

People talking: oral history and the Lancaster Medical Museum

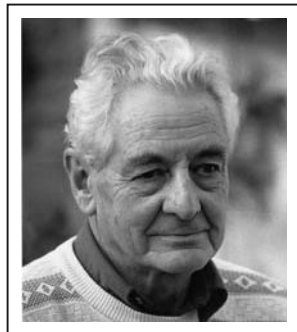
Transcribed and edited by Valerie Anderson, retired associate specialist in medicine

As part of the museum archives there are 15 CDs and tapes of oral history recorded in 2006 by Dr J Carne with the help of the NW Sound Archives. We wished to record the changes in the NHS and developments that have occurred in medicine and the allied services from the staffs' point of view. This is a varied collection that includes histories of nurses, hospital secretaries, general practitioners, hospital porters, technical and medical staff.

The CDs can be accessed in the Library of the Education Centre, Royal Lancaster Infirmary (RLI).

Here is a 'taster' of two of them. There has been minor editing of the extracts.

DR DOUGLAS YOUNG



Chest physician at Beaumont Hospital and Meathop, Grange-over-Sands. Later general physician with an interest in chest diseases, Lancaster and Kendal Hospitals 1959-1983 (61 minutes duration)

The disc starts with a brief description of his training and then his service, in the Second

World War, when he was in the Royal Naval Volunteer Reserve as a surgeon lieutenant on small ships. He served in Aden, India, Burma, Bombay, Ceylon, Malaya and the Pacific.

Following this he describes his experience with tuberculosis (TB) in the services after the war in the Emergency Medical Services in Scotland. Later, as a resident medical officer (in July 1948 the title was changed to junior registrar) moving from one sanatorium to another to eventually become a deputy superintendent.

We start with the war and penicillin.

We had a fairly limited number of medicines available. In fact when I got to the Pacific, that would be in . . . early part of 1945, I obtained my first penicillin. I was provided . . . and was told I had to look after it with extreme care, a box of phials of penicillin with 10,000 units of penicillin in each phial. I got ten vials. So I had

100,000 units to treat any battle casualties, which actually I used on somebody's hand. They got a septic hand and I used it on that. It did serve its purpose. In fact it wasn't even 'my hand' – it wasn't even my ship's company. It was on a Dutch tanker and I had to go over in a bosun's chair to the tanker to see this man as the first mate was very concerned about him. I used my penicillin for him and I hoped not to run short after that, but all was well.

We now move to after the war, when he moved to Scotland. In the next two extracts he describes his experiences with anti-tuberculosis treatment. TB was quite common in the Navy, particularly in the confined space of a submarine.

. . . one of the two meningitis units in Scotland where streptomycin was being used in its very early days. From its introduction it was reserved entirely for military TB and TB meningitis because these were both invariably fatal. It was felt that a new drug should be used for something which might save a life and a lot of success was obtained but of course the problem, as we knew later, we were giving streptomycin as a single drug and resistance develops quite, quite quickly, but we had a crowded meningitis unit and we were giving intrathecal streptomycin as a trial. I can remember the beds being quite close together and daily lumbar punctures (LP) were being carried out . . .

Daily LPs, and fluid was taken out from the needle so the patient would lie on his side, or her side, and the patient in the next bed when the needle was put in – the doctor would move to the next bed rather like a blood transfusion session – and the patient in the next bed curled up and would hold out his arm and take the little phial and hold it under the needle to collect the drops. So it was a sort of patient DIY job.

We found of course there was quite a lot of toxicity with deafness from the streptomycin but these were all very early trials and it certainly did produce improvements. Military TB did improve too and if you could get rid of it before resistance developed you were lucky . . .

. . . avoid the PAS (para-aminosalicylic acid), not a nice drug to take. They were big cachets and swallowed as a cachet like swallowing an oyster whole, but certainly not

1963: methadone maintenance treatment

Nyswander and Dole claimed that heroin addiction was a metabolic disease, and that methadone could be used as a drug to treat this disease, contradicting earlier beliefs that addiction was purely a personality disorder:

1965: second Brain Report

Reported on 'new' heroin addicts (most lived in London). Their supply was thought to be obtained from a small number of doctors. The report advocated the notification of addicts, restrictions on prescribing rights, and the establishment of special clinics for the provision of drug

treatment. The right to prescribe heroin and cocaine to addicts was now limited to specialist licenced psychiatrists.

1966: LSD prohibited

Coming after usage spills over from research to recreation and reaches levels thought to be problematic.



as pleasant. It was difficult to get people to take PAS because frequently the nurses would hand out the PAS to a queue of patients coming past. They were given the cachets . . . would walk on, put it in their mouth and given a glass of water to swallow it and then on they went along the corridor back to their ward.

