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ORIGINAL RESEARCH

# "It is Sometimes Soul-Destroying": Doctors' Reflections on Unemployment and Health in Thatcher's Britain

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**Abstract**
Through an analysis of two sets of writing in the *British Medical Journal* from the 1980s, this article explores relationships between unemployment and health. "Unemployment in My Practice," published in 1981, was a series of nine short essays by general practitioners from across the United Kingdom. This was followed by "Occupationless Health" in 1985, made up of fourteen essays, composed by the assistant editor of the journal, Dr. Richard Smith. Both series demonstrate how deeply frustrating it was for doctors to confront mass unemployment in light of the policy decisions of the Thatcher government. They present a call to medical practitioners to be aware of the health dimensions of unemployment and a growing sensitivity to the lives of working-class patients. Rich with perceptions about the relationships among work, gender, class, age, and health, these essays argue that unemployment was not just an economic problem, but one doctors needed to monitor. Doctors found their professional identities shaped in new ways by their broader economic and cultural contexts.

**Keywords** Unemployment · Health · Health disparities · Masculinity · Britain · Thatcher · Economics · British Medical Journal · General practitioners · Primary care · Identity

Writing in the October 1985 issue of the *British Medical Journal* (*BMJ*), Dr. Richard Smith, the assistant editor, posed the questions, "Need doctors concern themselves with unemployment? Does it have much effect on the health of their patients, and even if it does what can they do? . . . Isn't unemployment more an economic than a medical problem?" (1985a). Smith certainly believed doctors should be well-versed in the medical implications of unemployment, arguing that "unemployment is far too important an issue to be left to economists" (1985a). Because of its impact on Britons' health and the healthcare system itself, doctors needed to pay close attention to the relationships between the economic and the medical realms.

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A series of nine short essays entitled "Unemployment in My Practice," published in the *BMJ* four years earlier in 1981 also saw unemployment as a medical problem. These essays were written by general practitioners (GPs) from a variety of locations across the United Kingdom, with contributions coming from England, Ireland, and Scotland, and from rural and urban areas. From the content of the essays, it is clear that a *BMJ* editor had asked the GPs to reflect on how increasing unemployment had been affecting their patients and what the overall economic situation meant for their practices. I am speculating that it was the deputy editor, Dr. Tony Smith, who had an interest in putting the series together. His obituary describes him as a committed socialist who came from a working-class family that had experienced hard times (*Guardian* 2009). Asking doctors to reflect on the impact of unemployment on their practices would seem to be right up his alley.

My approach in this article is a close reading of the general practitioners' 1981 essays set against Dr. Richard Smith's series of articles published in the *BMJ* in 1985 and 1986 under the heading "Occupationless Health." A deep encounter with these sources brings forward the voices of GPs struggling with the changing circumstances of their patients, their practices, and their wider socio-political environments. Smith's research-driven series helps us see the 1981 essays from his more scholarly, but still emotive, perspective. Smith worked at the *BMJ* for twenty-five years and was editor of the journal from 1991 to 2004 (Kmietowicz 2004). His writings address more analytically the themes the GPs' essays raised in 1981 and provide a useful context for understanding some of the GPs' responses to unemployment. As Smith commented in the introduction to his series, "certainly many doctors are not aware of the powerful effect that unemployment is having on the nation's health" (1985a). Smith's reflections came four years after the large *BMJ* community had likely read what the nine general practitioners had to say about unemployment in their practices. Clearly, in Smith's perspective, "the substantial body of research on how unemployment harms health . . . has not perhaps had the prominence it deserves" among the medical profession (1985a). Indeed, the doctors' essays from 1981 reflect only a tentative encounter with the meanings of unemployment to health and the practice of medicine. The *BMJ* perhaps gave the GPs the opportunity to put into words what many doctors might have been experiencing as the economic conditions of their patients changed. While these two sets of essays obviously cannot speak for all doctors' interactions with unemployment and health, they can open a window on what Britain's leading medical journal thought was important for its readership to confront as well as shed light on GPs' sometimes intense reactions to unemployment in the lives of their patients.

