AUDIO INTERVIEW TRANSCRIPT

Waters, Estlin: transcript of an audio interview (14-Jul-2000)

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Waters, Estlin: transcript of an audio interview (14-Jul-2000)*

Biography: Professor Estlin Waters (b. 1934) born in Toronto, Canada, was Senior House Officer at the Pneumoconiosis Research Unit, Llandough Hospital, Penarth, Cardiff, from 1960, joining the Epidemiology Research Unit in 1965 until moving to the University of Southampton on his appointment as Senior Lecturer in 1970, Reader in 1975 and Professor of Community Medicine from 1976 to 1990. He was Professorial Fellow until his retirement in 1994, later Emeritus. He was on the Council of the International Epidemiological Association from 1971 to 1977 and 1981 to 1984, serving as Membership Secretary and General Secretary from 1974 to 1977.

AN: Andy Ness

EW: Estlin Waters

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AN: If we can start by you just telling me where and when you were born and a little bit about your early family life.

EW: I was born in Toronto, Canada, on 6 November 1934. I don’t really remember much about it, but we crossed the Atlantic three times I think before the Second World War, because my father, who was at the University of Toronto used to come back to this country in the long vacation. We were out there during the war and then returned to this country in 1947, when I was 12 years old. Originally it was to be a long holiday, but my father applied for a post at the university in Cardiff and got it while we were on holiday and so he went back to sort out things there and the rest of the family just stayed on here.

AN: He was a senior lecturer in physiology?

EW: Physiology, yes. Not medically qualified, but with a PhD and DSc.

AN: Did you have brothers and sisters?

EW: Yes I have two sisters and one brother. One of the sisters did medicine, married a doctor and they have been farming in the Pembrokeshire National Park ever since.

AN: Where did you go to school and what do you remember about the school?

EW: After arriving in this country, first of all I went to Abertillery Grammar School (Monmouthshire) and then to Cardiff High School for Boys. I remember just getting in, I think it was on my parents’ reputation, without doing the 11-plus. I was just over the age when I came here. I don’t remember a lot about school really. I didn’t dislike it, but I wouldn’t say that I particularly enjoyed it.

AN: When did you first think about doing medicine or realize that you wanted to do medicine?

* Interview conducted by Dr Andy Ness, for the History of Twentieth Century Medicine Research Group, UCL, 14 July 2000. Transcribed by Mrs Jaqui Carter, and edited by Professor Tilli Tansey and Dr Hugh Thomas
EW: Well, my father is a physiologist, not medically qualified. My mother was a doctor and she did pathology originally, then school clinics and public health. I had three uncles who were medically qualified, so I suppose medicine was in the family and always was one of the things I might do. I was certainly keen on science, rather than the arts in school. I wasn’t that good at maths and in those days, for advanced level [A level], people either did maths, physics, and chemistry, or physics, chemistry, and biology. I did the latter. So doing biology really equipped one for medicine or dentistry or for biology. I think that biology was the other possible career I might have had. However, in those days (1950s) there were rather few posts in biology other than as a schoolteacher.

AN: Was there any defining moment or turning point, when you realized that you wanted to do medicine?

EW: I can’t remember any particular moment. I think most of the boys in my school who were doing A level biology did medicine, so I went along with it and it did seem a natural thing to do. Perhaps it’s surprising that I did medicine because I can remember being quite sure that I didn’t want to be a GP and I didn’t want to be a consultant. I wasn’t quite sure at that stage what else there was to do in medicine.

AN: Where did you go to medical school?

EW: I went to Barts in 1953.

AN: What did you do after Barts? Did you do a series of hospital jobs?

EW: Yes, I did the first house job at the fever hospital for six months (Hither Green in south London) where Barts sent all their students, and then I did a surgical job in South Wales (East Glamorgan Hospital). Then after that I suppose I was looking to do some sort of physician’s job and I was looking for a post where I could have time to do Membership of the Royal College of Physicians. This is why I was encouraged to become a senior house officer at the MRC Pneumoconiosis [Research] Unit (PRU). This was a clinical job, looking after the 20-something beds, which were fairly long-stay beds, so it was in no way a demanding job, particularly after having done two busy house jobs. And I did that job with the object really of studying for the Membership exam.

AN: So you came to the Pneumoconiosis Unit when?

EW: February 1960, I think it was. Well, it was a year as a senior house officer (SHO), but this was just at the time National Service was finishing and I had always been given deferment to do my medical studies and then to do the hospital jobs. If they had given me any more deferment I would have missed National Service altogether, which would have pleased me at that time. I was called up into the army in the middle of that SHO job at the Pneumoconiosis Unit, so I was just there for just six months. But that’s when I met Archie Cochrane and John Gilson and the other people at the PRU. I didn’t see a lot of them. I was actually employed by the Medical Research Council, but the job was entirely clinical, but, because I was an MRC employee, I could have my tea and coffee with the other members of the Pneumoconiosis Unit. And I suppose in many ways it was that experience that made me decide that I would like to do research, if I could. The discussions that Archie Cochrane, Peter Oldham, who was a statistician, and John Gilson had over tea and coffee were so wonderful somehow. They obviously enjoyed their work so much, it just seemed to me that this would be a good thing to do if I could.

AN: So the only scientific contact you had would be just sitting round at the table having tea with them?

EW: Yes. I was very keen on doing some reading for the Membership exam. Not that I actually did that much of it. The MRC staff were quite keen that I had a research project. I don’t remember the details, it was something to do with measuring lung function after aerosols of various drugs, in random orders, and whatnot. I did collect a bit of data there, but never really enough to analyse properly. I never wrote it up,
never mind got it published, but there was some slight pressure to do some research project of my own and I didn't do it very well.

AN: And then you went off for National Service.

EW: Then I went off for National Service. Well, I said when I was interviewed at the beginning of my National Service that I would like to do medical research and there was a lot of laughter. It was out of the question. I was a very keen birdwatcher, even in those days, and I wanted to go to St Kilda, which is a remote island in the Hebrides where there was a rocket range. It was an absolute haven for sea birds, which I was particularly interested in and for bird migration. But I was simply told that all our intake had to go abroad. It was so for every fortnight of intake, one lot went abroad and one lot stayed in this country, and my group had to go abroad. So I went out to Cyprus and as soon as I got there I started birdwatching. The Chief Medical Officer for the Middle East had just come from Scottish Command. So, as soon as he knew I was a birdwatcher he said, 'You ought to go to St Kilda'. I already knew enough about the army then not to say that's just where I wanted to go. They had great difficulty in getting regular medical officers on St Kilda. Medically it was a rather unattractive post, but I said that if I was offered the post there I would take it. And he said he would get me there, but it might take six months. Well, it did. I went on from Cyprus to Libya, had six exciting months there, then was posted back to St Kilda for 18 wonderful months.

AN: And you were doing medical work in the army were you?

EW: Yes, but because it was at the end of National Service, there were a lot of doctors like me all called up together and the amount of medical work available was very little indeed. But yes, I was nominally in Cyprus and Libya looking after families and regiments and so on. The medical experience that we got was very minimal and on St Kilda there were 30 specially selected fit soldiers to look after, so there wasn't really very much medicine there. I did more dentistry than medicine, because the Spanish trawlermen who fished around St Kilda found out that medical officers could pull teeth. And in fact, in preparation for St Kilda, the army sent me on a two-week dental course in Glasgow, just on pulling teeth, so I did quite a bit of that. But thank heavens not a lot of medical work, although my predecessor had to amputate a leg on St Kilda, with the commanding officer giving the anaesthetic. But always in the back of one's mind was that if some horrible accident happened, St Kilda was sufficiently far out, especially in those days, one just had to deal with it the best one could.

AN: So how long were you on St Kilda?

EW: I was on St Kilda for 16 months, coming off only twice during that time. I was Medical Officer, obviously, which probably didn't take up more than 30 minutes a day, but I was also in charge of the catering, the post and library, and various other things, but did spend a lot of my time birdwatching. I studied bird migration through St Kilda and did a census on the St Kilda wren. This is a subspecies of wren and I counted the total number of wrens on the island. This may have been something to do with my interest in epidemiology, counting and measuring.