At one stage in one hospital, I recall, the gardeners complained that all the plants under the windows of this corridor all died and when it was investigated they found the place was littered with the cachets. All you did was put them into your pouches of your mouth like a hamster, and walk along the corridor where the windows were open then you just took them out and dropped them out the window. Because they gave you gastritis in a lot of people and indigestion and they were not nice things to take. You had to treat patients for two years . . .

He continues with further details of his career and a detailed account of the incidence, treatment and control of TB such as tuberculin-tested herds, BCG vaccination and the role of public health measures as well as medication. Treatment was switched to the home rather than sanatoria due to research here and a big Medical Research Council trial in Madras, India, when it was discovered that with careful compliance, patients could be treated in their own homes. The sanatoria were phased out.

As a result of local treatment, one day, after a ward round, he was able to open a bottle of champagne as, for the first time, the hospital group was clear of new cases of TB. This was in the 1970s.

He then tells us, and gives details, that the TB patients were gradually replaced by those with chronic bronchitis and emphysema and cancer of the lung.

After these he discusses a rather rare disease, farmer's lung.

We got farmers lung (FL) up here because it is a country where we grow oats, grass, hay and all way down the west side of the country from the west side of Scotland . . . [to the] Cornwall area and so on. FL became a problem; in the east it wasn't.

I remember attending . . . a symposium where FL was one of the subjects and I was able to produce a chest radiograph of the person who was diagnosed as miliary TB and admitted to hospital in . . . Barrow-in-Furness and my predecessor, Dr Campbell, who was the Superintendent at Meathop, he was asked to see this patient and take him in to hospital. He did and he was unhappy with the diagnosis although the X-ray just looked typically miliary TB . . . He thought about this a lot and he said, finally, it was not miliary TB, he didn't know what it was but it was something to do with his occupation – he was a farmer's labourer . . .

. . . the symptoms of FL, had been known about from at least the 1400s. People wrote about it in Italy in the 1400s. They didn't know what caused it but they knew that certain, some, farmers got very breathless and quite ill during the winter. Eventually Campbell was really the first person to put this forward or the first person locally, and probably nationally, here and that this was related to something they did in the farming occupation that would produce this picture in the lung. We got more and more of it and it was obvious when somebody researched, showed it was of course due to actinomyces, inhaled when hay was stored damp.

Get a nice dry summer and cut your hay, bale it, put it into your barn, nice and dry, all was well. When the winter came and you wanted it for fodder, you just cut the cords, took it out, spread it out for the stock to eat, no problems. If it was raining and when you baled it it went to the barns damp, it would grow a mould. As soon as you opened the bale . . . a great cloud of white dust would go up. These were the spores and a number of people had an allergic sensitivity to these and these were the people who suffered . . . This was the condition known as farmer's lung.

I was able to produce that first X-ray. One chap got up and said he was the chest specialist in Ipswich and he covered, of course, a fair amount of the area of Suffolk. He said, 'I have no experience of this condition whatsoever, I don't know anything about it. I have read that it happens and I have never seen it.' Because of course they have acres of wheat fields and barley and dry usually, it just didn't happen. They weren't putting away damp grass so he had never seen it, but down the west we all saw it.

The answer was to try and wear a decent mask, but of course wearing an ordinary mask around the face, even though an industrial one, with filters, was not much good. Because the farmer would stomp out of the barn, take his mask off and hang it on a nail by the – inside the door and go out. All the spores in the air would settle down inside the mask . . . So it was a waste of time. The only mask you really could wear for protection was a complete hood, like a plastic hood, with a rubber bottom end, you could just drop over the shoulders rather like a diver's helmet . . . and an air line running out through the barn into the yard, well clear, into the fresh air where you had a pump.

Now you had to have electricity to run the pump or you had (a) petrol/diesel generator to run it, whatever. Not (an) easy thing to organise but a damn nuisance for the farmers. It was the only safe way you could work in that environment. The alternative, of course, was not to cut hay but to make it into silage and that is what has now gradually happened over a large amount of the farming area. They silage now rather than hay make and that

1968: Medicines Act

Three types of medicines described:

- prescription-only medicines
- pharmacy medicines, which may be supplied only from registered premises under the supervision of a pharmacist
- general sales list medicines, which may be supplied to the public from any lockable premises

1971: United Nations Convention on Psychotropic Substances

International control extended to synthetic drugs, including amphetamine, depressants, barbiturates and hallucinogens. As in the 1961 Single Convention, the drugs are classified according to four schedules associated with their perceived potential for abuse and their therapeutic value.

