HACOY WEEK 4 (MIDLANDS)

TRAVELLING LINDA
BETOOS CHRISTMAS

Chapter 12

Birmingham: The Right Medicine

Birmingham is one of the world's unloved cities. It's always being slagged off, not only in a bored-taxi-driver way, but seriously, by university types who draw up league tables suggesting that the quality of life is awful in Birmingham. Glasgow University, in an analysis of desirable places to live, said that Edinburgh came top of the form and Birmingham bottom of the class: 38 out of 38 – the least desirable place to live. Well, is it true, or is it a fearful slander? It is of course neither. I wouldn't willingly live in Birmingham. I hate the accent for one thing: it is the sound of a headcold, of chronic catarrh. But as a place to live it is no worse than Bradford, only bigger. Much bigger. One million people live in the city. One million people imprisoned by a ring road and, if they try to fight their way out, they'll be caught in a figure of eight called a spaghetti junction. Birmingham sold out to the car years ago. By comparison, Newcastle's motorway, which caused me to get lost and to curse the car, is but a slight blemish on the cheek. This is a massive deformity, the kind that makes you want to stare and look away at the same time. Prince Charles, our future king, does not like Birmingham. I don't think his tongue has ever lacerated the spaghetti junction, but that's because he's a buildings chap, and he has been exceedingly rude about some of the city's architecture. He said that the new conference centre (to be completed in the nineties) was 'an unmitigated disaster', and that the public library looks like a place for incinerating rather than keeping books. Such *bons mots* tend to cling around the neck of the recipient for ever more. The game is fun: I like it. I think most of the Prince's subjects like it too. I don't think many of them have much visual sense, and I don't think many of them have a real feel for cities, and these two facts mean that we have some ugliness around us. We thoroughly enjoy Prince Charles having a go; it makes a pleasant change from endless pap about female members of the royal

family. The Prince of Wales has raised the profile of the debate to a dizzy height but we must not lose sight of the fact that architectural mess is a worldwide and dogged problem. In some ways our mistakes seem mild compared to those of other countries; the glass pyramid outside the Louvre in Paris, designed by a Chinese-American, shows madness on a par with the spaghetti junction. What *is* happening?

Criticism of modern architecture, from the bleak, cheap stuff I saw passing as factories on estates in the Welsh valleys to grand development schemes, to piecemeal additions to art galleries, is widespread. But then there is nothing new in disliking contemporary buildings; the Victorians disliked Georgian neatness and uniformity, the sixties lot disliked Victorian offerings, the eighties dislikes the fruits of the sixties, and the result is confusion. What do we like and why? Our schools offer not a scrap of visual education; most of us don't have even the vocabulary to describe a building.

Throughout history there have been two basic schools of architecture: one school designs buildings that gently lie down with nature; the other designs buildings that proudly stand up in contrast. Then along came a third kind (so the writer Robin Boyd has taught me): one that is neither sympathetic to its surroundings nor challenging. It is evasive, a nervous chattering as opposed to a statement that is bold, straightforward and honest. And it is not lack of imagination or lack of sensitivity or lack of originality that causes this, but an overabundance of these qualities without the discipline of a common artistic aim. Architects are a supreme example of rampant individualism. Thus we are presented with buildings, each one crying, 'Look at me,' each one self-consciously different; all determined to be arresting; all showing off their isolated moments of conception. And when our eyes are finally drawn to one building, they are given no rest, but are forced to race across broken planes and interrupted lines. Technology has liberated the architect and he, poor thing, is floundering in his freedom. And fouling our cities.

Birmingham sees itself as a Victorian city, despite the fact that it existed before and has taken a hammering since. It is a manufacturing city, a city of a thousand trades; it makes buttons and belts, jewellery and firearms, steel pen-nibs and kettles. Joseph Chamberlain's family produced screws. Chamberlain was once mayor of Birmingham. He passed legislation banning the building of back-to-back housing, municipalized gas and water, planted many trees and inaugurated the building of 'a great new street, as broad as a Paris boulevard, to let light and air into an insanitary area'. For this he was much criticized. The redevelopment cost a fortune, all of which had to be borrowed and

paid for on the rates. But Corporation Street in part still stands, and so does Victoria Square, built at the same time to be the city's administrative and cultural centre. The town hall is intact and so is the museum and art gallery, but alongside it is the reference library, rebuilt to resemble an incinerator. It is easy enough to find the remnants of the city that Chamberlain made famous, but it has been swamped by an ugly Birmingham. Everywhere the roads seem to be barricaded by buses, blue and white buses, three abreast, with noisy squealing brakes and shrieking banners saying, 'Smoking kills.' Birmingham likes banners. The motor show was on. It seems fitting that the city that sold out to the car with spaghetti junction should host the motor show and be inordinately proud of the fact that the centre's streets can be turned into a Grand Prix track. There were banners across the streets saying, 'Welcome to the Motor Show'. Perhaps it is possible to design beautiful banners, but I have seen no evidence of it. Banners are by definition downmarket and tacky. Birmingham, the city of garish banners; of loud advertising and of hideous shop fronts: Pizzaland and Pizzahut, Dayville Ice-Creams and Spud-U-Like, and Kentucky Fried Chicken. The city's advertising says: 'JR would feel at home in Birmingham.' He probably would. It's why I don't. Birmingham has a reputation for producing and liking the cheap and showy. There's a word in the dictionary to prove it: Brummagem. Brummagem is an article that is counterfeit, cheap and showy. The dictionary says it is an allusion to plated goods and to counterfeit groats made here in the seventeenth century.