AN: So you ringed them presumably.

EW: I ringed some of them, yes, but it was basically plotting where they were singing in the early morning and joining up the lines, because each pair had their own territory. I counted 92 singing males on this island of 1575 acres. This and other observations on the St Kilda wren were published, with photographs in British Birds. In all I wrote seven papers and several short notes on birds, as a result of my stay on St Kilda.

AN: That's a lot. When you came off St Kilda, had you finished your military service then?

EW: Yes, it was right at the end of my military service.
AN: And then where did you go?

EW: I went to another island in the Hebrides, North Rona, on a seal expedition. When I was on St Kilda one of the things I found was that grey seal pups caught pneumonia if they were washed into the sea. I made some slides and found pneumococci and gave them out-of-date army penicillin until they recovered. So because of my interest in seal pathology I then went with the Nature Conservancy expedition, camping on North Rona for about 16 days and doing post-mortems on all the seal pups that died there.

AN: Specifically concentrating on their lungs?

EW: Yes, but finding out the cause of death, there was virtually nothing known then about grey seal mortality in the wild. There were a few people at the London Zoo who had published what happened to seals in zoos. On North Rona a lot of them failed to thrive or were crushed by other seals in the more congested parts of the colony. So, yes, I was an animal pathologist for a short time.

AN: And then what did you do?

EW: And then I applied for a senior house officer job in medicine at Sully Hospital, which was the old tuberculosis hospital near Cardiff, which I did for a year.

AN: So that would be about 1963.

EW: I came out of the forces in October 1962 and this would have started in early 1963.

AN: And you worked at Sully for a year.

EW: I worked at Sully for a year, met my wife there and we got married as soon as that was over, so I actually went on honeymoon with no job. I came back to find that I had been awarded a Leverhulme Fellowship to do a diploma in occupational/industrial health in Dundee, which was part of St Andrews University. Actually I wanted to do public health. I didn't have particular leanings towards occupational medicine, although the contents of the two courses are rather similar. I don't know who I asked, or indeed whether I asked anyone, but I knew people who had got a DPH (diploma in public health) first and they could do the industrial health course in one term afterwards. I assumed I could do it the other way round and do a three-term industrial health and then do a DPH afterwards in one term, but that was not possible. I think my motivation for doing that industrial health course was that it included statistics and epidemiology. I wanted to do the public health course afterwards, but it would have been another whole year if I had done that.

AN: So that was up in Dundee?

EW: Yes, but it was a University of St Andrews’ diploma. The Fellowship paid the fees for the course and gave me reasonable living money for that year. I think something that is rather forgotten now is that, in those days, to do a public health diploma, you either had to become a school medical officer with a local authority and do it part-time, or you had to finance it yourself. It was not really possible to do public health from a hospital job.

AN: So you did your diploma and then what did you do after that?

EW: After that I had applied for a lectureship in Cardiff, in the department of occupational and social medicine I think it was called, with Professor Ron Lowe. Perhaps it was a bit presumptuous of me to do that, because I hadn't got any medical publications, but I thought it sounded an interesting job. I don't quite know how I came to be interviewed by Archie Cochrane for a job at the MRC Epidemiology Unit, but the interview took place in his farmhouse with just the two of us. Maybe I got in touch with him at about that time and asked if there were there jobs in the MRC. So I went straight from that occupational health
course to the Epidemiology Research Unit at 4 Richmond Road, Cardiff. I started in July 1965 with really no experience of medical research. I did a dissertation on fractured fingers for the occupational health course, but that was never published. I probably could have published it, but I never did, and that was my only experience of research when I joined the MRC.

AN: Apart from your work with animals.

EW: Apart from my work with animals, yes.

AN: And when you started what sort of things were you doing?

EW: When I started I worked mainly with Peter Elwood on his various anaemia projects – prevalence of anaemia, causes of anaemia, treatment for anaemia, and symptoms of anaemia. I should think that must have taken roughly half my time. Certainly when he was doing a survey, it would be all my time on the survey – taking blood, checking people in, and so on. Very early on Archie Cochrane suggested I should have my own interest, and he suggested urinary tract infection. He told me that very few people had done surveys on the epidemiology of the urinary tract infection, which was probably true for many things in the 1960s. There was a group of people in the Cardiff Royal Infirmary, Max Sussman, a bacteriologist who became Professor of Bacteriology at Newcastle upon Tyne, and Bill Asscher, who was senior lecturer in medicine (and later Sir William Asscher, Professor of Medicine at the University of Cardiff) who were starting to do some studies of bacteriuria in women, pregnant and otherwise. So I started to be the epidemiologist on that group. That was my own subject, as it were. And then very shortly after I joined the Unit they were doing a nine-year follow-up at Staveley, a Derbyshire village with mixed dust exposure. There was a chemical industry, mining and steel. Basically I was given the job of organizing the survey, from the sort of manpower, door-knocking, trade union point of view. I suppose it was rather throwing me in at the deep end. Ian Higgins, who had been at the Unit previously and I think had done the original Staveley survey, just came over from the United States, where he was a professor at Ann Arbor, Michigan, about ten days before the survey was due to start to run the more scientific side of the X-rays and so on. My contribution was mainly administrative and practical, but that meant going up to Staveley each Sunday night, coming back Saturday morning, for the two months or so, I think, that it took us to do the follow-up survey.

AN: Were you given much guidance in how to do these things, or training?

EW: Not really. I suppose having been a doctor one was used to being thrown in at the deep end. You watch one, you do one, you teach one, and that’s it. I wasn’t given a lot of guidance. But I didn’t really feel out of my depth in it, and I had the feeling that Archie was always very supportive. You just sort of assumed that everything would go alright and if it didn’t he would certainly help in any way he could.

AN: And what came out of your urinary tract work, surveys of bacteriuria, and so on?

EW: That the prevalence was quite high, about 5 per cent in women at any one time, and often without symptoms. We followed up quite a few of these people and we also did a randomized trial in which half the women were given antibiotics and half were not. This actually showed that the antibiotic might even be detrimental. It seemed that the antibiotic did remove the organism that was there, but very often it was followed by reinfection, when the antibiotics stopped and the reinfection was often with a different organism or different strain and that often coincided with the onset of symptoms.

AN: And did you continue to work on urinary tract infection?

EW: I did quite a bit of work. I must have published about 15 papers in all on it. We also looked at pH osmolality of urine and how good that was as a culture medium. This was with Bill Asscher in the medical unit in the Infirmary. So a lot of it was slightly laboratory-based, but I was fairly closely involved in doing that work and in writing it up. Also at that time, and perhaps this is why Archie Cochrane suggested
urinary tract infection, I met Ed Kass, who was for a long time the editor of the *Journal of Infectious Diseases*. He was professor at Harvard, in Boston, and did a lot of work with Bill Miall in Jamaica on blood pressure and on bacteriuria. I got to know Ed Kass quite well and spent a short time in Jamaica with him. At that time there was a feeling that you might be able to screen for bacteriuria and treat those non-pregnant women to prevent end-stage renal disease. I think by the time this was all finished, and probably Ed Kass was the person who did most on this, there was a feeling that this was not the way to do it, that urinary tract infection in adult women probably didn’t lead to kidney damage except in a small minority of cases. It was if it happened in children with a growing kidney that you got renal scarring. And Bill Asscher was also doing a lot of lab work on rats and again finding that if the kidney was growing, and if it was subject to infection, you got nasty scarring and eventually blood pressure developed in a proportion of cases. But urinary tract infection when the kidney was full size didn’t seem to make much difference.

AN: So did you work alongside Bill Miall in Jamaica then?

EW: Yes, but only for a short time. In fact I stayed in his house for a couple of weeks.

AN: And what else did you do? You did the Staveley follow-up and what else did you do in your time at the Epidemiology Unit?

