

AUDIO INTERVIEW TRANSCRIPT

Kilpatrick, Stewart: transcript of an audio interview (23-May-2000)

Interviewer: Andy Ness

Transcriber: Jaqui Carter

Editors: Tilli Tansey, Hugh Thomas

Date of publication: 03-Feb-2017

Date of interview: 23-May-2000

Publisher: Queen Mary University of London

Collection: History of Modern Biomedicine Interviews (Digital Collection)

Reference: e2017049

Number of pages: 15

DOI: 10.17636/01019163

Acknowledgments: The History of Modern Biomedicine Research Group is funded by the Wellcome Trust, which is a registered charity (no. 210183). The interview was funded by a Wellcome Trust (grant 059533; 1999-2001; awarded to Professor George Davey-Smith, Dr A R Ness and Dr E M Tansey) and its publication by a Wellcome Trust Strategic Award entitled “Makers of modern biomedicine: testimonies and legacy” (2012-2017; awarded to Professor Tilli Tansey).

Citation: Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Kilpatrick, Stewart: transcript of an audio interview (23-May-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017049. London: Queen Mary University of London.

Note: Audio interviews are conducted following standard oral history methodology, and received ethical approval from UCL (2000) and QMUL (reference QMREC 0642). Related material has been deposited in the Wellcome Library.

© The Trustee of the Wellcome Trust, London, 2017

Kilpatrick, Stewart: transcript of an audio interview (23-May-2000)*

Biography: Professor Stewart Kilpatrick OBE FRCP (1925-2013) was Registrar at the Pneumoconiosis Research Unit in South Wales from 1952 to 1955. He followed Archie Cochrane as David Davies Professor of Tuberculosis and Chest Diseases at the University of Wales College of Medicine, Cardiff, from 1971, and was Dean of Clinical Studies and later Vice-Provost from 1987 until his retirement in 1990, and Consultant Physician for the South Glamorgan Area Health Authority from 1963 to 1990.

AN: Andy Ness

SK: Stewart Kilpatrick

AN: I wonder if we can start and if I could ask you to tell me where and when you were born and a little bit about your early family life.

SK: I was born in Edinburgh in 1925, so I am nearly 75 years of age now. I was at school in Edinburgh, George Watson's College, and then the University of Edinburgh, where I qualified in medicine in 1947. I did my house jobs in Edinburgh with Professor Sir Derrick Dunlop, who was professor of therapeutics at that time, and then I moved on to do some chest work in Southfield Hospital in Edinburgh. Subsequently I did my national service in the army, where I specialized in chest disease in the Connaught Military Hospital in Surrey. After I came out of the army I took my Membership in Edinburgh and then did a few locum jobs, before travelling down to South Wales in 1952 to be a member of the staff of the Pneumoconiosis Research Unit in Llandough Hospital, Cardiff. It was there that I first met Charles Fletcher and Archie Cochrane, both of whom had a very considerable influence on my career and helped me very considerably.

I was interested in respiratory disease at that time, both in tuberculosis and in pneumoconiosis particularly and I published a number of papers during my time at the Pneumoconiosis Unit. I also had the privilege of then staying with Archie Cochrane in his house in Rhoose – a very beautiful house, a very lovely garden – and he was a very striking person, admirable, radical, difficult at times, although I got on with him very well. He taught me a lot about research. He taught me a lot about various other things and we travelled fairly extensively through Europe, attending meetings and other things at that time. Subsequently, I went to the Brompton Hospital in London, then to Sir John Crofton's unit in Edinburgh, where I studied further respiratory disease, before I came back to Cardiff in 1957 to join the medical unit under Professor [Harold] Scarborough. At that time we had an association with the Epidemiology Research Unit and Peter Elwood, and we did a number of studies, particularly in relation to blood pressure, coronary artery disease, and anaemia. I subsequently became senior lecturer and consultant physician to the Glamorgan health board and when Archie Cochrane retired from the David Davies chair I was appointed as his successor. I was also appointed Dean of Clinical Studies in the University of Wales College of Medicine (1972–1987) and subsequently Vice-provost (1987–1990). I continued in this chair until I retired in 1990, taking considerable academic interest in teaching, rather than in research, although I did some research, and my association with Archie Cochrane continued: every Sunday morning I went out and had a glass of gin with him before lunch and very fruitful, pleasant conversations.

* Interview conducted by Dr Andy Ness, for the History of Twentieth Century Medicine Research Group UCL, 23 May 2000. Transcribed by Mrs Jaqui Carter, and edited by Professor Tilli Tansey and Dr Hugh Thomas.

AN: Tell me a little bit more about your family. Were your family medical?

SK: No, well not exactly. I had an uncle who was medically qualified and he was a consultant paediatrician in Hull. My father worked in a bank in Edinburgh and my mother, apart from voluntary work, didn't do anything very much. I have one younger brother who was a quantity surveyor in Edinburgh. I enjoyed my time in Edinburgh very much and I still go back and visit that city as frequently as I can, and I am very fond of having holidays in Scotland as well.

AN: Was it a conscious decision to leave, because many people's medical careers were in Edinburgh, it wasn't a city that people wanted to leave?

SK: No, I didn't particularly want to leave Edinburgh, I would have liked to in many ways stayed there, but when I saw the advertisement for the Pneumoconiosis Research Unit [PRU] in the *BMJ* [*British Medical Journal*] or *Lancet*, I thought well that's interesting, Wales is a country I have not been to, it's a well-known research establishment, and I thought that if I went there I could get useful training and experience and I did. And this helped me very considerably. I went back to Edinburgh briefly, but there was no sort of continuous opportunity there, in the respiratory field, and that's why I moved back to Cardiff.

