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**Sir Christopher Paine in interview with Sir Gordon Wolstenholme  
Oxford, 12 May 1997**

GW Chris, I'm very grateful to you for driving up from Exmoor to Oxford today for this interview. You are at the moment the president of the Royal Society of Medicine, and you have been already the president of the Royal College of Radiologists and of the British Oncological Association. This is perhaps a little unusual a career for an old Etonian. When you were at Eton, did you have any idea that this would be the kind of life you would lead?

CP None whatsoever Gordon, no. I enjoyed my time at Eton. I particularly enjoyed I think the science and biology, and so I was I suppose going in that direction at that time. But I had no idea until the very end, but my last year or so at Eton I realised that I was probably going to do medicine and go to a medical school.

GW And you went up to Oxford, but did you then believe that you were going into a medical career?

CP Yes. I did realise then, because of course I had a medical place at Oxford.

GW Oh yes.

CP But I remember my housemaster at Eton telling me that, you know, he was very surprised. He thought I was quite unsuitable for medicine, and it was in any case quite improper for me to have got into Oxford at all because his interest really was in classics and things of that sort, and he didn't see a lot of value in scientists. And so, I didn't really go with his blessing.

GW That's an interesting comment because I shared it, to some extent. My college at Cambridge equally didn't think that a medical career was one that any, well, reasonably ... gentleman would approach!

CP No. I don't think I got into Oxford<sup>1</sup> on account of any great academic abilities. I think that was possible in those days, because I remember the warden – who was Geoffrey Mure at that time – interviewed me, and there were several dons, I think probably seven or eight round the table, but his only question to me was... He said 'Oh Christopher' – because he'd known my grandfather and my father before – he said 'How many days a week do you hunt with the Old Berks?' And I was absolutely terrified because I knew that whatever I said, I had never hunted with the Old Berks in my life actually, and I knew whatever I said would not appeal to most of the dons round the table. So I can't now remember what my answer was, quite.

GW Well, you seem to have sort of accelerated quickly from that start at Oxford. I

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<sup>1</sup> Christopher Paine attended Merton College.

mean, you got your, you qualified in '61 I think and already in '64 you'd got your Membership of the Royal College of Physicians. Did you then have any idea in which direction your medical career would take you?

CP I was beginning to have because I worked at that time, I was houseman, I suppose that was just afterwards but I was houseman in the Nuffield department of medicine, at Oxford, and I'd been a student on Bodley Scott's<sup>2</sup> firm at Barts [St Bartholemew's] and so I became interested in haematological malignancies, from the beginning. I was very interested in his work on lymphomas and with mercaptopurine and the other cytotoxics. And I think it really started when I was a student actually.

GW You, when you had qualified, you did your junior jobs at Oxford, London and in France, I believe. Where did, where in fact did you start? You started in Oxford, I presume.

CP Well, I started, I didn't get a job at Barts, there was ... I wanted to have a medical job if possible but didn't get one. And so I thought well, what about Oxford? So I went back to Oxford and saw somebody who was an administrator then, the assistant establishment officer, called Geoff Thomas-Harvey(?). And he said, in a rather grand way, 'Oh I can't offer you any jobs in Oxford this time round, but I have one at High Wycombe.' He seemed to feel that he was the possessor of the job! So I went to High Wycombe where there was a very relieved surgeon by the name of Kenneth Taylor(?), whose house job I subsequently did. And I remember arriving there in a snowstorm on January the first of whichever year it was, and there were about thirty Colles' fractures, and I had never seen one at all before when I was at Barts I don't think, and one really had to immediately start work. And I enjoyed that surgical job enormously at High Wycombe, and subsequently did a radiotherapy clinic there for about thirty years so I got to know Wycombe very well. But that was the first job and then afterwards I did a house job with Professor Witts<sup>3</sup> in Oxford because, fortunately, the Oxford graduates of that moment all failed and so what would otherwise have been rather a plum job in the Nuffield department of medicine fell to me. And of course, I then met all of the other people working on that firm – Sheila Callender and John Badenoch and so on, and Sidney Truelove. And so that carried me forward. But I became even more interested in malignancy during that job because of course it was an interest of the Nuffield department at that time, of Witts himself and also of Sheila Callender.

GW Right, yes. What was then, in fact, your first official job in connection with cancer?

CP Well I suppose I did a short-term job as temporary registrar in pathology, because I thought that was something I wanted to know more about, with Rob Smith(?), and again was quite interested. But that was, that was a sort of side job in a way. My first proper job was as registrar in the department at the Churchill because Frank Ellis, who was in charge then, kindly took me on. There wasn't great competition for radiotherapy.

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<sup>2</sup> Sir Ronald Bodley Scott.

<sup>3</sup> Professor Leslie Witts.

GW No, and the distinction, presumably, at that time wasn't made between radiotherapy and radiodiagnosis, I mean, or at least not in career terms?

CP Well, yes, it was.