EW: Although Archie Cochrane suggested that urinary tract infection would be a good subject for me to get into, and yes I did write a lot of papers and attended conferences on that, I was working in a team. It wasn’t my own thing, so I was thinking what else could I do that really would be mine, in the same way that Peter Elwood had ‘got’ anaemia. I was helping him, but it was his subject, and again I think it was probably Archie Cochrane who suggested headache and migraine, because Archie himself suffered from migraine. At that time Peter Elwood had actually started a survey, the first survey that the Epidemiology Unit did on headache and migraine. He had just got to the stage of collecting the questionnaires and he very kindly said that if that was the subject I wanted, that it was mine. He very generously handed it all over to me, and really that was the subject, headache and migraine, that I did on my own then. I did lots of surveys of various sorts, including randomized trials of treatment of ergotamine tartrate. I spent a long while on headache and migraine both at the Epidemiology Unit and later when I went to Southampton.

AN: So what were the studies that you did on migraine while you were in South Wales?

EW: One of the problems of migraine is how you define it. Definitions were not satisfactory, and varied widely. It quickly became apparent to me that all the definitions were really just descriptions. Typically migraine was usually unilateral, sometimes accompanied by nausea or vomiting, and sometimes with a warning that it was coming, but very few of the definitions stressed how often this had to happen, and whether it had to happen in every attack or whether all the features had to be present. What I did was to work out the prevalence of headache and the prevalence of each of these symptoms, without making up my mind whether individuals had migraine or not. So I would say of all the headaches, what proportion were unilateral or sometimes unilateral?

Archie Cochrane was very keen, I am sure he was right, that any questionnaire needs a clinical validation. So we had Paddy O’Connor (later Air Vice-Marshall Patrick O’Connor CB), who was in the RAF, to see people who had completed our questionnaires. His job, or one of his jobs as the chief neurologist in the Air Force, was to decide if people had migraine or not, and if they had migraine they were not allowed to be a pilot or a navigator. So as far as he was concerned they either had it, or they didn’t have it. We got leave of absence for him from the RAF so he came down, and he lived in my Cardiff house. He used to go round houses in the Rhondda seeing people who had completed my questionnaires, and he did this blindly, not knowing what they had said on the questionnaire, and he decided whether they had migraine or not. He more or less put them into two camps, migraine or not migraine. He did a little group of GOK (God Only Knows), but I think it was only three or four cases in 120, where he couldn’t make up his mind. Because I had given him randomly selected people, I was able to work out the prevalence of migraine as if he had seen everyone in the Rhondda and this created quite a stir, because it really hadn’t
been done in this way before. At that time the Migraine Trust, with Princess Margaret as patron, had started up and was active, having a symposium every year. So I think I got quite well known for the migraine studies.

I did the randomized trial for ergotamine tartrate on people who had completed the headache questionnaire, because one neat definition was ‘migraine is a headache that responds to ergotamine’. It’s such an unpleasant drug that if you didn’t have migraine, you wouldn’t take it. So I did this randomized trial between ergotamine and a placebo and found no benefit of ergotamine at all. At that time the only two other randomized studies on oral ergotamine had also shown that it had no effect, but it was widely used as the main drug for the treatment of migraine. It was supposed to be specific, if the attack responded it was migraine. At that time we used ergotamine only, which was widely used, but a lot of ergotamine was combined with caffeine and other drugs. Of course caffeine could have an effect on ordinary headache as well as migraine, so we didn’t use it. But it has subsequently been shown that caffeine increases the absorption of ergotamine, so maybe the pharmaceutical industry was ahead of the evidence at that time by putting caffeine with ergotamine.

For a long time many headache researchers never accepted the finding of my ergotamine trial. Then I tested various hypotheses about migraine, whether it occurs more often in higher social classes, more intelligent people, in people with higher blood pressure, and whether it ran in families. We did studies on all these hypotheses, and almost all were completely negative. For example, when testing the hypothesis that migraine people were more intelligent, we found that in the population as a whole there was no link between intelligence (nor social class) and having migraine. But the higher social classes, classes 1 and 2, and the more intelligent people, were much more likely to go to their doctors with their symptoms. Many people with migraine, including many that Paddy O’Connor had clinically diagnosed, had never been to their doctor for their headaches. So what really interested me was that doctors managed to pick out this association between intelligence and social class and suffering from migraine. This was true in patients who went to see doctors. But they drew the wrong conclusion in saying that it was more common in the general population than in these groups. So I was quite impressed how doctors could spot a relatively small difference, but nevertheless the material they had was biased. Incidentally it is actually true that after I wrote a paper showing that migraine wasn’t associated with intelligence and higher social class, I left Archie Cochrane’s unit. He was a well-known sufferer from migraine, and he often told that story and said ‘look what happened to people who don’t get the right answers!’

AN: And did you work on any other studies while you were at the Unit? The migraine work, the urinary work, and the Staveley follow-up, and helping Peter Elwood.

EW: Yes, there were surveys called the random sample of Wales that Hubert Campbell was particularly involved in. This was a cluster sample of the population of Wales, or in certain constituencies, because they used to sample mainly from electoral rolls in those days, and we were measuring a variety of things – haemoglobin, urea, vitamin B12 and various others. Basically, it involved a blood test and a short questionnaire to people spread all over Wales. I did quite a few of those surveys, particularly some of the ones in mid-Wales and North Wales, which involved administering a relatively short questionnaire and taking about 20 cc of blood. That survey probably wasn’t a great success and we published the results for haemoglobin, urea, and vitamin B12 and I think one or two other things, but we did actually measure a lot more. For various reasons, I am not quite sure now what they were, but there was some trouble with the laboratory. We did find significantly different haemoglobin levels in two parliamentary constituencies in North Wales. This was highly significant, and just as we got quite excited about this, we found that the apparatus they were using for measuring the haemoglobin had broken between analysing the two surveys and they then had a new bit of equipment for the second study. That rather destroyed our faith in the results that we were getting.

AN: This was a piece of work that was led by the Epidemiology Unit?
EW: Yes, it was a piece of work that was done by the Epidemiology Unit. Hubert Campbell was then a half-time appointment between the medical school in Cardiff and the MRC. He subsequently got the chair of medical statistics and became full-time in the Cardiff medical school. I was at the Epidemiology Unit for just over five years, and I got involved in a number of other surveys. One of them was with Dr Philip Wood on arthritis. This was in the little Rhondda. Wood came down to live in his caravan there for a couple of months in the summer. We were looking at the relation between a clinical examination of joints, which he did, the X-ray evidence of arthritis in joints, and DAT (Differential Agglutination Titre), the blood test for rheumatoid arthritis. One of the things that came out was that these three things were really fairly independent. There wasn't a high correlation between the three of them. This was a bit surprising at that time, because the blood test was very much used to diagnose rheumatoid arthritis. We also did a lot of ESRs (Erythrocyte Sedimentation Rates), I remember. Again they were not very specific for arthritis. I think they had a slight predictive value, but it was so slight that you wondered why clinicians would worry about not doing them. I also did a few surveys on eyes with the ophthalmologists in Cardiff.

AN: Fred Hollows?

EW: No, Fred Hollows had left for Australia, I think. Peter Graham was the consultant ophthalmologist. I was very much a fieldworker. The survey involved measuring intraocular pressures and the detection of glaucoma. I wasn't really very involved in that study and I wasn't involved in the writing up. This survey was one of the many Archie Cochrane was involved with to establish whether screening for various diseases was scientifically justified.

AN: Just thinking a little bit about your time at the Unit, you talked about links and working in collaboration with quite a few different people in the Unit, but also quite a few scientists and so on, I was just wondering how extensive and formal those links were with other people?

