Attitudes to healthcare—then and now

A season of short documentary films from the 1950s, ’60s, and ’70s on topics such as family planning, polio, and epilepsy show how much social attitudes have changed, writes Peter Davies

Were the 1950s a lost golden age of social solidarity, buoyed by peace, prosperity, and universal welfare provision? Or was Britain then still dominated by class-bound attitudes, the dreary rules of petty officieldom, and a shabby, monochrome austerity? Did the nation really blossom into colour only with the new affluence and freedoms of the 1960s, before lapsing into a harsher mood in the 1970s, one still familiar today?

The British Film Institute’s project Boom Britain showcases 32 short documentary films made between 1951 and 1977. There could hardly be a more vivid way of examining the nation’s post-war social history, and among them is a clutch of films with health related themes, all dating from the 1950s and 1960s. These were commissioned mainly by charities, although one was funded by the NHS and another by a drug company. Some of their topics were controversial in their day, others are more controversial now. Some films were widely screened, others only ever reached a select audience. One won an Oscar. As with most documentaries, they languished in obscurity after their moment of perceived usefulness had passed.

Today they have a new usefulness, not necessarily quite what their makers intended. These films are certainly important records of services that have developed out of recognition or disappeared altogether. But what hits you hardest is how they reflect, in all innocence, attitudes that are a deep anathema to us now: the past, even as it appeared altogether. But what hits you hardest is that have developed out of recognition or disappearance.

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For example, Birthright (1958), made for the Family Planning Association, sets out to overcome the “embarrassment and distaste” associated with contraception. Different patients are seen in consultation with doctors who advise them in the manner of an officer addressing inarticulate other ranks. Couples in a discussion group chaired by a vicar talk of the difficulty of living with their parents after marriage, of a wife sharing her husband’s income, and of marrying someone from a different religion. Three “eminent scientists” lament the 150 illegal abortions carried out every day in Britain and bemoan the unreliability of “mechanical and chemical devices” in the hands of those who are not “trained and careful people.”

Manchester’s regional hospital board commissioned There Was a Door (1957) to illustrate its services for people with learning disabilities. Narrated by an actor playing a general practitioner, it describes his dilemma in finding accommodation for 19 year old John, who has Down’s syndrome (the term is never used) and whose mother can no longer cope with him. “How could she go on being mother to a man with the mind of a child?” John, far from being troublesome, appears placid throughout, yet his opinions on his future are at no point sought. His fate is to be confined to a long stay institution for “mental defectives,” where he can be “amongst his equals instead of being avoided or looked down upon by those more fortunate than himself.”

If we deplore the social attitudes of the time, we should at least give credit to the humane purpose with which the film makers tackled their work. Their commitment to making a better society is evident throughout. Often they put their skills at the disposal of disadvantaged groups, presenting them with sympathy and sensitivity, rarely compromising their dignity and always aiming to win them equality and understanding. Three films in the BFI collection illustrate this particularly well.

No gawping: stills from Birthright (left), about contraception, and People Apart, which looked at epilepsy

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Thursday’s Children (1956) focuses on infants at the Royal School for the Deaf in Margate. Narrated by Richard Burton, it won an Oscar for its codirector Lindsay Anderson, later to achieve fame for the rather more lavishly produced If. . . and O Lucky Man. The camera barely leaves the children’s lively, expressive faces as they tackle with patience, humour, and enthusiasm the dauntingly laborious process of learning to read and speak (although here too 1950s social attitudes intrude: their text is Little Black Sambo).

For people with epilepsy, fear of seizures was aggravated by stigma. People Apart (1957) confronts public prejudice and mistaken beliefs about the condition. Its six subjects give candid and unscripted accounts of their problems finding and holding on to a job or facing up to the loss of friends fearful that they may witness a fit.

Polio outbreaks in the 1950s and early 1960s are the context for Four People (1962), tracing the progress of the disease in four patients (played by actors) from onset to rehabilitation. This is the world of iron lungs, callipers, and tottering invalid cars, of menacing antiquated gadgetry, more Dr Strangelove than Heath Robinson. Polio reduces each of the four to varying degrees of dependence, yet the film remains optimistic, showing them reconciled to their circumstances.