AN: But how did you become interested in respiratory medicine?

SK: I don't know exactly, I suppose that Sir Derrick Dunlop, who was my chief in Edinburgh, was interested in chest disease. I then did a job as a house surgeon to a thoracic surgeon, Mr Andrew Logan, and I learnt a great deal from him in relation to seeing X-ray pictures of people's chest diseases, then at operation seeing the actual lesions, at operation, and this intrigued me. We saw a certain amount of tuberculosis, and I did a tuberculosis job in Southfield Hospital in Edinburgh, and then went to the Connaught Military Hospital as I said, in the army, where I was concerned completely with tuberculosis. So I had experience in tuberculosis. It fascinated me. I was intrigued by it, and I had always wanted from a very early age to be a doctor. And why exactly respiratory diseases, I don't know, but I continued with it and I have always been intrigued by chest diseases.

AN: And when you first came to the Unit in 1952, what was your role exactly. What were you to do?

SK: My role really was registrar, employed by the MRC, but looking after National Health Service patients, and the PRU at that time had one ward for pneumoconiosis patients and I was responsible for their day-to-day care, under firstly Charles Fletcher, and then John Gilson. I was encouraged, obviously, at that time to take part in some research schemes and I did in relation to attacks of chronic bronchitis, acute respiratory infections, common colds, that sort of thing, and I learnt a great deal from particularly John Gilson I suppose, and Peter Oldham who was a statistician about controlled trials and the importance of careful data recording.

AN: And was it just you looking after these patients. Did you have a team, a houseman?

SK: Yes I had a houseman and I suppose Colin McKerrow, who was a sort of senior registrar, and one above me, but my main responsibility was the day-to-day care of these people.

AN: You said a little bit about Charles Fletcher, John Gilson as well. I wonder if you would just tell me more about working with them and the things they were interested in.

SK: Charles Fletcher was a quite extraordinary person and I got to know him well and I met him frequently in later years, even when he retired. As you probably know, he was a severe diabetic, he diagnosed himself as having diabetes: he said at 4 pm on a Monday afternoon in Cambridge, when he tested his urine because he was thirsty, and he had diabetes. Since which time he was on insulin and he was careful to inject his insulin himself, always through his trousers, without any antiseptic, or anything else. He used to occasionally have hypoglycaemia, but that was why he would never travel abroad without his wife, Lou Fletcher, and that was

wise. He left the same year as I went to Cardiff, to go up to Hammersmith Hospital, and as I said I met him frequently at that time. He was particularly interested in chronic bronchitis, emphysema, and respiratory function tests, and I learnt a great deal from him. John Gilson, a very able director, who succeeded Charles Fletcher, more mechanically interested I suppose, in as much as he constructed and made his invalid wife at that time a dishwasher machine, from first principles, he was a very able person. His wife had been ill, but she got better and is still surviving, living in Devon. He was interested in research, particularly in respiratory function, and published a number of papers on that. He was a very stimulating person with whom to work, and the combination of Charles Fletcher, John Gilson, Archie Cochrane, and Peter Oldham, this was an environment in which I was involved for some three or four years and I learnt a great deal. I hope I contributed to a certain extent as well, but I learnt a lot.

AN: Peter Oldham, he was the statistician. Can you say a bit about him?

SK: Peter Oldham was non-medically qualified, a statistician, and an Oxford graduate. I first met Peter Oldham funnily enough with Kingsley Amis, the author, in a pub in Cowbridge (Cardiff). And then I went to stay with Archie Cochrane, and Peter Oldham was also a resident there at that time. He was an extremely able statistician, a very pleasant person, and a very interesting person. He tried to help people to do research and did, but was quite prepared to put people off if he didn't think it was a reasonable thing to do. Peter Oldham was a very pleasant companion, he died about ten years ago now, but his widow still lives in Penmark, a village in the Vale of Glamorgan.

AN: So during the three or four years that you were there as a registrar, what research did you do?

SK: I did some research, a controlled trial in acute respiratory infections in chronic bronchitic people, I reviewed some X-rays of pneumoconiosis, I wrote my MD thesis at that time, on progressive massive fibrosis and its various forms and complications, and I got my MD from Edinburgh in 1954 as a result of the work I did there.

AN: What was your trial?

SK: The trial was antibiotics, or placebos, in people with acute exacerbation to chronic bronchitis. Well it didn't really work out very well. Well can I correct that? The trial was to see whether antibiotics made any difference to acute attacks of bronchitis in chronic bronchitic people. It showed the antibiotics had no benefit. This hasn't prevented innumerable trials since then of people giving antibiotics in the same sort of way, without any benefit either.

AN: So it had no effect on practice. My experience when I worked as a medical registrar at Chesterfield was that if someone came in with an exacerbation you would give them an antibiotic.

SK: And this depends a little bit, of course, on the severity of the episode or whether they had sputum or not. But just giving them at the first sign of an acute respiratory infection didn't seem to make any difference. And this was interesting and it taught me about controlled trials.

AN: Because randomized controlled trial methodology was fairly new then, wasn't it?

SK: Yes, it was indeed. I think the first controlled trial that I had heard about at that time, a controlled study, was actually Cochrane's two valley scheme, when one valley was a controlled valley and the other was the experimental valley. That was the first time I really recognized a controlled trial in any shape or form.

AN: There was the streptomycin trial I think in 1948.