The Bull Ring says it all. It was opened in 1964, a vast purpose-built shopping-centre. Walter Gropius, a German, one of the founders of the modern movement in architecture, whom some consider a great twentieth-century architect, spoke admiringly of the Bull Ring. He is said to have been some kind of socialist with a dislike of decoration and a contempt for styles from the past. The Bull Ring is a concrete bunker, a weather-stained coal hole. Those who have been to East Berlin say it reminds them of that city. The Bull Ring is earmarked for an expensive – £400m – face-lift. The gossip is that the planners intend to repeat the initial mistake by building yet another vast shopping-centre. This time it will be stone clad.

After an hour of the Bull Ring, I sought comfort in the art gallery. The art gallery in Birmingham is famous for its collection of Pre-Raphaelite paintings and drawings. Sir Edward Burne-Jones was born in this city, the son of a carver and gilder who, though hardly rich, was not poor. At Oxford he met William Morris, born in Walthamstow before it was cockneyfied and jerry-built over. Morris was rich. Together

the two decided that they would establish a society dedicated to a crusade and holy war against the age in which they lived. They hated industrial Britain; they worshipped the past, particularly the creative labour of craftsmen, which led them to relish all things medieval. The two came under the influence of Dante Gabriel Rossetti who, also having difficulty with things present, became leader of the Pre-Raphaelite school – for those who believed that after Raphael art declined rather than advanced. Every age throws up men who hate the present. I have always been irritated by such men, and particularly this little group who did so much to turn our hearts and minds against industrialism instead of using their remarkable influence to improve the things they disliked. They were responsible, at least in part, for rich industrialists rushing off to buy country houses and sending their sons to schools where they learned to become 'gentlemen' and spurn industry. William Morris was the worst of the lot. He called himself a socialist and yet he worshipped the Middle Ages. It is said that the Normans introduced into England the feudal system; that they introduced the concept of the idle gentlemen and the aristocratic ideal; that they introduced class divisions. How can you be a socialist and a medievalist at the same time? Only by choosing selectively from the goodies in the past and blotting out the bits that don't suit your thesis, in which case you might just as well choose selectively from the goodies in the present, rather than arrogantly condemn the lot. The Pre-Raphaelites' exaggerated rejection of the world in which they lived was futile. I think that it is the most delicious joke to find this famous Pre-Raphaelite collection of paintings in Birmingham. It is the perfect irony to see works by men who hated ugliness and who fought for the return of creative labour hanging in the art gallery of a city that is well known for its ugliness and for the poor quality of life it offers its citizens. What would Burne-Jones, Morris and Rossetti have made of modern Birmingham? Perhaps they too would have seen it as an exquisite joke.

I tried to catch a bus to Acocks Green in East Birmingham, where I was staying; although there were many of them, I couldn't find the right one and so headed instead for the 5.25 commuter train, which was packed to the gills. A girl fainted, although there wasn't much room to faint properly. A woman got up and gave her a seat. The men pretended that nothing had happened – the medieval concept of chivalry is hard to find in Birmingham.

I had selected to stay in East Birmingham not because I intended to visit the motor show, but because I was going to spend several days in hospital. Fortunately, my visit to East Birmingham hospital was not as a patient. I was meeting Peter Freeman, a senior registrar. That

weekend he was in charge of the accident and emergency unit (alias Casualty to those who watch television). He had said on the phone that when I arrived he would put a white coat on me and that for the following forty-eight hours I could be his shadow. And that's what happened. At 8.30 in the morning, I put on a crisp white coat and became a shadow. It is as good a way as any of seeing the health service at close quarters. I was sick of reading about it; sick of tales that Britain's post-war pride and joy was being crippled at the young age of forty by a government dedicated to cost-benefit analysis.

There's a small overnight-stay ward at the hospital, where A. and E. cases can be kept for observation. Peter Freeman's first task was to make a ward round and see who could go home. In the first bed there was 'a domestic injury'; a middle-aged woman had stitches in her head; she had been hit by a flower-pot thrown by her husband. She had been drinking lager and brandy at the time. Peter looked at the bump on her head and told her she could go home and report to her own doctor.

'Who is at home now?' he asked.

'My husband.'

'Do you need any help? Would you like a visit from the social services?'

'No.'

Peter walked to the next bed. I was dying to ask all sorts of questions of the woman.

'You won't want to get so involved by the end of the day,' said Peter laughing. 'A. and E. is for quick assessment. If it is a baby or a minor, it's different. But for adults I can pick up the gross things quickly. We see far too many domestic disputes. We leave it to the patient to seek help.'

This woman had no shoes, no handbag, no money and could only hope that a member of her family would come and get her. In the end, the nurse had to wrap her feet in plastic slippers and send her away in a cab for which someone at the other end would pay.

The next bed contained a lovable elderly man of seventy-seven who had a glass eye and who had fallen and hurt his heel and foot. We looked at the wound and the dressing and Peter decided to get a physiotherapist to assess his ability to cope at home with crutches.

