The ‘hunger march’ of unemployed men from Jarrow to London in 1936 is the best known of the marches which took place in the early 1930s to protest against the high rates of unemployment and the low rates of benefit. It was another of these marches on which I, and a small group of third year medical students from University College London, met on the outskirts of London in 1933.

Our intention was to show support for the march and to provide any first aid that might be necessary. This turned out to be mainly the dressing of blisters.

It was this experience, combined with the publication by the British Medical Association in 1933 of its report on minimum diets considered adequate for those on unemployment benefit that stimulated me to write the article on malnutrition in England.¹

Sir Richard Doll described a similar experience when interviewed by Sue Lawley on the UK BBC Radio programme ‘Desert Island Discs’ in 2002. He related how he, with another recently qualified doctor, marched a good part of the way with the Jarrow marchers and how he had been moved to see one of the men take the meat out of his sandwich and put it into an envelope to send home to his family, because they had not had meat for some weeks.

In 1934 we began our clinical studies. I do not think that our teachers, the ‘honorary’, most of whom were at the top of their specialties, ever discussed the relationship between the harsh living conditions which many people suffered, as revealed by the hunger marches, and the diseases we studied. Large areas of ill health in which social conditions were very important, such as mental illness, infectious diseases, pulmonary tuberculosis, and the disabilities of old age were relatively neglected. This was probably because patients with these conditions were not normally admitted to teaching hospitals. These diseases were covered to a small extent by lectures and by sending students on a few visits to the municipal hospitals that cared for them.

Tuberculosis was a huge problem. In 1934, for example, there were 30 882 deaths from this disease in England and Wales. Looking back it seems surprising, in view of its prevalence, that so little time was devoted to it in our training, or to the underlying social conditions—including overcrowding and malnutrition—which were so important in its causation.

Figure 1 Second year medical students University College London, 1932. John Pemberton fourth from right, back row
In the early 1930s there was much poverty due to unemployment. Nearly 3 million were without jobs. Unemployment Benefit, Public Assistance, and Children’s Allowances were at a miserable level, insufficient to provide an adequate diet to prevent malnutrition. 

Women, especially in the poorer classes, were still having large families. Knowledge of birth control was scarce and family planning clinics almost unknown.

Those of us who were becoming aware of the important connection between ill health and bad living conditions were often introduced to these concepts, not by our clinical teachers, but by political or medico-political organizations such as the Socialist Medical Association (SMA). This was founded in 1930 and its history has been fully recorded by Stewart.

There were a few medical men and women in the 1930s, already distinguished in their fields, who WERE aware of the importance of the social environment in the causation of disease. These few doctors attempted to make the public and, very importantly, the politicians aware of these factors by articles in the press, by speaking at public meetings, by research, and in a few cases by entering politics and becoming Members of Parliament.

Somerville Hastings, consultant ear, nose and throat surgeon at the Middlesex Hospital was one of these. As a founder and first president of the SMA and later, as an MP and member of the London County Council and chairman of its Hospital and Medical Services Committee, he exerted considerable influence, through the Labour Party, in the formulation of the principles underlying the National Health Service.

John (later Lord) Boyd Orr, Director of the Rowett Research Institute, Aberdeen, did a great deal to make the public and the politicians aware of the extent of malnutrition in the general population. He did this by his study of food consumption in relation to income, reported in his classic book, Food, Health and Income, and by trenchant broadcasts on BBC Radio. The significance of his book is demonstrated by the fact that the then Conservative Minister of Agriculture, Walter Elliot, persuaded him to delay its publication until after the General Election of November 1935—by which time a new Conservative government had been elected—because it was thought that it would help Labour in the election.

Few leading clinicians called attention to the effects of poverty on health and nutrition in the 1930s. James Spence, a consultant physician at the Royal Victoria Infirmary, Newcastle and later the first Professor of Child Health in Britain, was one who did. He found that the average heights, weights, and haemoglobin concentrations of children from the poor areas of the city were considerably lower than those of ‘professional’ class children, and that the incidence of childhood respiratory illnesses was considerably higher.

Another clinician, Philip d’Arcy Hart, now 102, was a young consultant physician at University College Hospital in 1937. I was his House Physician at the time and I recall how surprised his colleagues were when he decided to give up clinical medicine and devote his career to research on tuberculosis. His report, Tuberculosis and Social Conditions in England, provided much evidence of the importance of unfavourable social conditions, including malnutrition, in the causation of this disease.

A book published in 1936 by the Medical Officer of Health for Stockton on Tees, GCM M’Gonigle, and a sanitary inspector, J Kirby, Poverty and Public Health, provided some startling evidence of the importance of an adequate diet for health. Part of the population of a very poor area had been rehoused in a new housing estate. They found that the mortality rate of this group, already high, went up still further after they had been moved. The authors attributed this to the fact that the rent was doubled in the new estate was nearly twice as high as the rent on the slum property and in consequence the money available for food was considerably less.