SK: Oh yes, that was [Austin] Bradford Hill and that was a very important milestone in relation to the treatment of tuberculosis, it showed quite conclusively that streptomycin benefited people with tuberculosis. It then went on to show that if you give streptomycin alone, they got drug-resistant strains, and for that reason

subsequent trials in 1949, 1950, incorporated PAS (para-aminosalicylic acid) and showed that streptomycin and PAS were of greater benefit given together than streptomycin alone, and in 1952, I think it was, the trial included isoniazid as well as streptomycin PAS, and these three drugs overall gave very much better results than either trial done before. And these trials were instigated by Bradford Hill, who was one of Peter Oldham's mentors and Doll and Bradford Hill, of course, did their studies in relation to smoking. And Sir Richard Doll is still alive, he is 87, he can still work and he is still publishing as you probably know.

AN: That's right. He chaired our Witness Seminar last year. And did you have any direct involvement in the two valleys project, did you do any work on it?

SK: The only work I did was really going round persuading people to come and be X-rayed, I wasn't directly involved. I was involved in the publication of it, but the only actual work I did was going round persuading people to come in to be X-rayed. This was hard work, going up the valleys night after night and not always getting a very favourable reception. Well when I say that, people just weren't very necessarily keen, they thought there must be something in it for us, rather than for them.

AN: There's quite a lot of description about the relationship with the miners. I wonder if you could just expand on this.

SK: Oh the actual relationship of the miners with Archie Cochrane was particularly good. He was very particular. He worked fairly closely with the National Union of Mineworkers, who were initially a little suspicious of it all, but eventually Archie persuaded them all to get X-rayed, and about 99 per cent, as you probably know, of the people got X-rayed, history taken, and all the rest of it. And the relationship [of] Archie and the miners and Charles Fletcher and the miners was very good. My only regret at that time and subsequently was that the PRU wasn't more closely associated with Cardiff Medical School, University of Wales College of Medicine. Why this was so, I don't know. I think partly, and I have got to be a little careful about this, a lot of the PRU people lived on the west side of Cardiff, whereas the medical school was in the centre of Cardiff, and they didn't particularly want to go into Cardiff, and they had a loyalty to Llandough Hospital, which was perfectly understandable. The other problem that Archie and Charles Fletcher had, and I think this was mentioned in the meeting, that the relationship with Professor [Jethro] Gough was not necessarily very good. He was the Professor of Pathology and opinionated, a very able man, but not an easy man and he and Archie Cochrane and Charles Fletcher didn't get on very well together, which was a pity.

AN: And a thread going through the whole history of the Epidemiology Unit and PRU as it was before, is this relationship with Cardiff and local researchers, and it didn't seem to get any closer.

SK: Not much closer, it got a little closer when Archie Cochrane and Harold Scarborough, who was Professor of Medicine then, and myself as a research fellow, we did some work on anaemia and hypertension and coronary artery disease. So there was a closer relationship at that time. Peter Elwood was not terribly popular with the medical school for reasons that are not completely clear.

AN: Talking to Peter he says how he was always very keen to try and ensure that there were links and go to meetings.

SK: He didn't come to many meetings. I think if he had shown a greater interest, it might have been better. I mean there were all sorts of medical unit meetings that he could have come to, but he didn't.

AN: Interesting. While we are on this subject, I am struck by how many people related to the Unit were not Welsh. The first director was a Scot, the second director was an Ulsterman, yourself Scottish. I am just interested how much you perceived that it actually served the people, it was a research unit using defined populations in a Welsh community, how much the Welsh people were involved, if you see what I mean, how much was given back to them.

SK: I think there are two things about that. First, I always say the Scots can't drink all the whisky they distil and they can't employ all the doctors they educate, therefore there is bound to be a migration. I was happy to move, because I am a traveller in a way and was keen to see new countries. The Scots have always had a fairly good relationship I think with the Welsh, because I remember when we first were married, and I married an English girl and lived in South Wales, this person asked me whether she was a Scot and I said, 'No', and this person knew I was a Scot, and he said, 'It's the English we don't like'. But I think on the whole, the Welsh people benefited from the research work done, certainly the miners did, there's no doubt about that at all. And I think as you probably know even now there's a new scheme for the compensation of ex-miners who have bronchitis and emphysema. I am one of the assessors for that, so I know quite a lot about it, and that was all really based on a lot of the work that was done mostly in the Pneumoconiosis Unit, but mostly under Archie Cochrane, so I think the Welsh people have benefited from its presence there. Educationally, there's no doubt that the medical students have benefited from both these units and the research that they have done. And I was Dean of Clinical Studies in the University of Wales College of Medicine for 16 years, so I have had quite a lot to do with the education of medical students and the choosing of them at that time. At the same time I was Professor of Chest Diseases, so I really had rather a busy professional life.

AN: And I think the medical students used to go out to see Professor Cochrane on a relatively informal basis, but were there every formal education commitments to the Unit?

SK: Not to the undergraduates much at that time, though that subsequently improved. Most of the educational aspect of Archie Cochrane's unit was postgraduate education, doctors from overseas, and we ran, and I continued to run all the time I was in the chair, the course, the Diploma in Tuberculosis and Chest Diseases for doctors from overseas. Subsequently, the undergraduates were given more chest experience by going out to Llandough Hospital and to Sully Hospital, which was then one of the main hospitals, now about to be closed.

AN: Sully was the new sanatorium, wasn't it?

SK: Yes, built in 1936. Built in 1936, out at Sully, which was about what six miles out of Cardiff, because the city fathers didn't want a nasty infectious disease hospital in the centre of the city. But it was a good hospital and I treated a great number of people with tuberculosis. I had beds there and was very happy there. Then [it] subsequently moved to Llandough Hospital, partly because they were nearer the Pneumoconiosis Unit, and partly because the chest centre really was Llandough Hospital.

