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Brendan Devlin CBE in interview with Dr Michael Ashley-Miller
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Part One

MAM Brendan Devlin, thank you for coming to us. I think by any standards you've had a, a remarkable surgical career. And one particular bit of it, I think, is of … well, just international renown, which is the perioperative death study. But I'd like to work up to that, if I may, and could I start with where you were born and your family? So, was your father medical? Do you come from a medical family?

BD My father was a GP, an Irish GP, who had come over to England in the Depression era, and came over to work in Lancashire. And I was born of an Irish mother, in Lancashire, on the way to get the boat train back to Dublin. So I was born in Britain, but three weeks later I was Irish. And then I came back to England and my father went into practice in Fleetwood in Lancashire, in 1937, and I lived there with him throughout the war years and post, and immediately following that, interspersed with long, enormous holidays in Ireland. And it's, it's my one regret that, actually, I haven't remained in Ireland, because that was, actually, my home in the sense that my father was Irish – he was from the centre of Ireland – and my mother was Irish, from County Cork.

MAM Have you any brothers and family?

BD I have one brother and two sisters. My sisters are both in the United States, as all the Irish get to eventually. My brother as far as I know is in Australia.

MAM Are they … were they medical at all?

BD None of them had anything to do with medicine.

MAM So it's just you.

BD Just me.

MAM Was your mother…

BD No, my mother was nothing, no.

MAM Were you attracted by medicine and influenced by your father? I mean, was that the…

BD Well, I suppose my, my father did have an enormous influence on me. My father had started life as a pharmaceutical chemist, and had changed over to being a

GP after some years in pharmaceutical chemist, chemical practice in, just outside Dundalk, in Ireland. And he qualified in four and a half years in Dublin, and...

MAM That was good going.

BD That was good going. He got loads of prizes too, so I suppose I, I suppose I was influenced by all these prizes, these medals, these trinkets around the place. And he did influence me, yes.

MAM Did you ever want to do general practice – because that's the, the next obvious question – did that appeal to you?

BD No.

MAM You didn't…

BD No, never. No, no, never.

MAM So you went to school in Lancashire, or…

BD No, I went to school in Staffordshire, in England. And then from that… That was secondary school. I went to the Christian Brothers first, the Irish Christian Brothers and then I went to school, postoperatively so to speak, to, to the school in Staffordshire. And then I went back to Dublin, to Trinity College, Dublin.

MAM Was that a sort of call back to the roots? Or did you…

BD No. It was a … I was focused back there. I suppose my parents propelled me there.

MAM Was Dublin a big medical school in those days, or…

BD No. There were about 60 new entrants.

MAM Oh, you were small.

BD Small, yes.

MAM Did you shine as a student, at all? Or…

BD No. We had a rather curious medical training actually, when I look back on it now, where I am now. First of all, everybody in Trinity had to read for a BA degree in anything, any other subject. And for some curious reason, I elected to read public administration and politics. So I got a very good grounding in public administration, for which I'm eternally grateful. It really is one of the most important things in my life. In fact, I was almost, at a stage of going through as an undergraduate, of saying to my father 'I would rather stay and do this rather than carry on in medicine.' So I did that, and then I carried on in medicine.

MAM Fascinating. Was that taken sort of as a module in the medical training, or did you actually stop for a year and study…

BD It was, it was taken contemporaneously with the medical, yes.

MAM It was, yes. That obviously – because I know a bit about your history – [you were] influenced quite a lot … by that.

BD Very considerably.

MAM And yet, I suspect, at the time, you didn't really want to do this, did you?

BD Well, it was something…

MAM Most medical students want to do medicine.

BD I wanted to do medicine. I liked medicine, particularly the scientific side of medicine, yes.

MAM Even in those days, you were interested in the…

BD Even in those days…yes.

MAM …in the science of medicine. Was there any one teacher who influenced you, if you like?

BD Well, the answer is yes. I mean in anatomy I was very influenced by the professor of anatomy, who was called Erskine, Professor Erskine[1], with whom, with whom I am still very friendly. He's a very old man now. But he has been a great strength to me all my life. And then when I got onto clinical work, the most outspoken and most difficult clinician I had to cope with was the senior surgeon at Sir Patrick Dun's Hospital, who was from the North of Ireland, who was called Frederick Gill. He was president of the Irish College of Surgeons, he was … he had a very short fuse, he lost his temper very easily, but he never lost his temper with me once. And I was very influenced by him. He apparently liked me, which I couldn't understand. He got me assisting him, as a third year student even. And from that I just carried on. And he persuaded me surgery was the thing to do.

MAM I was going to say, at what stage in… You went to university – what, at sort of 18/19?

BD Yes, that's right.

MAM At what stage in your medical training did you begin to think that surgery was for you?

BD Oh, about my third or fourth year as a medical student.

[1] Professor CA Erskine.

MAM I see. As early as that. And did you ever waiver, or…

BD Well I didn't know which branch of surgery, because surgery was surgery just then. I mean I, I thought initially that I would do orthopaedic surgery. My father had been the GP in Fleetwood and he'd also been the local orthopaedic surgeon, you might say, during the war, throughout those years. He did all the fractures and stitched up all the wounds and things like that, and that influenced me. And I was very interested in orthopaedics, so I…

MAM That was the start?

BD That was the start, yes.

MAM Now, you qualified in Dublin.

BD That's right.

MAM Did you have honours, or…

BD Yes.

MAM What did you get?

BD I don't know. I've just forgotten, forgotten!

MAM Right.

BD I got honours, I remember, in pathology, and obstetrics and gynaecology. The one I didn't get honours in was medicine. And I got honours in surgery.

MAM Well, that's not a bad… What did you do to follow a surgical career?

BD Well, I got the house, I got the key house job…

MAM Right.

BD …with Freddie Gill.

MAM This is still in Dublin?

BD It's still in Dublin. I did that. And then I felt, really, I needed to see a bit more of life. In particular I felt I was lacking in knowledge of people – medicine, and the medicine of people. And I went over and worked for an Irishman in Burnley in Lancashire, a chap called Dunn[2], who was a friend of my father's – the same generation as my father. And Dr Dunn had a second physician that worked in Burnley

[2] Dr William James Dunn

with him, called Dr Shafar[3], who was an endocrinologist. And I worked with them for six months. And that really was … perhaps the most formative six months of my life, in the sense that I was working in Burnley, which was a very deprived part of Lancashire at the time. Dr Dunn was very intelligent, very bright; Dr Shafar was incredibly bright in the scientific pursuit of what was the matter with the patients, and the two of them worked well together, and I...

MAM Were you a houseman, or…

BD A houseman.

MAM Still a houseman.

BD And I, during that period I worked very hard. And there was a surgeon there who was very interesting – a man called Robinson[4] who died a couple of years ago, who was a senior lecturer in Manchester. So I helped him a bit, and I did that six months, and decided then and there that surgery was for me.

MAM You've twice mentioned, firstly as an undergraduate and then in that last house job, your developing interest in, if you like, the scientific bases, as opposed to purely clinical medicine. And this, presumably, was beginning to get into your very being, if you like, that...

BD Yes, I suppose it was part of my bones by then.

MAM Yes. Science was going to be as important as clinical medicine.

BD Mmm.

MAM Right. Where did you go after that?

BD I went back to Dublin to Professor Erskine – who I mentioned earlier – who took me on as a demonstrator in anatomy for a year. So I did that for a year, and during that period I got my Primary FRCS.

MAM Yes. Which was quite a common way of…

BD It was a routine way.

MAM Right, and then…

BD Then I went back to Sir Patrick Dun's in Dublin, back to Freddie Gill, and to the other surgeons, as a surgical registrar.

MAM Right, and what … when you say surgical registrar, what, what branch of surgery?

[3] Dr Jacob Shafar
[4] Dr Brian Powell Robinson.

BD It was effectively what we used to call general surgery. We did everything.

MAM Right. Including orthopaedics or not? Because that tended to be rather separate.

BD No, that was, that was separate. The particular bit of surgery I did an enormous amount of in that period was head and neck surgery. Freddie Gill was head and neck surgeon. He was very interested in cancer of the thyroid, thyroid disease, and also cancer of the pharynx. And Robert Woods, who was the ENT surgeon, was also interested in facial, in oral-facial surgery, cancers and things like that, and the two of them worked together. And I got the plum job of assisting them twice a week at doing reconstructions to the head and neck.

MAM Were they plastic surgeons, in one sense, or reconstructive surgeons?

BD They were … they were really what all surgeons should be. They were just very careful technicians, very good. They could handle tissue nicely.

MAM Yes, yes.

BD And that was all there is … that's all there is to surgery, you know, Michael!

MAM I think you're being a bit modest there! We'll get on to that. Right, where did you go after that? Because you're obviously still … you're now, what, a registrar?

BD I'm now a registrar. I then put in for the MCH [Master of Surgery] ortho course in Liverpool, intending to go into orthopaedics. And I did that for a year… Hmm, that wasn't really a great success.

MAM Did it teach you you didn't want to do orthopaedics, or…

BD Well, it taught me a lot of things about surgeons that I've remembered all my life, but which I'd like not to know.

MAM Okay! I think we'll come to that later!

