

The Royal College of Physicians and Oxford Brookes University  
Medical Science Video Archive MSVA 105

**Dame Margaret Turner-Warwick in interview with Sir Christopher Booth  
Oxford, 10 February 1994**

**Part One**

CB Dame Margaret Turner-Warwick, it's a very great pleasure to have the opportunity of talking with you here this morning, and we're very grateful to you for coming along. Of course, I suppose for many people you will be remembered in history as the first woman to be elected president of the Royal College of Physicians of London since 1518, which is a very real achievement for which we all respect you highly. What I think we might do is perhaps go through your career and see really how and why that happened. Could we, do you think, begin with your family background and what your background was?

MTW My mother and father, I think you would call intellectuals but they weren't especially clever. My father was a lawyer and he read history and law at Oxford like his father before him. And he was a very kind man, a little bit remote and very disciplined, but he taught us a lot of very careful, important principles in life. And I don't think we actually appreciated his kindness and humanity as much as we should at the time, as a matter of fact. But he loved, for example, to play his little harmonium last thing at night. He couldn't go to bed unless he'd had a tune. And we used to lie in bed listening to this gorgeous music, not played frightfully well, but it was his own and therefore ours. So that was the sort of man he was. My mother was probably cleverer and she was brought up as a Presbyterian. She was a great niece of the Chief Scout, [Robert] Baden-Powell. She lost her father.

CB She was a niece of...?

MTW Baden-Powell.

CB Baden-Powell, so you have a Baden-Powell background.

MTW She was B-P and with that streak of originality and unconventionalness of all of them. She lost her father when she was three and she lost her mother when she was sixteen, so she was really an orphan brought by, up as a ward of, partly a ward of the Chief Scout. And she had to plough her own way very much. She was brought up a Presbyterian but later became Church of England when she married because she wanted unity in the family, and then later was a converted Quaker because that's where her philosophy and her mysticism really lay. So again she was an intellectual person but with a mystic...

CB She had a rather non-conformist background.

MTW Yes, and very much the principles. I mean I didn't bet and I haven't bet since, I may tell you. So there was lots of space for us. My father said that there were no

dowries in our family but there was any amount of education. And there were four of us, four girls. Their principle was, and they always had little rationalisations: two replacements and two spares, and I was the first spare.

CB Now, was this in the country or in the town?

MTW And we oscillated between living in the Temple, which was a marvellous place, because of his legal practice. And when I was about four it is alleged that I pleaded with them that I didn't really like town and could we have a little place in the country. And as my father had great leanings to the country and my mother was a very good gardener, we oscillated between either commuting to London or living in London. And then he was on the western circuit so he suddenly said, 'Well, why do I keep on going away on the western circuit following the quarter sessions around? Why don't we move to Exeter,' - he was from a West Country family - 'and the judges will come to me.'

CB So that is the origins of your link with the West Country.

MTW And that is why we moved down to Exeter and I was at school there for a while.

CB How very interesting. And where were you at school?

MTW City of London when we were in London and I really first started, and then moved down to the Maynard School at Exeter, and then he had to go back to London because he was looking after some of the Bar when the younger lawyers, of course were away, and we came back and so my sixth form time was at St. Paul's.

CB Right. Now what was it then that decided you for medicine because you must have made that decision at St. Paul's at a time, when few women went into medicine?

MTW It's a real story because my father said any education. And my oldest sister, who I respected and loved very much, did botany, read botany, and went to Exeter and London University and became a plant pathologist of some note. And my second sister was a linguist, read French and German at St. Anne's at Oxford. And he turned to me when she'd just got settled, and I suppose I was about ten at the time, and said, 'Maggie, now, what are you going to do?' And I thought well science is covered, languages is covered, we've run out of options, and I said 'Medicine' quickly, because I was determined to keep up with them. And of course, I think through a little bit of obstinacy, but also once you've made up your mind, the more I thought of this wonderful subject, the more I thought how absolutely splendid. And I took an interest in our local GP, and we had quite a lot of sickness one way and another in the family, as children do. And so once I got my sights on what doctors did, it seemed to me an extraordinarily marvellous mix of the humanity and science, and so I didn't change.

CB And so you went up to Oxford about 1942, or '43 was it? Certainly during the war.

MTW '43, yes.

CB And you went to Lady Margaret Hall. What was Oxford like in those days?

MTW Well, Oxford for medical students... Oxford for women to begin with – of course, it was one thing getting a place at Oxford. And there's a little story there that I think has a moral to it, because I was at St. Paul's, as I said, and at St. Paul's you didn't take your Oxford scholarships until the year after you'd taken your higher certificate; that's the way they got their good academic records, and very good they were too. There was the war on, my father wanted me to get ahead quickly and insisted that I took it beforehand and I wasn't ready, and really I shouldn't have got a place. And it was in the days when you had that paper: part one was for the scholars and part two was for the people who wanted just a place. I was told 'Do what you can, if your father really insists you go in for this exam.' I looked at this paper - and this is really absolutely true and genuine – and there wasn't a single question I could answer on the pass bit. And I looked at the top bit and thought the only thing do is to go for the questions that I can answer, and went for that, not because I was a scholarship one, but for practical reasons. And unfortunately, I must have taken in somebody because they gave me the scholarship. I felt very sorry for the school because it was quite, quite unfair. But they were very gracious.