Out of ear-shot Peter said: 'He's probably got a permanent disability, but there's nothing we can do but let it heal by itself as best as possible.' His voice seemed cold and I decided I'd never make a doctor. For the next hour I kept thinking about that old man and wondering if I could nip back to see how he was getting on. But Peter was right, by the end of the day something had happened. I too saw

people as 'cases' and had lost my usual appetite for questions and involvement.

Bed three had a policeman sitting at the side. In the bed was a thirty-year-old male, an Asian taxi driver. At 2.15 a.m. three youths had hopped out of his cab and refused to pay. A brawl followed; he got beaten about the head and one of the youths had been stabbed with a Stanley knife. The man with the stab wound was in another ward. They had to separate them. It looked as though this thirty-year-old Asian taxi driver's next stop would be a prison cell. But for the moment he needed an X-ray to see if he had a broken nose.

By 9.10 we were in the plaster clinic – an excellent idea; those who have been plastered the day before return to make sure that the plaster is not too tight/loose. The first case was a perfect illustration. The patient's hand had swollen overnight. This clinic is a conveyor-belt in winter, with old people slipping and fracturing wrists. It was October and it was pretty full: there were young and old, there were sullen faces and smiling faces; there were black faces and there were white. For an hour we looked at yesterday's plasters. I was mistaken for a doctor. A young woman who'd fallen downstairs and badly sprained her foot had been put in plaster because it was more comfortable. She was a cashier in a Safeway's supermarket and had taken time off to serve drinks at the motor show. A plastered leg is not what is wanted of young women hired for decoration at the motor show. Her sprain was costing her money. 'Do you think I should go back to Safeway?' she asked me.

'You'd better ask the doctor,' I said.

'I thought you were a doctor.' she said, eyeing my white coat.

'But you are Dr Freeman's patient.' I was careful not to lie. Many, many times during the next forty-eight hours I was taken for a doctor. I loved it.

The Asian taxi driver's X-rays showed that he had a broken nose. We went back to his bedside to tell the policeman that he could now be moved.

'Please, please, will you stay in touch to see if I'm OK?' the driver asked Peter.

'No, the police have their own doctors. You'll be looked after.'

The taxi driver then apologized for the noise and fuss he had made the night before when he was brought in.

It was time for the hand clinic. Hands are a neglected field, and they are Peter's speciality. It fits in well with A. and E. work. For an hour we looked at hands. There was a building worker who had put his hand through a sheet of glass in a fit of anger. He hadn't done himself

serious harm. There was a seventy-one-year-old who had spiked his hand on a pole. There was a woman whose hand had seized up while she was Hoovering. Four fingers had gone 'dead'. They seemed better, but stiff. She had to report to physiotherapy on Monday. There was an Asian who had been attacked in a spot of 'Paki-bashing'. He'd had stitches to his head where he'd been hit with a bottle, and his hand was swollen. There was a crushed thumb. Its owner asked for a letter saying that he was able to do light duties. He'd only had his job for a month and was afraid of losing it. Peter treated his cases speedily, pausing after each patient to fill in records. He didn't stop to chat. He didn't stop for anything for three hours and then we stopped for coffee.

We went back to see the old man with the damaged heel. He was to be discharged. His wife was at home to help him. 'Hospitals are for treatment. If treatment is not needed then it is best that patients go home. No, it's nothing to do with funds; I'm sending him home because he'll be better off there. It's been proved that people get better more quickly if they are at home, particularly the elderly who get confused in hospital. When you are old, being in hospital is associated with death, so it is much better if he goes home. I'd feel happier if the local social services department had more funds and could offer more support in the home. Let's hope his wife can manage.'

East Midlands General Hospital is old. It was once a TB hospital, and that became obvious once I'd wandered around the grounds – several wards still had large covered-in verandas. Since then the hospital had grown up piecemeal, blobs of red brick on a campus. The accident and emergency block was small, and reasonably welcoming. It conformed to my image of an NHS hospital: basic, no frills, no comforts, scrubbed clean. This unit treats 60,000 new patients a year. It is due to be rebuilt; it's about fifteenth on the list and Peter said that if Birmingham had been chosen as the site for the next Olympics, it would have shot to the top of the list. A. and E. has been the Cinderella of the hospital service, which is surprising. Most people's experience of hospitals is as an out-patient and it is from this experience that they form their impression of hospitals in general. But for many years the effective treatment of those injured or taken suddenly ill has been a problem. When the NHS was inaugurated in 1948, it inherited casualty departments that were 'round the back of the hospital', staffed by young doctors. Most of the treatment was handled by nurses. There was a consultant in charge who rarely visited his patch. No one gave much thought to all this until the fifties, when road accidents increased. Then it became obvious that casualty departments were not designed,

equipped or staffed to cope. A report in 1962 rejected special 'accident hospitals' along American lines, and instead argued for a twin system: some hospitals could handle minor problems, but general hospitals were to handle major problems. Orthopaedic surgeons were put in charge of the newly named accident and emergency departments, and much of the work was to remain in the hands of young doctors. The Platt Report said that 'Accident surgery is unlikely to provide a satisfying career for a consultant.' Such a comment angered those who knew this not to be the case. They had to be patient. Platt's proposals didn't work. A report in 1970 found that standards were still low and that there were 'insufficient junior doctors with inadequate senior cover'. In 1962 it might have seemed a good idea to put orthopaedic surgeons in charge, but it hadn't worked out. While that branch of medicine had seen its workload diminish, with fewer cases of rickets, polio and TB of joints, it had only been a temporary lull, for new technology meant that there was a growing demand for new hips and new knees. Orthopaedic surgeons had their hands full again, and had little interest in A. and E. work beyond 'fractures', which, while an important slice of the work, was only part of it; there were other areas – heart cases, overdoses and acute asthma – in which they had no expertise.