BD And after that I didn't quite know what to do, because at that period Freddie Gill had died in Dublin – he'd had a heart attack and died – and I was a bit without a leader, so to speak. And John Kinmonth in St Thomas' then took me on as a surgical registrar. So that started my association with St Thomas'. I went to St Thomas' initially for a year, and it ended up as nine years!

MAM It was nine years?

BD That's right, yes.

MAM As what? Registrar, senior registrar…

BD Registrar … then I was an MRC [Medical Research Council] Fellow, and then I was a senior registrar and lecturer.

MAM Was that an academic side as, as well?

BD Initially it was academic, initially it was the surgical unit registrar job, and then it was an MRC Fellow in the surgical unit. And then eventually after, you know, the perambulations around St Thomas' I went to … to Nevin[5] and Lockhart-Mummery[6], which was colorectal surgery.

MAM Right. Now, in that period of nearly nine years at Thomas', you presumably did most branches of surgery, did you?

BD That's right.

MAM Because in those days, surgical units were general surgery.

BD You did general…

MAM Were you developing a specialised interest in surgery, or were you still, if you like, a general surgeon?

BD I suppose I was still a general surgeon, surgeon, because in the course of that time I worked for Cockett[7] and Kinmonth doing vascular surgery, and lymphatics and veins and things like that. And then I did a year down in Portsmouth as a senior registrar with Wiggins-Davies[8], doing…

MAM Was that a link with Thomas'?

BD …a rotation with St Thomas', doing urology. And then I did … you know, short spells on all the firms in St Thomas'. And eventually I ended up with Lockhart-Mummery and Nevin doing colorectal work.

MAM So we're now really … you've, you've done almost all except gynaecology.

BD That's right.

MAM Did you have much to do with children, or was this always adults?

BD I had something to do with children insofar as we did them in St Thomas'. And Kinmonth did a fair amount of children's vascular surgery side, dealt with that. And then when I was with Nevin, we and Lockhart-Mummery, we did what you might call general surgery of children.

MAM Because children's surgery seems to have become a specialist subject...

[5] Bob Nevin.
[6] Sir Hugh Evelyn Lockhart-Mummery.
[7] Frank Bernard Cockett.
[8] Walter Wiggins-Davies.

BD It's a specialist subject.

MAM …a subject in its own right. But you were doing some in those times. At St Thomas', did you have to do much teaching – because there were days when lecturers actually did a bit of research rather than that – did you do teaching at all?

BD I did a fair amount of teaching. In fact, it's only last week I walked into a meeting in the children's, Red Cross Children's Hospital in Cape Town, and the professor came to introduce, to be introduced to me. He said 'I know Brendan well, very well. He taught me surgery in St Thomas'!' However, it's a…

MAM I know, in your later time, obviously in your career you have done what I would call postgraduate teaching. Do you have any particular likes and dislikes for teaching? Do you like teaching the young, or postgraduates, or … do you like teaching?

BD I just like teaching.

MAM Right. It doesn't really matter to you…

BD I like, I like teaching, particularly in small group teaching. I like talking with people.

MAM More seminars than lectures?

BD I like talking to people about, you know, the topic, and getting their feedback on it and so on.

MAM Yes. So more of a seminar than a lecture theatre, although, presumably, you've done a fair bit of what I call 'lecture theatre'.

BD Far too many!

MAM Far too many! But you, you like teaching?

BD I very much like that, yes.

MAM Now, here you are, you've done nine years – admittedly some of it away on rotation – at St Thomas'. You must, at that stage, have been … I mean you've, you've had your Fellowship for, what, nearly ten years?

BD Oh, for a long time. I got my Fellowship first time.

MAM You are well-qualified, in fact you've probably time expired as a consultant! What did you decide to do? Because it seems to me you've been at one of the great teaching hospitals, or it thinks it's the greatest… Are you not at a watershed, to a certain extent, of whether to have an academic career? Your interest in science, and presumably you'd done some research during your time at Tommy's, and teaching…

Or are you going to be a 'general surgeon'– I'll put that in inverted commas! – but an NHS general surgeon? How did you resolve … were you drawn to academic life, or did you decide 'No, I'm going to go for a consultantship in the NHS'?

BD Well, there were other pressures, Michael, you must realise. You don't live as an isolated being in the world. There are other pressures. I was married, I had five children – I needed money. So that was one pressure. The second pressure I suppose I had was that … I had a sense of unease about where academic medicine would lead at the time – I'll be quite positive – and said 'I had a positive unease about it.' I felt that the academics weren't really addressing the issues that I perceived in medicine. And I will come back to this, maybe, a bit later. So I didn't know where to go. I mean somebody suggested I took a senior lecturer job in London. And I thought about this, and I, but I thought that doing that for four or five years, and then having to look again for something else, i.e. a Chair, would be unfair on my wife and family's side. Put that out there, coupled with the fact that I was very unhappy with London academics at the time. While I was in St Thomas'… it mightn't be the right thing to say, but while I was in St Thomas' I saw a lot of colorectal cancer, an enormous amount. And everybody told me that 'If you're going to have a cancer, Brendan, have a colorectal cancer, they do very well.' Yet I had the job of doing all the outpatients, and I never recall these patients coming back. They were all dead. And I applied for a research grant and got some funding to do an outcome study, looking at what happened to the colorectal cancer patients. And I recruited all the ones done over ten years in St Thomas', and for a control group I got all the ones done in Southend. And I went out and followed up all these patients. I not only looked up all their notes and records, but I also went and examined every one of these patients, at home, that were still alive. And only 30 per cent of these patients were still alive. And we did a social profile on them all, and we showed that the social outcome was very bad, and...

MAM The social outcome?

BD Social outcome. Many of them were living socially isolated lives, they had secondaries here there and everywhere, they couldn't get out. So the outcome for these patients wasn't really cheerful. And I, I put all this together and I wrote it up very carefully with two colleagues – two research colleagues, people who were doing research, not doctors – and I sent it off to a surgical journal. And I got it almost back by return of post, with a letter saying this was sociology not surgery. And they wouldn't publish it. So I sent it then, almost on the rebound, to the editor of the *BMJ* who published it immediately.[9] And only last month, I saw a review of my paper, yet again, in *The Annals of the Royal College of Surgeons of England*, and they were pointing out to me that there were a lot of methodological problems unsolved in 1969/70, in my paper, and these were now being tackled.[10] So I felt that I'd really made a really good contribution to science, at that stage.

MAM But, presumably it did not endear yourself to…

[9] HB Devlin, JA Plant, M Griffin, 'Aftermath of surgery for anorectal cancer', *British Medical Journal*, 1971, 3:413-18.
[10] See I Taylor, 'Colorectal cancer and the liver', *Annals of the Royal College of Surgeons of England*, 79:5, September 1997, 315-18.

BD No, no, it didn't. It was a mistake to do that. As a young man, never do anything like that.

MAM Yes. But, interesting that, even at this stage, because of what we're going to talk about later on in the national study, you were actually interested in outcome, not technical brilliance or anything else, but... And also I get the, the impression that you were starting to look not just at surgery and, you know, discharge, outpatients, wash your hands, but you were actually interested in the social well-being and the results of surgery. And that was relatively unusual, was it not?

BD That's, your summary…

MAM That's my impression.

BD …your summary is 100 per cent correct, and I agree with it.

MAM In your general sense, what were your worries about academic surgery at the time?

BD My worries then were academic surgery, to me, was operating on rats, rabbits, and other small mammals.

MAM I see, yes.

BD And there, there were…

MAM Not doing…

BD There were big issues, I felt.

MAM Right, yes. I should, perhaps … when I, in my ignorance, talk about academic surgery, or academic medicine, I'm … we're obviously talking about medicine primarily. What was wrong with the London scene? Was it too Harley Street bent, or … just a rather closed shop?

BD It was … I certainly never came up against a closed shop in any way, I mean...

MAM Was it claustrophobic?

BD It was claustrophobic, and it was Harley Street bent.

MAM Yes, yes. So, apart from very obvious financial advantages of getting a consultantship, there were dissatisfactions if you like between your developing interests, which were not really being addressed by academic surgeons. So, right, here you are, pretty poor…

BD Very poor!

MAM …not made the best of friends with your orbit of colorectal cancer, and you decide 'Right, I want to leave London and get a consultantship.' And presumably, a pursuit of an academic career, even outside of London, you had virtually ruled out. So where did you go?