CB Very good for you.

MTW So that is the story there, I take no credit for it. LMH was a very nice college.

CB It was entirely women at that stage?

MTW It was entirely women at that stage. But of course getting into Oxford was one thing and getting on to the medical quota of course was something else. And I think there were seven women out of the entry of a hundred. So we got used to working in a robust but strict minority right at the early stages, and that stood me in very good stead ever since.

CB Now, who were the people as teachers you remember, because you did your pre-clinical work in Oxford?

MTW Yes, that's right. Well, the professor of anatomy was Professor [Wilfrid] Le Gros Clark, a very interesting man, and there's another story about him, I'll tell you in a moment. Then there were people like Alice Carleton – the great anatomy - she was a dermatologist but a great anatomy teacher. And there was Graham Weddell, who did a lot of very interesting neurophysiology work, but also because it was the war they had all sorts of practical research and I remember his job was to adapt seats in tanks, that would make them more comfortable and better organised... So many of the people who were teaching us were researching not only their own intellectual things, but actually very practical things for the war.

CB What about Noel Browne?

MTW No, I don't think...

CB Because he was then chairman of the Royal Navy Personnel Committee.

MTW That didn't really cross our...

CB He was the professor of physiology, of course.

MTW Well, I think it was [Edward] Liddell.

CB That was how it came.

MTW But then there were people like Sinclair, of course, who was working out the nutrition of the country. And then the people working on BAL, the British anti-lewisite<sup>1</sup>.

CB And Sinclair was one of the great eccentrics of all time.

MTW Of course. But the nice thing about Oxford then, one was very aware that here they were - it wasn't remote ivory towers, and you were lucky to be there and you weren't doing your war effort. You were actually part of the joint, and these great people were adapting, doing really important things for the war effort at the same time as keeping the training of medical students going.

CB That's an important point. What about Howard Florey, did you meet him?

MTW Yes, of course. He was of course in the William Dunn Pathology School, and of course because pathology came in later, not the pre-clinical, we met him a little bit but not as much as the mainstream anatomists and physiologists.

CB Were you aware, as a medical student during that time, of this dramatic development of penicillin going on in the Dunn Institute?

MTW Not really. I mean you just heard about it as another thing that they were doing down there. But I don't think the impact, right at the beginning, was quite perceived, or perhaps we were just a little bit remote from it doing our anatomy and physiology.

CB Well, you must have finished in Oxford at the end of the war, about '46 and then you came down to London.

MTW In those days there was an accelerated course for medical students - a two year course - but they did... and again this shows great wisdom under those very hard times, they allowed out of this entry of a hundred, ten or twelve people to stay back for their honours third physiology year because they felt there should be an opportunity for maintaining perhaps the more academic... not quorum, just a tenth of them. This of course was highly competitive. It was much more important than really getting through your exam to get on to the quota for that. My husband Richard did the year before, and I was determined that if he could get on to that quota, I would the following year. Of course, long before we were married.

---

<sup>1</sup> British Anti-Lewisite (BAL). 2,3 dimercaptopropanol discovered as an antidote to the chemical war gas lewisite by British biochemist Sir Rudolph Albert Peters (1889-1982) and co-workers during World War II.

CB You must have met him in Oxford.

MTW The story was very straightforward.

CB Your husband, if I can just get clear, he was a rowing blue.

MTW He was a rowing blue, later. He rowed for three years actually, and was president of course in '46. I first noted him when... we only had two lectures a week, one from Professor Le Gros Clark who scanned the breadth of medicine in a marvellous way, and Alice Carleton who created these drawings of anatomical things. And Professor Le Gros Clark was talking about the aqueous humour and Richard actually had done a study of this, a holiday task for the Walshe anatomy prize. And Le Gros Clark, in his view, had got his facts wrong and this medical student challenged the great professor, very nicely but absolutely uncompromising as is Richard's wont. And the fact that it just never occurred to him that you couldn't put somebody straight in a nice way. And Le Gros was splendid; he said, 'Well, Richard, if that's a what you say, I don't think your right, but we'll both go away and look it up.' And he came back the next week and he said, 'I want the class to know that Richard was absolutely right.'

CB Well, of course, Richard has become a very distinguished surgical urologist, but we're here to talk about his wife, so let's get back.

MTW Well, he was a big part of it. But the next point was, and it does come back to it, was that he stopped me on his bicycle a few weeks later and said, 'Congratulations for being top of the histology terms exam, you ought to go in for the Walshe Prize in anatomy, and I will tell you how you have to go about this and you'd better come to tea.' So that's the end of that little bit of the story of Richard. But I did go in for the anatomy prize and that was interesting because this particular year, it was '45, it was skins - '44, I beg your pardon. It was anything... anatomy of the skin, that's not a very promising thing to do. But I took the histology and I got a lot of very interesting skin special stains, it was histological really, and did all the drawings myself, the paintings myself.

CB Well, you're an accomplished painter but we'll come to that later. Can I just ask, at that time how many girls were there?

MTW I think there were seven out of the hundred, something like that.

CB Seven out of a hundred, so you were a pretty minority group. Right.

MTW Very useful training because you just got used to ignoring it, and that stands you in good stead.

CB Well, you finished and took your degree in physiology etc, and came down to London and you went to University College Hospital, is that right?