1971: Misuse of Drugs Act

The UN Convention implemented, providing a new statutory framework for the control and regulation of 'dangerous or otherwise harmful' drugs, which, from this time, usually became known as 'controlled' drugs, which were divided into Classes A, B and C. Upon this classification depended the severity of the penalties that could be imposed under the

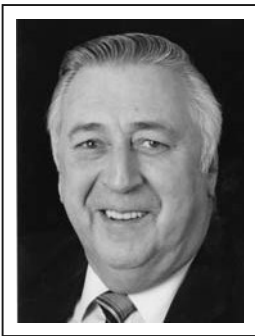
makes a lot of difference. Also of course the fact that cortisone is a very good treatment. For it made a world of difference; you could treat it rather than let them get chronically ill.

The disc closes with general comments on the function of the hospital specialists before and after the NHS; the difficulty of running a ward in Beaumont Hospital, so far away from an intensive care unit at the Infirmary; the change when taking up general medicine again; and the coming of medical students from Manchester.

He also points out the changes in management, and in particular the nursing staff, together with the increase in number of the staff and the stresses of the present-day staff.

He thoroughly enjoyed and was very happy in his work, particularly within the NHS, and was pleased he practised at the time he did.

MR IAN WILSON



Laboratory Manager, Pathology Department, Lancaster and Kendal Hospitals 1951-1996 (30 minutes duration)

The disc starts with the usual personal details and then how he came to work in the Pathology Department of the Lancaster Moor Hospital (LMH), and:

... each hospital had a separate pathology laboratory staff, so there were three in the area. There was one at the Royal Lancaster Infirmary, one at the Moor Hospital and one at the Queen Victoria Hospital in Morecambe and they all ran totally independently of each other. They were totally separate at that time. Then eventually, over the years, the whole of the pathology service gradually consolidated into one service ...

The training was an apprenticeship with examinations set by the Institute of Medical Laboratory Technicians. He had to gain experience in all the departments and take the examination after three years. National Service was in force so he was deferred for the three years, but eventually joined the Royal Army Medical Corps College in Millbank and the Queen Alexandra Hospital for training in parasitology so that he could be posted to Singapore. However, this was changed to Germany.

... then I was posted to Berlin where I worked in the Pathology Laboratory in Berlin because there was no pathologist in Berlin. So I was working without a pathologist and I think the reason I was sent there was because I knew how to do post mortem examinations ...

He later explains why he was trained to do post mortems.

... I had already done post mortems when I was training at the Lancaster Moor because there was no pathologist at the Lancaster Moor either, so I was trained to do the post mortems even though I never had medical qualifications.

I used to do them with the ward doctors, apart from the occasional Coroner's case when they shipped a pathologist in ... but all the hospital ones we did ourselves ...

Going back to his National Service:

So I spent the rest of my National Service career in Berlin, during which time I had dealings with most of the German war criminals who were in Spandau. So I met Funk, Hess and Doenitz, who were all patients whilst I was at Berlin. So I had dealings with all of them while I was there, so that was quite an interesting part of my career I suppose ...

At the end of the disc, when he was talking about other experiences, he adds some more information about the war criminals.

... it was all very high security. I didn't actually go down to the prison at all. They came to us. We had a security ward on the top floor of the hospital. I actually went into the wards and took blood from them ...

I remember ... I think it was Doenitz – could have been Funk – everything they got was censored so he was sat in bed reading this newspaper. It had great big holes in it where people had cut out bits that he wasn't allowed to read.

And the performance getting them there, as it was always a worry that something was going to happen to them between the prison and the hospital. What they used to do was have some ambulances going different routes so there were two or three ambulances with escorts all taking different routes to the hospital, so nobody would know which one he was in.

The Russian guards being around the hospital; I remember them drinking vodka with their breakfast.

I enjoyed my National Service. Of course it was in the middle of the cold war before the Wall was built ...

Returning to civilian life and a post at RLI, and after passing his final exams, he spent four more years gaining additional qualifications in biochemistry and haematology. He worked up the ranks via the Lancaster Moor Hospital (a smaller and more general lab), then at RLI until his final post as manager.

criminal law and confusingly further divided all controlled drugs into four Schedules for the regulation of medicinal use.

1977: Ecstasy added to Misuse of Drugs Act
Following widespread street availability ecstasy becomes a Class A drug.

1984: just say no
In the USA, Nancy Reagan's 'Just Say No' anti-drug campaign becomes a centrepiece of the Reagan administration's anti-drug campaign.

