This talk was given via Zoom to the Royal Institution of South Wales on Thursday 3rd March 2022, as the third in a series of talks about Dr Julian Tudor Hart.

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Thank you for the invitation to talk and reflect about my friend and colleague, Julian Tudor Hart. It’s a pleasure to follow the excellent presentations in this series, first by Brian Gibbons, and then by Jonathon Richards and Gareth Jones, which are well worth watching on the RISW You Tube channel.
Of course, as many of you know, Julian didn’t achieve what he achieved by himself.

There were two of them.
Julian was many things – a scientist, a writer, a philosopher, an artist, a social advocate, a community activist. Many people do some of these things but very few while also working as a family doctor looking after the medical needs of 2000 people. It was the combination of these activities which gave Julian his authority and influence – Dr “Art, the local G - Dr Julian Tudor Hart, the world famous general practitioner.

As part of this series of talks I’m going to cover where his energy, talents and values came from; the career journey that took him to Glyncorwrwg; the work he did there and his wider influence outside Wales. The adage of “acting locally, thinking globally” could not be more apt.
The name Tudor Hart has an Elizabethan ring but its roots were in North America. The Tudors and Harts were closely related business families, including Ephraim Hart (originally Hirz), a Bavarian Jew, New York merchant and politician, and Frederic Tudor, the Boston Ice King who made his fortune exporting ice, before refrigeration, from Massachusetts to Cuba and India. The combined surname arose when Julian’s great grandmother, a Tudor, divorcing his great grandfather, a Hart, wanted to keep both names.
Julian’s Canadian grandfather, Percyval Tudor Hart, was sent to study medicine in Paris, which he hated, so he left to become a painter. Cut off from parental support, he became a starving artist, a fellow student with Henri Matisse, a neighbour of Toulouse Lautrec. His career picked up, teaching painting in Paris until the Great War, then London, then back to Canada. He became a world expert on picture restoration. In Paris, his first wife, Eleonora Kleczkowska, called “Nellie”, came from minor Polish aristocracy. She gave birth to Julian’s father Alexander in Florence, but died young from tuberculosis. It’s the plot of *La Boheme*.
While Julian’s paternal grandparents were Canadian and Polish, his maternal grandparents were Scottish, his father Alexander having married Alison Macbeth, daughter of Norman Macbeth, born in Glasgow, educated in Edinburgh, an apprentice engineer in a Clyde shipbuilding firm, and Annie McNicol from Helensburgh. The couple moved to Bolton, where he worked as an engineer for 30 years and where they brought up a family of 9 children.
The eldest was Ann Macbeth, one of the Glasgow Girls, an associate of Jessie Newberry and Charles Rennie Mackintosh at Glasgow School of Art, where she was head of needlecraft and embroidery, but also a suffragette, designing a banner for a famous Edinburgh procession, for which she was imprisoned, put in solitary and force-fed in 1912. As a teenager, Julian spent summer holidays with his aunt at her retirement home in the Lake District.
In 1926, Ann’s sister, Alison Macbeth, married Alexander Tudor Hart. They were both left wing doctors, but split up when Julian was three. After the divorce, his father went to fight in the Spanish Civil War, having married Edith Suchitsky in Vienna, enabling her to live in the UK as Edith Tudor Hart. She was a photographer her work (as shown, including a picture of a South Wales march), a KGB agent and spymaster for the Cambridge Four – Mclean, Philby, Blunt and Burgess. As he said in the recent documentary *Tracking Edith*, Julian had little contact with his step-mother. He was brought up in Woburn Square in London by his mother Alison, a single parent who became an endocrinologist.
It’s a complicated background. There was medicine, engineering, art and politics on both sides of the family. Based on his grandparents, and where he lived, Julian could have played rugby for Scotland, England, Wales, Italy, France, Poland and Canada.
Julian went to a progressive school, Dartington Hall in Devon, before being sent to stay with his grandparents in Canada during World War 2. On his return he studied medicine at Cambridge and then St Georges in London, graduating in 1952.

