The Royal College of Physicians and Oxford Brookes University
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Sir Roy Calne FRS in interview with Dr Max Blythe
Addenbrooke's Hospital, Cambridge, 12 December 1996
Interview One

MB Roy, we are in Addenbrooke's in the University Surgery Department, which you have been running now for thirty years.

RC Thirty one.

MB Thirty one years. The pressure in this life, I know, is quite extensive, you don't stop very often, you're always on the move, I have witnessed that while I have been here. Tell me a little bit about the working week you have.

RC One of the interesting things about it is that it is variable so it can be very full of hasslement and difficulty, and it can be relatively straight forward as planned. So we have an ordinary planned surgical commitment of clinics, ward-rounds, operating sessions which has certain days and times, but also there are emergencies. I was appointed here, and still am, a general surgeon, so I do a lot of ordinary surgery. And I started transplantation here – before it didn't exist – and it started off as a very small bit and was just part of the general surgery, just another branch of it, but now the transplantation has become a very major endeavour. I have good assistants here and we all work very hard. We do about a hundred livers [transplants] a year and about eighty or so kidneys, so that means that there is enough work, it's like adding a whole new job on to what we have already got.

MB Is it really a valuable acquisition for the local health authority, the fact that you are doing so many transplants, is it a good earner?

RC The health authority gets a very large grant directly from the government for the liver transplants and then the other work is all negotiated. I have never thought about it in terms of money, it's really providing a service for people who previously had no treatment, the transplants.

MB I know you have been very concerned about a health service that has got more and more preoccupied with finance and pushing money from place to place.

RC Well, that has happened in other walks of life, but particularly in the health service, and I have been exasperated by the fact that it is not real money, it's money that they talk about and then if the chips are down, the government bails them out. So it becomes a bit of a game and a great deal of money is spent by the health service in administration, which in my opinion achieves nothing; highly paid, very skilful and often very pleasant, well-motivated accountants who argue with each other – the hospital trust against the other negotiating bodies. And they come back with big smiles on their faces after a day's negotiating, having brought the price down or made a contract that seems favourable. And that seems to be unrelated to the care of sick patients. I do think that it is

possible to be extremely wasteful in any kind of health provision, but I don't think anything is nearly as wasteful as the bureaucracy, plus the danger of losing the goodwill, which means that many people – I think everybody in my department – works far harder than any hours arrangement would permit. And if there are continual frustrations and hasslements – cancelled operations, no beds for the patients, no ICU beds – then that goodwill will be lost, and the health service will lose far more than any money they think they are gaining by these petty, so-called reforms, which, I think, for the most part have had the opposite effect.

MB You have talked about hassles in your life. In our conversation earlier, you have talked about having difficulties in sometimes finding an operating theatre.

RC Yes.

MB Is that a symptom of the time?

RC Yes, it happens frequently, it doesn't happen all the time. Sometimes you hang around all day waiting to get a patient in, who should have been operated on first thing in the morning, because there may by a road-traffic accident or something else builds up. And this can be very wasteful because surgeons are then being paid for doing nothing, just waiting. Then, of course, we also have a completely additional burden of working out of hours, so we may have to do transplants during the night. We may have to do general surgery during the night and then have to work all day. Or we may have the responsibilities of the day work plus emergencies both having to take place, as far as one can do, at the same time, and that means that the day can be very long. It can be easily a twelve hour working day after being up all night, but not regularly, intermittently. And that becomes stressful.

MB You are the university department and we have talked of the health service departments of surgery – has the whole pattern of relationships between these departments of surgery got better?