GW Was it? Already?

CP Yes, in this country I think the war was the, I don't exactly know when the dividing time came but since the war, since the last war, radiology and radiotherapy have been completely separate – the training and the professional career structure – so that's not new. In fact, there aren't very many countries in the world in which the two are still done, even now, you know.

GW No, but there was a period when I think there was some confusion.

CP Oh, there was certainly. Yes, I think that was probably between the wars. In England, by 1938/39, I think people did one thing or the other. One was cancer and the other one was diagnosis, and they'd become sufficiently distinct, yes.

GW And in a way, you went to radiotherapy via your interest in cancer, rather than the other way round I should imagine.

CP Yes, yes. I had to learn all about radiation; I knew nothing at all about radiation. But I went to, I did a job at the Hammersmith, a house job there, right at the start and that, I became interested in the cyclotron that they had there at that time and had for another 25 years. And so I quite rapidly acquired some knowledge and interest in medical physics.

GW How did you come to go to France at all?

CP Well that was a, I'd been a registrar for a year or two in Oxford then, I think it was 1964, and an advertisement came through to the department from the Institut Gustave Roussy in the southern part of Paris, just advertising for what were known as *résidant clinicien* there. It was a kind of registrar post, it was funded by the French government and doesn't exist any more I'm afraid. But it enabled a few English people to go out there and sometimes other people to come back here, so it was a kind of exchange scheme. And I was there for only four or five months but I found it immensely valuable in, in teaching me a different way to look at medicine generally, quite apart from radiation.

GW Was it recognised as a part of your training?

CP Yes it was, yes, yes. The College<sup>4</sup>, I had to sort of plead with them, but I think there was no, it was a well-known institute, and it was... I went there, really, to learn about the newer developments following radium needles, because when I first started as a radiotherapist you used radium needles for implanting into tumours. And I remember one Thursday afternoon stitching thirty little radium needles onto the back of somebody's hand. It took me an hour and a half because each one had to be put

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<sup>4</sup> The Royal College of Radiologists.

into some rubber tubing so it didn't get lost, and I thought well, I must have received a radiation dose while I was doing this. But Frank said 'Oh no, it's quite all right', because, you know, in his heaviest period of radiation exposure he'd all his children and they were all right, weren't they? And so, after that I took no notice of things of that sort and... But I did think it would be better if we didn't actually have to handle radium needles at all. And they'd, they were leading on that transition in France, and there were various newer wires which you could get that were radioactive which could be afterloaded, as we called it, into a plastic tube which you would put in the patient at the time of surgery. So that removed much of the radiation hazard from the operator.

GW They were the first to consider protection of the administrator, so to speak?

CP Well, I don't think... I mean everyone, ever since it was realised that a lot of the original radiation workers of course had died from radiation, medical radiation exposures, people had tried to improve technology and to avoid exposure of staff and of the patient to unnecessary dose, and the general public. So it was a general trend. But the French I think have always been in the forefront of developments in radiation, right from the beginning when Madame Curie<sup>5</sup> of course and Becquerel<sup>6</sup> made these great advances.

GW Yes. Did you ever go to the Becquerel house?

CP No, I've never been to the Becquerel house.

GW Well, it's sort of a shrine to him, and I think it was his daughter that I met, fifteen, twenty years ago, and who was worshipping her father and his memory. And it still had everything in; memorabilia connected with his early work.

CP He was an amazing man. One of his, one of his things was that he carried radium needles or whatever, little tubes I suppose they were in about 1906, in his waistcoat pocket, the left hand one, and after a time developed a red patch on the skin of his chest – the 'Becquerel burn' so called. But he denied for ages that it was due to the radiation, and it had to be, he had to be persuaded to carry them in the other pocket and get it on the other side before he could be quite convinced!

GW I tried to get Sir Brian Windeyer in one of these interviews to talk about the early days of his use of radium in Australia, and why they ever came to be putting it in the form of little needles on, around the lesion, whatever the lesion was. Mostly skin cancer, I think.

CP Yes, well they did it of course because you couldn't get things that were very radioactive at that time. They simply weren't available; cobalt, of course, hadn't been really discovered. And you could have a thing called a radium bomb in which you had a piece of radium, which was about the size of a golf ball inside an apparatus that was at a distance from the patient. But the amount of radiation that came out of it was comparatively small, and it really wouldn't, you had to have it so close that it didn't

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<sup>5</sup> Marie Curie.

<sup>6</sup> Henri Becquerel.

act as a radiation machine from a distance. And so therefore they thought well, let's have the radiation in the needles and put it actually in the tumour because there it will be as close to the tumour as possible, and you will not damage the normal tissues round about the tumour more than minimally. So that's why radium needles were first used. And now iridium wires, which I worked on in France and many other people have done too, they are now still very valuable for some tumours. For instance in the tongue – in the mobile portion of the tongue, anterior two-thirds of the tongue – you can cure small cancers there easily by that means and you preserve entirely the normal architecture of the tongue so the person still has a normal tongue, whereas if you have a hemiglossectomy then of course the tongue is deformed. I mean you can still speak perfectly well but it's not quite such a good cosmetic result. So the technique still has a place. In skin cancer I think probably it hardly has a place any longer because there are better methods, better methods of treatment now.