1985: crack cocaine
Crack, a potent form of smokeable cocaine developed in the

early 1980s, begins to flourish in the New York region.

1987: MDMA use increases
Famously formed in Ibiza, ecstasy is in widespread use at raves and dance parties. Ecstasy becomes a cornerstone of British rave culture.



He enjoyed practical laboratory bench work and lists some of the testing he did. There was a lot of public health work as well as hospital work – milk, water, ice cream were given as examples. Also a lot of TB work, from the chest unit in Beaumont Hospital (Dr Young).

The next extract starts with his work then and the changes over subsequent years.

... almost like working in a chemistry laboratory. We were using test tubes and pipettes and things, which nowadays of course they don't use. It's all done by machinery nowadays. It's probably the biggest change I have seen in pathology, is the degree of automation which has been introduced into all the departments really.

The only one that really hasn't changed an enormous amount is probably histopathology, because the techniques in there are still very much as they were, although there is some automation. All other departments are very highly automated now. It's almost a case of putting a bottle on one end and a load of results coming out the other end where before there was a lot of manual work involved, counting cells under the microscope and doing actual chemical analysis in the test tubes and things. So that's a huge change.

When asked about the present staffs' experience he replied:

... it's a different sort of experience. I wouldn't say they don't have the experience I have ... First of all the qualifications system has changed now. They are all graduates. They all come in with a degree in Medical Laboratory Science to start with ... although they need to understand the basic chemistry and things behind what's going on in the machines ...

It's probably not as much as, say, judgemental work, forming an opinion, which is what I enjoyed. Looking at things under the microscope and forming an opinion about them. Nowadays it's done automatically ...

... and the volume of work has increased enormously. That is absolutely huge now. When I first started at the Moor Hospital, I can remember it was a busy week if we dealt with 100 specimens by Thursday afternoon ... I was talking to one of my colleagues only a fortnight ago ... now well over 1,000 specimens a day in biochemistry alone. So I mean that has been absolutely huge. Of course the staff has increased as well, but a lot of it has been taken up with the automation.

Of course everything is becoming super-specialist now. Same with the medically qualified pathologist ...

He discusses the early medical pathologists in the group with whom he worked, and the medical and surgical staff and general practitioners who had hospital sessions. He continues with the changes,

The other big thing that has changed in the Infirmary is ... the old Nightingale wards with their beds down both sides of the ward. The place to me, looking back on it, I suppose, was run in a much more disciplined way that it is now. Whether it was anything to do with the fact we had just come to, virtually to the end of the Second World War, and a lot of people had seen service in the forces. The discipline was much more rigorous and Matron ruled with a rod of iron.

Miss Walton was the Matron, if I remember rightly; Sister Greenwood Deputy Matron and Home Sister, as she was called in those days. And the sisters in charge of their own wards ruled their own wards. They looked after everything on their own ward. The domestics were responsible to the sister on the ward. That wasn't a bad system; there is a lot to be said for it.

Dr Carne asked about any contact that he had with the patients.

We used to go round the wards collecting samples ... we used to assemble the forms for the various tests, mainly blood tests obviously, and then we used to go round the wards collecting the samples from the patients. So there was quite a lot of contact with the patients.

Also we did the ante-natal clinics – not the actual clinics – but we did all the blood tests for the ante-natal clinics. So we had certain days when we did certain clinics. Two days we did a diabetic clinic. Two days we did ante-natal clinics. Monday mornings I used to hate, because they were fractional test meals ... pushing tubes down patients' throats, especially first thing Monday morning. Then we used to have a day when we did glucose tolerances.

So there was quite a lot of contact with the patients, and there was a lot of contact with the medical and nursing staff and GPs. The GPs used to pop in and out. The lab was quite a social centre at one time. I remember the GPs used to come in and scribble requests on prescription pads, on bits of toilet paper and all sorts of things – can you do this for me, can you do that for me ...

He then comes back to the social life in the hospital, which played a big part in our lives at that time.

The hospital itself was very sociable. We ran a hospital cricket team, we had a table tennis team, we had a darts team, we had a swimming pool, we had a tennis team and used to play in the various leagues. There was very much a social atmosphere about the hospital which doesn't seem to exist nowadays ... I suppose it was smaller then and more people knew each other ... one of the questions at my interview was what sports did I play? Apparently, particularly at the Moor Hospital which had a good sporting reputation and was a frequent winner of the

1992: President Clinton

'When I was in England, I experimented with marijuana a time or two, and I didn't like it. I didn't inhale and never tried it again.'