It was back to the drawing board, and in the early seventies a committee under Sir John Bruce decided that the time had come for A. and E. to have its own consultants, with their own training programme and career structure. In time it was also clear that all medical undergraduates should have some training in emergency work. A new speciality was born, and it has been a huge success. The absentee landlord was banished and the brightest young doctors were tempted to look anew at an area that in the past had received their attention only while they were in training. Choosing a career in A. and E. meant the chance of becoming a consultant at a much younger age: within six months of our meeting, Peter Freeman, then thirty-four, was to move to Wolverhampton as a consultant.

I relate the transformation of casualty into A. and E. with a purpose. It is a perfect illustration of how the NHS workload has grown; each decade throws up new problems, like road accidents; each decade throws up new possibilities, like new hips; each year knowledge becomes greater and skills become specialized. To this must be added the fact that the lowering of infant mortality now means there are many more elderly people in the population, an age group which makes great demands on the service. And they live longer; a bout of pneumonia no longer signifies a quick release from old age. Nor are

we anywhere near the end of medical advances to keep man alive: each year younger premature babies survive; each year tiny babies born with multiple problems are subjected to multiple operations. Each year a man badly smashed up in a car accident has a greater chance of survival; each year costly and complex intensive-care equipment prolongs life. It then becomes perfectly obvious that each year more money is needed. Ten years ago, under the last Labour government, the health service absorbed just over 11 per cent of public spending in real terms. In 1989–90 the equivalent figure is 14 per cent. The question remains: where is that money to come from to meet all our needs and our rising expectations? The founders of the health service were wrong when they anticipated that in time a healthy nation would make fewer demands on the service.

Our coffee break and chat about the history of A. and E. went uninterrupted. The 'bleep' did not summon us. There were plenty of accidents, but no emergencies. A little girl awaited our return. She had glass in her foot. Peter extracted it with the aid of a local anaesthetic. Another slightly older girl had a cyst on her head which had become infected. A woman had been stung by a wasp while working on her allotment. A tiny girl had fractured her arm. Then came a young man whose case was particularly interesting. He was a teenager with a pellet in his head. He'd had a gash stitched the day before.

Afterwards he remembered that something hit him before he fell. Then his mate found an empty pellet case. That made him think. Peter removed the pellet. The fifteen-year-old boy did not like needles. He and I had a friendly chat about our hatred of needles. I thought I might hold his hand to calm his fears, but then since he was fifteen, I thought perhaps I had better not.

We managed twenty minutes for lunch before being bleeped to give advice on a man who had cut the top of his finger. The food, risotto and carrots, was not the sort to linger over. Anyway, Peter was taking a break in the evening and going home and I was going with him. The afternoon was routine. The department was not busy; for one thing there was a bus strike on and in this poor area of Birmingham people would not think of using a taxi; and some hesitate before calling out an ambulance.

Peter lived in Sutton Coldfield. His wife manages to combine part-time nursing with running a nursery school and bringing up two children. They are both levelheaded in their assessment of the health service. The shroud waving and panic statements of which we have heard so much in recent years serve no purpose. The public no longer know what to think, with figures and opinions being flung in anger by

the service at the government and vice versa. The Freemans' view is clear enough: the system is not falling apart, but standards are falling. 'We are,' Peter Freeman argues, 'being asked to accept lower standards than those instilled by our training.' Much had been done to make the system more efficient, trimming fat was painful but necessary, but, as any surgeon knows, going too close to the bone is risky. The district general manager had insisted that the hospital was wasteful and extravagant; that patients remained in East Birmingham longer than they did in other hospitals in the area, sometimes twice as long. 'I agree that the system needed tightening up – most big organizations could benefit from a tightening of procedures. There was waste, I'll admit that, but we have to be careful how far we go. Apart from anything else, shortening bed stays does not save money; it means you treat more patients, and that costs more money.'

Three wards had been closed. The closure of two children's wards had been accepted without too much huffing and puffing. There had been four children's wards, and figures proved that for much of the time the four were only three quarters full; closing one did not affect services. Closing an adult ward was another matter. Any cutback in beds would affect A. and E. because emergency cases could be held up for hours while a bed was located. These are considerations that no doctor has had to contemplate in the past. The hospital now had a red-alert system when beds were in short supply.

'Red alert has been activated several times. I remember an asthma patient who needed intensive care and couldn't be admitted at East Birmingham and had to go to the General Hospital seven miles away. A senior nurse and an anaesthetist went with him. It could have been crucial. But most of the time it means that new patients are hanging around on trolleys in A. and E. for longer than is necessary; sometimes four hours or more.'