GW Radiotherapy, in, before the war, in my time so to speak, was something quite distinctive. It wasn't in a way part of oncology, I mean, it was obviously treating cancer patients – I'm talking about the Marsden Institute at The Middlesex – and yet the career, if you like, of oncology has developed enormously over the last forty years hasn't it?

CP It has done, yes.

GW And people are really looking at the treatment of malignant disease in total, aren't they, and not from one particular chemotherapeutic or radiotherapeutic angle?

CP Yes. Thank goodness that is so. I mean, it was certainly necessary before because I think some of the problems with oncology, if one could call it that even before the term was really known about, was that, you know, everybody had their own idea of it. And there was Halstead<sup>7</sup> doing his radical mastectomies, people doing super-radical mastectomies, other people saying 'No, implant the breast with radium,' or give patients in those days very toxic cytotoxic agents. I mean the bringing together of these strands of thought, whether it be surgery or radiation or medical treatments as there are today, has been I think to the very great benefit of the patient.

GW Yes, I would think so. Certainly it, there was even competition between the different attitudes.

CP Oh yes. Well doctors are not slow to compete, are they?

GW Well, I mean there were so many mutilating operations that possibly were, now would be regarded as unnecessary.

CP I think that's right, yes.

GW But you did, your first interest as you said was really in haematology and the malignancies that might come from the, from blood and I suppose lymphomas and Hodgkin's disease and things of that kind.

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<sup>7</sup> WS Halstead. The operation he devised – the removal of the whole breast – became known as the Halstead radical mastectomy.

CP Yes, I mean I was interested in that partly of course because the firms that I happened to be working on as a junior doctor, it was their interest, and... But a lot of it was very difficult, sad and tragic stuff. I mean, the acute leukaemias for instance, most of which died; young people, and [they] usually died pretty quickly. But I found that, you know, treatment was beginning to influence those, even in adults. And I also found that it was really a fascinating scientific study. I mean, I was very interested in leukaemia trials when they first came. As Professor Witts said, at that time, I mean, one cures practically no one but at least we now have in the country a national trials organisation and the moment some new drug comes along we can immediately submit it to clinical trials. So it was, I was responsible for organising two or three of those trials nationally at that time for Professor Witts, and I found that structure interesting. And I also liked looking after patients – they were young people, tremendously courageous. And I really enjoyed that, and enjoyed of course where we were able to produce remissions in their disease; it was marvellously satisfying.

GW It must have been tremendously exciting.

CP Yes it was, yes, yes.

GW And radiation remains extremely effective in many of these particular blood disorders, doesn't it?

CP Yes. Well it, I think not so much in the blood disorders because chemotherapy on the whole... I mean of course there is bone marrow transplantation and all that sort of thing now, but I think on the whole chemotherapy has taken over in the more systemic forms of malignancy. But, I mean, radiation certainly still has an important part to play in treating cancer in different phases of the disease and different aspects of malignant disease. But I think it's, the part it needs to play is now better defined than it was when I started and the treatment is altogether safer, better for the patient, more accurate. All these things have improved enormously.

GW Were you, did you find time for research in all this?

CP I did a certain amount of research. It was mainly to do with new technology for implantation because that's always been my interest, and it's probably rather a technical thing, but different ways and different timings. Because when we had radium needles, they were made, they were ... radium is mined with a half-life of 1500 years and you can't change its activity of course. But with the iridium wires, the activity depended entirely upon the length of time you leave it in the atomic pile that renders it radioactive. So you could have very active wires and you could therefore treat the patients in two or three days instead of seven or eight days, and give the same dose of radiation. And it then became necessary to know whether, biologically, these shorter treatment times were equivalent to the traditional longer treatment times of around a week which, say, Sir Stanford Cade or Sir Brian Windeyer would have, would have used and the Manchester school devised before the war. And we found that on the whole, we did a rather large study on that in France and in England actually, mainly in France, and found that you could treat in much shorter treatment times with the same biological effect and the same advantage of sparing normal tissues and killing tumour cells. So that, I think, helped patients a bit in that they had

to have these unpleasant needles, wires and plastic tubes in their mouths and skin for a shorter time.

GW Yes. And then, has adjuvant therapy helped in developing these techniques?