1995: death linked to ecstasy

Leah Betts' death was attributed to ecstasy. Later it appears

she died from a cerebral oedema caused by overhydration, rather than a direct toxic effect of MDMA.

1996: more drugs added

Controls were extended to 48 anabolic and androgenic steroids and to six similar products, all liable to misuse by sportsmen and sportswomen. Temazepam was transferred

from Schedule 4 to Schedule 3.

1998: UN General Assembly Special Session on Drugs

Kofi Annan stated: 'Our commitment is to make real progress towards eliminating drug crops by the year 2008.'

Manchester Hospital Trophy in cricket, if you were a sportsman you had a good chance of getting a job at the Moor Hospital.

He returns to further changes in the administrative staff, the comments being similar to Dr Young's, and the huge increase in staff generally.

The disc finishes with his retirement, and because he missed being with people he took up other activities. He gives his view of the NHS as a patient and also lists some professional anecdotes, one of which is:

. . . very large coach crash up on Shap, just outside Kendal. I can remember haring up there with Tony

Rickards (the medical pathologist) in his shooting brake. We took every bottle of blood that was available from the RLI, both the blood cross-matched for patients and had cross-matched [other blood, ie virtually everything], put the whole lot in his car . . . he was driving 'like the clappers' and all I could think about going up to Kendal, we would have a crash and the road would be swimming in blood and we could be alright . . .

Like Dr Young, he also enjoyed his career and as he put it:

It was fun, some tragedies and some laughs along the way.

INTERVIEWS WITH COLLEAGUES ON CDs

These are now available in the library of the Education Centre, Royal Lancaster Infirmary. The interviews, from various employees of the health services, were recorded in 2006/2007 and provide an oral history from the 1940s onwards. These should be of interest to present and future generations.

A computer in the library has been set up to play the CDs via headphones (of your own or purchased at the desk for £1).

The Library is open Mondays to Fridays, 9am – 5pm.

Available interviews:

- | | |
|----------------------------|---|
| 1. Dr Douglas Young | Consultant Chest Physician, Lancaster and Kendal hospitals (1959-1983) |
| 2. Mr John Whitehead | Consultant General Surgeon, Lancaster and Kendal hospitals (1965-1988) |
| 3. Dr Sandy Kilpatrick | Consultant Anaesthetist, Lancaster and Kendal hospitals (1955-1986) |
| 4. Mr George Turnbull | Consultant Obstetrician and Gynaecologist, Lancaster and Kendal hospitals (1969-1991) |
| 5. Dr John Dyer | Director of Public Health, N Lancs/Morecambe Bay (1968-1993) |
| 6. Dr Graham Mathews | General Practitioner, Kirkby Lonsdale and Hornsby (1956-1988) |
| 7. Dr Hugh McKinney | General Practitioner, Morecambe (1962-1993) |
| 8. Dr David Austin | General Practitioner, Crewkerne, Somerset (1959-1989) |
| 9. Dr John Carne | General Practitioner, Meadowside, Lancaster (1963-1991) |
| 10. Mr Richard Harrison | Dispensary Chemist, Ullswater Rd, Lancaster (1948-1978) |
| 11. Mrs Milly Shepherd | Nursing Sister, Lancaster (1953-1989 approx) |
| 12. Mr Ian Wilson | Laboratory Technician and later Manager, Pathology Dept, Lancaster and Kendal hospitals (1951-1996) |
| 13. Mrs Joanne Braithwaite | Medical Secretary to various consultants (on and off, 1947-1965) |
| 14. Mr George Lucas | Deputy Head Porter, Royal Lancaster Infirmary (1972-2007) |
| 15. Mr Victor Bolton | Head Messenger, Royal Lancaster Infirmary (1979-2008) |

1998: drug tsar appointed

Keith Hellawell, former Chief Constable of West Yorkshire, named as the UK's National Anti-Drugs Coordinator, or 'Drugs Tsar'. (By 2002, Hellawell had departed and his unit had dissolved, having made little impact.)

2000: Harold Shipman

Found guilty of murdering 15 of his patients using diamorphine.

2000: Runciman Report

A comprehensive analysis of the failings of UK drug policy: it made recommendations, including calls for cannabis to be reclassified from Class B to Class C, and MDMA from A to B.

2001: Misuse of Drugs Act

Controls the export, import, supply and possession of dangerous or otherwise harmful drugs. In effect, the Act largely renders unlawful all activities in the drugs controlled under the act except provided for under the regulations made under the Act. Thirty-six additional substances were brought within the controls for the first time.