Nineteen eighty-one was an ideal year for the *BMJ* to publish doctors' reflections on unemployment in relationship to their medical lives. Margaret Thatcher had been Prime Minister for two years, and her Conservative policy mandates had had time to have an impact on the nation. The Inequalities in Health Research Working Group, which had been appointed by the previous Labour Government in 1977, had published the *Black Report* in 1980, but the Thatcher Government quickly ignored this report. Two basic ideas that the *Black Report* put forward were condemned and disregarded by the Conservatives: "that health inequalities existed at all and that there was any causal relation between social conditions and health" (Bartley et al. 1998). According to a study on health disparities in Europe, "Any mention of health inequalities disappear[ed] from official vocabulary and statistics" in 1980s Britain, even though medical and nursing organizations continued to publish analyses demonstrating the significance of growing health inequalities and the importance of social and environmental factors for health outcomes (Whitehead 1998). Milton Terris, an American public health physician, lectured that "The Conservative government adopted a deliberate policy of starving

the National Health Service in order to reduce the quantity and quality of services and thereby encourage shifts to private insurance and private hospitals" (1999). This approach damaged working-class people's access to medical services and frustrated the general practitioners who cared for them.

Additionally, by 1981, unemployment had reached 12% nationally, with significant regional variations (Warr et al. 1988). Scholars have shown that Thatcher and her ministers "accept[ed] . . . mass unemployment as a price worth paying" to push through privatization, free-market policies, assaults on trade unions, and cuts to the welfare state. (Scott-Samuel et al. 2014). One result of Thatcher's willingness to see both unemployment and health inequities rise, the *BMJ* essays suggest, was that, by 1981, general practitioners had become sounding boards for the growing numbers of unemployed people and their families; their surgeries were places people could go to fill up empty time. Doctors found themselves not only treating the physical and mental illnesses that resulted from unemployment, but also serving as community counselors addressing emotional needs, their professional identities shaped in new ways by the broader economic and cultural contexts.

My main interest in this article is to explore what the general practitioners' writings demonstrate about doctors' perceptions of the relationships between unemployment and health. I am also interested in examining what the general practitioners *themselves* learned from their encounters with their patients: about the meanings of work and health, about what it meant to live a working-class life, about the emotional impact of unemployment. Their musings are rich sources for establishing senses of place, for examining assumptions about gender and age, and for understanding how deeply frustrating it was for these doctors to confront mass unemployment.

Scholars have recognized the mutually supporting relationship between the implementation of Thatcherite policies and an increase in health problems among the poor. And those who fell into the category "poor" increased significantly in the early eighties. The number of people applying for unemployment benefits grew from about one million in 1981 to about three million in 1983 (Scott-Samuel et al. 2014). Middle-aged people who had worked all their lives were made "redundant." Young people graduated from school with no employment prospects. As Dr. Richard Smith noted in 1985, "the young, the old, the unskilled, the single, men with large families, the disabled, the socially disadvantaged, and members of ethnic minorities are all over-represented among the unemployed" (1985a). Stringent attitudes toward welfare did not help unemployed people shake the feeling of stigma created by Thatcher's very public pronouncements that if they would only try harder, they would find jobs: "My policies," she famously argued, "are based not on some economics theory, but on things I and millions like me were brought up with: an honest day's work for an honest day's pay; live within your means; put by a nest egg for a rainy day; pay your bills on time; support the police" (Quoted in McCann 1981).

The medical studies on unemployment and health of the time recognized that "the possible effect of unemployment on health has been ignored to a remarkable extent by various authorities throughout the years" (Rees), as a leader from the *BMJ* put it in December 1981, the same year the GPs were writing their essays. Two letters responded to this leading article, indicating that some doctors were already well aware of the dangers of unemployment to health, with one commenting that "the medical profession may be unable to change the complex economic and social factors involved, but it can continue to draw attention to the health implications of unemployment for those who are fit to work" (Hannay 1982). Smith suggested in 1985 that government inertia was to blame for a lack of research into the links