CP It has enormously. I mean, I've never been, I haven't really sort of followed with my original interest in medical oncology, because of course a whole new science of medical oncology has really developed now. And I became very much a radiotherapist when I first qualified, and my first sort of ten, fifteen or twenty years were almost entirely radiotherapy. And we now have of course, in Oxford, I'm glad to say a considerable medical oncology enterprise in the ICRF [Imperial Cancer Research Fund] Unit which I'm glad to say that I managed to foster when I was general manager years later. But, you know, we have experts there who know much more about that than I do. Although I do think that clinical oncologists, as radiotherapists now call themselves, I mean they on the whole do have good training in both – medical oncology and radiation oncology. And on the whole, nation-wide, because of their numbers, they are going to be the people that will mostly advise patients about this.

GW Your current... When did you come back to Oxford?

CP Well I came back, I haven't been away very much I'm afraid! I went away to France for a short time, I went to The Hammersmith for a short time, otherwise when I came back I was registrar, senior registrar in Oxford with Frank [Ellis], and then Frank, when Frank retired in 1970 I became consultant and stayed there.

GW In the Churchill?

CP Yes, and stayed there as consultant, clinical oncologist, until I retired myself two or three years ago.

GW Yes. But you've done other work in Oxford, quite a bit, I mean apart from becoming officially a lecturer in radiotherapy and so on.

CP Yes, I think the lecturer in radiotherapy was, is a bit of a name really. We always had students I'm glad to say, we had them regularly attached, 6 students in our unit much of the year, and I think they enjoyed it. It was a...

GW Mainly British?

CP Oh yes, medical students from the, from the medical school, yes. Yes, I mean, I never did very much outside radiotherapy except that for a time Rosemary Rue told me I was to do something else and I became district clinical tutor. And all I remember about that was that I signed the section 63 attendance records(?) for general practitioners who attended lectures, but I don't think that was a very onerous job. But then I became director of clinical studies in the medical school, and dean of that, and that was a fascinating time. I was rather reluctant to take it on because I thought I wouldn't have time to do it, but in the end my colleagues were extremely kind and did some of my clinical work then, and I continued with the rest of it.

GW What did that involve?

CP Well, it's really the clinical dean, in charge of the 300 students we had on the campus and 100 new students a year in the clinical school.

GW And did that extend to the end of the pre-registration year?

CP No, it extended only to qualification, but it was interesting. Half of the students came from Oxford colleges – the Oxford pre-clinical course in other words – and the other half came from mainly Cambridge but a scattering from all around the world really. And it was quite an interesting getting together, I think unlike many medical schools where most of the pre-clinical students go on to do clinical studies in the same place. Not in Cambridge, but in most other places. Here we do have this mixover, changeover at that point, which I thought was really very good for people really.

GW This must have been at a time when this was developing very strongly in Oxford.

CP Yes. Well the clinical school was already developed strongly, I mean John Ledingham was my predecessor, he did a marvellous job in building it up and actually he went back to doing it later on – he's a glutton for punishment, of course, John! And, but he left it in a very good state, but the only thing, the only way it was not in a good state was at that time we were being told by the University Grants Committee as it then was that we'd got to take 100 new students a year. And John had succeeded in always taking less, he said 'We must take as few as possible, Chris, because then they'll get much better teaching.' So he said 'If you go one over 90 you'll have done a bad job.' Anyway, in the first year that I was appointed that was fine; I think we had about 95 and he thought I'd slightly gone too far. And then the next year the UGC suddenly realised what was happening in Oxford and they said 'We shall remove one per cent of your grant for every student less than 100 that you take in.' So, I absolutely had to take 100, and not 101, because that would have spread the money a bit more thinly because the colleges all wanted their share. And so that was an abrupt change and I had to recruit... I think I can say at this length of time afterwards the final student, student was recruited on the hills of Exmoor when she came to be interviewed about the day before the deciding date! But on the whole, you know, we've ... ever since we've had to take the number they say.

GW Well, that administrative or largely administrative experience, did that lead to the Health Authority appointment?

CP I suppose it did. I mean, I always enjoyed the deanship very much indeed, because I think there one was dealing mainly with students and they would all come and complain about the professor of surgery, and say that he thought they, you know, weren't treating them properly. And I enjoyed that enormously. When I, I think the Health Authority work was much more arduous. I mean, I came into that through having been on the management board as it then was, as a member of the district management team because I was dean. And so then Mrs Thatcher and Sir Roy Griffiths introduced general management into the health service. And I ... the new chairman, Mrs Caroline Miles, who became chairman of the authority in succession to Lady McCarthy(?) because the politics changed, I knew her because she and I had



worked in St Luke's Nursing Home in Latimer Road and got that through some financial difficulties. I mean Mrs Miles did, not me, but I worked with her at it. And, so we knew one another, and she rang me up one evening and she said 'You'll never know what's happened Chris, I'm going to be the, your new chairman of the health authority', and she said 'I do need to know much more about it.' So obviously we talked quite a bit then, and then she said 'Have you, have you thought whether you might be the general manager?' And I said 'No Caroline, it's never crossed my mind,' and she said 'Well, you know, they want to have doctors in it, don't you think [they] should? Because you've had some management experience – you've managed your farm and the medical students and the radiotherapy.' I was in charge of the radiotherapy department then. And so, the long and short of it was that, and I knew Rosemary Rue reasonably well, and I went to see Rosemary and said 'Should I do it?' And she said 'Well, I think it may be all right,' or something! And so that's what happened!