During my weekend visit there were fifty beds available. But the fear of a shortage puts added stress on doctors and puts them at odds with the management. Doctors in the past have felt that management's role is simply to argue for more money, but the new breed of hospital managers, brought in after a report suggested that the NHS was poorly run, are wedded to notions of cost effectiveness. And so they should be. In the past hospitals were not asked to cost the services they gave. They had no idea *how* to cost an operation so that Hospital A's costs could be examined against Hospital B. Several pilot schemes now in place could highlight large differences and help hospitals to learn from each other. Doctors could have much to gain from the upheaval of the eighties once the new management structures, new systems of

budget control and vital computers to aid this work are all in place. Meanwhile they fear they have much to lose. Above all, they do not want men who understand balance sheets interfering with their clinical judgements. The answer to that is to involve the doctors in the running of their units, make them responsible for budgets. The days of the blank cheque and doctors not wanting to bore or bother themselves with costs have gone. Peter Freeman is happy enough to be involved in budget management. 'It's not in the interest of the NHS for us to get bogged down in budgets, but I think it is reasonable enough for someone to come to me and say, "Item X costs £1 and Item Y costs £2. Is there any reason why we should not stock the cheaper item?" That makes sense, and it means that the money saved can be spent in other areas. In recent years we've had to sharpen up and we have benefited from having our medical decisions questioned. For that reason I'm glad that GPs are now facing changes and are being made accountable. If they provide a better service it will be of great help to A. and E. departments. It could mean that I don't have to handle the young man who comes in asking for a wart to be removed: a GP can do that. Just as it will be some time before we can really evaluate all the changes in the way hospitals are run, so it will be some time before we can evaluate the changes to GPs. On the whole I think good doctors have little to fear. There are areas where there could be problems, but it all comes back to adequate funding.'

We went back to the hospital at 11 p.m. The atmosphere had changed. The patients tended to be noisy. Peter's first task on our return was to sort out a Mrs X. Mrs X was known to the department. A regular pest. She sat now in the waiting room and was refusing to move. With her was her daughter, who was about eleven, long-haired and white-faced and strangely silent and detached. Mrs X, who was thirty-four, had a urological problem. She claims that surgery had made matters worse because 'an incision was made in the wrong place'. Since then, Peter said, she kept turning up and demanding attention. Whatever the rights and wrongs of her case, A. and E. was not the place for her to air them. The doctors on duty refused to see her. I curbed my desire to ask a score of questions and stood silently at Peter's side.

'I repeat: you should not be here in A. and E. Go home. Hospital is no place for your daughter at this hour.'

She began to answer him, saying she needed to see a doctor.

Peter got agitated. 'You have an obsessional condition. You do not need this department. You need the help of a psychiatrist.'

'Bullshit!' she screamed at him. 'Bullshit! I work in a psychiatric hospital. Just because I am behaving in a way you don't approve of,

doesn't make me a psychiatric case.' And then she launched into a stream of abuse, laced with quotations from Karl Marx, and ended up saying that there were psychopaths running the country, while the meek and mild were in mental homes. Up to this point, and not knowing the rights and wrongs of the case, I thought that Peter had been rather tough on her. I could now see he had no option. There were others who needed his attention. He told her once more to leave. For some time she hung around quietly. I offered to go and talk to her, but Peter advised me not to get involved. We let her be and finally she left.

The fuss from Mrs X was a suitable curtain-raiser. Saturday nights in A. and E. are known to be noisy. Most of the noise is caused by drink. For the next few hours I was to feel sad and sickened by what I saw. I was saddened by a sixteen-year-old boy who drank half a bottle of whisky and was groaning, in some discomfort; he had banged his head while being sick, which had not helped. Before too long he was asleep and it was decided to keep him in overnight; there was much chat about what could be given to help his hangover. 'Bloody hell, I'm not giving him anything,' said a strident female voice. 'I'm not even giving him Paracetamol when he wakes up tomorrow.'

'Oh why, oh why, do they do such things?' said a nurse loudly in the corridor as she walked away to get some form or other. The drunken boy had just started a new job. His brother had committed suicide a year ago.

Two drunks were in each of the next two cubicles. They had been drinking together and had been assaulted as they left the pub. So they said. One could not stop shaking and had double vision. The other had a swollen eye and cuts on his knee.

'How did it happen?' I asked.

'Don't worry, we know who done it. We'll sort it out in our own little way. Let's leave it at that, shall we?'

My sympathetic curiosity was thwarted – and wasted. X-rays were taken of their skulls. Drunks can be a real problem for doctors. There was once a drunk who fell or who was pushed off a bridge. Next morning he woke up paralysed and his family were suing the hospital. They argued that if the right X-rays had been taken, he might have been helped. You can't get much sense out of a drunken man. As a safety precaution, costly X-rays are taken.

There were many more drunken patients. At one point screams attracted me to a curtained cubicle.

'Oh no, don't cut my hair. Not my fucking hair! Not my hair! Not my hair!'

I peered in. The drunken youth thought he spotted a potential ally. His shoulder-length hair had been bleached and permed. He had a wound on his head that needed stitches. A nurse was trying to clear the way for the needle.

'Doctor! Doctor! You're a woman, you understand. Don't let them ruin my hair. I don't want a bald patch.'