between unemployment and health (1985a), and, indeed, that the literature that was developing around unemployment and health in the 1970s and 1980s tended to reach back to what was known in the 1930s (Smith 1985c). Studies from the 1930s, the first time that medical professionals and social scientists undertook systematic studies of the relationships between unemployment and health, had found that "extreme hardship, with accompanying physical and mental deterioration, was the norm for the unemployed and that emotional instability, general loss of morale, distorted time sense and social isolation were common" (Donovan and Oddy 1982). During the 1980s, studies continued to conclude that "unemployed people experience higher levels of depression, anxiety, and general distress, together with lower self-esteem and confidence" (Warr et al. 1988). The *BMJ* itself published articles speaking to the "hazards of unemployment," which included "increased rates of both mental and physical illnesses" (Hazards of Unemployment 1981), although Smith argued that the evidence for the links between unemployment and mental illness was much more persuasive (1985c). The *BMJ* recommended that doctors look for the signs of depression and anxiety caused by unemployment, so that they might offer "more informal help and . . . start collecting information as opportunity offers" (Hazards of Unemployment 1981), since the Government was not moving forward. Overall, a review of the literature of the early 1980s suggests a medical profession with fuzzy knowledge and lack of concerted approaches to unemployment and health.

This is why the *BMJ*'s 1981 series "Unemployment in My Practice" was so significant. Not only did it provide broad statistics about unemployment in different areas of the country, it also humanized the relationships between unemployment and medicine by allowing doctors to speak in their own voices about individual people who were unemployed and whose health suffered from their economic circumstances. These essays offered British medical practitioners a way to enter the conversation about unemployment and medicine on both a clinical and emotional level.

Several of the GPs who wrote the 1981 *BMJ* essays reflected the attitude that poor men were untrustworthy, and that perhaps Thatcher's tough love was a good thing. They wrote that before the unemployment crisis, their normal interactions with working-class men were transactional: men in their towns most often came to see GPs with requests for medical certificates attesting that they were unable to work due to health reasons. The language doctors used to describe these interactions spoke of their patients somewhat unsympathetically and condescendingly. Dr. K.B. Thomas, for example, a general practitioner from Waterlooville, a suburb of Portsmouth in the south of England, told the story of "a gentleman" who "is much better known to me than I would have wished:"

> He used to burst into my room without knocking, with the words, 'It's gone again, Doc.' I always asked, 'What's gone?' although I knew perfectly well. And he would reply, 'My back.' Then after a negative examination, I would mention the subject of work. He would purse his lips and inhale a volume of air audibly, while half closing his eyes. His expression was a mixture of incredulity, sadness at the thought that I should expect him to work, and pain at the idea of actually performing it. A moment later he had taken my proffered certificate and departed with an agility through the door. He was never interested in treatment.

In this narrative, produced for other medical professionals, working-class men are tricksters in the medical encounter who do not want to work and who manipulate doctors to avoid performing their jobs. They would rather be on disability pay. Here, the practitioner might have aligned with Thatcherite views that emphasized a bloated welfare state fed by unearned

benefits. Still, the passage also suggests a somewhat close relationship with the patient, a familiarity, which in the end resulted in the patient's desired outcome, even though the physician believed the patient was "faking it." Interestingly, Thomas's research agenda included studies that challenged what he saw as the overmedication of patients in general practice (1987).

Thomas went on to describe a more recent encounter with this same man, which suggested a shift in their professional relationship. The "gentleman" came to him with a cold, for which the doctor gave him a prescription: "Then there was a pause as I waited for him to ask for a certificate." Now, however, the man was unemployed, which Dr. Thomas knew simply from "the faint wistful smile that was almost apologetic, regretful that he could not fulfil his traditional role." Again, while Thomas's narrative is somewhat patronizing, he recognized that "the rules of the game had been changed," and he felt "a little sad" (1981). Unemployment altered the bond between this doctor and his patient, disrupting their usual patterns and transforming the practitioner's attitude from condescension to sympathy. Whereas it was the patient who felt "sad" in the first exchange, because the physician expected him to work, in the second instance, Dr. Thomas himself expressed sadness at the changed circumstances. The patient no longer had the power manipulate the system, the certificate was useless, and he was failing his family as an unemployed man, unable to "fulfil his traditional role" as the breadwinner. The physician, likewise, was helpless to do anything to assist his patient, as a certificate of poor health would no longer result in benefits. His own authority in the work-health interaction was thus diminished.