GW You don't regret it?

CP No, I don't... Well, it is a thing of mixed retrospective feelings, I suppose. I mean, it was an extremely exciting time. I really enjoyed many of the new things that I was able to learn and do then. I mean I, for instance, one was immediately involved in a crisis affecting mentally handicapped people, now of course people with learning disabilities. We were trying to, we were, under a government initiative of that time, moving them out of the very Dickensian, terrible, run-down slum hospitals like Bradwell Grove, which was just wartime huts, into purpose built houses in, dotted around Oxfordshire. I think there were eight or nine of them. They were Rosemary's, Rosemary [Rue] had found the money to do it, it was ten or twenty million pounds I think, and it was our job to do this within Oxfordshire. So I found that kind of thing extremely interesting.

GW Was Kitt Anstead(?) involved in this at all?

CP No, he wasn't really, no, no. He was child psychiatry, wasn't he, more, rather... This was adult mental handicap, which were the people who were being moved out then. But I found that interesting and I found that going around the county to the various hospitals that there were, Banbury and the Oxford hospitals, seeing what happened with district nurses and health visitors in the community ... none of which I knew anything about before, I mean it was all interesting stuff. And, but very hard work because we were always on the end of some terrible argument or publicity scandal or another, and I found myself permanently in the front line there from the... You know, we had a, one or two very difficult cases and things, scares to do with cervical smears and every kind of thing while I was there and so I really learnt to deal with that.

GW You were telling me earlier, before we came on camera, about the dialysis problem in which you were plunged into the media world.

CP Yes, well that was the, that was one of the first ... that was about three days after I became general manager. Our renal physician, Des Oliver, came to see me and said 'Oh, we're going to turn off a patient from dialysis and I thought you'd better know because there's going to be some publicity.' And so I said 'Well, thank you very

much Des, do you want to tell me any more?' He said 'Yes, he was, he's been dialysed for some years now, but he is now [of] gradually declining mental ability, incontinent, and goes round in the dialysis unit pulling the tubes out of the other patients. And we can't, just can't do it any more. And he's now got [to] such a low level, though he was quite a high intellectual man at one time.' So I said 'Well, that's fine', and I said 'You must do what you think and we shall support you.' And so, after about 24 hours, the first press call arrived because somebody had discovered that having been dialysed the previous Friday he was not ever going to be dialysed again and, therefore, he was going to be dead within a few days. And it built up enormously and we had all of the press, the national press round here, it was on all the television channels, I was interviewed. Well I was told by the press officers 'Now are you prepared, Dr Paine, to be interviewed on this case by the television? You've been interviewed before I suppose?' And I said, 'No, I haven't actually.' And they said 'Oh Lord alive, well there's no time for any training. Well, have you seen Mrs Thatcher on television?' And I said 'No, I'm afraid to say we haven't got a television.' And really the poor fellow didn't know what to say and he said 'Well, just sit down, sit on the front of your chair, and say what you, say it as though you meant it.' And so I sat on the front of my chair and said what the circumstances were, as I have just said. And the television and press all scribbled away furiously in their notebooks. And I was seen on the television by John Badenoch who was in China and somebody else in America, and I had a telegram from the Right to Life Association in Melbourne saying 'You're a filthy Nazi assassin.' And that was one of many sort of very vindictive, difficult things. It didn't matter to me much, but it was much worse for the renal unit.

GW Indeed.

CP And in fact the Sister in charge had a nervous breakdown, several of the staff left. There was real difficulty for a long time.

GW It's always a very difficult nursing problem anyway, isn't it?

CP Yes.

GW I mean, they're under great pressure.

CP And the pressure at the windows, you know, with their cameras; it was all most unpleasant. And so that was my first brush with the press, and...

GW And that was the very beginning for you!

CP Yes, well, and two or three days later we had another one because Rivermead Rehabilitation Centre for young people, mainly with brain stem and brain injuries after accidents, we closed a few beds in that. I've forgotten exactly why we wanted to close them, to save money I suppose, and that was picketed and we had, you know, the same again and...! They were exciting times and I learnt a lot.

GW How long did you do that?

CP Three years.

GW Three years, yes.

CP I was appointed for three years, and after three years I didn't, really I wanted to go back to medicine as a matter of fact. And it was, it was a long, it was a very arduous job; I mean I started, I got in every morning about seven and I never got home before seven or eight at night. And I would like to say that, you know, all of the administrative staff in that district health authority headquarters worked just as hard as I did. It was quite amazing how, you know, how they would, how hard they worked and got really no credit for it at all, just criticism from our colleagues and others...