RC No, it has got worse and it is almost inevitable. Until very recently university doctors were not allowed to do any private practice whereas the health service people do a lot of private practice, some of them enormous private practice, particularly surgeons and gynaecologists and obstetricians. So there is the tendency for young trainees to look and see the style of life and the way of life of an academic compared with life in the health service, and many good people who might have been excellent research workers, and advanced the field of surgery, have gone into the health service with private practice as the main objective. Maybe that means that they were not sufficiently motivated, but there is the hasslement and difficulties of an academic post. It is very difficult to get money to do research, to get grant money. If one is working with animals, which is often essential in surgical research, then there is even the danger of physical attack, and terrible bureaucracy in order to get a licence to do the work. So, many people are throwing up their hands and saying 'Is it worth it?' The actual relationship between health service doctors and university doctors with health service contracts, which is what we are, I think that has deteriorated too. There is a feeling that the health service lot are making too much money, from our point of view. From their point of view, we get too good a life because we get invited to go and talk all over the world and get a certain prestige which is lacking in their private practice. So there is not really very much harmony between the two sides.

I think that every teaching hospital should have a single form of contract and that everybody appointed should be on the same contract, with a limited amount of private practice permitted, and with encouragement to do research and teaching. But at the moment there is them and us, and depending on who you ask, it is either them or us.

MB Bringing the two together is not a message that you are getting across?

RC No, I mean if a university hospital was in fact a university hospital run by the university with a health service contract, taking care of health service patients, then if a surgeon wanted to apply for working in a university hospital, they would know what it involved, a certain contract. If they didn't like that and wanted to do more private practice they would choose another place where that was permitted, another trust hospital elsewhere.

MB Roy, I know that you have been frustrated over the last few years by many administrative nonsenses. What would you like to see as the big steps towards an improved future health service? You talk about the flexibility not being there to allow sometimes things that are essential to happen. What would you like to do to open the way to a better, more pliable health service?

RC Well, I think that it is difficult. I don't believe that the government, the department of health, and the civil servants have an easy time, because as soon as they think they have made some kind of a new arrangement which is suitable, medicine advances or moves in another direction, and there is a clamour for more facilities for doing things often that are very expensive. So inevitably, whether one likes it or not, whatever health system you have, there is a certain size of cake and that implies that there will be some kind of rationing either by how much you can pay to get private treatment or rationing by what age you are, or what kind of disease you have. You could ration according to outcome and say if you have a disease where the outlook is really dreadful, it is not worth having a really expensive form of treatment. But whatever it is, the fact is that there is a limited cake and medicine has advanced beyond the possibility of offering this cake in full to everyone. That is a bitter pill. It is a very difficult nettle to grasp, especially by politicians who are looking for votes. And so they don't want to, and I can understand how they feel, they don't want to say, 'Look, we can't give you everything that you want, there is going to have to be a rationing and the reasons are that medical technology has moved on, people are being treated for things that previously they couldn't be treated for at all, and now we need to decide what the priorities are going to be.' I don't think that that is easy for a government in a democratic country to do, and even in an autocratic country, I think it would be difficult.

MB Even in a country with economic resources that are surely limited.

RC Well, with every country, even the United States, the economic resources are limited, and what kind of health care we have, and are able to afford, needs to be something that is clearly and honestly explained to the electorate, and I don't think that has been done, and part of it is lack of understanding. I mean, if you just take transplantation, liver transplantation, it is possible from about the age of one month, a child of a month's age to somebody of seventy-five, it is possible to do liver transplants in them. But we need to look at the results in patients over seventy or under six months and say, 'Is it worth it?' But there will always be one or two patients that have done

well in each of these categories and that is what makes it so difficult. I don't think it is easy, I mean it is easy to criticise but if you look at it honestly it is not an easy task to get right.

MB You are suggesting we need a better dialogue with the client, with the population, to actually understand health services so that we can have more recognised rationing than the kind of unofficial rationing that you have to impose now?