EW: Right from the very beginning when I joined the Unit, I was given an honorary contract with the Cardiff Royal Infirmary as Honorary Clinical Assistant. Archie said if I wanted to get back into clinical medicine, it would look good on my CV. So I did have, on paper, an honorary attachment to the Infirmary, but it was the work on urinary tract infections with Bill Asscher that was my real involvement with the Infirmary and I don't think I got that connection because of the paper contract. Otherwise, we didn't have a lot of contact with the Infirmary. We were within five minutes' walk, I suppose, of the Infirmary where the Medical School was really based. We didn't have a lot of other contacts there. Surprisingly we didn't have many contacts with Ron Lowe, who was Professor of Social and Preventive Medicine, then based in the Parade that was, again, very close to the Richmond Road Epidemiology Unit. I think Archie got on well with Ron Lowe and the few contacts I had with him were very pleasant. He was always very encouraging. He was then the editor of The British Journal of Preventive and Social Medicine, where we used to publish a number of our papers. I remember when I had a paper I wanted to submit I used to walk across and give it to Ron Lowe in person, rather than use the post. He was always very helpful and complimentary. Yet we never really had much of a link with other people on his staff. This was obvious, particularly when I went abroad and people would ask, ‘Well, what are they doing in the university in Cardiff?’ and I wouldn't know, which seemed a bit strange in view of how close we were geographically.

AN: Why do you think that was?

EW: I really don't know. There was a journal club that the University had, I think about once a month, and I used to go to that when I could. But usually, even though it was literally a five-minute walk in each direction, I often was busy, or, of course, we were out on surveys, and you got out of the habit of going then. So we didn't have very close links with them. We felt that it would be nice to have closer links if they had developed naturally, and I think we would then have pursued it. If not, there were enough people in the MRC unit to keep stimulating conversation going. Many people were doing different surveys, and the Unit at that time had a lot of visitors from all over the world, who used to come and stay with Archie in his home at Rhoose Farm House, for a couple of nights. I remember often, oh right from the time of joining, I would be asked to take someone up the Rhondda for a day, just to see surveys that were in
progress, whether I was involved with them or not. I would take them out for a cafe lunch, where the miners would then all come in straight from the pits, with their dirty faces and dusty clothes and whatnot. Yes, a stimulating lot of people used to come like that and such contacts were enjoyable and often useful.

AN: The collaboration you had with scientists on the urinary tract work, this again seems quite ad hoc, there weren’t general links with other scientists or points where you might meet and find out about the science going on in the medical school.

EW: No, I wouldn’t have known what other projects the medical school were doing. I perhaps saw their annual report, or something like that, with papers published. Archie Cochrane had a close friendship with the professor of medicine in Cardiff at that time, Harold Scarborough. I don’t think Professor Scarborough was especially interested in epidemiology, but he was an influential person in the Cardiff area and well outside this too. Every six months or so we used to have a meeting where people working in the MRC unit would present the work that they had been doing to about 20 people. Harold Scarborough used to come to these meetings quite regularly and if we gave a talk he would ask searching questions, ‘How do you know this?’ Those meetings were very stimulating and a few other people from the medical school used to come. I think Archie put a lot of effort into getting those going and the meetings were where I had my first experience of presenting epidemiological results.

AN: I am interested where the impetus or ideas came from for your studies. How did ideas come to the surface in the Unit?

EW: Well, the short answer is through Archie. I mean every day he seemed to come up with something, related to medicine, or not. He would have ideas of how you could test for all sorts of things. For a lot of diseases in those days the epidemiology was virtually unknown in random samples of the population. There may have been bits in textbooks, people with cholecystitis were ‘fair, fat, and 40’, but I don’t think many people had tested on a population basis whether that was true. So if one did a survey, certainly a survey using random samples of the population, it was quite likely to be a first. Sometime unkind people used to say that Archie would cream things off, he would get in right at the beginning and do the first thorough surveys. Archie didn’t take it lightly and was obviously very concerned about diagnosis and accuracy and that sort of thing. But, yes, when you did such a survey, it was worth a paper in a good journal, because often it hadn’t been done before, in that way, on random samples of the population. I suppose what the Unit was able to do was to study any disease that was common enough to find in random samples of the general population. It would need a percentage of 1 or 2 per cent as a minimum, because most of our surveys were a few hundred, 500, sometimes up to 1000 or more, but it was that sort of number, so any disease that didn’t have a prevalence of 1 per cent or more, you couldn’t do, but anything that had a prevalence of 1 per cent, you could do, and it may not have been done before.

Archie often suggested a number of things. Varicose veins was something he thought would be worth looking at. Jean Weddell came and did studies on varicose veins very shortly afterwards. Archie also thought a study of inguinal hernia would be very interesting. Piles and prostate disease were other suggestions. I think that is why I did migraine! But he always had lots of ideas. He didn’t push too much, if you didn’t pick them up. But Archie expected you to work hard. He worked very hard himself, but it always seemed interesting. The hours he used to put in! I also did a little bit on pneumoconiosis when I was at the Epidemiology Unit and I certainly spent days and days and evenings and evenings reading X-rays with Archie, all in random order.

AN: So what are your memories of working with Archie Cochrane?

EW: I suppose I would say he was fun to work for, as he really made life fun if he was around. He was always so interested in it, he always had an unusual way of looking at something, he was always stimulating. He was always encouraging. Archie gave one considerable freedom to do it the way one wanted to get on and do it. He led from the front, he worked hard, and I think he expected you to work hard. I don’t think he would mind if you wanted to go off to the dentist or to get your hair done in the middle of a survey, or
something like that, and if it fitted in. He didn't look at the hours you did, but as a consequence I think he got pretty long hours out of us, certainly when we were on survey. I used to leave the house before our young boys were up in the morning, usually half-past seven, to get up to the Rhondda, and I would often not be back until half-past eleven at night, and that's five days a week. We were doing the survey all day and we also had evening clinics for people who couldn't come in during the day. Then we had the blood samples to spin down, or whatever it was, and often take them back to the Infirmary, when it was virtually locked up. So there were long hours. I suppose it was quite hard work in a way, but there was no feeling of pressure, it just took a long while to do it. And on many surveys when we were taking blood we each used to take well over 100 samples of blood in a day, as well as administering a questionnaire, perhaps, measuring blood pressure and doing a few other things. I wouldn't say that I found it relaxing, but compared with clinical work, which could be quite stressful it was very satisfying. You may have had a few people waiting to have a blood test, but they were usually very smoothly organized. We didn't have queues. It was pleasant work, although I think I was conscious that perhaps I wasn't spending as much time with my family as I would have liked. It really didn't allow much time for anything else. It was long hours, but I enjoyed it all.

AN: And you left to go to Southampton. What prompted you to leave, did you think you had had enough time there?

EW: No, I think when I joined the Unit I had a two-year contract. It was a rolling contract, it could be renewed a year before it ran out, so I was never taken up to the wire on it. I don't think that I worried very much about where this was all leading, or what sort of career I would have. At that time there weren't many jobs in epidemiology. I just enjoyed it and felt that I was doing something interesting and worthwhile. I felt that I was quite good at it, and so I stayed on in the Unit for over five years.

I think one of the things you mentioned was how we felt working for the MRC. Archie Cochrane did all the negotiating for everything like that. It wasn't that he didn't trust us, he just did it and he did it very easily, and we didn't have much to do with the administrative MRC people. Occasionally one or two of them would come down and visit the Unit. I remember Archie would often produce a timetable and the MRC visitor might spend half-an-hour with me and then some time with Peter Elwood and the other people. I don't really know if the Unit was being assessed at that time, I suppose it was. Archie gave the impression that the Unit would go on as long as he was there, and that was a long while at that stage. But I did have a talk with someone at the MRC. I think I may have raised a question about my contract and how long it could go on. I was told that it would always be short term and that if I wanted anything 'permanent' I would have to go elsewhere. Then Southampton University was selected for a new medical school. Donald Acheson was appointed the first Dean. He was an epidemiologist and also a clinician, a rather rare combination. I knew him from meetings, but I don't suppose he knew me any more than vaguely. They were advertising for a senior lecturer in epidemiology. I didn't know much about Southampton, or this part of the country at that stage. I had caught a transatlantic liner as a child from Southampton. I thought that I would apply and got the job. It put me on the consultant salary scale, which, with two small boys, was useful. Academic posts, certainly at that time, were much more secure and, with a young family, this was important to me. I think I am right in saying that when I worked for the MRC, I don't know if it is still true now, but we were paid as non-medical scientists, not as doctors.