I told him that the patch was going to be tiny and no reason for him to behave like a baby. It was not what he expected to hear. And then I fled before he could see or hear my helpless laughter. There was another boy with a tattoo on his face that had gone septic. He called it a Borstal spot. It was nearly 1 o'clock when a father brought in his son, who had a high temperature and a cough. He said he had seen his GP in the week and was not happy. The baby was checked for pneumonia and meningitis and then allowed to go home.

Around 1.30 my notebook records the arrival of 'tarts with wounds'. There were two of them, with tiny black skirts and messy blonde hair. They had been drinking, and one had slashed her wrists. She had slashed her wrists before; she was known to the department. The other girl was her friend. Half an hour after they arrived, I found them giggling and laughing with a couple of drunken boys who were also waiting for attention. I was tired and running out of patience with self-abuse victims. I thought I'd go to bed. Peter had already gone home. He was 'on call', but did not need to be in the hospital. Just as I had gathered up my coat, there was a real emergency. A seventy-seven-year-old woman had been driven from Warwick. Coventry would have been nearer, but there had been a problem with intensive-care facilities. She was prepared for surgery in silence and with speed. She was operated on for an aortic aneurism and died in the night. A motor accident followed soon afterwards. He was rushed into intensive care. I stood on the sidelines and watched admiringly as the department sped into action to save lives.

I went to bed well after 2 o'clock. I had been allocated a doctor's room. I didn't sleep. I was too tired and too easily distracted by the sound of car doors slamming and by feet as they scuffled past the door and thumped down the stairs. I met Peter the next morning at 8.20.

I wanted to talk to the nurses. It takes a special kind of nurse to cope with A. and E. work. A senior sister explained: 'Most of us would be bored on the wards. We don't like routine. We like going from cruising to top speed very quickly. We like the pressure – we work best under pressure. We also have better relationships with our doctors and consultants: we work as a team. And we are able to do more things; we do 95 per cent of the stitching and plastering.'

All the nurses agreed, although I did find a student nurse who seemed confused by it all and who told me that she was disappointed with her lot. She had not realized that she would have to spend time clearing up mess from the floor. She seemed a bit pathetic. She said she wanted to be able to spend more time with the sick, but shortages of staff meant that there was no time.

'What would you like to do that you haven't got time to do?' I asked.

'Comb their hair, and things like that.'

She did not belong in A. and E.

The senior sister analysed the department's workload for me. I wanted to be certain that what I had seen the night before, particularly the self-abuse and the drunkenness, was representative.

'The system is sorely abused. I reckon the biggest group are the fifteen to twenty-two-year-olds. The majority of those come in with problems related to drink. Many of the others just wander in because they can't be bothered to go to their GP. We are open all day and all night and they treat us just like a bus service. That fifteen to twenty-two-year-old age group has been spoiled. Whatever they want they want immediately. I know my words are harsh, but you have seen for yourself what we have to put up with. At times, I'm full of sympathy for them, there are some very poor GPs out there who do everything to avoid home visits. There are Asian doctors who make their patients pay £5 for a home visit.

'But on the whole it is alcohol abuse that's made our workload rise so much in the last fifteen years. Those with problems are getting younger and younger. If they are not actually drunk then they are under the influence of drink.'

By now there was a group of us sipping coffee and chatting. We talked about the social cost of drinking. None of them passed judgemental comments – only the nurse who the night before had said she refused to worry about the hangover of the young boy who had drunk half a bottle of whisky. None of the others betrayed any anger at having to mop up the mess people made for themselves. So I'll be angry for them. Before I had spent the night at East Birmingham hospital I had not realized the extent to which the system was under strain because we are all so stupid and thoughtless and selfish. Excessive drinking has become a major, major problem. Research has shown that alcohol consumption per head has doubled since 1950. Research has shown that something like 8 million working days a year are lost through alcohol-related illnesses. Research has also shown that much violence is related to drink. The NHS is left picking up the

bill: one figure, so gross it is hardly believable, suggests that hospital admissions for alcoholism have risen by 2,500 per cent since 1950. The media regularly draw our attention to drug problems; rarely do they look at drink. Mrs Thatcher's government has done much to focus on the drink-driving issue, but not nearly enough to make people aware of the hidden costs of alcoholism. The Beveridge Report of 1942 contained these words: 'Restoration of a sick person to health is a duty of the state *and the sick person.*' The youngsters I saw the night before were not even sick. Beveridge knew only too well the difference between liberty and licence.

Peter took me to intensive care. I wanted to see what it was like and he wanted to see how the overnight accident was getting on. It was a spacious room, silent, and laden with hi-tech grey boxes covered with circular clock faces and sprouting wires. A consultant anaesthetist was sitting by a computer. The ward was designed for six beds and needed twenty-nine nurses, but they were five short. There were four beds in use. One was occupied by a thirteen-year-old girl who had a virus and who, after two days of constant observation, was about to be moved to a ward. She was sitting up in bed talking to her mother. There was an elderly man with complex problems and a middle-aged Burmese man on total life-support. He was tiny and stick-thin; he looked like a little bird. His eyes were closed with tape and his body was wired up to machines that winked and blinked. He had been like this for some time. When he was found he had pneumonia and had been starving himself. His wife had been suing him for divorce. She now spent part of most days sitting by his bed. The nurse in charge said that if he lived now there was certain to be brain damage. Why then did they continue with all this expensive effort? The answer was confused. The general view was that you can't let a middle-aged man die.