AN: So you worked from 1952 for three or four years, to about 1954, 1955, went to the Brompton, then to Edinburgh, and then you came back again.

SK: To the medical unit in the Cardiff Royal Infirmary.

AN: But you did some work with Peter Elwood and Professor Cochrane.

SK: Yes at that time, from the medical unit.

AN: And what was the work you did then?

SK: That was mostly on anaemia. We did a big anaemia survey and we did some follow-ups of people with coronary artery disease and what else did we do? I can't remember what it was we did, a number of things. And I cooperated with Peter Elwood on his iron study with bread, made the bread and put iron into it.

AN: So what was the anaemia study that you did?

SK: The anaemia study really was to see if the prevalence of anaemia had varied at all since the original anaemia studies were done by Professor Sir Stanley Davidson in Aberdeen in the 1930s. And we did studies in

anaemia in the Rhondda Valley, in Wensleydale, in Yorkshire, and the prevalence of anaemia, and we did at the same time B₁₂ studies and serum iron, mostly just gathering information. In fact, we showed I think that the anaemia and haemoglobin levels hadn't changed very much since the 1930s.

AN: Was anaemia research an interest of yours?

SK: That was particularly mine, that was my interest at that time. I don't know why, partly I think because I worked partially with Professor (Roger) Hardisty who was very keen on haematology in Cardiff Royal Infirmary and I was stimulated to think about anaemia, which I hadn't really thought about before.

AN: And you said you did a couple of other things with them. You did some work on coronary artery disease?

SK: Coronary artery disease. We did a follow-up of coronary artery disease only mostly in relation to hypertension, because Bill Miall had done studies on hypertension with Ian Higgins and the ERU [Epidemiology Research Unit] and we followed some of these people up, I can't remember the details of this actually, it wasn't a terribly important study.

AN: Going back, you said you lived with Professor Cochrane and were a close friend of his for many years. I wonder if you could just say a bit more about him. He has certainly written a fair amount himself, and I don't think he glosses over too much in what he says, but it would be interesting to just have another perspective from people that he had known and what he was like to work with.

SK: He was a very interesting person. He was an atheist. He was a heavy consumer of cigarettes, he enjoyed a drink, though not in any way excessively so. He was very fond of foreign travel. He had a sister, his sister is still alive in her nineties, in Galashiels in Scotland. She developed porphyria and Archie Cochrane went up to Scotland when he heard his sister was ill and when they made the diagnosis of porphyria Archie then decided he would like to know a bit more about porphyria, so he bought all the books he could on porphyria, he looked up all the articles on porphyria, and then did a study of his family tree in relation to porphyria, which you probably know about, and this took him all over the world, and he got specimens from all over the world. He was a great reader, he was a great thinker, he was a very good and meticulous research worker, he enjoyed doing research, but didn't like writing up the research work that he did, he couldn't really be bothered about that. He was fortunate in being of independent financial means. I think I explained one time before, that he suddenly realized when his grandfather's will was read out that he never need again fill in the stub of any cheque that he ever issued. Independent financial means, not extravagant, except perhaps in cars, he used to drive a large Jaguar car, which he enjoyed very much and I always remember the second Jaguar he got, he was in Llandough Hospital and a girl said, 'I have come to deliver your Jaguar, here's the keys'. He said, 'Thank you very much'. She said, 'Well, aren't you going to go and look at it?' And he said, 'I will see it when I go home'. Completely offhand in relation to that sort of thing. The house he lived in in Rhoose, a very pleasant house, a very lovely garden. He didn't know very much about gardening, but was prepared to take advice about gardening, some of which he got from my wife. He had a servant and his wife, who looked after him, and looked after him very well, and the house and garden and the swimming pool, where we used to go and see him. He was a slightly selfish man on occasions, very critical on occasions and could be rude on occasions and abrasive if necessary. It didn't worry him. But in some ways he was, I won't say undependable, but slightly problematical. I got on with him very well, because I think we were on the same sort of wavelength, possibly because we were both Scots, I don't know.

AN: I was just wondering about the contrast between him and Dr Elwood. Dr Elwood's talked about himself a little bit, about the contrast in styles between the two of them and my sense is that Professor Cochrane for all his difficult nature in some respects, was actually very good at going out and building links and so on and so forth.

SK: Yes that's true. I think that Archie Cochrane's strength was that he would let people get on with things, if you needed encouragement or advice, he would always be prepared to give them. What he wasn't terribly

good at, he wasn't very good at training epidemiologists. I mean he did train some, but he didn't make that one of the missions in his life, which I think he perhaps should have done, because he was a superb epidemiologist himself, with all due respect, much better than Peter Elwood.

AN: And then you moved on from being back at the medical unit, am I right you went away again?

SK: No I stayed. I became a senior lecturer in the medical unit in association with Archie Cochrane at Sully, in as much as I had beds in the general medical unit at the Infirmary, chest beds, ostensibly under Archie Cochrane, although, of course, he wasn't clinically involved in Sully Hospital. And I continued that link between the two things until 1974, in which case I gave up my general medical beds in the Infirmary, but had general medical beds in Llandough Hospital, with chest beds in Llandough Hospital. I moved my chest beds from Sully to Llandough Hospital.

AN: So although you didn't work with the Epidemiology Unit you essentially worked with Professor Cochrane?

SK: Yes. I didn't in fact do very much work with the Epidemiology Unit as such, apart from that anaemia survey. My work was mostly with Archie Cochrane, and mostly educational, rather research.

AN: Could you say a bit more about that. You mentioned the Diploma, can you tell me about that?