AN: I don't know if that is still the case.

EW: My salary when I went to the MRC was about the same as an SHO and it didn't go up very much for several years. Certainly at that stage I would have been a registrar if I had stayed in the health service and would have been getting, I suppose, half as much again. So the attractions of a consultant's salary in 1970 were great and also the attractions of a new medical school. I was somewhat disappointed in my medical student days, as I didn't feel that I learnt much science at all. It was all an apprenticeship and I felt it could have been far more scientifically structured. I felt that I had learnt quite a lot of science at the Epidemiology Unit, so the move to a medical school, especially a new medical school, was exciting. With Donald Acheson as Dean, from 1968, we had a big department of epidemiologists and statisticians. We
got Martin Gardner who I think at that time was probably one of the best medical statisticians in the country, so it was an exciting place to move to. I managed to continue quite a bit of the research I was doing with the MRC, especially in my migraine research, but I didn’t do many epidemiological surveys in Southampton.

AN: **Was this because of the teaching commitment?**

EW: Yes, I think teaching and other commitments. Donald Acheson was both head of the department and the Dean of the medical school and was really quite content for me to run a lot of the administrative side of the department, so I had quite a lot of organizing tasks. As you know, at university there are all sorts of committees, the student selection committees, the examination committees, and so on, and they all take time. At the MRC I had to give the occasional lecture to Archie Cochrane’s chest disease course. I gave some lectures on statistics, believe it or not, and epidemiology, but perhaps half a dozen lectures a year. These were small groups, a couple of dozen or so. The only experience I had of talking to large audiences, before coming to Southampton, was lecturing to natural history societies on birds! At the MRC there were papers at conferences or talking about one’s own research. But I don’t remember being on any committee at all. Archie didn’t have regular meetings, he was quite unlike Peter Elwood in that respect. He rarely had meetings in the Unit. But yet I felt we were very informed about what was happening, we would meet everyone for tea and coffee and Archie himself would always talk about what was going on, or what might happen, both locally and nationally.

AN: **Tell us more about Southampton and setting up the new medical school and what you did in Southampton.**

EW: I arrived at Southampton exactly 12 months before the first students, so we had quite some time to prepare the sort of teaching we would like to do. It did get rather bogged down in committees, because we had to consider other people’s teaching. To some extent we had to justify what we wanted to teach and they had to justify what they wanted to teach and it took a lot of time doing this and trying to arrange an integrated course. The philosophy at Southampton, as with many new medical schools at that time, was that of a medical school for a region. One of the reasons why I think Southampton got the medical school was that the proposal to set it up, unusual in fact, was a joint application from the University of Southampton and the Wessex Regional Health Authority. Whenever possible we tried to bring the region into the teaching. A lot of the examples we would give had to be from the Wessex region. For example, when talking about population pyramids, we didn’t show England and Wales, but Wessex, because that’s where we were. However, it wasn’t where all the students came from, they came from all around. We had a slight predominance of Wessex students, but it was only slight. I am not really sure that it was any better than what was happening elsewhere.

AN: **What else was new about the medical school?**

EW: I think the most revolutionary thing about the medical school – which partly followed Nottingham, whose medical school started one year before Southampton – was that the students did a project in the fourth year, which took perhaps five months or so, but was spread over an academic year. Students, individually or sometimes in pairs, worked on this project. There were widely differing views on the value of the project. Some staff didn’t like it, particularly the clinicians who felt students were losing out on clinical medicine, especially bedside teaching. I think it’s true to say some of the students didn’t like it, they too wanted to be at the bedside. But a considerable proportion of the staff, I don’t know whether it would be one-half or so, were really keen on the projects, and I suppose for me some of my most satisfying moments at Southampton were certainly with the students and their projects. They really got into them, you could see how their horizons were broadening and the satisfaction they gained from doing the project. Many of the projects were published in the British Medical Journal, The Lancet, and other good journals. Sometimes the student was the only author and sometimes the paper was written with a member of staff, perhaps after more data had been collected and analysed.
**AN:** Could you give an example of a project that the students did during these five months?

**EW:** It was a complete spectrum. Sometimes it was the student who selected the topic and sometimes the supervisor suggested possible topics. Some departments, I fear, virtually used them as unpaid lab technicians, to do the titrations and whatnot. In other departments, and we tended to be in this latter category, the students would come to us and say they would like to do this, that, or the other. Sometimes the suggested topics just weren’t suitable. I couldn’t see any way within the resources and time that we had that some topics could be done.

But there were some quite surprising studies. I remember one of the students at the beginning of the AIDS epidemic, who wanted to know what the people of Southampton knew about AIDS. I think my initial reaction was that it wasn’t quite the thing for a medical student to do. Anyhow she devised a questionnaire, sent it out, and got a fairly good response rate. Then this big government-sponsored campaign about AIDS was published in the newspapers and appeared on television. The student realized, and I realized, that she had actually asked a lot of the questions that the campaign covered. Her study took place before the national health education campaign took place. So after she left, after completing her course, we managed to repeat the survey on a new sample, using exactly the same questionnaire. We found that most of the people in the sample knew most of the things that were appearing in the government-sponsored health education programmes even before the campaign, and that the level of knowledge had not increased after the campaign. So those that didn’t know before, didn’t know afterwards. We had tried to get from the Department of Health the cost of the campaign. There was a bit, I think, in a popular national newspaper, that the campaign had cost so many million pounds. We could never get the Department of Health to confirm or deny that. This was the time that Donald Acheson was Chief Medical Officer.

I do remember once being a bit embarrassed. I was invited to a dinner at the University – a week after we had published this paper in the *British Medical Journal* – at which Donald Acheson was the chief guest. The paper showed that the health education campaign didn’t seem to have any effect. Professor Acheson made a comment in his speech, I thought it was rather nice. Our paper had caused a lot of publicity in the national papers and on the television. The week following the publication in the *BMJ*, Margaret Thatcher, then Prime Minister, got Willie Whitelaw to head a committee on information on AIDS. This was really something for a rather academic epidemiologist to be suddenly in the middle of politics. It is a good example of serendipity and it started from a fourth-year student project. Anyway Donald Acheson’s comment was that the Department had come under a bit of criticism recently, but, if it was being criticized, he was quite pleased that it was a student from his old medical school.

**AN:** So you went to Southampton and you didn’t move on again.

**EW:** No, I didn’t move again. I went to Southampton as a senior lecturer in 1970, and was promoted to reader in 1975 and then Donald Acheson decided to stay on as Dean of the Medical School for another term. But because he was doing that, he didn’t want to run as head of department, the community medicine department. So, for the first time, in 1976 a chair in community medicine was advertised. There hadn’t been one before, because Donald Acheson was Professor of Clinical Epidemiology and head of the department. Because he was staying on as Dean, he didn’t really want to get involved in the departmental administration side. I don’t think I actually wanted to become a professor, particularly at that stage. I knew that I was not doing as much research as I would have liked, and it would be even less if I was officially head of the department. I was already doing quite a bit of the administration, not that it was that much. I decided to apply for the chair. So, yes, then I became professor in 1976. One of my claims to fame was that after Donald Acheson’s term as Dean finished, he actually came back as a member of ‘my’ department for a year. He worked fairly independently, and then he set up the MRC Environmental Epidemiology Unit in Southampton.

**AN:** Why did he choose to set up a whole new unit rather than within your department or a department in Southampton? What was the thinking?
EW: I don’t know. Donald Acheson was Dean at a fairly early age [c.42]. He had been Dean for two, if not three, terms from 1968 to 1978, and having set up a new medical school, he didn’t want to run a department. He was doing quite a lot of work on asbestos. I think other people thought he ought to be in medical research. I think Sir Richard Doll was very instrumental in setting up the MRC Environmental Epidemiology Unit.