MTW There's another little interlude there, but I think it's fair to record. In my last term at Oxford just before that big finals exam, I suddenly developed a rather large

lymph node just above the clavicle, here, about out an inch across. In those days it was called a Virchow's gland, as you know, and Virchow's gland only meant one thing and that was that you had stomach cancer, and if you were very young and that was funny, you probably had Hodgkin's [lymphoma]. And so I really had to be removed from Oxford in my final term while this thing was sorted out. And they didn't sort it out and the exam was three weeks away. And they were very good they gave me three choices: I could either have an egratate - that is they will pass because my record was such, they will give you a degree, but you won't get a class; or I could go away and come back and do the year again and I'd be on the next years quota; or I could just go back to Oxford, carry on, try and do the exam as best I could and get on with it. And because the prognosis was very doubtful at that time, it seemed much the best thing was just to come back.

CB What was the histology?

MTW It was tubercle.

CB And that could be treated then?

MTW Well, it couldn't be, no, and that was another story because then that took a year out.

CB Because streptomycin came in, when?

MTW '47.

CB '47. So this was before streptomycin?

MTW Before '47. And I had an artificial pneumothorax for five years and was in Switzerland.

CB Quite a dangerous thing to have then.

MTW And it was still by no means safe, it was a bit safer than the other two. But I learnt a great deal in that year when I was in bed most of the time.

CB As a patient?

MTW As a patient. And the anxieties and the uncertainties of death, I suppose, really... but how various things become extremely important to you and how your fears and fancies when life is perilous... And, you know, I really do believe that there is always a silver lining.

CB Yes indeed. That must have been a shattering experience at that time. Anyway, having got over that, and you got your degree and you came to University College in London [UCH] and you did your clinical training there.

MTW And that also was by design. In '48 suddenly all the London hospitals were open to women, and it was very interesting to see how this rather bright branch of my colleagues at Oxford were choosing where they would like to go. Some went to Barts

[St Bartholomew's Hospital] and were wonderfully looked after. They were cherished as little goddesses; they were tremendous. Others went to other hospitals, which I think should be nameless, and had a really rough time because they were resented, they were bullied, they were teased - most unpleasant. I thought that I didn't want either of those. I didn't know that was going to happen but I sensed it might, and being somebody who perhaps isn't very adventurous, I thought let's try and go to one of the ones that has a good academic background but nevertheless is used to women so that we can have fair play: if we're good, we'll be taken on face value, if we're not, we won't say people are against us. And University College Hospital was clearly the hospital with that tradition, so that's why I chose it, and fortunately I was taken.

CB And, of course, they had already been taking women for some time.

MTW Precisely. Since the First [World War].

CB Which was unlike all the other schools except the Royal Free [Hospital].

MTW And King's [College Hospital].

CB And King's too, was it? Now, what was University College like?

MTW At that time it was tremendous, particularly in medicine. There were wonderful people like [Edward Eric] Eric Pochin who did a lot of work in nuclear medicine, and a great scientist with the MRC. My first firm was with Eric Pochin - there were only three of us - and he just treated us as equals. He said, 'Well, you've just been to Oxford, you've got a lot of scientific information that I've forgotten and don't know, so let you teach me me as much as I will teach you.'

CB Now, he was the successor to Sir Thomas Lewis as head of the Medical Research Council unit there.

MTW Absolutely.

CB You were working at the research level right from the start then

MTW Well, these people, they were very keen on teaching us good clinical medicine, but one had that enormous respect for their academic dimension as well. And of course this was perfect when you come from the Oxford tradition with no lectures, bar these two that I mentioned. It was all trying to get your information from source and so it suited my style marvellously, and it was a continuum and it was most exciting.

CB Now the professor of medicine at that time must have been Sir Harold Himsworth, as he later became. Any comments on him?

MTW I saw him doing a liver biopsy in his inimitable way. And of course that professor of medicine was doing it himself because it was something which of course, was a very new technique in those days, and he'd had a lot to do with its development and he preferred to make his patient as safe as possible by doing it himself. He was a great teacher and then of course Max Rosenheim followed him.

CB But Harry Himsworth had a reputation for being a very stimulating teacher.

MTW Wonderful teacher, wonderful teacher. And of course they had the Saturday morning circus where everybody came, the students... it was the grand round, way back in the 1940s, and no holds barred for anybody trying to learn from everyone else, irrespective of whether it was a medical student or the professor and all stops between.

CB And Max Rosenheim was the assistant on the medical unit, one of your predecessors as president of the Royal College of Physicians.

MTW Wonderful president too.

CB Absolutely, yes. So they were your medical teachers. Do you remember any of the other teachers, surgeons or pathologists and others?

MTW Yes, of course, there were some very great people. There was John Stokes - wonderful physician and a tremendous bedside teacher. Then there was John Hawksley' who again had a tremendous breadth. And I think it was that cluster of people who were very, very good wise clinicians with the art of medicine and observation and that tradition, balanced by the academics who were also very good clinicians but also seeking pathogenesis in the more academic things, that made the medical tradition at UCH at that time so especially stimulating, but also very exciting because you didn't just get carried away in the ivory tower.

CB Now you must have finished your clinical career in about '49 or '50 was it?

MTW I qualified in 1950.

CB 1950. And then came back to Oxford?