SK: Yes. The Diploma course was originally started in 1921 in which year there was one applicant and he passed the exam. It subsequently developed into a bigger course, we had anything between 20 and 24 people from all over the world, people who were medically qualified, who were interested in respiratory diseases, particularly interested in tuberculosis, because tuberculosis in the developing countries, is a very common condition. We designed, Archie Cochrane and I, we designed the course and brought it up to date so to speak to encompass the developments in tuberculosis treatment, in tuberculosis research, and we taught these students for six months of the year. Subsequently I used to travel very extensively, largely under the auspices of the International Union Against Tuberculosis, to lecture and to meet some of the ex-students and I visited India, all the countries of South America, most of the countries in Africa, China, South East Asia, to renew contact with these students. I would like to think this was a useful exercise educationally, which I think it was.

AN: How did this Diploma come to be set up in Cardiff?

SK: I don't know, I don't know exactly. I suppose that the then professor of tuberculosis must have thought that it was a good idea, and then subsequently I suppose with Professor Gough in the pathology of chest diseases, and the beginning of the PRU at Llandough Hospital, which was the centre of respiratory disease really, in Cardiff.

AN: Were there other similar diplomas?

SK: No, not at that time. There never was another diploma course until 1970 or 80, 70-ish. There was one in Japan and in the 1980s one started in the Brompton Hospital in London, but that was a very expensive course and people still used to come to Cardiff and I was sorry when my successor was appointed he didn't continue with the course, but then it wasn't his primary interest.

AN: I am interested in that this course in Cardiff actually led the world in one respect, in the teaching about tuberculosis.

SK: It did.

AN: I was wondering if it was related to the Welsh experience with tuberculosis. TB in Wales seemed a particular problem, obviously I have heard historians talk about it, and this whole movement in

South Wales, drives to try and control tuberculosis and some of the things that were being advocated in the past, we would not advocate today.

SK: I think to a certain extent. I think the national tuberculosis scheme started in 1912 by Lord David Davies of Llandinam and he initially gave money and provision for research and all the rest of it. It was rather ironic in a way that when the first mass miniature radiography unit was set up in Cardiff to detect early cases of tuberculosis Lord David Davies of Llandinam was X-rayed and found to have carcinoma of the lung, which was an ironic thing to happen.

AN: Is he the David Davies who gave you his chair?

SK: Yes. There was a lot of tuberculosis in Wales, but then there was a lot of tuberculosis in the United Kingdom, but in a way, of course, it was a combination of tuberculosis and pneumoconiosis, they were two really serious diseases at that time, before the advent of streptomycin and people used to die very considerably of both of these conditions. So I think there was a Welsh element in tuberculosis, but this has continued through the chair of tuberculosis and education in the universities.

AN: I wonder given that you have seen during your working lifetime amazing changes in tuberculosis, you didn't see the opening of Sully, but you were around to see its closure and see it run down. I wonder if you would like to say a bit about that.

SK: What I did see a lot of, when I did my first tuberculosis job in Edinburgh in 1949, there was a trial of streptomycin in tuberculous meningitis, which was again a very serious condition and I used to do between 12 and 20 lumbar punctures every morning, so I became quite good at lumbar punctures and learned a great deal about tuberculosis and we realized at that time, because at that time there was only streptomycin, and people were still dying of TB. The changes I have seen in tuberculosis over the years have been the instigation of streptomycin, PAS and isoniazid, and subsequently rifampicin, a very much better drug, and the mortality rate has fallen very considerably. There is, as you probably know, a slight resurgence of tuberculosis in this country, not much in this country, but in sub-Saharan Africa particularly, the combination of HIV infection and AIDS is going to decimate the populations of much of Africa, some of India, and some of South East Asia. So I rather thought when I retired 10 years ago, that tuberculosis was going to continue to fall and I had contributed in a small way to it, but it hasn't. In fact there has been a resurgence, and there is very much more interest in tuberculosis now than there has been for the last 20 or 30 years.

AN: I wanted to talk about the decline, because some of it towards the end was effective treatment, but a large proportion of the decline occurred before we had effective drugs. In part it was argued that this was very much just people's better living conditions, but more recently people have begun to say that it was related to medical understanding, and I wondered how people you had met with tuberculosis and patients, what their understanding of tuberculosis was and what their lay beliefs and things were.

SK: I think two things. Firstly as you say the decline in the mortality in tuberculosis was beginning to occur at the beginning of this century. There was a blip in the First World War, there was a blip in the Second World War, probably due to perhaps partly nutritional, partly overcrowding, partly medical conditions. The lay public have always regarded tuberculosis as a serious disease, often as a fatal disease, and there is still I am sorry to say a certain stigma in relation to tuberculosis. I was appalled to read *The Sunday Times* a fortnight ago, which said that tuberculosis could be caught in an aircraft, even from someone seated 12 seats away, and this was a nasty fatal disease. This was in a responsible Sunday newspaper! But there still is a stigma in tuberculosis, but not anything like as much as there was, because nowadays people realize that it can be treated.

AN: As you say you were very much working in education and then within the university, I wonder if you can just give me some sense of what you thought of the MRC unit's work from at arm's length now.

SK: I think two things about that. Firstly I have always thought that the Unit run by Charles Fletcher and John Gilson with Archie Cochrane was absolutely superb and it was highly regarded by most people in the medical school and they in fact would have quite liked to be rather more part of the medical school, but for reasons that are not completely clear, it didn't happen. When Archie went to the ERU, there was some contact with the general medical unit in Cardiff Royal Infirmary, but as you have said yourself, it didn't seem to gel very much, and I think that sometimes I felt that Peter Elwood was slightly out on a limb and wasn't perhaps respected as much, certainly not as much as Archie Cochrane was. Why this was so, I don't know.