GW And yet, I think Oxford tended to have a better reputation than most.

CP I think the Health Authority had quite a good reputation. I mean, we had a lot of good public debates in the Health Authority. And I always thought that the Health Authority as it was then – with the local health, local authority people on it and quite a wide, and public debates every month – I mean I thought that that was quite a good thing. I was sad to see that go when the, when the new trusts came, actually.

GW Were you living in Oxford then, or...?

CP We lived at Watlington for 25 years, so fifteen miles out. It was actually, we lived there because I also did the radiotherapy at High Wycombe as I think I said earlier on and it was sort of half, well it wasn't half way but a little way up there.

GW And you were able to maintain that, throughout this period?

CP Oh yes, I lived there all the...

GW It must have been a very tough life indeed.

CP Well, I think it was in a way tougher when I was a junior doctor because I sometimes had to come in at night and so on. I never came in in the middle of the night with the Health Authority, just dreamt about it!

GW Yes, it must have interfered with your dreams!

CP Well I think it did a bit, yes!

GW The, how do you see the future of, oncology to start with in the... Do you see that the, I mean, do you feel it's being developed? New drugs of course are always coming in sight, but they are in a way I suppose mainly applicable, fresh ways of approaching a problem by molecular readjustment or whatever.

CP Well I hope there will be. I think just at the moment, as we sit here today, the only drugs we've got are only marginally better than those drugs that were available when I was a medical student actually. I mean the same kinds of cytotoxic drugs are being used, they are being used in slightly more effective combinations, but they're not helping in the treatment of the big killers like lung cancer and breast cancer and ovarian cancer that much. And I think radiation, the same; radiation can be used, it

can cure some small numbers of early tumours in particular sites, but the big killers of people by cancer are not touched by the radiation or by drug treatment. And I think the position of surgery hasn't advanced that much. I mean, one can do radical surgery much better now by means of the new technology that they have, with free grafts for reconstruction and with endoscopic surgery and all this sort of thing. But it hasn't really altered the game that much for the big killers. I do however think that over the next ten, twenty or thirty years – probably better take a nought off because things are expanding so rapidly – that with the new, when molecular medicine really comes into its own, I think there probably will be whole new varieties of drugs developed here which will be much more effective and much more targeted against particular cancers. That must be the hope, I think.

GW And problems of carcinogenesis are likely to be better understood.

CP Yes, I think they may be. And maybe – we were talking about this beforehand a bit – but I mean maybe public education and health changes so that cancer can be avoided. I mean, it is one of the, one of the targets in the Health of the Nation, to reduce some cancers. And, you know, there's no doubt at all that sunlight and skin cancer, smoking and lung cancer – there are changes in habit there that can improve the incidence of cancers if the message can be got through.

GW Yes, this is an interesting one, just thinking of the skin cancer. We were talking about what you could do to change peoples' attitudes before we came on camera. In Australia and countries with a lot of sun exposure, people really do seem to have got the message.

CP They do.

GW The most ordinary people will be hat-conscious, and so on.

CP Yes, yes. Well, we have a daughter and grandchildren in Australia, so I've been able to watch that at work... But I think that the general population there are much more conscious of sun damage to skin. And in particular I think that a lot of this was because, partly because of very good research done in Queensland with malignant melanoma where it was demonstrated how rapidly the incidence was rising. But of course it's also rising very rapidly here and that message is being got through, I think, to some extent, and one can only hope that it will be more, because it is a preventable disease.

GW The public tends to be rather scoffing about diminution of the ozone layer and the, and the risks that this may impose, and climate warming and so on. The time-scale is too difficult for most people to grasp.

CP Well, it is difficult, and I think none of us really quite believe that the scientists really know what they are saying about this, they don't know what the end... It's a bit like diet. We really don't know – we were discussing this beforehand too – we don't know really what foods you should be eating and what you shouldn't be eating. We have certain views at the moment, they're different to what they were ten years ago in certain respects, and they'll probably be different again in twenty years time. So, I think there is an absence of basic knowledge here which, you know, we can only

hope, and I'm sure with the passing of further science and understanding we shall know more.

GW Would you agree that in our educational system, and particularly in secondary education, that we're still woefully inadequate in teaching people about their own bodies? I mean, human reproduction is virtually, I mean other than sex education, is simply not understood at all.

CP It is very odd isn't it? I mean, there's a remarkable difference between Americans and ourselves, or at least I perceive that difference. Whether it's real or not I am not quite sure, but the Americans one talks to or meets here or in New York or somewhere mostly seem to understand more or less how the system, how their system works. They have a much better knowledge of it. The English almost seem not to want to know. I mean that you have to, of course people must do what they want. I mean, I had a very interesting thing a few weeks ago; a great friend of ours died of a very unpleasant kind of uterine leiomyosarcoma which she'd actually had for ten or fifteen years. But when it finally spread and was obviously going to be fatal during the last two years of her life, she absolutely didn't want to discuss it or know anything about it. She wanted to live a normal life without being told things by the doctors the whole time and her criticism is, and remained to the day she died, that she was always told far too much and against her will. And, in a way, perhaps that reflects the English view, the view of some English people about what they want to know about medicine and their health. They sometimes don't want to discuss things.