MTW No, I did my training at UCH and then I did some house jobs and then I did some paediatrics - never let it be forgotten I did paediatrics. And that was interesting because I as a lady, and I remember very well at the time, felt uncomfortable with paediatrics because I just hated to hear those children crying and lonely and frightened. And I found... I am always intrigued by so many of our wonderful lady paediatricians. But there was that emotional... - it was before I had my family - that I found too distressing really, and I thought I would go to people who I could talk to and explain.

BC So what else did you do?

MTW So then I came back to UCH.

CB A series of jobs in London then.

MTW That's right. And of course I had to keep in London, you had to adapt your training because I married in 1950, and therefore of course I couldn't just travel



round, it had to be within the context of Richard's training as a surgeon. But it worked out fairly well, and then I was CMO at UCH.

CB CMO?

MTW Casualty medical officer. Now that was an important job because it was really like general practice.

CB Yes it would be.

MTW And there was a wonderful general practitioner just around the corner who used to write little notes, and it was the most charming letter, he used to say 'Please see for safety's sake.'

CB That's lovely.

MTW But it did actually give you in a career that became rather academic afterwards, it gave you that real solid... people coming in unconscious; the acute end of practical medicine, with trivia, frightened... psychology, all sorts, the mish-mash of general practice but in a hospital environment.

CB Now, obviously you soon decided on a career in hospital medicine and you came back to Oxford.

MTW No, I didn't come back to Oxford. I didn't do any of my career at Oxford afterwards I only did my undergraduate.

CB Well, how did you meet Alec Cooke then?

MTW Well, because Alec in those early days - with no lectures as a pre-clinical student - he on a Wednesday afternoon, I think, or was it a Tuesday afternoon... I think he corrected me and I think he said it was a Tuesday afternoon at two o'clock, he would come in with a patient and show us that the physiology or the anatomy of that clinical problem was why we were studying anatomy and physiology. So it was integrated teaching in, quite a long time ago.

CB At a very early stage of that development.

MTW First term, first year at Oxford as a pre-clinical student, it was integrated at Oxford and long may Alec get the credit for running, perhaps, although I hate the word, the first integrated medical course in a minor form.

CB I see, I hadn't completely realised that. So that your career after you graduated was entirely in London?

MTW Absolutely.

CB Now what took you then into thoracic medicine, which became your speciality?

MTW That was quite a long time later actually, because I still enjoyed the breadth of medicine. During my registrar training I did cardiology. I did some geriatrics too, so that was interesting. And I think that a lot of the people who were wanting to go into hospital medicine did the tour. They went to one of the postgraduate schools; it could have been Queen Square - neurology - or the Heart Hospital, or the Brompton or the Hammersmith, of course. And there was that circuit, that people who were wanting to go on in academic medicine tended to go on. And I went to the Brompton. I may tell you that I took three goes in getting a house job at the Brompton. I failed twice, so it's not all swimming, but I stuck to it and got there. And then I became very interested in the opportunities for chest medicine, but of course it was just undergoing this fabulous revolution because of treatment of tuberculosis.

CB Yes, which had come in '47, and the clinical trial of streptomycin...

MTW Well, a very interesting series... In '47 it was flown over from the States for one or two people. And when I was in Switzerland, I remember one of the first people who had been treated with streptomycin. I was also involved in the first MRC trial, I think, in 1952, when isoniazid was introduced in combination with streptomycin, combination therapy, for one whole month. And we were fascinated by the patients; their temperatures came down, their sedimentation rates improved, they felt marvellously better. And at the end of the month of course they stopped - a month's treatment was a long time at that time - and they all relapsed. And the people who were running this trial said, 'You know, that's nearly the right drug, but it's never going to take on because of course they relapse when you stop it.'

CB Now, who was running it? Was it the MRC from Mill Hill? [Philip] D'Arcy Hart? D'Arcy Hart and Tony Bradford Hill, I presume.

MTW Yes. We were an outpost, actually, because I was just doing a locum during my first pregnancy and I was doing a locum at Edgware, and the Edgware chest clinic was participating in it. And I remember so well how, at the coal face, that trial might so easily have given quite the wrong message unless somebody said, 'Why stop?' And of course again, I'm not sure that everybody would agree with this, but in my experience one of the people who said so strongly, 'Why stop?' was [John] Clifford Hoyle.

CB From Brompton and King's was it?

MTW Brompton and King's. And he indeed wrote a paper with Howard Nicholson and John Batten and myself - John and I were the sort of stooges on this paper - which was his experience of treating people with combination PAS [para-aminosalicylic acid], isoniazid and streptomycin, for a whole eighteen months. It was heavily criticised because it was uncontrolled, but that was the way that he established writing up his experience, and of course I think that was certainly one of the very early thinkings behind you needing eighteen months to two years treatment.

CB So this was really how you got into thoracic medicine and through going to the Brompton.

MTW There was a lot of research going on.

CB And after 1957 you never left it.

MTW Well, yes I did, because then the question is what do you do when you're a lady and you are fully trained and you're certainly not going to get an undergraduate teaching hospital post, and you're certainly not going to get...

CB You mean that was your view at that time, that as a lady you'd never have any chance.

MTW I was told.

CB Really?

MTW Oh absolutely. That wasn't in any sense... nobody was being nasty to me, it was a fact of life. So they said the best chance would be to go for a post at the Elizabeth Garrett Anderson Hospital as a general physician because it was associated with the Royal Free, it was close to UCH, and we had medical students so you could teach and do your thing.