About the same time a medico-political body was founded whose specific object was to call attention to the problem of malnutrition. This was the Committee Against Malnutrition. It was led by the charismatic W Le Gros Clark who had been blinded in World War I. A number of distinguished doctors supported its campaign and spoke at its public meetings including Professors JR Marrack, VH Mottram, VE le Gros Clark, and Dr Janet Vaughan.

A government report which provided a great deal of evidence of poverty as an underlying cause of much disease was The Registrar-General’s Decennial Supplement on Occupational Mortality 1931 published in 1938. This recorded in detail the higher standardized mortality ratios from many diseases suffered by the poorer social classes. Unfortunately not many doctors read it.

The great physiologist JBS Haldane did, and in writing about it in the socialist paper the Daily Worker wrote ‘If the workers read this report there would be a revolution tomorrow’.

In 1937 Jerry Morris and I organized some small meetings for housemen at University College Hospital to try and promote discussions on medicine and social factors. When I went across to University College London to ask Professor Haldane if he could spare the time to come and talk to our little group he said ‘Wednesday is it? Let me see I’m going to America on Thursday. Yes I’ll come, certainly.’ We were immensely impressed. Going to the USA by liner in 1937 was more pleasant but required more preparation than the journey today.

The 1930s were bleak years characterized in the early part by very high rates of unemployment. The low rates of benefit and public assistance caused much poverty and widespread malnutrition. The last half of the decade was overshadowed by the growth of fascism in Germany and Italy and by the expectation of war. Paradoxically the war, when it came, by leading to a great drop in the number of unemployed, to food rationing, controlled prices of basic foods, and vitamin supplements for children, ensured that even the poorest families in the population could purchase enough of the basic foods for an adequate diet. The result was an overall improvement in the nation’s diet and the elimination of widespread malnutrition.

During the war years there was a growing recognition within the medical profession of the importance of a social as well as an individual approach to the problems of disease. In 1942 the Royal College of Physicians set up a Social Medicine Committee which recommended that every medical school should establish a Department of Social and Preventive Medicine. In the same year the first Professor of Social Medicine in the UK, John Ryle, was appointed by Oxford University. Birmingham and Edinburgh universities followed suit and soon nearly every medical school in the UK had a Department of Social or Community Medicine.

Studying the effect of social conditions on health thus became an accepted (although still a minority) component of academic
medicine. As Jerry Morris discusses in his accompanying commentary, it remains as necessary today as it was in 1934.

References


Commentary: Minimum incomes for healthy living: then, now—and tomorrow?

JN Morris

I have not seen John Pemberton’s article, published in the summer of 1934, before. Qualifying as a doctor from University College Hospital (UCH) in the spring of that year, and typically broke, I departed straightaway to a general practice in the country. There within 3 days, and solo, I was delivering the reluctant wife of the local policeman ... Anyhow, I returned safely to UCH in the autumn of that year as House Physician (Resident) to Thomas Lewis, the great Heart man, whose clinical clerk I had previously been in a life-changing experience for close on a year. Soon, some of us, residents and students, started a Socialist Study Group on the future of health services. The Dean, however, would not have any such ‘political activity’, so we renamed it the Hippocratic Club. But John Pemberton in his article seems to have got away with it. I am lost in admiration for this truly pioneer effort.

There was growing concern during the 1930’s depression years over the health and nutrition of the poor, and particularly the unemployed, whence the British Medical Association’s (BMA) Committee. This consisted of Health Officers, nutritionists, an eminent paediatrician, and so on. Their absorbing report was published as a special supplement in the British Medical Journal (BMJ) of 25 November 1933. It consists mainly of tables of model diets, with their minimal costs, for a range of families and individuals, based on current knowledge of minimal nutritional needs for ‘health and working capacity’. (Memo to BMA and BMJ: What about an update? The time could scarcely be more opportune.)

Remarkably, there was no discussion in the report, not even a mention, of the practical implications of the costs of the approved diets. This was all the more surprising as the secretary of the committee, a local Health Officer, was already engaged in the research that was to become a classic of social medicine.5 Nor did the accompanying BMJ editorial on The Feeding of the Nation6 rectify this silence. One must wonder about ‘pressures’. There is a PhD surely here in-waiting.

Such silence however was not good enough for Pemberton, a medical student in his junior clinical year by my reckoning, and he waded in as social-medical analyst with the article now reprinted.1 That the unemployed could not afford the recommended diets is demonstrated, and he proceeds to discuss evidence on malnutrition and health.

I must not digress to consider the nature and quality of the diets proposed in accordance with the knowledge of the 1930s. But just one brief example—the family of father, mother, and three children under 16 on which Pemberton focuses (Diet no. 16), by my assessment, seems to consume about 10% of today’s consumption. Quite unrealistic.

How do statutory minimum incomes today compare? What progress has been made in the intervening 70 years? The direct

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