AN: Looking at their portfolio of work back over 40 years, I would have been proud to have done a small amount of that by the end of my career. I enjoyed the work on aspirin, the work that Michael Burr did on dietary trials, the asthma surveys that Michael did, the early work on the miners, respiratory function, and so on that Professor Cochrane did and other cross-section surveys. You look at the Unit and you think this is formidable. Was that the perception that Cardiff had something great there?

SK: Oh, I think so. Two things. The decline in tubercle and the closure of Sully Hospital meant that fewer people were attracted to come south to study respiratory disease and then when we moved to Llandough Hospital there were certain personality difficulties with some other physicians and fewer people came to Cardiff for respiratory training and this was a pity. We did what we could to try and correct that, but by the time I retired, apart from the postgraduate course and extension teaching to undergraduates, we didn't seem to be able to attract the same sort of calibre of people to be trained in respiratory disease.

AN: Was getting people to come out to work in South Wales a problem? We had this MRC outpost, essentially administered from London, and quite a few people did come from outside, and I wondered how easy it was to get people to come and make a long-term commitment to Wales.

SK: Two things about that, I think I mentioned at the meeting we had in London, that when Charles Fletcher was appointed to the directorship at Llandough Hospital, he regarded this as a slightly outlandish place, and he would only take the job provided he had unlimited travel to meetings in London, and that he did. There is some slight problem now attracting people to Wales, partly because a lot of people don't know very much about Wales, it's a very beautiful country, an interesting country and the Welsh people, by and large, are very pleasant. But one snag that a lot of people, I won't say a lot of people, a number of people, find that if they have their children in Wales they have to learn Welsh, whether they like it or not, and they would rather speak Spanish, but they have to learn Welsh. Now this is not very popular among the in-coming people. Now whether this will have a long-term affect or not, I don't know.

AN: I can understand that. It's ironic that I think Dr Tudor Hart learnt Spanish now he has retired. I wonder why he chose Spanish.

SK: I have lived there now for over 40 years, I like it very much, I like the country, I like the people, I have always been made welcome, I hope I have contributed to a certain extent to the Welsh establishment, and while I am very fond of Scotland, I wouldn't want to go back to Scotland, leave my life-support systems in South Wales.

AN: So in a sense you don't regret ending up in Wales.

SK: Not in any way. I live in a small village in the Vale of Glamorgan, I am entirely happy there, and while I go up to Edinburgh twice a year, it's colder there, but my life-support systems, my garden and my friends, are in South Wales, I am not going to leave them.

AN: I can understand that. I think your wife also worked at the Unit?

SK: Yes, she worked at the Epidemiology Research Unit. Interesting that. My wife and Archie always got on very well together and at the time when I was very busy and travelling a lot, Archie Cochrane said 'one of the problems with childless ladies in middle age, they sometimes take to drink, I think you ought to come and work with me and give you something to do'. So she went and was a sort of I don't know what, epidemiological scribe I suppose, she didn't actually do research herself, but she did a great deal of painstaking analysis of data and she enjoyed it. She worked for about 12, 14 years with Archie Cochrane.

AN: Did she say much about it? What were her feelings about the Unit and so on?

SK: Oh, I think she respected Archie Cochrane very much. She enjoyed his company, she respected him, she was quite happy to work and do almost anything for him. She didn't particularly like Peter Elwood. She didn't respect the work he did, I am afraid, and for that reason she gave up work when Archie sort of completely retired.

AN: Something else I am just interested in, having talked to a number of people now, is how much it was beliefs that somehow shaped what they did and were important. You said yourself how Archie was an atheist but Peter Elwood certainly had a very clear Christian faith, as does Michael Burr. It's quite interesting to me, how the Unit was shaped by that. But I wondered if you had a belief or how you perceived that, whether you thought it was important, or whether it was just chance that these people happened to be there.

SK: Oh I think it was pure chance. I am, I like to think, an apolitical person, I am not particularly concerned with beliefs or politics or anything else. I am fervently interested in medicine in all its branches and I have very few other outside interests I am afraid. We have no family, we have a small garden, a very lovely house and entirely happy from that point of view and I enjoy foreign travel, but apart from some photography, reading, and a little bit of watercolour painting, I have very few other interests. And I am still practising some form [of], not clinical medicine, but the bronchitis and emphysema people in miners and I used to do medical appeal tribunals in relation to disability benefits. So peripheral medicine, but not clinical medicine. I didn't want to continue doing locums in clinical medicine, because there is no continuity of care and things were advancing so quickly that I thought it better to be an assessor rather than practise clinical medicine.

AN: I think that is right.

SK: I am sure. I thought a lot about this, but I have been very happy. All the things I have done since I retired ten years ago, firstly I was concerned with the training of overseas doctors in London and to a certain extent in Cardiff. I was concerned with the revamping of the undergraduate curriculum in medical schools in Cardiff. The medical appeal tribunals and recently the bronchitis and emphysema, so it's all given me something to continue my interest and kept me out of mischief and given me some pocket money.

AN: And do you still travel extensively?

SK: Not as much as I used to. Partly because I have very bad arthritis in my knees and I can't travel to the same extent as I did, but a year ago I went to Bangkok to a meeting, two years' ago I went to the Galapagos Islands and three years ago I went to Antarctica.

AN: As you know, my department, the Department of Social Medicine in Bristol, has taken on all the MRC unit files, which should be a major boost to us. You have watched this unit grow, what advice would you give to us having inherited 40 years of epidemiology in the Welsh valleys?