CB A sympathetic view to women.

MTW And it was jobs for the ladies because they only had ladies, except one anaesthetist - how he crept in I don't know. But it was quite clear, their view was that, of course, it was for women patients and children, but that this was an opportunity for consultant posts for women and they were unrepentant about it. I did a little survey while I was there to find out how many of the women patients really went there because it was women clinicians or what were their motivations. And that was quite interesting because the women in the surgical and the medical wards - many of them didn't realise it was an all women's hospital anyway and they didn't really mind who looked after them provided they got better - but the people who really had gone there specially, were people with dermatological complaints, skin complaints and people with psychiatric problems. And those were the two key people that the women at that stage were doing a very special job [for], more so actually, interestingly enough, than gynaecology although that came a third.

CB So your first senior post was at Elizabeth Garrett Anderson.

MTW Absolutely.

CB But you were still working at Brompton at that time?

MTW No. I'd finished that. I'd finished my senior registrar.

CB When did you go back to Brompton?

MTW And then I realised that I really did want to specialise. I was satisfied with the breadth of medicine, because with the Royal Free specialists there and UCH... There were my senior colleagues that knew much more about most of the things I was looking after than I did and that I didn't find satisfactory, and I kept on transferring

the patients there, not because of lack of confidence but I just thought tertiary referral, really, that they would do better. And then of course that wasn't really a very satisfactory environment and so I had the opportunity of going back to the Brompton.

CB Were you invited back then?

MTW Well, I must say it was rather a prejudiced advertisement that they put up. It had to be a part-time senior lecturer, suitable for somebody with a broad breadth of general medicine, but with an interest of thoracic medicine.

CB Well, they obviously had their eye on you.

MTW And that was of course Professor Scadding; Guy Scadding was professor at the time.

CB And Guy Scadding was professor, and did you go and work with him then?

MTW I was the senior lecturer.

CB With Guy Scadding?

MTW Yes.

CB Now what was it that took you into respiratory medicine? Because I remember that period very well, and it was a period when most of respiratory medicine was physiology, and you had people like [E J] Moran Campbell, Keith Westgate, John West - a whole generation of people. And yet you didn't move into that type of work, you moved into a totally different thing. What was it that happened?

MTW Well, I think it was a very exciting time. All the really clever people were physiologists, and they were very clever, they were very good, all the people you have mentioned. But the trouble is that I didn't understand physics for one thing and that aspect of pure science didn't really attract...

CB Mathematical analysis.

MTW Absolutely. They were also largely talking about the normal lung and I was much more interested... and the reason for that was, I asked [J H] Comroe, 'Why all this physiology of normal lung.'

CB Comroe was the distinguished American physiologist.

MTW That's right, yes at California. And he said, 'Because the diseased lung is too complicated.' So that seemed fairly unsatisfactory, but I think because the academic - if you weren't a physiologist you were nobody in respiratory medicine - it actually held back the development of modern pulmonary medicine a long way.

CB I entirely agree.

MTW So it wasn't their fault but it was the historical fact. Just at that time, the late sixties, early seventies, was the new era of immunology with new techniques of immunofluorescence and measurement of all sorts of antibodies that hadn't been identified before - purification of antigens so that you could have a handle on the laboratory techniques; complement system. It was suddenly was exploding.

CB Margaret, you've moved on just a bit because you went back to the Brompton I think in '57, you became a member of the staff at the Brompton Hospital in '67.

MTW That's right.

CB And you're now talking about the immediate period after that. Can you just say something about that period between '57 and '67, because you must have been the first lady consultant at Brompton.

MTW No, Margaret Macpherson was the first lady, and she did the children's tuberculosis clinic.

CB But you were a rare bird, let's face it.

MTW And there was an anaesthetist consultant. I think, I perhaps was the first thoracic physician apart from Margaret doing her special thing.

CB Yes. And now after '67 and, as you say, this enormous expansion, what took you into that?

MTW Because nobody was doing anything in the lung. I remember going over to the Scripps clinic and the very early days of when I was just exploring in a very simple way some of the immunofluorescent work we'd been doing on the lung, because Deborah Doniach of immunology fame had very kindly trained me a bit while I was a senior lecturer.

CB Now Deborah Doniach was an immunologist interested in autoimmunity.

MTW Precisely. And I trained with her because of a clinical starter. Here she'd been working on chronic active hepatitis and she was at the days where you had organ specific autoantibodies, like the thyroid or the parietal cells in the stomach, and the non-organ specific like antinuclear antibody and rheumatoid factor. And she had this condition of chronic active hepatitis, which is a progressive - as you know so well - a progressive fibrosing disease confined to a single organ...

CB The liver.

MTW And yet the characteristics, the immunological characteristics, were of non-organ specific autoantibodies, rheumatoid factor and antinuclear factor, that is antibodies to the nuclei of cells. And in a rather naive, lateral thinking way, I said fibrosing alveolitis - which is a thing that has been very close to my heart for most of my research life - is a progressive fibrosing condition of the lungs; nothing to do with tuberculosis, nothing to do with any known infection, that runs quite a progressive

lethal course - half of them are dead within five years, nasty condition. And looking at the histology, it had all the analogies of chronic active hepatitis.

CB So you saw a link between these two.