In another essay, the general practitioner C.P. Tanner of South Shields, near Newcastle in the north of England, described how things had changed for his patients now that "more than one in five [were] out of work" (1981). Indeed, the area was one of the hardest hit by Thatcher's policies. One patient, Eddie, a miner, had usually requested a medical certificate but now was clearly too afraid to lose his job if he missed a day by claiming illness. Dr. Tanner described the situation:

> Eddie is 40. He works in the pit and has severe obstructive airways disease. In the past he has had a lot of time off work and has been noticeably reluctant to go back. Today his chest is worse again. His treatment is adjusted and I reach for the certificate. 'Not this time doctor.' 'Do you think you can manage?' He stands up and seems a foot taller. 'I'll manage' (1981).

Tanner was clearly aware of the tensions brought on by his patient's health problems, since health and work were obviously in conflict. He struggled with the ethics of sending Eddie back to the pit with dangerous breathing issues and was willing to certify Eddie's inability to work. Eddie, however, needed to stay at his job throughout his period of ill health in order to avoid unemployment. Even so, Eddie expressed pride in his ability to "manage," sick though he was, since work was so important to his identity. It was one thing to be temporarily off work with a medical certificate; it was another thing entirely to be unemployed.

Dr. Tanner explained that local industries were using their employees' health problems as an excuse to lay men off: "if the condition comes to light at whatever stage of his career, he is discharged. . . . As one such discharged chief [shipping] engineer said, 'I wish I'd never listened to all that crap you fed me about my blood pressure; I might not have lived as long but at least it would have been a better life for me and my family'" (1981). Having a job and living with poor health to this man were compatible, as they were to Eddie; unemployment was the true danger to his status as a breadwinner. In these encounters, the doctor urged the men to take

time off to heal, which meant the doctor could become a threat to men's working lives. As workers, the men regarded missing work for ill health as the first step to the loss of a job and could blame their doctors for their unemployed status. The GP Roger Higgs of Walworth in southeast London commented in this regard, "Time and rest are effective remedies and hitherto cheap, but they are becoming more difficult to prescribe" (1981). Men who before would have been pleased to rest at home now went to work with serious medical conditions and in pain in order to provide for their families and maintain their sense of masculine identity as workers. Dr. John Mackay of Glasgow, who came from a working-class background (*Herald* 2011), expressed his own sense of powerlessness in face of the circumstances: "I feel frustrated because I find it difficult to restore a man's self-respect when he is obviously devalued in his own eyes and in the view of his family" (1981). Here Mackay assumes that unemployed men's inability to provide for their families automatically "devalues" them, because they have failed key expectations of masculinity: holding a job and maintaining a family.

According to these *BMJ* essays, then, doctors were well aware of the messy connections between health status and unemployment. A man in poor health was more likely to join the ranks of the unemployed, and so workers tried not to give in to their ailments. As Mervyn Goodman, a GP from Liverpool put it, "The requests for National Insurance Statements of Incapacity have dropped considerably. Many patients fear that absence *through* illness may jeopardise their jobs, especially when there is any possibility of manpower reduction, while those who are unemployed now have no need for such statements" (1981). Anxiety about losing a job kept employed men from going to the doctor in the first place: according to the GP Albert Jacob of Dundee in Scotland, "those with an uncertain job future are prevented from seeking attention for fear of work absence" (1981). Simply by asking for time off to see a doctor, a man put his job at risk. Why would an employer keep on a worker with potential health problems when he had his pick of men for the position? Dr. Tanner of South Shields objected that industries were undertaking very strict surveillance of men they assumed had health issues, waiting for something to emerge to "shake out" men who were not completely healthy (1981).

Doctors had particular worries about their middle-aged male patients whose unemployment caused them to react to their bodies and health dilemmas in new ways. Dr. John Wilson, from a rural area outside Belfast, described "Healthy middle-aged men [who] arrive with complaints – with minimal pathology – but insist on full check-ups because they now have more time, with the result that the fears of serious illness are greater" (1981). Without work, unemployed middle-aged men fixated on their bodies and contemplated illness possibilities. They constructed somatic problems where earlier none had existed.