After five years in general practice in west London (where a visiting Paul Robeson was a patient), and the end of his first marriage, Julian moved to South Wales, where he spent the remaining 60 years of his life, initially, at the suggestion of his friend Richard Doll, to obtain research experience at the MRC Epidemiology Research Unit, led by Archie Cochrane. There he learned a democratic type of research, employing streetwise local people to generate high response rates, the last person as important, though often different, as the first.
But Julian was frustrated, seeing many people with clinical problems which as a researcher he could observe but not treat. So he left, and in later life recalled his decision, in a phrase from JP Hartley’s novel The Go-Between, exchanging “a life of facts for the facts of life.”
In moving to Glyncorrwg, a mining village at the head of the Afan valley, isolated with only one road in and out, the back of beyond as many would have seen it, he was finally, aged 35, on track for his life’s work.

He had always wanted to be a general practitioner in a coal-mining community - partly following his father’s example at Llanelli, partly due to the romance of mining practice, as described in AJ Cronin’s novel *The Citadel*, but mainly because with his privileged, exclusive background it was the type of community to which he wanted to belong and be included.
As Gerald Davies, one of his patients, said in the BBC documentary *The Good Doctor*, Julian wasn’t aloof like the other doctors, the headmaster and the colliery manager. He lived in the village and shared the common experience, his children going to the local schools.

Although mainly an industrial village in a rural setting, there were several farming families on his practice list. Here on the right, crossing the footbridge, is Julian returning from a home visit to a hillside farm.
Glyncorrwg was isolated enough for him to pursue without interference his vision for general practice, as he described in a careers pamphlet for medical students published by the Lancet.

“No one is a stranger; they are not only patients but fellow citizens. From many direct and indirect contacts, in schools, shops and gossip, I have come to understand how ignorant I would be if I knew them only as a doctor seeing them when they were ill.”

With great effort any doctor can get to know all his patients, even in a city with a high migrant turnover. Only then can he learn to think of a responsibility, not only to the patient sitting in the surgery, but to the whole population for whose care he is paid and for whose health he is responsible. He can then see his role as the ultimate custodian of the public health on a defined section of a world front against misery and disease.

The greatest rewards in primary care are going to be found in those areas that most need good doctoring, but which at present are least likely to get it. To do this one must discard the sorts of ambition still encouraged by some teaching hospitals. We need more liberty, more equality, but above all more fraternity; the doctor living and working within a community, sharing as much as he can of the common experience, is better able than any other to discard privilege and stand on two firm legs of earned respect.

Julian Tudor Hart
Lancet Career Guide for Medical Students 1973
But at the beginning the future was a long way off. The work was hard, with huge surgeries, long visiting lists and many out of hours calls. Computers and mobile phones were still in the future. Being on call meant being answerable to an answering machine. Local doctors didn’t all welcome this new doctor with strange ideas.

Initially he was on his own, and lonely, but in 1961 he married Mary Thomas, whom he had met at the MRC Unit, lost touch with, but found her again, famously trawling through the South Wales telephone directory looking for a farming family called Thomas. Without doubt marrying Mary was the best decision Julian ever made.

In the 1950s a study of general practice in poor areas by Collings observed that the conditions in which many general practitioners had to work were often bad enough to turn a good doctor into a bad doctor in a short period of time. There was a lot of work to do, therefore, beginning with putting the records into shape, emptying the old Lloyd George envelopes, putting the letters in date order, summarising the problems, so that consultations could begin with and build on this knowledge. It took years for Julian and Mary to complete this task in evenings after work.
Later the records were converted to A4 folders and bound together in family files. A system of colour stickers highlighted particular conditions – high blood pressure, diabetes, smoking etc.
Initially the surgery was a wooden hut but soon the practice moved to the newly built health centre, the first health centre in Wales.
In 1966 he took full advantage of the new GP contract to employ the maximum number of ancillary staff – receptionists and nurses, the beginning of what would become a large team of practice colleagues, community health staff, researchers and doctors in training. These changes and improvements were the platform on which he could build.
Julian was the first doctor in the world to measure the blood pressures of all his patients. The Veterans Administration Study in the US had shown that treating moderate to severely elevated blood pressure could prevent strokes. Julian knew from the studies of the MRC Epidemiology Unit in the Rhodda Fach that high blood pressure often occurred without symptoms. The only way to find hypertensive patients was to measure blood pressure in everybody.
The first step was to screen the notes, to see who needed a BP measurement next time they visited, and to put a reminder in the notes. The practice nurses were trained to use a random zero mercury sphygmomanometer – state of the art then, obsolete now. The use of routine appointments to collect such measurements, instead of separate screening arrangements or clinics, Julian called anticipatory care. Later on, the blood pressure data were entered on these forms, sent to London for computer entry and returned as computer printouts. It’s much easier now.
Eventually one man, Charlie Dixon, was the last man to take part, on condition that he was the last man. He had the highest blood pressure in the village, with a diastolic pressure of 170 but after being put on treatment was still alive 25 years later.