AN: So when was that set up?

EW: It was agreed about 1979, but it took a number of years to build. They had a purpose-built building in the grounds of Southampton General Hospital, which was quite difficult to do at that time. There were already parking problems and whatnot and the only place they could put the building was over a car park. The compromise was actually to leave the car park underneath and to put the building on stilts. It’s a two-storey building and that probably took a year or two to build.

It is interesting you ask that, why a unit and not part of the department, because it was actually a disaster for the department. At the end of the 1970s Southampton probably had as big an academic department of community medicine as anywhere in the country. The staff included Donald Acheson, myself, David Barker, Stuart Donnan, and Ken Cliff. Right there were five medical people. There was Martin Gardner as senior lecturer in medical statistics, and we also had a lecturer in statistics. This was all from UGC (University Grants Committee) money. We also had research staff on various grants. But once the MRC unit was set up, Donald Acheson, David Barker, and Martin Gardner became full-time with the MRC. The university didn’t replace them. It was just the time, 1981, that cuts were coming in higher education including medical schools, so the timing was a bit unfortunate. Donald Acheson has subsequently said to me that he wouldn’t have set up the MRC unit if he had known that it was going to have such an effect on the medical school side of community medicine. The MRC people were there, and to be fair, they did some of the teaching, lecturing, and small group seminars and whatnot, but they didn’t get involved in the setting of exam questions, and marking exams and the nitty-gritty of the organisation of courses, booking theatres and all that sort of thing. So we got left with rather more of the dogsbody work. I suppose they had the sort of research life that I had previously enjoyed in Cardiff at the epidemiology unit there. We used to meet at lunchtimes, but we were separate, us from them, as the MRC unit in Cardiff was from the medical school in Cardiff. In the end, they had more of a critical mass than we did, they had more scientific staff. I suppose we had more need of them than they did of us. We both tried to run seminars and whatnot and come to each other’s activities, but it never really seemed very successful. For our seminars, mainly university people came. Their seminars were mainly for themselves and one or two outsiders. I don’t know how much that matters. I think we were the ones that suffered.

AN: And did the department pick up eventually? Did it get bigger again?

EW: No, at least not in my time there. It went downhill in terms of staff numbers from then on.

AN: And has it continued to live in the shadow?

EW: At one time I was the only medically qualified person in the community medicine department. For a time we had a non-medical lecturer, who was very good, but when she left I was the only university-paid person, except for my secretary. The department declined from among the largest at the end of the 1970s, to one of the smallest, perhaps with Belfast, by the end of the 1980s.

AN: You were teaching 130 medical students single-handedly, essentially.

EW: Not quite. We could use the MRC staff for some lectures, and also for the seminars. We used to break up the students in groups of about 12 for seminars, and the MRC people were very good at coming and helping. It was just the more administrative side of the teaching, and booking, and timetabling, and
fighting one's corner with other people who wanted that lecture theatre or that time. The MRC people were not involved in that, nor should they have been, I suppose.

AN: So the Unit came into being in the late 1970s, and then it was over a few years that the department declined to just you.

EW: It was during the 1980s that people left, yes.

AN: And the university had a policy of not replacing the people or not filling the posts?

EW: They had a policy certainly at one time of leaving positions vacant for six months as a means of saving money. Because of staff turnover that policy actually saved quite a proportion of the budget. Then each post was discussed on its own merits. When Donald Acheson was Dean, he built the biggest, and in many ways the best, department. Maybe there was some reaction locally that he put too many resources into it, so that afterwards there may have been a reaction against the department, so that whenever a post came up, it was voted down. But, yes, when various people left, one of my senior lecturers, Ken Cliff, left to join the NHS. Stuart Donnan left to become professor in Hong Kong. These two were not replaced. The statisticians were replaced. I think the medical school in Southampton realized the value of statisticians to the whole medical school. I don't think they always realized the value of epidemiology. I would like to think that it was relevant to more than just what I was doing. In fact I did do quite a bit of joint research with the professor of medicine and with other people in the medical school. It never really seemed to pay off in terms of papers or influence. I might have been better doing my own thing, I think. But at the time I thought it was the right thing for me to do.

AN: So you retired when?

EW: I retired in 1990. There was a bit of a mix up. There was a new regional medical officer, Graham Winyard, who was keen on improving the public health medicine side of the medical school and he promised some considerable help in terms of money. At Southampton, we got help from Southampton District for a statistician. Half of Mike Campbell's salary was paid by the district for a time and he used to help NHS people on projects and statistics, but we never got any money for medical staff from either region, area, or district. I think most medical schools at that time were getting at least some money, or one or two posts, or a joint post, or something like that from the NHS. We never had any of that money, but Graham Winyard promised money to the medical school and wanted an Institute of Public Health Medicine, which would include both the NHS and the university. The institute would do all the teaching and would replace the university department. I didn't like that idea and even less the geography; the NHS region was based in Winchester. The university department was based in the general hospital in Southampton, but a lot of our teaching was actually done in the first year when the medical students were on the university campus, three miles away from the hospital. The thought of having an institute based at Winchester, twelve miles from the hospital, and ten miles from the university campus did not appeal to me. I thought the academic and the teaching side would get a low priority. So I let it be known that I was not happy about this proposal and I was offered early retirement in 1990. I became a Professorial Fellow, with a three-year contract, half-time, so I actually started to pick up my pension in 1990. With a part-time NHS contract, it gave me virtually the same money as I was earning before. Additionally I was told that the attraction was I would lose all my administrative responsibilities. This wasn't quite true, because there was no one else around. It was about eighteen months before anyone else was appointed, so I was the only one for a time. It was a bit of an unsatisfactory time, all round, I think.

AN: And so was it John Gabbay who came in?

EW: John Gabbay came in at the Wessex Institute.

AN: He was your replacement?
EW: Yes, with this joint NHS/university money. He quickly got quite a big department including some very able people. I think some of them have now left. I think the institute is much more service, than academic, but they do teach the medical students and have an active postgraduate teaching programme.

AN: And there was epidemiology going on I suppose under Professor Ann Louise Kinmonth. Would that be after your time?

EW: No, she was at the Primary Medical Care at Alderwood Health Centre, in Southampton. That was the first University Grants Committee (as it then was)-funded, general practice building. The university actually built the health centre. Professor Kinmonth was the third Professor of Primary Medical Care [later first Professor of General Practice at Cambridge]. Originally primary medical care was in the department of community medicine. In fact Donald Acheson's definition of community medicine in 1970, at the beginning of the medical school, was ‘medicine outside the hospital’, so it included general practice as well as public health, epidemiology, and statistics. This is before the Faculty of Community Medicine [now the Faculty of Public Health], established in 1974, confined itself to public health and epidemiology. So yes, we had a good link with Primary Medical Care right from the beginning. They were within the same department and building originally. But by the time Kinmonth came, or certainly by the time that she became professor there (she had been senior lecturer there before), we had less close links and we were in separate buildings. I knew little about the research they did, until they gave talks about their work. The statisticians at Southampton were not involved. The statistics for a lot of Primary Medical Care studies on cardiovascular surveys and whatnot were done by statisticians in London. I think the statisticians and computing people at Southampton were a bit put out that they knew nothing about it. At the meetings of the Society of Social Medicine and other meetings this would come up, and everyone would assume that we were doing the statistics for Primary Medical Care. I don't quite know why this came about.

AN: So you stopped working altogether in 1993?