RC That's right. I mean it is an *ad hoc* rationing now. Also, I feel that the training of our doctors is inappropriate for modern technology. There are many things in medicine and surgery which are highly technical, needing to be repeated every day or many times in the course of a year, otherwise skill is lost. The training needs to be special for that. It's like an airline pilot who has got to learn the skills of flying, say, a Boeing 747, and he will retain that licence as long as he puts up so many hours, does it correctly and has the right training, but he will not be allowed to go into some other kind of plane without again going through special training. That, of course, implies a technological kind of training. If you are going to do endoscopy in the knee, day in, day out, then the anatomy of the knee you need to know better than anybody else and you need to understand all the different diseases of the knee, but it is a limited portfolio, as it were. There need to be some doctors, I think, who are trained in that, which is a small area of special training, but they do not, in my opinion, need five years of training that we have at the moment over a wide general field. They do not need to know about psychiatry, they do not need to know about dermatology if they are only going to be working in one area, and *vice versa.*

MB So your thesis is that they should specialise in these directions earlier and not take massive funding for a general education that goes on too long.

RC Which is massive funding, it's a huge amount for a medical student, to get him or her through.

MB I think it's more than two hundred thousand pounds now.

RC And, of course, the other side of the coin is that you cannot have everybody highly specialised in a finite field, you need some generalists. So there need to be some of the traditional kind of medical schools, I call them the archaic training, and perhaps that fits best for academic doctors in medicine and surgery and general practitioners.

MB But you would have a bifurcation, the specialist going one way and the generalist the other...

RC From the beginning, the decision right at the beginning.

MB Right from early on in the training?

RC But, of course, I am sure my profession would fight that off.

MB Have you made this point strongly in arenas ... ?

RC I have made it strongly and at the moment it is totally ignored as the best way of not facing it. I think if it had to be faced it would be resisted very strongly because there

would be a lot of vested interest, there would be a lot of rocking of what is now a comfortable boat for many of the medical teachers to sail in.

MB Roy, just in winding up, we have talked about some of the difficulties, the hassle, some of the considerations about greater efficiency, some of them that are not getting anywhere at present. But looking at the advances that have been made, you have built a department from a man and a dog team when you first came here, it was not a very large department...

RC It was nothing, it wasn't a department.

MB You have built a colossal department now that has an enormous impact on local surgical interests. What have been the great advances that you have enjoyed? We have talked about difficulties with the health service, but what have been the greatest gains of the last thirty years?

RC Without any doubt it is to see patients ten years, twenty years, thirty years after receiving a transplant who would otherwise be dead, and especially when they have done well and had families and lived normal lives and had occupations that are worthwhile. I mean that is complete satisfaction. I don't think you could have a better job, actually. It can be hard at times but it's worth it.

MB Just amazing. You couldn't have believed when you came here, could you, what was going to happen?

RC No, but I was aiming in that direction.

MB But you couldn't have believed what was going to take place?

RC No.

MB Roy, we are going to see you in theatre, in a clip of film, then going to look at your list today, and then we will come back and probably digest what has happened before we move to the last part of our interview. For the moment, thank you.

RC Good.

MB Well, we have had cameras in theatre, can you finally digest for us what has been seen on these clips today, Roy? It's rather special, I think.

RC I have had to do a general list today and I had two gall bladders to do, but also there was an emergency, a young patient with a liver transplant whose bowel became obstructed, completely obstructed over a period of time and did not respond to what we call medical treatment. We didn't know the cause of the obstruction but it was absolutely essential to operate because you cannot leave an obstructed bowel. What we found, as you saw, was a rather dramatic, dilated bowel and then at the lower end of the bowel, a narrow ring constricting the bowel, and the ring was held down by an adhesion, that is a little bit of fibrous tissue, about as thick as a piece of thread and about a quarter of an inch long. The

cure of the patient was one snip with the scissors.

MB Spectacular.

RC Yes, I wish it was always as easy in surgery. But it is interesting to just contemplate that without surgery that patient would have died, and one snip of the scissors was all that was necessary and the patient should do very well now.

MB Roy, for that opportunity to see you in operation in the theatre, thank you very much.

RC A pleasure.