MTW And I also knew that some patients with rheumatoid arthritis would have this condition in the lung. Systemic sclerosis, another autoimmune condition, had this condition in the lung rarely, and systemic lupus. So I went to Deborah and said, 'You've got your - and isn't it interesting - a single organ fibrosing, characterised by non-organ specific autoantibodies; what about fibrosing alveolitis?' So that's why we wrote that first paper together in 1965, I think. And then we said, 'Furthermore, if this is true we should be able to go out and find patients that have both chronic active hepatitis and cryptogenic fibrosing alveolitis.' And we both went out and searched; we found eight cases, and that was the presentation I made to the Association of Physicians sometime later.

CB I remember it. Well, that must have been a very exciting period and that took you into really the immunology of the lung and autoimmunity and the lung, and really your career at a scientific level has, very rightly, concentrated on that. Is that fair? You've published a lot of other papers, I know.

MTW That was the thing that excited me, personally at the time.

CB And made your reputation as a scientist.

MTW But I think the point that struck me then was the balance of clinical science. There were the laboratory people on the one hand, marvellous immunologists or other scientists, who were meticulous about the pH, the temperature control, every conceivable minutia to get their laboratory results exactly right. They would then say, 'How can we use this for medicine?' And they would say, 'Give me fifty patients with chronic active hepatitis, or give me fifty patients with sarcoidosis.' And they were as naive about the heterogeneity of a clinical group of patients with different stages, different types, on the clinical side, as many clinicians were naive about the minutiae that were necessary to give laboratory results. And so it was really the inexperience, the naivety of the misconception of the two polarised groups that made me want to try and work somewhere in the middle - a real laboratory where we could have teams of PhD people. Later on, of course, it was the people working with me who were doing all the work. But nevertheless it was being meticulous about the clinical sub-groups, and particularly, what are those laboratory factors that will be prognosticating factors, prognosticating for better treatment or better survival and so on. So it was always actually dominated by the clinical questions.

CB But during that period when you were developing your scientific career, Brompton really was associated more with part-time clinicians with private practices and links with other London hospitals, whereas you were, apart from your appointment at the Elizabeth Garrett Anderson, working virtually whole-time.

MTW Absolutely. And then of course later I quite quickly... they put me on the staff - both the London Chest and the Brompton - and that was interesting, as well as having my research links with Guy [Scadding].

CB And fairly soon you became professor of medicine.

MTW In 1972.

CB Now, who did you succeed? Was it Guy Scadding?

MTW I succeeded Guy.

CB It was Guy Scadding you succeeded.

MTW And Guy did so much at the Brompton to say that on the institute side, that is the postgraduate medical school side, we really had got a wonderful opportunity of research and development.

CB Yes, and he of course worked at Hammersmith as well, so there was a close link.

MTW Exactly.

CB And you became professor in '72. What do you see as your achievements as professor then?

MTW Then, I think it changed a bit, but it does come back to where respiratory was going.

CB Can I just say, you were entitled professor of medicine?

MTW Medicine.

CB Not respiratory medicine?

MW You're absolutely right. I was very proud of that and Guy Scadding was before me. And the reason for that is that I think both of us saw opportunities of research and thinking in the lung against the background of the breadth of medicine. We both had that training, not least the Elizabeth Garrett Anderson Hospital, but the whole other training, and I think that that again enabled us to have a much broader comprehension of opportunities in respiratory medicine than if we'd just been an immunologist, or a physiologist or whatever.

CB But when you were professor you must have had certain dreams and aims; what were they?

MTW Well, again it's part of the over all theme, and you may not agree with this. I think a lot of people wouldn't, because there's a great idea now that you'll only get anywhere in research if you're very focused, and you only get your money if you're very focused, and that of course is absolutely right. But if you look at the longer term in a subject, I think there are stages where, because of techniques or because of ideas in life, you have to open up and do almost like a radar screen, to say there are a lot of

other things out here, should we not put some investment in several areas and then see which of those ones we should really pull down and comb.

CB So what did you do particularly?

MTW So what I did was to try and broaden, based on Guy's work, but developed... Actually, I think there were five department, small departments with different scientific aspects. We developed pulmonary pharmacology. Physiology was already there. There was my own little interest in autoimmunity and then sort of molecular biology as a special one. Professor Peter Cole developed his interest in protective immunity and host defence; the relationships between microbiology and pulmonary disease. And one that I felt very strongly about, we must have more biochemistry and got a collagen biochemist in that set up in that unit. Three out of those five teams were headed by PhD people and I was proud of that. Well, I am not proud...

CB Well, you should be. I think you should be.

MTW ...but I was delighted with that because there we had really good quality committed scientists; we could hopefully be really clinicians and that was why our whole emphasis of the work, what is clinically useful out of the laboratory in specific ways, but we did have the breadth.

CB Now you were the first lady professor at Brompton?

MTW I think that's right.

CB And then you became the first lady dean.

MTW No, I wasn't. Lynne Reid was the first.

CB Lynne Reid was. She was an immunologist too, wasn't she?

MTW No. She was a brilliant pathologist and anatomist and did a lot of work on the lung development.

CB Now did you succeed her as dean?

MTW No. I think I succeeded Eddie [Edwin] Keal, who was a clinician.

CB I remember him very well.

MTW And then there was Phillip Zorab before and Joe Smart. So they had a number of deans.