BD Well I, I had some difficulties, you know. I looked round the countryside for jobs, and the job I eventually went to in Stockton-on-Tees I came to by chance, insofar as I was walking down the main corridor in St Thomas' one day, when Lyn Lockhart-Mummery, who was a really great friend and mentor to me, said 'By the way, they're thinking of setting up a gastrointestinal unit in the Northern Region. They're looking for a surgeon. Would you be interested?' And I said 'Well, I've never been to the north-east of England, you know, but yes I would be.' So he said 'Well, the interview is on Monday morning.' This was on Friday, or something … or that sort of juxtaposition of time. So I arrived at this interview. And I'd never really been to the north-east of England in my life, but I got on the train at King's Cross and arrived. And John – Professor John Goligher – was the external assessor, and I had this interview which went like a dream. And then they called me back in and said 'Would you like the job?' That was the last thing I wanted! So Goligher at this moment got up…

MAM Was it one of those that say that you must tell us now whether you'll…

BD That's right, yes. Goligher got up from his seat and walked round, and took me out. He put his hand on my shoulder and led me outside. And he said 'Look, Devlin' he said, 'This is a good job.' He said 'You can do what you like with it. There's no competition. You'll do it to the best of your ability, and I'll be just down the road.' And he said 'We'll, we will be very supportive of you'– everything like this. He said 'Go away and think of it, and let me know next week what you think.' So I went away and thought about it. I needed a job. I needed the money. They would give me four increments on my salary if I went there. So I went there. And I was horrified with what I, I walked into. It was in the old hospital in Sedgefield[11], which is in the middle of County Durham, an old wartime hutted hospital, it was…

MAM Oh, one of the, the temporary emergency…

BD That's, that's right. There were sessions there. And there were sessions in the Stockton and Thornaby Hospital, which was the old upper-class Stockton hospital paid for out of, you know, subscriptions from working men, and things like that. The old royal infirmary, I suppose. And I, and I was the sole surgeon in The Children's Hospital on Teeside.

MAM There were other surgeons at the, the other two?

BD There were other surgeons at the other two hospitals, but I was the youngest. And certainly in The Children's Hospital I was the only general surgeon. There was a plastic surgeon, there was an orthopaedic surgeon and I think an ophthalmic surgeon, and there was me. So it meant quite a lot of work.

[11] Sedgefield General Hospital.

MAM Ah, yes, I should think there's a whole-time job in that!

BD And I remember then I arrived, I said I'd take it. And I arrived up to do my first list in Sedgefield [General] Hospital, and I said I needed to cystoscope a patient. It's right in my memory, this. 'I need to cystoscope a patient.' And everybody thought this was a bit mad, you know, cystoscoping a patient who's got bladder symptoms and gut symptoms and so on, you want to know what you're doing. But eventually they brought out the cystoscope, and it had 'Gift of the Canadian Red Cross, 1941' on it! And it really was … a big job, sorting all this out. But the promise was there to build a new hospital, and they would put in a regional gastrointestinal unit, and I did have connections with the university. And Professor Goligher actually…

MAM Which university was it?

BD Newcastle. And Professor Goligher, who was then in Leeds University, did keep in touch and provided me with support, you know, talked to me and things like that. So I got on with this, which was quite a tough job.

MAM Tell me, when you walk into something like that, which I think you're being quite polite, was pretty rudimentary surgery to say the least, it's presumably pretty back-breaking to get that on, even on a reasonable keel. Were you given additional resources? Did you have senior registrars, or registrars, or…

BD No.

MAM You were on your own?

BD I was on my own. I had … a registrar from India in Sedgefield, and a registrar from the other end of India in Stockton and Thornaby Hospital. Really it was, you were starting from … a pretty negative…

MAM What was the population served?

BD I suppose the population served would have been about 230,000 or something like that.

MAM Phew! It's as big as that. That's a tremendous load.

BD I mean, Teeside had an overall population I suppose of about 700,000, and this was all the north of the river, our pitch.

MAM Now, in that time obviously you set about putting things on a better keel, if I can put it that way. I'm sure you worked desperately hard, because you didn't have that much support. Did you tend to say 'Well, I can't do everything. I'm going to concentrate, say, on GU surgery', or were you still a general surgeon?

BD Well, I was still a general surgeon. I had no alternative. I mean, there were two other general surgeons. One of them was a man of 61, who was dying of cancer. And the other was a man of, I suppose, about 58 who had a very bad heart, and was repeatedly having heart attacks. So I had to do all the emergencies myself. And I set about … the first, the first thing I remember doing was saying 'We need another surgeon.'

MAM Did you get one?

BD We got one after about a year, which the regional health authority were very helpful about. And the second thing was, you'll hardly believe this, I put into the MRC for a research grant, and got it!

MAM You sound surprised.

BD Well, I … and I, along with David Newell, the professor of statistics in Newcastle, we set up a project to look at day cases and how they were dealt with, and the costs, and the, the economics of day case surgery. And that was a complete breakthrough for that part of the world, to have somebody on this.

MAM Now, when you started that, that was how soon after you were taking up your appointment?

BD About nine, ten months.

MAM So already, despite this rather chaotic situation, despite an enormous workload, without too much help on, on the other side, you still had time to say 'I'm not going to get immersed purely in clinical work, I'm going to do research', and teamed up, as you say, with Newell, and started looking… Again it's a, we're looking at outcomes and costs, aren't we?

BD That's right, yes.

MAM So this interest, even despite all the burdens, was still one that you locked in fairly early in, in your career there.

BD That's right.

MAM Right. Now, amongst the … in this maelstrom, I imagine, did you set about more research? Did you have ideas about research? Or did you let the clinical medicine throw up the problems?

BD Well, I let the clinical medicine throw up the problems, but of course I read a lot, and did things like that, say … heard what problems were around.

MAM Now, when was the, the new hospital[12] and decent facilities…

[12] North Tees General Hospital.

BD Decent … the new hospital came in about two years later.

MAM Oh, I see, that was reasonably…

BD Reasonably quickly. I had a long period of sort of sorting out what was, and an even more … probably a period of anxieties over commissioning the new hospital.

MAM You got involved in that?

BD I was very heavily involved, [on] the surgical side. All the mistakes made on that were my mistakes. And I am fully aware of them today.

MAM Were there…

BD Oh, there were, yes. I mean, I have no doubt about it.

MAM I mean, I don't imagine anyone's ever commissioned a new building without making mistakes!

BD You, you can't do it.

MAM No. You want to do it about three times over.

BD That's right. And there were all sorts of big issues in surgery you've got to think about. Are the artery, artery instruments, the forceps, you know, that you clip on and everything, are they going to be nine inches long, or eight inches long, or seven inches long, or five inches long? And, I mean, these are big issues. And if you're buying the whole lot for six theatres, you get them all wrong, you've got too many artery forceps of the wrong size. I mean things like that.

MAM That, again, must have been an additional burden. But on the other hand that would be worthwhile wouldn't it…

BD Very.

MAM …because you were beginning to set the empire.

BD That's right.

MAM I don't mean that rudely but, you know, you were beginning…

BD Setting, setting the ground, yes.

MAM What about the children's side? Did, did you get a paediatric surgeon, or you were still carrying that?

BD No, I carried on. I did all the routine general surgery in children. The, what you might call the very neonatal paediatric surgery, like the oesophageal fistula, that was sent to Newcastle.

MAM Yes, I see. To…

BD But the routine intussusceptions, the midgut malrotations, the Ladd's bands, all the hernias and descended testicles, thyroaplasias(?), I did those. You see, all my life I've had one thing on my side, Michael, and that was I've never found technical surgery difficult. I've found it very easy to operate. You just handle the tissues very gently like I was taught in my first house job by Gill and Woods in Dublin, the rest is easy, if you do it meticulously and carefully.

MAM I think you're being a bit modest about that, but I'll let it go.

BD Oh, for God's sake don't have any bloodbath, because that is the real bad news.

MAM Yes. Did all the clinical facilities, your, you know, single-story hutted hospitals, did they all come into the new hospital?

BD They were all moved in, yeah.

MAM So one advantage was you didn't have to travel…

BD That's right, yeah. We concentrated everything in one place.

MAM …which takes energy and time.

BD That's right, yeah.

MAM So you at least had it all in one place. Did you get any more surgeons, once the, the place was built?

BD Yes. I was very lucky at first, because one of the boys who had been a houseman with me in Thomas' was doing an MCH, working in, at the London Hospital, and he couldn't, he was short of clinical material for his MS [Master of Surgery], which was on gallstones. And his boss – David Ritchie, who was the professor at London – was telling me about this, and I said 'Well look, I'm inundated with gall bladders and stones in the gall bladder. If he'll come and do it for me, he'd have all the cases he'd like, and I will provide all the facilities and help to do it.' And I persuaded the regional health authority to pay his salary. And he came as the senior registrar to me for some months, three or four months, maybe longer.

MAM Now, there you are, the hospitals built, you're beginning to get some help. And … presumably with your energy you were also beginning to expand your research interests. Is that right?

BD Mmm, that's right.

MAM Were they … I know, looking at your enormous publications list, I don't know how you found time to write, let alone make it sense, you … correct me if I'm wrong,

but I got the impression that a tremendous number of your publications have been on GI surgery.

BD That's right, the majority.

MAM What I call 'the gut downwards'. Was that becoming a predominant interest at this stage?

BD Well, the first surgeon we got as an extra surgeon after I came was a urologist. So that meant I gave up urology.

MAM Right.

BD The next person we got was another gut surgeon, and then we got a vascular surgeon. So I gave up all vascular work. And I just concentrated, really, on the lower gut, because that was...

MAM Right. So that in many… Did you choose that those two specialities should be looked after separately?

BD Well, I suppose I was part of the committee structure.

MAM Right. But I mean … I should have thought vascular surgery was a good one to hive off, because I think at that stage, am I right, that it was becoming very specialised?

BD Very specialised and a lot of work.

MAM Yes, and a great deal of work. So, in many ways, your organisation of the surgical division, because by now I think you were head of the surgical division…

BD That's right.

MAM …was almost set, that you were going to concentrate on gut surgery.

BD Yeah.

MAM Which accounts for the enormous predominance of that.