EW: No, my Professorial Fellowship was extended to September 1994 as I got additional funds for this extension. At about that time I became involved with Health Trends, the Department of Health’s journal. I was responsible for a lot of the assessment of papers. So I continued at the University of Southampton until the October 1994, when I became self-employed, working for the Department of Health, mainly on the journal. The work was done at home and by post, which suited me very well. So I was able to ease off gradually, which was quite nice in many ways. Particularly because I felt that the department was at rock bottom after having been a powerful department. It was not much fun being at the other end, and I didn't see much hope of climbing up, even if we had been given one extra post or something. It would still have been a small department. When retirement came, I was quite glad to leave, however, I did offer to help with some of the teaching, or student projects, or in any way I could. I would have been quite happy to have had a part-time role doing what they wanted but there was really nothing that they asked me to do, or that they wanted me to do. I attended the occasional seminar for a while after retirement, but it really became very, very occasional. Parking had got to be an absolute nightmare at the General Hospital, and once I retired I didn't have a special car park ticket, so it became a hassle to go in. I really am quite out of touch with what's happening there now.

AN: And do you do any work now? Do you do any epidemiology?

EW: I still get the occasional paper for the International Journal of Epidemiology [IJE] and, yes, other papers to referee, that sort of thing, but that's about all that I do now. No more epidemiology.

AN: The editorship of the IJE has just moved to Bristol.

EW: Peter Pharoah has been the editor of the IJE for a long while. This was one of the other traumatic things that happened about the time that I took early retirement. In 1987, at the Helsinki meeting, I was appointed to be editor of the International Journal of Epidemiology, to succeed Charles Florey, at a time to be agreed in the next three years. I had a note from the Dean congratulating me and [saying] what a good
thing it was to bring this honour to Southampton and whatnot. I went up to see Charles Florey several times in Dundee and gradually got into how he was doing it. I was ready to take it over and then, suddenly, the Dean of the Medical School said that I couldn’t edit it in university time. I was told that if I wanted to be editor, I would have to take early retirement. The proposed scheme was to give me slight enhancement, five years on the pension, and work part-time for the university, and that I could do the journal in the other half (on my pension). I decided that I would do that and became editor of the JIE in June 1990. This was the time when the Wessex Institute of Public Health and Medicine was being set up, but it was also the time that the International Epidemiological Association [IEA] were having an international meeting in Los Angeles. I was asked by the IEA to give a definite commitment, ‘Would I or would I not be editor?’ I took on the duties, papers started to come to me, but the university didn’t give me my early retirement or my new part-time contract. It is a long and complicated story, but Graham Winyard had actually circulated a paper, which was seen outside the university, saying that I was retiring. This was before anyone told me and I remember having some very strange conversations with Walter Holland, David Miller, and others in Los Angeles. They had read this paper that said I was retiring and I hadn’t then been offered retirement! I hadn’t even seen that paper. It ended up that I had to give up the editorship of the journal, because they wanted to know at the Los Angeles meeting, in order to appoint someone else if I couldn’t do it. I didn’t then know whether or not I could do it, because the university had said I couldn’t do it in their time. I could only do it if I was given early retirement, and my application for early retirement to edit the journal had been in for over a year and nothing had happened. So I was editor for only a month or so and then Peter Pharoah in Liverpool took it on. I remember immediately they appointed John Ashton to be head of the department and gave Peter Pharoah much time to edit the journal. A completely different reaction to the one I had got at Southampton. Who is doing it in Bristol now?

AN: George Davey-Smith and Shah Ebrahim have taken over, jointly, since Peter's retirement.

EW: I was very interested and active in the IEA from the days that I was at the MRC in Cardiff. I felt that epidemiology had a lot to offer medicine in all countries of the world. I was on the council for nine years from 1971 to 1977 and from 1981 to 1984. Archie Cochrane encouraged me, and got me onto the council, when I was really quite young. Archie never actually served in any official position in the IEA, I don’t think, but he was always very keen on it. He used to attend all their meetings. I was secretary of the IEA for three years and on the Executive Committee, which was quite a big undertaking. That was the mid-1970s, and it may not have been a good time for me to do it. I think I was better known internationally than I was in Southampton! This often happens and maybe it weakened my position as it took a lot of time, being secretary, and travelling to many meetings. I much enjoyed it, but it wasn’t Southampton work.

AN: Looking back over your career, how would you see your time at the MRC unit. You said before that you felt that it had trained you. Were there any other things that you feel that came from that time at the Unit?

EW: It certainly trained me in epidemiology. I enjoyed it and it has been the most enjoyable part of my medical career, by a long way. It established me to get a consultant-level job, relatively quickly I suppose. I don’t know what more it could have done. Yes, I thought I had a really good training and I enjoyed it all, and the work. Except perhaps for the financial side, I could happily have just stayed there. I didn’t tire of doing surveys. Whether I could have done it all my life, I don’t know. I very much benefited from all the ideas that Archie Cochrane had, and although one gets into the way of thinking how things can be done, I was certainly never the sort of person who could spark off ideas like Archie did. He really was so stimulating, and not just about epidemiology or medicine, but politics, art, or anything. In conversation he would bounce all sorts of ideas around. One thing I know he was interested in, and never actually got money for, was to do a survey of the pictures that people had in their homes in a random sample of houses in Wales. I thought that would be a wonderful idea. Archie was very interested in the arts. If he had done that, as a big archive somewhere, and someone could do it again, 20 years later, pictures would probably have changed quite a lot, but no one will know.
Another of his great ideas was a series for television on ‘What is the evidence’ for various topics. He would have tackled subjects like corporal punishment and comprehensive education, and get experts on both sides talking about it. I think that you could have had a wonderful series on television on this. Just talking over coffee, often he used to just come out with these sorts of ideas. I don’t know how much he had been thinking about it, I think his mind just worked like that. Most of these ideas were feasible, they weren’t scatter-brained ideas at all.

AN: I have interviewed quite a few people who have come to epidemiology from different backgrounds. I just wonder if you think there are defining characteristics that define the people who go into epidemiology and public health. Are there things about them that are particular or peculiar to them?

EW: Perhaps they tend to think in terms of populations and statistics, perhaps rather than individuals. I think they probably had to have that approach. But otherwise, I don’t know. Sometimes it’s linked with an abstract and slightly left-wing view of the world, where numbers are important. I think Stalin is supposed to have said, ‘The death of one man is a tragedy, the death of millions is a statistic’. Perhaps epidemiologists think in terms of the overall picture rather than of case presentation of a single individual, which is the more usual approach in clinical medicine. If the government bring in something, the media will often interview one person that would be involved; I think that epidemiologists wouldn’t like that individual approach. Other than that I don’t know. I remember vaguely a meeting in London where one of the sessions was on how to recruit epidemiologists. Several speakers had some fairly sensible ideas about how we could do this in a structured way. Then I remember Archie Cochrane got up from the floor and gave details of epidemiologists who had worked for him. I think he gave three examples, and they had nothing in common. One of them, Bill Miall, had been his batman in the Second World War; another, Jean Weddell, had done epidemiology as rehabilitation for a broken leg following a cycle accident, and got a life-long interest. I have forgotten the third now, but it was equally unstructured and unplanned. Archie said there was no common feature you looked for in epidemiologists and I suspect he was right.

I think one of Archie Cochrane’s real strengths was in the people that he appointed to his unit, as scientific staff they have done well, either there or since. Also his field survey workers, including Tom Benjamin, Hugh Bates, Gwilym Jonathan, and Fred Moore worked for I don’t know, fifteen, twenty years with him, and were outstandingly successful at their jobs. I don’t know how he selected these people in the early days. Irene Calford was his secretary, who stayed with him all the time he was there, I think. So he had this ability of appointing people and getting on well with them and who were successful and stayed. There was very little turnover really, except for perhaps scientific staff, who tended to move off to university and other jobs.

Incidentally, the members of my community medicine department at Southampton have all done well since leaving. Three of the five with medical qualifications have become professors, as well as two of the statisticians and at least two of the NHS registrars and senior registrars in public health who were linked to my department. Maybe there are more professors nowadays?

AN: But one of the striking things that comes up while interviewing people is the length of time that many people did work at the Unit and do you think that was peculiar to the Unit? Was it peculiar to MRC units?