Julian became an international authority on blood pressure control in general practice and wrote a book about it which went to three editions and was translated into several languages, with a companion book for patients.
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A key step was what he called the measurement of omission. In the British Medical Journal he wrote, 

*Back in the 1960s, before rubella immunisation and the Abortion Act, a sixth (unwanted) pregnancy in a 42-year-old Glyncorrwg woman resulted in a child with severe brain damage. The mother had had no apparent illness, but there had been an epidemic of rubella in our village during the first weeks of her pregnancy. The whole family was affected: the father’s smoking and alcohol problems went out of control. As the child grew he became unmanageable; with all ground floor windows smashed and replaced by cardboard. The home became a cave. In the insensitive jargon of health economists he became a high consumer of services, first diagnostically, later for social educational support, now (as his exhausted relatives die or capitulate) for the most costly service of all, full-time residential care.*

So, when rubella immunisation became possible, we wanted it to succeed. At that time secondary school absence was running at 20% in 13-year olds at the local comprehensive, and at least this proportion was therefore presumably not immunised. I wrote to our local medical officer asking for a list of girls missed, so that we could get them immunised. “I can give you the names of the ones we did,” he wrote back, “but how can I know the ones we didn’t?”
The answer was to have an information system that included everybody – the denominator at risk rather than the numerator of activity. By measuring omission, Julian was able to address the rule of halves, the tendency in most systems for things not to be done or to be done poorly, and to increase the proportions of patients who were diagnosed, treated and controlled.

Julian hated when bad things happened to his patients, especially when they could have been prevented. In his last 28 years at Glyncorrwg, there wasn’t a single death in women from cervical cancer – the result of well organised and informed preventive care.
Ascertainment and diagnosis were only the beginning. In his book *A New Kind of Doctor*, he described a man, invalided out of the steel industry after a leg fracture, aged 42. With no further use for his big muscular body, he had become obese, had high blood pressure and cholesterol, got gout and was drinking too much.
Overall the story is a success …

For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exciting things have been the events that have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.

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25 years later, Julian described how, after 310 consultations and 41 hours of work, initially face to face, eventually side by side, the most satisfying and exciting things had been the events that had not happened: no strokes, no heart attacks, no complications of diabetes. He described this as the real stuff of primary medical care.

At a seminar in Glasgow, we asked Julian what happened next. The man had died, of something else, a late-onset cancer I think, but when Julian told us this, there was a tear in his eye. His patient had become his friend.
After 25 years, involving 210,000 patient encounters, about 180 per week, he could show 30% lower premature mortality rates, compared with conventional care in a neighbouring population—the only example in the world literature of what a general practitioner can achieve in a lifetime’s practice.
He did this partly by a population approach to the delivery of evidence-based medicine but also by providing unconditional, personalised continuity of care for all his patients.

Julian showed that long term commitment to a particular community could improve health, lengthen lives and narrow health inequalities, in the most deprived community in West Glamorgan.

In his time, addressing the challenges he faced with the resources available, he not only imagined but also realised the exceptional potential of general practice and primary care.
Julian described audit as measuring what you do and being honest with the results, his most spectacular example being a review of 500 consecutive deaths in his practice, over many years. It showed that deaths were occurring at older ages. Fewer deaths were due to smoking.
Brecht’s *The Life of Galileo* was his favourite play and he often quoted Brecht’s line, “The figures compel us.” Julian didn’t pursue scientific knowledge for its own sake. He could never have been an ivory tower academic and was correct to turn down offers of university chairs. His research always had the direct purpose of helping to improve people’s lives.