CB But you were involved as dean in the seventies with some very major developments.

MTW No I was dean in 1984 to 1987.



CB In the 1980s right, but you were involved in some major developments at the Brompton.

MTW Yes, that was a fun time.

CB Tell us about that.

MTW Well, partly because by that time a lot of other parts of the Institute had built up as well as just the department of medicine, of course. And so research was then well on the map and we were going well with MRC programme grants and everybody was well away. We were also bringing the Institute of Cardiology into the merger.

CB Who were based at that time in..?

MTW Westmoreland Street.

CB In Westmoreland Street, which is up in the Harley Street area.

MTW That's right.

CB So you brought them down, didn't you?

MTW We knew the plan, the long term plan was for the hospital to move down and we created in the early eighties the Cardiothoracic Institute, which was the merger of the institutes.

CB Which really made a new institute with a new name.

MTW Exactly.

CB With a wider remit.

MTW And we were working increasingly closely together, and as a dean, of course, a few years later it was my job, I felt at that time, to build up as many senior academic appointments in cardiology, of course, as well as respiratory and paediatrics, as we could. And I think it was in my deanship - I hope I've got my facts right - that Professor Paul Wilson was made a dean.

CB Now he became professor of cardiology?

MTW He's now professor of cardiology. Professor Bob Anderson I think had been made a professor just before I started, but very much in that same era.

CB But clearly you expanded Brompton's interests during that time and you were involved very much in building a new hospital.

MTW Two things. Well the hospital had been on the stocks for a long time because our old hospital went back to 1842 and was, you know, a little bit on the old fashioned side.

CB That's a fair comment.

MTW But a great spirit. So I was on the planning team as one of the youngest consultants, the youngest consultant, in 1967 when it started.

CB As far back as that.

MTW Yes, and the idea was that at least I and my colleagues would be the ones working in it. In fact, it opened three months after I had retired. But of course that is par for the course in planning. But the institute didn't take so long because we were bursting our seams in the institute and it was causing great frustration and loss of moral, where good people just cannot get on with their work. And we had this building that was actually a little convent sitting just next door to where the new hospital was going to be, and so we said, 'Lets not wait for the new hospital, lets convert that.'

CB And it's been a great success.

MTW I hope so. It certainly was tremendous fun. Of course, it was all funded from an appeal and the conversion... we actually got much more space by converting a building in London than if we'd pulled it down.

CB Now one of the things that Guy Scadding draws attention to in his account of Brompton, which he's lodged at the Royal College of Physicians library, is the old statue that used to be in the Brompton Hospital - is it of the Good Samaritan, I forget - and it moved over to the new hospital, in the foyer as you go in. Do you remember that?

MTW Yes, I do indeed. Of course, I'm not a great historian. I do know... I suppose I love people so much and so it's the human stories I remember. You do know why the Brompton was built in the first place?

CB Do tell us.

MTW Because Sir Phillip Rose was a solicitor and his clerk got tuberculosis and Sir Phillip Rose was so despairing of the conditions under which this poor clerk was looked after in a workhouse hospital that he said, 'We'll build our own.' And in two years, two years or maybe three, he had collected the money from his chums - legal chums, - he had designed, he had built the beginning of the Brompton.

CB That's a fascinating story. Coming back to the more modern era, you were dean there in the eighties, and if one could just ask your views about the place of a place like the Brompton within the University [London], because it's a unique feature of London that there are a whole lot of specialist hospitals like Brompton, National Heart, Queen Square for nervous diseases, and St John's for the skin. And Francis Fraser - if I get my history right - and he - I knew him very well, of course - founded the Postgraduate Medical Federation, which was a federation of all these institutes and special hospitals. And you were part of that, and then, either when you were dean or soon after, you became chairman of their academic council.

MTW Central academic council.

CB Tell us about the Postgraduate Institute. Was it a good idea and did it work?

MTW I am strictly prejudiced for two reasons: a) to answer your question, I think it was an absolutely unique idea – again, unique I hate these words – but it was very, very important. Secondly, I really do believe that there are several ways of killing a cat. There is a huge theory out that you cannot do specialist medicine unless you've got the whole backup of the general medicine. And I think in research there is breadth and there is depth. The great advantage to me... my own research, as you know, was lung involvement in a whole number of very general medical conditions, but because we were all specialists in the Brompton, I was able to go into collaboration with Mr [Ronald] Crick who knew about sarcoidosis at King's College Hospital, I was able to go to the Hammersmith when I had patients with haemosiderosis that we were researching on a number of... polymyositis in lung disease. I was able to go to a number of institutions around London, all within a five mile radius, where I went into partnership for special patients with special combined diseases without putting anyone's nose out of joint. If I'd been at St X, I couldn't have used somebody else's ophthalmologist or somebody else's nephrologist because of 'What's wrong with your own?' But the microcosm of London enabled people to mix and match that a) was very good for clinical science, but was also very good for patient care when they had difficult problems. Now, that's only one way of solving the problem. Of course, you've got to have good intensive care. We did actually have very good intensive care because of our cardiac operations, so if anybody got seriously ill we had all the multi-system support there, so we weren't that sort of a specialist hospital. And secondly, of course, we had St Stephen's just down the road, now Westminster and Chelsea, an excellent hospital within five miles that for ordinary things when you haven't got the thing yourself, you got support. And as dean... and my passion for data collection, I counted it one time, the number of our patients that had to be transferred for breadth of in-patient care, and it was very, very few and it's been re-counted since. So the fact is that we at the Brompton and these other places as well have objectively had a good UGC [University Grants Committee], UFC [Universities' Funding Council] track record. So the proof of the pudding is there, objectively assessed outside ourselves.