BD That's right.

MAM Now, apart from an enormous number of clinical papers, primarily concentrating in that area and they seem to have gone on all through your career until very recently. Is that right?

BD Well very, very recently!

MAM Very recently!

BD I won't comment on that.

MAM On the, the wider area, we've already seen that you were becoming interested in a certain area – I'm going to call it 'audit', I know there's other fashionable words, but I think 'audit' is a rather good word – and in the social aspects of patients' welfare after surgery. Did this develop a strong … once you'd got the hospital sorted out, division sorted out, did you become more interested, because you clearly had time and organisation to look at those issues? And if that's true, were you interested in the issues wider than the GI surgery that you were concentrating on?

BD The answer is yes. I, I was interested in this. Let's just go back to day case surgery, which was the first big project I did. I looked at the outcomes in terms of the clinical outcomes and the costs of this. And I did this both in the hospital and in patients' homes, and indeed made a film about this at the time. And then from that…

MAM What sort of year was this?

BD This is seventies, '76 or something.

MAM So you're one of the forerunners of day-case surgery?

BD Mmm, probably. I think I wrote the first paper on the costs of day-case surgery in '74/'75, by randomised patients between day-case and conventional surgery. So yes, I was very interested in that. And it struck me that this was a big area that could be explored. And I also did a lot of work about the same time on the management of patients with colostomies and then ileostomies and the social cost of that, and wrote a book about that.[13] And this expanded … I mean, just like Topsy!

MAM Yes, because once you pick an audit theme, you may look at your own work. But of course, the technique applies to various other branches.

BD Mmm, that's right, yes.

MAM Were there any that you were particularly interested in? Because the ones you've described were very much your own interest anyway.

BD They were my own interest, yes.

MAM Did you start expanding into what I call 'other areas', or not at this stage?

BD Not at that stage, no. I mean, at this stage I was concerned about running my own department, which was a big department then. We had a lot of registrars, we had four registrars, we had eight SHOs [senior house officers], we had God knows how many house surgeons. And I felt my duty very much was to them, in terms of that I'd got to help them do their work, I'd got to teach them surgery, actual clinical surgery. Above all I'd got to teach them to get through the exams. And in all the period I was

[13] Brendan Devlin, *Stoma Care Today*, Oxford: Published for the Medicine Publishing Foundation by Medical Education Services, c. 1985.

in Stockton, every boy that came to me, or came to our department as an SHO, always got his Fellowship. We had no failures in the entire time.

MAM You must have had a lot of applications towards the end!

BD But, I mean, my colleagues really are responsible for this. They did all the teaching rather than me. And we had a weekly … every Friday afternoon we always had the whole afternoon off. We did a weekly grand round, and then after that we had a seminar on something. We took it in turns to do it. And it really worked, because I've got these boys all over the world now who have been with us. And wherever I go one of them will turn up.

MAM It must be very satisfying to look back on … you know, that number of people that you've trained as competent people. I mean, that seems to be the, the thing you can be really proud of. Can I … just to get the time span right, when you went to Stockton…

BD In 1970.

MAM …in 1970. By the time that you were head of surgical division, you had four senior registrars, did you say, and various housemen? What's that sort of time span?

BD Oh, about four years.

MAM As, as quick…

BD I did it very quickly.

MAM Goodness me!

BD You'll remember, in the seventies there was no limit on cash in the health service, so I could expand.

MAM Yes, it was happy days! There wasn't much in the research either! Right. So you, you really moved quite extraordinarily quickly to a very big, well-staffed [department], and certainly, in a training sense, one to be aimed at by young men who want to be trained well and pass their exams quickly, in a span of 4-5 years, which is quite remarkable. And still managed to do some research. Did you have research assistants, or…

BD No.

MAM The bulk of this was on your own?

BD The bulk of it was done by me – I had a research secretary, which I got out of soft money.

MAM But otherwise it was mainly…

BD Otherwise…

MAM Did you … I have to go back a bit, but did you actually have any formal training in outcome studies? I mean, this is epidemiology and, you know, a variety of skills apart from clinical knowledge. Was this self-taught, or did you go and talk to people?

BD I went and talked to people. I used to go to meetings of the Society for Social Medicine, which is the epidemiologists' society. In fact I hosted their meeting in Stockton in 1979 or '80. So yes, I went and talked to people, and picked it up as I went along…

MAM A quick learner.

BD Quick learner.

MAM Now, another interest to me was the development of your involvement with the College. Now, the Royal College of Surgeons, like most of the Royal Colleges if we're going back to the seventies and early eighties, were dominated… Tell me if I'm wrong, but my impression was that they were dominated by the establishment, most of the establishment was in London, and nearly all of the establishment were academics. Now here you are, not in London, fairly far north – I mean, they did accept the Home Counties, but you were going pretty far north! And yet you managed to become a pivotal figure in the College. Now, at what stage did you, can I use the phrase 'infiltrate the College'?

BD This is a rather long story, and I'll probably bore you by telling you all of it. But my first attempt at infiltration was I was elected on to the board of the *British Journal of Surgery*, I think around about 1974.

MAM That's an editorial board?

BD Editorial board, 1974. But that consisted of the establishment of British surgery, the board. And I was elected on to that. And two years later I was made the vice-chairman, and effectively…

MAM Do you know how you got elected on to the board?

BD I have no idea at all. It was completely…

MAM Out of the blue.

BD Totally out of the blue. A Professor LeQuesne[14], who was then the professor in the Middlesex [Hospital], rang me up and said would I like this job? And I got the job. And I had to do my tour of reviewing papers, going to editorial meetings and all this, and two years later I became the vice-chairman which was a pivotal role at that point. So, that was the first thing that happened. The next thing was, then I got

[14] Leslie Philip LeQuesne.

elected on to the council of the Association of Surgeons for four years. And I immediately finished that and I thought 'Well, now we really need somebody from the North of England on to the…'

MAM Is that just a surgical association.

BD Surgical association.

MAM Like a club, if I could call it that?

BD Yeah. But they, they would think of themselves as better than the average club. But…

MAM Yes. But they had conferences and meetings?

BD That's right, yes.

MAM Did they have a journal?

BD No, no. And then from that I put my name up for the council of the College of Surgeons and got elected…

MAM That's interesting, yes.

BD …and…

MAM What were the rules of election? Did you have to be nominated, or seconded by…?

BD You had to, you had to be nominated and seconded, and then your name went on the ballot paper. And then all the Fellows would vote for you and it's first past the post voting.

MAM Right. Was it the iniquitous system of all the Fellows who were in college on a particular day, or was it a postal vote?

BD Oh no, it's a postal vote.

MAM Yes … I'm slightly critical of the way physicians conduct their affairs! I'm just interested…

BD Well, I'm critical, I'm critical of the way all the colleges…

MAM You, so you suddenly found yourself on the council of the College…

BD That's right.

MAM …which of course is a major stepping stone, obviously. How many members of council are there?

BD Twenty-four.

MAM Twenty-four. And that was in what year?

BD Ah, it's ten… I'm just trying to think – It's ten years ago now, we're now seventy…

MAM Right. Are you re-elected after a, a period?

BD Yes. I, after six years you come up for re-election…

MAM After six years.

BD …and I was re-elected.

MAM And I think I'm right, you became vice-president of the college was it, or…

BD No. I've never held any college honour at all.

MAM Oh, you've not held a college post?

BD No.

MAM You've always been a council member?

BD I've been a member of council now, run the audit all the time. I was chairman of the exams board for a fair while, and I've had all these other things, you know, like all the orations…

MAM So you've done what is well-known as council members … you only take a, once a month a meeting, you suddenly find you're doing a lot of work.

BD Well, I found I was doing a lot of work.

MAM Yes. Have you enjoyed that?

BD I've enjoyed it very much. Yes, very much. Over the years, it's been a very fulfilling exercise. I, at the end of my career, as I am now, I really think the … there's a big need for the colleges really to sit back and have a, a think-tank on what they're doing, and do it better. I think that there are too many colleges, far too many colleges…

MAM Well, I think we could all agree…

BD …and they're competing. Yes.

MAM …there are too many voices.

BD That's right, yes. And they're competing about non-entity problems.

MAM Right. So this is the way a career has developed really very rapidly, hasn't it. And in an unfashionable part of the world, you've now broken into the College. As soon as you do that sort of thing, you, you automatically become part of the establishment, like it or not, and you must have been… Everybody in, in that sort of position has jobs for the College and various 'Would you run seminars? Would you be on the editorial board?' I mean, that seems to be almost part, certainly of an academic's life, for anyone who reaches that position, and part of your life as well. But there's one additional job, if you like, which is particularly influential committees. Now, some of these are what I call the sort of MRC, or … the grant-giving bodies. But there is another component, of course, which is government committees. And … I wonder if you'd like to tell me … I know you've served, and will inevitably have served on a number of committees, some of which are not particularly influential or great, but would you like to pick out one or two that have been in your view particularly important? Sort of seminal committees.

BD On the national basis, I think the committee of the *British Journal of Surgery* was very important, because the *British Journal of Surgery* is, perhaps, the biggest surgical journal world-wide. So I had an enormous influence right around the world, and particularly in Europe. And I wanted very much to lead the *British Journal of Surgery* to be more focused on Europe, which I think I succeeded in doing. We now, we made … we revamped our, our finances so we made big profits and we turned this profit into funds for Fellows to visit centres, particularly in Europe. So I think that was very important.