The road accident victim was unconscious. He was to remain unconscious for three days. Peter was needed back in A. and E. and left me talking to the senior nurses. They explained how their job had changed and why it was so difficult to attract nurses to intensive care. The work is unsatisfying; there is little patient contact and plenty of machine-minding. Nurses prefer the former. Intensive-care nursing has become a job for a technician.

'The sort of patients we care for nowadays would have died ten years ago. We still have a high death rate, which makes it depressing work, but on the other hand it is very rewarding when people live when we had expected them to die. That gives us job satisfaction.' My hunch is that in time intensive care will be the province of male nurses; men are happier having relationships with machines and they do not

seem to need the patient contact that female nurses require. My hunch is that before long we are going to have to ask ourselves some awkward questions. In a perfect world the National Health Service ought to be funded from taxation to do everything and anything; there ought to be bright, shiny new hospitals everywhere and no waiting lists and no lazy GPs and no arrogant consultants. To write such a sentence is easy; it adds nothing whatsoever to the debate. There is no perfect world and therefore we need to ask ourselves whether or not we are trying too hard to keep people alive. Ought we now to slow down and *think* about what we are doing? What effect does it have on very premature babies to be kept for months in incubators? No one knows. What effect does it have on babies with multiple handicaps to spend their early years in and out of hospital? No one knows. Does anyone care? Is it right to condemn a brain damaged man to live? And what about the very old? In the geriatric ward of this East Birmingham hospital I saw a woman of ninety who could neither see nor hear who was spoonfed by a male nurse. She never received a visitor.

Did Beveridge envisage a 'free' health system for boys who paid to have their bodies tattooed and then expected the NHS to come to their rescue? Did Beveridge envisage a service for infertile women? Such questions are unpalatable. They are being asked in the universities. Academics with an interest in health policy are daring to suggest that some treatments should not be offered on the NHS; others are daring to ask clever doctors and scientists to stop and think about the *quality* of life they are offering to those they keep alive. I found it difficult to ask the male nurse in the geriatric ward why he was spoonfeeding the little old lady to keep her alive, so that she could spend another day in bed. I found it difficult because such thoughts are not to be spoken. I got the words out in the end. He looked at me with contempt. 'Are you asking me to play God?' he answered. It's a cop-out answer for those who are not prepared to examine what they are doing and for those who do not wish to make difficult decisions.

The A. and E. department was busy on Sunday morning. There were a fair number of sports injuries: chipped ankle bones, sprains and broken limbs. 'I think we should contemplate banning Sunday-morning sports,' I quipped to Peter. A father overheard the remark and, not being used to my sense of humour, gave me a lecture on all the money he had collected for the children's hospital and the donation he had made to funds for a body scanner. In the afternoon Peter was performing two hand or, rather, finger operations. He invited me to watch and I accepted. And then fretted. I had once disgraced myself by fainting in a hospital in Russia. We were being shown fancy work with eyes and

lasers and one minute I was watching intently and the next minute I was on the floor. I need not have worried. Watching Peter slice into a finger did not make me queasy. I was more interested in the anaesthetist. Peter had said to me that they were far more important than any surgeon; that is to say, they had the potential to do far greater harm. In the end, the most upsetting moment was listening to the two men coming around from the anaesthetic. One huge man groaned and groaned. 'The pain; oh, the pain. The pain's too much.' Over and over again he said this. I gather it is commonplace.

At 5.30 p.m. we were called to look at a young man of twenty-five whose head, throat and eyes hurt. His neck ached and he had a temperature. Peter was fairly certain that the young man's tonsils were causing the problem, but he was worried about meningitis.

'It terrifies me. If you miss it you can be in real trouble. You can have a vegetable on your hands, as well as a lawsuit.' He left the cubicle to check bed space so that the young man could be kept in overnight for observation.

'Look, please, I don't want to stay in. I'm frightened of hospitals. I once had a lumbar puncture that went a bit wrong. They apologized but look, I'm very unhappy in hospitals. I can go home, can't I?' I was beginning to think that Peter and I made a good team. Whenever he left, the patient would start talking and providing valuable information. He had to stay in. His temperature rose and in the night he started vomiting. It was a tonsil problem.

Our next concern was a man with breathing difficulties. Two of his brothers had died, at forty-two and forty-eight, of heart attacks. His wife had brought him in. She thought his blood pressure was too high. She called me over to her side and began to whisper: 'Come here, doctor. I can talk to another woman. Look, he smokes too much, around fifty a day. He'll tell you lies; he'll say it's much less. Could you have a chat with him about his smoking?'

Peter returned and began his questioning. He asked the man how much he smoked and the reply came: 'Oh, about twenty-five a day, doctor.' The wife winked at me.

'You'll get more sympathy from doctors if you stop.' Another wink came my way. I hadn't had a chance to say anything to Peter; perhaps she thought we benefited from telepathy.

At the end of my weekend I felt so at home in the East Birmingham hospital that Peter suggested that I could walk on to the ward and give instructions to nurses without them querying my authority. I felt like playing the game, and only one thing stopped me. I was too tired. I needed to sleep. One young doctor said to me as I was leaving: 'You

don't look too good. Take the advice of a doctor – go and get some rest.'