In a different scenario, Dr. Jacob of Dundee wrote of "Mr. M," whose chronic back pain had forced him to quit his job as a bus driver. Finding another job was "a non-starter for a man in his mid-fifties with no skills other than his ability to drive a bus. In any case no employer is likely to look favourably on a recruit with a physical difficulty if he can get a fit man to do the job; and with unemployment there are plenty of fit men looking for work" (1981). Any kind of disability would be a threat to employment. Dr. Jacob signed off on a certificate indicating that Mr. M. should not work. Writing about his own sense of powerlessness, Jacob explained,

> I have not seen the last of Mr. M. He still has his backache. He will not get a job and his morale is dropping. He will need a great deal of support, and yet 10 years ago he would have been in one of our factories within weeks of the original accident, happily contributing to the welfare of the community (1981).

If Mr. M could have found employment other than driving a bus, he would have had a chance. Since no jobs were available, however, Jacob believed Mr. M's unemployment would be permanent once his disability prevented him from driving. He could no longer fulfill his role as a man, "contributing to the welfare of the community."

Once a man reached a certain age, he essentially became unemployable, because there were so many younger men available to take the few jobs that were on offer. Dr. Jacob of Dundee commented in regard to this problem that "there is a nagging feeling that too many middle-aged men are being thrown on the industrial junkheap" (1981). Dr. Goodman of Liverpool mentioned that older middle-aged men "who have minor handicaps or a minimal degree of ill health" had to take "early retirement" because of the lack of jobs. He remarked that it was useless to send these men to look for new positions they had not trained for, both because of their age and because of the nonexistence of the jobs (1981). Smith argued in 1985 that those over fifty-five "are more likely to be made redundant and also to find it more difficult to get another job" (1985b). They made up a good portion of the long-term unemployed.

Age affected those on the other end of the life cycle, as well. Smith noted in 1985, "as unemployment rises, it rises disproportionately among the young." Between 1979 and 1982 "total male unemployment" grew from 6.6% to 15%, and by July 1982 21% of those under twenty-five had been unemployed for longer than a year (1985b). The GPs wrote particularly about the "school leaver" who had no job when he finished school. The problem of "school leavers" was particularly acute in Thatcher's Britain. These were the generally sixteen year olds who could not find their first job and immediately went on benefits. A study of unemployed school leavers found that they suffered from many of the same issues as unemployed adults: depression, boredom, and low self-esteem. Additionally, however, the study also remarked on the central place of work in developing an adult identity. If a teenager did not make a smooth transition from boy to man through finding work, he could develop other mental and physical health problems (Donovan and Oddy 1982). (All of this literature is very gendered – the overall concern of social scientists and health care professionals was with adolescents becoming men, although Smith does mention that unemployment was even higher for young women than it was for young men [1985b]. I will have more to say about this below, as will the GPs.)

The lack of available work was the case with "Billy," a patient of Dr. Jacob's of Dundee, "one of the many school-leavers who has failed to find a job" (1981). Billy was having problems with drugs and alcohol. Jacob seemed attuned to the issues unemployment posed for the identity and adulthood of young men in his community. According to this GP,

> Of course, unemployment does not cause drug abuse or alcoholism but prolonged idleness gives these youngsters an opportunity they would not have otherwise for this type of activity. . . . The problem is that a job gives one self respect. To work means to contribute and play one's part as a full adult. It should be the first step a youngster takes toward the development of his adult psyche. Without this he (and it is usually he in my practice) will look for other avenues in which to assert his adulthood.

Adulthood also meant taking on particular gender roles. For working-class men, this meant above all a job and providing for families. Yet unemployment stripped away the possibility of fulfilling those roles. The GP Jacob continued his commentary on Billy, reflecting, "In my part of the world alcohol intake is equated with manliness, and these youngsters compensate for the other deficiencies in their developing life-style by demonstrating their prowess with the bottle" (1981). Rather than modeling masculinity through work and home life, these young men were

left with alcohol and street culture. Jacob astutely remarked, "Male chauvinism is not all advantage to the male" (1981), as the pressure to provide created particular stresses for those who were unable to fulfill the expectations of being a man (Levine-Clark 2015). Dr. John Wilson worried that "My fear is for the youth of the practice. They are now showing signs of vandalism, drunkenness, rowdiness, and general loss of morale. They need help, even if it is only having someone agree that they have a problem because their problems will only end when employment comes back to our practice," which could be a long time coming (1981).