MAM That's a major achievement.

BD That's right. And we also brought out a Spanish edition, in Spanish, which almost dominated the scene and still does. So, you know, this was a major achievement I think that I can claim some of the credit for. I mean, I had my colleagues on the committee who helped me…

MAM Yes.

BD …but, yeah … so that was some, some way forward for the *British Journal of Surgery* committee. I found, somehow I got on to the management committee of the King's Fund. I'd always been interested in that type of medicine, the sort of medicine, social side of medicine, and I'd done numerous courses. And in fact I'd done the highline management course at the King's Fund in 1966, I think it was, and they eventually put me on their management committee.

MAM A sort of roll of honour for those courses, aren't they?

BD And I found the King's Fund a very worthwhile job to do. I've just finished on the management committee there. It was influential in the sense that it brought you, brought me into contact both with government on the one side, and also people throughout the whole of the NHS. I've travelled all over the NHS and know everybody. So that was influential. And then latterly I've been heavily involved with

the King's Fund commission on [the future of] acute services for London, and now more recently I'm a member of the King's Fund commission on services for London. So I've had that role in the…

MAM Any government committees that you … I mean, you've obviously served on them.

BD I've served on them.

MAM Are there any particularly important ones?

BD Well, I was an adviser to the Merrison commission on the Health Service.[15]

MAM Oh, were you? Was that one of his special advisers?

BD Yes, yes. And that, again, brought me into contact with endless people. I was … then I've been on the Joint Consultants Committee of the government to the BMN(?), a couple of royal colleges. I've been on the information management group for the Health Service. Patient Empowerment Group(?) for the Health Service. All these various committees, nowadays, about audit and things like that I've been a member of.

MAM Are you particularly skilled in information services? Or are you particularly skilled in what information services should provide?

BD I'm very skilled in knowing what information services should be provided.

MAM Yes. Sorry, you're on that.

BD I'm not a…

MAM You're not an IT whiz kid.

BD No!

MAM But in many ways, it always seems to be the technology, actually, isn't that difficult. It's actually what you, what you get. And that's the expertise, really.

BD That's what you want(?).

MAM Can I bring you back to one that intrigues me which is your involvement with King's Fund review of acute services in London? I say that because, as I'm sure you're aware, a lot of people are extremely critical of that report, and indeed the King's Fund, or Robert Maxwell, the secretary of the King's Fund, admitted that they'd probably got it wrong. Most of the criticism, I think, would not only have got it wrong, but you were very influential on the subsequent government review by

[15] *Royal Commission on the National Health Service*, (Chairman: Sir Alec Merrison), London: HMSO, 1979.

Tomlinson.[16] Now, you were a member of that committee, and I'd be very intrigued to know if you felt that you'd got it right at the time, but yes you, in the long run you were wrong, or whether, in fact, you would defend it and say 'No, we weren't wrong.'

BD Well, I would defend it. I would say 'No, we weren't wrong, but we did make some fundamental mistakes.' First of all, it was a very rewarding committee to be on. It was a very intriguing issue – how do you sort out London? London is like all the other cities of the world. I mean … and people fail to remember all the time that London is the biggest city in Europe, with the biggest problems – the biggest, bigger ethnic problems than Berlin has, bigger language problems than Paris has and so on. So it has enormous problems. The King's Fund commission on London had to somehow address these problems and come up with some long-term view. And if you read the first report we published, it was, the view was that 20 years hence.[17] And this was immediately grabbed, for political reasons, by politicians, and a politician's life frame is only … is only hours or weeks. I mean, I've got a son who's a politician, I know all about politicians! And they wanted it all done in three or four or five years, I think was the deal. And that really wasn't on. That wasn't on the agenda.

MAM I see. So the time frame was hi-jacked, to a certain extent?

BD The time frame was hi-jacked. And then some bits of it, the report were hi-jacked for political aims again, or other aims. There's the big problem in London of stake-holders. I mean, every stake-holder knows he's got the best stake. But the problem is you can't build a fence without the stakes, and the stakes must inter-relate, and you must put the bars between the fence. And that wasn't done. So, I feel that the King's Fund commission, the first one around, was the great answer but it was badly handled … in political and media terms.

MAM So you're, you're really saying that report made a lot of common sense, but in a time frame which was quite divorced from…

BD That's right.

MAM …the very short-termism which it was treated in.

BD Mmm.

MAM Which, I think you would agree, has led to enormous problems. By shifting that time frame, [it] has put a blight on some hospitals much too early.

BD Well, I think it's put a blight on a lot of things, not only on hospitals but on careers of people working there.

MAM Well, yes, people have left blighted hospitals.

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[16] Sir Bernard Tomlinson, *Report of the inquiry into London's health service, medical education and research: presented to the Secretaries of State for Health and Education*, London: HMSO, 1992.
[17] King's Fund Commission on the Future of London's Acute Services, *London Health Care 2010: changing the future of services in the capital. A report of the King's Fund Commission*, London: King's Fund Initiative, 1992.

BD They've left blighted hospitals. And if you look at London from outside as I've learnt to do working in the north-east, London is reactionary, is sort of very conservative compared with outside London. I mean, if I just give you one example about this: if we talk of curriculum development in medical schools and so on, the curriculum we've got now in Newcastle and the north of England is developing all the time. People are talking about it all the time. But yet I sense in London it's locked in stone, it's not moving. And the only curriculum development that average students are getting – I daren't say this really, but I will say it – is probably on the tube, you know! Because they just don't have the facilities locally to do it, so they've got to use the tube to develop their curriculum. And … it's difficult to say these things. I think the idea of London going now to four or five big medical centres is an enormous breakthrough, and the King's Fund has been largely responsible for driving this message home, and indeed facilitating it. I mean, the number of dinners I've had with deans of medical schools in London, just talking about how they could get together… I mean, we, the King's Fund hasn't put any of them together or anything like that, all it's done is facilitate them talking to each other.

MAM Therefore much more… It's a major contribution.

BD Well, very major.

MAM Providing you ignore the damage done on the way, which is...

BD Well, there's bound to be damage on the way.

MAM Yes.

BD I think the damage was … not at the, not caused by the King's Fund. I think the damage was very often caused by the time-scales, caused by the time-scales of politicians.

MAM I mean, we all know that there seem to be a disproportionate amount of resources going to London, there were too many people. Certainly in an area I was interested in, you know, there were about nine departments of paediatrics who claimed to be international, and they weren't even very good national ones. So, I mean, that needed cleaning up if you like. Are you associated … do you remember … Maxwell decided that things had gone wrong, and he set up a new committee to review. Are you associated with the new committee?

BD I'm a member of it.

MAM You're a member of it. Have you started work on, on that?

BD Yes. We're well … I've spent many hours poring over papers!

MAM I beg your pardon…! Do you think, is the committee more or less the same, in fact?

BD Well, it's expanded from … I mean, we have got … the difference this time is we have got people from mental health there in a big way…

MAM I see.

BD …and we've just published a report on mental health, while I was away.[18] So, you know, it's working away.

MAM And what sort of time-scale are they going to be when they…

BD I guess they're going to do the same.

MAM …produce another report?

BD They will produce another report, I would think, in July this year after this election…

MAM Oh, as soon as that.

BD …and I would say they will put a, a health warning on the report saying 'This Report is a vision of the next 20 years. It's not…'

MAM Next week!

BD Yes.

MAM At the end of your career, in that you've retired now from the NHS, what would you say was, if you like, where has surgery been, where is it now, and where is it going, as a discipline?

BD Well, it's been a rather crude mechanistic idea in the past. I think it's now moving into a more refined mode – and I hope it is. Surgery was, when I started surgery, was to do with a lot of pain and anguish postoperatively and so on. This has now disappeared. People have now realised with good anaesthesia and good patient care you can avoid all that, and yet achieve the mechanical functions, which is all surgery is about, without the pain.

MAM That's, that's a very minor advance … I mean major for the patient, but a fairly minor advance. Is there anything, technically if you like, that surgery has moved into a new field?

BD Oh, laparoscopic surgery, that's been a big breakthrough.

MAM I see.

[18] *London's mental health: the report for the King's Fund London Commission*, ed. by Sonia Johnson et al, London: King's Fund Publishing, 1997.

BD But I don't know how big laparoscopic surgery will become. Much of laparoscopic surgery, I think, has been pushed along by hype from manufacturers of machines, rather than by any well-tried techniques. And in fact, if you put laparoscopic surgery with modern anaesthesia, modern suture materials and pain control, you can get away with most of the things you can do laparoscopically without the laparoscope and the costs.

MAM And very much easier?

BD Very much easier.

MAM Where do you see surgery going? A lot of disciplines – and you've talked about, in your career, of vascular surgeons, orthopaedic surgeons – are we going to end up with little specialist boxes, the particular bits of surgery?

BD Probably, yes. I think it's inevitable.

MAM Right.

BD I think, if you're doing surgery all the time, the, the guy who's doing something well does it frequently, the guy who's doing something frequently tends to do it better.

MAM So we will see surgery continuing, probably it advances technically.

BD Yes.