GW I think my impression is that the Americans want to know all this, and I'm not sure that when they get the information that they are any more pleased to have it.

CP No, no. Well you, you may well be right there. And there's the difference between knowing something when you're perfectly well and knowing something which is very bad news when you're actually suffering from it.

GW Yes, yes. Well, just rather jumping to, back to your other interests, and this is in regard to the Health Service, we've been going through an extremely difficult time. We're never not going through a difficult time. But how do you see this becoming more – what can I say? – more patient-orientated and more ... perhaps a better medical, or health professional interest, input into the problems of health?

CP Into the problems of managing the Health Service?

GW Into managing the Health Service, yes.

CP It is a very difficult one. I mean, I think that the reforms that Mrs Thatcher brought in, first of all general management and then the purchaser and provider mechanism, which is actually rather after my time ... I mean one could see why both things were done. And I think they did have some advantages, particularly I think hospitals had got into a fairly idle way of looking at what they did and looking at the use of their buildings and all that kind of thing. That wasn't new, it had been going on a long time, and I think it really crystallised the thoughts quite a bit. But I think it's had many downsides. I mean, I think that it has introduced competition, perhaps particularly between doctors and good units, that actually has been rather destructive

rather than bringing together and making the most of advantages. I mean, I've seen that I think in Oxford, where now there are two alternative and competitive ways in which you can have your back attended to – either by the neurosurgeons or by the Nuffield Orthopaedic Centre. That's common in other parts of the country too, that particular competition. And I don't know that it's been, it's been, even resulted in acrimonious correspondence in the local newspapers. And I don't think that does patients much good, because they can see people who should be caring for them arguing about things that really are not satisfactory. And I think that to have, we now have I think eight or ten trusts in Oxfordshire whereas we had one health authority before and that health authority had, more or less, the power to oversee what was going on, and so did the regional health authority above it. And I think the loss of that has meant there is no real body now overseeing what is, what is the health need of the population, trying to assess like Rosemary Rue was able to do what were the things she could do that would improve things that were clearly unsatisfactory, and do something about it. She was able to do that in the fifteen or twenty years of the regional health authority, and I think that has now been lost. And I think that the new government may have to think about putting some sort of layer of that sort back again.

GW Yes, I mean that stimulus to evolution has to come from somewhere.

CP Yes, I think it does, and as we were also saying before in the matter of training, you know, training has fallen between all of the stools really. And so has medical science, because medical scientists, you know, find themselves in difficulties with university funding and difficulties of the NHS. And they're not protected in the way that they were before when the regional health authority held a number of strings there and could facilitate good work, good units and good progress, for the benefit of patients.

GW And of course academic medicine has been particularly badly hit, hasn't it?

CP Yes, well that was really what I meant when I said medical science, although the scientists themselves, but also the academics working in medicine have... I mean, having said that, there is Oxford where, led now by David Weatherall, we have marvellous developments and lots of people want to come here, thank goodness, and do good work and so they do to other places. So it hasn't been entirely lost, we are...

GW No, but it is threatened rather severely.

CP Yes, it's threatened.

GW One fears that it will get to a level at which it will be very difficult to recover.

CP Yes, I think that's true, and I think it's also even more dependent upon grant and outside funding than it used to be perhaps. And, you know, whether people should be spending all their time looking for money when they ought to be getting on with the good work I'm not sure.

GW We've both been considerably concerned with the Royal Society of Medicine. I get the impression that the Royal Society of Medicine today is rising to the challenges very well, and that this is really making a major contribution to this discussion of

these problems. Problems of ... clinical problems as well but also these more administrative and political problems.

CP Yes I think it is. I mean, I think many of the things you did in the Royal Society of Medicine when you were there yourself have stood in good stead. I think the sections of the individual medical specialists, specialisms are working well together. I think the development of the academic department – now under Adrian Marsden(?), previously Paul Turner – has been very good at bringing some of the section meetings together, because I think our problem in medicine is not so much having individual specialists now as trying to bring the different ones together. That has been good. And I think the development of the forum system, whereby people who are not medical can come together with medical people and have general discussions, all that's been fine. That was nothing to do with me, it was already going. And I think that the conferences the RSM's organising, whether it be on the medical aspects of terrorism or genetic engineering in food production, which were two recent ones, things like that are well attended and obviously of great interest to people. So I think that's been good. And I'm, I very much hope that later this summer the restructuring of the RSM, which is taking place because our council is now so large, is going to allow development which you I know put forward, in other words to have an academic board in charge of the whole thing. And it looks as though that is now, touch wood, gaining favour.