Dr. Tanner of South Shields described another model of the school leaver, one who gave in to social isolation, also a noted effect of unemployment. He wrote about "The young man of 18 with a rising attendance rate to surgery presents with increasing introspection and concern with his soma and turns out to have never had a job. He is bored and uninterested, with little to look forward to and fewer ideas about how to occupy himself" (1981). Here, we have the detached teenager turned inward, focusing on his body, perhaps as a way to avoid the outside world. He visited the doctor because he had nothing else to do, maybe imagining phantom illnesses to explain to himself why he could not get a job. Chances are he also set up the appointment because he simply wanted to talk to someone.

Problems with alcohol were not limited to school leavers. Indeed, almost all of the GPs discussed how unemployment increased alcohol consumption among men in general. Dr. Roger Higgs of Walworth in southeast London wrote of Jimmy, an Irishman, who he described as "quite bright, well built, and usually healthy." Unemployment, however, had led to heavy drinking, and Jimmy found companionship at the pub instead of at work. He lost his lodging, and, according to Higgs, his self-esteem. Higgs wrote, "Now dry and in control, we could both see how he had to climb back up again, and the first step was a job. But this treatment was no longer on the market." Here, as in several other cases, the doctor explicitly medicalizes employment itself as the "cure" for being out of work, meaning that simultaneously unemployment is medicalized as the disease. Higgs was tempted to prescribe tranquilizers, since he was unable to find Jimmy a job, but decided against this alternative potentially addictive substance (1981). He ended the essay frustrated by a lack of answers. Since no employment was available, he did not feel he had a permanent solution to Jimmy's health problems.

As the examples in the GPs' narratives demonstrate, their patients feared "being regarded as a failure." They worried "about the future and about becoming unemployable, losing their self respect. . . . Even with more than three million people unemployed [in 1985] those out of work tend to think that they have failed in some way, and the status of the unemployed is low" (1985d). Their doctors were unable to provide the solution to the mental distress these patients experienced: moving people from unemployment to employment. Smith, in his 1985 *BMJ* series, emphasized that unemployment damaged mental health far more than physical health (Smith 1985d).

The GPs saw men whose bodies did not stand up to mass layoffs. They saw men whose psychological profiles were damaged by the failure to find meaning in their lives without the opportunity to take up a job. They also saw women. Yet few of the doctors who wrote these essays discuss women primarily as workers who had to deal with the problems of their own unemployment. Women as workers are present in the essays, but they are in the background. For example, Dr. Jacob began his essay describing Dundee as a city that had been dominated by female labor in the jam and jute industries, so men were historically "disadvantaged in their search for work." He remarked, "It is hardly surprising that Dundee has one of the worst employment problems in the country," by implication blaming women's labor for men's

unemployment (1981). For these doctors in their predominantly working-class neighborhoods, unemployment was a problem for men.

Rather than concentrate on women's own unemployment, the GPs wrote about women as wives who lived with unemployed husbands. They focused particularly on wives' problems with anxiety and stress. A 1988 study of Boston, which also represented men as workers and women as wives, found that, while husbands' depression and anxiety came on fairly immediately with unemployment, their wives' symptoms were delayed and tended to be expressed after their husbands were unemployed for several months. When they did react to their husbands' unemployment, however, wives experienced "somatic complaints, interpersonal sensitivity, hostility, depression, and anxiety" (Liem and Huser-Liem 1988). And, interestingly, the Boston study argued, these experiences were unique to blue-collar women. Mothers, according to Smith in 1985, seemed "to be protected from the psychological distress associated with unemployment. This may be because they have plenty of work to do, whether or not they have a job, and their responsibilities with their children provide a purpose and matter more than any other commitment. But single women and women who are principal wage earners are as affected by unemployment as men" (1985d). Here Smith acknowledged women as wage earners, but created an opposition between mother and wage earner.

The GPs writing in the *British Medical Journal* explained that wives' anxiety increased because their husbands were around the house too much. For working-class women, the home was supposed to be women's space; men belonged at work and in the pub (Bourke 1993). This is not to say that women did not also work, but things became distorted if a man hung around the house. For example, Dr. John Mackay of Glasgow wrote, "To the overburdened wife the husband about the house is like having another child, almost a handicapped child, constantly around her feet. Stress eventually develops, and health visitors report increased abuse of the wives" (1981). It was not enough for this doctor to liken the unemployed man to a child, suggesting another dependent for his wife to deal with, but using the language of the day, "almost a handicapped child," he highlights the point about the husband's helplessness around the home, which requires the wife-mother to be entirely on call. His description of an unemployed man as "handicapped" implies the husband's loss of full functionality, which the wife-mother needs to support. Considering the audience for this essay would be other medical professionals, Mackay's allusion to a disabled child suggests a shared understanding among the medical community that disability caused enormous burdens for poor families. An unemployed man, then, created an enormous burden.