Glyncorrwg became the first general practice in the UK to receive research funding from the Medical Research Council. As an outstation of the MRC Epidemiology and Medical Care Unit at Northwick Park Hospital in Middlesex, the research team, led by Mary Hart delivered very high response rates for a series of studies on the prevalence of urinary incontinence, the role of bacteria in stool samples in predicting bowel cancer, and a trail of anticoagulant therapy in people at high risk of heart disease.
I first visited Glyncorrwg in 1975, as an Aberdeen medical student, on my final year general practice attachment. Returning to the university, bursting with enthusiasm, I was disconcerted to be cut off whenever I attempted to join the group discussion. As the professor said, he was glad there was one Julian Tudor Hart, but only one. He did not want his class contaminated by progressive ideas.

In those days Julian had been a communist, standing for parliament in 1964, 66 and 70, and losing his deposit three times. This alarmed many of his conservative contemporaries, quite a contrast to how he is revered now. The difference being that he speaks now from a lifetime of worked examples in his practice. Advocacy was not only what he said and wrote, but also what he did.

Reflecting on this change many years later, he described “re-entering the world as it actually was, rather than the fantasy world of our imaginations.” “The first rule of politics, Julian said, was to start where you are with the people you’ve got”
I resolved to go back. Julian was not only imagining the future but making it happen - Inclusive medical care, everybody on board, epidemiology his map, science his compass. Wherever my career would go, I was certain it had to involve more time with Julian and Mary at Glyncorwg. So I joined what became the unofficial university of Glyncorwg, one of about 20 GP registrars and MRC research fellows who spent time there, including Andy Haines, John Robson, John Frey and Anne Delahunty. Brian Gibbons at the back, was Julian’s partner in the neighbouring village of Blaengwynfi.

The MRC research registrar post allowed Julian a day every week, a Thursday, when he was free to do his writing, speaking and other work
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I’d been attracted first by Julian’s writing. He had a lucid, sometimes coruscating turn of phrase.

When a Conservative Minister of Health Keith Joseph announced that increased dental charges would give a financial incentive to patients to look after their teeth, Julian commented that while the Government had not yet put a tax on coffins to reduce mortality, Sir Keith was assured of a place in the history of preventive medicine.
The medical schools do not deliberately set out to impart smugness, careerism and values unrelated to the needs of real patients in the real world; it comes quite naturally to them.

Julian Tudor Hart
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Julian Tudor Hart

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It is true the personal ambitions and professional satisfactions of doctors overlap with the needs of patients, but they do not coincide; yet that is the assumption of a great part of medical education.
Intellectual opposition to social injustice, even when present, is only the beginning of understanding.

If students are to retain patient-oriented rather than disease-oriented motivation, they must learn to identify in complex, concrete, detailed terms with people they know only as crude stereotypes, and of whom they are usually afraid.

Julian Tudor Hart

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As a young medical student, far away in the north-east of Scotland, I found this intoxicating stuff.
It was my good fortune to be involved in the Salt Studies, exploring the ideas that high salt intake might increase blood pressure and that some people might be more susceptible than others – the first studies generated by the research team in Glyncorrwg and not directed by the MRC Unit. We obtained funding from the British Heart Foundation – the first time it had given a grant for research in general practice. The first question we asked was “Were people with a strong family history of high blood pressure “salt hungry”? With Julian’s blood pressure data it was easy to identify offspring whose parents either both had high or both had low blood pressure.
We measured their sodium intakes, using plastic jugs and containers to collect 24 hour urines.
Not just once, but on seven consecutive days, so that no one flushed their toilet for a week. There was no evidence that people with a family history were “salt hungry”. But everyone’s salt intake was high, so then there was a second question - Might people with a family history of high blood pressure be more sensitive to the high levels of salt they consumed?
That required an experiment, in which everyone reduced their salt intake to less than 3 grams a day, equivalent to a South Seas island diet, while taking part in a randomised controlled trial of salt tablets, bringing their intake back to their usual, or placebo tablets, keeping it at the reduced level. We borrowed the study design and the tablets from Professor Graham McGregor at Charing Cross Hospital who had shown that salt restriction reduced blood pressure in patients with pressures high enough to need treatment.
To pilot the procedures and using Julian’s blood pressure data, we identified people with mildly elevated pressures, not high enough to need treatment and in whom salt restriction might be a preventive measure. Here he is in a classroom in the local primary school explaining the study to potential participants.
The lines on these graphs show for each participant changes in sodium excretion on the left and blood pressure on the right, each dot representing four weeks of diet and measurements for one individual. Salt intakes were reduced, with two exceptions, but blood pressures hardly changed.