GW Yes, there's a time for everything, I suppose! I was the wrong time. But it was really that people... They hungered for such a body and then weren't prepared to give the time to it. Maybe they'll be under greater pressure to do so now.

CP Well let's hope so, but it will need to be carefully supported by, you know, my successors over the first two years I think.

GW Yes, and it does need the infrastructure. They have to be aware that meetings are going to be held, when and where they [are], and so on.

CP Yes. Well, I think that all that will be...

GW It must be.

CP ...that will certainly be done. It has a better chance now because we now have the academic department to underpin it, which you didn't have at that time, and I very much hope that that will help it along.

GW Do, are any of your family going into medicine?

CP No, no. We have four children. Three of them are in commerce and so on. The other one actually – Alice, our youngest daughter – is interested in medical things. She's not medically qualified, she was at London University but is now actually the administrator of the accident and emergency department at Milton Keynes. So, she has... And she worked as assistant secretary of the CHC [Community Health Council] in Buckinghamshire, dealing with the patients' complaints beforehand, so...

GW Very interesting! That must give you an input; I mean you must supply a lot of

information.

CP Oh she, well, I don't think she would like that to be said!

GW That aside, would you, if you had a child now wishing to do medicine, would you feel happy about it?

CP I'd feel very happy about it because I've always felt, and I think it's fairly obvious, that medicine's an enormous wide profession. And you can be a manager, you can be a scientist, you can be a doctor with patients or a doctor who doesn't see patients – a pathologist or someone. All these possibilities are there. It's a very interesting life. I've had a very interesting life certainly. And you can change, as I've been able to do, what you do a little bit as you go along. And all that I've found fascinating and I don't see why it should be any different in the next fifty years, compared with the last thirty or forty.

GW It is true that when you qualify in medicine nearly everything is still open, isn't it? Nearly every other career that you can think of.

CP Yes, it is. You can even become a politician, like Dr David Owen, or something.

GW Well, maybe that will, has now become a good thing!

CP Well I... Yes.

GW Well, I think I've exhausted my questions – are there some, anything you feel about your own experience and life that you feel would, you'd like to put on the record?

CP Well, I've enjoyed what I have done all the time. I mean, I do feel that it's always better to be busy, and the advice I always have given, if asked, to younger people is if you get any kind of challenge offered to you for heavens sake take it, because things come up. And even when I was quite undecided whether to be dean or not, I mean, I went to see David Weatherall and he said 'I think it would be a good thing if you did it.' And I said 'I don't think I can,' and then I realised that perhaps it could be fitted in. And then again when I came to be general manager it was a very arduous job. But I think one should take opportunities, and I think those arise in medicine. And that's what I hope, you know, any successors of mine would do.

GW I think I was very disappointed at the beginning of the war when my own contemporaries, many of my own contemporaries didn't want the experience. I mean, nobody wanted to go into the army, or whatever, but having been made to go in it was possible to find all sorts of interesting things to do. And some of them could think of absolutely nothing else but opting out. I always felt that that was a very great mistake.

CP Well I think it is a great mistake. And I think what is also sad is to see, I mean, we went through this particularly three or four years ago in the whole profession, how negative people can be. I think that it may not be a good thing to have trusts, it may not be a good thing to do this or do that, but if you go to the extent of advertising in surgeries against reforms I think that's very negative. And I think we should always



try, as a profession, to see what a thing... If the government are going to do a certain change, and no doubt this one will make some changes like the last one did, then we have to try and make the best of them, and learn what are the good things and mould the thing rather than just being thoroughly negative about it. That's my strongly held view.

GW Just one other point. You went to France, which is unusual, to have part of your training at an early stage. Have you kept any international links in your...

CP Yes, I mean not enormously – I've never been to the States a great deal, I went out there for a short time when I was young too but I've never been back very much. But I've kept in close touch with French colleagues in radiotherapy. And we've done research together over the years, and I know several of the people who've worked, mostly now retired, from the Institut Gustave Roussy, but I know their successors very well indeed. And it's been a marvellous thing and I really enjoyed that, and so did my wife. And, you know, we had a house out there and really became part of the French fraternity, and we've kept in touch on an off ever since, yes.

GW So you would agree we have much to give each other, really?

CP Oh I would. I mean, well, you know, you're not asking me about the deeper questions of the community, we've fought of course many European nationals for thousands of years. But I think that we also have a different way of looking at things, and medicine is one of them, which can only be helpful.

GW Well Chris, I am most grateful to you. It's very good of you to come and submit yourself to this, and I hope that you won't think afterwards of other things that you wish you had said! I am very grateful for what you have said and I would like to thank you most warmly.

CP Well I'm very grateful to you for asking me, and I've enjoyed the spotlight and I'm afraid that, you know, I've, probably my red face, which is off the hills of Exmoor, may look rather puce, but I've enjoyed it enormously Gordon! Thank you very much.

GW We'll just envy you for that! Thank you.