MAM But, perhaps much more specialist departments.

BD I would hope so. I would hope so.

MAM If you do that, what shape will training take?

BD Well, you'll have to train people in the sort of basic module of what surgery is all about, and this means teaching them about haemodynamics, about blood clotting, about wound healing, about suture materials, about what you can put in a body, about biocompatible things. And that will be the sort of basic groundwork. And after that, they'll branch out to their own thing.

MAM What about the young man who says – after all, take your case – 'Yes, I'd like to do surgery', had an opportunity to be a general surgeon, as it was known in those days, and became skilled in a great number of things, and then decided, either himself or through circumstances, that's the bit I want to specialise in. How do you give a young man general surgical experience? Or don't you?

BD Well, you probably don't, as, as the way things are going. The question is whether this will deprive surgery of the cutting edge of itself, the power to motivate new ideas and so on. And that I think is a very big problem.

MAM So actual specialisation, in it's own way…

BD May kill us off.

MAM …may be slightly dangerous?

BD Yes.

MAM Yes. Is there a danger that there will become associations of specialist areas?

BD Oh, this is already happening.

MAM So you, you may lose … the surgeons as a group, and just become groups of specialist surgeons?

BD I, I think this is going to happen, inevitably.

MAM I think at this stage I'm going to turn to what I think you yourself admit is your major research contribution, which is the survey of perioperative deaths. But before I do this, someone who's written so much, who's worked so hard … just a word about the family. You, you have, I think, four sons living at the moment, all of whom… Could you tell us what they are? I think they've all achieved a, a memorable niche actually, but are not medical.

BD No, not medical. I have a wife who qualified as a doctor with me, but she's never practised. She worked for the MRC for one year, and she's never done any since, since that. And she actually has brought up my sons, not me. My eldest son is an MP. He's parliamentary private secretary for trade at the moment. My second son is a trader, commodity trader, who trained as a mining engineer and then started digging up stones somewhere and found he could sell these all over the world, and now he's a millionaire, literally. And my next son is an actuary. And my youngest son is a linguist and a lawyer, who works in the Brussels Commission as a lawyer.

MAM It's not a bad … bad tower of sons to leave behind you, is it?

BD No, it's not, is it!

MAM And I suppose, like … you know, there's the corny joke, behind every successful man stands a, a surprised wife! But I'm sure that you couldn't have done this without enormous support from her. I mean, you couldn't devote that amount of time without enormous tolerance and support. Would that be true?

BD That's very true there. Not only tolerance and support, but energy to make things get done.

MAM Right. Well shall we stop there, and come as I say to sequel visits known as the major, I hope you'll agree, the major bit of your research. But thank you very much, that's a very nice view of a very interesting and in fact fascinating career for what one might say is just an ordinary NHS consultant. So, thank you very much.

BD Thank you Michael.

MAM We'll stop there for the moment.

Part Two

MAM I wonder if we can now turn to what has been so important in your career, and recognised internationally, which is the perioperative mortality survey. Now this was a study between anaesthetists and surgeons, or involving both of them. I believe there was an earlier one, was there not, of just anaesthetists?

BD That's right.

MAM But that wasn't terribly productive, was it?

BD There was one conducted by Mushin[19], the professor – then in Cardiff, wasn't he? – and John Lunn, the Reader in Cardiff, into deaths after anaesthesia, and that published round about 1980 … round about 1980 I think, or thereabouts[20]. And they looked just at deaths related to anaesthesia. They had no direct surgical involvement. And it was just after that that I met up with John Lunn by pure chance. I was examining in Cairo, in physiology of all things! Examining in physiology. And John Lunn was examining, I think, in pharmacology. And we met by chance. And we got talking about this one day, and we said 'Wouldn't it be a great idea to actually marry the two disciplines together, and take in the whole body of the surgical disciplines and look at it like this.' And that's how it started.

MAM So it was born in Cairo?

BD Well, it wasn't even born in Cairo, it was actually born in the Valley of the Kings, south of Cairo, where we'd gone out one day to have a day out, and we then refined the idea between ourselves over the remaining exam.

MAM Right. So could you just quickly define what 'perioperative' means?

BD By 'perioperative' we mean any trauma or death that happens within the whole period of operation, that is, from the moment the surgeon has decided to operate, until 30 days after the operation.

MAM I see. So it's from the decision, rather than the first incision!

BD It's from the decision to 30 days.

MAM Right. Now, the study would obviously have, was going to have to involve a great number of people, and it was always going to involve a great number of people consenting if you like to provide what at times must be difficult information for them, because we all take wrong decisions. Could you, from the moment of the inception, that surgeons and anaesthetists should look at the outcome of … misadventure if you like, and also attribute something to causation. How did you go ahead planning this study? I mean, what was the size of the sample? What were you going to involve?

[19] William Woolf Mushin.
[20] JN Lunn, WW Mushin, *Mortality Associated with Anaesthesia*, London: Nuffield Provincial Hospitals Trust, 1982.

BD Well, the first thing we did was, we both came back from Cairo, and I went to the Association of Surgeons – I was then on their council – and said 'Wouldn't this be a bright idea.' And after some persuasion, they agreed it wasn't a bad idea!

MAM Real enthusiasm!

BD It wasn't overwhelming enthusiasm but it wasn't entirely negative. I went to the then College, I went to the College of Surgeons in London … that was less enthusiastic…

MAM Really?

BD …on the grounds that it just couldn't be done.

MAM Oh I see, yes.

BD 'You're not going to really ask the chaps this sort of thing, are you Brendan?' Or, 'Maybe they won't tell you.' Nonetheless, we decided to press ahead and we got together a little group of people to think it through, under the banner of the Association of Anaesthetists and the Association of Surgeons. And they actually paid, I think, for one or two committee meetings to discuss it. And we then, John Lunn and I had by this time decided it should roll. And we then went off to your predecessor at Nuffield – Gordon McLachlan wasn't it? – and to Robert Maxwell at the King's Fund, and said would they help us with some funding towards this? We wanted first of all to explore how it could be done, and secondly then to do a pilot study whether it could be done. You know, if we put these in the modern jargon, one would be 'explanatory' or 'exploratory', and the other would be 'pragmatic'. So we got this funding, and then we had a, a very long lag period while we had to think through a whole load of issues. First of all there was the legal issue. How could you preserve confidentiality and prevent anybody getting sued? And we were very much helped in this by the Department of Health and particularly I think by Barney Hayhoe, who was, who was then the minister. But anyway, the outcome of this was that they supplied us with a letter, saying that they would use public interest immunity certificates to defend the data if anybody was ever sued. We've talked briefly about the finances for it. By this time we were able to work out some costing to do it on a pilot scale. And fortunately Nuffield, then the King's Fund, came up with the costing. And then we had to actually test it on the ground. What we did [was], we decided we'd test it in three sites. One was Darlington…

MAM Was this purely … you've sounded it in theory, now we're going to have a go in practice, but as a, a pilot. Is that right.

BD As a pilot, yes. We had, we didn't even know what we wanted to collect or how we should go about it. We had to try out different forms of data collection. And we set this up in Exeter, in the Middlesex Hospital in London, and in Darlington. So we'd got three totally dissimilar groups. And the first thing was … John Lunn and I went and saw all the clinicians at these three sites, and explained to them what we wanted to do, and explained not only what we wanted to do, but how they could tell us

as we went along how to modify it to make it better. And we did this I think over a period of about four years, trying out questionnaires.

MAM Four years?

BD Yes. Trying out questionnaires and doing it. That would take us from 1980 to, to 1986. And then we…

MAM So this was a … sorry to interrupt … a sort of constant improvement and expansion of the, of the questions and questionnaire?

BD That's right. I mean there was, there was the whole question of defining the questions. I may say to you 'Why did that patient die?' But that mightn't mean the same thing to you as to me. We've got to go this way. So we went through that exercise. And then we had got a questionnaire that worked and gave us the answers we want, wanted. You'd call that 'validity', I suppose, in today's jargon. And we decided we'd test that in three regions. And we tried the Northern Region, North East Thames, and South West Thames. And we went round, and we saw every single consultant surgeon, gynaecologist, and anaesthetist in all those regions. I actually spoke…

MAM How long did it take you?

BD It, that took us a long time. I mean, this was a rolling programme.

MAM This was, did you talk to them in groups, or…

BD In groups, yes. And if they wanted us to come back and talk one by one … and we also left our telephone number behind if they wanted to get on to us then. And then we set up and run, and ran a one-year study in these three regions. And that study was completed around about the middle of 1987, and we then amalgamated the results and published them as the original report in late 1987 – December, wasn't it, 1987.[21]

MAM Now, could you go into a little bit of detail of the, the data that was sent to you … and how did you preserve confidentiality?

BD Well, the first thing we did was … this was all data on patients that had died, so the Data Protection Act[22] didn't apply to it, because it only applies to living persons. So that was point number one to get firmly stuck in our minds. The second thing that we … all the data that came to us, we first of all removed the identity of the sender from the data, so that the data came to us, you could never identify who had sent it or where it had come from, or the name of the patient.

MAM That was done at what stage?

BD That was done after the data came back to us. We had offices…

[21] N Buck, HB Devlin, JN Lunn, *The Report of a Confidential Enquiry into Perioperative Deaths*, London: Nuffield Provincial Hospitals Trust, King Edward's Hospital's Fund for London, 1987.
[22] Data Protection Act 1984.

