be done over lunchtime are an elderly man with paralysing anxiety and chest pains. Since the lockdowns of the pandemic he has been too frightened to leave his house, and his history of heart disease means I'll have to see him at his home to decide whether the pain might be coming from his heart, or whether it's a resurgence of his anxiety. When time is short the temptation to admit to hospital directly for blood tests and an ECG is strong, but I resist it – bad for the patient as well as for the overwhelmed A&E. The other home visit of the day is to Helen R., home now with a replacement of the hip that was broken when she fell on the ward. The joint has been repaired, but she is now unable to walk. The visit is to see whether we can better manage her pain, and assess whether there is enough care coming in from social services to keep her clean and fed. She sits in her front room, heating on low to save money, a blanket over her knees and a woolly hat on her head. 'Mustn't grumble,' she says in her Cockney accent, 'but I don't think I can stick this, sitting

here on my own. Do you think I should move into a home?' We spend a while talking about local sheltered housing, and whether one of them might suit her better than a care home.

On my way back to the surgery I buy a sandwich to be eaten at my desk while going through the rest of the correspondence. The local university disability service has written to me about a patient with suspected attention deficit disorder, asking that I write a one-page summary of the difficulties he is having and how the university should adapt their expectations. There are two insurance forms to fill in, and a request for a medical supporting letter for someone's benefits application. Gastroenterology, cardiology, neurology, rheumatology – each of these specialties has its own language, and its own expectations of how I, in the community, might take pressure off their service by doing more for our mutual patient. I go through each of them arranging prescription changes, follow-up appointments and new blood tests based on the letters' recommendations. Clinical colleagues in hospital

understandably want me to do more in the interests of economy and convenience for the patient, but it's extremely rare that I receive a letter asking me to do less, or prescribe less. It's always more. The cumulative effect of all these requests, and the frailty of an ageing population, as well as rising expectations of what medicine can do, all contribute to making my days much busier than they were when I started as a GP two decades ago. Primary care conducts about 90 per cent of the encounters in today's NHS, and it does it with less than 10 per cent of the funding. It's a very efficient way of offering medical care – good for patients and good for taxpayers, but it's been starved of the funding required to do what the people, politicians and specialists are now asking of it. Most GPs passionately want to do the best by their patients and are crying out for ways of making their workload more sustainable.

That afternoon I attend a meeting of doctors from all the GP practices in my sector of the city. We don't get together very often because we've all got far too much clinical

work to do. While hospital doctor numbers have been rising steadily, there are 10 per cent fewer GPs now in real terms than there were in 2015, though the number of appointments offered has increased. Many practices in the area are folding – some because they can't recruit replacement staff, others because the antiquated system whereby GPs must provide their own premises doesn't work any more. When GPs get together there's often a great deal of moaning, but there's laughter too – most of us still enjoy helping our patients, and want to find ways of making the system work more sustainably.

None of the GPs in our group have any experience in managing the colossal budgets wielded by the twenty-first-century NHS – we're clinicians, not managers. You would have thought that having spent a minimum of ten years training in clinical medicine (and often as many as twenty years) would mean that we'd self-selected against wanting to manage budgets, but that is exactly what the government believes we should aspire to do. There

was a vogue a few years ago for encouraging GPs to sign up for 'leadership training' and 'resilience training', as well as workshops on 'managing change'. That has diminished now as the profession drops into survival mode. I was never sure anyway who was expected to go on seeing the patients while GPs took on these new roles.

The principal speaker was a well-known, widely respected, energetic and accessible consultant physician who has been charged with redesigning elements of how we manage the mounting numbers of frail elderly patients who shuttle back and forth between home and hospital. In my area, the total number of beds available for inpatient care across all specialties has dropped more than 20 per cent since 2003, while the city's population has increased by 25 per cent. The consultant physician told us about plans, already in place, to drop the number of beds available by a further 10 to 15 per cent. 'We can do this,' he said; '40 per cent of the patients in my ward don't need to be there.' This last statistic he quoted with a note

of irritation, as if the paucity of beds was somehow our fault as GPs for admitting people in the first place. 'What are you going to do,' he asked us, 'when you phone to admit a patient and we refuse to take them. Because we've no beds. Because there isn't enough money.'

There was a surprised silence. This was new: a senior clinician, involved at the highest level of strategic planning, stating that the system as it stands is on the verge of collapse, and explicitly shifting responsibility for the problem back to general practice, which is itself in deep crisis. Hospital managers are fond of talking about 'bed blockers', and it seems they were now contemplating the relief of blocked beds by refusing admissions. To use a plumbing analogy: if you were to ask a plumber what to do about a blockage, he'd be unlikely to forbid the opening of taps.

Being a GP is potentially the best job in the world: it involves meeting people of every kind, listening to their stories, diagnosing their difficulties, and coming up with plans

to improve the quality of their lives. For the entirety of my professional career the state has paid me to do that, and it, in turn, has expected me to act with integrity and professionalism, in the best interests of my patient. But it's getting harder and harder to do that job the way I was trained to do it, and more and more of my days are spent not in helping my patients feel better, but in helping them navigate a failing system.

For a patient to be seen by a GP costs about £38, to be seen in A&E costs about £200, while to call out an ambulance costs around £400. GPs offer more than 300 million consultations per year, while A&E, overwhelmed as it is, has just 23 million patient encounters. If even a fraction of the patients currently seen by GPs end up at the doors of the hospitals, those hospitals will be swamped. The current algorithms used by NHS Direct trigger about double the number of ambulance call-outs as GPs do when taking the same call – computers don't make good doctors. Another reason the ambulance service is overwhelmed has to do with patient perceptions of what constitutes

an emergency: one paramedic told me recently that he was called out for a 'bleeding wound' that on arrival proved to be a paper cut.

The National Health Service is an amazing institution, and almost unique in the world. Our country even chose it as the centrepiece of its Olympic opening ceremony in 2012 (though in terms of the quality provided by the service, 2012 now feels like a very long time ago, and it's difficult to imagine an Olympic opening ceremony in 2023 doing the same). That we still have a system the same for everyone, free for all at the point of contact regardless of means, is something worth celebrating and protecting. But the NHS is not working the way it was intended to.

I'm relieved that there's an ongoing national debate about the problems of the NHS, and about how they might be solved for people like you and me, for my patients Helen R. and William S., for the 67 million people of the UK as well as for the approximately 1.4 million people who work within the health service across the four nations. My intention

with this book is to make a modest contribution to that debate: to bring it up to the minute with stories that illustrate how poorly it is working right now, offer some suggestions for how things could so easily be better, and passionately defend it as an institution worth saving. It will celebrate the NHS's founding principles because they're good for patients, good for communities and good for my clinical colleagues – good for everyone except private company shareholders.

2
IN PLACE OF FEAR: THE ORIGINS OF THE NHS

With each year that goes by I have fewer patients who remember life before the NHS. One woman remembers her mother keeping a jar of money 'for the doctor' – they never took holidays, and any spare cash was put aside for medical fees. Another told me that her family made do with visits to the herbalist's shop – herbal medicines were less effective than pharmaceuticals but more affordable. Illness could ruin a family's prospects, and frequently did; healthcare for the poor was distributed through churches and charitable foundations with patchy coverage. In 1800, one in three