CB You mean in terms of assessment of your scientific value and teaching value by the authorities?

MTW Exactly. And we haven't been isolated academically as a matter of fact as judged objectively by those standards.

CB Because so many people outside, for example Lord Todd in 1972 and later I think Lord Flowers' report in London, recommending that all the special institutes should be linked with undergraduate teaching hospitals, and you were not a supporter of that?

MTW Well, the problem is you know, there are pluses and minuses. The breadth that you get being able to walk down the corridor and talk to a nephrologist or rheumatologist is obviously a great advantage. If you really want to, I think, you can

really walk a few paces away. I think what you can't do is to create a specialist thing right out in the sticks where it has no general support, but London is different.

CB You mean like at Midhurst. Should I mention Midhurst?

MTW Yes. Well, I think so, it's part of history. I think it was a wonderful idea to have an isolated research thing, but it didn't work because there wasn't a contact just as...

CB Let's just be clear, this was a privately funded research institute in Midhurst, working on the lung, which did become linked with you at Brompton.

MTW Absolutely, because eventually, and it was a sad story, but it became evident that it couldn't survive on its own financially.

CB You basically took it over to begin with and then moved it all up to Brompton, or whatever...

MTW For anyone who wanted to come and they mostly didn't.

CB I am sure that was right.

MTW But the point back to the breadth and depth, it's quite important; and let's take the Brompton as a model because I know, but I don't want to be parochial about it, you had twelve or thirteen chest physicians. Well, that can't be necessary, you know, value for money, these things. Each one of those, and it was partly by design, and as you know professor and dean... each one had his own place in the sun. We had somebody - John Batten had his place with cystic fibrosis with Margaret Hodson. Steve Spiro had oncology. I was doing my interstitial lung disease. Peter Cole was doing infectious diseases. Ken Gibson was still doing the difficult tuberculosis. So each one of those was a chest physician with a breadth but a depth. And so almost any difficult patient that came into the Brompton didn't just get one tertiary referral, you'd share them amongst your colleagues too. So, in fact, I think that was a huge strength, that even very large institutions doing postgraduate work at regional level or even... rarely have that depth, that critical mass. And you have to take your choice, you have to say, yes you can criticise that you haven't got immediate contact with your other discipline, but there are ways you can compensate, as I have indicated. But at the same time, even in those large institutions, the size of the individual specialities is relatively small. Now, in this day and age where I think the advances in medical specialities is going more and more specialised, the advantage of having that critical mass within respiratory medicine, within cardiology, is a huge advantage.

CB Well, Sir Francis Fraser, the late Sir Francis Fraser, who founded the Postgraduate Federation at the end of the war, following the Goodenough report which of course recommended it, would be delighted to hear what you said. Can I just ask, there's always been a very distinguished man who's been chairman, I think they call him, of the Postgraduate Federation; in your time, who were they and were they important men to you in terms of running the Brompton?

MTW The Federation of course was a very benign sort of leader. What they did, and also I think it was also Francis Fraser...

CB Well, they gave you your money.

MTW Absolutely, but it actually was a co-ordinating body. What the university said in its wisdom, 'We only want one school of the university to include all the postgraduate bits and pieces,' because they were relatively small on their own, and I accept that completely, 'so let's put them all together.' And that had two advantages: one is, it did get some co-ordination into it and so the critical mass is there, and secondly I think it just gave us a view of cohesion that we wouldn't have had if we were just working away at the Brompton.

CB Yes. I was in fact incorrect, the man was called the director of the federation.

MTW Director, you're quite right.

CB Now who were these men in your time and were they important to you and did they influence your decisions?

MTW Well, George Smart was a very good man, came down from Newcastle and David Innes Williams of course, a neurological paediatric surgeon but a very good person, has done a huge amount of..., and then of course Professor Michael Peckam.

CB Before he went to the Department of Health.

MTW And more recently Malcolm Green. So people have taken that job as co-ordinator of postgraduate medicine, and of course in the early days the Hammersmith was part of that team. And then in its wisdom, and of course it was rather a different structure and I have absolute respect for that, it decided that it could be on its own.

CB Now, do you think they were right?

MTW No, actually.

CB Tell me why?

MTW Because I think in the NHS there is this really - I was going to avoid using the word unique again - structure of these specialist hospitals, postgraduate specialist teaching units, and they were clustered together through the British Postgraduate Medical Federation. So there was a sort of organisation there with some funding and ideas, and we were all in London - ten mile radius. And because modern medicine is becoming research and development in the postgraduate sphere rather than the undergraduate, it was potentially a very, very powerful influence for good in the development of medicine.

CB And the loss of Hammersmith you felt was bad for Hammersmith, or the federation, or both?

MTW Both.

CB They became isolationist.

MTW I think it split this argument about breadth and depth. So long as we were all taking the advantage of both, with a certain amount of humility, that there are more ways of killing a cat, and instead of arguing whether it has to be this or that, let's say what is the track record and then both contribute.