The result was submitted to the British Medical Journal only 4 months after the study was first thought of – probably one of the fastest trials ever conducted – all because everything was already in place – the thinking, the information, the people, the relationships.

It couldn’t be done now. Not only would it take that long to get ethical permission, ethical permission would not be granted, saying that patients were being coerced to take part. But it wasn’t like that. The doctor had an exceptional reputation for helping his patients. Patients knew that and were willing to help the doctor in research. It was an unspoken understanding, something an ethical committee might not understand.
The negative result in people with mildly elevated blood pressures didn’t exclude the possibility that some people might be more susceptible than others, but our subsequent larger trial in young adults with and without a family history of high blood pressure was also negative, reported at this international conference in Finland and published in the BMJ. The results made us sceptical of the salt hypothesis. At best, it seemed a lot of effort for very little reward.
But quite apart from the scientific questions, this was an extraordinary undertaking to take place in a free-living community. I know of nothing like it, before or since. First of all, with Georgina Bingham, Mair Boast, and especially Evelyn Thomas, Pam Walton, Cath Edwards and Mary Hart, we had an exceptional research team of local talent. They asked nothing of study participants that they hadn’t already done themselves.
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A converted ambulance garage served as a laboratory and office
Low sodium bread was obtained from a local baker and delivered to study participants.
But their most important task was asking, informing and supporting local people to eat very differently for a 10 week period, avoiding a large list of conventional foods in red – despite this tea towel, a much longer list than the list of foods they were encouraged to eat, in green.

The tea towel was printed at Glasgow School of Art by my wife, who was a lecturer in printed textiles, 70 years after Julian’s aunt had worked there.
Common salt, as you know, salt is a chemical compound, sodium chloride, made up of a poisonous gas and a metal that explodes on contact with water. It would be dangerous were all that energy not locked away.

In the same way that Cochrane’s team galvanised whole communities for medical research, regularly achieving response rates of 90 to 95% - that’s ten times the response rate achieved by UK Biobank – the Salt studies revealed the huge reserves of energy goodwill, and cooperation waiting to be mined even in the most deprived communities - not underground but on the surface of the Welsh coalfield – perhaps the most important observation we made, and the lesson I most remember.

And from a personal point of view, the whole experience of working with Julian and Mary was a life-long battery charge. To work and live with them at Glyncorrwg was to live life at a higher level.
All of this, general clinical practice and general practice research, Julian communicated to the wider world in a series of over 150 research papers in major scientific journals.
And books, in several of which the footnotes, references and asides are worth reading on their own, reflecting his huge range of reading, contacts and opinions.
And advocacy, via a host of articles and proposals, often swimming against the tide.
He accepted speaking invitations from all over the world, notably Spain, Italy (here he is sketching his Italian colleagues), Norway, North America, Australia. Julian could deliver formal lectures but for brilliance and exhilarating an audience he was at his best in impromptu, unscripted exchange.

When principles were at stake, Julian could argue until the cows came home. In his younger years he took no prisoners. A famous medical professor reflected that he had been called many things, but never a snail. Julian did mellow in later years, but never lost his edge.

Dr Miriam Stoppard arrived in the village to interview Julian for her TV programme, determined to cast him in the role of a doctor who made life or death decisions concerning his patient’s access to renal dialysis and transplant. They battled for a whole afternoon, Stoppard trying to get Julian to say things on camera that fitted her script. He defied her, ending every sentence by mentioning how much dialysis and transplant surgery the cost of a single Trident missile could buy. She went away defeated and empty-handed.
The world also came to him, hundreds visiting Julian and Mary at the Queens in Glyncorrwg, as recorded in their visitor’s book – shown here are just two of 32 pages of visitors, at all stages of careers, some eminent already, many starting out, some worshipping, some sceptical, all learning.
Standing for election to the Council of the Royal College of General Practitioners, Julian topped the poll. What he offered GPs was a credible image of themselves as important members of the medical profession - alongside specialists, not beneath them.

It was his experience that when a general practitioner knew his patients well, the problems they had to deal with and how they had dealt with them, there were very few conversations on medical topics where he could not make a contribution. All this took place over 30 years ago. The world has moved on, so what is his legacy?
It’s certainly NOT the Inverse Care Law, described in a very early paper, his fifth, with another 150 to come, which he came to consider a banal observation, no more insightful or striking than “The people who need shoes the most are people without shoes”.