SK: Oh, I don't know whether I would give you any advice. I think that Archie Cochrane's strength, and that's where the epidemiology really started in the Welsh valleys.

AN: I was just asking you what advice you would give us in Bristol, given our inheritance.

SK: I think again one of Archie's strengths was that he had carefully defined populations, which he used. These have not been quite so strictly viewed recently, but by and large people in Wales have got to know about studies and surveys and I think that on the whole are prepared to take part. At one time somebody said look can you extrapolate from the studies in Wales to the rest of England, the rest of the country, and I think the answer is yes that we did studies in hypertension, anaemia, and other things in the Rhondda, in the Vale of Glamorgan, in Wensleydale, in Annan, in the south of Scotland, and in parts of the Midlands, Staveley, and on the whole these were reasonably comparable, so I think the studies should continue in Wales, and I would like to think that they would.

AN: And after the work in the valleys had moved closer to Cardiff and the setting up of the Caerphilly study, were you in any way involved in that?

SK: Not in that at all.

AN: Would you like to have been involved?

SK: Not particularly. I think because at that time when the Caerphilly thing was starting, I was busy being Professor of Chest Diseases and Dean of Clinical Studies and I had enough on my plate. So I had no regret, no strong feelings about that at all. My, as I have probably emphasized and you have probably realized from what I have said, my loyalties were entirely to Archie Cochrane.

AN: Was there anything that you would like to talk about that we haven't covered in the interviews, or anything else.

SK: I don't think so. No I think on the whole we have covered, I hope you think I have covered a fair amount of ground in relation to everything. I think my main regret initially was that there wasn't a closer union between the pneumoconiosis unit and the medical college. This did improve a bit. Professor Scarborough, who was Professor of Medicine at that time, was a very able person, not an easy person to know. He was like Archie a bachelor, lived in a large house in the Vale of Glamorgan, wasn't terribly easy to get on with from many points of view, but did contribute enormously to medical education and medicine in South Wales. And I was in a way fortunate, I think anyway, being bracketed between the MRC and the medical school and the health service. I think I saw, as I have said before, the best of both the academic work and health service in the 1960s, 1970s, and 1980s. Things were better and more stable than they are now.

AN: One thing, just getting you to reflect a little bit, having been involved for many years, how research has changed. I am trying to build up a picture of what it was like to do research in the 1950s and then how it changed over the time.

SK: Yes, I think two things about that. I don't think people nowadays are quite so keen on the hard work that much research involves, some of which is dull and painstaking, and I think people want immediate results. I think too there is less adequate funding than there was in the 1950s, 1960s. When we were doing research in various shapes and forms, money was no great problem. I mean you could get assistance from people without having to budget for everything and pay for every single test and analysis. On the other hand, I think that a lot of research is, I won't say nonsense, but a lot of social science research I think is not very good and not very profitable. I think pure scientific research is important. I think nowadays so much of it, of course, is going to be in relation to molecular biology and other advanced studies, that only relatively few people are going to be a) able to do it, and b) able to get the funding for it. I think there is still a place for people to do research, or should be, who are willing to devote time and energy to it. And Archie, for instance, who'd spend days, hours, all night working, whereas a lot of my colleagues nowadays knock off at five o'clock.

AN: So you would see research very much as a calling, a vocation?

SK: A bit, yes. I think so. I think it should be. I think to do proper research, it is a sort of calling and it's got to be taken seriously and a great deal of time and trouble has got to be taken in relation to it.

AN: So do you think that money has become more concentrated in certain centres than it was in the past in terms of research funding?

SK: I think probably yes, although again my experience is really with the MRC and the universities. University research money has always been a little difficult to get.

AN: And the early technicalities of doing research, people talk about things like ethics approval, about the way that they did fieldwork. From your experience what are the things that stand out for you that have changed over the years?

SK: Well certainly ethics committees have made a great deal of difference to research. I think probably rightly so, although I think sometimes they are a little too correct in their ways, but I think the ethical committees were necessary in relation to things. I think the public needs educating, certainly about controlled trials. I think the public needs to be informed better than they were in the past. I don't think there is any doubt about that. I think a lot of medicine was practised and covered things almost not exactly euthanasia, but people were eased of their suffering in a way that wouldn't necessarily be acceptable nowadays. Mind you that's a difficult area.

AN: Sure. Another thing I have been trying to ask you about is what MRC was like as an employer, of which I suppose you had only a limited experience.

SK: I had limited experience. As I say I was employed by the MRC as a sort of research registrar. I have no complaints about the MRC as an employer. I was given opportunities to do work in the PRU, all that I wanted to do, I had no complaints. I was given time off to analyse results, I was given money to travel to give papers, so as far as I was concerned, the MRC was a good employer, but then I wasn't employed for very long, and it wasn't a career.

AN: I am just interested in that particularly in some of the staff, perhaps like your wife who worked there for many years, essentially working for a paymaster in London, initially for this unit, and just where their allegiances lay. Usually what they say is that they felt they worked for this unit, which is understandable.

SK: I think that's true, I think that my wife worked because she enjoyed it. She is a rather pernickety person in as much that she takes an enormous amount of trouble over detail and all sorts of things, and the epidemiological analysis work appealed to her. She liked it. I think she realized it was MRC, but then her loyalty was to the epidemiological section and to Archie Cochrane, but she enjoyed it. She worked for a pittance, of course, but she wanted to do it and not having children made it easier and as I say I was travelling a fair amount, and this helped us all.

AN: So it was that the MRC wasn't a generous employer for its more junior research staff.

SK: No not particularly.

AN: And did she have training, was she formally trained in things, were there courses?