The other element Dr. Mackay emphasized was an increase in domestic abuse. John Wilson, the GP who worked in a rural area outside of Belfast, also found that "Wives are consulting more frequently with mild depression owing to financial problems, and the fact that the husband is around the house for too long each day causes marital disharmony – even to the stage of wife battering, almost unknown in the practice three years ago" (1981). The reality was that these unemployed men were not children, but rather adults whose inability to fulfill the male breadwinner role led to violence in their households. Wives not only suffered from "mild depression" but also from physical abuse. Their doctors recognized it, but it is unclear if they did anything about it other than prescribe valium.

As Dr. Wilson mentioned, wives also became depressed because of the financial strains of having husbands out of work. According to the GP Mervyn Goodman, wives sought out the doctor "with symptoms of anxiety depression resulting from economic factors." He thought that "It is surprising in how many households it is the wife who is left to cope with the family financial problems. In these instances the doctor has become the agency, par excellence, who is

expected to cure the problem or alleviate the symptoms, and it is difficult to explain that a prescription for benzodiazepines will not make the unpaid electricity or gas bill miraculously disappear" (1981). Working-class women had long been responsible for household budgets, a fact about which Goodman was seemingly ignorant (Bourke 1993). And his remarks regarding women's inability to understand the difference between the impact of benzodiazepines and the continuing existence of unpaid bills suggests a good deal of gender and class condescension.

As I alluded to earlier, unemployment itself, some of these doctors suggested, was the disease that made men sick. Dr. Wilson wrote that "A young man presented with chest pain on the afternoon he got his redundancy letter. One month later he was successful in getting an interview for a new occupation, and his pain cleared and has not recurred" (1981). The state of being without a job created a somatic response in this man, which his doctor took seriously. Somewhat differently, Dr. M Hamid Husain, of Rotherham in South Yorkshire, a deindustrializing steel region, argued that "In my experience the fear of unemployment and the feeling of insecurity that this can bring is more responsible for mental stress and psychological trauma than unemployment itself. It is almost as if the pressure is released once the catastrophe has happened" (1981). He also used the example of a young man who came to see him with chest pain, in this case, while "his firm's redundancy's plans were being drawn." However, he "has been conspicuously absent from the surgery," since he actually lost his job (Husain 1981). In these cases, employment equated to the normal healthy state of being, while being unemployed or the thought of unemployment brought on very real symptoms of illness. Unemployment, then, was not just an economic problem, but one doctors needed to monitor.

The GPs who wrote of the topic at all concluded that out-of-work women and immigrants managed unemployment better than did native British men. Unemployed women, they assumed, had other tasks to keep them occupied in the household, especially mothering, and so could keep themselves busy, not dwelling so much on being out work, as Smith also suggested. I would add that unlike for men, in the 1980s employment was still not a fundamental aspect of working-class women's identities. The lack of a job would therefore not have the same psychological impact for women as it would for men, who were expected to be the family breadwinners and to have work as a key aspect of becoming a man (Du Gay 1988; Japp 1991). Only Dr. Husain wrote about his perceptions of the impact of unemployment on the health of immigrants in his community. He found that the "Asians" he came into contact with "in spite of being disproportionately affected by unemployment" were "able to stand up to the stress of unemployment with fewer problems" than the native British population. He attributed this to their ability to deal more readily with poverty because of their strong family ties and minimal attachment to material goods (1981). Whether or not this was indeed the case, this physician's perception of the circumstances says something further about the isolation of unemployed, white, British men. Still, when jobs became available, immigrants would have had a much harder time securing them.