Simply observing that the availability of good medical care tends to vary inversely with the need for it in the population served, especially when market forces are at play, has had little effect in changing the situation. 50 years later, the inverse care law continues. Market forces are being allowed in, and encouraged, especially in England, generating social exclusion at both ends of the social spectrum, the poor involuntarily, the rich voluntarily as they opt for private medicine. It is a poison in the system, adding to the longstanding mismatch of resources, a service responding to demands rather than needs, and the maldistribution of doctors, based on where they want to work.

All this continues to be documented, in greater detail than Julian could ever muster, to no great effect. Despite numerous policy statements to the contrary, the inverse care law remains a de facto policy that restricts needs-based care.

Julian was unusual, however, as a commentator on inequalities in health, because unlike most commentators who have little connection with policy or practice, he
could do something about it.
At a symposium in Glasgow in 2006, marking his 80th birthday, I summarised his work showing that

*The combination of a population approach with long term productive relationships, between patients and professionals who know and trust each other, and who are guided by evidence and audit, is a powerful force not only for epidemiological research, but also for health improvement and a fairer, more convivial society.*
Important ingredients of his approach were

INCLUSIVENESS (his whole population approach, the last person as important as the first);

the importance of INFORMATION (using epidemiology to allow the measurement of omission);

straightforward FAMILY MEDICINE (providing unconditional, personalized continuity of care);

personal COMMITMENT (working in, with and for a local community);

and PERSEVERANCE (staying long enough to make a difference)
In a paper with Paul Dieppe, on “Caring Effects”, he described the harmful effects when for whatever reason, health professionals become indifferent to what happens to the patient in front of them. I remember Julian talking of the importance of finding something to like about every patient. There was nobody about whom there wasn’t something to like. Nobody was excluded.
Julian was the “worried doctor”, anticipating patients’ problems, not waiting for them to happen, and then avoiding them by joint endeavour. He began as a paternalistic, didactic doctor, but he changed, he had to change.

“Initially face to face, gradually shifting to side by side”, Julian was talking and writing about “co-production” with patients, and the pace at which it could be achieved in a deprived community, 20 years before it became a policy catchword.

The Glyncorrwg practice was one of the first in the UK to have a patient participation group, in which the experience and views of patients could influence the running of the practice.
His involvement in the local community went far beyond being a doctor. He campaigned for the setting up of the South Wales Miners Museum and was instrumental in setting up the Glyncorwg Pond Cooperative, the beginning of the transformation of the village and its economy from an abandoned mining village to a centre for outdoor sports.
Much of the pioneering work that Julian did is orthodox now, much of it incorporated in the GP contract. Information technology, in particular, has transformed what is possible, opening up a new set of challenges.

So Julian’s legacy is not the example he worked out in the microcosm of a Welsh mining village over 30 years ago; it is the present challenge of how we follow and give practical expression to his values, working in local communities, making a difference in addressing current and future problems. In honouring his memory, there is work for all of us to do.
At a conference in Glasgow in 2019 we celebrated three things: the life and work of Julian Tudor Hart; the publication of a book *The Exceptional Potential of General Practice* with 55 contributors from 11 countries, 44 of them general practitioners, the book dedicated to Julian and Mary. We also celebrated the work of four Deep End Projects. It was a conference that Julian would have enjoyed, with lots of young doctors imagining and working towards a better future. Many said it was the best conference, in terms of company and content, they had ever attended.
One of Julian’s cartoons gave rise to the Deep End analogy, highlighting the problems and challenges facing patients and doctors at the bottom end of the health care slope, or deep end of a swimming pool.
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The cartoon gave rise to the Deep End logo
Including the deep end of a pool, the steep slope of need, the flat line of resource, a sunset or sunrise depending on your disposition, a thistle for Scotland, a spurtle (or stirring instrument) down the side, the whole thing a flag for rallying under.
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The first Deep End conference in 2009, attended by GPs from two thirds of the 100 most deprived communities in Scotland, was the first time this group of practitioners had ever been convened or consulted. The seating plan was a circle with everyone in the front row. The starting point was to listen and record their experience and views.
Resulting in a long list of reports, available in short and long forms on the Deep End website,

And giving rise to the Deep End manifesto, addressing the inverse care law as the difference between what practitioners can do for patients under current conditions and what they could do with more time, better support and better connections.