SK: No, no. She didn't do any of that. She learnt all she knew about statistics from Peter Oldham and all she knew about analysis of things in studies and surveys, was from Archie Cochrane. So she had no formal training. She had been in the services during the war and she ran the whole of the north and north east England ordnance supplies for the whole of the country at that time, at 22 years of age. So she couldn't have been unable.

AN: MRC has obviously closed the Epidemiology Unit and is reviewing what to do with epidemiology because the two directors of the other units they support are coming up towards retirement age. I wonder, given your experiences, what you think the MRC should do in the future.

SK: I think this is always difficult because there was a criticism that the PRU was closed because it had outlived its usefulness. To a certain extent I suppose that is true. That wasn't quite the reason why it was closed I think, but I can see the MRC's difficulties in starting off any unit, the Common Cold Unit, or the Pneumoconiosis Unit, or whatever, in the hope that it will continue to be useful. Whereas an epidemiological unit ought to continue to be useful, provided it diversifies itself in its objects, so that it moves from respiratory disease to cardiovascular disease, mental disease and all that sort of thing. Epidemiological units should survive and should be encouraged to survive, whereas limited outlook units, such as the PRU and the Common Cold Unit, I think outlived their usefulness.

AN: I agree with that and it's certainly interesting that MRC did keep the Epidemiology Unit going for so long.

SK: On the other hand, I am quite keen that university departments such as yours should continue to do epidemiological work, rather than the MRC. I think universities have a very considerable responsibility and I have been an academic more or less all of my life and I believe therefore in academic medicine, I believe in the contribution that academic medicine can give to communities in general and I think it is probably in a way than the MRC, although the MRC, of course, has funds that the universities sometimes don't have.

AN: What do you see of the role of epidemiology in research, because many clinicians have no formal training, and many wouldn't see this as bona fide medical research?

SK: No, I think that's true and I think that the difference between epidemiology is that a lot of clinical clinicians don't understand it, and are not particularly interested in it, and yet the epidemiological research in relation to surveys of various disease, conditions, operations in coronary artery disease, chronic bronchitis, and that sort of thing, I think epidemiology has a contribution to make, though I think it makes it separately from clinical medicine. But complementary to clinical medicine. Archie Cochrane always used to say that any epidemiological work ought to be replicated in another laboratory or another department or another epidemiological unit. And I am sure that is right. I think the other contribution that epidemiologists can and should make, I don't know how you are involved, they should contribute to the teaching of undergraduate medical students. But I think that they ought to, if you don't teach medical students about epidemiology, and what it can do, you will never get people interested in epidemiology. I think the epidemiologists of today ought to be teachers, complementary teachers, to clinical undergraduates. Do you teach undergraduates at all?

AN: Oh yes. Probably not very well, but we try.

SK: I think that epidemiology ought to be not taught as a discipline necessarily as such, but epidemiologists ought to teach medical students and show them what epidemiology is all about.

AN: They are not the best audience we teach. You have the sense of just sowing some seeds and hoping that one or two come up.

SK: Well I think that's right, but I think it is important that the epidemiologists are seen by medical students to show them what they can do.

AN: I agree. Thank you so much for your time.

[END OF TRANSCRIPT]

Further related resources:

1. Ness A R, Reynolds L A, Tansey E M (eds) (2002) *Population-Based Research in South Wales: The MRC Pneumoconiosis Research Unit and the MRC Epidemiology Unit*. Wellcome Witnesses to Twentieth Century Medicine, vol. 13. London: The Wellcome Trust Centre for the History of Medicine at UCL.
2. Christie D A, Tansey E M. (eds) (2005) *Short-Course Chemotherapy for Tuberculosis*. Wellcome Witnesses to Twentieth Century Medicine, vol. 24. London: The Wellcome Trust Centre for the History of Medicine at UCL.
3. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Bainton, David: transcript of an audio interview (11-Jul-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017044. London: Queen Mary University of London.
4. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Elwood, Peter: transcript of an audio interview (14-Apr-2000; 28-Feb-2001)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017045. London: Queen Mary University of London.
5. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Hugh-Jones, Philip: transcript of an audio interview (05-Jul-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017046. London: Queen Mary University of London.
6. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Hughes, Janie: transcript of an audio interview (28-Mar-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017047. London: Queen Mary University of London.
7. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Jones, Marion: transcript of an audio interview (10-May-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017048. London: Queen Mary University of London.
8. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Miall, William: transcript of an audio interview (13-Aug-2001)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017050. London: Queen Mary University of London.
9. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *St Leger, Selwyn: transcript of an audio interview (27-Jul-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017051. London: Queen Mary University of London.
10. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Sweetnam, Peter: transcript of an audio interview (31-May-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017052. London: Queen Mary University of London.
11. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Tudor Hart, Julian & Thomas, Mary: transcript of an audio interview (14-Jun-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017053. London: Queen Mary University of London.
12. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Waters, Estlin: transcript of an audio interview (14-Jul-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017054. London: Queen Mary University of London.
13. Ness A R (intvr); Tansey E M, Thomas H (eds) (2017) *Yarnell, John: transcript of an audio interview (18-Apr-2000)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017055. London: Queen Mary University of London.
14. Tansey E M (intvr); Tansey E M, Beanland S (eds) (2017) *Nunn, Andrew: transcript of an audio interview (09-Aug-2016)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017056. London: Queen Mary University of London.
15. Tansey E M (intvr); Tansey E M, Beanland S (eds) (2017) *Nunn, Andrew: transcript of a video interview (09-Aug-2016)*. History of Modern Biomedicine Interviews (Digital Collection), item e2017057. London: Queen Mary University of London.