Their experiences with unemployed patients made these general practitioners think about work in new ways. Dr. Wilson who practiced outside Belfast commented, "It is sometimes soul-destroying when you know that you are writing references for six men, all of whom are after the same job" (1981). He could certify the health of these men, but he could not promise that their positive health status would secure them a job. Dr. Roger Higgs of Walworth in London wrote of his new understanding, "I had thought when I had seen the plasterer [his patient] that he simply needed work to get money. But as the weeks have passed I have seen that it is his own value, not that of the pay packet, that is in question." This doctor came to realize that for working-class men, having employment did not just mean being financially

stable; it was also a core part of their identities and therefore of their psychological stability. Higgs added that "For the others, losing work had threatened family survival and the only safe source of companionship and therapy" (1981). Through their often emotional encounters with their patients, these doctors came to the same conclusions as Marie Jahoda's famous 1930s study of unemployment in Marienthal in Austria, which found that paid employment

> imposes a time structure on the waking day; it enlarges the scope of social relations beyond the often emotionally highly charged family relations and those in the immediate neighbourhood; by virtue of the division of labour it demonstrates that the purposes and achievements of a collectivity transcend those for which an individual can aim; it assigns social status and clarifies personal identity; it requires regularity (Quoted in Smith 1985d).

Smith reflected in November 1985 that "[Jahoda's] list seems almost so acceptable as to be beyond dispute" (1985d). Yet this was seemingly new knowledge for the GPs writing in the 1981 *BMJ* series.

Still other doctors recognized the significance of work, but were willing to recommend solutions that devalued the worker himself. Dr. K.B. Thomas of Waterlooville, for example, commented, "Work is such an important part of our lives that if there is to be no work for some people, and I read that full employment may never come back, then work must be created, perhaps second-class work at a lower rate of pay. To have a large section of the community doing nothing for a long time is a certain recipe for disaster, disaster for the individual and perhaps disaster for society" (1981). Thomas certainly understood the connection between employment and well-being, but his solution harkened back to the draconian poor law and early public works programs, which would have stigmatized unemployed people (Levine-Clark 2015). John Mackay of Glasgow proposed that "Surely it would be better for the unemployed husband and father to be earning money repairing roads than wasting social hand-outs in a soul-destroying life of aimlessness and indolence" (1981). Focusing on propping up the male breadwinner, Mackay took a dim view of welfare benefits as opposed to physical labor in public works projects, especially in terms of a man's mental health.

The general practitioners who contributed to the "Unemployment in My Practice" series in the *British Medical Journal* revealed to their colleagues their frustrations in managing patients' relationships between unemployment and health. They saw men hiding health problems in order to hold onto jobs. They heard about employers looking for "weak," unhealthy men to find excuses to let them go. Once men experienced unemployment, their health problems increased, which made it less likely they would be reemployed. Men with existing health problems found themselves on the "scrap heap" with no hope, especially if they were past a certain age. Young school leavers entered the work force with no promise of a job and turned to alcohol and drugs. The essayists mostly expressed their own sense of powerlessness, confronting a situation in which curing a patient's illness or healing an injury did little to guarantee that patient would then be employable. The link between good health and employment was broken, and Thatcher's policies did little to promise a fix.

The doctors wrote openly about their patients' struggles with unemployment and their own challenges in becoming aware of the changing dynamics in their practices. Many GPs came to the realization that even the most alienating labor had meaning as a "job" that located a working-class man in a particular place in his self, his family, and his community. Without that job, men dealt with problems of identity, mental health, and physical health. Families broke down, and men no longer knew how to position themselves as men. Wives became anxious,

and husbands became abusive. Doctors' new understandings of work as more than a pay packet could only help in future encounters with their patients who were dealing with the health and other problems of unemployment. This broadened the GPs' sense of what medical "practice" meant in the face of economic insecurity.

The GPs' narratives constructed unemployment as a medical problem. According to their essays, Dr. Richard Smith was right when he wrote in 1985 that "unemployment is far too important an issue to be left to economists" (1985a). The medical profession had to be made aware of the health crisis in its midst caused by the millions out of work.

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## Compliance with Ethical Standards

**Conflict of Interest Statement** I work at the University of Colorado Denver (not Anschutz Medical Campus). I collaborate with Professor Tess Jones on our Health Humanities Programming and have served as a reviewer for the *Journal of Medical Humanities*. Professor Jones and I have a professional relationship. I have not received any feedback on this article from Professor Jones or anyone else who works on the *Journal of Medical Humanities*.

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