MAM I see. So you knew the patient and where it had come from, and at that stage you cleaned off…

BD We cleaned off…

MAM …that information and kept it separately?

BD That's right. And we, we kept that quite separately. And then we got, empanelled a whole load of advisers, specialists in different branches of surgery and anaesthesia. And we sent the data to them anonymously and asked them to comment on it. So they didn't know where the data had come from. All they had got to do was read the data, make a comment, and send it back to us.

MAM Were these individual cases they were looking at?

BD Yes.

MAM Not bulk data at all?

BD No, one case at once. And only we could aggregate it up. And that has remained the same ever since. We then … aggregated the data up, and we'd then got a sample of … I've forgotten now, it was something like three or four thousand deaths. A big sample – bigger than anybody had ever done before. And we put all these, all the sample together, the data together and, you know, and we could identify some particular things. And looking at it now, in retrospect, there were some things that stuck out. Certainly there was a clustering of deaths around individual … sites. I mean, I would even say individual consultants. So you could say there was something about that. We could say there were some practices that weren't very good practice. For instance, allowing junior doctors to operate in the dead of night, on patients that were very ill, was not, in the opinion of our assessors – these are the guys who referred, reviewed the patients anonymously – a good idea. So gradually we, we were in the central position, we could lock the whole lot together. And that's the data we published in 1987.

MAM And that was on four thousand-odd deaths?

BD That's right, yes. Mmm.

MAM I can see a problem, or I imagine a problem, in sorting out anaesthetic causes from surgical causes. Did you in fact just put them together and say 'Look at this case in the round', and not try and attribute…

BD No. We, we did it quite, we did the … anaesthetists reviewed the cases separately from the surgeons or gynaecologists.

MAM Was it possible – I can see in a number of cases, they might want to separate them. But that was not a great problem?

BD That wasn't a great problem. One of the problems was the lack of returns. You see if we sent out two questionnaires – an anaesthetist and a surgical one – you couldn't guarantee always to get the same data back. So, we had that. I've forgotten the percentages that we had … say 70 per cent of the anaesthetic questionnaires back, and 65 per cent of the surgical ones.

MAM Now what did you do about that?

BD Well we just did the best we could.

MAM I see, so…

BD And we published them separately.

MAM Right. In the … your sample of anaesthetists and surgeons in the three regions, how many agreed to participate in this study? Was it nearly all, or…

BD It was nearly all. I think we got about … one surgeon in the South Western Region said no. Quite a few surgeons and anaesthetists in North East Thames said no. And everybody agreed to participate in the Northern Region. Now that's not the same thing as saying we got all the data back, because the data came back differently in the three regions. The Northern Region produced the best, the best data. They returned … I've forgotten the figure, but over, over 80 per cent of the data came back. The South…

MAM And 80 per cent of the deaths gave you the data that you wanted?

BD That's right. The South Western Region was next. The worst region to get data back was North East Metropolitan.

MAM And they were?

BD They were about 60 per cent.

MAM Why was the… If you got, presumably everybody had said 'Yes, I'll participate'…

BD That's right, hmm.

MAM …everybody who was going to participate. Why were these, this data not therefore forthcoming? Because these were all senior people, is that right?

BD That's right.

MAM They were all consultants?

BD Well, there were lots, there were lots of issues involved in this. Firstly the data didn't come back because the notes had been lost in the hospitals, and this is and

continues to be a big problem. Notes of patients that die often disappear or get lost or something.

MAM So that would, that's not really their fault.

BD Not their fault, no. Secondly, some people would not send it back, because they'd read the questionnaires and found some of the questions maybe threatening or, you know, intrusive.

MAM Although they'd heard about this…

BD They'd heard about…

MAM …a full explanation, that's what they agreed.

BD That's right, yes. But even so…

MAM Perhaps in the…

BD The fullness of time.

MAM …the practice as opposed to the theory, yeah.

BD And, and then other people said the questionnaires were too long, and I agree – they were rather challenging, and did take time to fill in. But, all in all, the real message that I got out of it was it could be done. And we could recruit all the information.

MAM Yes, well, 65 per cent on, on those numbers, you're getting near it. Now, you just mentioned some of the … could you run through your main findings?

BD Well, I think the first thing was that preoperative decision-making wasn't always made by consultant surgeons.

MAM Right.

BD And, you must remember, these were all patients that had died. So they were all patients that were critically ill, and therefore the public and you and I had a right to expect consultants to make decisions on them, if they were going to die, or be at risk of dying. And yet this was not…

MAM They can't <u>all</u> have been seriously ill. There must have been some…

BD Oh there were some…

MAM …unexpected accidents on healthy, a perfectly healthy…

BD They're very small.

MAM Right. So they were mainly, in fact the overwhelming majority were patients who hit hospital who already were seriously ill.

BD That's right.

MAM Right.

BD I've forgotten the … numbers off the top of my head. But the majority were what we would call now 'ASA 4'(?) and 'ASA 5'(?). Really very ill patients … and elderly too. So, the first thing was consultant non-involvement in making the decision to operate. Secondly, consultant non-involvement in doing the operations – operations being left to relatively unskilled and junior people to do.

MAM Not necessarily difficult operations?

BD No.

MAM But in seriously ill people.

BD Well, risky operations, yes, or risky situations. We found problems with divided sites – you know, the intensive care unit would be there, and the operating theatre there. And there was really very little co-ordination between them for management issues like this.

MAM So the postoperative care might not be ideal?

BD No.

MAM But that would be … what, a structural or a management problem?

BD Management problem. But could be, but it could be sorted out. I remember getting one letter from one consultant, who wrote something like this. 'For the last 20 years I have been complaining that it is impossible to run a good surgical service in this hospital, because we don't have an intensive care unit. It's *x* miles away.'

MAM What, this is just a remark?

BD We found deaths due to quite simple things. There was one case of a patient died with a ruptured aneurysm, and the patient had got the ruptured aneurysm, had been carted into hospital 'A', which was on take that night. The surgeon that came to do the operation was a trained vascular surgeon. But the blood had been cross-matched in another hospital, and the blood was on a different budget, and they wouldn't transfer the budget and the blood over.

MAM Oh dear!

BD There was an example of a patient got the wrong side of their brain operated on for an extradural haemorrhage, because the x-rays weren't there. There were these

types of problems. And I must say, I very much … when I wrote the report out, adopted the 'warts and all' attitude, I just wrote it all up.

MAM: So, preoperative decision…

BD Skill…

MAM …not fully skilled people doing an operation…

BD That's right.

MAM …certain pretty obvious, but, nonetheless, very difficult management or logistic problems. Any other … or were they the key…

BD They were the key things there. Another was failure to recognise pre-existing medical diseases – like diabetics that were not adequately assessed, or patients with chronic obstructive airways disease weren't assessed enormously. Or elderly patients with fractured neck of the femur – there was no handing of these patients over to geriatricians or physicians to manage part of their postoperative care.

MAM Now, is that because coming in – most of these presumably, as urgent ill cases, or emergencies – that the Health Service is renownedly bad at providing information quickly, even on such simple things as being a diabetic.

BD Well, this is one problem. Another problem we found in this original study was patients didn't have, ever have their urine tested, preoperatively. You know, there were diabetics who went into diabetic coma, who hadn't had their urine tested. Or it had been tested and not handed on this information. I mean, there are a whole range of issues about information in hospitals.

MAM Of the three things that you're talking about, or the three main findings, would the decision one – i.e. that at the beginning – be probably the most important? It seems to me that the decision to operate … requires 'Have you tested the urine?' and various other things. But [it] also, would also determine who did the operation, and when it should be done. Would that be a fair comment that the…

BD That would be a, that would be a very fair comment. I mean, there are a, a raft of problems around this. The decision should certainly have been made by a senior person, i.e. a consultant. But clearly, at that time, there were far too few consultants, particularly in disciplines like orthopaedics, where they had a load of trauma to deal with. And our report highlighted this. Secondly was [that] the decision should have been made by the consultant. You were bound to ask yourself, as a consultant, as I was at the time with a big operating practice myself 'Where were the consultants?'

MAM Yes. And where were they?

BD Well, I…

MAM At home? Busy? Or junior staff not wanting to trouble them?

BD I have no information on that at all. The question I ask is 'Where?'

MAM Now, did your report make recommendations? Presumably it did, on these three facets.

BD It did. It said that consultants should be involved. What was most interesting to me then, with working in the north of England, was the consultants in the north of England went and saw far more of the patients than they did in North East Thames. Similarly, the consultants in South West Thames saw more, far more of the patients than they did in North East Thames.

MAM Right. Presumably, that has a bit to do with staff turnover, does it?

BD It might…

MAM Because I imagine the provinces are rather more stable than, say, London.

BD It might have to do with staff turnover. I don't know. I never did that sort of study particularly of that issue.

MAM Now, the question immediately arises… Here you've done this study, you've found out some really quite important things. What was the death rate? Was it, was it very horrendous or not?

BD It wasn't.

MAM It wasn't?

BD No. I mean, at that time, we were able to calculate death rates because this was data of 1986/87, so we knew the number of patients. The death rate, I've forgotten … was 0.5 per cent or something like that. It was low by international standards.