Once the tiredness had left me, I felt despondent. I'd seen the problems, and where were the answers? I believe that the NHS needed the shake-up it is receiving. There are many discrepancies in the service around the country. Why is it possible to have a hip-replacement operation within two months in one area and have to wait two years in another? Why do the figures that are emerging vary so much from one area to another? Why do some areas make good use of day surgery and others not? Until convincing arguments to the contrary are revealed, we must assume that the answer lies in the fact that some areas are more efficient than others. The NHS needed to examine itself, to be forced into thinking about new ways of doing things; new ways that save money, as well as new ideas which make the system more accountable to patients. Much has been made of hospitals allowing their laundry and cleaning to be done by outsiders at a lower cost. But at East Birmingham I talked to the cleaners, who said that the only reason private companies could do this was by paying their employees less. East Birmingham's cleaners said they were paid up to £28 a week less by their new 'private' employer. They accepted this situation, they argued, because the alternative was the dole.

The birth of the NHS was accompanied by well documented resistance and cries of pain from those who feared the worst, so it is not surprising to find that there are many who dislike the present upheavals; they'd hate anything except a bigger cheque each year. When it was first mooted that hospitals should raise funds through their own income-generation schemes, there was a chorus of disapproval. The unions, particularly NUPE, disliked the idea on principle; the state should fund the system. Full stop. Others howled because they did not want to have to waste time thinking about money-raising ideas. A couple of years on, many hospitals have realized that they can in fact improve services to patients, staff and visitors through carefully chosen schemes *and* make extra money for themselves. With this discovery, it became intellectually respectable to think of hiring someone to take charge of income generation; someone who could easily cover the cost of his or her salary through schemes that lease out hospital land to provide space for banks, hairdressers, shops and cafés, through schemes that allow hospital premises to be hired out for conferences, and through amusing little enterprises like providing pregnant mums with photographs of their 'scans'. In the end of course the money raised is peanuts compared with total budgets, but they are useful peanuts and they bring additional benefits to patients, staff and visitors.

Once the efficiency drive has trimmed the fat, and once these new ideas are in place, then what? Two things: a campaign to make people feel more responsible for their own health, to stop them being so selfish and so careless with the health service (not another word about drugs until the social cost of drinking is well understood), and a hard look at just how far the wonders of modern medical science should be available on the health service. And after that the most vital question of all: how are we to pay for our increased needs and rising expectations? The answer is, quite simply, via state funding through taxation. The growth of a divisive two-tier system of private and NHS medicine should not be encouraged. Giving tax relief on private insurance is not the answer. Private medicine has *nothing* to offer other than speedier service and it is not beyond the NHS to improve its appointment system and its waiting lists. Fortunately, I think there is little danger of private medicine taking hold because the public have made it clear that they don't want it. Private insurance may have grown from 5 per cent to 10 per cent since 1979, but most of that has been through companies doling out private insurance as a perk, and even that figure has peaked. There are now private hospitals with empty beds. The private sector over-estimated our desire to quit the NHS. The result is that the private sector no longer sees the future as a straight competition between the two. Instead it sees the future in cooperation; building and sharing facilities in much the same way as they share the skills of doctors. No government has been able to face the prospect of outlawing the private sector, which says much about political stamina. If it was not possible to outlaw it in 1948, there was certainly a time in the mid-sixties when the Labour party could and should have grasped the nettle. Instead, Mrs Barbara Castle fought against pay-beds in the NHS. That was wrong. If she had wanted to kill pay-beds she should have killed all private medicine. Her halfway house started a spate of private-hospital building and was responsible for the uptake of private insurance. If no one has had the guts to kill off the competition, it is better that the two sectors work together. And Mrs Thatcher should not be allowed to starve the health service of funds. The money is there if we choose to spend it. I'm not impressed by figures that suggest that other countries spend more than we do. No other country has a system that is worth apeing, and higher spending does not necessarily mean a better service. I'm still puzzled by figures that suggest that we have eight beds for every 1,000 of the population, compared with America's six, when America's spending well exceeds ours. I'm still puzzled by figures that suggest that the NHS employs eighty nurses per 10,000 of the population compared

with America's fifty and France's forty-five and West Germany's thirty-five. We must be misusing our nurses. In other countries orderlies do the bedpan-emptying and nurses do many things that are done here by junior doctors.

We can afford to fund the health service from taxation if we desire to do so, of that I am certain. When Mrs Thatcher came to power she was determined to cut public expenditure. And despite giving billions more to the health service, this she has managed to do. In 1975–6 public expenditure ate 48 per cent of the gross domestic product. By 1988 public spending was below 40 per cent of the GDP for the first time in twenty years. I don't know what is magical about this figure, but if it brings happiness to the Treasury and the Chancellor, so be it. I do know what is magical about the National Health Service: it is the sight of nurses putting stitches in the head of a tiny child; it is the sight of a young doctor eating a Mars bar at 1 o'clock in the morning as he copes without murmur with a succession of drunks; it is the sight of Peter Freeman in the operating theatre, proudly explaining his every move to me as he fights to ensure that a middle-aged man can live the rest of his life without the hindrance of a stiff finger.