Today’s television schedules abound with programmes about health, but mostly they belong to a different genre. Voyeurism has ousted humanity, sensationalism has replaced sensitivity. With the honourable exception of occasional, usually BBC made, big budget, science based documentary series, our staple fare too often comprises prurient peeps into cosmetic surgery or gawping at the freakishly obese. The BFI collection, by contrast, comes from the tradition of the public information film, precious documents of a past close at hand but now forever out of reach.

Boom Britain: Documenting the Nation’s Life on Film launches on 8 November 2010 and continues at BFI Southbank, London, and around the country from December until spring 2011. Shadows of Progress: Documentary Film in Post-War Britain 1951-1977, a set of 38 films on four DVDs, will be issued on 15 November 2010.

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We must do more for doctors trained abroad

Setting up appropriate training and a useful induction scheme would help

The patient had a crown of plum sized abscesses on his head. After a brief exchange the doctor started screaming at the patient. It was an old fashioned telling off. The outburst over, the patient hurried out of the consultation room. Later that morning he returned, his head shorn of hair offered to some Hindu deity and revealing some unsightly lunar landscape of mounds and craters. The doctor drained the abscesses. The look of agony on the patient as the scissors dug deep into his scalp will stay with me for ever. “Would some anaesthetic be helpful?” I suggested to the surgeon, gingerly, as I pinned down the patient’s legs. “I won’t give him any unless he says it’s intolerable. Western doctors give too much anaesthetic.” The patient, writhing in pain, didn’t utter a word.

I often wondered what would become of the doctors I befriended in rural India if they were to work in the United Kingdom. The principle of respect for autonomy, so prominent in India, would soon be the subject of complaints in England, not because of a technical mishap—they seemed to my untrained eye to be technically proficient—but because of a certain manner that British patients, relatives, or medical staff would consider rough, uncaring, or paternalistic. It was no surprise, then, to discover that international medical graduates are over-represented in General Medical Council fitness to practise hearings (BMJ 2008;337:a682; www.gmc-uk.org/news/1510.asp). A recent study of doctors who did not qualify in the UK, commissioned by the GMC, highlights some of the difficulties that such doctors face when making the transition to the UK medical setting. The study referred to “a marked lack of relevant information about legal, ethical and professional standards and guidance prior to registration, variable levels of training and support specifically in the areas of communication and ethical decision making, and isolation in non-training posts” (www.gmc-uk.org/FINAL_GMC_Warwick_Report.pdf). The statistics concerning the GMC hearings refer to a small number of doctors, but we do not know how many doctors trained abroad are the subject of complaints that fail to reach the GMC or how much struggle in silence to adapt to the happenings of their workplace.

These doctors, newly arrived in an unfamiliar environment, are easy targets. They may look different, speak in hesitant English, and appear somewhat ill at ease. They are seen by some UK graduates as unfair competition, “stealing” jobs that should be their preserve. Their voice is muted, for who are they to complain? Yet they represent about 30% of doctors currently registered in the UK, and their contribution to the healthcare system is undisputed (www.gmc-uk.org/Primary_Medical_Qualification.pdf). The GMC’s study notes that current differences in training for non-UK graduates “focuses mainly on practicalities of immigration, registration, availability of posts and, where required, passing the relevant examinations.” The authors call for better resources and induction for international medical graduates to prepare them for the local ethical and cultural context. International graduates can undergo clinical attachments that allow them, sometimes for a fee, to observe the activities of an NHS hospital, but more is needed. The doctor in the opening paragraph may wander about the wards for a month but still not know, at the end of his stint, that shouting at patients is unacceptable. Sociocultural and ethical practices are generally harder to spot than preferred drugs or doses. Although it may pose logistical challenges, newly arrived doctors should ideally be paired up, in a sort of “buddy scheme,” with graduates from their own country who have worked for several years in the NHS. So diverse are cultural habits and beliefs that it would be difficult for a Pakistani doctor, for example, to appreciate what it must be like for a Nigerian doctor.

A nurse who had moved from a developing country to a large US hospital once told me how she remarked to a female colleague that the colleague had put on weight. She was surprised at the bad reaction. Back home, the nurse said, this was a compliment. Even if foreign trained doctors do not say that the situation is intolerable, common decency dictates that we should help them in their transition. On a personal level this may mean adopting an open minded attitude and a willingness to explain cultural differences. On an institutional and governmental level this means setting up appropriate training and a useful induction scheme. This might result not only in fewer complaints but also in happier doctors and, ultimately, patients.

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