MAM So, considering the, the sort of people that surgeons and anaesthetists were coping with…

BD It was a very good rate.

MAM …was actually a pretty good record…

BD Yes, yes.

MAM …despite these recommendations and findings.

BD Mmm.

MAM Now, the question arises that you say, right, you've done this. You've shown there are unsatisfactory practices, you can tell people, you know 'Don't do this, don't

do that.' What you want to know is whether that work actually has borne fruit in that anybody takes any notice. So presumably, as you were coming to the end of that study and looking at the data, it must have already been crossing your mind that ideally one should repeat this. … Or either, either continue it and expand it, or repeat it in those three regions in, say, two to three years. Was that true? I mean, were you worried about this?

BD That was true. I mean, when we were putting the data together, of course the answers began to come, come to us, and we talked to other people about them, colleagues and people like that. So people knew the information was coming along, and then we published it. And the next day, Mr Tony Newton – who was then the minister of health – got up in the House of Commons and said they would fund a similar study like this in the future. And they got John Lunn and myself in to see them, to say would we run it for them, which we agreed to do.

MAM Was, was that to be continued in just a small number of regions?

BD No, made national.

MAM This was going to be a national study?

BD This would be all of England and all of Wales.

MAM So your report – which I'm sure Mr Newton and his officials saw long before he stood up in the House – was in fact instrumental in the government saying 'This is so important that it ought to be continued, but not just in a limited number', it was to be national. Is that right?

BD Yes, that's right. And done properly.

MAM Well, it seems to have been done very properly anyway!

BD Yes. But what I mean is … universally would be a better word.

MAM Now, the problem arises if you're going to do it nationally, I imagine the … I mean the logistics change, obviously. But basically you had all the instruments worked out. What you now faced was an enormous number of consultants of both disciplines, to agree to do this. Or, or did you decide to take sampling?

BD No, we decided to ask … go for the lot.

MAM For the lot.

BD Yeah.

MAM Right. How did you set about that? Because that's a huge task. Did you go round every region?

BD Well, we went round every region, but we didn't go and aim to see every surgeon. We went to big surgical societies, or anaesthetical societies, and made presentations to them.

MAM Right. And then spread it out?

BD And spread it out.

MAM What was the agreement rate of the consultants? Was it any different from the regions?

BD No. Very high, very. The interesting thing was the vast majority of surgeons, and anaesthetists – I say surgeons because I dealt with the surgeons most of the times – was they would all join in. I mean, I've only even … up to today, only had one or two surgeons who say outright they don't believe in it.

MAM So there was, to what extent was the CEPOD [Confidential Enquiry into Perioperative Deaths] report – that's your first study – influential on people's agreement to take part in a national study?

BD I think…

MAM Did you find most of them had…

BD Most of them had read it. They'd heard about it. We'd spoken at all the big surgical societies…

MAM With, sort of axle-bashing, acts of passion(?) if you like, I mean agreement that this was important?

BD Well, with agreement that this was important. I think we'd actually almost made the culture change – people had got now to start looking…

MAM With the first report?

BD …at their outcomes. And, I mean, their culture change was even larger than CEPOD. Their culture change was part of a change to the whole concept of looking at outcomes, looking at what you're doing … audits, so to speak. And this culture change, I think, started with CEPOD.

MAM I was going to say … but I think you've answered the question, in many ways you shouldn't answer, but it strikes me that that study has been the one major initial audit study. I mean, people talk about quality assurance. But it seemed to be CEPOD was the first great audit study anywhere in the world, actually.

BD Yes.

MAM Would you agree?

BD I would agree with that, yes.

MAM So we have an awful lot … to be grateful for, for that study. Now when you came to the national study, we're talking about something much bigger in terms of data handling. It was done, based I think at the College. Is that right?

BD We had a great struggle.

MAM Why? In what way?

BD Well, I had to find somewhere to put it…

MAM Yes.

BD …you know, in terms of an office and so on. And I had to use a lot of charm persuading the College of Surgeons to take us in.

MAM Well, of course, they've always been under pressure for room anyway, and you would need quite a lot of staff for this wouldn't you?

BD We'd need quite a lot of staff, yes… Not very big – at the, at the height of the study we maybe have seven permanent staff.

MAM Oh, it's not as many as I thought.

BD Then, and then we have a whole load of people working as advisers. You see, the system we're using at the moment – which we've used all the time – was that we run it, run the system centrally, but we ask all the specialist groups to nominate advisers to us on an annual basis. So if we're looking this year, say, at operations on children under five, we ask the people who are doing operations on them to nominate *x* number of people to… We now know the epidemiology of death very well, so we can estimate how many deaths in any sample we'll get, and we know how much work that will involve.

MAM I see. So you can actually be very precise about the logistics. You're still using every case being reviewed?

BD That's right.

MAM That's still the same technique?

BD Yes. We, we use the same technique of every time a death occurs, that will be reported to us. And then we will decide if it is in the sample we're going to look at that year. And we will recruit advisers in that sample frame, to advise on it.

MAM In the national study … which has been running how long now?

BD Since 1987.

MAM So we're, we're almost a decade at the national study.

BD That's right, yeah.

MAM Are you able to say 'Yes, things have improved in those three key recommendations'?

BD The answer is yes. We have clear evidence now that the number of operations done out of speciality, the number of operations done by juniors has fallen, the number of consultants seeing patients preoperatively has risen. I mean, this year for instance something like 92 per cent of all the patients who die after operation have been seen by a consultant before the operation started, and the decision has been made by a consultant. There's been a dramatic improvement.

MAM So what is the future of the national study? Is that … do you feel that ought to go on, or has it run its course? Should one do, you know, intermittent studies now rather than continuous?

BD Well of course the national study must be seen within the context of today. The context of today is very different from the context of 1982, when we started this. The context of today is … we have audit, quality assurance, outcome measures right across the country. Everybody knows about them, and they think they're part of today's environment. They don't think anything odd about them. I mean, currently we're looking at out of, out of hours operating, and we've got panels of registrars looking at the cases rather than consultants. And it's very interesting talking to those registrars. They accept accountability for what they do, and what outcomes we get, quite differently from the consultants that I talked to in 1982. So there's been a culture change here.

MAM And genuinely not a lip-service but a real culture change.

BD Oh a real, real commitment.

MAM I mean, people see this as part of their duty.

BD It's part of their job as a professional person.

MAM Yes. That's an enormous achievement, isn't it?

BD Mmm.

MAM Has any other country taken this…

BD Yes.

MAM Lock, stock and barrel?

BD Lock, stock and barrel. I mean … well Australia's doing it, and the Netherlands have got a similar type of system. Singapore's setting up a system,

Malaysia has got a very good system. Scotland has taken it up two years ago, and has got an, an even more elaborate system than the English system. But of course the Scots have got far more money per head of the population than we have in Britain.

MAM Myth! A myth, says he who worked in Scotland!

BD No, but the, it is quite differently organised, and is producing good results.

MAM But it may be that that study will have to change. As you say, there's been a seed change, but there's been a seed change in data collection anyway, so it may in time be superseded by a, a rather more routine system rather than a special one.

BD Well, I think this will happen, I… And I would hope this would happen. I think that the data systems that are coming on stream this year, in England and Wales, should solve the problem, just bring it up routinely. We should be able to get the answers without any elaborate sampling method or anything like that.

MAM Are you still getting high returns?

BD Yes. They're going up.

MAM That's a, a major achievement then, I must say. Could I put it to you that in your career, that must be in the research sense the absolute highlight?

BD Well, that's very kind of you to say that. It is, it certainly is something different.

MAM I mean it's the start of audit, a fantastic … first study, taken on board as a national study, seems to me a tremendous achievement. And presumably, Dr Lunn takes a pretty equal share in…

BD Oh, exactly. Fifty per cent of the share.

MAM Yes, yes.

BD I mean, he and I have worked tirelessly for this. And it's very interesting looking at it, looking at how things have changed since 1982. This was difficult to set up, but in my present job – running the epidemiology and audit unit of the College – we are now able to run big studies, say, of… We've done one recently on upper GI endoscopy; we've done another one on upper GI haemorrhage,[23] where we were able to recruit 99 per cent of the data.

MAM And … especially recruit this?

BD That's right.

MAM But it's, it's now become much easier to do that sort of study?

[23] National Audit on Acute Gastrointestinal Haemorrhage.

BD That's right. People expect to.

MAM Is that … because I believe the College have an audit unit, which is, is separate from the national study…

BD Quite so. Quite so.

MAM But that's the sort of work the audit unit are doing?

BD That's right, yes.

MAM So you've not only a seed change in people willing, but also to provide and examine their own performance, but also a willingness to take … part in one-off studies. So there's really been a… It's been quite a remarkable change in, what, ten years?

BD Well, 1982 … 15 years since it…

MAM Thank you very much for talking to us. It's been a fascinating career with, I would have thought, a lot of personal pride in achievement. I know you're not a particularly proud person, but you must look back with considerable, I'll use the word 'satisfaction', on a number of facets. But the CEPOD one, in my mind, stands out as an outstanding achievement, as the forerunner of audit, which is developing all the time. So thank you very much indeed. Most grateful.

BD Thank you Michael, thank you.