We have had some successes based on worked examples in demonstration projects – the rollout to all Deep End practices of community link workers and embedded financial advisors – but we are still campaigning for more consultation time.
A PhD student of mine, Breannon Babbel from Oregon interviewed a sample of GPs working in deprived areas in Glasgow. All saw their role in clinical consultations. Some saw no further than that, while others tuned in to patient’s social situations, viewed the local community as a resource, saw the social and political determinants of poor health being played out in front of them, and wanted to do something about it. The Deep End Projects connect and support practitioners with this wider view.
For an increasing group of Deep End practitioners, from newcomers to old hands, this is what they aspire to do, it is the direction they want their careers to take and it is the collegiate culture they want to be part of. Here is the Scottish Deep End steering group, meeting recently, lots of young GPs, mostly women. They are the future, the beating heart of the project, not waiting to be asked, not waiting for the future to happen, but imagining the future they want and making it happen. We don’t have magic solutions, but we do have a direction of travel.
Following the example of the Scottish Deep End Project, there are now ten other Deep End Projects in Ireland, Australia, Denmark and seven areas in England. They are local networks of GPs and practices with a wider vision of what they can achieve, with shared activities spanning workforce, education advocacy and research. This is something that Julian never had and which he very much welcomed.

In these difficult times I think of the Deep End Project increasingly as a resistance movement.
There have been six Deep End International Bulletins, each with 40 pages of news and views from the various Deep End Projects, all available on the Scottish Deep End Project website.

The projects have given identity, voice, shared activity, shared learning and policy impact to a previously neglected group of general practitioners and, by proxy, the patients and communities they serve.
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Julian has been their example and inspiration, and left them with more to do, commenting in one of the early reports “Everything depends on leaders at practice level, demanding media attention, gaining public support, and insisting on material resourcing from governments, in return for which they can guarantee immensely greater efficiency of care generated by people who know each other”. He knew that to achieve change, new alliances would be needed, with politicians and the public, to put pressure on the establishment.
Drawing on his reading of Marx, he saw health care as a form of production, producing not profits but social value, shared knowledge, confidence, the ability to live better with conditions, achieved not by the doctor alone but by doctors, nurses, patients and others working together. Patients are partners, not customers or consumers.

The NHS should never be a business to make money but a social institution based on mutuality and trust - the ultimate gift economy, getting what you need, giving what you can, a model for how society might run as a whole. In re-building society, co-operation would trump competition, not marginally, but as steam once surpassed horsepower. The Glyncorrwg research studies showed glimpses of that social power.
In 1971, with the NHS barely 20 years old, he was concerned about the re-entry of the market into UK health care. As night follows day this is a prescription for inequity and inequality. Asked how long the NHS would last, Aneurin Bevan replied, “for as long as people are prepared to fight for it”, implying not one single effort such as the battle over the 1948 NHS Act, but a sustained defence campaign, like maintaining a Dutch dyke, keeping the tides of market interest at bay. As NHS England steadily succumbs to market encroachment, and privatisation by stealth, would-be defenders of the NHS are being tested as never before.

The NHS should be at its best where it is needed most. Otherwise health care widens inequality, some groups benefitting more than others. Tackling the inverse care law needs cash, not words. Any other approach is building on sand. The main underexploited resource is social capital. How can that be harnessed? Can the Cochrane approach to high participation research be applied to integrated care? Who can lead such development?
Working in a remote village in West Glamorgan in the 60s, 70s and 80s, it took an exceptional person to break and re-set the mould of general practice. There are different challenges now, for which we need not only pioneers but also collegiality, sharing experience, evidence and learning, and solidarity, pursuing the common interest.

Two weeks ago, In a Guardian article reflecting on her clinical last session in general practice before retirement, the President of the RCGP, Clare Gerada, reflected that every patient had been a stronger. In 1973, writing for medical students, Julian wrote that “No one is a stranger”.
Julian saw the NHS not as the finished article but as a work in progress, which we still have to imagine and realise. The world has caught up with him in many ways but there is still lots of catch up to do. His example and views have never been more topical or more important.

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