EW: I am not sure. I don’t know enough about other units. I don’t really know enough about the Southampton MRC unit, how their secretarial staff and others have changed. I can remember the feeling that things were pretty permanent in Cardiff, that things didn’t change whereas in the university I got the feeling that everyone was always leaving, that you always had to convene an appointments committee and get permission to re-advertise etc, etc. You didn’t get that feeling at all in the Cardiff MRC unit. But perhaps I saw it from different viewpoints: junior in Cardiff, more senior in Southampton.
AN: One thing we were talking about earlier was the fact that you are a keen birdwatcher and I know that Peter Elwood is and whether there’s something about people who like counting birds that predisposes you to a career in epidemiology. I don’t know if you think that’s the case.

EW: Well, certainly in my case there was an overlap between the two. I had been interested in birds from a very young age, when I was in Canada, but I was also interested in the scientific side of birdwatching, bird migration and bird numbers. When I was on St Kilda I wrote about a dozen papers and short notes for ornithological journals and for the Proceedings of the Zoological Society of London on various aspects of birds and on the grey seal. I was interested as a naturalist. At that time I didn’t have any real knowledge of statistics. I can remember during my medical student days, it was my birdwatching that kept me scientific. I used to read some of the bird journals. I found the medical journals too heavy to read as a student. I don’t know how some of our medical students now manage to read medical journals, but they can and do. I felt the teaching we had at London was not very scientific, it was more of an apprenticeship: I do this, so you do this. The birdwatching kept me critical of the scientific side of things. When I joined the MRC it was very much the other way round, of course. It was the epidemiology that was the scientific side and I think I have been able to apply a bit of it to my birdwatching. The two have run together, one perhaps ahead of the other, but the two are related. I think that someone who wants to count wrens on St Kilda has got something in common with someone who measures the haemoglobin level in a population. My experience of waking alone on St Kilda and writing papers on natural history probably helped me when starting in medical research.

AN: I agree. I think so.

EW: I can remember when I collected some of this data, I think one of them was a random sample of blood urea, I found something fascinating about this distribution that was taken from a random sample of population. I just found the whole concept, and the data, enthralling somehow.

AN: I can share that, it’s very interesting. Is there anything else that we haven’t covered that, thinking over the interview, that you would like to say a little bit about or any other points that we haven’t drawn out?

EW: Well we haven’t really discussed careers in epidemiology and how that has changed over time. When I joined the MRC unit, which was before the 1974 reorganization of the health service, it wasn’t very clear at all what sort of career paths there were. One could become a medical officer of health, which really meant doing school medical examinations for years and years, before you got to the top. I don’t think I was particularly attracted to that. Or one could somehow get a university post, but many of the university lecturer jobs didn’t have a lot of time for research. There were a few research fellow jobs, but they were often given to people who were distinguished clinically, and wanted a year or so to do an MD, or whatever it was. Yes, I probably wouldn’t have gone on in research, if I hadn’t gone to the MRC unit.

AN: At that time it was a very important training progression for epidemiologists, but probably also public health physicians. I know that David Bainton, for example, went there and then went on to work in public health. Ian Baker was the same, as was Jane Lazell.

EW: Peter Elwood stayed on at Cardiff. Bill Miall has stayed with the MRC, or in Jamaica, most of the time. Ian Higgins went to a university post in the United States. Michael Burr stayed for many years and is now a senior lecturer in Cardiff. I suppose, yes, they went both ways. Some stayed there, some went on to university posts, some went into public health. Of course, as a recruitment to public health it was only a couple of people for what, a thousand jobs, whereas on the academic side it was probably more important, because there are only some 30 medical schools and they each have two or so epidemiologists, so it was probably proportionally a more important training ground for academics, I should think.

AN: The Wellcome fellowship programme in epidemiology was fairly recent, wasn’t it?
EW: We had one in Southampton and that was in the mid-1980s, I think.

AN: Yes, that seems to have been a career track for many of the current generation of academic epidemiologists.

EW: That's right, the Wellcome fellowship was quite substantial at the time, wasn't it? Three years?

AN: Yes, three years. Did you have much to do with the Faculty of Public Health? We talked a little bit, before we started talking about the Faculty and how it had an affect on training and so on. Did you have much to do with them when you were at Southampton?

EW: I was the Wessex region representative in the Faculty for quite a number of years. I was also on their scientific meetings committee for four years at the beginning, but I don't think I did very much on that. Later I was on their examinations committee for a number of years, 1977 to 1980, doing some of the marking and whatnot. I was on the education committee in the early 1980s and also Faculty Visitor for three regions. I was an examiner for many Part II submissions for the MFCM (Member of the Faculty of Community Medicine). But no, I didn't have a lot to do with the Faculty, even when Archie Cochrane was the first president. We also had Tom Galloway, who was the Hampshire area medical officer. He was very active in the Faculty and vice-president for a number of years. I used to go to some of the Faculty meetings. I didn't think they were particularly good, despite having been on the meetings committee. I can certainly remember on one occasion, going to a Faculty meeting, and thinking it was all very dry and full of waffle and anyhow not epidemiology. Then the following day, I heard our fourth-year medical students. As well as writing their report, they have a full day conference, and they each have to talk for 20 minutes or so on their project. This was the day after the Faculty meeting and I was amazed how much sharper, more critical, the students were in their presentations, than the Faculty speakers had been the day before. That was one of the real joys, how the students put on this meeting. Generally they came to the conclusion that their numbers were not perhaps good enough and so on, but they really seemed to have very sharp minds as to what the possibilities were, and often found the unexpected: they expected this, but they found that. And they discussed the possible reasons.

AN: And during your career you didn’t do a higher degree or exams such as Membership of the Faculty. Am I right?

EW: No, I didn’t, all I got is a diploma in industrial health, for my one year in Dundee. I applied for and was granted honorary membership of the Faculty, because I was in at the beginning. There were certain criteria, you had to be in the discipline for three more years, you had to be off the bottom rung, so when I became senior lecturer in Southampton, that entitled me to honorary membership, so I did it without doing the exam. I nearly submitted an MD on a number of occasions, but never actually got around to it. It would have been on migraine and I am sure that I had enough to do it, I just never really got round to it, and I rather felt that I had done so much research and published so much, that doing an MD for me wasn’t that much of a challenge. I think if I had done the Membership of the Royal College of Physicians, not being a born physician, that would have been an accolade, and I think if clinicians get an MD, that’s an accolade, but I didn’t feel that my going for it would have helped. And this was just about the time that I moved to Southampton, so I got my consultant post without it, so in many ways I felt I needn’t do it. And then I also became conscious in the 1970s that if you had an academic background, you sometimes had a very rough ride with higher degrees or even the Part II of the faculty.

AN: Don’t I know it.

EW: And I know a few people, a few professors, who have struggled. Now they are not only professors, they are very good, and I think somehow they are judged in a quite different way, so I wasn’t sure I wanted to put up my MD at that stage in the 1970s, when I didn’t need it. So I have never done a higher degree. I have supervised PhDs. MDs don’t have to be supervised, not in Southampton anyway, but I have helped with MDs and I have been an examiner for PhDs and MDs, completely unbiased, because I haven’t done
it myself. I probably should have done one. My father was always encouraging me, I should have done it early. But I didn’t feel the need for doing it when I was in the MRC and then having got a consultant post, I knew I didn’t need it. I remember one of my senior lecturers that I had, a very nice chap, who came from the health service and returned to the health service after about six years. I think he really felt that he wasn’t really an academic and because of that he did an MD while he was a senior lecturer and got it, and then he did a PhD while he was a senior lecturer, and got it, but he spent a lot of his time chasing those two higher degrees. He is very well qualified now, but perhaps he hasn’t actually published all that much. I feel they are very mixed things, these higher degrees, they have got some good points, but sometimes they actually stop good research, because you have got to carry on doing what you said you were going to do, to complete it, even when something comes up that you really wish you’d done something a little bit differently.

AN: That’s all been very interesting. I am happy to finish there, unless you think there is anything else. Thank you very much.

[END OF TRANSCRIPT]

Further related resources: